NHS
Yorkshire and the Humber

Yorkshire and the Humber LSA Annual Report to the Nursing and Midwifery Council

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1 April 2007 – 31 March 2008

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September 2008

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This report format fulfills the Nursing and Midwifery Council guidance for the 2007 – 08 Local Supervising Authority (LSA) annual report submission and evidences achievement of the 53 standards within the NMC (2004) "*Midwives rules and standards*". The report is authored by the LSA Midwifery Officer and signed off by the Chief Executive of the Yorkshire and the Humber LSA. The report is in the public domain and its distribution is described.

Context
NHS Yorkshire and the Humber is the fourth largest Strategic Health Authority (SHA) in the UK. It is a high achieving SHA and LSA. It was risk assessed on the 2006 – 07 LSA annual reports as the joint-lowest risk scoring in the UK. Further it had comparatively good 2006 - 07 annual health ratings and reviews of its maternity services by the Healthcare Commission in 2007. The implementation of *Maternity Matters* and NHS Yorkshire and the Humber *Healthy Ambitions* (Next Stage Review) are high priority initiatives and the report outlines the key recommendations to enhance the care to mothers and babies over the next 10 years.

The region is near the bottom of the English prosperity table with 29.6% of the region falling within the country's 20% most deprived. It has a number of 'spearhead areas' with a complexity of case mix. Wide variations in health status across the region and even within individual Primary Care Trusts (PCTs) areas are noted and key health improvement activities include reducing the rates of smoking in pregnancy, encouraging more breastfeeding and ensuring that women, especially those from vulnerable groups, have better access to high quality antenatal services.

Birth trends and service impact
The 63,894 births in Yorkshire and the Humber represent a tenth of the births in England. According to Office for National Statistics (ONS) data a growth of 13.2% births over recent years, was higher than the national average and the third highest growth in England. Antenatal bookings increased by 1.6% in the last year and 9.5% from 2 years ago. Births increased by 3% this last year.

Many of the maternity outcomes for the 63,894 women who gave birth in the Yorkshire and the Humber compare favourably against the Information Centre (2007) 2005-06 Maternity HES bulletin[1]. The home birth rate increased to 2.4%. The unassisted birth rate is 9% higher than the national rate. A reduced elective caesarean section rate is noted and the emergency caesarean section and induced labour rates are all lower than nationally. However, the breastfeeding initiation rate only increased marginally to 61.6%, but is lower than the national rate, with large variations across Trusts. One-to-one care in labour data could not be provided by all Trusts. Raw data from all Trusts is provided in the appendices.

[1] Maternity HES bulletin accessible at http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/maternity

Increased clinical activity has impacted upon maternity services. The reports of temporary suspensions of home birth services, or women being diverted to an alternative maternity unit are outlined and are incorporated within the SHA governance.

The range of midwife to birth ratios varies widely, with 8 of the 14 Trusts having ratios worse than the average rate within the Healthcare Commission maternity review. 7 of the 8 Trusts' ratios have worsened. A recommendation within *Health Ambitions* is that the *Safer Childbirth* workforce recommendations be implemented. Within the 2008-09 practice year some investment in midwifery staffing has been noted, with LSA Midwifery Officer engagement with commissioners much increased this year.

Supervisors of midwives

There were 194 supervisors of midwives practising on 20th March 2008, with many being clinical midwives. This represents a 4% decrease from the previous practice year. Trends in the appointment of supervisors, "time-out", resignations and retirements are provided. Appointments are almost half those of the previous year and resignations continue to rise above the last two practice years, being double the two earlier practice years. Reasons for resignations include difficulties balancing the commitments of a substantive post and supervisory activities and some lack of recognition of supervision. Increased levels of clinical activity have challenged the capacity for leadership development of supervisors over the last year and will be a priority this year.

There were no removals of supervisors, but an allegation that was made against a supervisor's supervisory practice was upheld. The supervisor subsequently stood down and undertook some supervisory developmental.

A ratio of 1 supervisor to 15 midwives supports the protection of the public by promoting best midwifery practice, preventing poor practice and intervening in unacceptable practice. 12 of the 14 Trusts within the LSA had ratios of supervisors to midwives better than the NMC 1:15 standard. The other 2 Trusts are also now compliant. Ratios ranged from 7 – 16 which represents an improvement from last year. Where supervisors are integral to the clinical governance within their employing organisations excellent standards ensue. This has been demonstrated with a100% achievement across all pilot Clinical Negligence Scheme for Trusts standards within a maternity unit locally.

Supervisors have engaged in LSA-facilitated working groups and educational forums. This optimises the sharing of best practice and patient safety initiatives to enhance midwifery and supervisory standards. It also assists supervisors to meet their NMC (2006) continuing professional development requirement. The report will outline the robust LSA communication systems and the integration of the LSA Midwifery Officer role within the SHA. Examples of good midwifery and supervisory practice and innovations and contact details are included.

9 new Yorkshire and the Humber LSA guidelines were produced and distributed this year and the LSAMO contributed to the development of 5 new LSA National Forum (UK) guidelines for supervisors of midwives[2].

Midwifery and supervisory practice

2581 midwives notified their 2008 – 2009 Intention to practise form (ITP) to the LSA office by March 2008, with the exception of new starters being given a choice of supervisor. Systems for contacting a supervisor of midwives are outlined. Some Trusts have a dedicated "Supervisors of midwives" office. All Trusts have a Contact supervisor who fulfills the role within the LSA National Forum UK guideline[3].

At 20th March 2008 almost 10% of the midwives practising in Yorkshire and the Humber were aged 55 years and above. There is under representation in some Black and Minority Ethnic (BME) groups, with certain parts of the region needing to explore more fully the composition of their local population and the staff they have in place to work effectively with their mothers and families. Part time and flexible working is a great retention aid in the maternity workforce but that it also presents challenges. For every 1 qualified full time post, it requires the education and employment of 1.26 midwives and for every non-registered full time post, it requires the employment of 1.36. This may increase in future and has to be taken into account when commissioning education.

LSA, supervisory and midwifery standards were audited at the LSA audit visits to all Trusts. The schedule of LSA audits is presented in the report, evidencing service user involvement. As in previous years, data quality from Trusts remains a concern to the LSA office. It also featured in the Healthcare Commission's maternity review and the King's Fund. LSA recommendations to 9 Trusts reflected concerns regarding clinical activity and staffing issues. 8 Trusts were requested to improve either their rates of, or their data collection of one to one care in labour; to enhance the birthing environment to be less clinical and to increase the focus on normality and non-interventionist care. Much continuing professional development has focused on mandatory updating this year.

The majority of the 469 midwives who completed a LSA questionnaire evidence positive, engaging relationships with supervisors. Midwives view supervisors as supportive, clinical champions and role-models. Numerous examples of supervision improving care to women and enhancing midwifery practice are also provided at the audit visits. Best practice is often shared at LSA facilitated events and within the monthly electronic LSA Briefing. It is disappointing to report again that the main challenges to effective supervision are a lack of protected time and administrative support, but also increasing clinical and supervisory activity. Almost half of the 104 supervisors who

[2] LSA National Forum (UK) and the Yorkshire and the Humber guidelines for supervisors of midwives are published on the SHA website at: http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/

[3] See footnote 2

responded stated that they do not get protected time. The 54 who in theory get protected time, forego it to support colleagues with clinical activity.

LSA activities

The LSA database purchased to upload ITPs directly to the NMC and other notifications to the LSA, has optimised LSA office and supervisory time, data governance and consistent approaches to supervisory functions. Training, LSA support and quality assurance have embedded it into supervisory and LSA practice this year. LSA database reports have been incorporated within the LSA audit tool for the 2008 - 09 practice year.

The involvement of the LSA Midwifery Officer with the 7 of the 10 Universities that provide midwifery education is described. The outcomes of the 2 supervisors' preparation programmes at the Universities of Leeds and Sheffield are outlined. Challenges to the preparation and appointment of supervisors are the time commitment to the NMC-prescribed structured learning practice hours and applying the NMC mentor criteria, although this has eased with the recently published updated criteria.

Joint-working with the SHA workforce development department has principally been with regard to Return to Practice programmes, workforce trends and liaison in relation to the successful Graduate employment schemes to support newly qualified midwives into midwifery employment. The decrease in RTP enquiries during the report year is outlined, but a 3-fold increase is noted in the first quarter of the 2008 - 09. 3 midwives are currently on RTP programmes. The SHA stance to the national support for RTP midwives can be found on the SHA web-site[4].

The 4 appointed Link supervisors optimise consistency of supervisory approach, advice and guidance in the LSA. Their contact details and those of the LSA are published in each monthly electronic LSA Briefing.

Incidents and investigations

88 issues were reported to the LSA of which 21 were serious untoward incidents (SUIs). This represents a reduction of 5 from the previous year.

27 supervisory investigations were undertaken, an increase of 8 this year. Reasons for the increase are explored. Work during 2008 – 09 will further quality assure supervisory activities and the reasons for variations in supervisory investigations across Trusts. 2 supervisory investigations were undertaken resulting from service user referrals directly to the LSA Midwifery Officer. The allegations were upheld in 1 investigation.

Of the 27 investigation, 8 midwives successfully undertook supervised practice successfully. However 2 were unsuccessful and were referred to the

[4] SHA stance to the national support for RTP midwives can be found on the SHA web-site at http://www.yorksandhumber.nhs.uk/what_we_do/workforce_education_and_training/education_and_training/return_to_practice/

NMC as per process. 16 midwives required developmental support and 15 had reflection with their named supervisor. Incident themes and potential solutions are described.

The LSA conducted 4 investigations which resulted in 2 NMC referrals in 2007-08 and 1 NMC referral in 2008-09. The other LSA investigation resulted from a serious concern about a midwife's health, but she subsequently recognised her ill health and complied with treatment.

The LSAMO successfully bid for a 0.8 wte LSA Midwife secondment for a year. This will support further implementation of the LSA roles and responsibilities within Maternity Matters. The post commenced in July 2008 and it will be evaluated in the 2008-09 LSA annual report.

Progress with LSA 2007-08 priorities are outlined and new priorities for 2008-09 include supporting supervisors in implementing *Healthy Ambitions,* further enhancing the quality assurance and leadership development of the supervisors in Yorkshire and the Humber, exploring IT solutions to support supervisory workload and further analysis and publication nationally of key Yorkshire and the Humber LSA data for the benefit of women, babies, midwives and supervisors.

Conclusion

This has been yet another extremely rewarding but challenging year for the LSA due to high midwifery, supervisory and LSA activity. Decreases in whole time equivalent midwives have continued despite increases in birth rates. Supervisory activity levels have been high as midwives have required and benefited from increased support and advice during service remodelling. The LSA Midwifery Officer and supervisors have, and will continue to increase the potential of women, babies and midwives through the proactive supervision of midwives.

Introduction

The LSA annual report

This report fulfils the guidance issued by the Nursing and Midwifery Council in a letter dated 2nd June 2008 entitled: *"Guidance for Local Supervising Authority annual report submission to the NMC for supervisory year 2007-08".*

A self assessment evidences achievement of the 53 standards within the NMC (2004) "*Midwives rules and standards*" (Appendix 1). Also, the NMC risk assessed this LSA as the joint-lowest risk scoring LSA in the UK from the 2006 – 07 annual reports submitted by the 16 UK LSAs. It has a risk profile of 15 (Appendix 2), a reduction from 23 last year benchmarked by the NMC within their Framework risk register key (Appendix 3).

The report will outline the many achievements and challenges of the 2007 – 08 practice year. LSAMO activities are provided throughout the text and within Appendices 4 and 17. The LSA priorities for 2008/09 are also outlined.

The Chief Executive Officer (CEO) of NHS Yorkshire and the Humber is Margaret Edwards and the LSAMO is Carol Paeglis. The LSAMO is full time and the LSA function is also supported by Elaine French, LSA Support Officer (1wte). Their contact details are: NHS Yorkshire and the Humber, Blenheim House, West One, Duncombe Street, Leeds, West Yorkshire, LS1 4PL. Telephone: 0113 2952000, Web-site: www.yorksandhumber.nhs.uk
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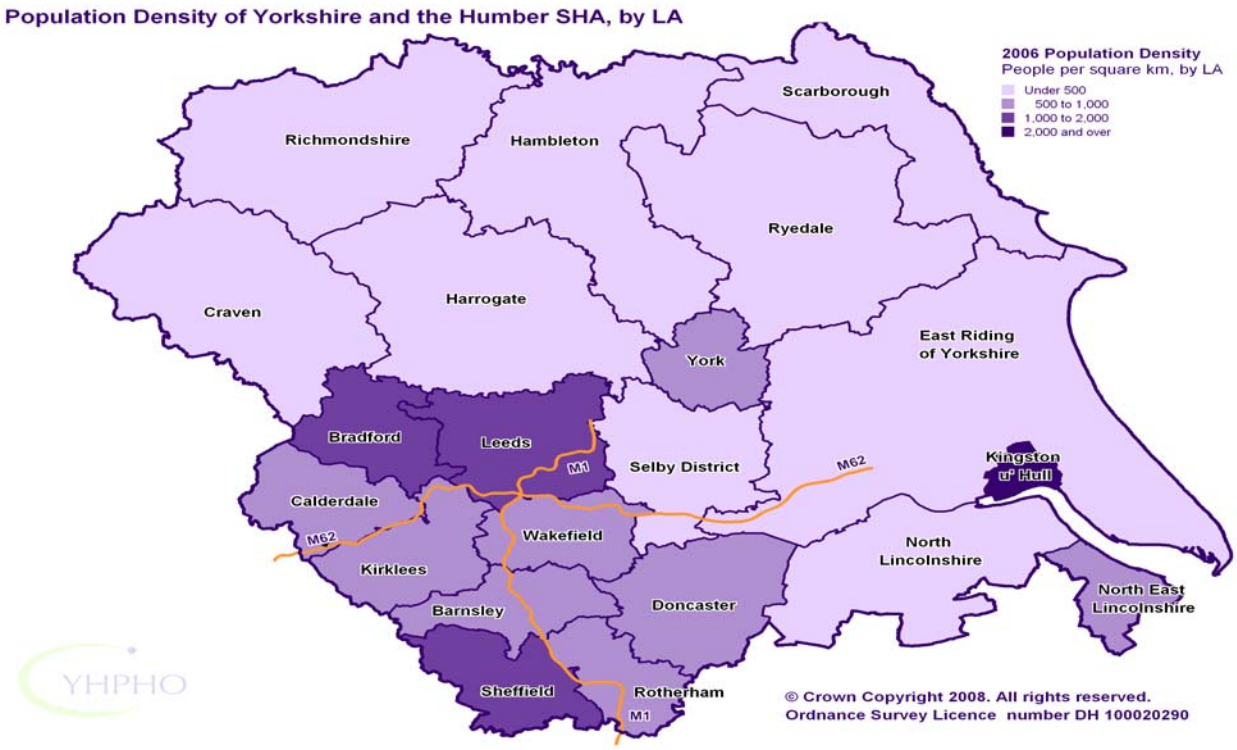
NHS Yorkshire and the Humber in context

NHS Yorkshire and the Humber is a high achieving Strategic Health Authority. The 2006 - 07 Healthcare Commission annual health ratings published in October 2007 indicated that NHS organisations across Yorkshire and the Humber were making steady progress in the quality and effectiveness of their healthcare services, with a tripling of the number of NHS organisations who scored excellent in all categories and more than half of the NHS organisations in Yorkshire and the Humber improving on their 2005 - 06 ratings.

More recently, the Healthcare Commission review of maternity services (January 2008) demonstrated that the overall scores for NHS Yorkshire and the Humber were good, with 11 services rated *"best performing*" and "*better performing*", one trust rated *"fair performing*" and only 2 rated as *"least well performing*. This compares favourably with other Strategic Health Authorities.

The implementation of Department of Health *Maternity Matters* is a priority and 10 year strategic framework for NHS Yorkshire and the Humber is within *Healthy Ambitions* (Next Stage Review)[5].

[5] *Healthy Ambitions* (Next Stage Review) accessible at: www.yorksandhumber.nhs.uk .



The context that Yorkshire and the Humber maternity services work within include:

- The 15,000 square mile SHA geography with areas of high and low population density raise challenges for our maternity services
- The region is near the bottom of the English prosperity table whilst also having some of the wealthiest communities in the country. The Index of Multiple Deprivation shows that 29.6% of all Super Output Areas (SOAs) in the region fall within the country's 20% most deprived – the third highest of the nine English government regions.
- The region has a number of 'spearhead areas' – Barnsley, Bradford, Doncaster, Hull, North East Lincolnshire, Rotherham and Wakefield.
- Parts of the region such as Hull have experienced large numbers of European economic migrants. This has had an unpredicted rise in the birth rate and in the complexity of case mix.
- the wide variations in health status across the region, even within individual PCT areas.
- The percentage of children in low income households, working age people in workless households without qualifications and the percentage of households experiencing fuel poverty are well above the national average.

  Regional data from Yorkshire and Humber Public Health Observatory
  http://www.yhpho.org.uk/viewResource.aspx?id=948

ONS birth projections and actual births

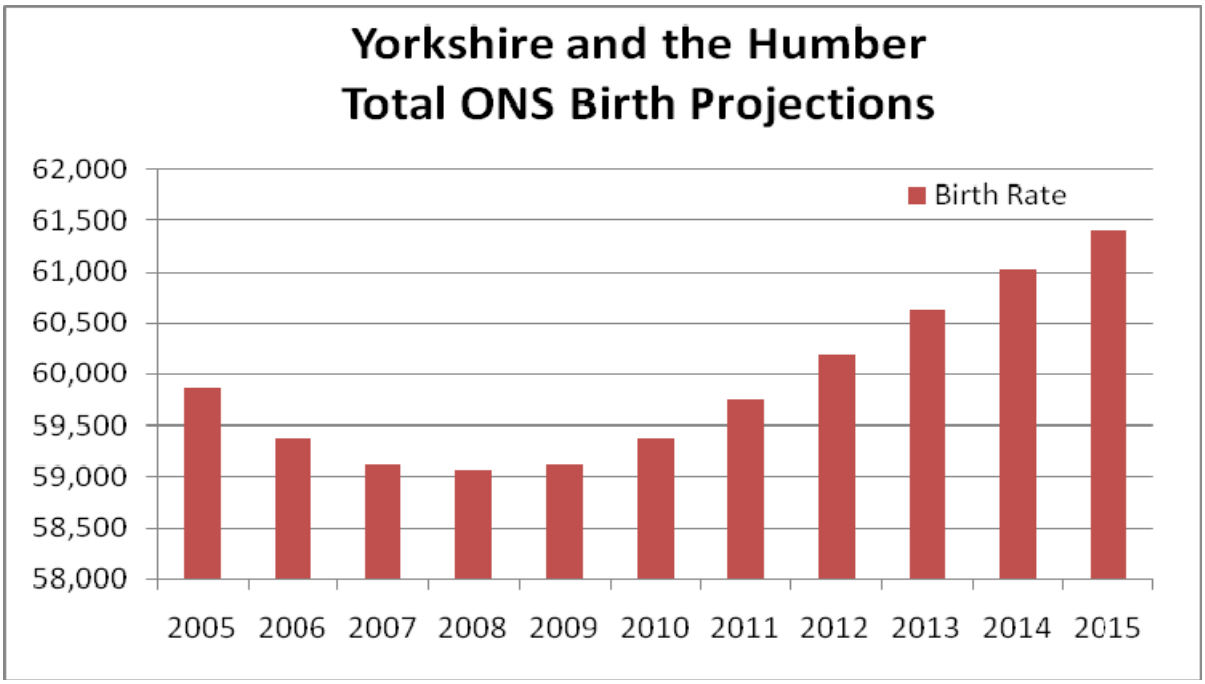
Table 1 below shows the 5 year growth in the birth rate in Yorkshire and the Humber using ONS data. Births reached the third highest position in England i.e. a 13.2% increase and higher than the national average.

Table 1

	No of Births						
	2001	2002	2003	2004	2005	2006	2001 - 2006 % increase
England	**563,744**	**565,709**	**589,851**	**607,184**	**613,028**	**635,748**	**12.8%**
North East SHA	25,949	26,271	27,005	27,815	28,249	29,184	12.5%
North West SHA	75,201	74,641	77,847	81,164	81,722	84,155	11.9%
Yorkshire & the Humber SHA	55,625	55,535	57,923	60,193	60,665	62,955	13.2%
East Midlands SHA	44,642	45,039	46,916	48,245	49,080	50,717	13.6%
West Midlands SHA	60,818	61,035	63,694	65,911	65,956	67,688	11.3%
East of England SHA	60,090	60,171	62,711	64,250	64,687	66,870	11.3%
London SHA	104,162	105,603	110,437	113,679	116,019	120,898	16.1%
South East Coast SHA and South Central SHA	88,510	88,082	91,842	93,634	93,921	98,566	11.4%
South West SHA	48,747	49,332	51,476	52,293	52,729	54,715	12.2%

ONS projections accessed in Autumn 2007 suggested that births across Yorkshire and the Humber from 2005 to 2008 would fall overall but then from 2008 to 2015 would rise quite steeply. This masked that in some areas, especially Bradford and Leeds, the rates were projected to increase steeply each year. However as will be expanded upon later, the actual births in Yorkshire and the Humber from 2005 have consistently increased and the 2007 - 08 births already equal those predicted by ONS for 2015. However updated ONS projections are now comparable with actual 2007-08 births.

Chart 1



The report format now follows NMC guidance.

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

The LSA report is available to the public via the Strategic Health Authority (SHA) website[6]. It is also presented to SHA Board meeting held in public. It is published electronically and in hard copy and presentations are offered to the Maternity Services Liaison Committees within the LSA. Copies are distributed to the NHS Yorkshire and the Humber Chief Executive and Board, to all Heads of Midwifery, Contact supervisors of midwives, Chief Executive and Directors of Nursing at each of the 14 Trusts and PCTs, and to the NMC to be made available to the public.

Last year a hard copy was made available to all supervisors of midwives and additional copies were requested from the Royal College of Midwives and the Healthcare Commission.

2. Numbers of supervisor of midwives appointments, resignations and removal

There were 194 supervisors of midwives practising within the Yorkshire and the Humber LSA on 20th March 2008 – see list in Appendix 5. This is 9 fewer than at the same time in the previous practice year i.e. a 4% decrease.

During the report year, 8 supervisors were newly appointed i.e. half the number appointed in the previous practice year; 1 was re-appointed; 20 resigned, 2 retired and 2 requested time out from supervision and were given the opportunity to 'step down' from supervisory duties. There were no removals of supervisors, but an allegation was made against a supervisors' supervisory practice. The supervisor was supported to continue to practice during the investigation. The allegation was upheld and the supervisor subsequently stood down whilst undertaking some supervisory developmental support.

Data on the number of supervisors of midwives newly appointed, resigned or removed for this and 4 previous years is detailed within Table 2. The number of appointments this year is almost half the previous year and resignations continue to rise above the last 2 years and are double the 2 earlier years. This trend seems unrelated to retirements which remain comparable. However the age profile of supervisors of midwives (Chart 2) indicates that almost 7% of supervisors are over 55 years old.

Reasons stated for resignations include difficulties balancing the commitments of the substantive post and supervisory activities and a lack of recognition of supervision within individual trusts. Of note, 2 Trusts have still not yet agreed remuneration for supervisors of midwives through the Agenda for Change process and clinical and supervisory activity have remained high.

[6] The LSA report is available to the public via the Strategic Health Authority (SHA) website at: www.yorksandhumber.nhs.uk

The 2007-08 LSA priority of urging all Trusts to succession plan towards a ratio of 1:12 supervisor to midwife and to discuss with Trusts to increase their commitment to protected time and administrative support to supervisors was pursued through LSA audit visits and at all LSA forums. The SHA Chair wrote to all Trust and PCT Chairs supporting the recommendation. A LSA paper to the SHA Senior Management Team to set the LSA ratio at 1:12 will be resubmitted in 2008 - 09.

Individual Trust data for this year and the Trust trends of ratio of supervisors to midwives, numbers of whole-time equivalent midwives, numbers of midwives supervised by Trust supervisory teams and numbers of supervisors are shown within Appendices 5 and 6.

Chart 2: Age profile of Yorkshire and the Humber supervisors of midwives at 20th March 2008

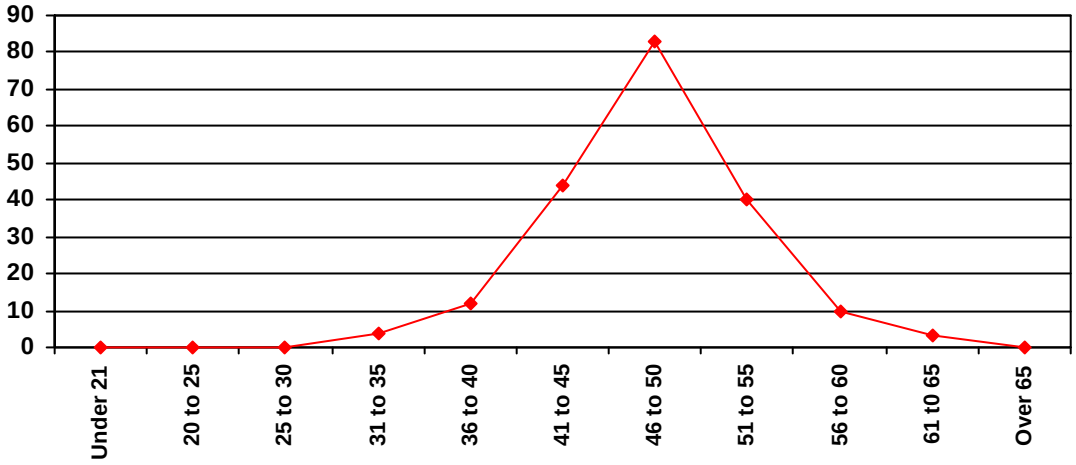


Chart 3: Appointments, re-appointments and resignations of supervisors during 2007-08

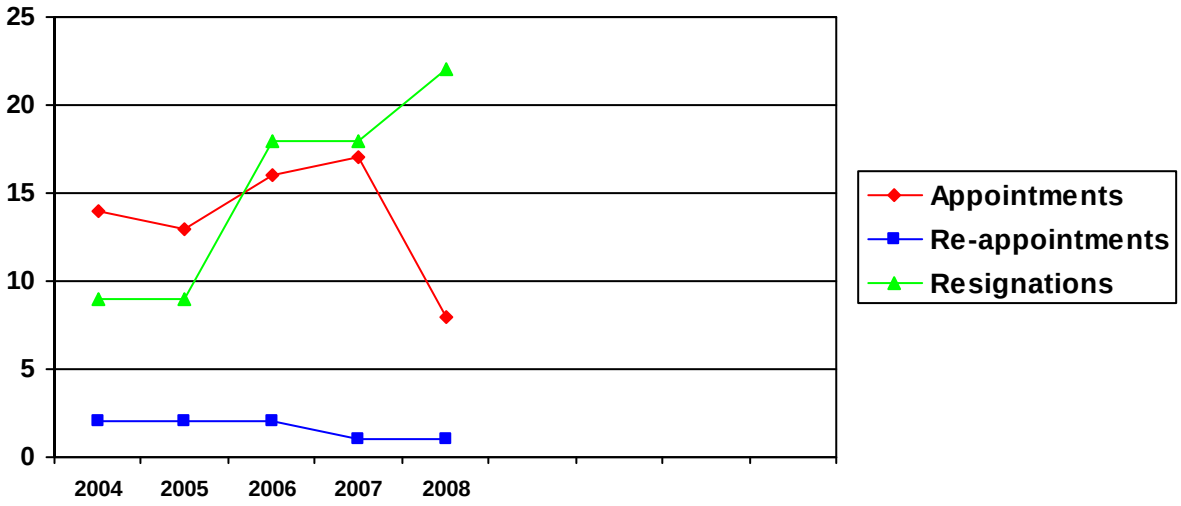


Table 2: Appointments, resignations, removals and time out / standing down of supervisors of midwives within the LSA (* LSA Supervisor to midwife ratio per practice year, which for previous 3 practice years, represents the former West Yorkshire and North and East Yorkshire and Northern Lincolnshire Consortium only.

Practice year	Appointments	Resignations	Removals	Time Out / Standing Down
2007 – 2008 ***1:12 ratio**	9, 1 was a re-appointment	22, 2 were retirements	0	3
2006 – 2007 *** 1:13 ratio**	17, 1 was a re-appointment	18, 4 were retirements	0	2
2005 – 2006 *** 1:13 ratio**	16, 2 were re-appointments	18, 3 were retirements	0	1
2004 – 2005 *** 1:12 ratio**	13, 2 were re-appointments	9, 3 were retirements	0	2
2003 – 2004 *** 1:13 ratio**	14, 2 were re-appointments	9, 3 were retirements	0	1

At 20th March 2008, 12 of the 14 trusts within the LSA had ratios of supervisor to midwives better than the NMC 1:15 standard; Leeds Teaching Hospitals NHS Trust had a ratio of 1:15 and Hull and East Yorkshire NHS Trust exceeded the NMC standard with a 1:16 ratio. The ratio at Hull and East Yorkshire NHS Trust has since improved to 1:14.5 with the qualification of 2 new supervisors. The range of ratios across the LSA was 7 – 16. This represents an improvement on last year (Appendices 5 and 6).

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

During this report year the following systems were audited at the LSA annual audit visits to Trusts by questioning supervisors and midwives about the processes in place and by asking midwives, student midwives and non-midwives about their experiences. No issues were identified.

3.1 Choice of a named supervisor of midwives

2581 midwives notified their 2008 – 2009 Intention to Practise form (ITP) to the LSA office by March 2008. All but new starters are given a choice of supervisor in the LSA. New starters are normally assigned a supervisor initially and then invited to choose a new supervisor or keep the one they were allocated after the six-month orientation period. The most common process used is to invite midwives to select three supervisors from the full list of

supervisors working in the trust. This usually guarantees every midwife having a supervisor of her choice and also allows even caseloads for the supervisors.

3.2 Contacting a supervisor of midwives

Supervisors provide their personal contact details for ad hoc contact, as well as arranging a formal meeting every year for the supervisory review. All Trusts in the LSA provide 24-hour on-call cover by supervisors of midwives for contacting a supervisor when the named supervisor is off duty or in the event of an incident or concerns about a practice issue. In all but 1 Trust, the on-call rota is kept in a central point and available to all midwives and independent midwives working in the area. A booklet containing the above information about supervision is provided for each midwife on appointment. It is also repeated within the supervisory review documentation. For the remaining Trust, midwives can contact any supervisor but they report that this has not been problematic.

Some Trusts also have a dedicated "Supervisors of midwives" office where the supervisor on call is based. 1 Trust in particular has stated that this has raised the profile and day to day and ad hoc access to supervisors by not only midwives, but other healthcare professional.

3.3 Contact supervisors of midwives

Each Trust has a Contact supervisor. The remit of this role is outlined within the relevant guideline on the LSA web-page[7].

3.4 Link supervisors of midwives

There are 4 Link supervisors appointed within the LSA. Their contact details and those of the LSA are published in each monthly electronic LSA Briefing.

4. Details of how the practice of midwifery is supervised and LSA communication with supervisors.

4.1 LSA Annual monitoring visits

Annual monitoring visits provide the LSAMO and a LSA audit team, the opportunity to ensure that all midwives have their practice supervised by the supervisors of midwives in their trust. The audit tool incorporates midwives' views of the essential competencies of their supervisors of midwives NMC (2007) Standards for the preparation and practice of supervisors of midwives[8].

[7] Contact supervisor guideline accessible on the LSA web-page at: http://www.yorksandhumber.nhs.uk/document.php?o=1368

[8] NMC (2007) Standards for the preparation and practice of supervisors of midwives at: http://www.nmc-uk.org/aArticle.aspx?ArticleID=1658

There were no suggestions of inadequate supervision being carried out on a daily basis. This was generally done through supervisors of midwives working alongside their supervisees in the clinical areas and through annual supervisory reviews. The programme of the 2007-08 LSA audits (Appendix 7) lists when audit visits to all Trusts were undertaken, the type of audit visit and the composition of the audit team.

Appendix 8 summarises some of the key national and LSA annual data used to benchmark Trust data when LSA audit visits are done. Whilst the raw data was cross-checked at the LSA when it was submitted, some discrepancies remain and are highlighted as such (Appendix 9). Data quality from Trusts within the LSA remains a concern to the LSA office and also featured in the Healthcare Commission's maternity programme of work and the King's Fund.

Table 2 shows data from the 469 midwives (19%) who completed a LSA questionnaire in the 2007-08 LSA audit cycle. The data indicate that the midwives who responded are likely to engage with supervision, as they describe positive relationships with their supervisors. They very much view them as the clinical champions and role-models and they are aware of the proactive work that they do.

Table 2. Midwife responses from the 2007-08 LSA questionnaires

Do you have a positive relationship with your supervisor?	98.1% (460)
Are you aware of the proactive work of your supervisors?	83.6% (392)
Do you consider your named supervisor of midwives as a good role model in relation to:	
Promoting normality	96.2% (451)
Record keeping	94.5% (443)
Communication style	94% (441)
Multidisciplinary working	95% (447)
Evidence-based practice	95% (447)
Conflict management	90.6% (425)
Supporting change	95.5% (448)

4.1.1 Examples of where supervision has improved care to women and what impedes supervision

Numerous examples of where and how supervision has improved care to women or enhanced and supported the practice of midwives are provided at the LSA annual audit visits. These examples are often shared at LSA

facilitated events and within the monthly electronic LSA Briefing – see 4.6 and 4.7.

The main challenges that impede effective supervision are lack of protected time and administrative support for supervisors, which remain themes at LSA audit visits and are of concern. 50 supervisors responded to a LSA questionnaire and stated that they do not have protected time for supervision. The 54 supervisors who did get time, qualified it as obviously coming secondary to clinical activity, with numerous comments and LSA data acknowledging that clinical and supervisory activity continues to increase.

4.2 Supervisory reviews

Supervisors are responsible for checking the registration status for midwives on their caseload and the LSA does it when midwives are the subject of an LSA investigation. The LSA Midwifery Officer ceased practising as a supervisor in December 2007 in line with the NMC Circular 06/2008[9].

A supervisory review within the last practice year is a requirement so that the named supervisor of midwives can sign each supervisee's Intention to Practise form. This verifies that the midwives on the supervisor's caseload have achieved their PREP requirements. There may be valid reasons why a midwife has not had a supervisory review within the last practice year e.g. maternity leave, sick leave, but the incidence should be minimal.

The LSAMO and LSA Support Officer as LSA database administrators can access some data on the LSA database by Yorkshire and the Humber supervisors. This includes dates of supervisory reviews, but not their content for confidentiality.

4.3 The LSA database

This was purchased during the 2006 - 07 practice year. This has helped to optimise LSA office and supervisory time, has improved data governance, moved towards paperless systems and ensured consistent approaches to supervisory functions. The 2007 - 08 practice year encompassed training for supervisors in the use of the database, additional LSA support to embed its use in day-to-day supervisory practice and into LSA processes. Quality assurance of data input has also been provided and reports from the LSA database now feature within the LSA audit tool for the 2008 - 09 practice year.

Manual systems ran in parallel to the LSA database for 6 months to allow it to embed into supervisory and LSA practice. Reports activated 6 months after its initial use were uploads to the NMC, Maternal death notifications (see Section 9) and closures, attempted closures and suspensions of aspects of maternity services (see Section 8).

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[9] NMC Circular 06/2008 accessible at: http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=3931

4.4 Supervisory involvement in clinical governance

One of the LSA Annual audit questionnaire to asks supervisors to list what clinical governance activities they are involved in, within their employing organisation. This is to ensure that supervisors are integrated where possible to proactively enhance midwifery practice, but also in a position to respond reactively where indicated. Typical responses include supervisors attending supervisors' meetings, being a member of guidelines groups, risk management groups /clinical case review meetings, audit groups, infection control groups, perinatal mortality groups, research groups, labour ward forums and clinical governance groups. They also cite involvement in training and education, drugs and therapeutics, patient and public involvement and complaints monitoring and feedback.

Supervisory involvement in LSA-facilitated working groups gives the opportunity for supervisors to share learning from good practice and from incidents to enhance midwifery and supervisory practice. It also enables supervisors to accumulate their 6 hours annually to meet the NMC (2006) continuing professional development requirement as a supervisor. Examples include being a member of the LSA guidelines group, the LSA audit, the LSA strategy and education Group, the Link supervisors group, participating in LSA conferences, undertaking Link supervisor or Contact supervisor roles, participating in other LSA events, being a mentor to prospective supervisors, leading supervisory investigations where required and being involved in the monitoring of developmental support or supervised practice programmes where necessary.

4.5 Link supervisors of midwives

The Link supervisor role supports a consistent approach to supervisory function and formalises experienced supervisory advice across the LSA. Link supervisors in conjunction with the LSAMO, consider proactive and reactive measures to clinical issues and incident trends.

Within the LSA, there were five Link supervisors of midwives; Julie Hinchliffe from Airedale NHS Trust, Margaret Jackson from York Hospitals NHS Foundation Trust, Karen Thirsk from Hull and East Yorkshire NHS Trust, Sue Townend from Calderdale and Huddersfield NHS Foundation Trust and Julie Walsh from Sheffield NHS Foundation Trust. As ever, an acknowledgement of the support of the Link supervisors is made. The sounding board they provide for LSA decisions is essential for the LSAMO role as well as the personal support provided. This report year was no exception.

4.6 LSA facilitated events for supervisors of midwives

The following LSA facilitated meetings / events were held with supervisors of midwives and with prospective supervisors to count towards the practice hours of their preparation programmes. All LSA events are planned and evaluated through the LSA Strategy and Education group meeting, so have

supervisory and educationalist input in their development, with suggestions of future educational topics invited.

4.6.1 Conferences for supervisors of midwives

Two conferences for supervisors of midwives were facilitated and a total of 110 supervisors of midwives attended. These are the only LSA facilitated events charged to supervisors. Details of forthcoming events and summaries of the key learning from events attended are disseminated in the monthly LSA Briefing, to optimise learning across and out-with the LSA.

55 Yorkshire and the Humber supervisors attended the Summer conference in July 2007 entitled "Supervisors: Protecting women and babies, midwives and supervision" (see Appendix 10). It was supported by the University of Leeds and an anticipated financial deficit of £2,440.45 was incurred, which is usually recouped through the Winter conference. Speakers included Jill Demilew, Consultant Midwife from Kings College Hospital who presented *Supervision in Maternity Matters;* Ali Broderick and Nicki Mason from the NHS Institute for Innovation and Improvement who outlined *"Pathways to Success: a self-improvement toolkit. Focus on normal birth and reducing Caesarean section rates"*[10]; Dr Dee Kyle, Consultant in Public Health Medicine, Bradford and Airedale PCT on the role of midwives and supervisors in reducing infant mortality rates as outlined in the Bradford District Infant Mortality Commission[11]; Review of the Health Inequalities Infant Mortality Public Service Agreement Target by the Health inequalities Unit[12] and the Confidential Enquiry into Maternal and Child Health – Perinatal Mortality 2005 – April 2007[13]. Sue Eardley, Strategy Manager for the Healthcare Commission shared progress with the maternity programme of work and Professor Mary Renfrew, Mother and Infant Health Unit, University of York promoted discussions about evidencing the difference that supervision makes.

Each Trust presented a trigger session on supervisors working with service users to enhance the safety of mother and baby. Topics included home births, car safety, *Health on the Streets,* initiatives to promote early booking and a *Lean Thinking* project on midwife access to scan bookings.

55 Yorkshire and the Humber supervisors and 14 supervisors from other LSAs attended the Winter conference in October 2007 entitled "Getting to the Root Causes of Safety within Maternity Services". Frances Healey, NPSA Safety Manager facilitated the day applying NPSA tools and techniques on a case scenario compiled from key themes and incidents reported through supervision. Root Cause Analysis, Cognitive interviewing and the NHS

[10] "Pathways to Success: a self-improvement toolkit**.** Focus on normal birth and reducing Caesarean section rates" (www.institutenhs.uk)
[11] Bradford District Infant Mortality Commission (www.bdimc.bradford.nhs.uk)
[12] Review of the Health Inequalities Infant Mortality Public Service Agreement Target by the Health inequalities Unit (www.dh.gov.uk/publications)
[13] Confidential Enquiry into Maternal and Child Health – Perinatal Mortality 2005 – April 2007 (www.cemach.org.uk).

Yorkshire and the Humber Good Practice Principles for Incident Management were particularly emphasised.

4.6.2 Bi-annual supervisors' meeting

63 Yorkshire and the Humber supervisors attended this full day event held in September 2007. Themes of sharing good midwifery and supervisory practice were optimised, as was learning from incidents. "Back to basics" sessions were also undertaken to share learning and to ensure consistency of supervisory standards.

The event had varied content and format, including speed-networking, 3 minute "profiles", formal presentations, theatre, headlines, trigger sessions and table-top discussions. Formal feedback and updates are placed within the monthly LSA Briefing, which then optimised interactive time at the meetings.
The event included updates from the CEMACH Regional Midwifery Assessor, conflict handling / asking difficult questions / challenging behaviours were discussed, the Intrapartum deaths section within "On the State of Public Health: Annual Report of the CMO 2006"[14]; the CEMACH (2007) report "Perinatal Mortality 2005 England, Wales & Northern Ireland"[15], NMC (2006) "Personal Professional Profiles[16], midwives and medicines management, alcohol misuse / Alcohol strategy[17] and the role of the Labour ward Co-ordinator.

4.6.3 Bi-annual LSA network meetings held in local trusts

A total of 61 Yorkshire and the Humber supervisors attended four half day meetings, two held in May and two in November 2007. These are smaller forums where the learning from a clinical incident or good practice is shared, where the LSA provides updates not featured within the monthly electronic LSA Briefing, open space to discuss current issues impacting on supervisory and midwifery practice and suggestions of future supervisory educational topics.

Topics have included the NPSA alert on neonatal resuscitaires, PREP for midwives in a range of posts, Freedom of Information requests, NMC (2007) Standards for the supervised practice of midwives, Maternity Matters, the NMC Pilot review of LSAs, home births, mentor registers, hypno-birthing and water births.

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[14] "On the State of Public Health: Annual Report of the CMO 2006" (www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_076817),
[15] CEMACH (2007) "Perinatal Mortality 2005 England, Wales & Northern Ireland" (www.cemach.org.uk/getattachment/8e42a059-783b-4497-b5d1-2dd94feba25b/Perinatal-Mortality-2005-England,-Wales---Northern.aspx
[16] NMC (2006) "Personal Professional Profiles (http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=1583),
[17] Home Office (2007) Safe, Sensible, Social" (www.homeoffice.gov.uk/documents/Alcohol-strategy.pdf?view=Binary

4.6.4 Quarterly newly appointed supervisors meetings held at the LSA

These meetings utilise action learning and provide an opportunity for each newly appointed supervisor, in a confidential arena, to share experiences and also to verify his/her actions with the LSAMO. The meetings were well attended and highly valued to the extent that there was a reluctance to stop attending when the initial year of appointment drew to a close.

4.6.5 Liaison supervisor and Independent midwives workshops

The LSAMO facilitated a workshop for independent midwives, their named supervisors of midwives and the liaison supervisors of midwives for independent midwives at each Trust. The workshop evaluated well providing a forum to improve working relationships, for sharing practice, supporting team-working, challenging ways of working and contributing to guidelines and practice debates.

4.6.6 Ad hoc supervisory events attended by the LSAMO

The LSAMO attempted to attend a local supervisory team meeting at each trust 6 months after their LSA annual audit visit (Appendix 7), but focused particularly on teams geographically isolated and those who had particular challenges. The LSAMO was also invited and attended the Yorkshire and the Humber Heads of Midwifery time-out and was invited to the supervisory time-out of some teams.

4.7. Communication with supervisors of midwives

A “Contact supervisor” within each Trust acts as a focal point for communication to and from the LSAMO, but this does not preclude direct communication.

The LSAMO has sent approximately 100 emails to the Contact Supervisor circulation list either for direct action or for dissemination to all supervisors or to midwives. Topics have included educational and funding opportunities, research dissemination and involvement and Department of Health, NMC, LSA National Forum (UK), NICE, NPSA, CSIP, Healthcare Commission, Connecting for Health, MDA, NHS Yorkshire and the Humber consultations, guidance and events.

A Contact supervisor workshop was facilitated by the LSAMO in June 2007 with the aims of sharing good practice related to the Contact Supervisor role, to determine what additional support may have been required by Contact supervisors, to provide a forum to develop prospective Contact supervisors and a forum to feedback the positive aspects of LSA support systems and ones that could be enhanced.

A monthly, electronic LSA Briefing is produced and circulated to all supervisors for dissemination to their supervisees and within their own Trusts,

with additional recipients added on request, including the Healthcare Commission, all LMEs, student supervisors of midwives, potential return to midwifery practice students, key SHA staff and some Directors of Nursing within the region. Examples of front pages can be seen in Appendix 11.

4.8 LSAMO integration with the wider work of the Strategic Health Authority

The LSAMO resides in the SHA Patient Care and Partnership Directorate and has strong working links with many parts of the wider SHA. Work with the Integrated governance team includes reviewing serious untoward incidents and providing clinical advice. She is also a member of the SHA Patient Safety Advisory Team (PSAT), contributing to the culture of patient safety across Yorkshire and the Humber by attendance or representation by Link supervisors at networking events.

The LSAMO links with the Clinical engagement team, contributing to the Directors of Nursing Network where acute trusts and PCTs are represented. The LSAMO has done two presentations at this forum, raising awareness of the LSA role with commissioners. Also, there are links with the Workforce development team; with the Children and Families Manager, Communications, Public health and NPFIT teams. Recent joint working with the NPFIT team has resulted in a project for an IT innovation to enhance supervisory time and processes being piloted.

As stated elsewhere, all of the 14 annual LSA audit visit reports are shared with the Director of Patient Care and Partnerships, the Head of Clinical Engagement, the Head of Integrated Governance and the Families and Children's Manager. Additionally, a 3 monthly report of maternity unit closures, attempted closures and suspension of aspects of maternity services are forwarded to the Head of Clinical Engagement, the Head of Integrated Governance, the Families and Children's Manager and the Performance Directorate.

