STATUTORY SUPERVISION OF MIDWIVES

1. Annual LSA Audit of Standards 2016-17
2. Supervision for midwives: moving from a statutory to an employer led model for Scotland

Report prepared by Dr Helen Bryers, Head of Midwifery, on behalf of Heidi May, Board Director of Nursing

The Board is asked to:

• Note the LSA Audit Report for 2016-17
• Note that this is the final LSA Audit report
• Note the transition arrangements and anticipated timescales for the changes from statutory to employer led supervision of midwives

Contribution to Highland Quality Approach Strategic Framework and Annual Objectives

This report contributes to the following Board Strategic priority:

• Effective Quality of Care: providing appropriate safe care

1. Outline and results of the Annual LSA Audit Report

The attached report contains the findings of Annual LSA Audit from April 2016- March 2017. This annual report provides NHS Highland with details on compliance with the standards set within the NMC Midwives Rules and Standards (NMC, 2012).

The Executive Summary (p 4) commends the Highland Supervisors of Midwives (SOM) on achieving the standard (Midwives Rule 9) that all midwives (247) received an annual review with their SOM in which their practice was reviewed and offered support for NMC revalidation.

NHS Highland SOMs fully met eight of the nine NMC Standards and partially met one of the Standards.

One Standard, Rule 4, was partially met. This standard asks that the LSA develops a mechanism to ensure that the Local Supervising Authority Midwifery Officer (LSAMO) is notified of adverse events. This is done through the use of an adverse event Scottish Trigger tool (Appendix 1 to the Annual Audit Report).

The audit showed that the Scottish trigger tool is implemented across NHS Highland and that these trigger tools were reviewed by a SOM. However, it was noted that not all of the trigger tools were notified to the LSAMO by use of the on-line database.
The SOM team acknowledged that there was a need to ensure that the process for completing and uploading the trigger tool into the LSA database was followed and agreed a system of cross referencing through NHS Highland maternity risk management process to ensure that all adverse triggers were recorded onto the LSA database.

The LSA Audit Report is presented to the Board, Clinical Governance and NMAHP Leadership and Advisory Committees to ensure that the contents of the report are shared and to acknowledge the contribution that statutory supervision of midwives makes to the governance agenda, including how Supervisors of Midwives can enhance protection of women and their babies.

2. System Change: moving from a statutory to an employer led model of supervision for midwives in Scotland

This will be the last annual LSAMO report and audit of NMC Midwives Rules and Standards.

In response to the Morecambe Bay Inquiry, the Nursing and Midwifery Council (NMC) and the United Kingdom (UK) Government, propose to separate statutory supervision of midwifery supervision from regulation. As Regulation is a matter reserved to the UK Parliament and the Department of Health (DH) in England, this will be taken forward through a change to the legislation before 31st March 2017. This is now completed and the legislation (section 60 of the Nursing and Midwifery Order) has been changed. The main changes relating to midwifery in the legislation (NMC Order) are:

- The statutory role and function of the LSA, the LSAMO and the SOM cease to exist
- The removal of the requirement for the NMC to provide the statutory supervision of midwives, a recommendation of the Morecambe Bay Inquiry
- The NMC statutory Midwifery Committee is abolished

Legislative change will mean that the LSA, the Local Supervising Authority (in Scotland this is the Health Board), along with the statutory roles and functions associated with its responsibility for governing the standard of midwifery practice on behalf of the NMC will cease to exist.

Removal of this additional layer of regulation brings midwives in line with other professions and means that governance for the standard of midwifery practice will rest exclusively with employers. This includes investigation of alleged misconduct or impaired fitness to practise and referral to the NMC where required; and is consistent with current processes and requirements for nurse registrants.

3. Moving Forward

Ministers in all four countries have agreed with the NMC decision and have supported work on the development of a professional, employer led model of supervision for midwives which preserves the supportive, rather than regulatory aspects of supervision in practice. All four UK countries have developed a model to take this forward.
In Scotland, this new model has been agreed by the Scottish Government in January 2017 and is now moving into an implementation phase which will be led by a national group. The new model will be based on clinical and restorative supervision.