The NMC report of the pilot review of the Yorkshire and the Humber LSA published in July 2007 cited excellent exemplars as the LSA robust practices and administrative systems, strong inter-departmental working and strong partnership working with external partners including service users. The report also recommended that the LSA develop a risk assurance system and that it do further work to ensure that public involvement reflects the profile of the local population. Additionally, it was advised to share its best practice locally and nationally and that because it is the fourth largest LSA in the UK, that the human resource be reviewed to ensure it continues to discharge its statutory role and responsibility.

The LSA has also continued to register as a stakeholder with NICE during this report year and was a Clinical Pathway Group (CPG) member of the Maternity and Newborn pathway of the Yorkshire and the Humber NHS Next Stage

Review "Healthy Ambitions"[18]. The key recommendations for the region within the Maternity and Newborn pathway, that the supervisors of midwives will be instrumental in supporting are:

- Maternity Matters (DH 2007) should be used as a firm foundation for the future commissioning and delivery of maternity and the newborn services across Yorkshire and the Humber.
- Maternity Matters self-assessments in all communities should lead to action plans to address priority gaps identified in these assessments; these should also take account of the Healthcare Commission report
- The workforce recommendations set out in Safer Childbirth should be implemented; PCTs and providers should include this in all subsequent contract negotiations until significant progress is made.
- In particular of our 19 obstetric units, there are 8 units delivering under 2500 births a year. The CPG recommend applying the same standards to these units as if they had 2500 births. All our units currently have 40 hour consultant cover, and should plan therefore to reach 60 hours cover in 2009 at the latest. Outcomes at these smaller units need to be kept under regular review to ensure that women and their babies are not disadvantaged.
- Additionally, we would expect the three units with over 4000 births to reach the 98 hour and 168 hour standards as appropriate.
- The introduction of the maternity phase of Connecting for Health should be accelerated.
- There should be a radical step up in action to reduce smoking in pregnancy and breastfeeding performance should be improved. Already PCTs are including action to improve breastfeeding and/or reduce smoking in pregnancy in their Local Area Agreements.
- There should be selective introduction of 'case-loading' as a means of targeting vulnerable and disadvantaged women and so ensure that they in particular receive a high degree of continuity of care.

The LSAMO and LSA Support Officer have attended various organisational development activities at the Strategic Health Authority.

4.9 Examples of good practice and innovative approaches making a positive difference to midwives' practice and for the care of women and their families.

Examples of good midwifery and supervisory practice and innovations are in Appendix 12, with contact details for the relevant Head of Midwifery.

[18] Yorkshire and the Humber NHS Next Stage Review "Healthy Ambitions" (http://www.healthyambitions.co.uk/).

5. Evidence that service users have been involved in monitoring supervision of midwives and assisting the LSAMO with the annual audits

Service user involvement and increasing public awareness of the role of supervision in protecting the public is done both at LSA and at Trust levels. The LSAMO attends Maternity Services Liaison Committees for two-way feedback on maternity services, although attendance has not been as frequent this year due to competing commitments. The LSA invites service user involvement onto the LSA Audit working group, onto the panel for the selection process for prospective supervisors and other forums.

Information about the Yorkshire and the Humber LSA is on the LSA web-page[19]. An information leaflet exists for service users interested in becoming involved in the LSA audit process (Appendix 14)

5.1 Annual audit visits

Since 2001 a triumvirate approach to audit of supervision and midwifery practice has been undertaken in this LSA. The audit team comprises the LSAMO, a supervisor of midwives from another Trust and a recent user of maternity services. Student supervisor involvement was also invited to contribute to their clinical practice hours. For the last 2 years service user involvement has included development of the LSA audit tool.

A full programme of visits was completed by the end of the report year – see Appendix 7. Service users were involved in LSA audit visits to 8 trusts and a student supervisor was involved in LSA audit visits to 8 trusts.

Formal LSA audit visits were completed at 8 Trusts, with informal LSA audit visits to the remaining 6 Trusts. Both the formal and informal LSA audit visits involve a comprehensive visit to assess evidence supporting the trust's self audit against the national Standards for supervision and an audit of supervisory and midwifery practice by the review of outcome statistics, progress with actions arising from the recommendations made at the previous audit visit, by visits to the clinical areas and by LSA questionnaires to supervisors, midwives, student midwives, non-midwives and service users and partners. The additional aspects of the formal audit visit are that separate focus groups are held with midwives, student midwives and with Midwifery lecturers; also a self-audit against the midwifery and supervisory implications with key national documents and drivers and completion of a table indicating progress with the implementation and audit of the key criteria within relevant NICE guidelines. Additionally, supervisory teams facilitate a presentation for the audit team, with the Trust Board, key Trust personnel and colleagues being invited.

[19] Information about the Yorkshire and the Humber LSA is on the LSA web-page at: http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/

A report from each visit, whether the full or informal audit visit, was submitted to the Director of Patient Care and Partnerships, the Head of Clinical Engagement, the Head of Integrated Governance and the Families and Children's Manager at the SHA as well as to the supervisors at the trust, who forward it to their Chief Executive and Director of Nursing and their relevant PCT and Maternity Services Liaison Committee. LSA analysis of themes from recommendations made to the 14 Trusts following the audit visits is included in section 9.

A feature of note within this practice year is the interest from Commissioners in the LSA audit reports, with additional copies being requested. Also, the Yorkshire and the Humber LSA audit process is seen as good practice as evidenced by one of the supervisors presenting it at the 2008 national LSA conference in East Midlands[20].

5.2. Selection and training of service users

The nomination of service users to support the audit of supervision and midwifery practice was previously done by the LSA office inviting Heads of Midwifery to use their Patient and Public Involvement Forums for recruitment. There has been no formal selection process as each nominated person was appropriate and eligible to be trained. More recently the SHA PPI networks have been utilised.

The LSAMO and an experienced supervisor of midwives, who had been part of an audit team, led the auditor training. Supervisor and service user auditors were trained at the same time. The intention was to ensure that service users had a good knowledge of supervision as well as understanding the purpose of the audit visits.

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

6.1 LSAMO and supervisory contribution to Midwifery Education

The LSAMO has close contact with the 7 of the 10 universities in the LSA that provide midwifery education. There is regular engagement with each of the Lead Midwives for Education (LMEs) and all our Universities have at least one Midwifery lecturer who is a supervisor. The LSAMO:

- holds focus groups with student midwives and collates LSA questionnaires responses from them in relation to their experience of

[20] Cairns J (2008) "Yorkshire and the Humber Audit Cycle Learning and Sharing" a presentation at the2008 national LSA conference in East Midlands. Accessible at: http://www.jmdevents.co.uk/Presentations/AM8.pdf

clinical education and midwifery and supervisory practice within the LSA audit process
- holds focus groups with midwives and supervisors and collates LSA questionnaire responses from them in relation to their experience of mentoring student midwives and student supervisors within the LSA audit process
- is a member of Bradford University's Advisory Board
- is a member of the Faculty of Health and Social Care, University of Hull Partnership Group and the University of York Partnership Group
- is a member of the Leeds-Sheffield Consortium with the Universities of Leeds and Sheffield for the Supervisors of midwives preparation programme
- is a member of the Nursing and Midwifery Steering Group of Sheffield Hallam University
- is a member of the York BA Midwifery Practice Course Management Team and the Curriculum Development Team for the long programme
- attends NMC LSA/LME Strategic Reference Group meetings and the LSA National Forum (UK) where the education of student midwives and supervisors are discussed
- submitted a joint paper for the 2007 NMC conference with a LME
- attended the Yorkshire and the Humber Heads of Midwifery 2007-08 time-out and meetings when the LMEs were in attendance

A theme of time constraints impacting on the quality of mentoring of students has been raised by some student midwives. Also, the issue of experienced supervisors being unable to mentor student supervisors was a concern, but this has been rectified since the publication of the NMC (2008) Standards to support learning and assessment in practice[21].

6.2 Selection and preparation of supervisors of midwives

The addresses of the two universities providing preparation of supervisors of midwives programmes and at what point in the year are:

January
University of Leeds
School of Healthcare Studies
Baines Wing
Woodhouse Lane
Leeds LS2 9UT

September
University of Sheffield
School of Nursing and Midwifery
Winter Street
Sheffield S3 7ND

The selection process for prospective supervisors of midwives fulfills the *NMC (2006) Standards for the preparation and practice of supervisors of midwives.* Trusts follow the national guideline for the nomination of prospective supervisors i.e. peer nomination and the LSA selection process now consists

[21] NMC (2008) Standards to support learning and assessment in practice http://www.nmc-uk.org/aArticle.aspx?ArticleID=1658

of service user involvement, personal statement, CV and portfolio review, an individual interview and a group activity.

The joint-working and good practice within the approaches taken to the preparation programmes within Yorkshire and the Humber, were evidenced by supervisors speaking at the 2008 national LSA conference in East Midlands[22].

9 midwives interested in becoming supervisors of midwives were interviewed during the report year and all were successful and 1 withdrew from the programme. 6 midwives undertook the programme at master's level and 2 at first-degree level. Of the 8 midwives who undertook the programme at Sheffield last September, 6 were successful at first attempt and the other 2 at second attempt. However, 4 required extensions to complete their clinical competencies / practice hours. 9 commenced in January 2008 and completed the programme, 1 required an extension, but results had not been published when this report was written.

Supervisors who are interested in being considered as a Mentor for prospective supervisors have to fulfil the LSA mentor criteria in line with the NMC (2008) *Standards to support learning and assessment in practice* with the mentor preparation being co-facilitated by the LSAMO and an LME.

6.3 Workforce development department

Joint-working with the SHA workforce development department has principally been with regard to Return to Practice, workforce trends and liaison in relation to newly qualified midwives unable to find midwifery employment. Graduate employment initiatives have proved an effective method in reducing overall the numbers of graduates without employment .

The LSAMO also successfully bid for a 0.8 wte LSA Midwife secondment for 1 year, from the NHS Yorkshire and the Humber Practice Learning Budget. The main aim of the post is to support the LSA in fulfilling the roles and responsibilities of the LSA within Maternity Matters. It will also contribute to the SHA's leadership role in supporting implementation of Maternity Matters, enhance clinical engagement and provide a leadership opportunity for an experienced supervisor of midwives, enhance engagement with Higher Education Institutions in the education of a workforce to deliver Maternity Matters and contribute to the delivery and monitoring of the Preparation of supervisors of midwives programme, provide a development opportunity for those with the career aspiration of being a LSA Midwifery Officer, provide a learning / development opportunity for an experienced midwife to gain strategic experience by working with the LSA Midwifery Officer and provide

[22] McAree T, Townend S, Walker A (2008) "Good practice in the preparation of supervisors of midwives programme and the support of new supervisors". A presentation at the 2008 national LSA conference in East Midlands accessible at: http://www.jmdevents.co.uk/Presentations/AM6.pdf

additional resource to the LSA office whose workload increased by 40% due to reconfiguration.

The LSA Midwife seconded post commenced in July 2008 and it will be evaluated in the 2008-09 LSA annual report.

6.4 Return to midwifery practice

The LSAMO determined the statutory requirements for midwives wishing to return to practice, acting as official correspondent. There was a decrease in enquiries during the report year to 18 from 28 and 24 over the last 2 years. 1 didn't need an RTP course; 17 were sent a form to complete and 9 returned completed forms and 3 are currently on RTP programmes.

To date for the first quarter of this practice year, 10 enquiries have been received which represents a 3-fold increase. This coincided with the national announcement for financial support to encourage RTP midwives[23].

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

7.1 Policy formulation

Policy formulation within the LSA has been through the three LSA working groups that have been established for several years to avoid. These three groups are the Strategy and Education Group, the Audit Working Group and the Guidelines Working Group. Terms of reference for each group are reviewed regularly and updates to all supervisors are via their nominated working group representative, through the monthly electronic "LSA Briefing" and by email if required. Prospective supervisors are encouraged to attend as development and towards their structured learning in practice hours.

7.2 Strategy Group

This working group comprises supervisors of midwives, midwifery educators, a Link supervisor of midwives and the LSAMO. The group predominantly plans learning activities for the supervisors of midwives, setting the agendas for the LSA events and conferences. The group meets every other month and the term of office for the supervisors of midwives representatives is for two years with a commitment to attend four out of six meetings per annum. The

[23] Yorkshire and the Humber SHA stance on Return to midwifery practice can be found on the SHA web-site at http://www.yorksandhumber.nhs.uk/what_we_do/workforce_education_and_training/education_and_training/return_to_practice/

working group approach enhances the “learning organisation” nature of the Yorkshire and the Humber LSA, in that key drivers, key challenges, good practice and learning from incidents are optimized at every opportunity.

7.3 Audit Working Group

This group regularly reviews and amends the benchmarks for the LSA audit of midwifery practice and supervision of midwives. As each new directive or confidential enquiry report is produced, the relevant recommendations for midwifery and or supervisory practice are translated into benchmarks. Service users continue to contribute to the production of the audit tool, prior to its use.

The group members also participate in planning and facilitating the training of supervisor and service user auditors. The term of office for the supervisors of midwives’ representatives is for two years.

7.4 Guidelines Working Group

The LSA Guidelines Working Group revises each set of guidelines for supervisors of midwives at least every three years, sooner if the need arises and creates new guidelines as identified. 9 new Yorkshire and the Humber LSA guidelines were produced and distributed, although many originated from LSAs prior to the reconfiguration to Yorkshire and the Humber (Appendix 13). The LSAMO contributed to the development of 5 new LSA National Forum (UK) guidelines for supervisors of midwives[24].

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

The LSA office has collated workforce and clinical outcome data for the last 9 years. The proforma is reviewed each year and circulated to Heads of Midwifery and Contact supervisors at the end of March for completion to the LSA office within 1 month. Considerable LSA time has again this year been spent re-requesting data that was not sent initially or requesting trusts to review their data for incompleteness and inaccuracy. Data analysis has been kindly supported by a data analyst, the LSA Support Officer and the LSAMO.

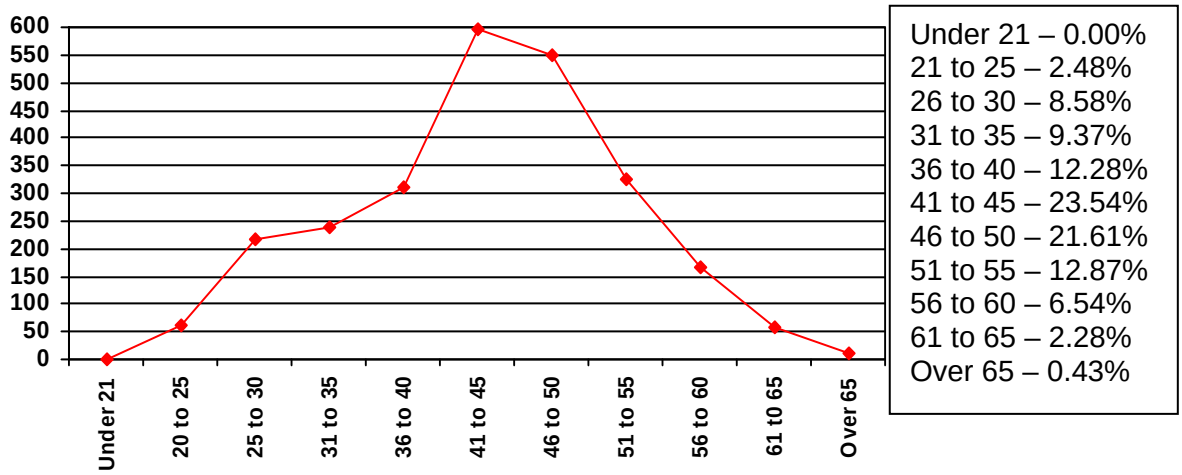
8.1 Age profile of midwives

NHS workforce data as at September 2007 indicated that there were 195 midwives over the age of 55, who are therefore eligible to retire at any time. Comparing this to data from the LSA database as at 20th March 2008, this has increased to 235 of a total of 2540 i.e. almost 10% of the midwives practising in Yorkshire and the Humber. Close working between the LSAMO and the

[24] See footnote 2 on page 6

Workforce directorate ensure that the LSA focus on the safety of midwifery practice is considered through their considerations in workforce planning.

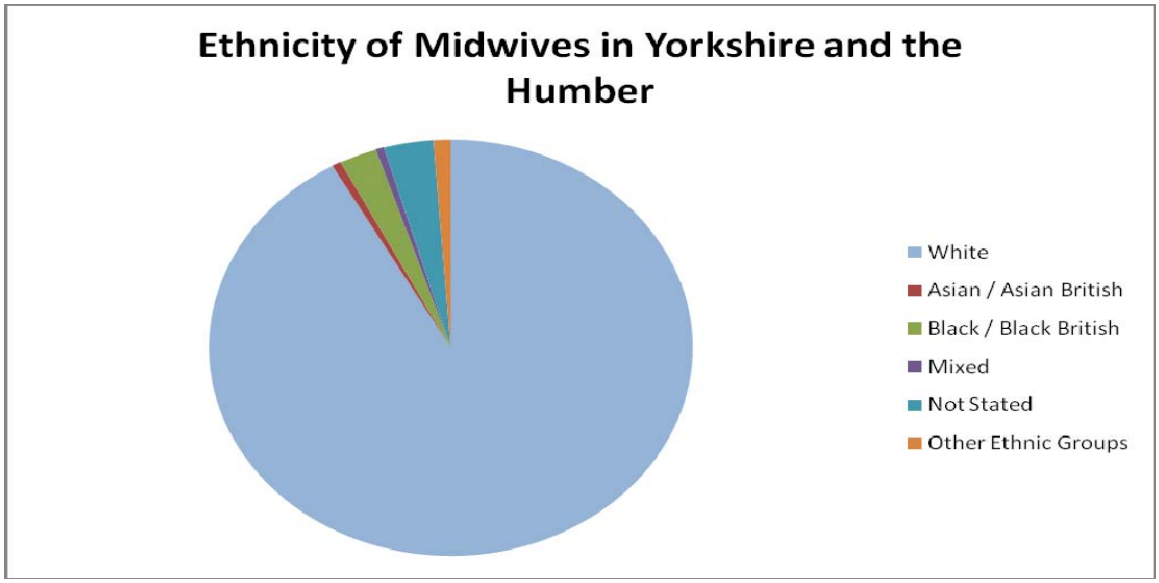
Chart 3: Age profile of midwives in Yorkshire and the Humber LSA at 20th March 2008



8.2 Ethnicity profile

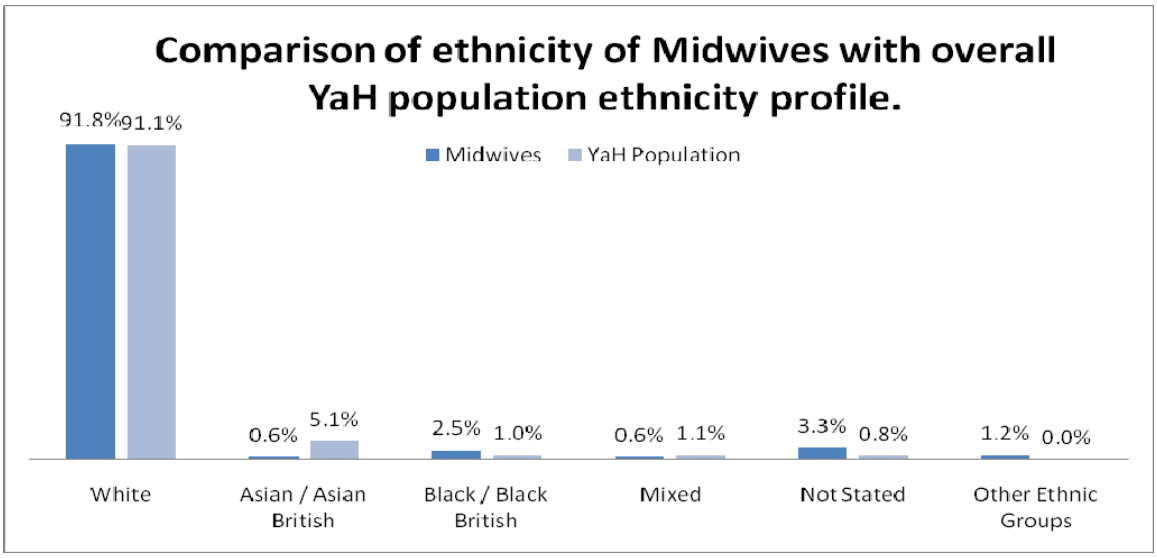
The broad ethnic group breakdown of the Yorkshire and the Humber midwifery workforce is shown in the Chart 4

Chart 4



The chart below is an SHA wide comparison of the local population ethnic distribution and that of the workforce. It is clear that there is under representation in the Asian group. Certain parts of the region need to explore more fully the composition of their local population and the staff they have in place to work effectively with their mothers and families.

Chart 5

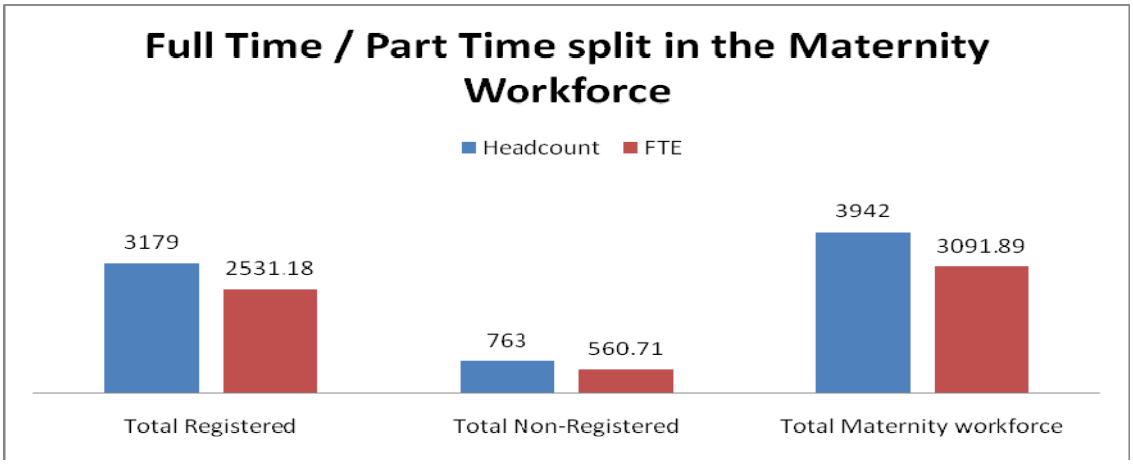


The main way of increasing diversity in the qualified workforce lies with the universities when they recruit students to courses, as Trusts can only recruit from the output the universities create.

8.3 Full time and part time working

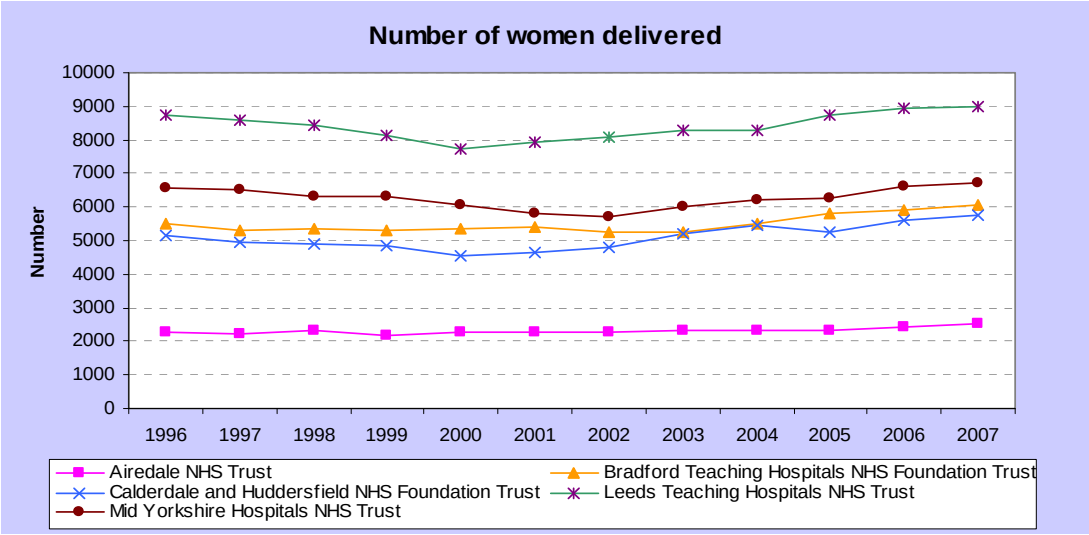
Chart 6 indicates that part time and flexible working is a great retention aid in the maternity workforce but that it also brings challenges in terms for planning staff cover and giving continuity of care for mothers. Additionally, for every 1 qualified whole time equivalent midwife, it requires the education and employment of 1.26 midwives and for every non-registered whole time equivalent, it requires the employment of 1.36. This may increase in future and has to be taken into account when commissioning education.

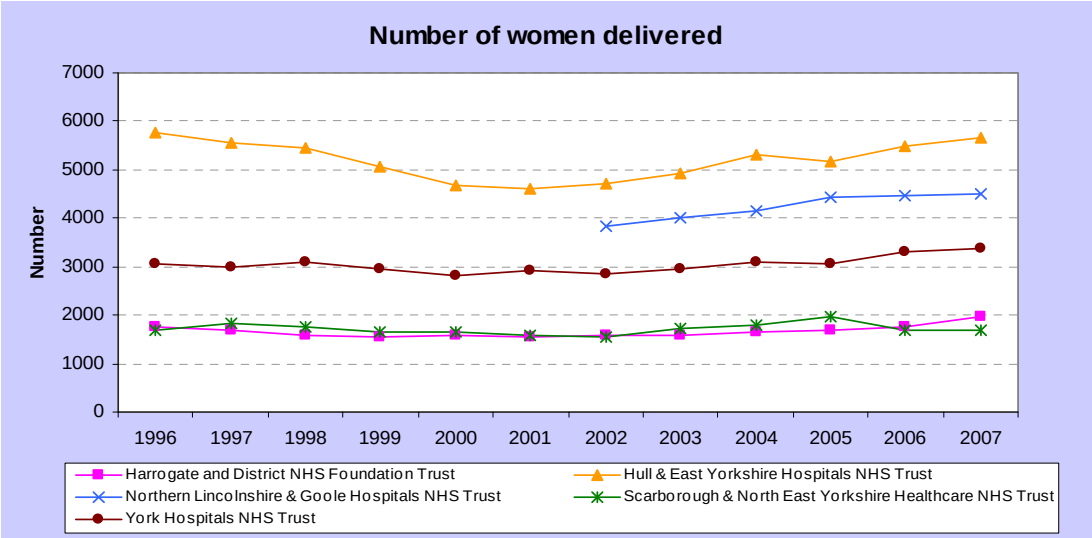
Chart 6

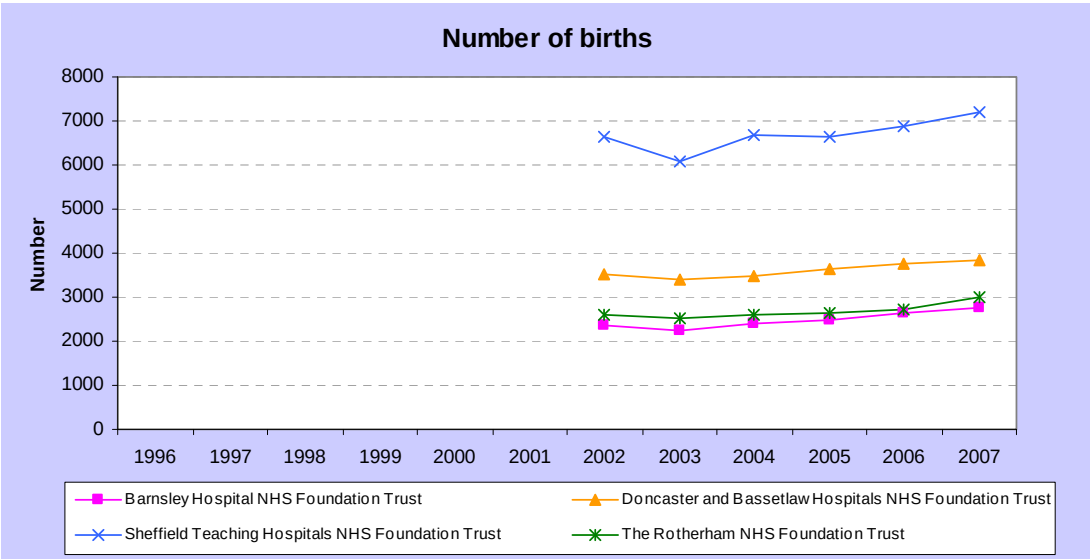


8.4 Midwife to birth ratios

Clinical activity continued to increase across Yorkshire and the Humber LSA. Antenatal bookings increased by 1.6% from the previous practice year and 9.5% from 2 years ago. Births have increased by 3%.







The range of midwife to birth ratios is from 1:25 - 1:37, or alternatively using midwife per 1,000 births the range is from 26.95 per 1000 to 40.00 per 1000 births. The range represents 8 of the 14 Trusts having midwife per 1000 birth ratio worse than that of the average rate within the Healthcare Commission

(HCC) maternity review. For 7 of the 8 Trusts, their ratios have worsened from last year, some due to increasing birth rates e.g. Harrogate with an increasing birth rate of 13.3% (Appendix 15). Moreover, the HCC "Compare" software recommends a ratio 36 per 1000 births to provide one to one care in labour and 40 per 1000 births for units handling more complex cases.

A recommendation within *Healthy Ambitions* is that "The workforce recommendations set out in Safer Childbirth should be implemented" and within the 2008-09 practice year, some investment in midwifery staffing has already been noted.

LSA action in response to variations in ratios or concerning trends includes direct discussion with the Trust, exploration of best practice and discussing concerns in trends at LSA events, inviting expert speakers e.g. NHS Institute for Improvement and Innovation and liaison with the SHA Integrated Governance Team and the PCTs as commissioners of the maternity services.

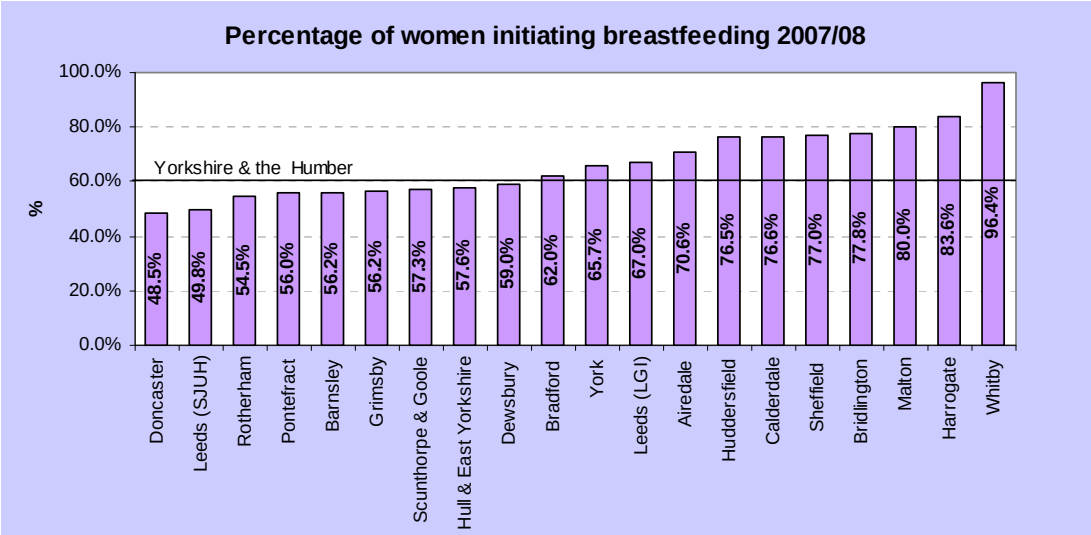
8.5 Maternal outcomes

The majority of the maternal maternity outcomes for the 63,894 women who gave birth in the Yorkshire and the Humber compare favourably against the 2005-06 Maternity HES bulletin published on 26th June 2007[25].

In summary, Yorkshire and the Humber has:

- an increased home birth rate to 2.4%. Whilst this is slightly lower than the national average of 2.6% it represents a major achievement in view of the continuing increase in clinical activity
- a 9% higher non-instrumental (unassisted) birth rate (62.7% : 53%)
- a reduced and lower than national % of elective caesarean sections (8.4 : 9.3)
- a lower than national % of emergency caesarean sections (13.5: 14.1)
- a lower % of induced labours (16.5 : 20.2)
- a marginally increased breastfeeding initiation rate over the last year in Yorkshire and the Humber to 61.6%, but this is 16% lower than the national rate, with large variations in Trust rates.

[25] See foot note 1 on page 4



Note: No data were available for Scarborough

The above graph shows the varying rates of breastfeeding initiation across the maternity units in Yorkshire and the Humber. The rates vary from 48.5% in Doncaster to 96.4% in Whitby. In most units levels of breastfeeding initiation had increased since 2006-07.

One-to-one care in labour data was requested by the LSA this year, but some Trusts could not provide it. A question was added to the 2007-08 LSA questionnaire to midwives asking them to rate how frequently they felt able to provide one-to-one care in labour and will be reported next year. Incomplete data also of concern was the ethnic breakdown of women using maternity services during 2007-08. This is demonstrated within appendix 16.

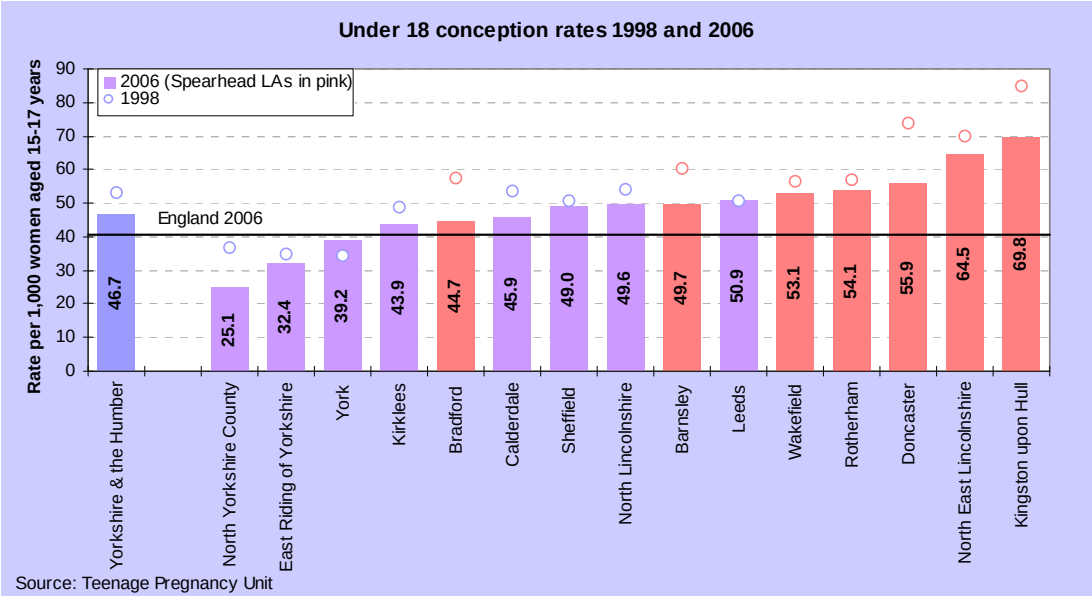
Please see Appendix 9 for the full raw data from Trusts and Appendix 6 for individual trust data for this practice year and Trust trends of ratio of supervisors to midwives, numbers of whole-time equivalent midwives, numbers of midwives supervised by trust supervisory teams and numbers of supervisors.

8.6 Public health

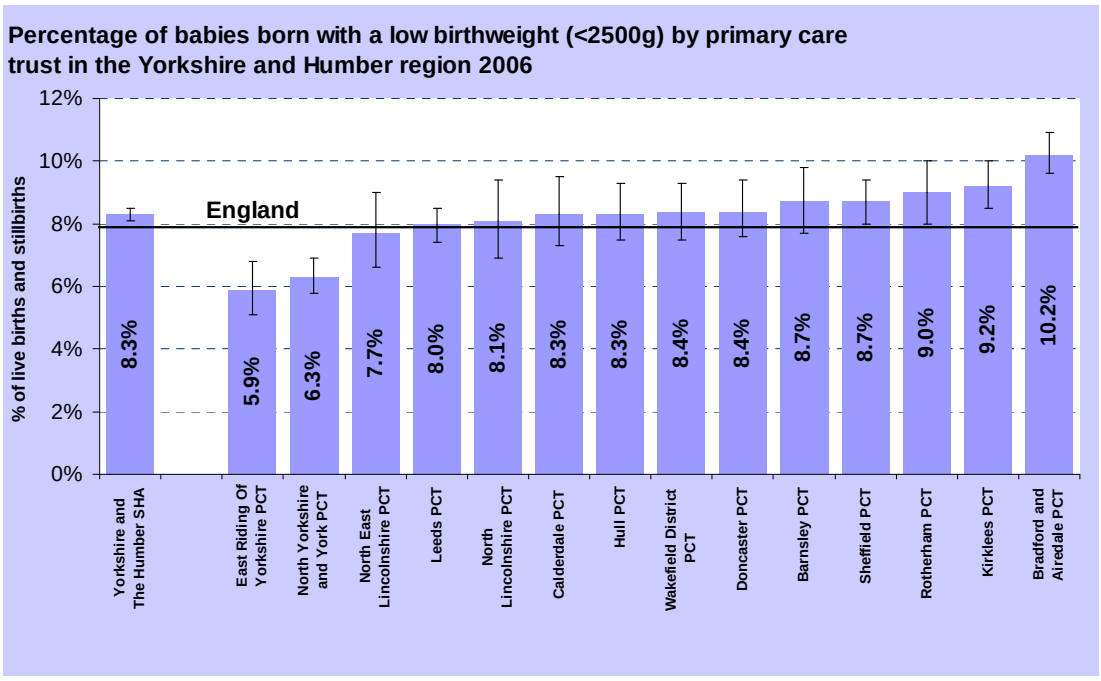
- **Teenage conceptions**

In all but two of the local authority areas in Yorkshire and the Humber conceptions in women aged under 18 have decreased between the target baseline year of 1998 and 2006. The exceptions to this are York and Leeds.

Seven of the eight spearhead local authorities in Yorkshire and the Humber have under 18 conception rates in the highest eight conception rates across the region. This continues to demonstrate the link between deprivation and under 18 conceptions.



- **Low birthweight births**



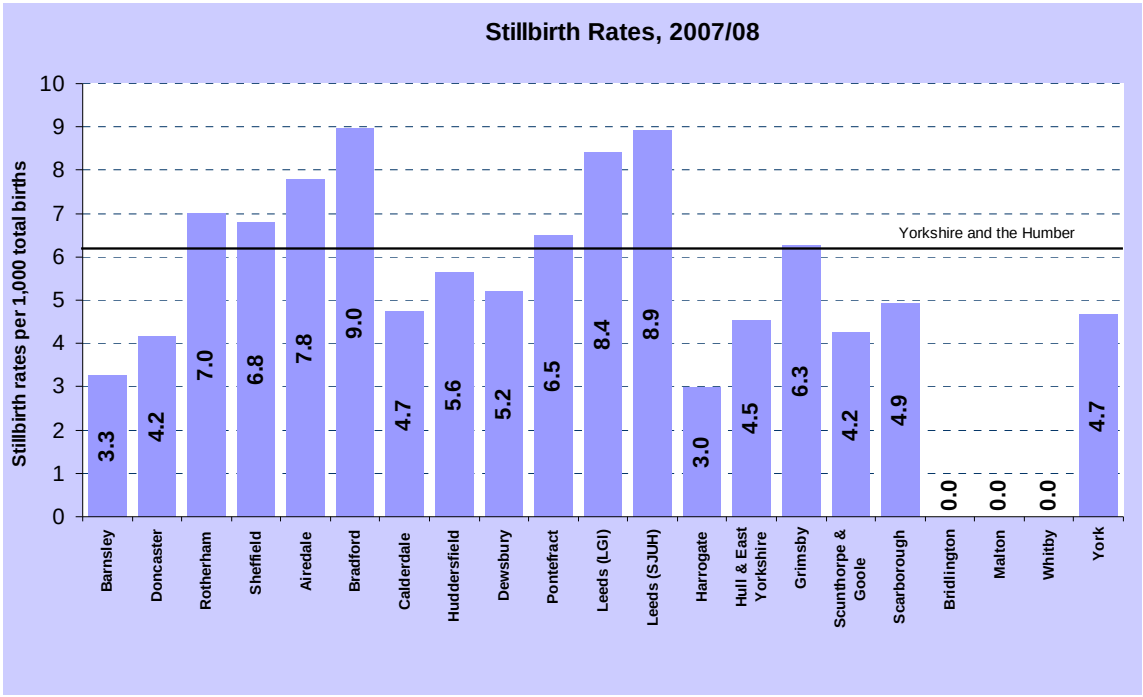
Two Primary Care Trusts (Kirklees and Bradford & Airedale) had significantly higher rates of low birthweight births than the national average in 2006. However, the East Riding of Yorkshire and North Yorkshire and York PCTs had rates of low birthweight births significantly lower than the England rate of 7.8% of total births.

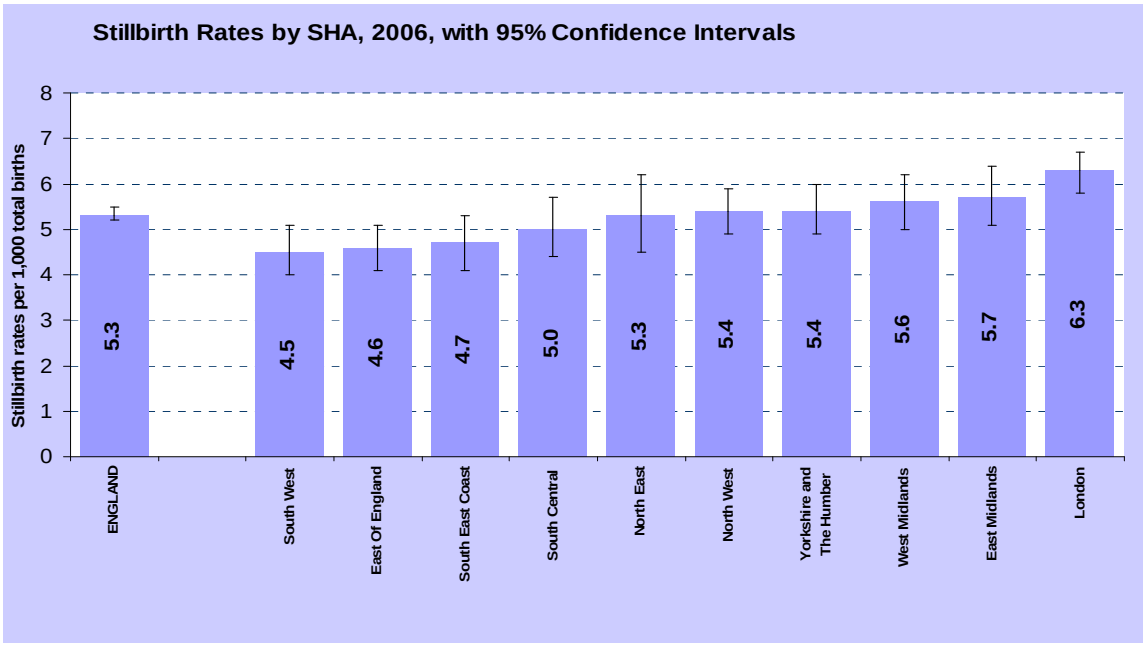
- **Stillbirths**

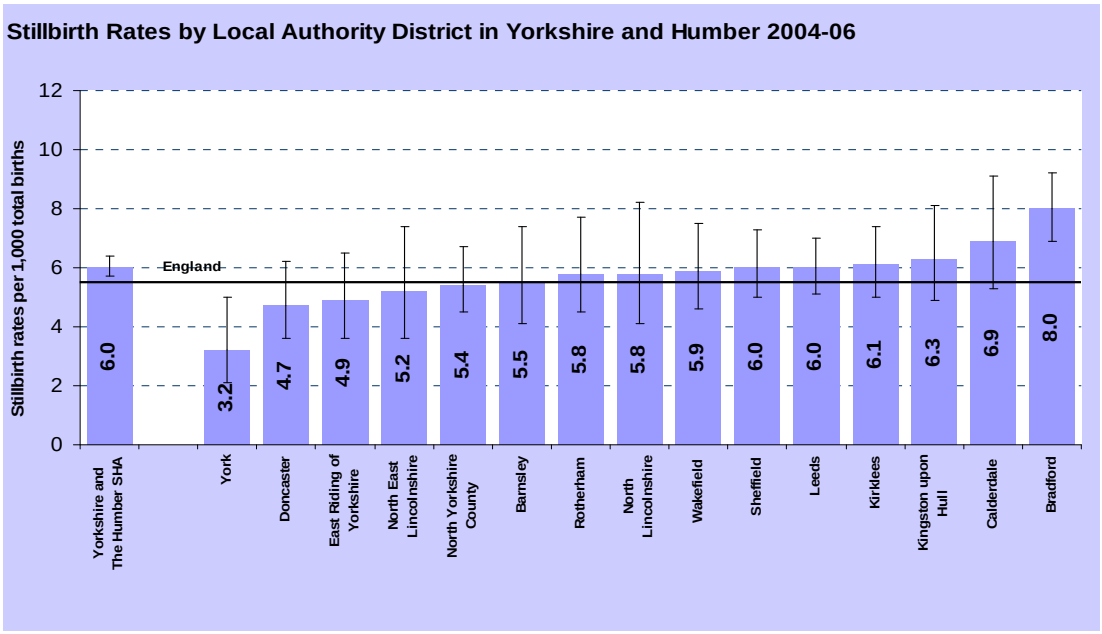
Stillbirth rates across the Yorkshire and the Humber maternity units varied widely in 2007/08 from zero in Bridlington, Malton and Whitby to 9.0 per 1000 total births in Bradford. The average across the LSA was 6.2 per 1000 total

births. This warrants continued attention, as it reflects the 2005 stillbirth rate which was then the highest in the country. Of note, the regional rate had decreased in 2006 to 5.4 per 1000 total births, just above the national rate of 5.3 and the fourth highest across the ten SHAs.