The fundamental aim of clinical supervision is to promote best clinical practice through a process of reflection, discussion and review of all aspects of clinical care; including the relationship between midwives, women and families. Restorative supervision is designed to address the emotional needs of staff and help them build resilience levels by reducing their own stress and burnout levels; thereby improving health and wellbeing. It creates a relationship that nurtures and cares for the person being supervised as well as facilitating reflection and self-awareness through critical analysis, exploration of events and feelings.

It is proposed that Scotland’s clinical supervision for midwives is based on:

- group supervision for cohorts of a maximum of 10 midwives, with sessions taking participants through a restorative process
- midwives attending a minimum of 1 group session per annum
- one to one supervision for individual midwives as required
- confidentiality and contracting for all sessions
- appropriate record keeping.

4. Implementation

In January this year, the Cabinet Secretary gave her approval to implement this new employer led model of supervision for midwives which retains the supportive, rather than regulatory aspects of supervision in practice.

National work is ongoing to support NHS Boards to implement the new supervision model in 2018. This work is being led by Anne Holmes, National Midwifery Advisor in the Chief Nursing Officer’s department. A national implementation group has been set up to support and advise Boards on the implementation of the new model. This work will include provision of a national information and education package for local use.

5. Contribution to Board Objectives

This report contributes to effective quality of care and safe care by ensuring that midwifery staff have an annual dedicated time allocation and mentor support to reflect on clinical practice. This will help to maintain high standards of midwifery practice.

6. Governance Implications

Over the next year, NHS Highland needs to phase out the current model of statutory supervision and implement the new model of professional supervision. Over this period, there will be implications for staff who are currently SOMs and the loss of their roles. Some of these SOMs may wish to become mentors in the new model. In addition, midwives interested and willing to become the new mentors need to be identified and trained. This work will be
lead and monitored through the Lead Midwives Group and the work guided by the national implementation group.

7. Planning for Fairness

The new model of clinical supervision will be for all midwives in clinical practice. This will be subject to national evaluation over a three year period. It is anticipated that the model will then be rolled out to other healthcare professionals in Scotland as a model of supportive supervision for clinical practice.

8. Engagement and Communication

The implementation plan for the new model will be communicated to Boards through the work of the national implementation group. The membership of the group will include a Head of Midwifery and representatives of the current supervisors of midwives, as well as academics and public representation.

Within NHS Highland, communication will be through Nursing Midwifery and AHP (NMAHP) Leadership Committee and the Lead Midwives Group.

Helen Bryers

15th March 2017

Further Reading/ References

NMC 2012 Midwives rules and Standards Available online @ http://www.nmcuk.org/Publications/Standards

NMC 2012 Supervision, Support and Safety, Report of the quality assurance of the local supervising authorities (LSAs) 2011-2012. Available online @ http://www.nmcuk.org/Publications/Midwifery-Supervision

Nursing and Midwifery Order 2001 Available online @ http://www.legislation.gov.uk/uksi/2002/253/contents/made

LOCAL SUPERVISING AUTHORITIES

ANNUAL REPORT

APRIL 2016 – MARCH 2017

Yvonne Bronsky
Local Supervising Authority Midwifery Officer
January 2017
Introduction
The purpose of this report is to inform NHS Highland of how they are meeting the standards set within the Nursing and Midwifery Council (NMC), Midwives rules and standards (2012).

This annual report provides the detail to comply with rule 13 of the NMC (Midwives) Rules 2012.

Nursing and Midwifery Council
The NMC was established under the Nursing and Midwifery Order 2001, as the body responsible for regulating the practice of those professions.

Articles 42 and 43 of the Order make provision for the practice of midwives to be supervised.

The local bodies responsible for the discharge of those functions are the LSAs.