Across the Local Authorities in the region there is a marked variation in stillbirth rates, from 3.2 per 1000 total births in York to 8.0 in Bradford.



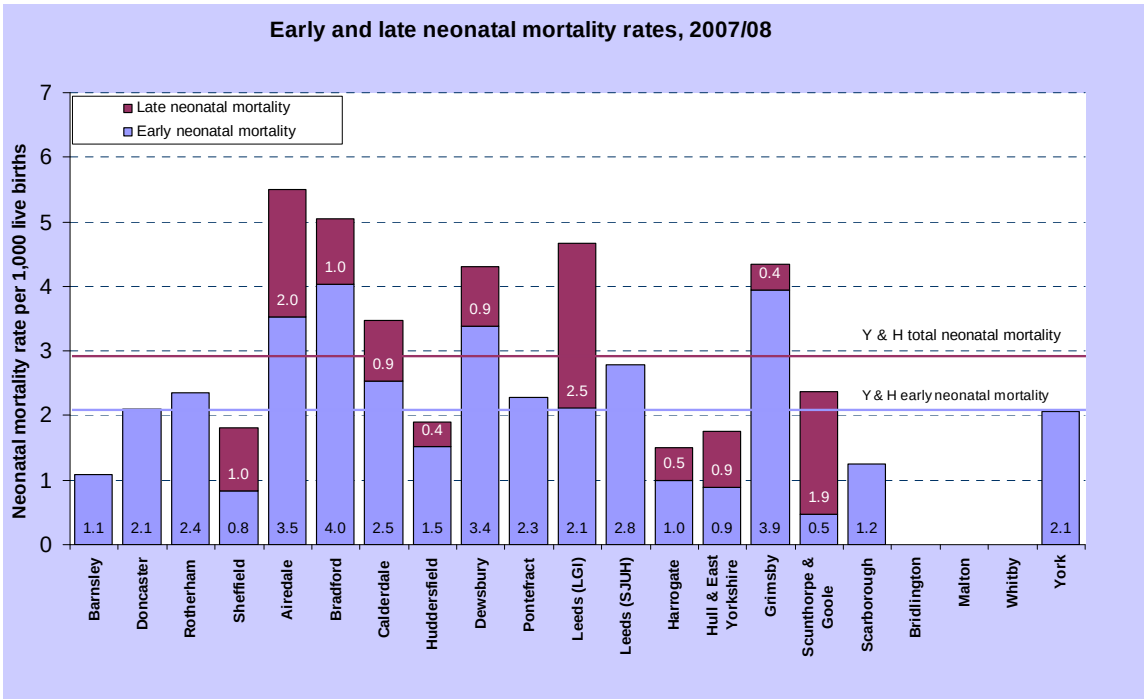


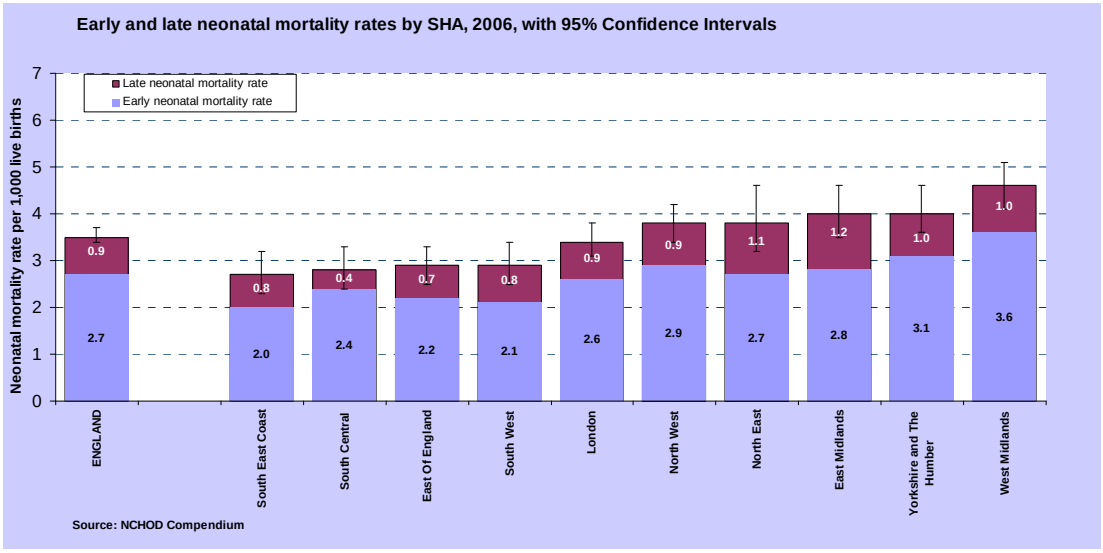


Neonatal mortality

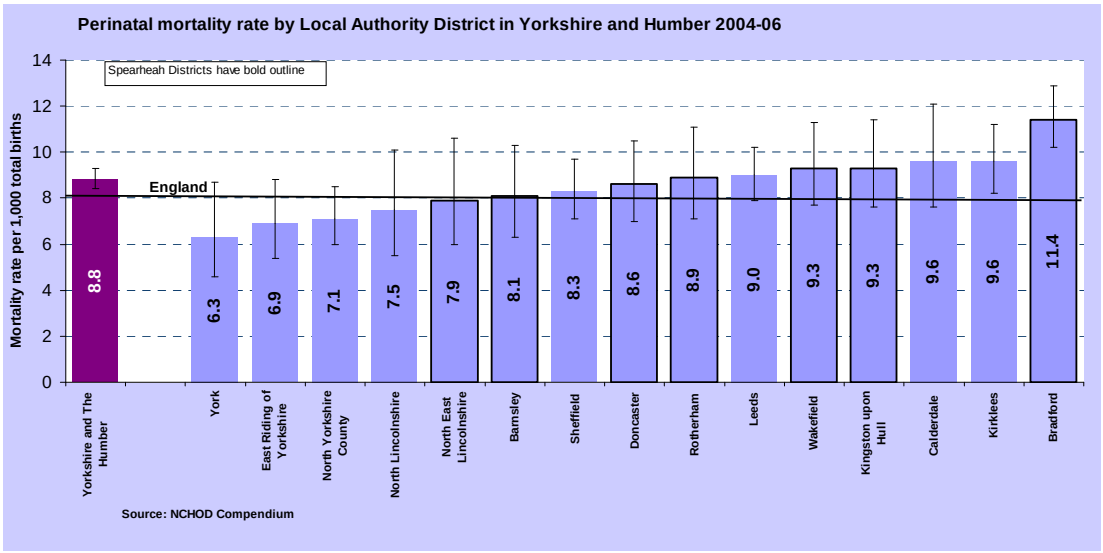
The neonatal mortality rate across Yorkshire and the Humber in 2007/08 was 2.9 per 1000 live births, the majority of which was early neonatal deaths occurring in the first seven days of an infant's life. The early neonatal mortality rate was 2.1 per 1000 live births. Neonatal mortality varied across the Yorkshire and the Humber maternity units ranging from zero in Bridlington, Malton and Whitby to 5.5 per 1000 live births in Airedale.

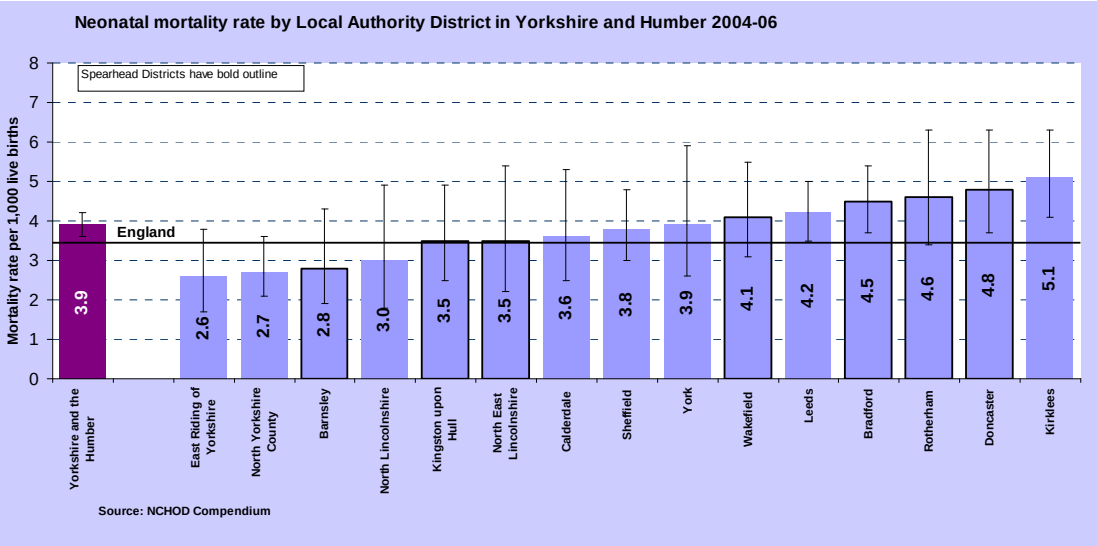
In 2006 Yorkshire and the Humber SHA had the second highest neonatal mortality rate across the ten English SHAs. However, late neonatal mortality, in infants aged between seven and 28 days, in Yorkshire and the Humber was relatively lower than in some other areas.

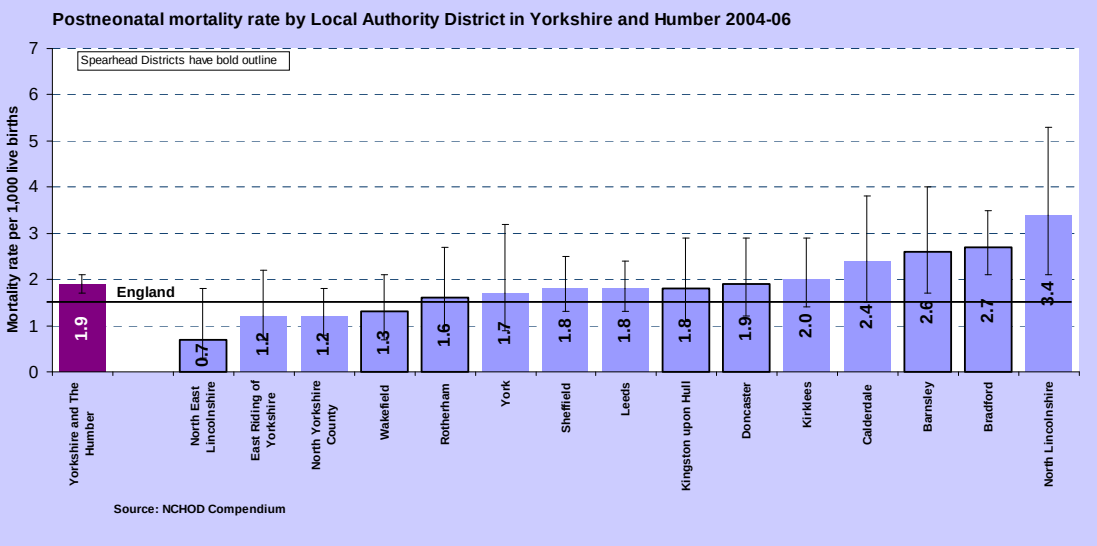




Within Yorkshire and the Humber the different categories of infant mortality, perinatal, neonatal and postneonatal, vary markedly between local authorities. However, the ranking of local authorities is not consistent across the three mortality rates. For example, in some areas later infant mortality ie postneonatal mortality is more of a concern than earlier infant mortality as measured by perinatal and neonatal mortality, eg North Lincolnshire.



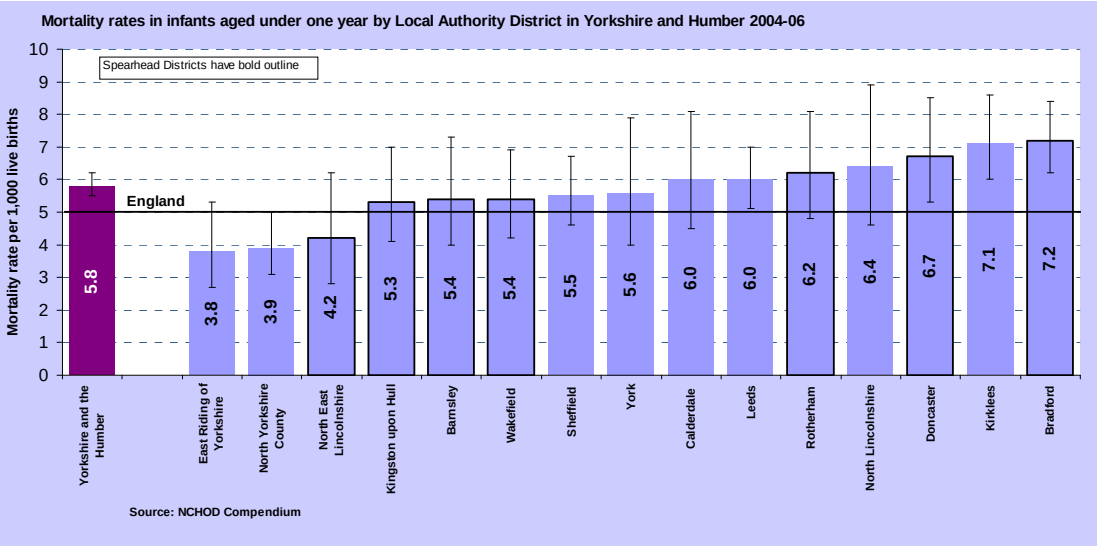




Mortality in infants aged under one year

Infant mortality varies widely across Yorkshire and the Humber from 3.8 deaths per 1000 live births in East Riding of Yorkshire to 7.2 in Bradford. Four local authorities, Bradford, Kirklees, Doncaster and Leeds, had significantly higher infant mortality rates than the national average of 5.0 deaths per 1000 live births.

Although some link between infant deaths and deprivation can be seen with a number of spearhead districts having the highest infant mortality rates, there appears to have been some downward movement in infant deaths in some more deprived areas. The spearhead district of North East Lincolnshire has an infant mortality rate lower than the national and regional averages and Hull, Barnsley and Wakefield have mortality rates below the rate across Yorkshire and the Humber.



8.7 Themes from LSA annual audit visits to Trusts

LSA analysis of themes from recommendations made to the 14 Trusts following the audit visits include:

- all 14 Trusts were urged to raise the profile of various health and practice issues, particularly the MHRA Top Ten Tips for measuring Blood Pressure, NICE Obesity Guidelines and the NMC (2006) Circular "Midwives and Home Births" and guidance on the management of jaundice after 7 days or lasting longer than 14 days in view of the CNOs concern of the national increase in Kernicterous.

- recommendations to 9 Trusts reflected LSAMO concerns regarding clinical workload and staffing issues and they were requested to examine differing issues e.g. the effects of cancelling mandatory training, of midwives being "pulled" to cover high risk areas, of the pressure on Delivery Suites, of formal preceptorship for supervisors and midwives, of supervisors supplementing staffing in an attempt to deal with the workload and to use their data to demonstrate the deficits in their midwife to birth ratios; exploring the incidence of stress on delivery suite and the orientation and preceptorship of new to area midwives.

- 8 Trusts were requested to improve their rates, or data collection of one to one care in labour; to enhance the birthing environment to a less clinical setting and to increase the focus on normality and non-interventionist care.

- 8 Trusts were recommended to develop supervisors through improved attendance at supervisors' meetings and timeouts; to use a buddy system during supervisory investigations, with 4 Trusts specifically requested to develop a strategy for supervisory succession planning and equity of caseloads.

- the audit of some key practice recommendations was recommended in some Trusts and include: the 4 fully implemented maternity NICE guidelines i.e. Induction of Labour, Electronic Fetal Monitoring in Labour, Antenatal Care and Routine Antenatal Anti D Prophylaxis; outcome data, metrics, complaints and risk management data; Waterbirths and Babies Born Before Arrival (BBA) and to continue to enhance record keeping audit and feedback.

- 4 Trusts were recommended to improve the awareness and involvement of supervision by student midwives; to examine the mentor support in place due to the ratio of full and part time mentors, and to examine specific theory practice gaps.

- Some Trusts were reminded of their statutory Rule 15 responsibility (NMC 2004) to ensure that

  "incidents that cause serious concern in its area relating to midwifery care or midwifery practice are notified to the LSA Midwifery Officer", including suspension of services.

8.8 Suspension of maternity services

Two quarterly reports of suspension of maternity services were produced from data inputted by Trusts on the LSA database. The reports are forwarded to the SHA Head of Clinical Engagement, the Head of Integrated Governance, the Families and Children's Manager and the SHA Performance Directorate. The reports represent a mixture of total unit closures (on single sites), one site closures (with other site open) and suspensions to the home birth services. Some Trusts still require reminding to enter that their unit has re-opened due to the system being new to this practice year.

A brief comparison of the two 3 monthly reports to date indicate that:

- October – December 2007 report: 4 Trusts reported data (3 non – Foundation and 1 Foundation Trust). Of which there were: 42 suspensions, 22 units not stated as re-opened
- January – March 2008 report: 9 Trusts reported (5 non – Foundation and 4 Foundation Trusts). Of which there were 55 suspensions, 12 units not stated as re-opened

The LSA Midwifery Officer has raised awareness of the RCOG (2008) Maternity Dashboard[26] through the electronic LSA Briefing, at a LSA conference and at various other LSA forums, as its use represents a tool that will assist maternity services to utilise their data more proactively to flag concerns to their Trust Boards e.g. excess bookings, peaks in sickness, challenges in staffing levels, supervisor to midwife ratios etc.

[26] RCOG (2008) Maternity Dashboard at: http://www.rcog.org.uk/index.asp?PageID=2289

8.9 Leadership

8.9.1 Leadership development of supervisors

Midwifery clinical activity has challenged the leadership development of supervisors within Trusts over the last year. Continuing professional development has been much reduced and has concentrated upon Mandatory updating. Of the 119 LSA questionnaires completed by supervisors during 2007-08, as part of the LSA audit process, 72 responded to the question

> *"Please state the type and date of the most recent leadership / communication styles assessment you have undertaken".*

29 supervisors had some development within their Trusts over the last 5 years e.g. Myers Brigg, LEA, LEO, Belbin; 15 others had not done any within the last 5 years; 13 had undertaken some but did not cite when and 8 stated that they had never done any. 7 supervisors responded that they had undertaken some leadership development within the last 5 years by completing the supervisors' preparation programme (x5), or at other LSA forums or supervisory forum (x2), 8 undertook some development or received feedback through practice initiatives e.g. leading a Root Cause Analysis, or involvement on the reconfiguration of maternity services, or in their Co-ordinator role.

As leadership is a key component and competency of a supervisor of midwives, the LSAMO will prioritise the leadership development of supervisors during 2008-09.

8.9.2 Leadership development of Link supervisors

The LSAMO has utilised opportunities to develop the Link supervisors and optimise involvement in key initiatives by supporting them to represent the LSA at events that she could not personally attend due to competing demands.

8.9.3 Leadership role of the LSA Midwifery Officer

The LSAMO attended bi-monthly LSA National Forum (UK) meetings and:

- Chaired the national forum until the end of 2007
- Was on the 2008 LSA National conference planning group
- Co-ordinated the LSA national guidelines work until the end of 2007
- Supported key LSA National Forum (UK) publications
- Manned the LSA National Forum (UK) stand at key events

The LSAMO was invited to 3 supervisory time-out sessions within the region and to the Yorkshire and the Humber Heads of Midwifery time-out. Invitations were also accepted from various national working groups including the Information Centre "HES meeting of Users", the NPSA "Intrapartum deaths", the RCM "Returning to midwifery practice Strategic group" and along with others was invited to 10 Downing Street in April 2007 to the "Celebration of maternity services" event.

The LSAMO has intentionally spent more time “filed-based” this year to provide additional support, guidance and leadership to supervisory teams and organisations. This has equated to approximately a quarter of her days being fully field-based, a quarter being partially office and partially field-based and half of her days fully office-based (Appendix 17). LSAMO time has continued to be optimised by not her choosing not to drive and using public transport to enable aspects of work to be done during travel time. This has been at the expense of continued personal development for the LSAMO.

Sustaining additional LSA support, guidance and leadership in the “field” will be possible in 2008 – 09 with the LSA Midwife secondment, but a business plan to continue this level of commitment is required to continue this into 2009 - 2010 and for succession planning.

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

There was 1 complaint by a midwife against a supervisors’ practice. The supervisor was supported to continue to practice during the investigation. The allegation was upheld and the supervisor subsequently stood down whilst undertaking some supervisory developmental support.

There were no complaints against the LSA, but there were 2 appeals by midwives against the LSA decision for referral to the NMC. One appeal was not pursued by the midwife when the SHA process commenced and the other appeal is in process.

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

10.1 Serious untoward incident data

The LSA links closely with the Integrated Governance team and through that to the SHA Board. The LSA is noted within the SHA Serious Untoward Incident Reporting guideline.

Through the annual reporting of LSA statistics to the LSA office, Trusts listed a total of 12 serious untoward incidents (SUIs) related to midwifery practice (1 Trust did not respond) and a total number of 125 complaints about midwifery practice (2 Trusts did not respond). However, on the LSA database for the report year there were 88 issues, of which 21 were SUIs, 1 which was subsequently “de-logged”. This represents a reduction of 5 from the previous year and there were 16 maternal deaths, an increase of 3.

Supervisory teams usually report maternity-related SUIs directly to the LSA office, but non – Foundation Trusts also report through the STEIS system to the SHA Integrated Governance team who liaise with the LSA, whilst the SUI process for Foundation Trusts is via their PCT.

Of the 21 SUIs, midwifery practice was not implicated in 7, themes in the others related to fetal monitoring/CTG interpretation (5), recordkeeping (4), referral to medical staff (2), lack of one to one care (1) and adult blood on a neonatal screening test (1).

The LSAMO and the Link supervisors have discussed and implemented strategies to reduce practice implications and to learn lessons from SUIs. However, this opportunity has the potential to be reduced as more PCTs commence the performance management of the SUI process with the transition of Trusts to Foundation status. The LSAMO will continue to work with commissioners to optimise this potential.

10.2 Supervisory and LSA investigations and their outcomes

27 supervisory investigations were done by supervisors within the LSA an increase in 8 (70%) from the previous practice year. 3 of the 14 Trusts did not report any supervisory investigations to the LSA office. The reasons for the increase and variation in supervisory investigations needs exploring and will form a 2008-09 practice year priority of quality assuring supervisory activities.

2 supervisory investigations were done as a result of service user referral to the LSA Midwifery Officer. The allegations made by 1 service user were upheld following investigation and related to intrapartum assessment and care planning involving the women. The other was not upheld. Another supervisory investigation resulted from a service user complaint to the Healthcare Commission who recommended that the LSAMO source a supervisor external to the Trust to investigate the service user complaint about the midwife's practice. The outcome for the midwife and the Trust related to recordkeeping standards.

8 midwives successfully undertook supervised practice, 1 being a self employed which presented considerable challenges for all involved. 2 midwives were unsuccessful and were referred to the NMC as per process. The increase in supervised practice programmes has represented a considerable increase in workload for the LSAMO, as she has attempted to be involved at initial, interim and final programme meetings for quality assurance purposes and has supported supervisors during investigations (Appendix 17 – LSAMO activity). 16 midwives required developmental support and 15 had reflection with their named supervisor.

The LSA conducted 4 investigations which resulted in 2 NMC referrals in the 2007-08 practice year (see above) and 1 NMC referral in the 2008-09 practice year. The other LSA investigation resulted from a serious concern about a midwife's health, but she subsequently recognised her ill health and complied with treatment. The cases of 2 midwives who were subject to supervisory investigations and subsequently successful supervisory action were referred directly to the NMC; 1 by service users and the other by her Trust. The cases are now on the NMC web-site.

LSA National Forum (UK) guidelines support supervisors of midwives as to when and how they should proceed with a local supervisory investigation. Direct advice from the LSAMO and from Link supervisors is also available.

The “Fresh eyes” or “Buddy” approach of CTG interpretations being checked by a midwife not involved in the care of that woman continues to evaluate well and resulted from incident themes from the 2006-07 practice year.

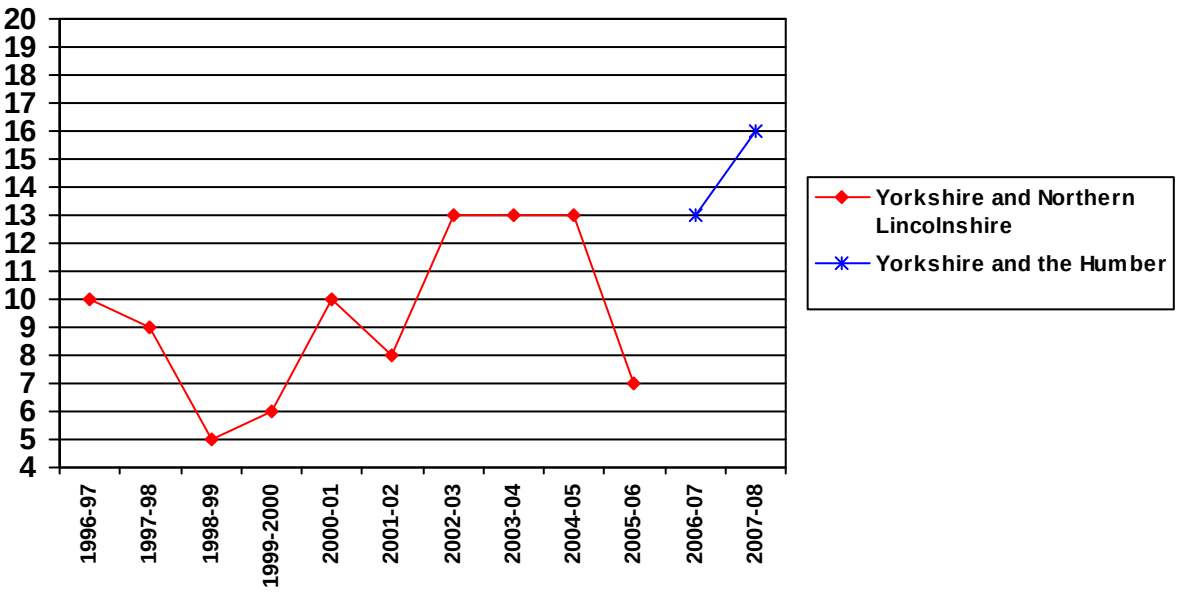
Awareness-raising with Trusts and within the SHA of Labour Ward Co-ordinators being implicated in practice issues when they have been managing clinical cases as well as co-ordinating the Labour Ward has continued. Group work on this topic was facilitated by the Kings Fund at the 2008 summer conference for supervisors. Data is being collected through the 2008-09 LSA audit process and the LSAMO has bid for SHA Patient Safety monies to pursue additional work on the topic. Clinical activity on the labour ward was noted in 9 of the 27 supervisory investigations.

The LSA has liaised with the NMC on an ad hoc basis for support and advice in relation to midwifery and supervisory concerns.

10.3. Maternal deaths

Maternal deaths within the LSA Office are classified by the date of death and not when they were reported.

Maternal deaths: 1996 - 2008



Supervisors follow the LSA guideline for maternal deaths developed in collaboration with CEMACH. They also provide reassurance to the LSAMO that midwifery practice has not been implicated in these tragic occurrences.

There were 16 maternal deaths in the report year. Notification of maternal deaths to the LSA is very prompt, through the LSA database and verbally.

Of the 16:

- 3 were antenatal, with the causes of death being:
  (i) Possible epileptic fit
  (ii) Stabbing
  (iii) Cardiac arrest

- 4 within six weeks of babies births, with the causes of death being:
  (i) Pulmonary embolus
  (ii) End stage cardiac failure
  (iii) Cardiac arrest
  (iv) Suspected pulmonary embolism

- 6 more than six weeks postnatally, with the causes of death being:
  (i) Suicide x 3
  (ii) Pneumonia and meningitis
  (iii) Cardiomyopathy
  (iv) Unsure (substance misuser)

- 1 post-termination of pregnancy

- 2 suicides (details of birth unknown in both cases)

Reporting through the supervisory route has remained robust with some deaths counted above despite them occurring out of the area. The tragedy of 6 of the 16 deaths being of violent means and of the increasing complexity of contemporary midwifery practice reinforces key messages within the CEMACH reports that are disseminated to supervisors by Margaret Jackson, Regional CEMACH Assessor at LSA forums.

11. LSA Budget

The LSA budget has, to date, never been overspent.

12. LSA Support Officer

The LSA Office is managed entirely by Elaine French, the LSA Support Officer and she is well respected by all the supervisors of midwives as well as SHA staff. Elaine French provides outstanding support to the LSA Midwifery Officer and to the supervisors of midwives.

13. LSA priorities for 2008 – 09 practice year

Some of the LSA 2007-08 priorities will remain for 2008-09, including:

- urge trusts to succession plan to a 1:12 supervisors to midwives ratio,
- urge trusts to increase their commitment to protected time and administrative support to supervisors, as they are the main impediment to effective supervision.
- monitor and support Trusts with data quality
- work with Trusts to enhance support systems, practice and the development of Labour Ward Co-ordinators
- work with Trusts to increase the home birth rate
- continue to link more closely with commissioners of maternity services to continually improve the quality and safety of mothers and babies with Yorkshire and the Humber.

New LSA priorities will be to:

- support supervisors in implementing *Healthy Ambitions*
- further enhance the quality assurance of the supervision of midwives in Yorkshire and the Humber
- support the Leadership development of supervisors of midwives
- analyse and publish nationally key Yorkshire and the Humber LSA data for the wider benefit of the practice of supervision and midwives
- support the LSA Midwife and evaluate the post and its outcomes
- explore IT solutions to support supervisory workload
- develop a business case to increase the LSA resource

14. Conclusion

This has been yet another extremely rewarding but challenging year for the LSA due to high midwifery, supervisory and LSA activity. Decreases in whole time equivalent midwives have continued despite increases in birth rates. Supervisory activity levels have been high as midwives have required and benefited from increased support and advice during service remodelling. The LSA Midwifery Officer and supervisors have, and will continue to increase the potential of women, babies and midwives through the proactive supervision of midwives.

Margaret Edwards, Chief Executive, NHS Yorkshire and the Humber

Carol Paeglis, LSA Midwifery Officer, Yorkshire and the Humber LSA

Rule No.	Self assessment against the 53 standards within NMC (2004) Midwives rules and standards Rule Description	Met	Partially Met	Not Met	Comments	Appendix 1
4	**Notifications by Local Supervising Authority**					
	In order to meet the statutory requirements for the supervision of midwives, a local supervising authority will:					
	* Publish annually the name and address of the person to whom the notice must be sent	**Yes**			Published in LSAMO annual report, in monthly LSA Briefing, by email to all supervisors and on LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/	
	* Publish annually the date by which it must receive intention to practise forms from midwives in its area	**Yes**			Published in LSAMO annual report, in monthly LSA Briefing, by email to all supervisors and on LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/	
	* Ensure accurate completion and timely delivery of intention to practise data to the NMC by the 20th of April each year	**Yes**			Verification by NMC. Direct uploads to the NMC from the LSA database have been operational from 1st October 2007	
	* Ensure intention to practise notifications, given after the annual submission, are delivered to the NMC by the 1st of each month	**Yes**			Verification by NMC. Direct uploads to the NMC from the London LSA database will be operational from 1st October 2007	
5	**Suspension from Practice by a Local Supervising Authority**					
	To demonstrate there are mechanisms for the notification and investigation of allegations of a midwife's impaired fitness to practice, a local supervising authority will:					
	* Publish how it will investigate any alleged impairment of a midwife's fitness to practise	**Yes**			On LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/	
	* Publish how it will determine whether or not to suspend a midwife from practice	**Yes**			On LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_su	

					pervising_authority__midwifery/
	* Ensure that midwives are informed in writing of the outcome of any investigation by a local supervising authority	**Yes**			On LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
	* Publish the process for appeal against any decision	**Yes**			On LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
9	**Records**				
	To ensure the safe preservation of records transferred to it in accordance with the Midwives rules, a local supervising authority will:				
	* Publish local procedures for the transfer of midwifery records from self-employed midwives	**Yes**			On LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
	* Agree local systems to ensure supervisors of midwives maintain records of their supervisory activity	**Yes**			On LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
	• Ensure supervisors of midwives records, relating to the statutory supervision of midwives, are kept for a minimum of seven years	**Yes**			On LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
	• Arrange for supervision records relating to an investigation of a clinical incident to be kept for a minimum of 25 years	**Yes**			Archive system at LSA office and locally
	• Publish local procedures for retention and transfer of records relating to statutory supervision	**Yes**			On LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
11	**Eligibility for Appointment as a Supervisor of midwives**				
	In order to ensure that supervisors of midwives meet the requirements of Rule 11 a local supervising authority will:				

	• Publish their policy for the appointment of any new supervisor of midwives in their area	**Yes**			On LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
	* Maintain a current list of supervisors of midwives	**Yes**			Published in LSA annual report – see Appendix 5 and on LSA Database
	* Demonstrate a commitment to providing continuing professional development and updating for all supervisors of midwives for a minimum of 6 hours per year	**Yes**			Published in LSA annual report and LSA guideline on LSA web page at: http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
12	**The Supervision of Midwives**				
	To ensure that a local framework exists to provide equitable, effective supervision for all midwives working with the local supervising authority, and that a supervisor of midwives is accessible at all times a local supervising authority will:				
	* Publish the local mechanism for confirming any midwife's eligibility to practise	**Yes**			On LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
	• Implement the NMC's rules and standards for supervision of midwives	**Yes**			As per LSA guidelines on LSA web page at: http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/. LSA audits Trusts using self audit standards.
	• Ensure that the supervisor of midwives to midwives ratio reflects local need and circumstances (will not normally exceed 1:15)	**Yes**			As per LSA annual report and LSA guideline on LSA web page at: http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
	To ensure a communications network, which facilitates ease of contact and the distribution of information between all supervisors of midwives and other local supervising authorities, a local supervising authority will:				
	* Set up systems to facilitate communication links between and across local supervising authority boundaries	**Yes**			As per LSA guideline on LSA web page at: http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/ and via Monthly LSA Briefing. National LSA newsletter. Email distribution lists e.g. LSAMOs, Contact supervisors, all supervisors, Heads

				of Midwifery Services
	* Enable timely distribution of information to all supervisors of midwives	**Yes**		Monthly LSA Briefing. National LSA newsletter. Email distribution lists e.g. LSAMOs, Contact supervisors, all supervisors, Heads of Midwifery Services. Verification by supervisors
	* Provide a direct communication link, which may be electronic, between each supervisor of midwives and the local supervising authority midwifery officer	**Yes**		Evidenced by emails and verification by supervisors
	* Provide for the local supervising authority midwifery officer to have regular meetings with supervisors of midwives to give support and agree strategies for developing key areas of practice	**Yes**		As per LSA annual report and LSA guideline on LSA web page at: http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/e
	To ensure there is support for the supervision of midwives the local supervising authority will:			
	* Monitor the provision of protected time and administrative support for supervisors of midwives	**Yes**		Monitored at annual LSA audit visits. Outcome reported in LSA annual report
	* Promote woman-centred, evidenced-based midwifery practice	**Yes**		Verification by supervisors, email communication, monthly LSA Briefing and LSA events
	* Ensure that supervisors of midwives maintain accurate data and records of all their supervisory activities and meetings with the midwives they supervise	**Yes**		Monitored at annual LSA audit visits by self audit and verification by supervisees
	A local supervising authority shall set standards for supervisors of midwives that incorporate the following broad principles:			
	* Supervisors of midwives are available to offer guidance and support to women accessing maternity services	**Yes**		Monitored during LSA annual audit visits to Trusts
	* Supervisors of midwives give advice and guidance regarding women-centred care and promote evidence-based midwifery practice	**Yes**		Monitored during LSA annual audit visits to Trusts

	* Supervisors of midwives are directly accountable to the local supervising authority for all matters relating to the statutory supervision of midwives	**Yes**			Verification by supervisors as per LSA guideline on LSA web page at: http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
	* Supervisors of midwives provide professional leadership	**Yes**			Verification by LSAMO, supervisors, midwives / supervisees and Heads of Midwifery Services and evidenced within LSA audit visit reports
	* Supervisors of midwives are approachable and accessible to midwives to support them in their practice	**Yes**			Monitored during LSA annual audit visits to Trusts, verification by midwives
13	**The Local Supervising Authority Midwifery Officer**				
	In order to discharge the local supervising authority supervisory function in its area through the local supervising authority midwifery officer, the local supervising authority will:				
	• Use the NMC core criteria and person specification when appointing a local supervising authority midwifery officer	**Yes**			Verification by the NMC Head of Midwifery
	• Involve a NMC nominated and appropriately experienced midwife in the selection and appointment process	**Yes**			Verification by the NMC Head of Midwifery
	• Manage the performance of the appointed local supervising authority midwifery officer	**Yes**			Verification by LSA line manager as per SHA HR policies.
	• Provide designated time and administrative support for a local supervising authority midwifery officer to discharge the statutory supervisory function	**Yes**			LSA Support Officer in post
	• Arrange for the local supervising authority midwifery officer to complete an annual audit of the practice and supervision of midwives within its area to ensure the requirements of the NMC are being met	**Yes**			Evidenced by LSA annual audit visit reports

15	Publication of Local Supervising Authority Procedures				
	To 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, a local supervising authority will:				
	* Develop mechanisms with NHS authorities and private sector employers to ensure that a local supervising authority midwifery officer is notified of all such incidents	**Yes**			SHA and LSA guidelines in place - http://www.yorksandhumber.nhs.uk/
	* Publish the investigative procedure	**Yes**			Published in LSA annual report and as per SHA and LSA guidelines http://www.yorksandhumber.nhs.uk/
	* Liaise with key stakeholders to enhance clinical governance systems	**Yes**			Verification by SHA Integrated Governance team
	To confirm the mechanisms for the notification and management of poor performance of a local supervising authority midwifery officer of supervisor of midwives, the local supervising authority will:				
	* Publish the process for the notification and management of complaints against any local supervising authority midwifery officer or supervisor of midwives	**Yes**			On LSA web page as per LSA National Forum guidance at http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
	• Publish the process for removing a local supervising authority midwifery officer or supervisor of midwives from appointment	**Yes**			SHA and LSA guidelines in place - http://www.yorksandhumber.nhs.uk/
	• Publish the process for appeal against the decision to remove	**Yes**			SHA and LSA guidelines in place - http://www.yorksandhumber.nhs.uk/
	* Ensure that a local supervising authority midwifery officer or supervisor of midwives is informed of the outcome of any local supervising authority investigation of poor performance, following its completion	**Yes**			SHA and LSA guidelines in place - http://www.yorksandhumber.nhs.uk/
	• Consult the NMC for advice and guidance in such matters	**Yes**			Verification by NMC Professional Midwifery Officers

16	Annual Report				
	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 30th of September of 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:				
	* Numbers of supervisor of midwives appointments, resignations and removals	**Yes**			Published in the LSA annual report. Verification on LSA database.
	* Details of how midwives are provided with continuous access to a supervisor of midwives	**Yes**			Published in the LSA annual report. Verification by midwives/supervisees.
	* Details of how the practice of midwifery is supervised	**Yes**			Published in the LSA annual report. LSA guidelines http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
	* Evidence that service users have been involved in monitoring supervision of midwives and assisting the local supervising authority midwifery officer with the annual audits	**Yes**			Published in the LSA annual report. Verification within LSA Audit Working Group minutes, within LSA audit reports and by speaking with service user representatives
	* Evidence of engagement with higher education institutions in relation to supervisory input into midwifery education	**Yes**			Published in the LSA annual report. Verification from LME's within Bradford, Huddersfield, Hull, Leeds, Sheffield, Sheffield Hallam and York University
	* Details of any new policies related to the supervision of midwives	**Yes**			Published in the LSA annual report. Verification from supervisors or Guidelines Working Group minutes. LSA guidelines: http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/
	• Evidence of developing trends affecting midwifery practice in the local supervising authority	**Yes**			Published in the LSA annual report. Discussed at Link supervisors and Strategy Group meetings
	• Details of the number of complaints regarding the discharge of the supervisory function	**Yes**			Published in the LSA annual report
	• Reports on all local supervising authority investigations undertaken during the year	**Yes**			Published in the LSA annual report

APPENDIX 2

Yorkshire and Humber Risk Profile 2006–07 = 15

LSA	Yorkshire & Humber	**Chief Executive**	Margaret Edwards
LSAMO	Carol Paeglis	**Contact details of LSA**	NHS Yorkshire and the Humber Blenheim House, West One, Duncombe Street Leeds LS1 4PL 0113 295 2094 carol.paeglis@yorksandhumber.nhs.uk

Ref	Date	Summary of concern / information	Source	Risk	Risk score		
					Likelihood	Impact	Overall
8	**Jan 08**	Evidence to suggest increasing births across the LSA of over 5-10% or increase in midwife to birth ratio.	**LSA Annual Report**	**Impact upon the protection of the public and suitability of clinical environment as a safe and supportive place for provision of care.** **Impact on appropriateness of clinical learning environment for pre registration midwifery students**	**3**	**5**	**15** AMBER

APPENDIX 3

NMC Framework Risk Register Key

Consequence/Severity of Impact

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

RISK Low Moderate High

1-8 9-15 16-25

Rating consequences and impact

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

Rating the likelihood

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

NMC Framework Risk Register						
Ref	Summary of information	Source	Risk	Likelihood	Impact	Risk score
Chief Executive sign off and quality of report						
1	Chief Executive did not sign annual report and no indication that it had been viewed by him/her.	LSA Annual Report	Lack of sign off may mean non-engagement with supervisory function at SHA/board level.	**2**	**8**	**16 RED**
2	Some requirements of rule 16 of the midwives rules and standards not described in the LSA annual report and NMC not assured that an effective supervisory framework is in place.	LSA Annual Report	Effective supervisory framework may not be in place and therefore unable to protect the public.	**4**	**4**	**16 RED**
3	Inconsistent description of supervision framework described and NMC not assured that an effective and consistent supervisory framework is in place.		Effective and consistent supervisory framework may not be in place and therefore unable to protect the public.	**4**	**4**	**16 RED**
Numbers of Supervisors of Midwives, appointments, resignations and removals						
4	SoM/MW ratio above 1:20 within individual services or across the LSA.	LSA Annual Report	Elements of supervisory framework unachievable or unsustainable due to lack of supervisors.	**3**	**4**	**12 AMBER**
5	SoM / MW ratio not stated.	LSA Annual Report	Elements of supervisory framework unachievable or unsustainable due to lack of supervisors	**4**	**4**	**16 RED**
Details of how midwives are provided with continuous access to a Supervisor of Midwives						

6	Description of how midwives are provided with continuous access to a SoM not described or variable across LSA and NMC not assured that an effective supervisory framework is in place. E.g. some areas within an LSA may use a 24/7 hour rota and some may use a contact list.	LSA Annual Report	That in an emergency midwives may not have clarity about how to contact a Supervisor of Midwives thereby delaying a decision that may have an influence on the outcome for a mother and baby.	**3**	**4**	**12 AMBER**
7	No evidence that '*continuous access to a SoM'* process is audited so lack of assurance that process is working effectively.	LSA Annual Report	Process may not be working effectively which may have impact during emergency situations (see above).	**3**	**4**	**12 AMBER**
Details of how the practice of midwives is supervised						
8	LSA audit process not described (or not described well) so NMC not assured that an effective supervisory framework is in place.	LSA Annual Report	Effective supervisory framework may not be in place and therefore unable to protect the public	**4**	**3**	**12 AMBER**
9	No description of ITP process.	LSA Annual Report	Lack of supervisory framework in place and inability to delivery function of supervision.	**4**	**4**	**16 RED**
10	LSA Audit Process stated as not undertaken.	LSA Annual Report	No mechanism in place to assure LSA that supervision is functioning and therefore NMC not assured that effective supervisory framework in place.	**5**	**4**	**20 RED**
Evidence that service users are assisting the LSAMO with the annual audits						
11	Public User Involvement in supervision audits not described.	LSA Annual Report	Lack of user input into development of supervisory framework. Risk in meeting rules and standards.	**4**	**3**	**12 AMBER**
12	Public User Involvement in supervision could be enhanced.	LSA Annual Report	Minimal user input into development of supervisory framework.	**2**	**2**	**4 GREEN**
Evidence of engagement with higher education institutions in relation to supervisory input in to student midwifery education						

13	No evidence of engagement with higher education institutions.	LSA Annual Report	Risk in meeting rules and standards.	**4**	**4**	**16 RED**
14	Indication that the clinical learning environment for student midwives is not an appropriate learning environment. This may include lack of qualified mentors, lack of support for undertaking mentorship programme or challenges in meeting student/mentor ratio.	LSA Annual Report QA Framework	Supervisory framework is not pro-active in improving learning environment for student midwives and/or students learning in an inappropriate clinical environment.	**4**	**4**	**16 RED**
Details of any new policies related to the supervision of midwives						
15	No detail of any new policies.	LSA Annual Report	Lack of pro-activity of LSA in supporting supervisors of midwives with policy development.	**4**	**4**	**16 RED**
Evidence of Developing Trends affecting midwifery practice in the local supervising authority						

16	Limited information or description provided on maternal death trends within LSA and interface with supervisory framework.	LSA Annual Report	Role of supervisory framework unclear. Limited analysis learning from trends and lack of opportunity to apply learning in the future to protect the public.	**4**	**4**	**16 RED**
17	Evidence to suggest increasing births across the LSA of over 5-10% or increase in midwife to birth ratio.	LSA Annual Report	Impact upon the protection of the public and suitability of clinical environment as a safe and supportive place for provision of care. Impact on appropriateness of clinical learning environment for pre registration midwifery students	**3**	**5**	**15 AMBER**
18	Maternity Service/s within LSA under review by NMC or other stakeholder or special measures in place by the Health Care Commission.	LSA Annual Report	Impact upon the protection of the public and suitability of clinical environment as a safe and supportive place for provision of care. Impact on appropriateness of clinical learning environment for pre registration midwifery	**3**	**5**	**15 AMBER**
Details of number of complaints regarding the discharge the Supervisory Function						
19	No description of complaints process or number of complaints.	LSA Annual Report	Possibility that complaints process is not in place or is not robust.	**3**	**5**	**15 AMBER**
20	Evidence of up held complaints against the LSA.	LSA Annual Report	That the LSA has been deemed to be in effective in its function to women or midwife (dependent on complaint). There may have been a compromises to protecting the public e.g. due to bullying, harassment or discrimination.	**4**	**4**	**16 RED**
Reports on all local supervising authority investigations undertaken during the year						

21	High or low percentage of supervisory practice programmes described and/or lack of definition on reasons for high or low numbers.	LSA Annual Report	Rules and Standards in relation to investigation leading to supervised practice not being interpreted appropriately/effectively. Risk that midwives being placed on a programme of supervised practice inappropriately.	**3**	**4**	**12 AMBER**
General concerns identified in the NMC framework for reviewing LSAs						
22	Inadequate supervisory framework in place to meet the Midwives Rules and Standards across the LSA.	NMC framework for reviewing LSAs	Effective supervisory framework not in place and therefore unable to protect the public.	**3**	**5**	**15 AMBER**
23	Where a midwife is reported to the NMC for clinical concerns without reference to the supervisory framework.	NMC framework for reviewing LSAs	Effective supervisory framework not in place and therefore unable to protect the public.	**3**	**5**	**15 AMBER**
24	Where the clinical environment is unsafe for midwife student learning or mentorship is ineffective and not supporting student midwives.	NMC framework for reviewing LSAs	Impact on appropriateness of clinical learning environment for pre registration midwifery	**3**	**5**	**15 AMBER**
25	Concerns regarding the function and performance of supervision within the LSA.	NMC framework for reviewing LSAs	Effective supervisory framework not in place and therefore unable to protect the public.	**3**	**5**	**15 AMBER**
26	Poor compliance with recommendations from any investigations reports from either the LSA or other bodies such as the Healthcare Commission.	NMC framework for reviewing LSAs	Effective supervisory framework not in place and therefore unable to protect the public.	**3**	**5**	**15 AMBER**
27	Concerns of conduct which relate to, for example, bullying, harassment or abuse of power from within the LSA or supervisory framework which may impact upon the function of supervision.	NMC framework for reviewing LSAs	Effective supervisory framework not in place and therefore unable to protect the public.	**3**	**5**	**15 AMBER**

APPENDIX 4

THE LSA YEAR IN BRIEF
APRIL 2007 – MARCH 2008

April 2007
- Independent midwife/Liaison supervisors workshop
- New supervisors meeting
- NMC audit of Yorkshire and the Humber LSA
- Training workshop for new LSA Database

May 2007
- Formal LSA audit visit to York
- Informal LSA audit visit to Bradford
- 2 LSA Midwifery Officer/supervisors of midwives neighbourhood meetings
- 5 Yorkshire and the Humber guidelines for supervisors of midwives launched
- LSA Midwifery Officer acted as reviewer on NMC review team auditing West Midlands LSA

June 2007
- Informal LSA audit visit to Hull & East Yorkshire
- Trained interview panel for prospective supervisors of midwives interviews
- 8 prospective supervisors of midwives interviewed and accepted for the Preparation of Supervisors of midwives course commencing September 2007.
- LSA Midwifery Officer attended Mid Yorkshire supervisors of midwives time out session

July 2007
- New supervisors meeting
- 56 supervisors of midwives attended the Annual Summer Conference, Harrogate
- 3 National guidelines for supervisors of midwives launched

August 2007
- Formal LSA audit visit to Harrogate

September 2007
- Yorkshire and Northern Lincolnshire supervisors of midwives bi-annual meeting at Askham Bryan College.
- Preparation of Supervisors of midwives programme commenced at Sheffield University.
- Mentor Preparation Workshop
- Formal LSA audit visit to Calderdale & Huddersfield
- Yorkshire and the Humber staff away day
- Budget holder training session

October 2007
- 7 prospective supervisors of midwives interviewed and accepted for the Preparation of Supervisors of midwives course commencing January 2008.
- Formal LSA audit visit to Barnsley
- New supervisors meeting
- Myers Briggs training
- 74 supervisors of midwives attended the 2007 Annual Winter Conference, Harrogate
- Maternal, fetal and neonatal workshop, Leeds
- Baby Lifeline Conference, Oxford
- LSA Midwifery Officer presented LSA Annual report and NMC Pilot review of Yorkshire and the Humber LSA at Trust Board Meeting.
- Responded to consultation on draft NICE antenatal care guideline.

November 2007
- Formal LSA audit visit to Airedale
- Formal LSA audit visit to Mid Yorkshire

- Independent midwife/Liaison supervisors workshop
- 2 LSA Midwifery Officer/supervisors of midwives neighbourhood meetings
- NPSA Intrapartum Deaths Workshop, London
- NMC Conference, Cardiff
- LSA Midwifery Officer attended Scarborough supervisors of midwives time out session
- LSA Midwifery Officer attended Calderdale & Huddersfield supervisors of midwives time out session
- 3 Yorkshire and the Humber and 2 National guidelines for supervisors of midwives launched.

December 2007

- Formal LSA audit visit to Rotherham
- Mentor Preparation Workshop
- LSA Midwifery Officer attended Heads of Midwifery time out day, Harrogate

January 2008

- New supervisors meeting
- Preparation of Supervisors of midwives programme commenced at Leeds University
- Informal LSA audit visit to Leeds
- Informal LSA audit visit to Northern Lincolnshire & Goole

February 2008

- Formal LSA audit visit to Sheffield
- 1 Yorkshire and the Humber guideline for supervisors of midwives launched
- Review of NHS Maternity Statistics Publication Workshop
- Interviewed for the LSA Midwife role and appointed successful candidate

March 2008

- Informal LSA audit visit to Scarborough
- Formal LSA audit visit to Doncaster & Bassetlaw
- Final day of SoMS September 2007 preparation programme - assessment and submission day

APPENDIX 5

YORKSHIRE AND THE HUMBER LSA SUPERVISORS OF MIDWIVES AT 20.30.2008 – TOTAL = 194

AIREDALE NHS TRUST (100)
Supervisor to Midwife ratio 1:12
Airedale General Hospital
Anne Tasker working towards appointment
Kath Walsh - HoM
Alison Mastrantuono - CSoM
Sue Bell **(Mentor)**
Shona Featherstone
Sue Speak **(Mentor)**
Aileen Stephen *(Resigning)*
Mary Stronach
Amanda Wright (Total: 8)

BARNSLEY HOSPITAL NHS FOUNDATION TRUST (99)
Supervisor to Midwife ratio 1:12
Elizabeth Turner – student on Sept 07 Sheffield cohort (end 17 Mar 08)
Sue Gibson - (HoM) **(Mentor)**
Sharon Hardy -(CSoM) **(Mentor)**
Bev Cicero
Bron Godwin **(Mentor)**
Sharon Hardy **(Mentor)**
Jill Murphy
Sandra Newman
Anne Smith (Total: 8)

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST (188)
Supervisor to Midwife ratio 1:12
Alison Broadley - student on Jan 07 Cohort 8 at Leeds (end 8 June 07)
Lynn Greenwood - student on Sept 07 Sheffield cohort (end 17 Mar 08)
Bradford Royal Infirmary
Julie Walker – HoM
Geraldine Dyas – CSoM **(Mentor)**
Julie Appleyard **(Mentor)**
Gwendolen Bradshaw **(Mentor)**
Alison Brown **(Mentor)**
Carol Cahill **(Mentor)** (Standing down for 6 months w.e.f date t.b.a)
Diane Daley
Helen Hall **(Mentor)**
Amanda Hardaker
Alex Horsfall
Andrea Massey **(Mentor)**
Jane Morgan **(Mentor)**
Tina Mori **(Mentor)**
Sheila Nolan **(Mentor)**
Alison Powell **(Mentor)** (Total: 15)

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST (186)
Supervisor to Midwife ratio 1:9
Calderdale Royal Hospital
Jacque Gerrard – *HoM* (Calderdale + Huddersfield)
Brenda Alderson *(HCC)*
Joyce Ayre
Jeannie Heptinstall
Linda Hill
Elspeth Pilling
Elaine Rollinson
Margaret Stephenson
Sue Townend – *Link SoM*

Huddersfield Royal Infirmary
Gillian Shaw – CSoM
Gina Augarde
Christine Bairstow
Ruth Hanson
Julie Hinchliffe – *Link SoM*
Michele Howland
Kathy Kershaw
Heather McNair
Julie Parkin
Helen Shallow
Janet Woodhouse (Total: 20)

DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST (163)
Supervisor to Midwife ratio 1:13
Debby McKnight – student on Sept 07 Sheffield cohort (end 17 Mar 08)
Sarah Lakeland - student on Jan 08 Leeds cohort (end 18 July 08)
Doncaster Royal Infirmary
Vivienne Knight - (HoM) **(Mentor)**
Carol Lee - (CSoM)
Pat Holland
Claire Keegan
Chris Livingston **(Mentor)**
Linda Mears
Mary Moffat
Julie Saunders
Sharon Smithson
Donna Wright
Bassetlaw Supervisors: Karen Cousins, Sharon Rainsforth and Alison Schofield – have been made supervisors at Doncaster on the LSA Database as they supervise midwives based in Doncaster. (Total: 13)

HARROGATE AND DISTRICT NHS FOUNDATION TRUST (72)
Supervisor to Midwife ratio 1:10
HARROGATE DISTRICT HOSPITAL
Jan Chaplin – HoM **(Mentor)**
Lesley Harris - CSoM
Janice Carrington **(Mentor)**
Joan Forbes **(Mentor)**
Jane Ford
Janet Gladman **(Mentor)**
Elizabeth Ross (moved from York 30.04.07 – standing down until further notice)
Sue Skelling (Total: 7)

HULL & EAST YORKSHIRE HOSPITALS NHS TRUST (247)
Supervisor to Midwife ratio 1:16
Susan Craughan and Nicky Foster – students
on Sept 07 Sheffield cohort (end 17 Mar 08)
Hull and East Yorkshire Women and Children's Hospital
Jubilee Birth Centre
Karen Thirsk – HoM + Link Som **(Mentor)**
Janet Cairns – CSoM **(Mentor)**
Lorraine Cooper
Sue Fairclough **(Mentor)**
Julie Green **(Mentor)**
Jayne Grimshaw (moved to Hull from NLAG in Nov 05 – standing down until further notice)
Jane Hardy
Caroline Harrison **(Mentor)**
Jackie Hatch **(Mentor)**
Abigail Hill **(Mentor)**
Heather Holland **(Mentor)**
Moira Lee **(Mentor)**
Jane McFarlane **(Mentor)**
Suzanne Procter **(Mentor)**
Sheryl Sykes **(Mentor)**
Julie Tuton **(Mentor)** **(Total:15)**

THE LEEDS TEACHING HOSPITALS NHS TRUST (315)
Supervisor to Midwife ratio 1:15
Jane Alcock, Kathryn Bentham, Helen Cassidy, Josephine Croton, Anna Proctor and Sarah Bennett - students on Jan 08 Leeds cohort (end 18 July 08)
Leeds General Infirmary and St James's University Hospital
Julie Scarfe – HoM
Paula Jenkins - CSoM
Mary Armitage
Annette Barnes
Julie Clarke
Lynn Deane
Sue Deighton **(Mentor)**
Anne-Marie Henshaw
Angela Hewett

Karen Holmes
Tracy Ibbeson **(Mentor)**
Fiona Kaye **(Mentor)**
Janette Kirk
Gail Knight
Alison McGowan
Alison McIntyre **(Mentor)**
Shelley Madden (stood down)
Andrew Steer
Jacqueline Turner
Susan Wallis
Anne Ward (stood down for 6 months w.e.f 04.12.06)
Karen Warner **(Mentor)**
Gail Wright (Total: 21)

MID YORKSHIRE HOSPITALS NHS TRUST (219)

Supervisor to Midwife ratio 1:11

Pontefract General Infirmary and Wakefield Birth Centre

Sharon Schofield – HoM
Angela South – CSoM (Mentor)
Wendy Dodson
Lois Fox
Sally Fox
Susanne Hobson
Shirley Leonard
Rosalyn Morley
Valerie Rowett
Gill Smethurst
Angela Waterson

Dewsbury and District Hospital

Lesley Cox
Diane Goodwin
Maxine Hey
Irene Hopkins
Lorna James **(Mentor)**
Helen Morris
Paula Roebuck
Caroline Weldon (Total: 19)

NORTHERN LINCOLNSHIRE & GOOLE HOSPITALS NHS FOUNDATION TRUST (189)

Supervisor to Midwife ratio 1:13

Scunthorpe General Hospital
Goole District Hospital

Debrah Shakespeare – HoM **(Mentor)**
Kim Sheppard – CSoM **(Mentor)**
Kathleen Hobson
Linda Keech
Carol Lilley
Karen Purves
Barbara Scott

Diana, Princess of Wales Hospital, Grimsby
Sue Briggs – CSoM (Mentor)
Michelle Barford
Yvonne Birtles
Sara Butcher
Julie Dixon
Sheila Skipworth (Mentor)
Sarah Wise
Sheila Youssef (Total: 15)

THE ROTHERHAM NHS FOUNDATION TRUST (122)
Supervisor to Midwife ratio 1:13
Rotherham District General Hospital
Karen Norton (HoM + CSoM) **(Mentor)**
Mandy Barnes **(Mentor)**
Kim Booth **(Mentor)**
Phyllis Calladine **(Mentor)**
Judith Gilliver **(Mentor)**
Theresa Jenkinson **(Mentor)**
Joanne Lancashire **(Mentor)**
Angela Spillane **(Mentor)**
Sue Velamail **(Mentor)** (Total: 9)

SCARBOROUGH & NORTH EAST YORKSHIRE HEALTHCARE NHS TRUST (67)
Supervisor to Midwife ratio 1:7
Scarborough General Hospital
Bridlington & District Hospital
Malton Community Hospital
Whitby Community Hospital
Helen Noble – Acting HoM **(Mentor)**
Sheila Strickland – CsoM **(Mentor)**
Wendy Beagles
Lynda Fairclough
Jacky Lawty
Freya Oliver **(Mentor)**
Lorraine Rae
Jane Tyler
Patsy Tyson (Total: 9)

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST (316)
Supervisor to Midwife ratio 1:13
Anne Morley - student on Jan 2007 Cohort 8 at Leeds (end 8 June 2007)
Karen Sabin, Michelle Crownshaw + Laura Rumsey – students on Sept 07 Sheffield cohort (end 17 Mar 08)
Jessop Wing Women's Hospital
Dotty Watkins (HoM and CSoM)
Di Bartholomew **(Mentor)**
Marcia Baxter **(Mentor)**

Janice Brennan
Cath Burke
Sharon Clarke
Karen Drabble **(Mentor)**
Susan Emery
Carol Ford
Sally Freeman
Gill Hunt **(Mentor)**
Rachel Jokhi
Carollynn Jones
Sally Kinnish
Lynn Longmuir **(Mentor)**
Wendy Martin
Teresa Oxley
Denise Robins
Gill Sear
Maxine Spencer
Julie Stafford
Adele Stanley
Chris Thornber **(Mentor)**
Julie Walsh – *Link SoM* (Total: 24)

SHEFFIELD HALLAM UNIVERSITY

Heather Wilkins (CSoM)
Kirsty Schofield
Celia Yeardley (Total: 3)

SHEFFIELD UNIVERSITY

Angela Walker (Total: 1)

YORK HOSPITALS NHS FOUNDATION TRUST (125)

Supervisor to Midwife ratio 1:12

Kath Chapman + Hilary Farrow: students on Jan – July 08 Leeds cohort

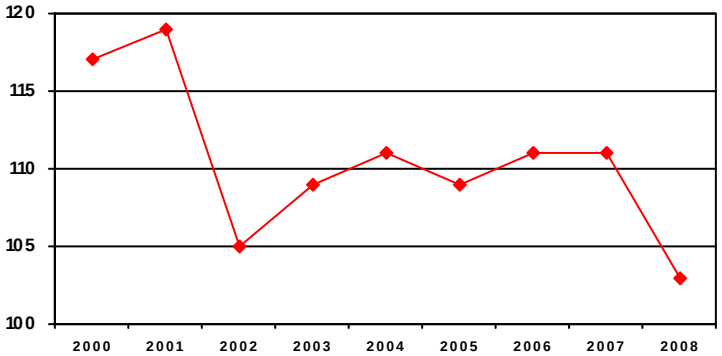
York Hospital

Margaret Jackson – HoM + Link SoM
Deborah Wright – CsoM
Susan Ayres
Elizabeth Barber
Helen Baston
Patricia Fowler
Helen Joyce
Joanna Lishman
Louvain Shaw **(Mentor)**
Kathleen Thompson (Total: 10)

APPENDIX 6

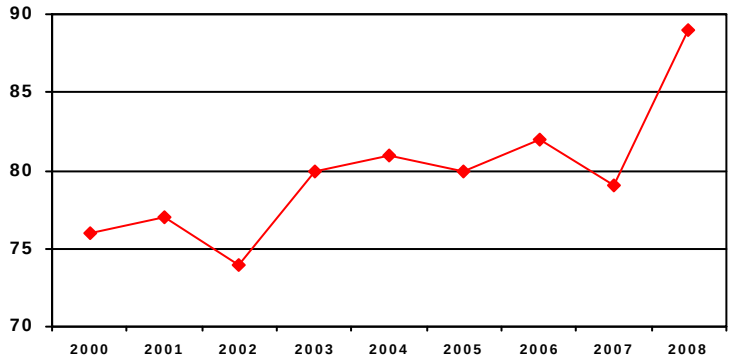
AIREDALE

Number of midwives supervised

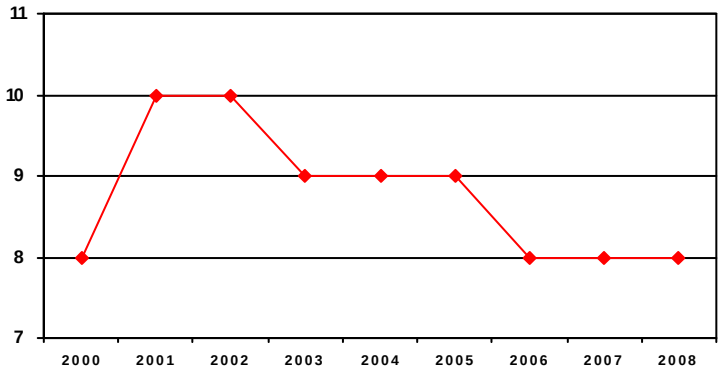


(2008 figure = total number of midwives notifying ITP)

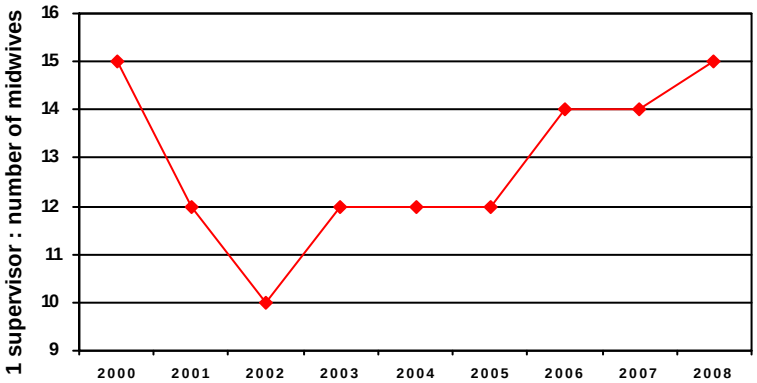
Whole Time Equivalent Midwives



Number of supervisors of midwives

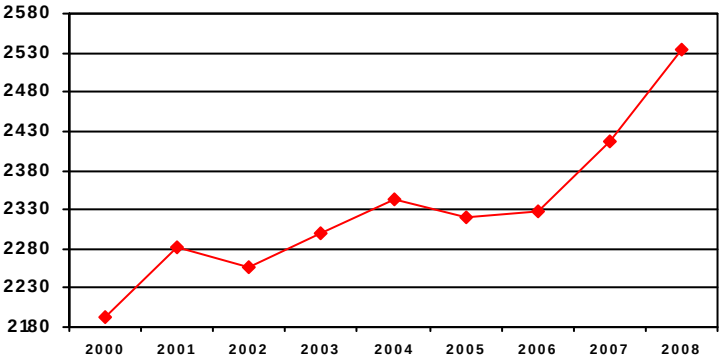


Supervisor : Midwife Ratio

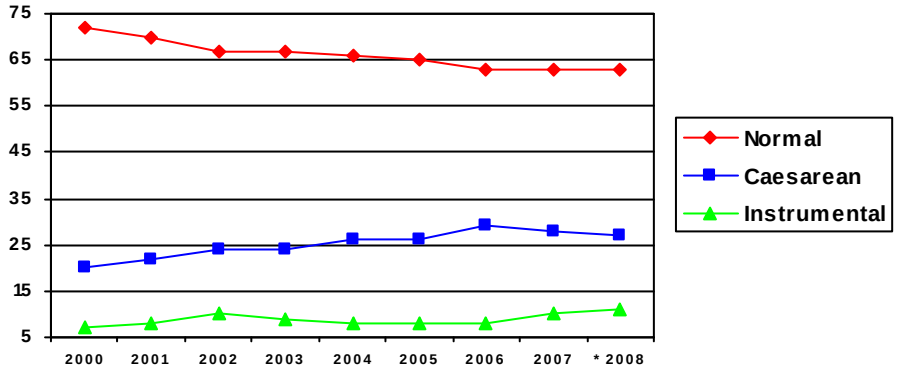


AIREDALE

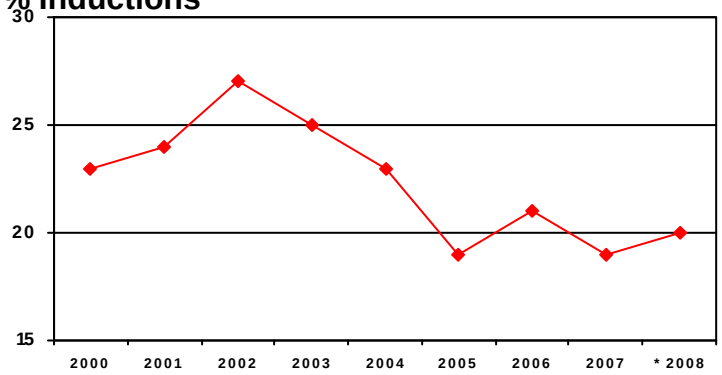
Total number of women delivered



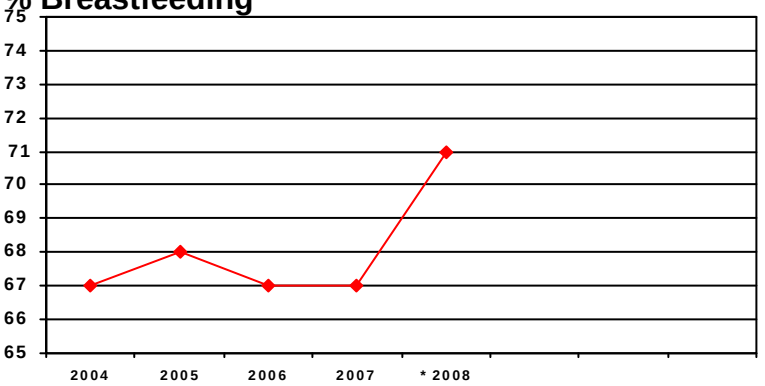
% Unassisted vaginal, caesarean + instrumental births



% Inductions



% Breastfeeding

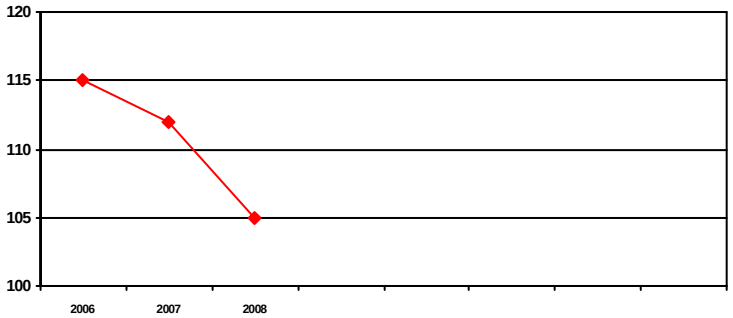


Breastfeeding data not collected prior to 2004

* 2008 figures based on total births (not women delivered)

BARNSLEY

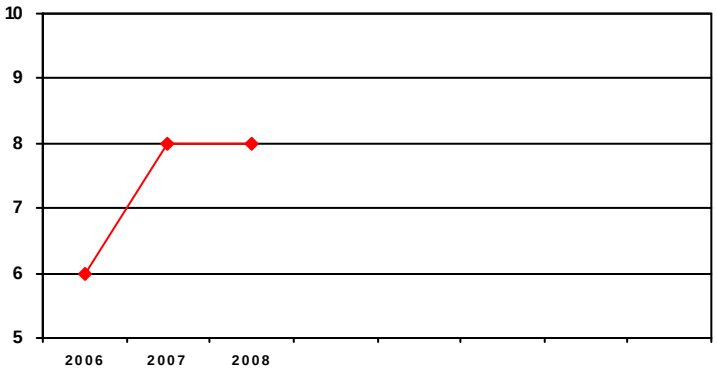
Number of midwives supervised



(2008 figure = total number of midwives notifying ITP)

Whole Time Equivalent Midwives

Number of supervisors of midwives

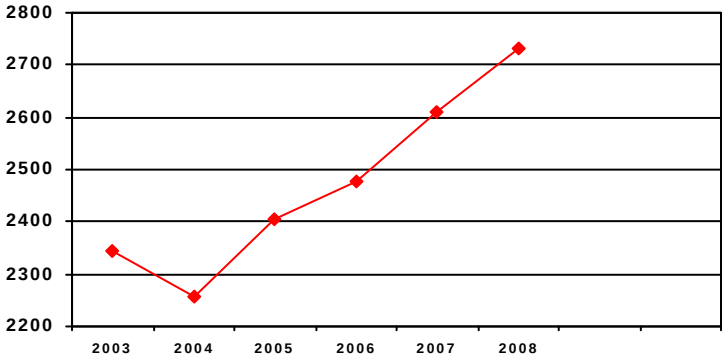


Supervisor : Midwife Ratio

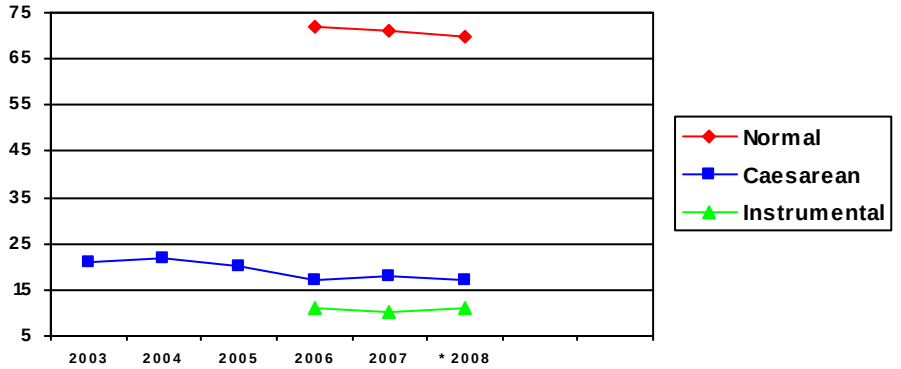
NB: This Trust has changed LSA at least three times over the last few years so collation of more historical data has not been possible.

BARNSLEY

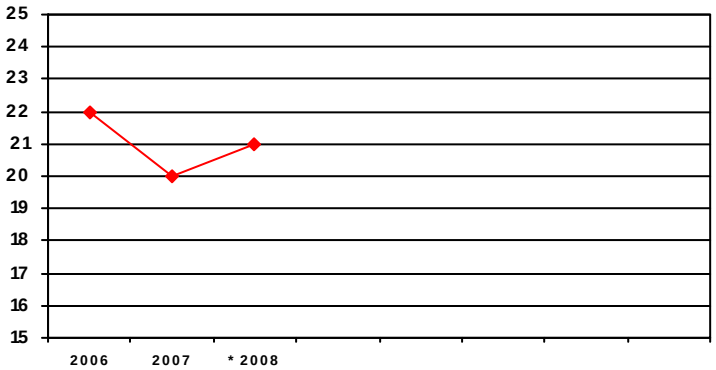
Total number of women delivered



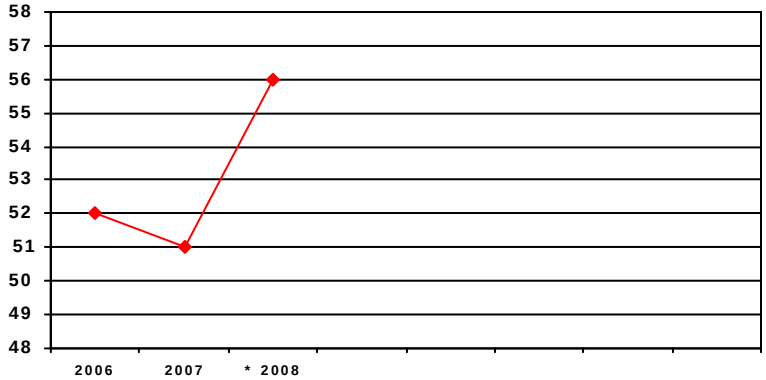
% Unassisted vaginal, caesarean + instrumental births



% Inductions



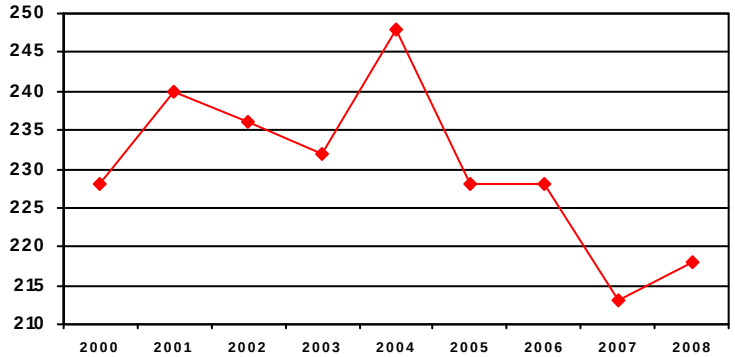
% Breastfeeding



NB: This Trust has changed LSA at least three times over the last few years so collation of more historical data has not been possible.
*** 2008 figures based on total births (not women delivered)**

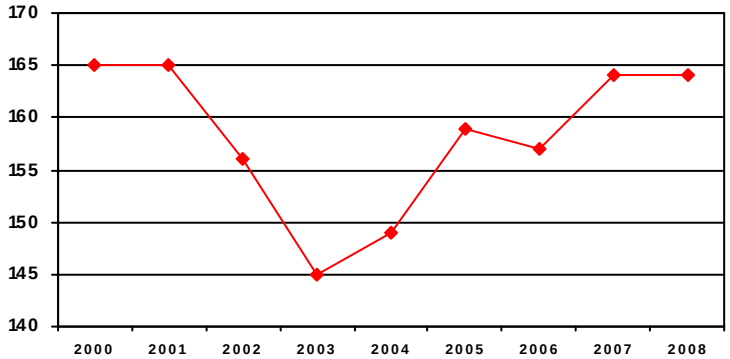
BRADFORD

Number of midwives supervised

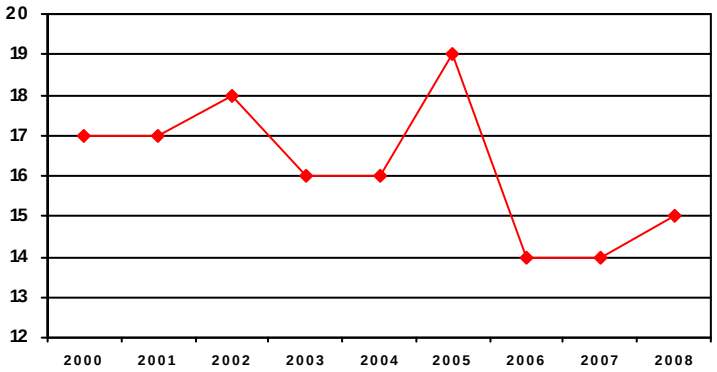


(2008 figure = total number of midwives notifying ITP)

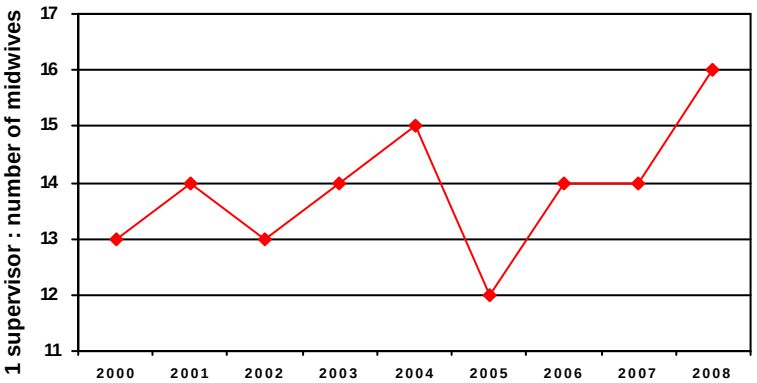
Whole Time Equivalent Midwives



Number of supervisors of midwives

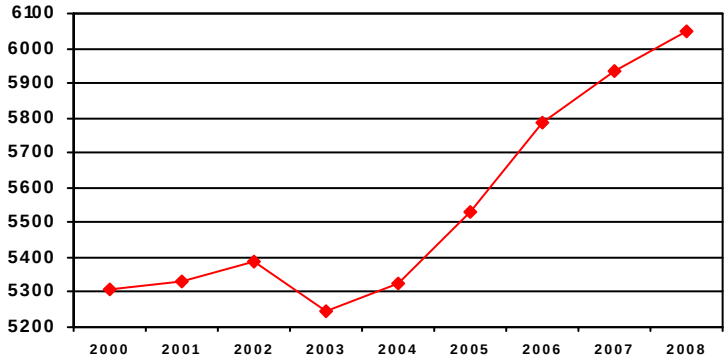


Supervisor : Midwife Ratio

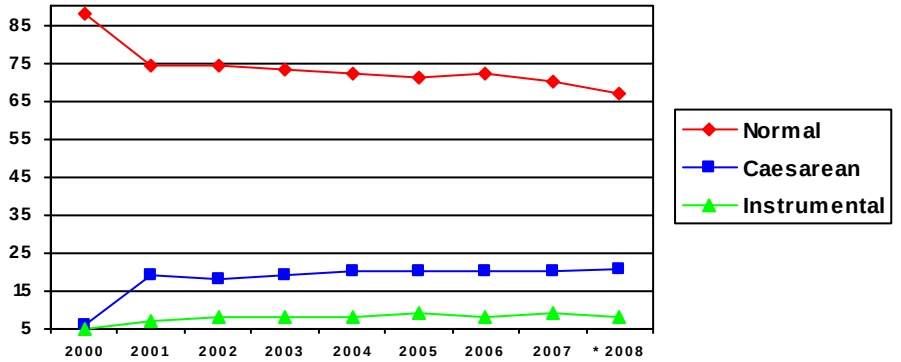


BRADFORD

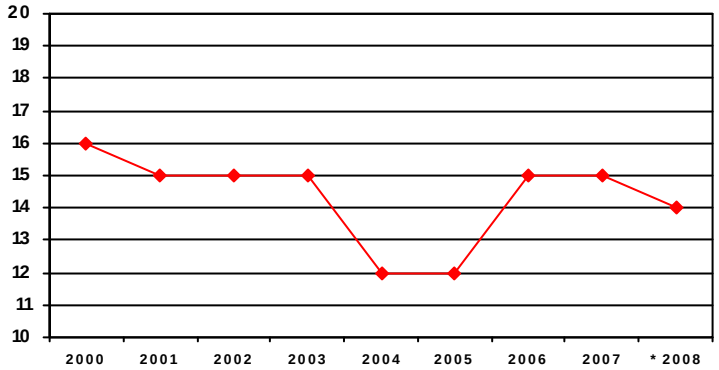
Total number of women delivered



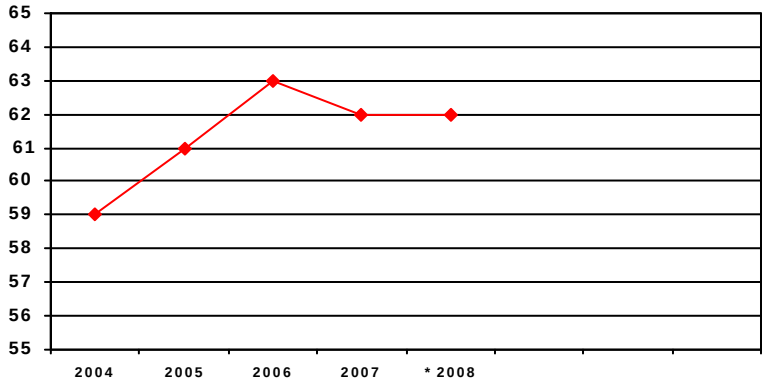
% Unassisted vaginal, caesarean + instrumental births



% Inductions



% Breastfeeding

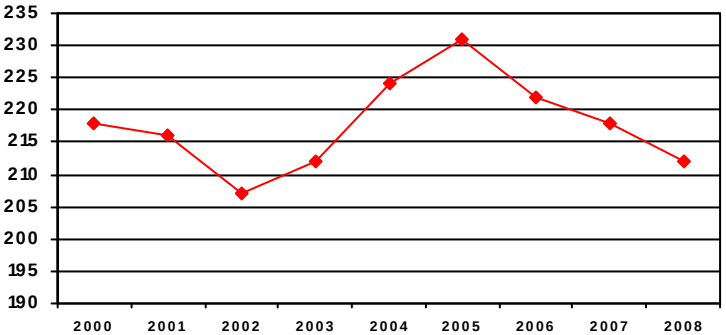


Breastfeeding data not collected prior to 2004

**** 2008 figures based on total births (not women delivered)***

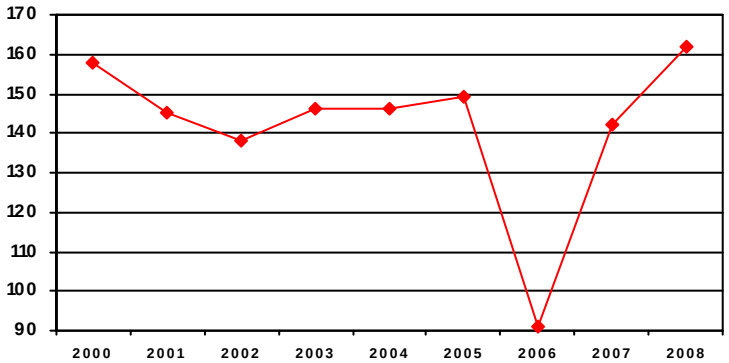
CALDERDALE AND HUDDERSFIELD

Number of midwives supervised



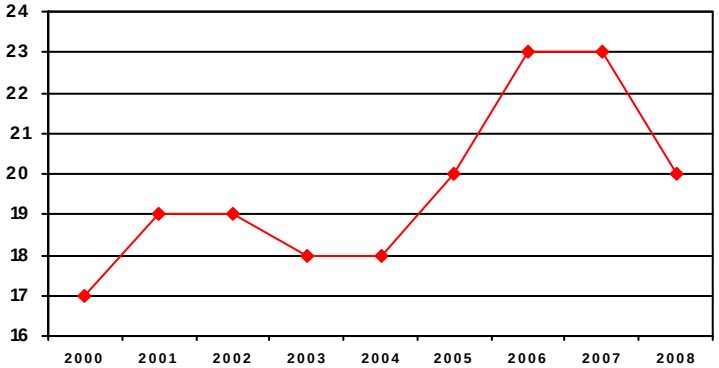
(2008 figure = total number of midwives notifying ITP)

Whole Time Equivalent Midwives

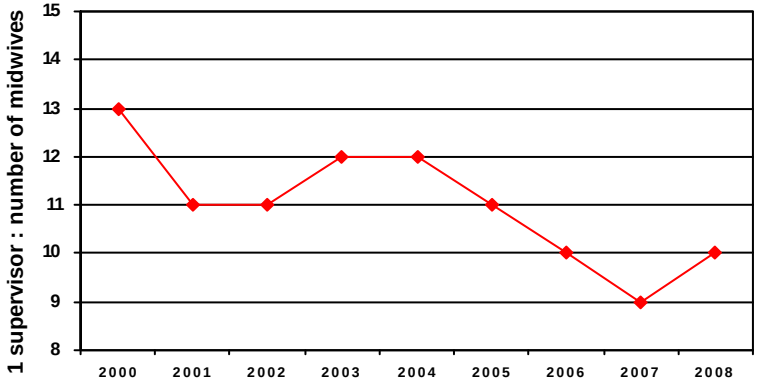


2006 figure refers to Hospital only

Number of supervisors of midwives



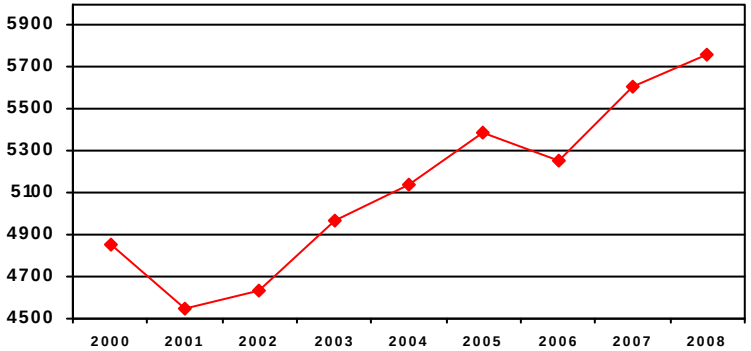
Supervisor : Midwife Ratio



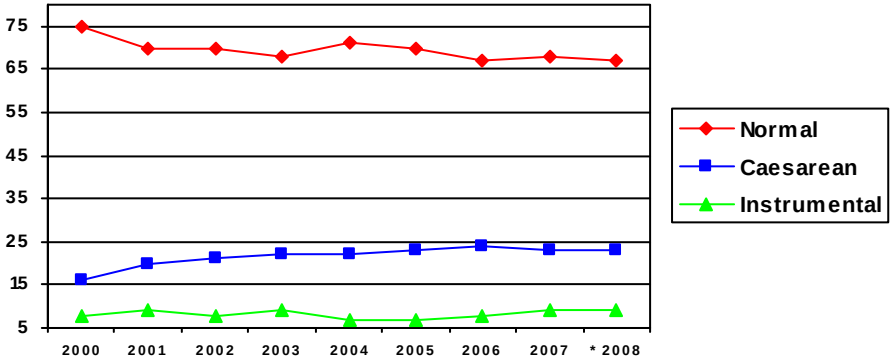
NB: All data preceding the Trust merger in 2003/04 was provided for each individual site but has been merged for the report for consistency.