The NMC commissioned the King’s Fund to review statutory supervision in the United Kingdom and they published their findings in 2015

The NMC as the health care professional regulator should have direct responsibility and accountability solely for the core functions of regulation. The legislation pertaining to the NMC should be revised to reflect this. This means that the additional layer of regulation currently in place for midwives and the extended role for the NMC over statutory supervision should end. (King’s Fund 2015)

The recommendations of the King’s Fund Report were subsequently accepted by the Nursing and Midwifery Council in January 2015. The Chair of the Council wrote to the Department of Health Minister calling for the government to provide an opportunity to amend the NMC’s legislation.
In the meantime, statutory supervision of midwives as it is currently framed must continue until the law changes. The NMC and the LSAs will need to develop strategies for ensuring that the Midwives rules and standards continue to be met in the interim.

At present the Scottish Government has convened a Transitioning Supervision of Midwives taskforce group, the purpose of this group is:

To oversee the transition from the regulatory model of statutory supervision for midwives to a national professional and employer led model of clinical and peer supervision for practising midwives within Scotland.

(Scottish Government 2015)

The Department of Health consultation findings were published on 11th January 2017 which signals the steps anticipated to be taken in the coming months.

While the Government acknowledges the concerns raised by midwives in relation to these changes, it also sets out clearly why it believes they are important. The response signals the Government will recommend these changes to parliament.

Although these changes mean that supervision will no longer be linked to regulation, this does not mean that it will not exist at all. Plans for a new model of supervision are now well advanced in each of the four countries of the UK. We are confident that the things about supervision most valued by midwives will continue in the future.

It’s important to remember that these changes do not alter the status of midwifery as a distinct profession with its own standards. There will be no change to the protected title of midwife, and delivering a baby remains a protected function for a midwife or a medical practitioner.

Parliament will debate the changes in spring 2017 and if approved, they are set to come into force shortly after. Until the law changes, what is required of midwives remains the same and this is set out in the Midwives Rules and Standards and the Code.

(NMC January 2017)
Executive Summary

This report contains the findings of the annual LSA audit and as we move forward into new ways of working an opportunity has been taken at this time to include and highlight two clinical governance priorities.

1. The number of supervisory reviews and supervisory investigations undertaken from January 2016 to December 2016 NMC Midwives rules and standards Rule 10 (2012)


Rule 9 – Standard MET

247 midwives registered their intention to practise within NHS Highland.

All of these midwives were issued with an annual review tool to complete and date to meet with their named SoM.

It is commendable that the SoM team all achieved the standard of ensuring that they met with their supervisees to review their practice and support them in preparation for NMC revalidation.

Rule 10 – Standard Partially Met

Supervisory reviews were undertaken following untoward incidences as identified on the Trigger List for reviews (Appendix One).
### NHS Highland
**Supervisor of Midwives Reviews, Investigations and Outcomes**
**August 15 to 31st December 2016**

<table>
<thead>
<tr>
<th>Practice year</th>
<th>No of Reviews</th>
<th>No of cases where good practice was identified</th>
<th>No of midwives with learning points (SBARs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2016-17</td>
<td>7</td>
<td>1</td>
<td>1</td>
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</table>

<table>
<thead>
<tr>
<th>Practice year</th>
<th>No of Investigations</th>
<th>No of midwives involved in investigations</th>
<th>Outcomes from investigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16</td>
<td>1</td>
<td>5</td>
<td>5 x LAP</td>
</tr>
<tr>
<td>2016-17</td>
<td>1</td>
<td>2</td>
<td>2 x LAP</td>
</tr>
</tbody>
</table>
Statutory Supervision of Midwives
Annual LSA Audit of Standards
NMC Midwives rules and standards 2012
2016-17

NHS..HIGHLAND.............
**Standard One**

**Rule 4 –**  
Intention to practise notifications are sent to the NMC by the annual submission date specified by the Council. 
Intention to practise notifications received after the annual submission date are sent to the NMC as soon as reasonably practicable.