CALDERDALE AND HUDDERSFIELD

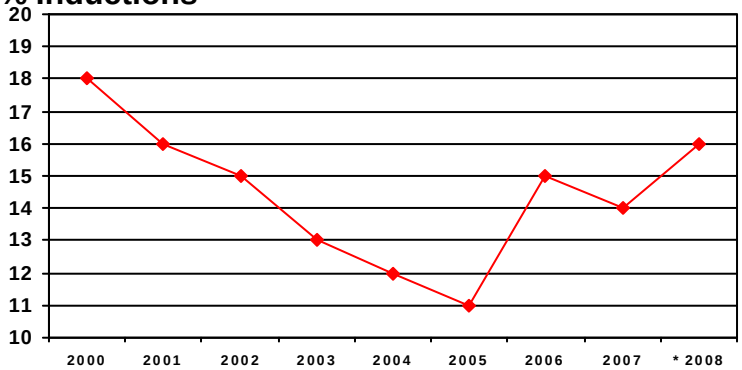
Total number of women delivered



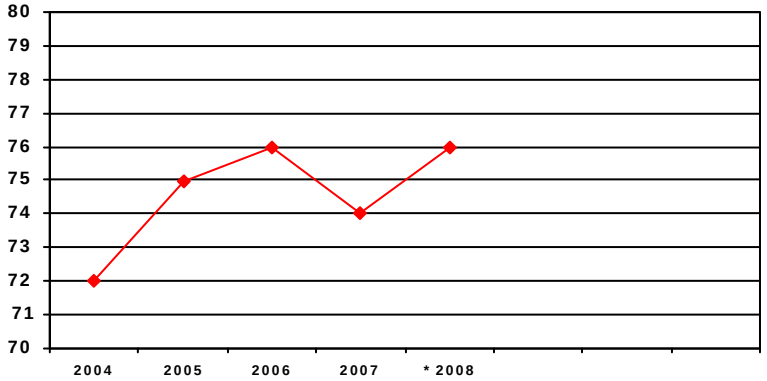
% Unassisted vaginal, caesarean + instrumental births



% Inductions



% Breastfeeding

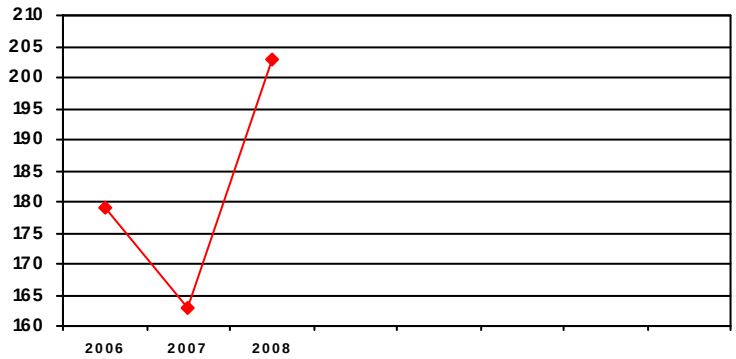


Breastfeeding data not collected prior to 2004

**** 2008 figures based on total births (not women delivered)***

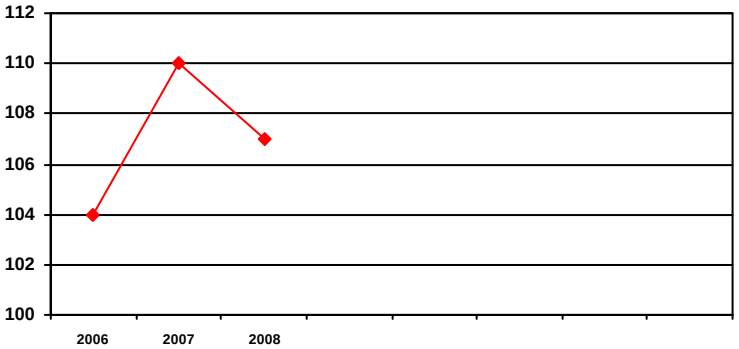
DONCASTER

Number of midwives supervised

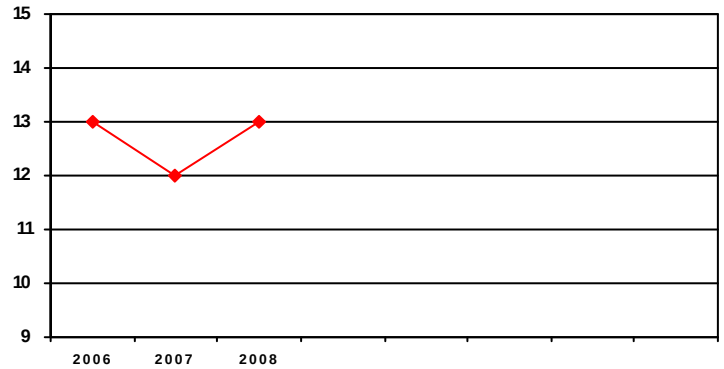


(2008 figure = total number of midwives notifying ITP)

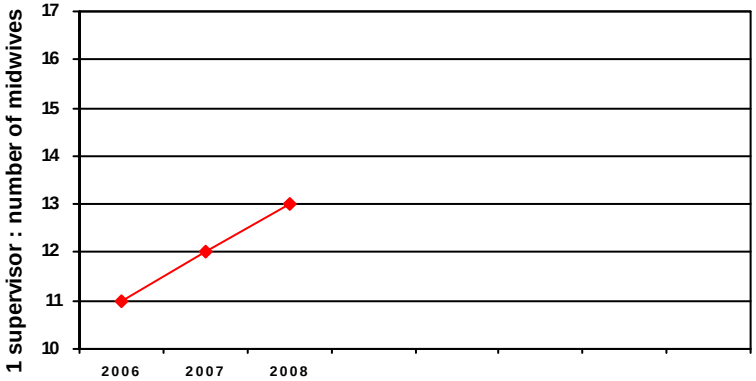
Whole Time Equivalent Midwives



Number of supervisors of midwives



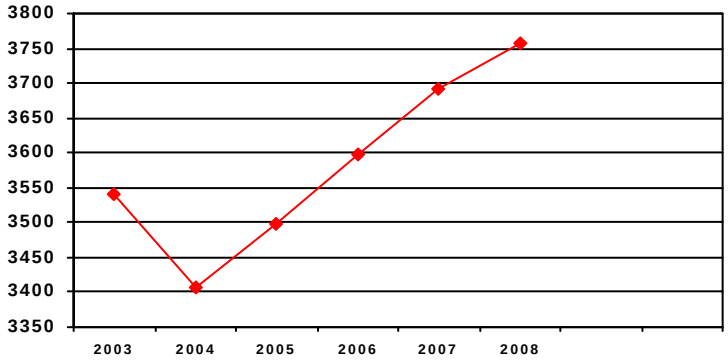
Supervisor : Midwife Ratio



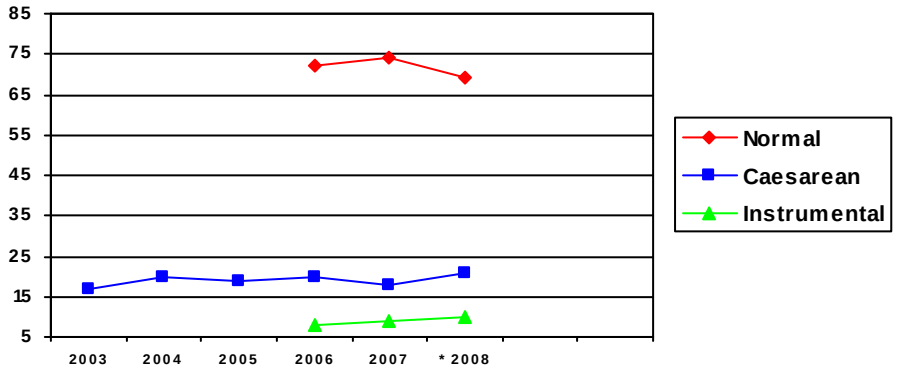
NB: This Trust has changed LSA at least three times over the last few years so collation of more historical data has not been possible.

DONCASTER

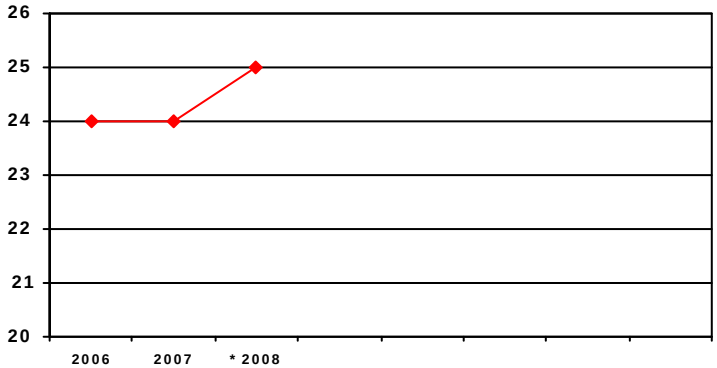
Total number of women delivered



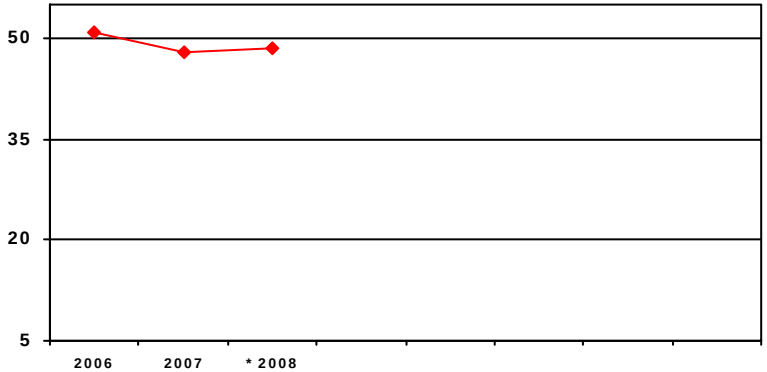
% Unassisted vaginal, caesarean + instrumental births



% Inductions



% Breastfeeding

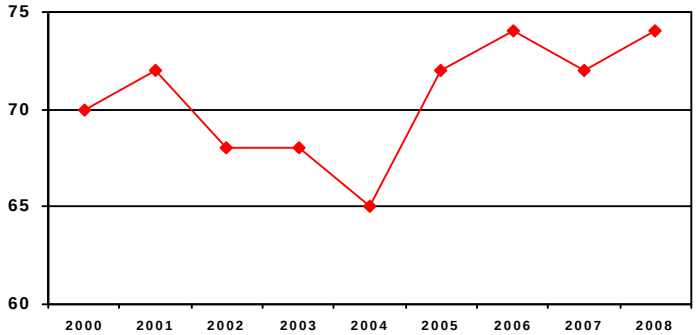


NB: This Trust has changed LSA at least three times over the last few years so collation of more historical data has not been possible.

**** 2008 figures based on total births (not women delivered)***

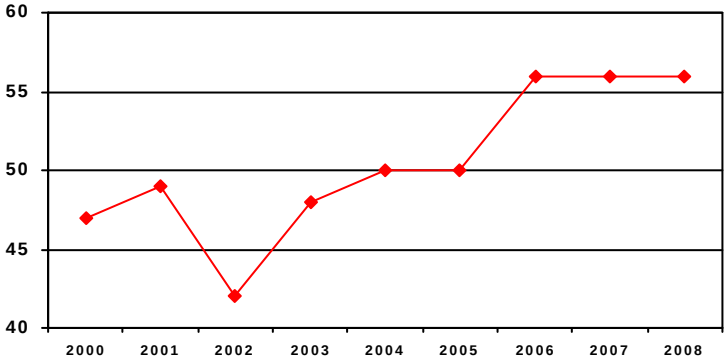
HARROGATE

Number of midwives supervised

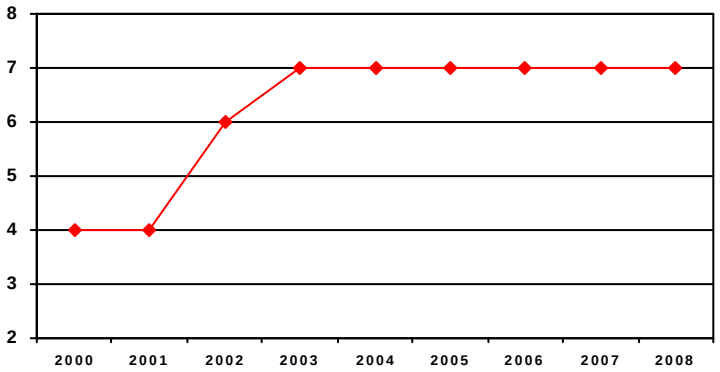


(2008 figure = total number of midwives notifying ITP)

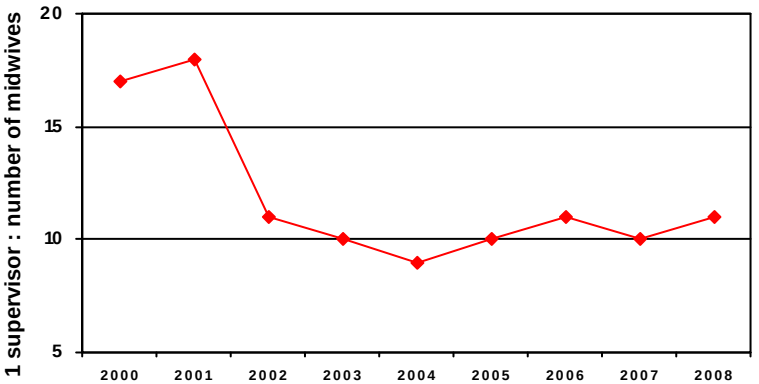
Whole Time Equivalent Midwives



Number of supervisors of midwives

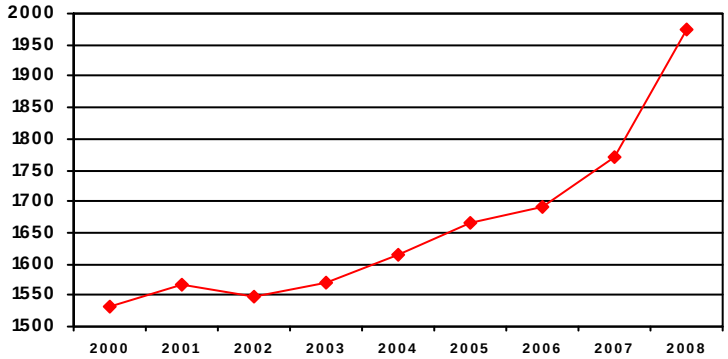


Supervisor : Midwife Ratio

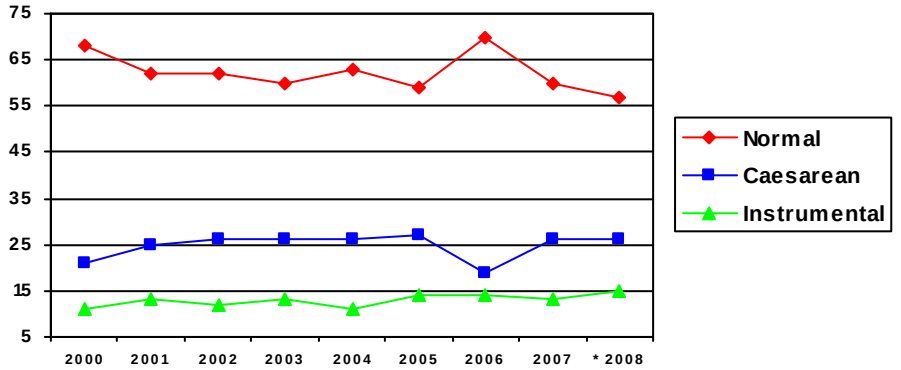


HARROGATE

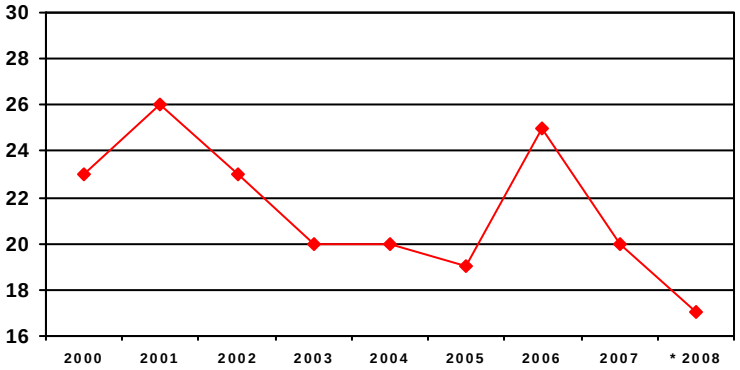
Total number of women delivered



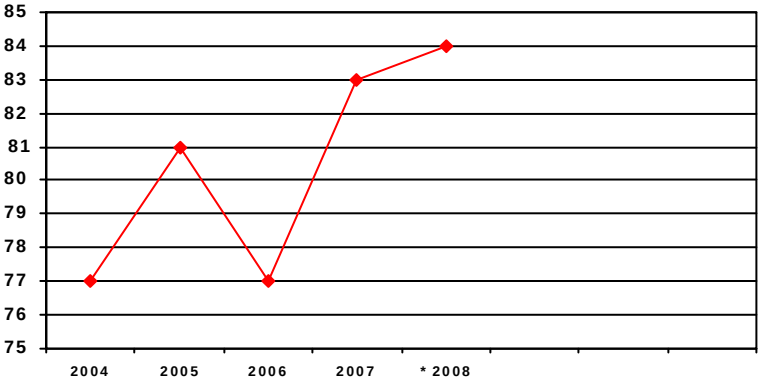
% Unassisted vaginal, caesarean + instrumental births



% Inductions



% Breastfeeding

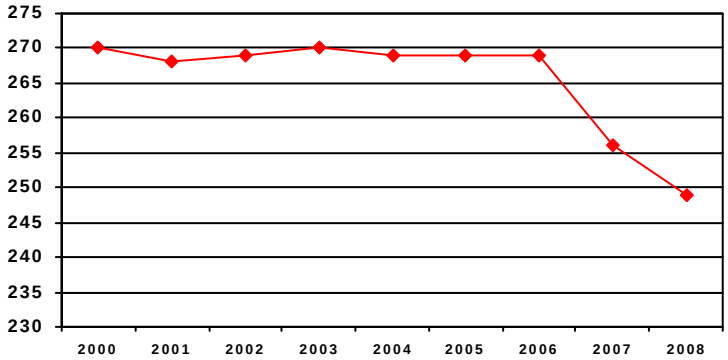


Breastfeeding data not collected prior to 2004

**** 2008 figures based on total births (not women delivered)***

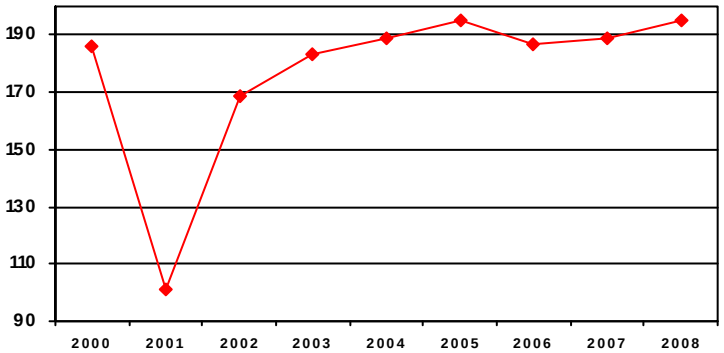
HULL & EAST YORKSHIRE

Number of midwives supervised



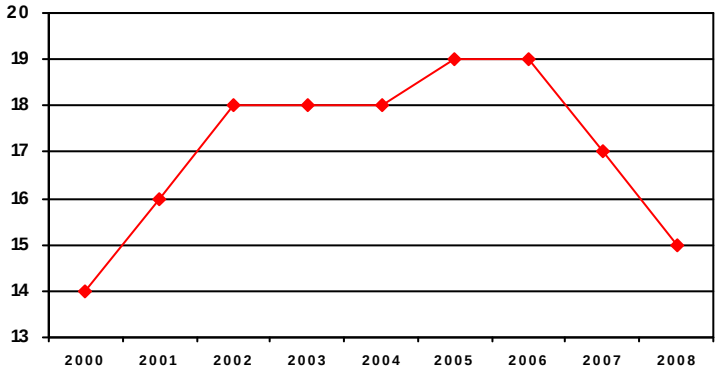
(2008 figure = total number of midwives notifying ITP)

Whole Time Equivalent Midwives

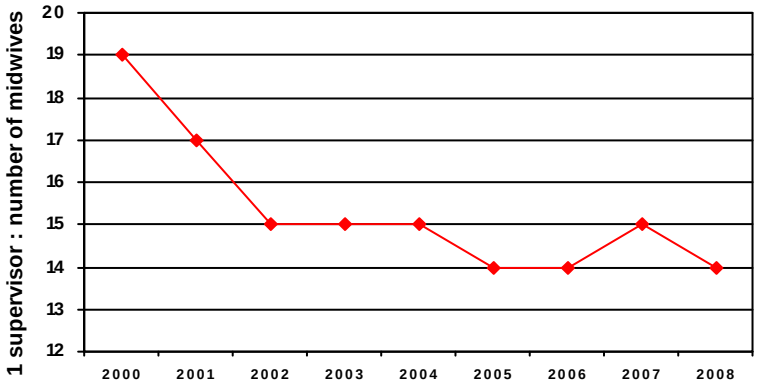


2001 figure -
Hull Maternity only

Number of supervisors of midwives

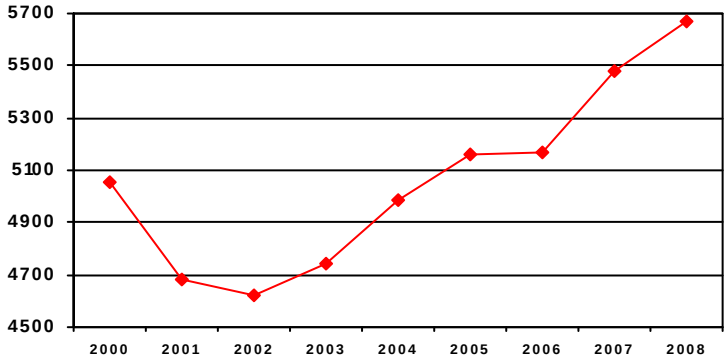


Supervisor : Midwife Ratio

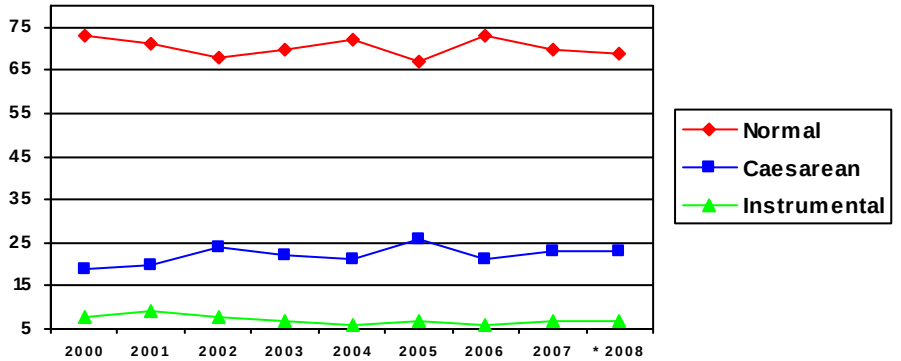


HULL & EAST YORKSHIRE

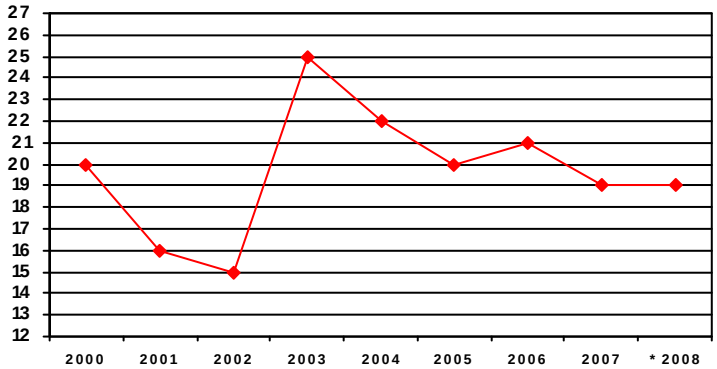
Total number of women delivered



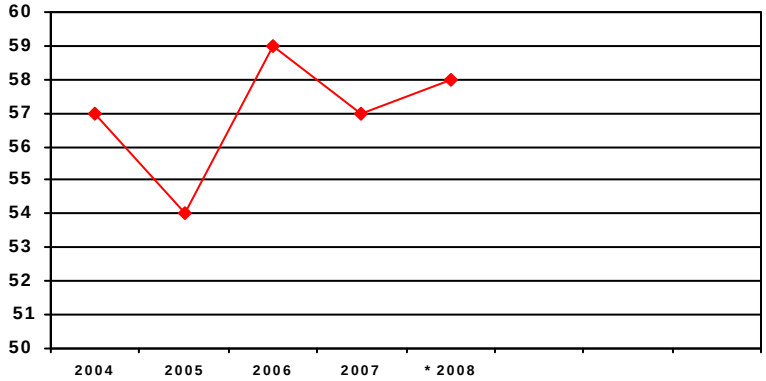
% Unassisted vaginal, caesarean + instrumental births



% Inductions



% Breastfeeding

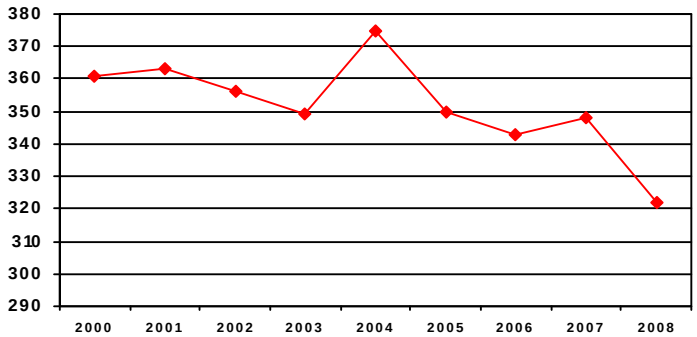


Breastfeeding data not collected prior to 2004

**** 2008 figures based on total births (not women delivered)***

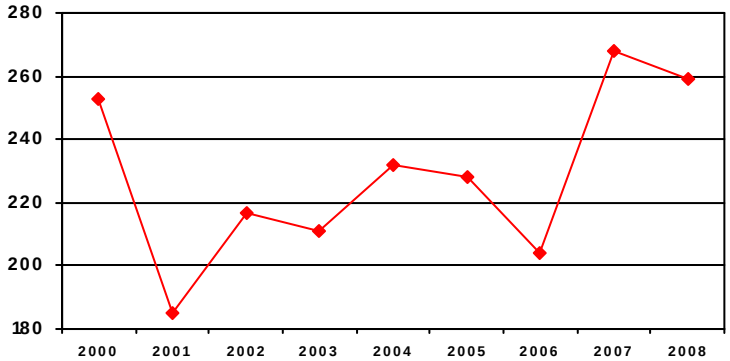
LEEDS

Number of midwives supervised

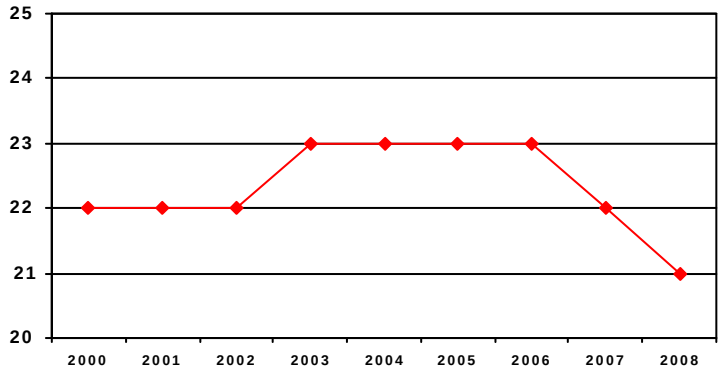


(2008 figure = total number of midwives notifying ITP)

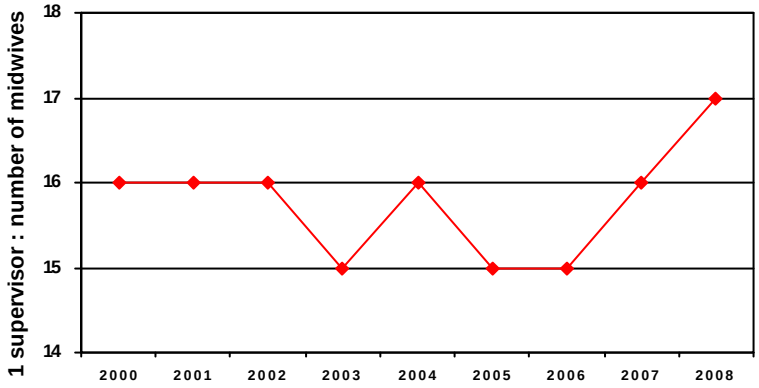
Whole Time Equivalent Midwives



Number of supervisors of midwives

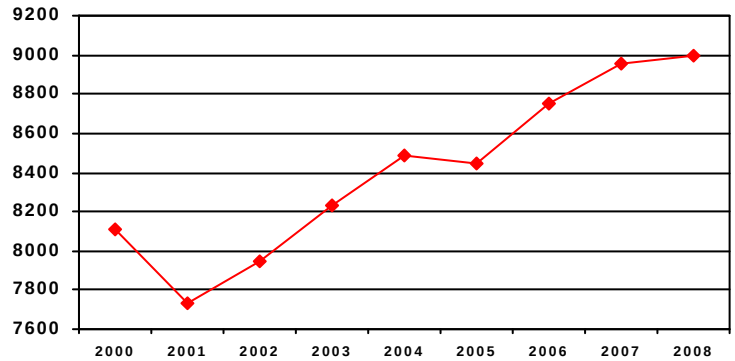


Supervisor : Midwife Ratio

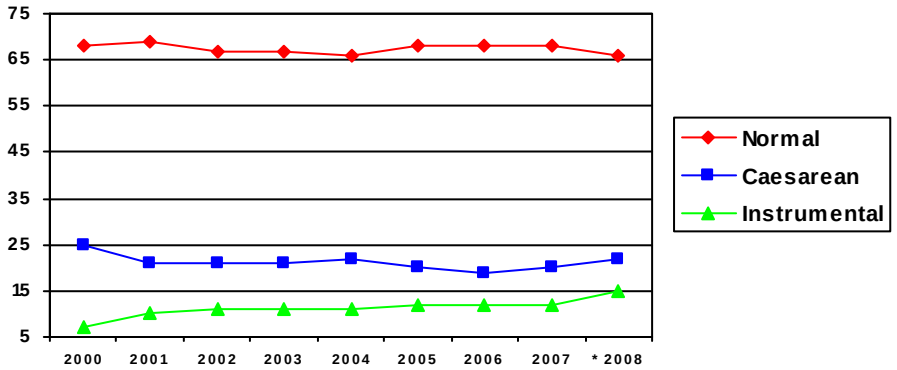


LEEDS

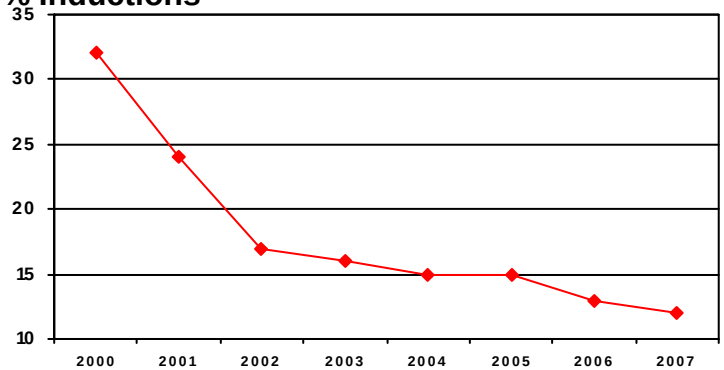
Total number of women delivered



% Unassisted vaginal, caesarean + instrumental births

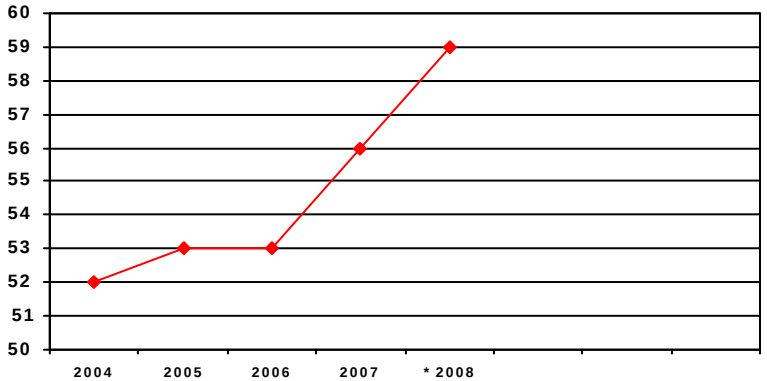


% Inductions



No 2008 data

% Breastfeeding

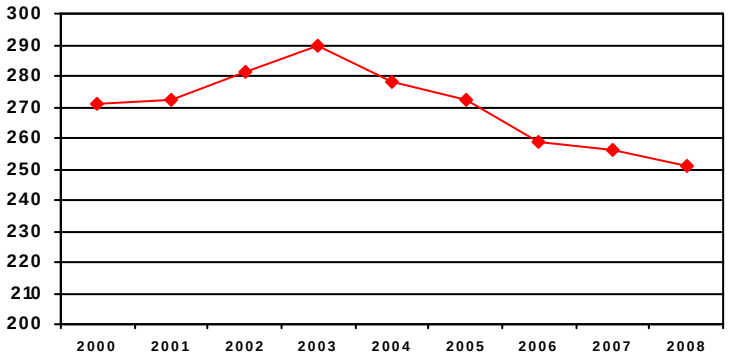


Breastfeeding data not collected prior to 2004

* 2008 figures based on total births (not women delivered)

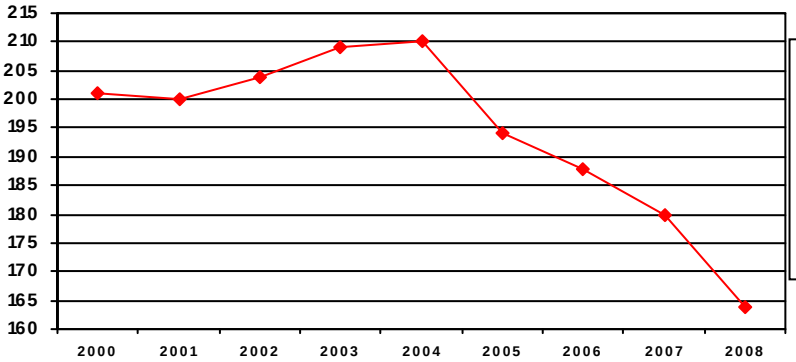
MID YORKSHIRE

Number of midwives supervised



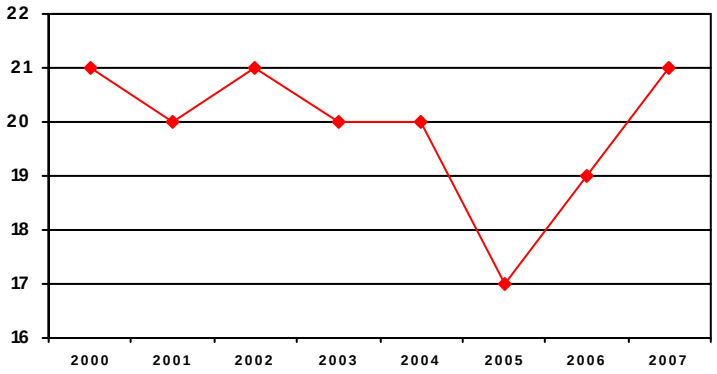
(2008 figure = total number of midwives notifying ITP)

Whole Time Equivalent Midwives

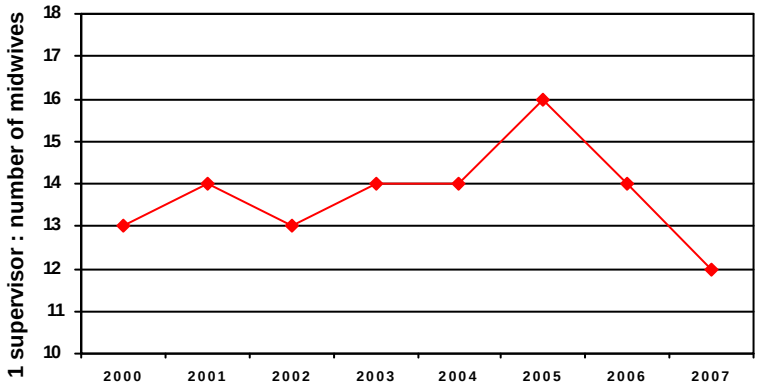


WTE data supplied for individual units – combined for consistency of graphs

Number of supervisors of midwives

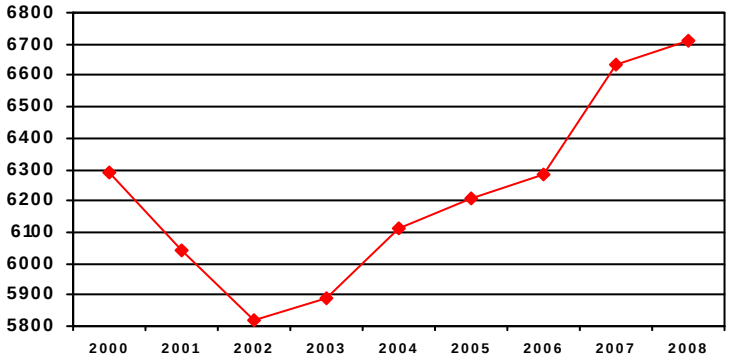


Supervisor : Midwife Ratio

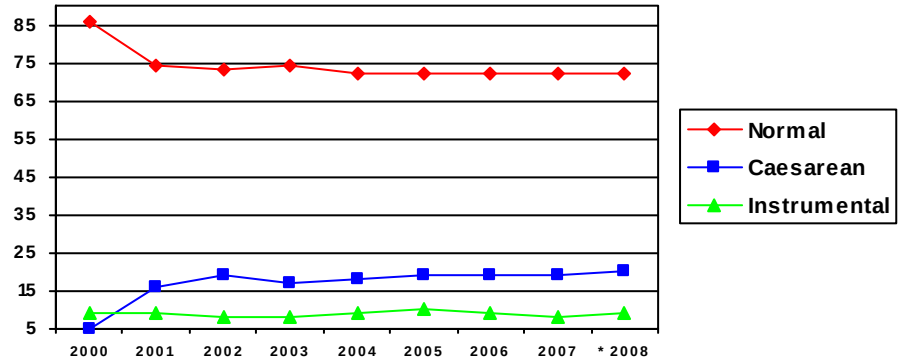


MID YORKSHIRE

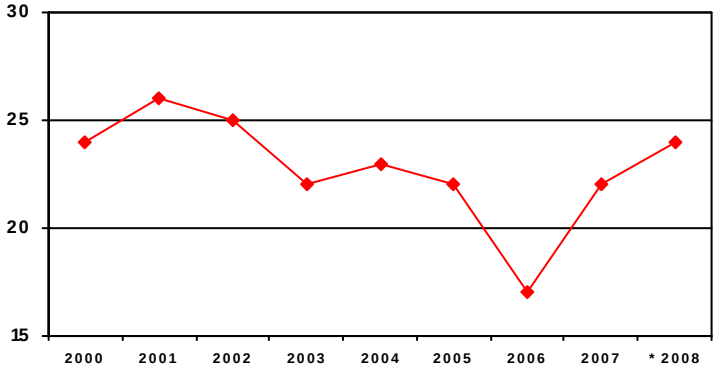
Total number of women delivered



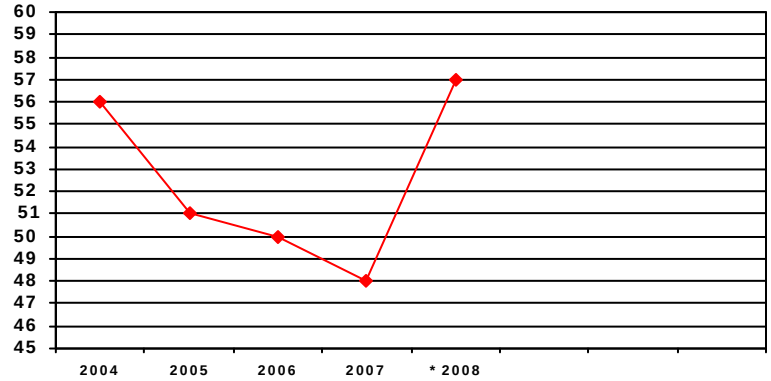
% Unassisted vaginal, caesarean + instrumental births



% Inductions



% Breastfeeding

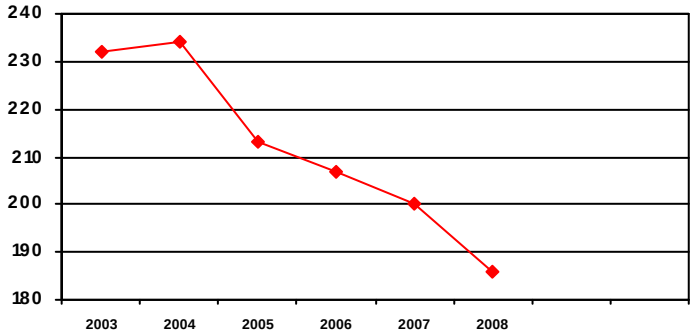


Breastfeeding data not collected prior to 2004

**** 2008 figures based on total births (not women delivered)***

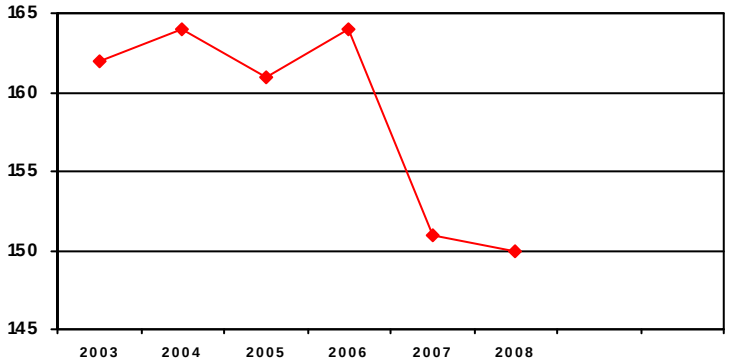
NORTHERN LINCOLNSHIRE & GOOLE

Number of midwives supervised



(2008 figure = total number of midwives notifying ITP)

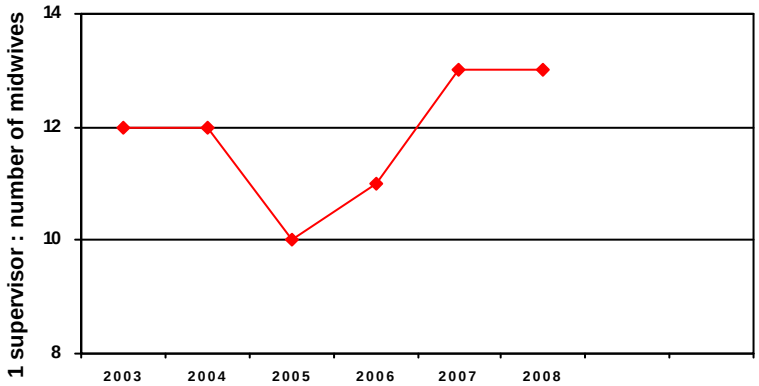
Whole Time Equivalent Midwives



WTE data supplied for individual units – combined for consistency of graphs

Number of supervisors of midwives

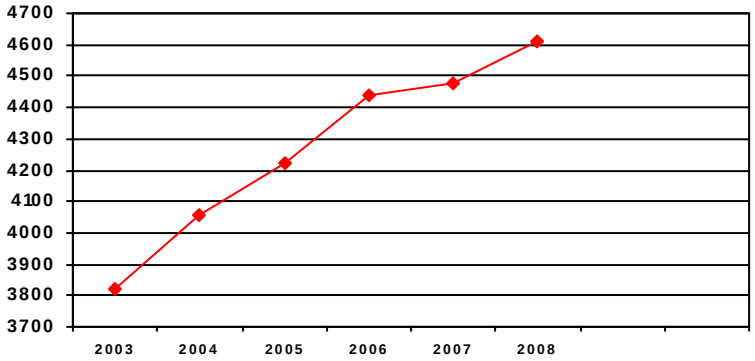
Supervisor : Midwife Ratio



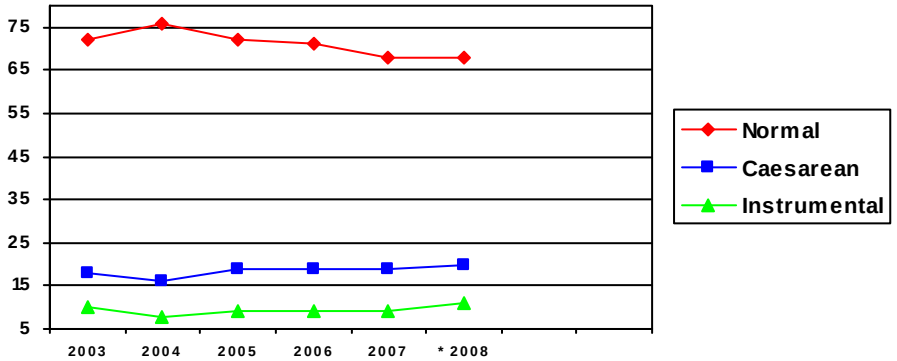
NB: Northern Lincs & Goole came into LSA during 2002/03 – no data available prior to this.

NORTHERN LINCOLNSHIRE & GOOLE

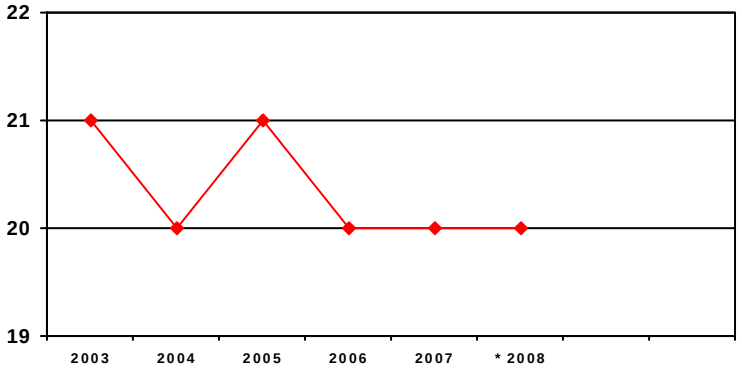
Total number of women delivered



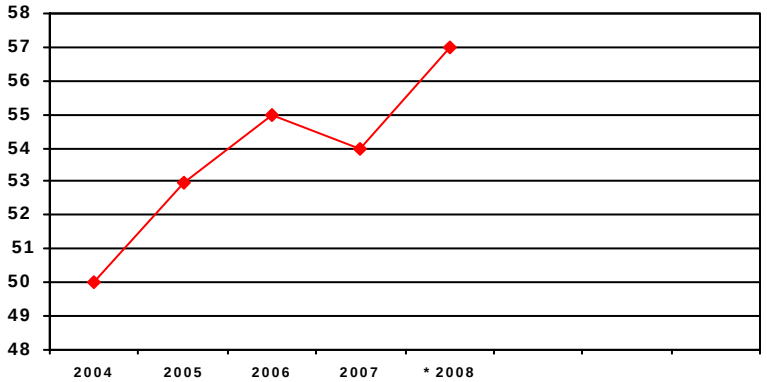
% Unassisted vaginal, caesarean + instrumental births



% Inductions



% Breastfeeding



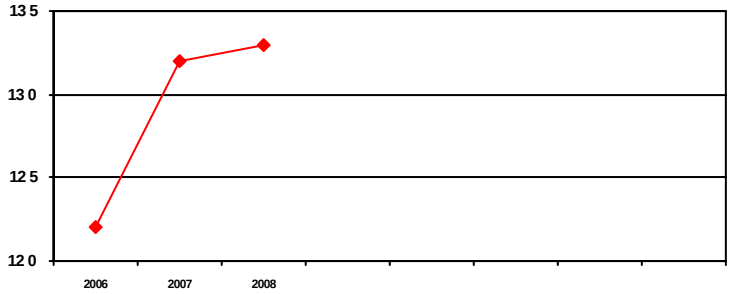
Breastfeeding data not collected prior to 2004

**** 2008 figures based on total births (not women delivered)***

NB: Northern Lincs & Goole came into LSA during 2002/03 – no data available prior to this.

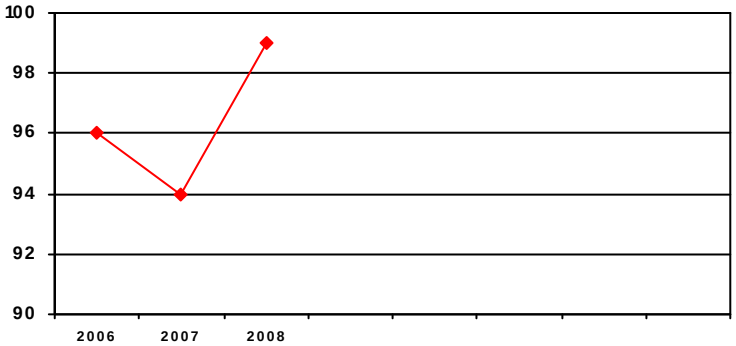
ROTHERHAM

Number of midwives supervised

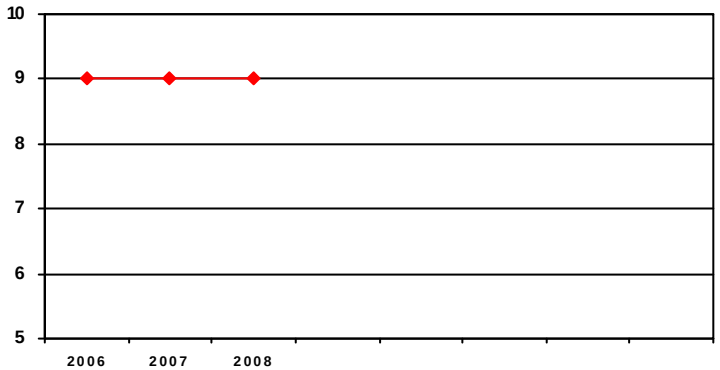


(2008 figure = total number of midwives notifying ITP)

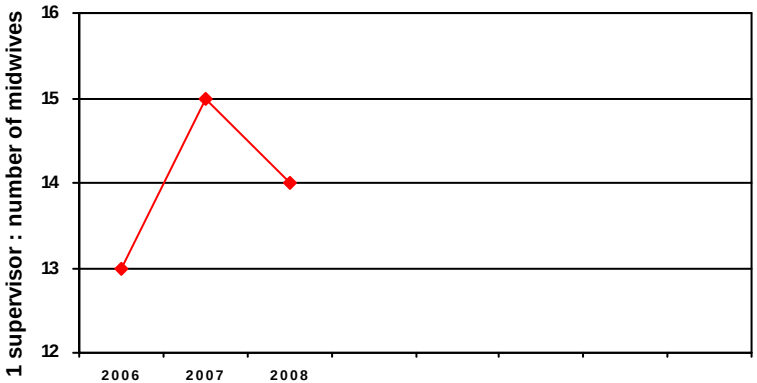
Whole Time Equivalent Midwives



Number of supervisors of midwives



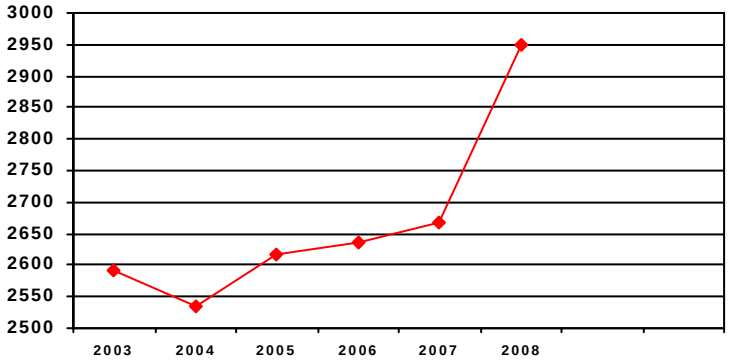
Supervisor : Midwife Ratio



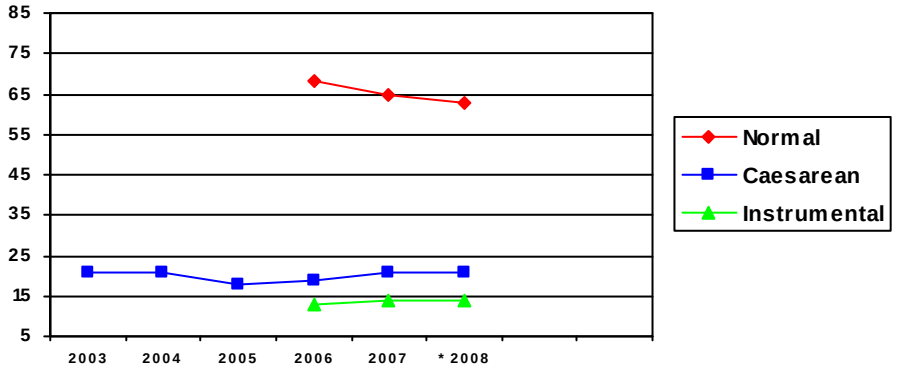
NB: This Trust has changed LSA at least three times over the last few years so collation of more historical data has not been possible.

ROTHERHAM

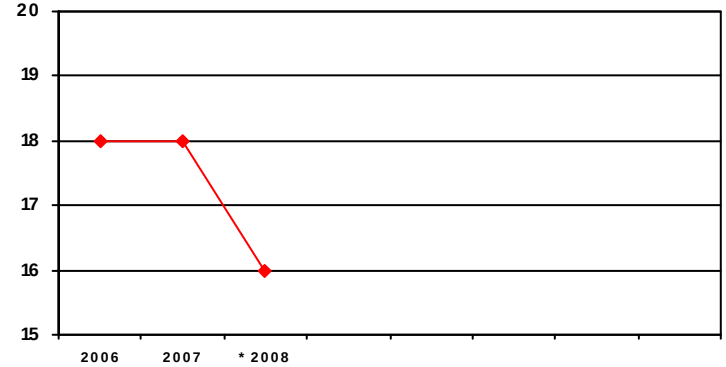
Total number of women delivered



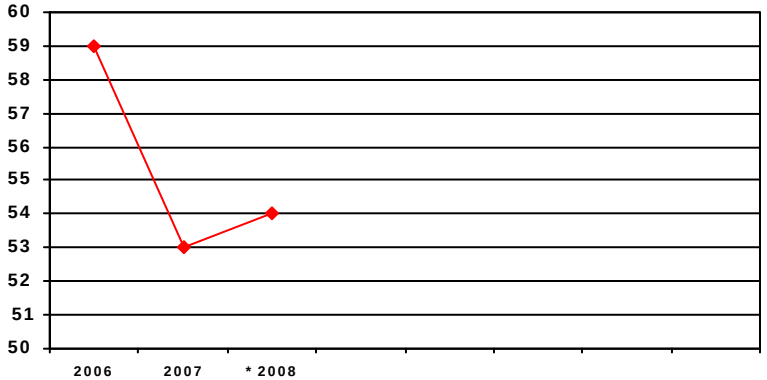
% Unassisted vaginal, caesarean + instrumental births



% Inductions



% Breastfeeding

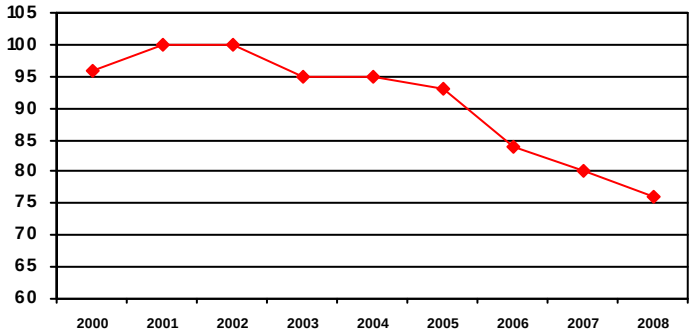


NB: This Trust has changed LSA at least three times over the last few years so collation of more historical data has not been possible.

**** 2008 figures based on total births (not women delivered)***

SCARBOROUGH & NORTH EAST YORKSHIRE

Number of midwives supervised

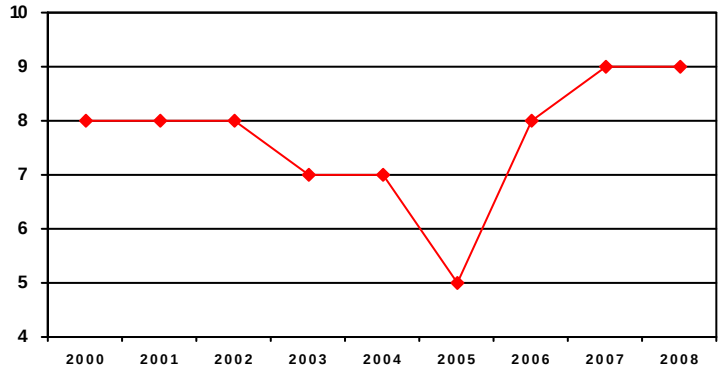


(2008 figure = total number of midwives notifying ITP)

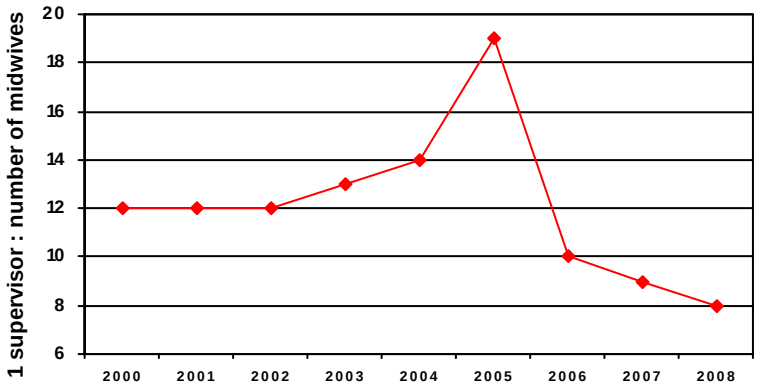
Whole Time Equivalent Midwives

WTE data supplied for individual units – combined for consistency of graphs

Number of supervisors of midwives

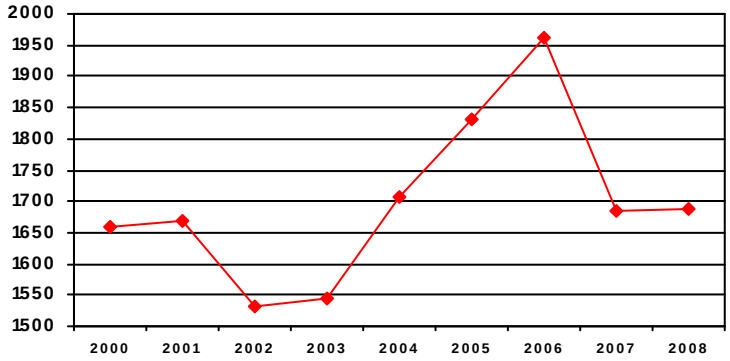


Supervisor : Midwife Ratio

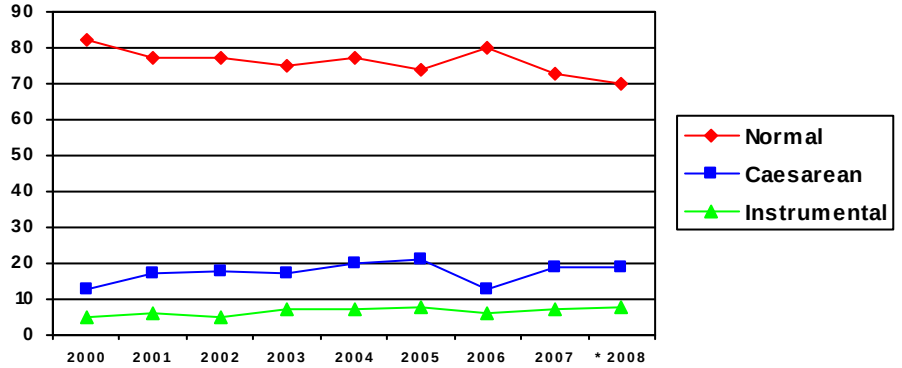


SCARBOROUGH & NORTH EAST YORKSHIRE

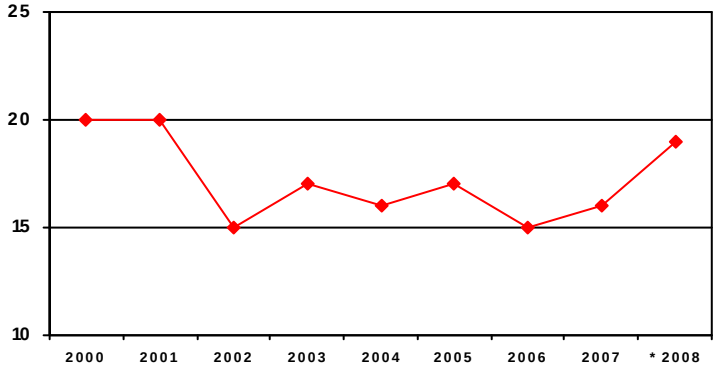
Total number of women delivered



% Unassisted vaginal, caesarean + instrumental births



% Inductions



% Breastfeeding

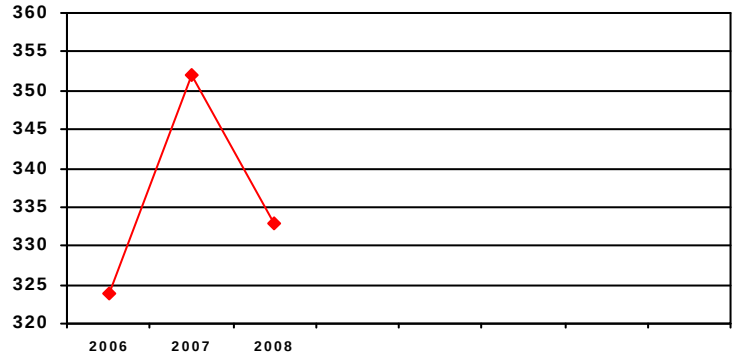
2004 figure refers to peripheral units only – no fig available for Scarborough
2008 – No data

Breastfeeding data not collected prior to 2004

**** 2008 figures based on total births (not women delivered)***

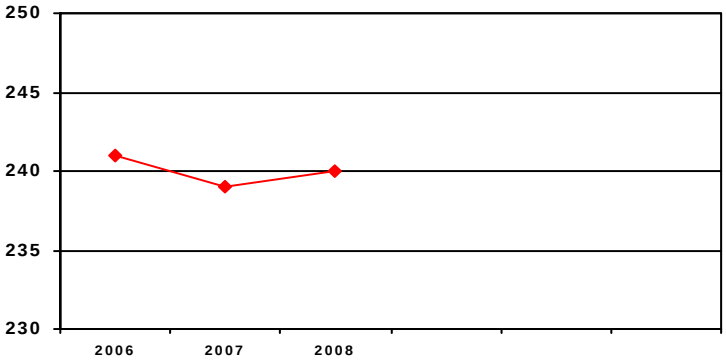
SHEFFIELD

Number of midwives supervised

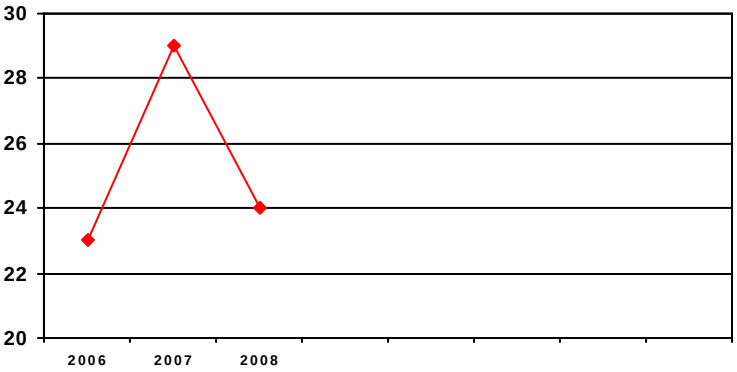


(2008 figure = total number of midwives notifying ITP)

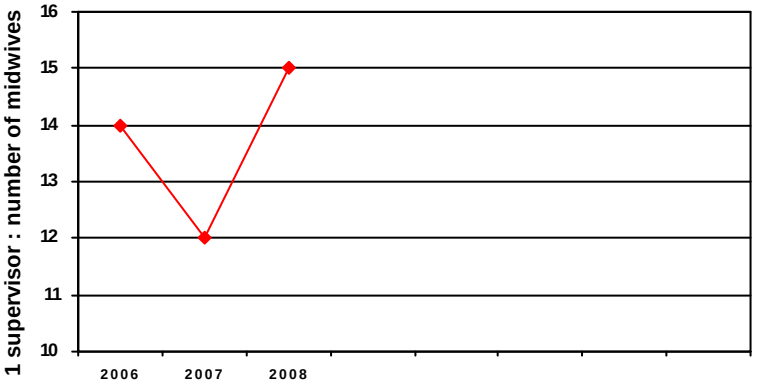
Whole Time Equivalent Midwives



Number of supervisors of midwives



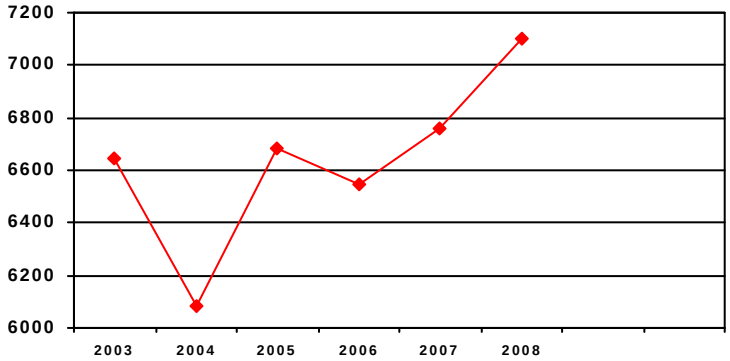
Supervisor : Midwife Ratio



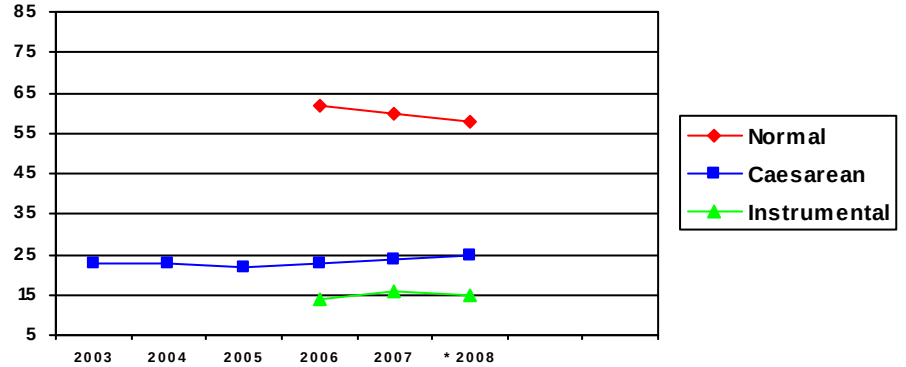
NB: This Trust has changed LSA at least three times over the last few years so collation of more historical data has not been possible.

SHEFFIELD

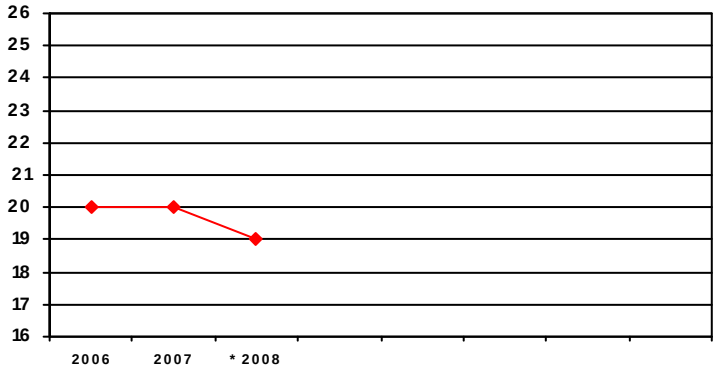
Total number of women delivered



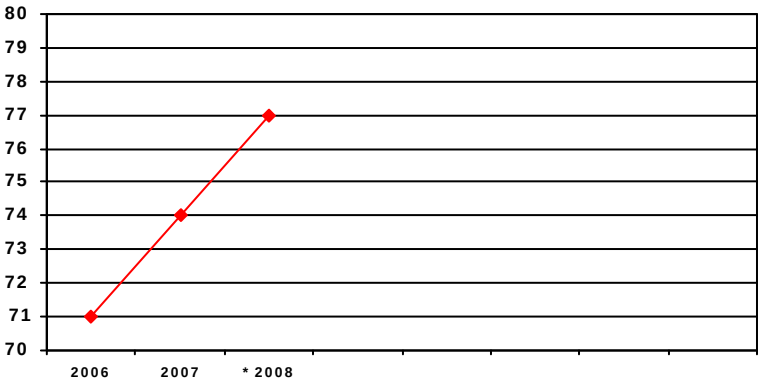
% Unassisted vaginal, caesarean + instrumental births



% Inductions



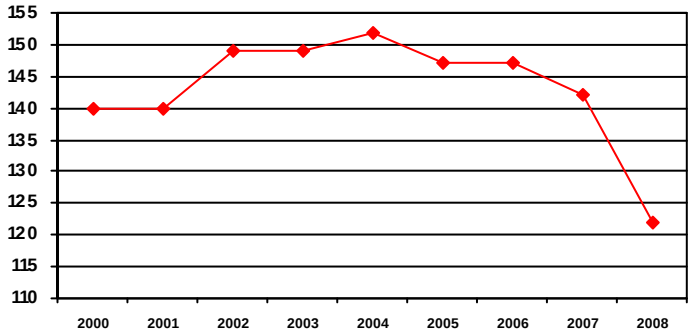
% Breastfeeding



NB: This Trust has changed LSA at least three times over the last few years so collation of more historical data has not been possible.
* 2008 figures based on total births (not women delivered)

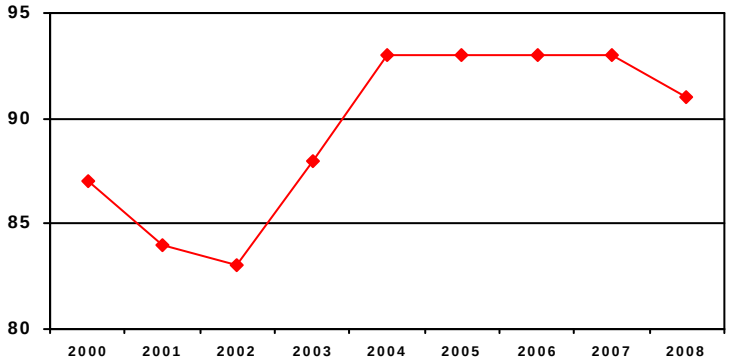
YORK

Number of midwives supervised

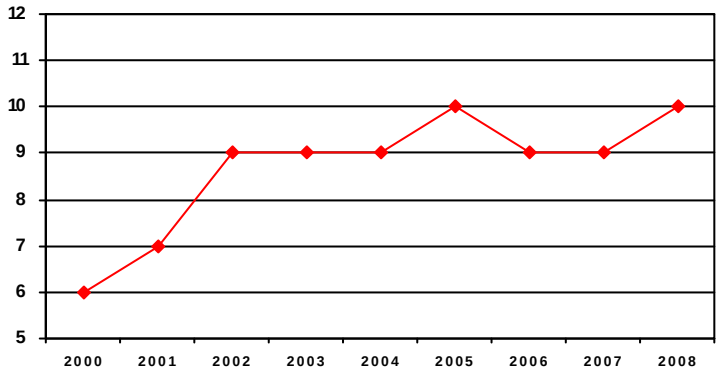


(2008 figure = total number of midwives notifying ITP)

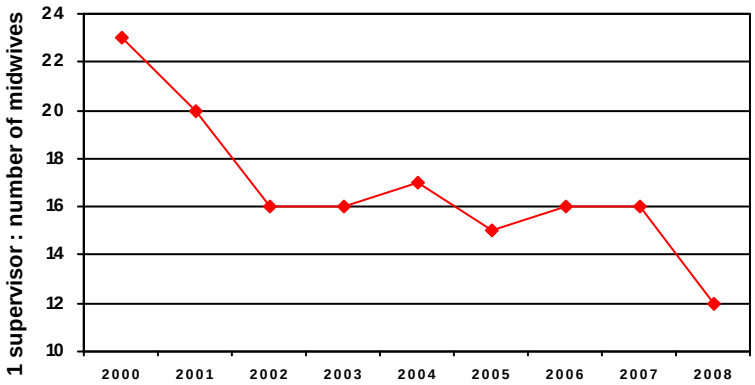
Whole Time Equivalent Midwives



Number of supervisors of midwives

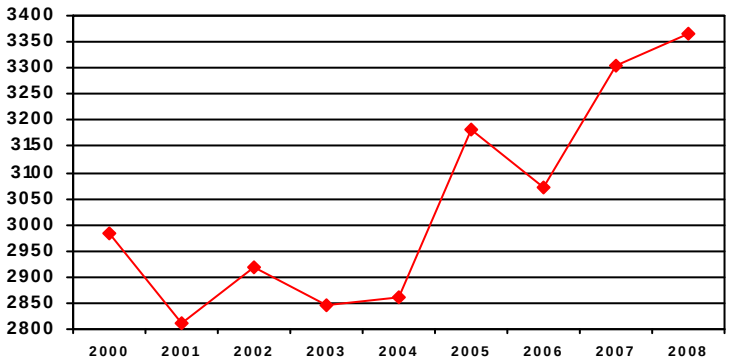


Supervisor : Midwife Ratio

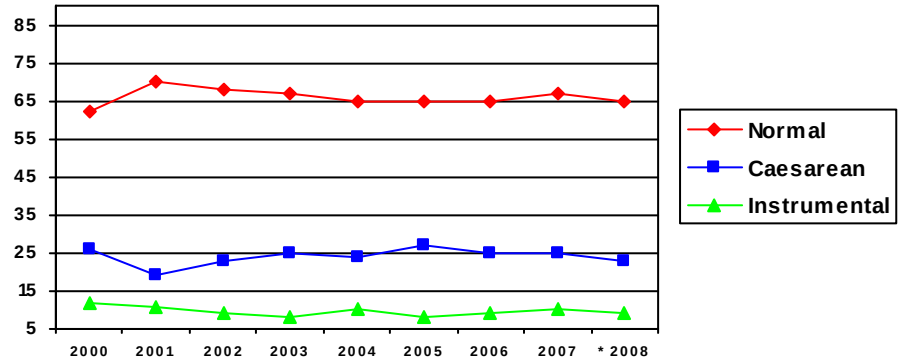


YORK

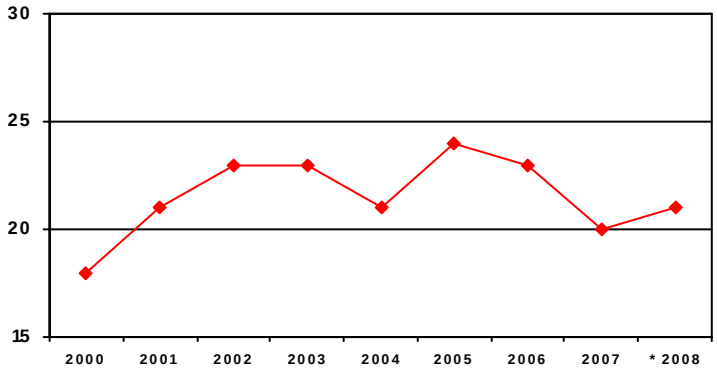
Total number of women delivered



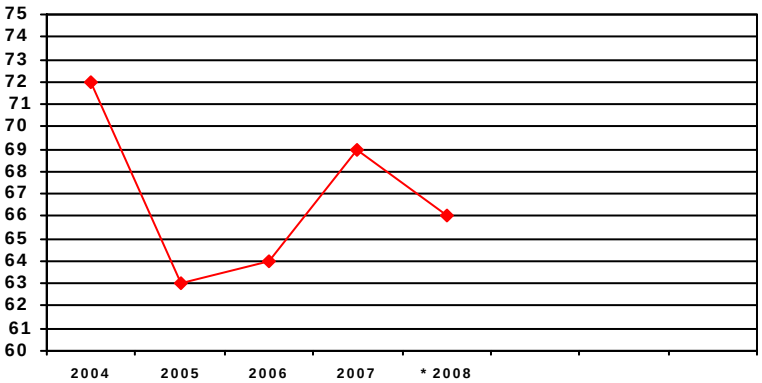
% Unassisted vaginal, caesarean + instrumental births



% Inductions



% Breastfeeding



Breastfeeding data not collected prior to 2004

**** 2008 figures based on total births (not women delivered)***

APPENDIX 7

YORKSHIRE AND THE HUMBER LOCAL SUPERVISING AUTHORITY

PROGRAMME FOR 2007/2008 SUPERVISORY AND MIDWIFERY PRACTICE AUDIT VISITS

Trust	Informal visits (10:00am – 1:30pm)	Formal Visits (Full day)	Audit Team (accompanying LSAMO)	Final report published	6-month follow up visit (10:00am – 12 noon)
Airedale		Thurs 22 Nov 2007	Supervisor Student Supervisor Service User	4 January 2008	Fri 23 May 08
Barnsley		Tues 16 Oct 2007	Supervisor Service User	17 December 2007	Fri 18 April 08
Bradford	Weds 9 May 2007		Supervisor Service User	27 June 2007	Mon 10 Dec 07 (1:30pm – 3:30pm)
Calderdale & Huddersfield	Thurs 27 Sept 2007		Supervisor Service User	9 November 2007	Fri 7 March 08
Doncaster & Bassetlaw		Weds 5 March 2008	Supervisor Student Supervisor	10 June 2008	Thurs 4 Sept 08
Harrogate		Weds 29 Aug 2007	Supervisor Service User	3 October 2007	Fri 29 Feb 08
Hull & East Yorkshire	Weds 20 June 2007		Supervisor	9 August 2007	Fri 7 Dec 07
Leeds	Weds 9 January 2008		Supervisor Student Supervisor	13 March 2008	Thurs 3 July 08

Trust	Informal visits (10:00am – 1:30pm)	Formal Visits (Full day)	Audit Team (accompanying LSAMO)	Final report published	6-month follow up visit (10:00am – 12 noon)
Mid Yorkshire		Tues 6 + Weds 7 November 2007	Supervisor Student Supervisor	7 January 2008	Thurs 1 May 08
Northern Lincs & Goole	Weds 30 Jan 08		Supervisor Student Supervisor Service User	2 April 2008	Thurs 31 July 08
Rotherham		Weds 12 Dec 2007	Supervisor Student Supervisor	23 February 2008	Thurs 12 June 08
Scarborough	Mon 31 March 2008		Supervisor Student Supervisor	26 June 2008	Fri 26 Sept 08
Sheffield		Weds 20 Feb 2008	Supervisor Student Supervisor Service User	30 April 2008	Thurs 21 Aug 08
York		Thurs 24 May 2007	Supervisor Service User	9 July 2008	Fri 30 Nov 07

APPENDICES 8 and 9

STATISTICAL SUMMARY FOR YORKSHIRE AND THE HUMBER AND RAW DATA 2007-08

Incidents/Complaints	**2006/07**	**2007/08**
Number of serious untoward incidents (SUIs) related to midwifery practice Trust (LSA) data LSA database data	35 (1) 26	12 (1) 21
Number of complaints about midwifery practice	169 (2)	125 (2)

Booking figures: January – December data	**2005**	**2006**	**2007**
Airedale NHS Trust	2706	2717	2928
Barnsley Hospital NHS Foundation Trust	2906	3265	2754
Bradford Teaching Hospitals NHS Foundation Trust	5579	6123	6589
Calderdale and Huddersfield NHS Foundation Trust	5844	6395	5968
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	3035	4509	5059
Harrogate and District NHS Foundation Trust	1905	1756	2001
Hull & East Yorkshire Hospitals NHS Trust	5206	5720	5610
Leeds Teaching Hospitals NHS Trust	9184	9616	9859
Mid Yorkshire Hospitals NHS Trust	6839	7809	7863
Northern Lincolnshire & Goole Hospitals NHS Trust	4357	4566	4802
Scarborough & North East Yorkshire Healthcare NHS Trust	2345	1885	1983
Sheffield Teaching Hospitals NHS Foundation Trust	6665	6657	6830
The Rotherham NHS Foundation Trust	2552	2881	2622
York Hospitals NHS Trust	3530	3631	3723
Total for Yorkshire and the Humber	**62653**	**67500**	**68591**

Data provided by Jill Walker, Regional Antenatal /Child Health Screening Manager, Yorkshire and the Humber

Note: The figures in brackets indicate the number of units for which data were missing.	**England 2005-06[a,3]**	**2006/07 Yorkshire and the Humber**	**2007/08 Yorkshire and the Humber[1]**
CLINICAL ACTIVITY			
Total women booked Trust (LSA) data Regional screening data		47284 (6) 67500	56433 (3) 68591
Total women birthed		61953	63894
Total birthed in hospital	97.4%	98.1% (60785)	97.5% (62292)
Total number of babies born		62785	64772
Hospital births in water		1.4% (884) (5)	1.0% 669 (4)
Births in midwife-led centres/birth centres		1.0% (624) (1)	0.8% (519) (1)
within main unit		5.5% (3433) (12)	6.9% (4471) (3)
Women booked under midwife-led care *(% of total bookings)*		28.0% (17376) (5)	28.3% (15956) (7)
Women transferred to consultant care *(% of women booked for midwife led care)*		4.7% (2940) (7)	19.7% (3151) (16)
Unassisted vaginal births[4]	53%	66.7%	62.7% (40582) (1)
HOME BIRTHS[2]			
Births in the home	2.6%	1.9%	2.4% (1552)
Intentional home births attended by a midwife		0.97% (599) (1)	1.0% 649 (2)
Women birthed at home with no midwife present, including those delivered at home or in transit by ambulance crew		0.58% (357)	0.7% (440) (2)
PUBLIC HEALTH DATA			
Women initiating breastfeeding	78%[b]	61% (37763)	61.6% (39877) (1)
MATERNITY OUTCOMES DATA			
Babies born alive	99.5%[c] (635748)	99.4% (62420)	99.1% (64210)
Stillbirths	0.53%[c] (3418)	0.6% (365)	0.62% (400)
Early neonatal deaths (i.e. at 6 days and under)	0.27%[c] (1689)	0.23% (143) (1)	0.23% (137)

Note: The figures in brackets indicate the number of units for which data were missing.	**England 2005-06[a,3]**	**2006/07 Yorkshire and the Humber**	**2007/08 Yorkshire and the Humber[1]**
Late neonatal deaths (i.e. 7 – 28 days)	0.09%[c] (549)	0.08% (50) (3)	0.08% 50 (3)
Neonatal deaths (i.e. at 28 days and under)	0.35%[c] (2238)	0.35% (218[1]) (3)	0.29% (187) (3)
INTERVENTIONS			
Planned inductions	20.2%	18% (11135)	16.5% (10715) (2)
Accelerated labours (including ARM and Syntocinon, or both)		13.5% (8339) (5)	16.8% (10856) (3)
Episiotomies *(% of unassisted vaginal births)*	5.6%	5.7% (3511) (2)	8.5% (3463) (1)
Epidurals with vaginal births *(% of total vaginal births)*	14.0%	14.1% (8737) (1)	17.6% (8891) (2)
Forcep births	3.9%	5.3%	6.2% (4022)
Ventouse births	7.2%	5.5%	4.9% (3156)
Total instrumental births	11%	10.8%	11.1% (7178)
Vaginal breech births	0.3%	0.6%	0.5% (312)
Epidurals/spinals with caesarean sections *(% of total caesarean sections)*	18.2%	14.4% (8905) (1)	60.0% (8485) (1)
Planned caesarean sections	9.3%	8.7% (5361)	8.4% (5410)
Emergency caesarean sections	14.1%	12.2% (7545)	13.5% (8743)
Total LSCS	23.5%	20.8% (12906)	21.9% (14153)

Notes: 1 All percentages for Yorkshire and the Humber are of total births unless specified otherwise.
2 Two units could not separate home births into the different categories intentional/unintentional and planned/unplanned. These births have been included in total births in the home but not in the other two home birth indicators.
3 All percentages are of all hospital deliveries.
4 Unassisted vaginal births include all women who had a birth not by forceps, ventouse or caesarean section.
a. Source: NHS Maternity Statistics, England: 2005-06. The Information Centre, 2007.
b. Source: Infant Feeding Survey 2005. The Information Centre, 2007.
c. Source: Clinical and Health Outcomes Knowledge Base. The Information Centre. Data for 2006. nww.nchod.nhs.uk

		Barnsley	Doncaster	Rotherham	Sheffield
CLINICAL ACTIVITY					
Total women booked 2007/08		3012	3802	3174	6812
Total women with a first booking appointment under 12 weeks *(% is of the total women booked)*		unable to provide at present	2361 62.1%	2723 85.8%	293 4.3%
Antenatal and postnatal cross-border activity - ie. births out-with your unit *(% is of the total women booked)*		12 0.4%		201 6.3%	n/a
Intrapartum cross-border activity - ie. births only within your unit *(% is of the total women booked)*		unable to provide at present		273 8.6%	n/a
Any other cross-border activity - please specify *(% is of the total women booked)*		unable to provide at present		0	n/a
Total women birthed		2731	3758	2948	7098
Total women who had 1:1 care in labour *(% is of the total women birthed)*		unable to provide at present			n/a
Total women birthed in the hospital *(% is of the total women birthed)*		2681 98.2%	3681 98.0%	2877 97.6%	6800 95.8%
Number of babies born:	Singletons	2693	3789	2908	6988
	Multiples	76	52	81	228
	Total	2769	3841	2989	7216
Hospital labours in water *(% is of total births)*		unable to provide at present	30 0.8%	not recorded	166 2.3%
Hospital births in water *(% is of total births)*		unable to provide at present	7 0.2%	0	34 0.5%
Total unassisted vaginal births (regardless of lead carer) *(% is of total births)*		1940 70.1%	2598 67.6%	1878 62.8%	4217 58.4%
Normal delivery (Information Centre definition: women whose labour starts spontaneously, progresses spontaneously without drugs and who give birth spontaneously. Excludes induction of labour, epidural or spinal, general anaesthetic, forceps or ventouse, caesarean section or episiotomy) *(% is of total births)*		unable to provide at present	119 3.1%	1878 62.8%	2172 30.1%
Number of medical terminations on labour ward/maternity areas		0	18	total not recorded	19
Range of gestation		from 20 weeks	12-term	12-24	16+6 - 33+2
Is women's choice of maternity unit or Gynaecology given?		Yes	Yes	Yes	Yes
Births in midwife-led centres/birth centres (please specify whether these are stand alone or within the main unit, or both)	Stand alone	0	0	0	
(% is of total births)	Within main unit	436 15.7%	516 13.4%	0	
Women booked under midwife-led care *(% is of total bookings)*		1258 41.8%	698 18.4%	not recorded	4800 70.5%
Women transferred to consultant care *(% is of women booked for midwife led care)*		235 18.7%	182 26.1%	not recorded	n/a
Are you able to monitor reasons for transfer?		No	Yes	No	Yes
HOME BIRTHS					
Planned home births attended by a midwife ie. place intended and attended *(% is of total births)*		20 0.7%	47 1.2%	58 1.9%	n/a
Planned home births with no midwife present ie place intended but unattended *(% is of total births)*		0	0	12 0.4%	n/a
Unplanned home birth, attended by a midwife eg intended/planned for hospital birth ie. unplanned and attended *(% is of total births)*		20 0.72%	12 0.31%	1 0.03%	n/a
Unplanned home birth, unattended by a midwife eg intended/planned for hospital birth ie. unplanned and unattended *(% is of total births)*		10 0.4%	18 0.5%	0	73 1.0%
Births in transit, car park *(% is of total births)*		0		0	4 0.1%
Total births in the home *(% is of total births)*		50 1.8%	77 2.0%	71 2.4%	294 4.1%
Home labours in water *(% is of total births)*		no data	2 0.1%	1 0.0%	52 0.7%
Home births in water *(% is of total births)*		no data	0 0.0%	0 0.0%	71 1.0%
PUBLIC HEALTH DATA					
Women initiating breastfeeding *(% is of total births)*		1555 56.2%	1864 48.5%	1630 54.5%	5556 77.0%
Women breastfeeding on discharge to Health Visitor *(% is of total births)*		1347 48.6%			4546 63.0%
Women breastfeeding at 6-8 weeks *(% is of total births)*					
Number of women smokers at time of:	Booking *(% is of total bookings)*	782 26.0%	994 26.1%	823 25.9%	796 11.7%
	Delivery *(% is of total bookings)*	650 21.6%		736 23.2%	993 14.6%
	Both			not recorded	
Women under 18 years old at time of birth *(% is of total births)*		82 3.0%	87 2.3%	100 3.3%	293 4.1%

	Barnsley	Doncaster	Rotherham	Sheffield
MATERNITY OUTCOMES DATA				
Babies born alive *(% is of total births)*	2760 99.7%	3825 99.6%	2968 99.3%	7167 99.3%
Stillbirths *(Rate is per 1000 total births)*	9 3.3	16 4.2	21 7.0	49 6.8
Early neonatal deaths (ie. at 6 days and under) *(Rate is per 1000 live births)*	3 1.1	8 2.1	7 2.4	6 0.8
Late neonatal deaths (ie. 7-28 days) *(Rate is per 1000 live births)*			0 0.0	7 1.0
INTERVENTIONS				
Planned inductions *(% is of total births)*	572 20.7%	955 24.9%	478 16.0%	1380 19.1%
Accelerated labours (ie. Including ARM, and Syntocinon, or both) *(% is of total births)*	372 13.4%	764 19.9%	not recorded	1224 17.0%
Episiotomies for unassisted vaginal births *(% is of unassisted vaginal births)*	334 17.2%	308 11.9%	90 4.8%	
Epidurals with vaginal births *(% is of total vaginal births)*	334 14.6%	586 19.2%	444 18.8%	
Epidurals/spinals with caesarean sections *(% is of total caesarean sections)*	432 90.8%	191 24.4%	513 82.1%	
Planned caesarean sections *(% is of total births)*	185 6.7%	341 8.9%	231 7.7%	627 8.7%
Emergency caesarean sections *(% is of total births)*	291 10.5%	442 11.5%	394 13.2%	1157 16.0%
Forceps births by midwife *(% is of total births)*	0	0	0	0
Forceps births by doctor *(% is of total births)*	122 4.4%	152 4.0%	133 4.4%	507 7.0%
Ventouse births by midwife *(% is of total births)*	0	0	0	0
Ventouse births by doctor *(% is of total births)*	191 6.9%	213 5.5%	282 9.4%	610 8.5%
Vaginal breech births by midwife *(% is of total births)*	unable to provide at present	10 0.3%	0 0.0%	2 0.03%
Vaginal breech births by doctor *(% is of total births)*	18 0.7%	12 0.3%	20 0.7%	45 0.6%
FACILITIES				
Type of unit: (Consultant/midwife/GP)	Consultant/ midwife	Consultant	Consultant/ midwife	Consultant/ midwife
Total number of maternity beds (including delivery beds)	39	63	44	18
Number of obstetric theatres	1	2	1	3
- Staffed by midwifery staff (other than receiving baby)	No	No	Yes	No
- Staffed by theatre staff	Yes	Yes	Yes	Yes
High dependency beds	Yes	Yes	Yes	Yes
Early pregnancy unit	Yes	Yes	Yes	Yes
Fetal medicine unit	No	No	Yes	Yes
Antenatal day assessment unit	Yes	Yes	Yes	Yes
Birthing pool	Yes	Yes	No	Yes
Bereavement/quiet room	Yes	Yes	Yes	Yes
Partners accommodation on AN ward	No	Special meals ordered if partners remain in the hospital	Yes	Yes
Family kitchens	No		No	No
Security system: - controlled door entry	Yes	Yes	Yes	Yes
- baby tagging	Yes	No	No	Yes
- pressure mattresses	Yesx1	No	No	No
- other (specify)				
Intrapartum GP care	No	No	No	No
Transitional care cots	No	No	Yes	Yes
Some midwives take responsibility for decision making and undertake:				
Neurophysiological examination of the newborn	Yes	Yes	Yes	Yes
Ultrasound scans	No	No	Yes	Yes
Amniocentesis	No	No	No	No
Induction of labour by prostaglandin	No	Yes	Yes	Yes
by syntocinon	No	Yes	Yes	Yes
Ventouse deliveries	No	No	No	No
Forceps deliveries	No	No	No	No
Six week postnatal examination	No	Yes	No	Yes
Cervical smears	No	Yes	No	Yes
Specialised counselling	Yes	No	Yes	Yes
External cephalic version	No	No	No	No
Other (please specify)				

	Barnsley	Doncaster	Rotherham	Sheffield
STAFFING:				
Total number of whole time equivalent midwives employed (clinical and non-clinical)	80.65	107.1	98.87	239.71
Midwives per 1000 births ratio	29.13	27.88	33.08	33.22
Total number of midwives employed (head count, ie. allowing for part-time staff)	105	162	132	326
Total number of midwives notifying intention to practise (including non-employed miswives, eg. Independent practitioners, educationalists, researchers)	105	203	133	333
Total use of NHS Professionals, Bank, Agency	0	13,543.25 hrs	1	344 shifts qualified 284 shifts unqualified
Vacancies according to funded establishment	5	0	0	0
Vacancies according to Birthrate Plus defined establishment	0	25.20 WTE	0	32
Birthrate Plus undertaken - which year	2006	2004	2006	2001
Birthrate Plus in progress	No	No	No	No
Birthrate Plus planned - when	No	No		
Ratio of births to midwives in post (WTE)	34.3	35.9	30.2	30.1
What percentage is built into the budget for sickness, annual leave and training?		17%	22%	24%
% annual sickness rate Long term Short term				2.60% 2.81%
Is non-achievement of optimum staffing levels a trigger for incident reporting?		Yes	Yes	Yes
Average length of postnatal stay	24 hours	1.3 days		2
Midwife to non-midwife skill mix		1 : 3.82	1 : 5	1 : 0.3
Current ratio of supervisors to midwives	1 : 15	1 : 16.2	1 : 14	1 : 15
Number of student supervisors of midwives	1	3	0	3
Number of enquiries for RTP placements	0		0	0
Number of RTP accepted for clinical placements	0	1	0	0
Specialist midwifery posts				
Consultant midwife	0	0	0	0
Lecturer practitioner	0	0	0	0
Practice Development Midwife	0	0	1 (0.6)	0
Infant Feeding Co-ordinator	1 (0.2)	0	1 (0.8)	1 (0.5)
Bereavement Midwife	1 (0.2)	1 (0.25)	1 (0.8)	
Sure Start Midwife	0	7	1 (1.0)	
Drug/alcohol dependency midwife	1 (1.0)	1 (1.0)	2 (2.0)	3 (2.8)
Child protection midwife	0	0	1 (0.6)	3 (2.38)
Pregnant teenagers co-ordinator	1 (1.0)	0	1 (0.4)	2 (0.5)
Midwife Ultrasonographer	0	0	1 (1.0)	4 (2.4)
Domestic Violence Midwife	0		1 (0.2)	1 (0.1)
Clinic Governance/Risk Management Midwife	1 (0.6)		1 (1.0)	3 (2.6)
Antenatal Screening Co-ordinator	2 (1.0)	0	1 (0.6)	4 (2.8)
Other: Diabetes Specialist Midwife Asylum & homeless A/N Screening midwife Professional development midwife/manager Health Education Midwife			1 (0.6)	1 (0.6)