**Guernsey Benchmark**

1.1 Public protection is placed at risk if midwives do not submit their Intention to Practise (ItP) to the NMC by the required annual submission date.

1.2 Midwives risk lapsing or losing their midwifery registration if ItPs are not submitted in time to the NMC.

1.1.1 All midwives have a named Supervisor of Midwives (SoM) to submit their ITP to

1.2.1 Accurate information and completion of ITPs submitted to the NMC by the date set by the Council.

<table>
<thead>
<tr>
<th>SoM team self assessment, comments and supporting evidence</th>
<th>LSA verification and comments</th>
<th>Measurement Met</th>
<th>Partially Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>All midwives within NHSH have a designated SoM to whom they submit their ItP form.</td>
<td>Clear evidence of a robust system in place to ensure all midwives have their ItP signed and uploaded by a SoM prior to commencing clinical practice.</td>
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<tr>
<td>SOP developed for Employment Services team to ensure newly appointed midwives have submitted ItP and are allocated SoM.</td>
<td>Evidence supplied that highlighted SoMs have taken an active lead to ensure both the directorate management team, senior charge midwives and bank managers are fully advised of process to be followed.</td>
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<td>All submissions have been on time as per NMC requirements. Submissions received after usual submission date would be dealt with swiftly and recorded on the LSA Database in a timely manner.</td>
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Standard Two

Rule 6 – All records relating to the care of the woman or baby must be kept securely for 25 years

Guernsey Benchmark

2.1 LSAs have inadequate data protection policies for the retention of midwifery records

2.1.1 LSAs ensure that there are clear and comprehensive local guidelines for the secure retention of midwifery records that addresses all requirements

3.1 Midwives do not store records securely, this poses a risk to public protection

3.1.1 Midwives comply with systems designed to accurately and securely store records for 25 years

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<thead>
<tr>
<th>SoM team self assessment, comments and supporting evidence</th>
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<tbody>
<tr>
<td>All maternity records are returned to the Medical Records department at Raigmore Maternity Unit and then sent on to Livingston for central storage. They would be stored as per protocol for 25 years in a secure environment.</td>
<td>Robust evidence available of training and education processes for all midwives in relation to data protection and medical records storage. Evidence supplied indicating robust process of ensuring community midwifery diaries that contain clinical information are securely stored.</td>
<td>MET</td>
<td></td>
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<tr>
<td>Maternity records in the Community Midwifery Units and Caithness are stored within medical records departments in the Rural General or Community Hospitals. They would be stored as per protocol for 25 years in a secure environment.</td>
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</table>
SoMs and midwives also work in accordance with NHSH policy.

Health and Social Care Records Management Policy.docx

Standard Three

Rule 9 – Each practising midwife within its area has a named SoM from among the SoMs appointed by the LSA. At least once a year a SoM meets each midwife for whom she is the named SoM to review the midwife’s practice and to identify her education needs. All SoMs within its area maintain records of their supervisory activities, including any meeting with a midwife. All practising midwives within its area have 24 hour access to a SoM. Equitable and effective supervision for all midwives working within the local supervising authority. Support for student midwives to enable them to have access to a supervisor of midwives. Strategy to enable effective communication between all SoMs. This should include communication with SoMs in other LSAs. Monitor and ensure that adequate resources are provided to enable SoMs to fulfil their role. Consistency in the approach taken by SoMs to the annual review of a midwife’s practice which include the SoM undertaking an assessment of the midwife’s compliance with the requirements to maintain midwifery registration. Ensure the availability of local systems to enable SoMs to maintain and securely store records of all their supervisory activities.