		Barnsley	Doncaster	Rotherham	Sheffield
TRANSFERS					
Is there a transfer policy?		Yes	Yes	Yes	Yes
How often has it been used within the last year?				30	
Number of intra-uterine transfers out to other units				17	These figures are not robustly collected
Number of intra-uterine transfers in from other units				12	These figures are not robustly collected
Number of other transfers	Mother Baby			2 2	
NEONATAL UNIT:					
Managed within the remit of the Head of Midwiferey		Yes	No	No	Yes
Regional or sub-regional referral centre		No	No	No	Yes
Number of midwives employed within NNU notifying their intention to practice		0		0	2
Total cots		14	20	16	38
neonatal intensive care		2	4	2	12
high dependency		3	0	3	8
special care		9	16	11	18
transitional care		0	0	0	6 (based on PN ward)
Parents' accommodation		Yes	Yes	Yes	Yes
NNU CLOSURES					
Reason for closure:	Staffing levels	Yes	Yes	No	No
	Skill mix	Yes	No	No	No
	Cot shortage	Yes	Yes	Yes	No
	Infection	Yes	No	No	No
Is there a guideline for closure of NNU?		Yes	Yes	Yes	Yes
ADDITIONAL STATISTICS					
CNST Level achieved		2 July 2007	0 January 2008	1 2006	1 February 2008
BFI Status		Certificate of commitment		Statement of commitment	Certificate of commitment
Number of complaints where midwifery practice is cited:			9	0	14
Number of serious untoward incidents (SUI) related to midwifery practice:		0	0	0	0

		Airedale	Bradford	Calderdale	Huddersfield
CLINICAL ACTIVITY					
Total women booked 2007/08		2886	6624	3395	2823
Total women with a first booking appointment under 12 weeks *(% is of the total women booked)*		2086 72.3%	 46.0%	1685 49.6%	1402 49.7%
Antenatal and postnatal cross-border activity - ie. births out-with your unit *(% is of the total women booked)*			891 13.5%		
Intrapartum cross-border activity - ie. births only within your unit *(% is of the total women booked)*					
Any other cross-border activity - please specify *(% is of the total women booked)*		267 9.3%			
Total women birthed		2533	6047	3127	2630
Total women who had 1:1 care in labour *(% is of the total women birthed)*		2169 85.6%			n/a
Total women birthed in the hospital *(% is of the total women birthed)*		2486 98.1%	5939 98.2%	3056 97.7%	2532 96.3%
Number of babies born:	Singletons	2501	5979	3078	2602
	Multiples	65	139	98	56
	Total	2566	6118	3176	2658
Hospital labours in water *(% is of total births)*		79 3.1%	0		n/a
Hospital births in water *(% is of total births)*		12 0.5%	0	31 1.0%	1 0.0%
Total unassisted vaginal births (regardless of lead carer) *(% is of total births)*		1614 62.9%	4107 67.1%	2040 64.2%	1877 70.6%
Normal delivery (Information Centre definition: women whose labour starts spontaneously, progresses spontaneously without drugs and who give birth spontaneously. Excludes induction of labour, epidural or spinal, general anaesthetic, forceps or ventouse, caesarean section or episiotomy) *(% is of total births)*		637 24.8%	2941 48.1%	1461 46.0%	1360 51.2%
Number of medical terminations on labour ward/maternity areas Range of gestation Is women's choice of maternity unit or Gynaecology given?		0 n/a n/a	28 16-23 Yes	n/a	n/a
Births in midwife-led centres/birth centres (please specify whether these are stand alone or within the main unit, or both) *(% is of total births)*	Stand alone Within main unit	n/a 536 20.9%	n/a	 666 21.0%	 35 1.3%
Women booked under midwife-led care *(% is of total bookings)*		1437 49.8%	2186 33.0%	n/a	n/a
Women transferred to consultant care *(% is of women booked for midwife led care)*		533 37.1%	2186 100.0%	n/a	n/a
Are you able to monitor reasons for transfer?		Yes			Yes
HOME BIRTHS					
Planned home births attended by a midwife ie. place intended and attended *(% is of total births)*		33 1.3%	36 0.6%	49 1.5%	55 2.1%
Planned home births with no midwife present ie place intended but unattended *(% is of total births)*		0	0	n/a	n/a
Unplanned home birth, attended by a midwife eg intended/planned for hospital birth ie. unplanned and attended *(% is of total births)*		0	72 1.18%	22 0.69%	6 0.23%
Unplanned home birth, unattended by a midwife eg intended/planned for hospital birth ie. unplanned and unattended *(% is of total births)*		12 0.5%		n/a	n/a
Births in transit, car park *(% is of total births)*		2 0.1%		n/a	37 1.4%
Total births in the home *(% is of total births)*		45 1.8%	108 1.8%	71 2.2%	61 2.3%
Home labours in water *(% is of total births)*		4 0.2%	2 0.0%	n/a	n/a
Home births in water *(% is of total births)*		4 0.2%	2 0.0%	n/a	n/a
PUBLIC HEALTH DATA					
Women initiating breastfeeding *(% is of total births)*		1812 70.6%	3793 62.0%	2433 76.6%	2034 76.5%
Women breastfeeding on discharge to Health Visitor *(% is of total births)*		999 38.9%		n/a	n/a
Women breastfeeding at 6-8 weeks *(% is of total births)*			37.0%	n/a	n/a
Number of women smokers at time of:	Booking *(% is of total bookings)*	397 13.8%	980 14.8%	578 17.0%	347 12.3%
	Delivery *(% is of total bookings)*	242 8.4%	900 13.6%	393 11.6%	323 11.4%
	Both				
Women under 18 years old at time of birth *(% is of total births)*		35 1.4%	54 0.9%	52 1.6%	41 1.5%

	Airedale	Bradford	Calderdale	Huddersfield
MATERNITY OUTCOMES DATA				
Babies born alive	2546	5938	3161	2643
(% is of total births)	99.2%	97.1%	99.5%	99.4%
Stillbirths	20	55	15	15
(Rate is per 1000 total births)	7.8	9.0	4.7	5.6
Early neonatal deaths (ie. at 6 days and under)	9	24	8	4
(Rate is per 1000 live births)	3.5	4.0	2.5	1.5
Late neonatal deaths (ie. 7-28 days)	5	6	3	1
(Rate is per 1000 live births)	2.0	1.0	0.9	0.4
INTERVENTIONS				
Planned inductions	517	851	545	385
(% is of total births)	20.1%	13.9%	17.2%	14.5%
Accelerated labours (ie. Including ARM, and Syntocinon, or both)	717		1079	908
(% is of total births)	27.9%		34.0%	34.2%
Episiotomies for unassisted vaginal births	130	435	165	137
(% is of unassisted vaginal births)	8.1%	10.6%	8.1%	7.3%
Epidurals with vaginal births	128	625	498	438
(% is of total vaginal births)	6.8%	12.9%	21.1%	20.6%
Epidurals/spinals with caesarean sections	244	1303	695	523
(% is of total caesarean sections)	36.0%	102.3%	85.0%	98.1%
Planned caesarean sections	333	446	306	208
(% is of total births)	13.0%	7.3%	9.6%	7.8%
Emergency caesarean sections	345	828	512	325
(% is of total births)	13.4%	13.5%	16.1%	12.2%
Forceps births by midwife	0		0	0
(% is of total births)				
Forceps births by doctor	147	316	213	128
(% is of total births)	5.7%	5.2%	6.7%	4.8%
Ventouse births by midwife	0	0	0	0
(% is of total births)				
Ventouse births by doctor	127	204	87	93
(% is of total births)	4.9%	3.3%	2.7%	3.5%
Vaginal breech births by midwife	4		0	0
(% is of total births)	0.16%			
Vaginal breech births by doctor	4	60	18	27
(% is of total births)	0.2%	1.0%	0.6%	1.0%
FACILITIES				
Type of unit: (Consultant/midwife/GP)	Consultant	Consultant	Consultant/ midwife	Consultant/ midwife
Total number of maternity beds (including delivery beds)	44	81 + 8 triage/ANDU	40	33
Number of obstetric theatres	1	2	1	1
- Staffed by midwifery staff (other than receiving baby)	Yes	Yes	Yes	Yes
- Staffed by theatre staff	No	No	Yes	Yes
High dependency beds	No	Yes	Yes	Yes
Early pregnancy unit	Yes	Yes	Yes	Yes
Fetal medicine unit	No	No	No	No
Antenatal day assessment unit	Yes	Yes	Yes	Yes
Birthing pool	Yes	Yes	Yes	Yes
Bereavement/quiet room	Yes	Yes	Yes	Yes
Partners accommodation on AN ward	Yes	No	Yes	Yes
Family kitchens	No	Yes	Yes	Yes
Security system: - controlled door entry	Yes	Yes	Yes	Yes
- baby tagging	Yes	No	No	No
- pressure mattresses	No	Yes	No	No
- other (specify)			CCTV	CCTV
Intrapartum GP care	No	No	No	No
Transitional care cots	No	Yes	No	No
Some midwives take responsibility for decision making and undertake:				
Neurophysiological examination of the newborn	Yes	Yes	Yes	Yes
Ultrasound scans	No	Yes	Yes	No
Amniocentesis	No	No	No	No
Induction of labour by prostaglandin	Yes	Yes	Yes	Yes
by syntocinon	Yes		No	Yes
Ventouse deliveries	No	No	No	No
Forceps deliveries	No	No	No	No
Six week postnatal examination	No	No	No	No
Cervical smears	No	No	No	No
Specialised counselling	No	Yes	Yes	Yes
External cephalic version	No	Yes	No	No
Other (please specify)			Moxibustion	Aromatherapy

	Airedale	Bradford	Calderdale	Huddersfield
STAFFING:				
Total number of whole time equivalent midwives employed (clinical and non-clinical)	88.84	164	85.9	76.58
Midwives per 1000 births ratio	34.62	26.81	27.05	28.81
Total number of midwives employed (head count, ie. allowing for part-time staff)	101	211	115	84
Total number of midwives notifying intention to practise (including non-employed miswives, eg. Independent practitioners, educationalists, researchers)	103	218	120	92
Total use of NHS Professionals, Bank, Agency	Not available	1	0	not midwifery
Vacancies according to funded establishment	0	5	3	2.6
Vacancies according to Birthrate Plus defined establishment	2 WTE	55 (not all midwives)	n/a	n/a
Birthrate Plus undertaken - which year	2003	2001 & 2007	2002	2002
Birthrate Plus in progress	No	No	No	No
Birthrate Plus planned - when	No	No	No	Not planned
Ratio of births to midwives in post (WTE)	28.9	37.3	37.0	34.7
What percentage is built into the budget for sickness, annual leave and training?	0%	18%	20%	20%
% annual sickness rate Long term / Short term	5.90%	5.79%	1.83 2.67	1.83% 2.67%
Is non-achievement of optimum staffing levels a trigger for incident reporting?	Yes	Yes	Yes	Yes
Average length of postnatal stay	LSCS: 3 days Vag dels: 1-2 days	2.83	1.2	1.5
Midwife to non-midwife skill mix	1 : 0.2		1 : 0.4	1 : 0.4
Current ratio of supervisors to midwives	1 : 15	1 : 16	1 : 15	1 : 17
Number of student supervisors of midwives	0	1	0	1
Number of enquiries for RTP placements	1	3	1	0
Number of RTP accepted for clinical placements	0	0	1	0
Specialist midwifery posts				
Consultant midwife	0	0	1 (0.5)	1 (1.0)
Lecturer practitioner	0	0	1 (0.4)	0
Practice Development Midwife	3 (1.5)	0	0	0
Infant Feeding Co-ordinator	1 (0.4)	1 (1.0)	1 (0.6)	2 (0.6)
Bereavement Midwife	0	1 (1.0)	0	0
Sure Start Midwife	0	0	0	0
Drug/alcohol dependency midwife	1 (0.4)	1 (1.0)	1 (0.6)	1 (1.0)
Child protection midwife	1 (0.2)	1 (1.0)	1	1
Pregnant teenagers co-ordinator	0	1 (0.1)	1 (1.0)	1
Midwife Ultrasonographer	0	1 (0.4)	1	0
Domestic Violence Midwife	0	1 (0.1)	1 (0.6)	1 (0.4)
Clinic Governance/Risk Management Midwife	0	1 (1.0)	0	0
Antenatal Screening Co-ordinator	1 (0.4)	1 (1.0)	1 (0.8)	1 (0.8)
Other: Diabetes Specialist Midwife Asylum & homeless A/N Screening midwife Professional development midwife/manager Health Education Midwife		1 (1.0)		1 (1.0)

		Airedale	Bradford	Calderdale	Huddersfield
TRANSFERS					
Is there a transfer policy?		Yes	No	Yes	Yes
How often has it been used within the last year?					15
Number of intra-uterine transfers out to other units		10	41	10	7
Number of intra-uterine transfers in from other units		15	Data collection from January 2008	6	8
Number of other transfers	Mother Baby			n/a n/a	n/a n/a
NEONATAL UNIT:					
Managed within the remit of the Head of Midwiferey		No	No	Yes	Yes
Regional or sub-regional referral centre		No	Yes	Sub regional	Yes
Number of midwives employed within NNU notifying their intention to practice		0		4	4
Total cots		15	27	14	14
neonatal intensive care		2	6	3	3
high dependency		1	4	3	0
special care		12	17	8	11
transitional care		0	9	0	0
Parents' accommodation		Yes	Yes		Yes
NNU CLOSURES					
Reason for closure:	Staffing levels	Yes	Yes	Yes	Yes
	Skill mix	No	No	No	No
	Cot shortage	Yes	Yes	Yes	Yes
	Infection	No	No	No	No
Is there a guideline for closure of NNU?		Yes	No	Yes	Yes
ADDITIONAL STATISTICS					
CNST Level achieved		2 October 2007	3 January 2007	1 November 2007	1 November 2007
BFI Status		Phase 1	Accredited BFI	Yes	Certificate of commitment
Number of complaints where midwifery practice is cited:		1	16	0	0
Number of serious untoward incidents (SUI) related to midwifery practice:		3	0	1	0

		Dewsbury	Pontefract	Leeds (LGI)	Leeds (SJUH)
CLINICAL ACTIVITY					
Total women booked 2007/08			3657	?	?
Total women with a first booking appointment under 12 weeks *(% is of the total women booked)*			1181 32.3%	?	?
Antenatal and postnatal cross-border activity - ie. births out-with your unit *(% is of the total women booked)*				?	?
Intrapartum cross-border activity - ie. births only within your unit *(% is of the total women booked)*				?	?
Any other cross-border activity - please specify *(% is of the total women booked)*				?	?
Total women birthed		3217	3493	4672	4327
Total women who had 1:1 care in labour *(% is of the total women birthed)*		Not known		?	?
Total women birthed in the hospital *(% is of the total women birthed)*		3176 98.7%	3267 93.5%	4622 98.9%	4252 98.3%
Number of babies born:	Singletons	3173	3448	4596	4246
	Multiples	90	90	152	127
	Total	3263	3538	4748	4373
Hospital labours in water *(% is of total births)*		Not known	15 0.4%	?	?
Hospital births in water *(% is of total births)*		Not known	40 1.1%	?	?
Total unassisted vaginal births (regardless of lead carer) *(% is of total births)*			2559 72.3%	3161 66.6%	2846 65.1%
Normal delivery (Information Centre definition: women whose labour starts spontaneously, progresses spontaneously without drugs and who give birth spontaneously. Excludes induction of labour, epidural or spinal, general anaesthetic, forceps or ventouse, caesarean section or episiotomy) *(% is of total births)*		2145 65.7%	1456 41.2%	? 	312 7.1%
Number of medical terminations on labour ward/maternity areas Range of gestation Is women's choice of maternity unit or Gynaecology given?			11 17-24 Yes	? No	50 14-23
Births in midwife-led centres/birth centres (please specify whether these are stand alone or within the main unit, or both) *(% is of total births)*	Stand alone Within main unit	Not collected separately	98	? ?	? ?
Women booked under midwife-led care *(% is of total bookings)*			2096 57.3%	?	?
Women transferred to consultant care *(% is of women booked for midwife led care)*				?	?
Are you able to monitor reasons for transfer?					
HOME BIRTHS					
Planned home births attended by a midwife ie. place intended and attended *(% is of total births)*		18 0.6%	73 2.1%	4 0.1%	63 1.4%
Planned home births with no midwife present ie place intended but unattended *(% is of total births)*		0		9 0.2%	21 0.5%
Unplanned home birth, attended by a midwife eg intended/planned for hospital birth ie. unplanned and attended *(% is of total births)*		2 0.06%	13 0.37%	0	0
Unplanned home birth, unattended by a midwife eg intended/planned for hospital birth ie. unplanned and unattended *(% is of total births)*		14 0.4%	19 0.5%	8 0.2%	7 0.2%
Births in transit, car park *(% is of total births)*		7 0.2%	5 0.1%	29 0.6%	20 0.5%
Total births in the home *(% is of total births)*		34 1.0%	105 3.0%	21 0.4%	91 2.1%
Home labours in water *(% is of total births)*				?	?
Home births in water *(% is of total births)*				?	?
PUBLIC HEALTH DATA					
Women initiating breastfeeding *(% is of total births)*		1924 59.0%	1982 56.0%	3181 67.0%	2178 49.8%
Women breastfeeding on discharge to Health Visitor *(% is of total births)*		1659 50.8%		?	?
Women breastfeeding at 6-8 weeks *(% is of total births)*				?	?
Number of women smokers at time of:	Booking *(% is of total bookings)*	586		886	766
	Delivery *(% is of total bookings)*	598		567	643
	Both	455		442	624
Women under 18 years old at time of birth *(% is of total births)*		76 2.3%		72 1.5%	93 2.1%

	Dewsbury	Pontefract	Leeds (LGI)	Leeds (SJUH)
MATERNITY OUTCOMES DATA				
Babies born alive	3246	3515	4708	4297
(% is of total births)	99.5%	99.3%	99.2%	98.3%
Stillbirths	17	23	40	39
(Rate is per 1000 total births)	5.2	6.5	8.4	8.9
Early neonatal deaths (ie. at 6 days and under)	11	8	10	12
(Rate is per 1000 live births)	3.4	2.3	2.1	2.8
Late neonatal deaths (ie. 7-28 days)	3		12	2
(Rate is per 1000 live births)	0.9		2.5	0.0
INTERVENTIONS				
Planned inductions	816	803	?	
(% is of total births)	25.0%	22.7%		
Accelerated labours (ie. Including ARM, and Syntocinon, or both)	223	684	?	1056
(% is of total births)	6.8%	19.3%		24.1%
Episiotomies for unassisted vaginal births	97	227	225	295
(% is of unassisted vaginal births)	#DIV/0!	8.9%	7.1%	10.4%
Epidurals with vaginal births	165		1022	1407
(% is of total vaginal births)	6.6%		25.7%	44.2%
Epidurals/spinals with caesarean sections	149	548	630	459
(% is of total caesarean sections)	19.7%	95.0%	81.0%	38.5%
Planned caesarean sections	257	208	295	413
(% is of total births)	7.9%	5.9%	6.2%	9.4%
Emergency caesarean sections	499	369	483	778
(% is of total births)	15.3%	10.4%	10.2%	17.8%
Forceps births by midwife	0		5	27
(% is of total births)				
Forceps births by doctor	129	172	442	495
(% is of total births)	4.0%	4.9%	9.3%	11.3%
Ventouse births by midwife	0		112	15
(% is of total births)				
Ventouse births by doctor	134	162	27	264
(% is of total births)	4.1%	4.6%	0.6%	6.0%
Vaginal breech births by midwife	0	11	12	16
(% is of total births)		0.3%	0.3%	0.37%
Vaginal breech births by doctor	11	10	13	18
(% is of total births)	0.3%	0.3%	0.3%	0.4%
FACILITIES				
Type of unit: (Consultant/midwife/GP)	Consultant/ midwife	Consultant	Consultant	Consultant
Total number of maternity beds (including delivery beds)	13	46	56	50
Number of obstetric theatres	2	2	2	2
- Staffed by midwifery staff (other than receiving baby)	Yes	Yes	Yes	Yes
- Staffed by theatre staff	No	No	Yes	Yes
High dependency beds	Yes	Yes	Yes	Yes
Early pregnancy unit	Yes	Yes	Yes	Yes
Fetal medicine unit	No	No	Yes	Yes
Antenatal day assessment unit	Yes	Yes	Yes	Yes
Birthing pool	Yes	Yes	Yes	Yes
Bereavement/quiet room	Yes	Yes	Yes	Yes
Partners accommodation on AN ward	No	No	No	No
Family kitchens	No	No	No	No
Security system: - controlled door entry	Yes	Yes	Yes	Yes
- baby tagging	No	No	No	No
- pressure mattresses	No	No	No	No
- other (specify)			Cot alarms	Cot alarms
Intrapartum GP care	No	No	No	No
Transitional care cots	No	No	No	No
Some midwives take responsibility for decision making and undertake:				
Neurophysiological examination of the newborn	Yes	Yes	Yes	Yes
Ultrasound scans	Yes	Yes	Yes	Yes
Amniocentesis	No	No	No	No
Induction of labour by prostaglandin	Yes	Yes	Yes	Yes
by syntocinon	No	No	Yes	Yes
Ventouse deliveries	No	No	Yes	Yes
Forceps deliveries	No	No	Yes	Yes
Six week postnatal examination	No	No	No	No
Cervical smears	No	No	No	No
Specialised counselling	No	No	No	No
External cephalic version	Yes	Yes	No	No
Other (please specify)				

	Dewsbury	Pontefract	Leeds (LGI)	Leeds (SJUH)
STAFFING:				
Total number of whole time equivalent midwives employed (clinical and non-clinical)	81.69	82.49	259	
Midwives per 1000 births ratio	25.04	23.32	28.40	
Total number of midwives employed (head count, ie. allowing for part-time staff)	100	113	297	
Total number of midwives notifying intention to practise (including non-employed miswives, eg. Independent practitioners, educationalists, researchers)	251		322	
Total use of NHS Professionals, Bank, Agency		?	9.6 WTE	
Vacancies according to funded establishment	2	1	19 WTE	
Vacancies according to Birthrate Plus defined establishment	service changed since BR plus	Service changed	?	
Birthrate Plus undertaken - which year	2006	2006	2003	
Birthrate Plus in progress			No	
Birthrate Plus planned - when			No	
Ratio of births to midwives in post (WTE)	39.9	42.9	35.2	
What percentage is built into the budget for sickness, annual leave and training?	22%	22%	20%	
% annual sickness rate Long term Short term			5%	
Is non-achievement of optimum staffing levels a trigger for incident reporting?	Yes	Yes	Yes	
Average length of postnatal stay			2	
Midwife to non-midwife skill mix	2.5 : 1	2.5 : 1	1 : 5.5	
Current ratio of supervisors to midwives	1 : 12	1 : 12	1 : 17	
Number of student supervisors of midwives	0	0	6	
Number of enquiries for RTP placements	0	0	0	
Number of RTP accepted for clinical placements	0	0	0	
Specialist midwifery posts				
Consultant midwife	0	0	0	
Lecturer practitioner	0	0	2 (1.0)	
Practice Development Midwife	0	0	2 (1.8)	
Infant Feeding Co-ordinator	1 (0.5)	1 (0.5)	1 (0.5)	
Bereavement Midwife	0	0	0 (0.5 vacant)	
Sure Start Midwife	0	0	1 (1.0)	
Drug/alcohol dependency midwife	0	1 (1.0)	3 (3.0)	
Child protection midwife	1 (0.3)	1 (0.3)	0	
Pregnant teenagers co-ordinator	0	0	2 (1.0)	
Midwife Ultrasonographer	0	1 (0.5)	1 (0.9)	
Domestic Violence Midwife	0	0	0	
Clinic Governance/Risk Management Midwife	1 (0.5)	1 (0.5)	2 (1.4)	
Antenatal Screening Co-ordinator	1 (0.6)	1 (0.6)	1 (1.0)	
Other: Diabetes Specialist Midwife Asylum & homeless A/N Screening midwife Professional development midwife/manager Health Education Midwife				

		Dewsbury	Pontefract	Leeds (LGI)	Leeds (SJUH)
TRANSFERS					
Is there a transfer policy?		No	Yes	Yes	Yes
How often has it been used within the last year?		Just collecting the data	Just collecting the data	?	?
Number of intra-uterine transfers out to other units				?	?
Number of intra-uterine transfers in from other units				?	?
Number of other transfers	Mother Baby			? ?	? ?
NEONATAL UNIT:					
Managed within the remit of the Head of Midwiferey		Yes	Yes	No	No
Regional or sub-regional referral centre		No	No	Yes	Yes
Number of midwives employed within NNU notifying their intention to practice			0	4	
Total cots		14	14	20	
neonatal intensive care		2	1	15	
high dependency		1	2	20	
special care		11	11	20	
transitional care				18	
Parents' accommodation		Yes	Yes	Yes	
NNU CLOSURES					
Reason for closure:	Staffing levels	No	No	No	Yes
	Skill mix	No	No	No	No
	Cot shortage	No	No	No	Yes
	Infection	No	No	No	No
Is there a guideline for closure of NNU?		Yes	Yes	Yes	Yes
ADDITIONAL STATISTICS					
CNST Level achieved		1 2006	1 2006	1 October 2006	1 October 2006
BFI Status		Certificate of achievement	Certificate of commitment		Certificate of commitment
Number of complaints where midwifery practice is cited:		9	7	16	16
Number of serious untoward incidents (SUI) related to midwifery practice:		0	1	1	3

		Harrogate	Hull & East Yorkshire	Grimsby	Scunthorpe & Goole
CLINICAL ACTIVITY					
Total women booked 2007/08		2331	6330	2745	2244
Total women with a first booking appointment under 12 weeks *(% is of the total women booked)*		n/a	2925 46.2%	1600 58.3%	1003 44.7%
Antenatal and postnatal cross-border activity - ie. births out-with your unit *(% is of the total women booked)*		n/a	246 3.9%	19 0.7%	270 12.0%
Intrapartum cross-border activity - ie. births only within your unit *(% is of the total women booked)*		616 26.4%		11 0.4%	n/k
Any other cross-border activity - please specify *(% is of the total women booked)*		n/a	300 4.7%	15 0.5%	201 9.0%
Total women birthed		1974	5669	2510	2104
Total women who had 1:1 care in labour *(% is of the total women birthed)*		1809 91.6%		2499 99.6%	2085 99.1%
Total women birthed in the hospital *(% is of the total women birthed)*		1939 98.2%	5549 97.9%	2472 98.5%	2021 96.1%
Number of babies born:	Singletons	1942	5617	2467	2085
	Multiples	64	105	85	38
	Total	2006	5722	2552	2123
Hospital labours in water *(% is of total births)*		96 4.8%	566 9.9%	45 1.8%	13 0.6%
Hospital births in water *(% is of total births)*		27 1.3%	302 5.3%	33 1.3%	27 1.3%
Total unassisted vaginal births (regardless of lead carer) *(% is of total births)*		1152 57.4%	3974 69.5%	1745 68.4%	1444 68.0%
Normal delivery (Information Centre definition: women whose labour starts spontaneously, progresses spontaneously without drugs and who give birth spontaneously. Excludes induction of labour, epidural or spinal, general anaesthetic, forceps or ventouse, caesarean section or episiotomy) *(% is of total births)*		n/a	1046 18.3%	122 4.8%	615 29.0%
Number of medical terminations on labour ward/maternity areas		12	25	5	12
Range of gestation		18-40	16-23	19-22	13-22
Is women's choice of maternity unit or Gynaecology given?		Yes	Maternity		Yes
Births in midwife-led centres/birth centres (please specify whether these are stand alone or within the main unit, or both)	Stand alone	0	352	0	6
(% is of total births)	Within main unit	0	1046 18.3%	0 0.0%	
Women booked under midwife-led care *(% is of total bookings)*		314 13.5%	No data	543 19.8%	166 7.4%
Women transferred to consultant care *(% is of women booked for midwife led care)*		n/a	No data	n/a	n/k
Are you able to monitor reasons for transfer?		No	No		
HOME BIRTHS					
Planned home births attended by a midwife ie. place intended and attended *(% is of total births)*		28 1.4%	n/a	13 0.5%	55 2.6%
Planned home births with no midwife present ie place intended but unattended *(% is of total births)*			0	3 0.1%	3 0.1%
Unplanned home birth, attended by a midwife eg intended/planned for hospital birth ie. unplanned and attended *(% is of total births)*		2 0.10%	n/k	4 0.16%	9 0.42%
Unplanned home birth, unattended by a midwife eg intended/planned for hospital birth ie. unplanned and unattended *(% is of total births)*		5 0.2%	n/k	13 0.5%	16 0.8%
Births in transit, car park *(% is of total births)*		0 0.0%	69 1.2%	5 0.2%	0
Total births in the home *(% is of total births)*		35 1.7%	51 0.9%	33 1.3%	83 3.9%
Home labours in water *(% is of total births)*		0 0.0%	3 0.1%	0 0.0%	0 0.0%
Home births in water *(% is of total births)*		0 0.0%	2 0.0%	0 0.0%	0 0.0%
PUBLIC HEALTH DATA					
Women initiating breastfeeding *(% is of total births)*		1678 83.6%	3297 57.6%	1435 56.2%	1217 57.3%
Women breastfeeding on discharge to Health Visitor *(% is of total births)*		n/a	1443 25.2%	917 35.9%	822 38.7%
Women breastfeeding at 6-8 weeks *(% is of total births)*		n/a	93 1.6%	n/k	
Number of women smokers at time of:	Booking *(% is of total bookings)*	205 8.8%	2504 39.6%	708 25.8%	510 22.7%
	Delivery *(% is of total bookings)*	180 7.7%	1473 23.3%	354 12.9%	402 17.9%
	Both	n/a	No data	639	
Women under 18 years old at time of birth *(% is of total births)*		88 4.4%	198 3.5%	64 2.5%	47 2.2%

	Harrogate	Hull & East Yorkshire	Grimsby	Scunthorpe & Goole
MATERNITY OUTCOMES DATA				
Babies born alive	2000	5696	2536	2114
(% is of total births)	99.7%	99.5%	99.4%	99.6%
Stillbirths	6	26	16	9
(Rate is per 1000 total births)	3.0	4.5	6.3	4.2
Early neonatal deaths (ie. at 6 days and under)	2	5	10	1
(Rate is per 1000 live births)	1.0	0.9	3.9	0.5
Late neonatal deaths (ie. 7-28 days)	1	5	1	4
(Rate is per 1000 live births)	0.5	0.9	0.4	1.9
INTERVENTIONS				
Planned inductions	337	1110	499	430
(% is of total births)	16.8%	19.4%	19.6%	20.3%
Accelerated labours (ie. Including ARM, and Syntocinon, or both)	430	1383	588	797
(% is of total births)	21.4%	24.2%	23.0%	37.5%
Episiotomies for unassisted vaginal births	145	211	177	100
(% is of unassisted vaginal births)	12.6%	5.3%	10.1%	6.9%
Epidurals with vaginal births	425	1543	325	166
(% is of total vaginal births)	28.7%	35.2%	15.4%	10.1%
Epidurals/spinals with caesarean sections	507	453	374	438
(% is of total caesarean sections)	96.8%	34.0%	84.0%	91.3%
Planned caesarean sections	165	560	208	135
(% is of total births)	8.2%	9.8%	8.2%	6.4%
Emergency caesarean sections	359	773	237	345
(% is of total births)	17.9%	13.5%	9.3%	16.3%
Forceps births by midwife	0	0	53	0
(% is of total births)				
Forceps births by doctor	152	260	193	83
(% is of total births)	7.6%	4.5%	7.6%	3.9%
Ventouse births by midwife	0	1	13	0
(% is of total births)				
Ventouse births by doctor	147	146	89	90
(% is of total births)	7.3%	2.6%	3.5%	4.2%
Vaginal breech births by midwife	2	14	1	0
(% is of total births)	0.10%	0.24%	0.0%	
Vaginal breech births by doctor	4	18	13	7
(% is of total births)	0.2%	0.3%	0.5%	0.3%
FACILITIES				
Type of unit: (Consultant/midwife/GP)	Consultant	Consultant/ midwife	Consultant	Consultant
Total number of maternity beds (including delivery beds)	31	81	37	26
Number of obstetric theatres	1	2	1	1
- Staffed by midwifery staff (other than receiving baby)	No	Yes	Yes	No
- Staffed by theatre staff	Yes	Yes	Yes	Yes
High dependency beds	No	Yes	Yes	Yes
Early pregnancy unit	Yes	Yes	Yes	Yes
Fetal medicine unit	No	No	No	No
Antenatal day assessment unit	Yes	Yes	Yes	Yes
Birthing pool	Yes	Yes	Yes	Yes
Bereavement/quiet room	Yes	Yes	Yes	Yes
Partners accommodation on AN ward	No	No	Yes	By negotiation
Family kitchens	No	No	No	No
Security system: - controlled door entry	Yes	Yes	Yes	Yes
- baby tagging	Yes	No	No	Yes
- pressure mattresses	No	Yes	Yes	
- other (specify)				
Intrapartum GP care	No	No	No	No
Transitional care cots	No	Yes	Yes	No
Some midwives take responsibility for decision making and undertake:				
Neurophysiological examination of the newborn	Yes	Yes	No	Yes
Ultrasound scans	No	No	Yes	No
Amniocentesis	No	No	No	No
Induction of labour by prostaglandin	No	Yes	No	No
by syntocinon	No	Yes	No	No
Ventouse deliveries	No	No	Yes	No
Forceps deliveries	No	No	No	No
Six week postnatal examination	Yes	No	No	No
Cervical smears	No	No	No	No
Specialised counselling	Yes	No	No	No
External cephalic version	No	No	No	No
Other (please specify)				

	Harrogate	Hull & East Yorkshire	Grimsby	Scunthorpe & Goole
STAFFING:				
Total number of whole time equivalent midwives employed (clinical and non-clinical)	55.78	194.65	76.08	74.28
Midwives per 1000 births ratio	27.81	34.02	29.81	34.99
Total number of midwives employed (head count, ie. allowing for part-time staff)	72	236	103	83
Total number of midwives notifying intention to practise (including non-employed miswives, eg. Independent practitioners, educationalists, researchers)	74	249	103	83
Total use of NHS Professionals, Bank, Agency	Minimal	700 shifts	2507 hours	1234.02 hours
Vacancies according to funded establishment	2	9	4.55	0.63 over
Vacancies according to Birthrate Plus defined establishment	n/a	15	12.75	7.42
Birthrate Plus undertaken - which year	n/a	2005	2002	2002
Birthrate Plus in progress	No		No	No
Birthrate Plus planned - when	No		No	No
Ratio of births to midwives in post (WTE)	36.0	29.4	33.5	28.6
What percentage is built into the budget for sickness, annual leave and training?	18%	22%	22%	22%
% annual sickness rate Long term Short term	2.50% 3.00%		4.9%	8.5%
Is non-achievement of optimum staffing levels a trigger for incident reporting?	Yes		Yes	Yes
Average length of postnatal stay	1.6 days	1.8 days	n/k	n/k
Midwife to non-midwife skill mix	1 : 0.2	1 : 0.26	1 : 0.5	1 : 0.3
Current ratio of supervisors to midwives	1 : 11.5	1 : 14	1 : 15	1 : 13
Number of student supervisors of midwives	0	1	0	0
Number of enquiries for RTP placements	0	0	2	2
Number of RTP accepted for clinical placements	0	0	1	1
Specialist midwifery posts				
Consultant midwife	0	0	1 (0.5)	1 (0.5)
Lecturer practitioner	0	0	0	0
Practice Development Midwife	1 (0.2)	1 (1.0)	0	0
Infant Feeding Co-ordinator	1 (0.6)	1 (1.0)	1 (0.8)	1 (0.8)
Bereavement Midwife	0	0	0	0
Sure Start Midwife	0	0	0	0
Drug/alcohol dependency midwife	1 (0.2)	1 (1.0)	0	1 (0.8)
Child protection midwife	1 (0.1)	0	0	0
Pregnant teenagers co-ordinator	1 (0.2)	0	0	0
Midwife Ultrasonographer	0	0	1 (0.6)	0
Domestic Violence Midwife	1 (0.1)	0	0	0
Clinic Governance/Risk Management Midwife	1 (0.8)	0	1 (0.5)	1 (0.5)
Antenatal Screening Co-ordinator	1 (0.6)	1 (1.0)	0	0
Other: Diabetes Specialist Midwife Asylum & homeless A/N Screening midwife Professional development midwife/manager Health Education Midwife		1 (1.0)		

		Harrogate	Hull & East Yorkshire	Grimsby	Scunthorpe & Goole
TRANSFERS					
Is there a transfer policy?		Yes		Yes	Yes
How often has it been used within the last year?		21		13	17
Number of intra-uterine transfers out to other units		21	37	2	16
Number of intra-uterine transfers in from other units		6	10	11	1
Number of other transfers	Mother Baby	30 30		6 30	
NEONATAL UNIT:					
Managed within the remit of the Head of Midwiferey		Yes	No	No	No
Regional or sub-regional referral centre		No	Yes	No	No
Number of midwives employed within NNU notifying their intention to practice		1	4	0	0
Total cots		10	30	16	15
neonatal intensive care		0	5	3	2
high dependency		0	4	1	2
special care		10	21	included in below	6
transitional care		0	4	12	5
Parents' accommodation		Yes	Yes	Yes	Yes
NNU CLOSURES					
Reason for closure:	Staffing levels	Yes	Yes	No	No
	Skill mix	No	No	No	No
	Cot shortage	No	No	No	No
	Infection	No	No	No	No
Is there a guideline for closure of NNU?		Yes	No	Yes	Yes
ADDITIONAL STATISTICS					
CNST Level achieved		2 January 2008	1 January 2007	2 September 2007	2 September 2007
BFI Status		Full award	Certificate of commitment	Certificate of commitment	Certificate of commitment
Number of complaints where midwifery practice is cited:		2	10	5	3
Number of serious untoward incidents (SUI) related to midwifery practice:		1	1	0	0

		Scarborough	Bridlington	Malton	Whitby	York
CLINICAL ACTIVITY						
Total women booked 2007/08		1710	432	457	350	3659
Total women with a first booking appointment under 12 weeks *(% is of the total women booked)*		No info	No info	Not known	No info	Not known
Antenatal and postnatal cross-border activity - ie. births out-with your unit *(% is of the total women booked)*		1 0.1%	12 2.8%	143 31.3%	457 130.6%	
Intrapartum cross-border activity - ie. births only within your unit *(% is of the total women booked)*		10 0.6%	0	0	0	
Any other cross-border activity - please specify *(% is of the total women booked)*		0	0	0	13 3.7%	
Total women birthed		1613	18	30	28	3367
Total women who had 1:1 care in labour *(% is of the total women birthed)*		No info	18 100.0%	30 100.0%	28 100.0%	Not available
Total women birthed in the hospital *(% is of the total women birthed)*		1590 98.6%	5 27.8%	16 53.3%	19 67.9%	3312 98.4%
Number of babies born:	Singletons	1604	18	30	28	3318
	Multiples	18	0	0	0	98
	Total	1622	18	30	28	3416
Hospital labours in water *(% is of total births)*		20 1.2%	0	9 30.0%	1 3.6%	199 5.8%
Hospital births in water *(% is of total births)*		19 1.2%	0	9 30.0%	1 3.6%	126 3.7%
Total unassisted vaginal births (regardless of lead carer) *(% is of total births)*		1147 70.7%	18 100.0%	30 100.0%	28 100.0%	2207 64.6%
Normal delivery (Information Centre definition: women whose labour starts spontaneously, progresses spontaneously without drugs and who give birth spontaneously. Excludes induction of labour, epidural or spinal, general anaesthetic, forceps or ventouse, caesarean section or episiotomy) *(% is of total births)*		No info	18 100.0%	30 100.0%	28 100.0%	421 12.3%
Number of medical terminations on labour ward/maternity areas Range of gestation Is women's choice of maternity unit or Gynaecology given?		10 20-22	0	0	0	14 16-23 weeks Yes
Births in midwife-led centres/birth centres (please specify whether these are stand alone or within the main unit, or both) *(% is of total births)*	Stand alone	0	5	30	28	
	Within main unit	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1236 36.2%
Women booked under midwife-led care *(% is of total bookings)*		477 27.9%	184 42.6%	243 53.2%	72 20.6%	1482 40.5%
Women transferred to consultant care *(% is of women booked for midwife led care)*		No info	No info	Not known		15 1.0%
Are you able to monitor reasons for transfer?		No	No	No		No
HOME BIRTHS						
Planned home births attended by a midwife ie. place intended and attended *(% is of total births)*		17 1.0%	9 50.0%	9 30.0%	7 25.0%	55 1.6%
Planned home births with no midwife present ie place intended but unattended *(% is of total births)*		0	1 5.6%	3 10.0%	0	4 0.1%
Unplanned home birth, attended by a midwife eg intended/planned for hospital birth ie. unplanned and attended *(% is of total births)*		2 0.12%	3 16.67%	2 6.67%	2 7.14%	19 0.56%
Unplanned home birth, unattended by a midwife eg intended/planned for hospital birth ie. unplanned and unattended *(% is of total births)*		2 0.1%	0 0.0%	0 0.0%	0 0.0%	1 0.0%
Births in transit, car park *(% is of total births)*		2 0.1%	0 0.0%	0 0.0%	0 0.0%	6 0.2%
Total births in the home *(% is of total births)*		21 1.3%	13 72.2%	14 46.7%	9 32.1%	79 2.3%
Home labours in water *(% is of total births)*		2 0.1%	0 0.0%	2 6.7%	0 0.0%	1 0.0%
Home births in water *(% is of total births)*		1 0.1%	0 0.0%	1 3.3%	0 0.0%	9 0.3%
PUBLIC HEALTH DATA						
Women initiating breastfeeding *(% is of total births)*		No info	14 77.8%	24 80.0%	27 96.4%	2243 65.7%
Women breastfeeding on discharge to Health Visitor *(% is of total births)*		No info	No info	Not known	24 85.7%	2052 60.1%
Women breastfeeding at 6-8 weeks *(% is of total births)*		No info	No info	Not known	No info	Not known
Number of women smokers at time of:	Booking *(% is of total bookings)*	No info	5 1.2%	67 14.7%	No info	878 24.0%
	Delivery *(% is of total bookings)*	No info	5 1.2%	2 0.4%	No info	600 16.4%
	Both	No info	5	?	No info	600
Women under 18 years old at time of birth *(% is of total births)*		No info	0 0.0%	1 3.3%	1 3.6%	86 2.5%

	Scarborough	Bridlington	Malton	Whitby	York
MATERNITY OUTCOMES DATA					
Babies born alive	1614	18	30	28	3400
(% is of total births)	99.5%	100.0%	100.0%	100.0%	99.5%
Stillbirths	8	0	0	0	16
(Rate is per 1000 total births)	4.9	0.0	0.0	0.0	4.7
Early neonatal deaths (ie. at 6 days and under)	2	0	0	0	7
(Rate is per 1000 live births)	1.2	0.0	0.0	0.0	2.1
Late neonatal deaths (ie. 7-28 days)	0	0	0	0	0
(Rate is per 1000 live births)	0.0	0.0	0.0	0.0	0.0
INTERVENTIONS					
Planned inductions	306	0	0	0	731
(% is of total births)	18.9%	0.0%	0.0%	0.0%	21.4%
Accelerated labours (ie. Including ARM, and Syntocinon, or both)	133	0	0	0	498
(% is of total births)	8.2%	0.0%	0.0%	0.0%	14.6%
Episiotomies for unassisted vaginal births	185	0	0	0	202
(% is of unassisted vaginal births)	16.1%	0.0%	0.0%	0.0%	9.2%
Epidurals with vaginal births	319	0	0	0	466
(% is of total vaginal births)	24.6%	0.0%	0.0%	0.0%	17.6%
Epidurals/spinals with caesarean sections	292	0	0	0	734
(% is of total caesarean sections)	90.1%	#DIV/0!	#DIV/0!	#DIV/0!	94.8%
Planned caesarean sections	146	0	0	0	346
(% is of total births)	9.0%	0.0%	0.0%	0.0%	10.1%
Emergency caesarean sections	178	0	0	0	428
(% is of total births)	11.0%	0.0%	0.0%	0.0%	12.5%
Forceps births by midwife	0	0	0	0	0
(% is of total births)					
Forceps births by doctor	73	0	0	0	220
(% is of total births)	4.5%	0.0%	0.0%	0.0%	6.4%
Ventouse births by midwife	0	0	0	0	0
(% is of total births)					
Ventouse births by doctor	65	0	0	0	84
(% is of total births)	4.0%	0.0%	0.0%	0.0%	2.5%
Vaginal breech births by midwife	0	0	0	0	3
(% is of total births)		0.0%	0.0%	0.0%	0.09%
Vaginal breech births by doctor	4	0	0	0	10
(% is of total births)	0.2%	0.0%	0.0%	0.0%	0.3%
FACILITIES					
Type of unit: (Consultant/midwife/GP)	Consultant/ midwife	Midwife	Midwife	Midwife	Consultant/ midwife
Total number of maternity beds (including delivery beds)	24	2	2	5	10
Number of obstetric theatres	1	0	0	0	2
- Staffed by midwifery staff (other than receiving baby)	Yes	No	No	No	Yes
- Staffed by theatre staff	No	No	No	No	Occasionally
High dependency beds	No	No	No	No	Yes
Early pregnancy unit	Yes	No	No	No	No
Fetal medicine unit	No	No	No	No	No
Antenatal day assessment unit	Yes	No	No	No	Yes
Birthing pool	Yes	No	Yes	Yes	Yes
Bereavement/quiet room	No	No	No	No	Yes
Partners accommodation on AN ward	No	Yes	No	No	No
Family kitchens	No	Yes	No	No	No
Security system: - controlled door entry	Yes	Yes	Yes	Yes	Yes
- baby tagging	Yes	No	No	No	Yes
- pressure mattresses		No	No	No	
- other (specify)					
Intrapartum GP care	No	No		No	No
Transitional care cots	No	No		No	No
Some midwives take responsibility for decision making and undertake:					
Neurophysiological examination of the newborn	Yes	Yes	No	Yes	Yes
Ultrasound scans	No	No	No	No	No
Amniocentesis	No	No	No	No	No
Induction of labour by prostaglandin	No	No	No	No	Yes
by syntocinon	No	No	No	No	Yes
Ventouse deliveries	No	No	No	No	No
Forceps deliveries	No	No	No	No	No
Six week postnatal examination	No	No	No	No	No
Cervical smears	No	No	No	No	No
Specialised counselling	No	No	No	Yes	Yes
External cephalic version	No	No	No	No	No
Other (please specify)					

	Scarborough	Bridlington	Malton	Whitby	York
STAFFING:					
Total number of whole time equivalent midwives employed (clinical and non-clinical)	51.8	7.4	4.2	4.8	90.74
Midwives per 1000 births ratio	31.94	411.11	140.00	171.43	26.56
Total number of midwives employed (head count, ie. allowing for part-time staff)	55	8	5	5	118
Total number of midwives notifying intention to practise (including non-employed miswives, eg. Independent practitioners, educationalists, researchers)	58	8	5	5	122
Total use of NHS Professionals, Bank, Agency	3	0	0	5	
Vacancies according to funded establishment	2.6	0	2	0	8.62%
Vacancies according to Birthrate Plus defined establishment	No info	n/a	Not done	No info	
Birthrate Plus undertaken - which year	2002	No info	2002	No info	2002
Birthrate Plus in progress	No	No	No	No	No
Birthrate Plus planned - when	No	No	No	No	Not planned
Ratio of births to midwives in post (WTE)	31.3	2.4	7.1	5.8	37.6
What percentage is built into the budget for sickness, annual leave and training?	23%	20%	23%	23%	18%
% annual sickness rate Long term Short term	No info 11.30%	No info 5.10%	No info 3.20%	No info 8.20%	
Is non-achievement of optimum staffing levels a trigger for incident reporting?	Yes	Yes	Yes		Yes
Average length of postnatal stay	24 hours	4 hours	6 hours	6 hours	1-3 days
Midwife to non-midwife skill mix		1 : 8		1 : 0	
Current ratio of supervisors to midwives	1 : 8	1 : 8	1 : 8	1 : 8	
Number of student supervisors of midwives	0	0	0	0	2
Number of enquiries for RTP placements	0	0	0	0	0
Number of RTP accepted for clinical placements	0	0	0	0	0
Specialist midwifery posts					
Consultant midwife	0	0	0	0	0
Lecturer practitioner	0	0	0	0	2
Practice Development Midwife	0	0	0	0	2 (1.0)
Infant Feeding Co-ordinator	0	0	0	0	2 (0.3)
Bereavement Midwife	0	0	0	0	2 (1.1)
Sure Start Midwife	0	0	0	0	2 (2.0)
Drug/alcohol dependency midwife	0	0	0	0	
Child protection midwife	1 (1.0)	0	0	0	
Pregnant teenagers co-ordinator	0	0	0	0	1 (0.6)
Midwife Ultrasonographer	0	0	0	0	0
Domestic Violence Midwife	0	0	0	0	1 (1.0)
Clinic Governance/Risk Management Midwife	0	0	0	0	2 (1.0)
Antenatal Screening Co-ordinator	1 (1.0)	0	0	0	2 (1.0)
Other: Diabetes Specialist Midwife Asylum & homeless A/N Screening midwife Professional development midwife/manager Health Education Midwife	1 (0.4)				

		Scarborough	Bridlington	Malton	Whitby	York
TRANSFERS						
Is there a transfer policy?		Yes	Yes	Yes	Yes	Yes
How often has it been used within the last year?		29	3	1	10	
Number of intra-uterine transfers out to other units		28	3	1	10	22
Number of intra-uterine transfers in from other units		1	0	0	0	n/k
Number of other transfers	Mother	0	0	0	0	22
	Baby	0	0	0	0	22
NEONATAL UNIT:						
Managed within the remit of the Head of Midwiferey		Yes	n/a	n/a	n/a	No
Regional or sub-regional referral centre		No	n/a	n/a	n/a	No
Number of midwives employed within NNU notifying their intention to practice		1	n/a	n/a	n/a	0
Total cots		8	n/a	n/a	n/a	15
neonatal intensive care		0	n/a	n/a	n/a	2
high dependency		0	n/a	n/a	n/a	0
special care		8	n/a	n/a	n/a	13
transitional care		0	n/a	n/a	n/a	0
Parents' accommodation		Yes	n/a	n/a	n/a	Yes
NNU CLOSURES						
Reason for closure:	Staffing levels	No	n/a	n/a	n/a	Yes
	Skill mix	No	n/a	n/a	n/a	No
	Cot shortage	No	n/a	n/a	n/a	Yes
	Infection	No	n/a	n/a	n/a	No
Is there a guideline for closure of NNU?		Yes	n/a	n/a	n/a	Yes
ADDITIONAL STATISTICS						
CNST Level achieved		1 March 2008	1 March 2008	1 March 2008	1 February 2008	1 March 2008
BFI Status		n/a	n/a	No	n/a	Working towards assessment
Number of complaints where midwifery practice is cited:		9	0		0	8
Number of serious untoward incidents (SUI) related to midwifery practice:		0	0		0	1

Notes: Total home births exclude births in transit where identified separately.
Total home births in Sheffield could not be fully broken down into whether intentional and whether attended by a midwife.
Smoking status at booking and delivery may be unknown for many women in some units.
For Bradford and Hull & East Yorkshire the total number of cots do not equal the sum of cots identified in each of the categories, as cots identified for transitional care may also be used for other purposes.

APPENDIX 10

"Supervisors: Protecting women and babies, midwives and supervision"

DAY 1 - THURSDAY 5TH JULY 2007

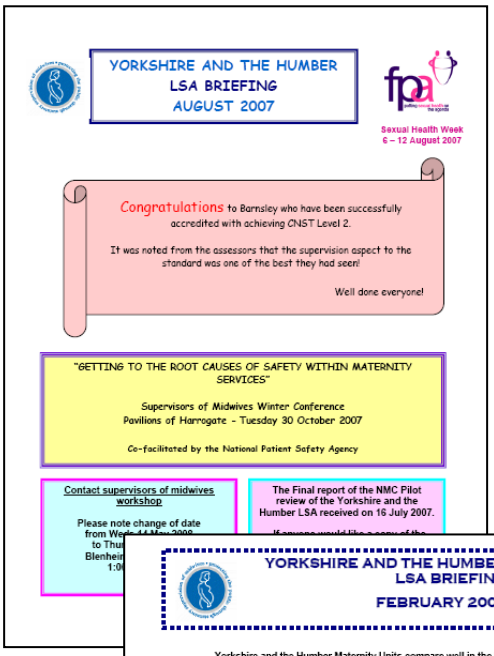
11.30 – 12.00	-	Arrival and registration
12.00 – 1.00	-	Lunch
1.00 – 1.15	-	Carol Paeglis, LSA Midwifery Officer **-** Introduction and Welcome
1.15 – 2.00	-	Supervision in Maternity Matters **- Jill Demilew, Consultant Midwife, Women's Care Group, King's College Hospitals Foundation Trust, London**
2.00– 2.45	-	**Focussing on normal birth and reducing caesarean section rates** Ali Brodrick and Nicki Mason, Midwife Consultants, NHS Institute for Innovation and Improvement
2.45 – 3.30	-	**Bumping along the bottom? What more can midwives do to help reduce infant mortality?' -** Dr Dee Kyle, Consultant in Public Health Medicine, Bradford and Airedale Teaching Primary Care Trust
3.30 – 4.00	-	Tea / coffee
4.00 – 5.15	-	**Working with women to enhance safety** – trigger sessions
5.15	-	**Chair's closing remarks**
7.30 – 10.00	-	Dinner

DAY 2 - FRIDAY 6TH JULY 2007

9.00 - 9.45	**Healthcare Commission Maternity Programme** - Sue Eardley, Strategy Manager, Children and Maternity, Children's Strategy Team, Healthcare Commission
9.45 – 10.15	**"Does supervision make a difference?"** – Dr Mary Renfrew, Professor of Mother and Infant Health, Director of the Mother and Infant Research Unit, The University of York
10.15 – 10.45	Table top discussions – *Examples of the difference supervision makes to safety of midwifery services*
10.45 – 11.15	Coffee
11.15 – 11.45	Feedback from table top discussions
11.45 – 12 noon	Carol Paeglis, LSA Midwifery Officer Closing remarks

APPENDIX 11

LSA BRIEFING



YORKSHIRE AND THE HUMBER
LSA BRIEFING
AUGUST 2007

Sexual Health Week
6 – 12 August 2007

Congratulations to Barnsley who have been successfully accredited with achieving CNST Level 2.

It was noted from the assessors that the supervision aspect to the standard was one of the best they had seen!

Well done everyone!

"GETTING TO THE ROOT CAUSES OF SAFETY WITHIN MATERNITY SERVICES"

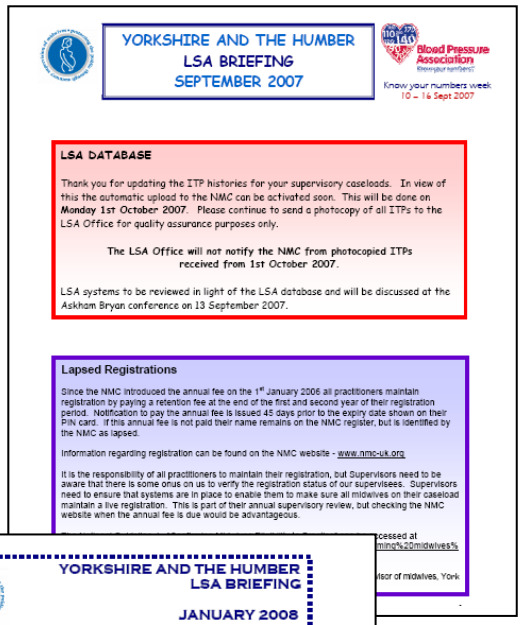
Supervisors of Midwives Winter Conference
Pavilions of Harrogate – Tuesday 30 October 2007

Co-facilitated by the National Patient Safety Agency

Contact supervisors of midwives workshop

Please note change of date from Wed 14 May 2008 to Thu … Blenheim 1:0…

The Final report of the NMC Pilot review of the Yorkshire and the Humber LSA received on 16 July 2007.



YORKSHIRE AND THE HUMBER
LSA BRIEFING
SEPTEMBER 2007

Blood Pressure Association
Know your numbers week
10 – 16 Sept 2007

LSA DATABASE

Thank you for updating the ITP histories for your supervisory caseloads. In view of this the automatic upload to the NMC can be activated soon. This will be done on Monday 1st October 2007. Please continue to send a photocopy of all ITPs to the LSA Office for quality assurance purposes only.

The LSA Office will not notify the NMC from photocopied ITPs received from 1st October 2007.

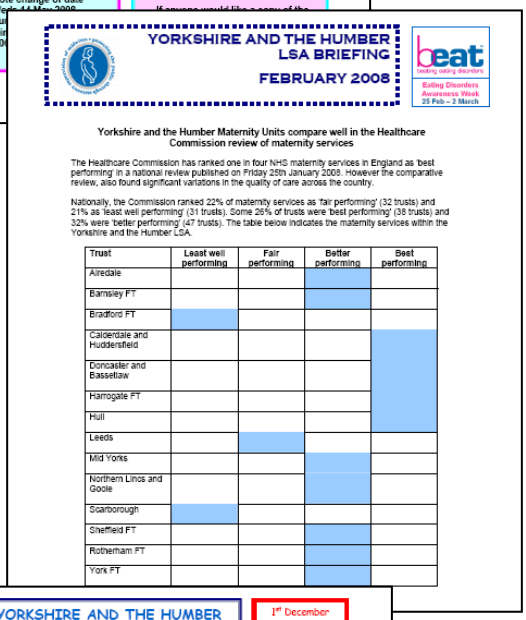
LSA systems to be reviewed in light of the LSA database and will be discussed at the Askham Bryan conference on 13 September 2007.

Lapsed Registrations

Since the NMC introduced the annual fee on the 1st January 2006 all practitioners maintain registration by paying a retention fee at the end of the first and second year of their registration period. Notification to pay the annual fee is issued 45 days prior to the expiry date shown on their PIN card. If this annual fee is not paid their name remains on the NMC register, but is identified by the NMC as lapsed.

Information regarding registration can be found on the NMC website - www.nmc-uk.org

It is the responsibility of all practitioners to maintain their registration, but Supervisors need to be aware that there is some onus on us to verify the registration status of our supervisees. Supervisors need to ensure that systems are in place to enable them to make sure all midwives on their caseload maintain a live registration. This is part of their annual supervisory review, but checking the NMC website when the annual fee is due would be advantageous.



YORKSHIRE AND THE HUMBER
LSA BRIEFING
FEBRUARY 2008

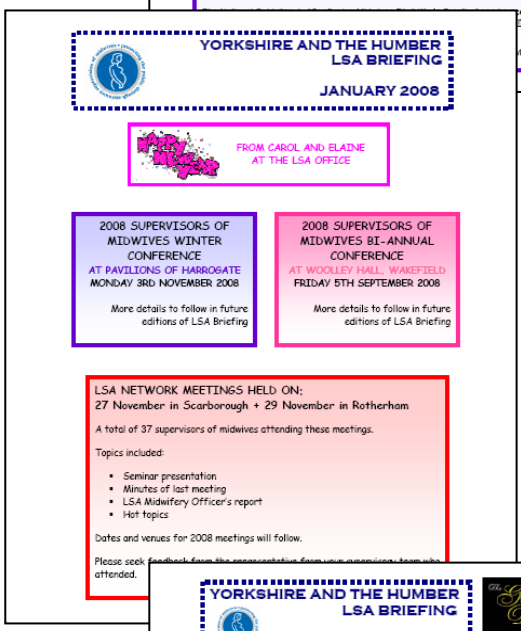
beat
Eating Disorders Awareness Week
25 Feb – 2 March

Yorkshire and the Humber Maternity Units compare well in the Healthcare Commission review of maternity services

The Healthcare Commission has ranked one in four NHS maternity services in England as 'best performing' in a national review published on Friday 25th January 2008. However the comparative review, also found significant variations in the quality of care across the country.

Nationally, the Commission ranked 22% of maternity services as 'fair performing' (32 trusts) and 21% as 'least well performing' (31 trusts). Some 26% of trusts were 'best performing' (38 trusts) and 32% were 'better performing' (47 trusts). The table below indicates the maternity services within the Yorkshire and the Humber LSA.

Trust	Least well performing	Fair performing	Better performing	Best performing
Airedale				
Barnsley FT				
Bradford FT				
Calderdale and Huddersfield				
Doncaster and Bassetlaw				
Harrogate FT				
Hull				
Leeds				
Mid Yorks				
Northern Lincs and Goole				
Scarborough				
Sheffield FT				
Rotherham FT				
York FT				



YORKSHIRE AND THE HUMBER
LSA BRIEFING
JANUARY 2008

FROM CAROL AND ELAINE
AT THE LSA OFFICE

2008 SUPERVISORS OF MIDWIVES WINTER CONFERENCE
AT PAVILIONS OF HARROGATE
MONDAY 3RD NOVEMBER 2008

More details to follow in future editions of LSA Briefing

2008 SUPERVISORS OF MIDWIVES BI-ANNUAL CONFERENCE
AT WOOLLEY HALL, WAKEFIELD
FRIDAY 5TH SEPTEMBER 2008

More details to follow in future editions of LSA Briefing

LSA NETWORK MEETINGS HELD ON:
27 November in Scarborough + 29 November in Rotherham

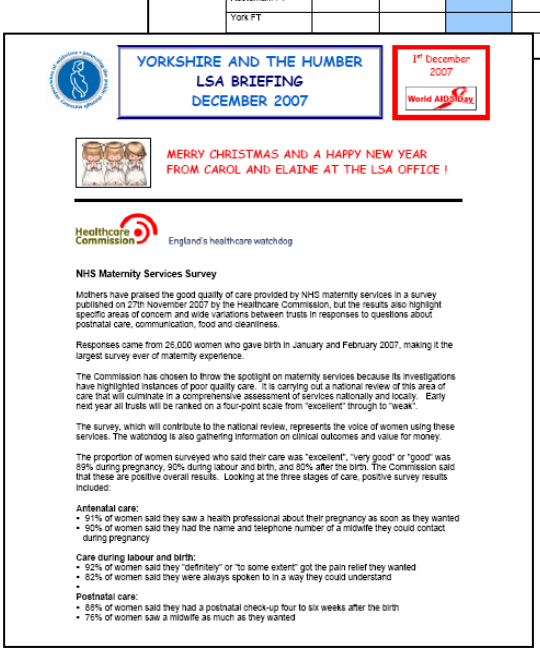
A total of 37 supervisors of midwives attending these meetings.

Topics included:

- Seminar presentation
- Minutes of last meeting
- LSA Midwifery Officer's report
- Hot topics

Dates and venues for 2008 meetings will follow.

Please seek feedback from the representative from your supervisory team who attended.



YORKSHIRE AND THE HUMBER
LSA BRIEFING
DECEMBER 2007

1st December 2007
World AIDS Day

MERRY CHRISTMAS AND A HAPPY NEW YEAR
FROM CAROL AND ELAINE AT THE LSA OFFICE !

Healthcare Commission
England's healthcare watchdog

NHS Maternity Services Survey

Mothers have praised the good quality of care provided by NHS maternity services in a survey published on 27th November 2007 by the Healthcare Commission, but the results also highlight specific areas of concern and wide variations between trusts in responses to questions about postnatal care, communication, food and cleanliness.

Responses came from 26,000 women who gave birth in January and February 2007, making it the largest survey ever of maternity experience.

The Commission has chosen to throw the spotlight on maternity services because its investigations have highlighted instances of poor quality care. It is carrying out a national review of this area of care that will culminate in a comprehensive assessment of services nationally and locally. Early next year all trusts will be ranked on a four-point scale from "excellent" through to "weak".

The survey, which will contribute to the national review, represents the voice of women using these services. The watchdog is also gathering information on clinical outcomes and value for money.

The proportion of women surveyed who said their care was "excellent", "very good" or "good" was 89% during pregnancy, 90% during labour and birth, and 85% after the birth. The Commission said that these are positive overall results. Looking at the three stages of care, positive survey results included:

Antenatal care:
- 91% of women said they saw a health professional about their pregnancy as soon as they wanted
- 90% of women said they had the name and telephone number of a midwife they could contact during pregnancy

Care during labour and birth:
- 92% of women said they "definitely" or "to some extent" got the pain relief they wanted
- 82% of women said they were always spoken to in a way they could understand

Postnatal care:
- 88% of women said they had a postnatal check-up four to six weeks after the birth
- 76% of women saw a midwife as much as they wanted

YORKSHIRE AND THE HUMBER
LSA BRIEFING
MARCH 2008

The Great Daffodil Appeal
Great Daffodil Appeal
1 – 31 March 2008

A DATE FOR YOUR DIARIES……

SUPERVISORS OF MIDWIVES SUMMER CONFERENCE 2008

WILL BE HELD ON

MONDAY 7TH AND TUESDAY 8TH JULY 2008

AT ST GEORGE SWALLOW HOTEL, HARROGATE

http://www.swallow-hotels.com/hotels/swallow-st-george

Further details will follow

Please note: the revised date/time for the Contact Supervisors of Midwives Workshop is:

Date: Friday 16th May 2008
Venue: Boardroom A, First Floor, Blenheim House, Leeds
Time: 9:30am – 12:30pm

Please note: the revised date for the Independent midwives/Liaison Supervisors of midwives Workshop is:

Date: Wednesday 23rd April 2008
Venue: Boardroom A, First Floor, Blenheim House, Leeds
Time: 12:45pm – 16:00pm

APPENDIX 12

Innovative approaches and good practice making positive differences to midwives' practice and the care of women and their families

Trust and contact details	*Brief description of practice*
AIREDALE NHS TRUST Kath Walsh, Head of Midwifery Email: kathryn.walsh@anhst.nhs.uk	Exception report done on 10 years of all CEMACH reports, with supervisory involvement in reviewing the Healthcare Commission's interim findings for the maternity service.
BARNSLEY NHS FOUNDATION TRUST Sue Gibson, Head of Midwifery Email: susangibson@nhs.net	Supervisors have protected time for supervision as per NMC (2004) Midwives rules and standards, with supervisors being involved in training and staff development and with women making more contact directly with supervisors
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST Julie Walker, Head of Midwifery Email: Julie.walker@bradfordhospitals.nhs.uk	Development of the parent education service, including a full-day Saturday session and specific classes on individual needs e.g. deaf woman, blind women, teenage pregnancy group in conjunction with Connexions and Surestart involvement and midwife involvement in pregnant girls within Upper schools. A Hyperemesis service, developed by a supervisor means that women who were previously admitted, can now self-refer after an initial assessment.
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST Helen Shallow, Head of Midwifery Email: helen.shallow@cht.nhs.uk	Integrated Antenatal care Integrated care pathway, with discussion of choice of birth at 36 weeks instead of at booking and incorporating the NICE Antenatal care, and Mental Health guidelines, the national screening standards and aspects of the national maternity notes.
DONCASTER AND BASSETLAW NHS FOUNDATION TRUST Vivienne Knight, Head of Midwifery Email: Vivienne.Knight@dbh.nhs.uk	Clear links exist between the Trust's Clinical Governance framework and Supervision. Most supervisors have undertaken assessments of their leadership and communication styles recently. Rolling programme of Polish parenting workshops
HARROGATE AND DISTRICT NHS FOUNDATION TRUST Jan Chaplin, Head of Midwifery Email: janet.chaplin@hdft.nhs.uk	Laminated 'self audit of record keeping' cards carried in midwives pockets whilst on duty were distributed by the Supervisors. Midwives report getting feedback from reporting untoward incidents
HULL AND EAST YORKSHIRE NHS TRUST Karen Thirsk, Head of Midwifery Email: karen.thirsk@hey.nhs.uk	Statutory supervision is within the Divisional Risk Management Strategy. Increased patient and public involvement in maternity work, including the local Quality Monitoring Programme – with Women's and Children's scores rating very highly.

Trust and contact details	***Brief description of practice***
LEEDS TEACHING HOSPITALS NHS TRUST Julie Scarfe, Head of Midwifery Email: Julie.scarfe@leedsth.nhs.uk	Vulnerable women team link into a forum with other specialist midwives and feed into service review groups
MID YORKSHIRE HOSPITALS NHS TRUST Sharon Schofield, Head of Midwifery Email: sharon.schofield@midyorks.nhs.uk	Good analysis of statistics through the trust's clinical governance and supervisory routes, with a recent move towards using Statistical Process Control
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST Debbie Shakespeare, Head of Midwifery Email: debrah.shakespeare@nlg.nhs.uk	All 51 midwives surveyed for the 2007 LSA audit visit cited having a positive relationship with their supervisor.
ROTHERHAM NHS FOUNDATION TRUST Karen Norton, Head of Midwifery Email: karen.norton@rothgen.nhs.uk	The maternity service can demonstrate an increase in funding during year of almost 5wte. Maternity services have had a £0.4 million investment in relation to safety with a Contact supervisor of midwives in post for three days per week, with dedicated funding
SCARBOROUGH AND EAST YORKSHIRE NHS TRUST Helen Noble, Head of Midwifery Email: helen.noble@acute.sney.nhs.uk	The visibility of supervisors within the unit and the support offered to midwives during reconfiguration of services. The Head of Midwifery sits on the trust "Lessons learned" group, with open access to all staff
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST Dotty Watkins, Head of Midwifery Email: dotty.watkins@sth.nhs.uk	Innovations include triage being implemented within the Children's centres and the development of a Pre-operative clinic. There has been a very promising increase in the home birth rate from 1 - 4%.
YORK DISTRICT NHS FOUNDATION TRUST Margaret Jackson, Head of Midwifery Email: margaret.jackson@york.nhs.uk	Practice developments including Labour Ward handover, the Antenatal and postnatal advice Proforma and the Postnatal care pathways. Production of a DVD virtual tour which will be issued via libraries and some community midwives

APPENDIX 13

New guidelines published in report year 1 April 2007 – 31 March 2008

Yorkshire and the Humber guidelines:

All these guidelines can be accessed from:
http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/

9 – Guidance for the continuing professional development of supervisors of midwives

10 – Supporting midwives dealing with potential/actual threatening Behaviour

11 – Maternal death

12 – Supervisors of midwives undertaking annual supervisory reviews

13 – Supervision: Student midwives, return to practice and adaptation course midwives

14 – Guiding principles for supervisory involvement

15 – Guidance for supervisors of midwives when a midwife wishes to, or has been requested to provide midwifery care to a relative or friend

16 – Supervision and self employed midwives

17 – In the event of a stillbirth at home

9 in total

National Guidelines:

All these guidelines can be accessed from:
http://www.yorksandhumber.nhs.uk/what_we_do/local_supervising_authority__midwifery/

H – Transfer of midwifery records from self employed midwives

I – Suspension of midwives from practise

J – Confirming midwives eligibility to practise

K – Guideline for the completion of the Intention to Practise form by a registered midwife

L – Investigation of a midwife's fitness to practice

5 in total

APPENDIX 14

YORKSHIRE AND THE HUMBER
LOCAL SUPERVISING AUTHORITY

Service user guide to the LSA audits of maternity services in Yorkshire and the Humber.

Introduction

This guide explains the organisation of maternity services in our region, the reason for the supervision of midwives, how this is achieved locally and how you might be involved as a service user during the next year. The guide was written with service user involvement.

Thank you for expressing an interest in providing much valued input into the annual review of the practice of midwives and supervisors in the Yorkshire and the Humber region. I hope that our working relationship will be mutually beneficial and that we, the maternity services within Yorkshire and the Humber and the women using them, as well as you, will gain much from us working together.

Carol Paeglis
Yorkshire and the Humber Local Supervising Authority Midwifery Officer

Maternity services in the Yorkshire and the Humber LSA

In the Yorkshire and Humber there are fourteen NHS and NHS Foundation trusts with a total of twenty four maternity units, supporting approximately 62,000 births per year.

In March 2008, there were 2,581 midwives working in Yorkshire and the Humber and 194 supervisors of midwives supporting the midwives in their practice.

The websites of maternity services located within Yorkshire and the Humber can be found on the Strategic Health Authority website at: http://www.yorksandhumber.nhs.uk/

What is supervision of midwives?

The 1902 Midwives Act introduced the statutory supervision of midwives and this became law in 1903. It was introduced at this time to reduce the death rates of mothers due to childbirth through routine inspection of services provided by midwives. The safety of mothers and babies is still the primary aim of the supervision of midwives, but it is now done by promoting best midwifery practice, preventing poor midwifery practice and intervening in unacceptable midwifery practice. If you have internet access, further details about the supervision of midwives can be found on the Nursing and Midwifery Council website at: http://www.nmc-uk.org/aArticle.aspx?ArticleID=2868

What is the role of the Local Supervising Authority?

The Local Supervising Authority (LSA) is a professional body that carries out the statutory supervision of midwives regionally. It ensures that midwifery practice is of a satisfactory standard, thus ensuring safe and secure midwifery care in that region.

There are 15 LSAs in the United Kingdom. In England they are linked to the Strategic Health Authorities, each with a LSA Midwifery Officer responsible for the LSA function. If you have access to the internet, more information can be found on the NMC website at: http://www.nmc-uk.org/aArticle.aspx?ArticleID=2095

In Yorkshire and the Humber, Carol Paeglis is the LSA Midwifery Officer (LSAMO) and Elaine French is the LSA Support Officer. They are supported by, and work with, supervisors of midwives across the region.

In Yorkshire and the Humber, supervision of midwives has three ways of improving midwifery practice and therefore improving midwifery care to women and their families:

- Supportive: supervisors and the LSAMO supporting women and midwives, whether employed within the NHS, privately employed or self employed.
- Collaborative: supervisors and the LSAMO working with women, midwives, other health professionals, Universities and agencies, at local, regional and national levels.
- Educative: supervisors and the LSAMO working with education providers to optimise education to student midwives, midwives and supervisors.

How does our region compare?

- In 2005-06, the Yorkshire and the Humber LSA was assessed by the Nursing and Midwifery Council as **very good**. *(Lowest risk scoring LSA from the 2005 - 06 LSA annual reports and the pilot of review of LSAs in 2007)*
- In 2006-07, it was assessed as **even better**. (The joint lowest risk scoring LSA with a lower risk score i.e. based on the 2006 – 07 LSA annual reports)

This shows that we are able to build on the good work that we do, as it results in improvements for women, babies and their families, and for midwives and their supervisors. More information about the LSA in Yorkshire and the Humber can be found on the Strategic Health Authority website at: http://www.yorksandhumber.nhs.uk/who-we-are/organisational-structures/nursing-and-patient-care/Local_Supervising_Authority_Introduction.asp

How will supervision be measured in our region for 2008-09?

The Nursing and Midwifery Council rules and standards require:
"*An annual audit of the practice and supervision of midwives within its area to ensure the requirements of the Nursing and Midwifery Council are being met*"

An audit is an evaluation of a person, organization, system, process, project or product. The Yorkshire and the Humber LSA supervisors of midwives audit group has produced an audit tool and process for the year 2008 – 09. The audit tool is a series of questionnaires used across all the maternity services in the region in a systematic way so that practice can be compared across local NHS Trusts. This has been created with support and advice from supervisors of midwives, midwifery teachers, Heads of Midwifery Services and service user representatives, and by being aware of the Healthcare Commission national maternity programme of work.

For each NHS Trust, the LSA audit consists of a full day "formal" visit to their maternity services one year and a half day "informal" visit the following year. The audit tool is sent to each trust for completion 8 weeks before the audit visit. LSA questionnaires are sent for completion to supervisors, midwives, student midwives, non-midwives and consent forms for telephone interviews with service users and partners. The completed audit tool and questionnaires are requested to be returned to the LSA office two weeks before the audit visit. The audit team use these to identify any themes worthy of further discussion during the audit visit.

The main aspects of the LSA annual visit are to:

1. To hear the supervisors key achievements and challenges from the previous year
2. To discuss with the supervisors of midwives the self-completed "Standards for Supervision" audit tool.
3. To discuss and explore any themes from the collated responses from the LSA questionnaires
4. To review progress with actions resulting from recommendations from the previous year's LSA audit visit, with the team of supervisors of midwives.
5. To discuss with the supervisors their latest annual LSA data
6. To visit the clinical areas to speak with staff and service users.

The LSA audit team usually consists of the LSA Midwifery Officer, a supervisor of midwives from a different Trust, a student supervisor if one is in training at the time and a service user auditor.

How do I contribute to the audit day?

A typical full day "formal" visit will take place at one of the region's hospitals. The auditors arrive around 9am, lunch is provided and the day finishes around 4pm. The audit team begin the day by discussing the particular strengths and challenges for that Trust as identified by the questionnaires and audit tools. You will consider what the user view is on these. You will be invited to look round the hospital at all the areas that women use during their maternity care (antenatal clinics, delivery suite, postnatal wards etc.). This can be done with one of the other auditors who can answer your questions about the service. You will be asked to talk to service users in the areas and to comment on

aspects such as the environment. There are opportunities during the day for the audit team to come together to talk about ideas. You may be asked to telephone service users who have consented to giving feedback in this way and there will be a presentation by the supervisors at the Trust to summarise their achievements during the year. The day ends with the audit team giving brief verbal feedback to senior staff. After the day you are asked to write a 2 page report on your findings and submit it within 2 weeks.

What can I expect if I am a service user auditor?

The LSA Midwifery Officer aims to:

- train you on the audit tool and the audit process
- respect you as a valuable member of the audit team
- involve you in producing the audit tool
- invite your comments on how audit visits are undertaken
- invite your comments on how audit reports are written
- recognise your other commitments and invite your contributions in a flexible and accommodating manner
- give you adequate notice and documentation to support your full contribution to the work
- pay your travel and child care expenses for the work you undertake
- book your train travel if you prefer not to drive

What is expected from you as an auditor?

- To know how much work you are able to support and how you work best e.g. by post, or by email
- To give as much notice as possible if anything prevents your involvement
- To have a sensitive manner when talking to service users, their partners and staff
- To be able to keep confidentiality within the audit team
- To pass concerns to the LSA Midwifery Officer or to the staff at the maternity unit, in the rare event that concerns are told directly to you
- To give brief verbal feedback with the audit team to the trust at the audit visit
- To produce a written report within two weeks of being on an audit visit

Some tips when writing your report

A report conveys information and (sometimes) recommendations from an author who has investigated a topic in detail. In the case of the LSA audit report, the audience are the clinical staff of the maternity service, the managers, the service users and the people who are responsible for commissioning i.e. buying the maternity services.

The content should therefore be correct, concise, clear, formal, sensitive and factual. It should also include what the service is doing well i.e. good practice points and what they could consider to do better i.e. recommendations. Tips to consider are:

- Don’t put off the report until near the two week deadline
- Start and pace yourself – “little and often” while it is still “fresh”
- Getting started can be difficult
- Collect your data / information with writing the report in mind
- Gather material and think about sub-headings and arrange it logically
- Consider your good practice points and your recommendations
- Devise, redraft, revise, redraft

In summary

The Yorkshire and the Humber LSA aims to learn from every opportunity in order to improve the care provided to women and their babies by midwives, through the supervision of midwives. The LSA audit is one way that this learning occurs. We will value your involvement in the LSA audit process and we look forward to working with you.

APPENDIX 15

Trust **Healthcare Commission Midwives / 1000 births average = 31 / 1000** **BirthratePlus average Trust = 35/1000**	**LSA 2007 / 08 data** Midwives/1000 (Midwife:birth ratio)	**LSA 2006/07 data** Midwives / 1000 (Midwife:birth ratio) LSA average 1 : 32.5	**HCC 2008 data** (July 2007) Midwives/1000 deliveries MSW/1000 deliveries MSW tasks (HCC max = 17)
York http://www.healthcarecommission.org.uk/_db/_documents/RCBScoredAssessment.pdf	26.95/1000 (1 : 37.11) ***Position worsened and worse than HCC average.*** ***1.45% increase in births***	28.14/1000 (1 : 35.4)	29.07/1000 (MSW 6.602/dels) (MSW tasks 11)
Bradford http://www.healthcarecommission.org.uk/_db/_documents/RAEScoredAssessment.pdf **Update as at 16th July 2008: Midwifery staffing increased to 173 after LSA submitted, so ratios are now: 28.7 / 1000 births (1 : 34.8)**	27.21/1000 (1.36.75) ***Position worsened and worse than HCC average.*** ***1.6 % increase in births***	27.65/1000 (1 : 36)	27.45/1000 (MSW 7.023/dels) (MSW tasks 11)
Mid Yorkshire http://www.healthcarecommission.org.uk/_db/_documents/RXFScoredAssessment.pdf	27.51/1000 (1:36.35) ***Position worsened and worse than HCC average.*** ***0.84 % increase in births***	27.3/1000 (1:36)	29.34/1000 (MSW 7.002/dels) (MSW tasks 9)
Calderdale and Huddersfield http://www.healthcarecommission.org.uk/_db/_documents/RWYScoredAssessment.pdf	28.22/1000 (1:35.43) ***Position improved, but still worse than HCC average.*** ***2.71 % increase in births***	25.21/1000 (1 : 37)	30.26/1000 (MSW 6.734/dels) (MSW tasks 15)
Harrogate http://www.healthcarecommission.org.uk/_db/_documents/RCDScoredAssessment.pdf	28.26/1000 (1:35.39) ***Position worsened and worse than HCC average.*** ***13.32 % increase in births***	27.17/1000 (1 : 30.9)	33.39/1000 (MSW 5.315/dels) (MSW tasks 9)
Doncaster http://www.healthcarecommission.org.uk/_db/_documents/RP5ScoredAssessment.pdf	28.50/1000 (1 : 35.09) ***Position worsened, worse than HCC average. 1.82 % increase in births***	29.92/1000 (1 : 33.5)	32.12/1000 (D and B) (MSW 8.162/dels) (MSW tasks 15)

Leeds http://www.healthcarecommission.org.uk/_db/_documents/RR8ScoredAssessment.pdf	28.60/1000 (1:34.97) ***Position worsened. Worse than HCC average. 1.09% increase in births***	29.88/1000 (1 : 33)	27.6/1000 (MSW 4.736/dels) (MSW tasks 13)
Barnsley http://www.healthcarecommission.org.uk/_db/_documents/RFFScoredAssessment.pdf	29.53/1000 (1:33.86) ***Position worsened. Worse than HCC average. 1.05% increase in births***	30.83/1000 (1:26)	33.58/1000 (MSW 7.44/dels) (MSW tasks 11)
NLAG: http://www.healthcarecommission.org.uk/_db/_documents/RJLScoredAssessment.pdf	32.59/1000 (1:30.69) ***Position worsened. Better than HCC average. 3.66% decrease in births***	33.33/1000 (1: 30)	34.87/1000 (MSW 10.03/dels) (MSW tasks 14)
Sheffield http://www.healthcarecommission.org.uk/_db/_documents/RHQScoredAssessment.pdf	33.77/1000 (1:29.61) ***Position worsened. Better than HCC average. 5.05 % increase in births***	35.39/1000 (1:28)	37.91/1000 (MSW 9.977/dels) (MSW tasks 11)
Rotherham http://www.healthcarecommission.org.uk/_db/_documents/RFRScoredAssessment.pdf	34.18/1000 (1:29.26) ***Position improved slightly. Better than HCC average. 8.39% increase in births***	35.34/1000 (1 : 30)	35.58/1000 (MSW 17.36/dels) (MSW tasks 14)
Hull and East Yorkshire http://www.healthcarecommission.org.uk/_db/_documents/RR8ScoredAssessment.pdf	34.62/1000 (1:28.89) ***Position improved. Better than HCC average. 2.61% increase in births***	34.49/1000 (1 : 29)	36.54/1000 (MSW 8.694/dels) (MSW tasks 16)
Airedale http://www.healthcarecommission.org.uk/_db/_documents/RCFScoredAssessment.pdf	35.06/1000 (1:28.52) ***Position improved. Better than HCC average. 4.88% increase in births***	32.66/1000 (1 : 32)	34.35/1000 (MSW 5.258/dels) (MSW tasks 12)
Scarborough and East Yorkshire http://www.healthcarecommission.org.uk/_db/_documents/RCCScoredAssessment.pdf	40.00/1000 (1:25) ***Position improved. Better than HCC average. 0.99% increase in births***	36.03/1000 (1:27.75)	42.51/1000 (MSW 70.03/dels) (MSW tasks 9)

APPENDIX 16

Ethnic breakdown of women using maternity services during 2007-08

	Case mix percentages by Family Origin as per Antenatal and Newborn Screening identification:									
Unit	A	B	C	D	E	F	G	H	I	Missing/NK
Barnsley						majority				
Doncaster	1.6%	2.9%	0.8%	2.4%	0.0%	91.4%	0.0%	2.5%	0.0%	-1.6%
Rotherham	0.6%	2.0%	0.5%	0.4%	1.3%	24.0%	0.1%	0.0%	0.0%	71.0%
Sheffield	Information not available as per Antenatal and Newborn Screening identification									100.0%
Airedale	0.4%	18.2%	1.3%	0.0%	2.2%	76.5%	0.0%	1.4%	0.0%	0.0%
Bradford	2.7%	14.7%	1.3%	1.5%	3.9%	35.2%	0.5%	2.0%	0.0%	38.3%
Calderdale	0.9%	13.7%	1.3%	0.9%	2.5%	80.3%	0.3%	0.1%	0.0%	0.0%
Huddersfield	3.7%	19.2%	0.7%	1.3%	2.8%	68.4%	3.8%	0.1%	0.0%	0.0%
Dewsbury										100.0%
Pontefract										100.0%
Leeds (LGI)										100.0%
Leeds (SJUH)										100.0%
Harrogate	0.9%	1.3%	1.2%	0.0%	5.5%	90.0%	0.0%	0.9%	0.2%	0.0%
Hull & East Yorkshire	0.6%	0.5%	0.5%	0.3%	1.8%	21.4%	0.5%	0.1%	0.4%	73.9%
Grimsby	0.2%	1.2%	1.0%	0.4%	1.9%	94.8%	0.4%	0.0%	0.0%	0.0%
Scunthorpe & Goole	0.6%	2.5%	0.5%	1.3%	3.0%	88.0%	0.0%	0.1%	0.0%	3.9%
Scarborough	Not able to provide ethnic breakdown information this year									100.0%
Bridlington										100.0%
Malton										100.0%
Whitby										100.0%
York	Only just started collecting									100.0%

Note: Percentages are of total women birthed

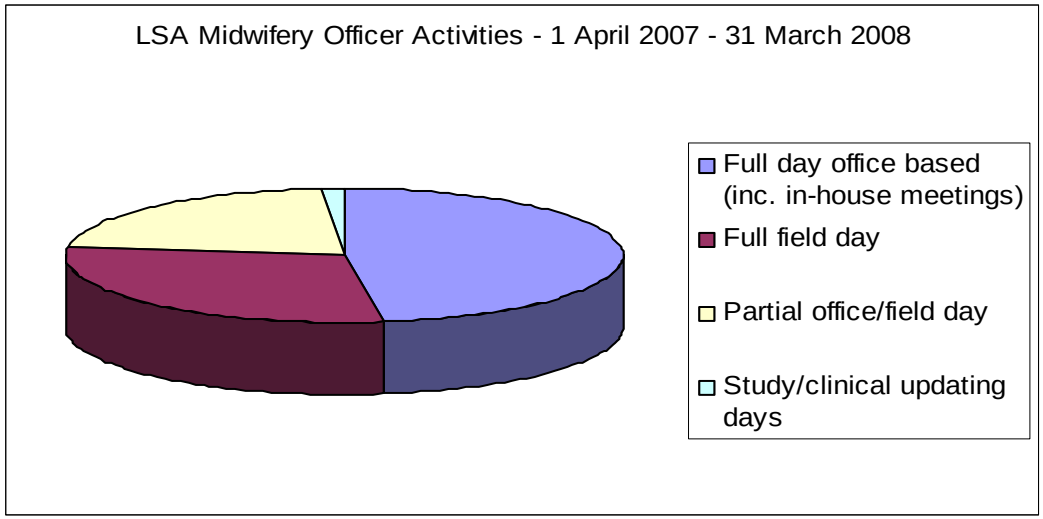
KEY

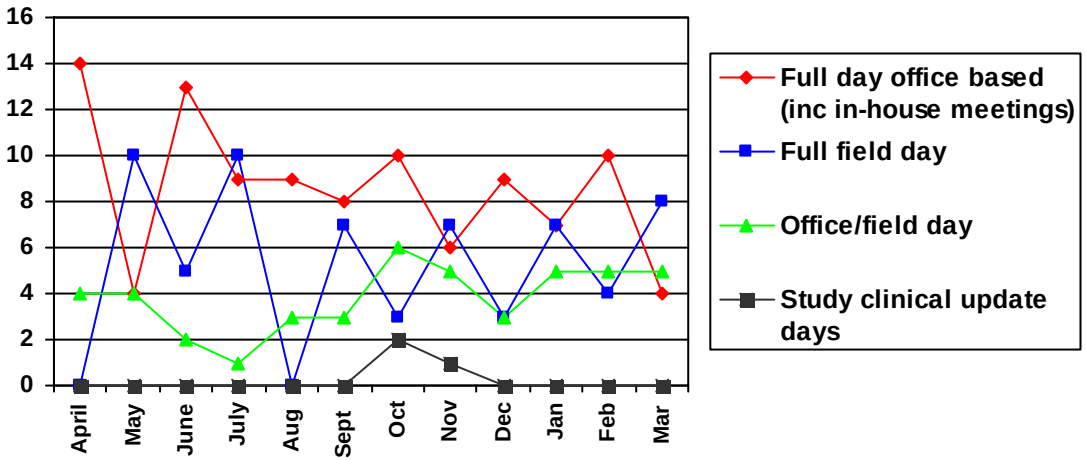
A - African or African-Caribbean (Black) B - South Asian (Asian) C - South East Asian (Asian) D - Other non-European (Other)
E - Southern & other European (White) F - United Kingdom (White) G - Northern European (White) H - Don't know
I - Declined to answer

NB: Not all units were able to provide ethnic breakdown of women birthed, due to either the information only recently being collected or data not being easily extracted from the data systems available.

APPENDIX 17

LSA Midwifery Officer activities





Carol Paeglis
NHS Yorkshire and the Humber
Blenheim House
West One
Duncombe Street
Leeds LS1 4PL
Sent via e-mail

1 October 2008

Ref: Yorkshire and the Humber
Direct line: 020 7333 6530
Email: susan.way@nmc-uk.org

Dear Carol.

Re: LSA Annual Report

I am writing to thank you and acknowledge receipt of the annual report to the NMC. I will contact you in due course if I require clarification or any further information.

Please let me know if you have any queries.

Yours sincerely

Susan Way
Midwifery Adviser