Guernsey Benchmark

4.1 The LSA consistently exceeds the recommended ratio of 1 SoM to 15 midwives (1.1, 1.2, 1.3, 1.4, 1.6)
4.2 The annual review identifies that a midwife has failed to meet the requirement to maintain their midwifery registration (1.5)

4.1.1 - LSAs have processes in place to ensure that recruitment supports the necessary number of SoMs to maintain the required ratio and that SoMs have adequate resources to undertake their role
4.2.1 - LSA Guidelines are clear in giving direction to SoMs as to the content of the annual review so that the SoM undertakes this in a way that a midwife has complied with the requirement to maintain their midwifery registration.
SoM team self assessment, comments and supporting evidence

LSA verification and comments

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<tr>
<th>Measurement</th>
<th>Partially Met</th>
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Each midwife has a SoM appointed from within the NHSH area.

Annual reviews with named SoM are carried out utilising the electronic proforma which is uploaded to the LSA Data Base. All annual reviews are recorded on the Data Base. Standard proforma used by all NHSH midwives.

All SoMs are aware of the requirement to record activity on the database. and their personal requirement to maintain accurate reporting.

SoM Rota is available to all areas within NHSH to allow staff to make contact with their own SoM or the designated on call SoM.

All midwives within NHS Highland have a named SoM and as such have been notified by their named SoM of their annual review date.

All midwives have been supplied with the Scottish LSA annual review template to complete prior to meeting their named SoM and ALL midwives eligible for an annual review with their named SoMs have had one undertaken in the past twelve months.

It is commendable that this standard has been met during what has been a challenging year for midwives and SoMs within NHS Highland.

It is envisaged that when the statutory supervision model is replaced that all midwives will use their annual review paperwork as a platform for revalidation preparation and to date many
NHSH ratio is in line with nationally agreed ratio of 1:15. However variation across operational units. Some SoMs take responsibility for higher ratio and do not feel it is compromising safety. Midwives choice and R&R geography has impacted on some caseloads. Currently 6 out of the 18 NHSH SoMs have a caseload exceeding ratio of 1:15.

2016
1 SoM re-appointed
1 SoM resigned

Total of 18 SoMs
Any new or orphaned midwives requiring a SoM have been allocated to SoMs with lower ratios.

SoMs have been accessed by their supervisees to request help and support in their preparations for revalidation.

Robust system of communication noted between SoMs and between SoMs and supervisees.

Evidence supplied to confirm that all records relating to supervision outwith open investigations are stored electronically and review/investigation paperwork is returned to the LSA office upon completion for safe storage.
All NHSH SoMs have email addresses and utilise this to communicate effectively across vast area which we cover.

Good communication through NHSH SoM forum which meets bi-monthly.

LSA Midwife attends NHSH SoM Forum on a regular basis.

All SoMs use the electronic annual review proforma and upload this to the LSA database.
Annually SoMs are checking registration dates and when fees due at ITP review. This runs in tandem with NHS Highland registration checking system.

SoMs should complete monthly activity sheet on LSA database. This identifies time spent on supervision.
NHSH allocate 4hrs / month for supervision.
Additional hours to undertake a supervisory investigation is negotiated locally with line managers.
SoMs have a system for keeping a record of dates SoMs have undertaken investigations, to ensure fair allocation of work across NHSH SoM group.

Utilise standard paperwork/processes and support of LSA Midwife for investigations.

### Standard Four

**Rule 10** Develop a system with employers of midwives and self employed midwives to ensure that a Local Supervising Au Midwifery Officer is notified of all adverse incidents, complaints or concerns relating to midwifery practice or allegation of impaired fitness to practise against a midwife.

### Guernsey Benchmark

5.1 LSAs do not complete supervisory investigations in an open, fair and timely manner
5.1.1 - LSAs have developed mechanisms to ensure investigations are carried out fairly, effectively, efficiently and to time

<table>
<thead>
<tr>
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<th>Measurement Met</th>
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<th>Not Met</th>
</tr>
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<tbody>
<tr>
<td>Robust systems are in place across NHSH for reporting of adverse incidents, complaints and concerns. All of above would be discussed at Risk</td>
<td>SoMs gave assurance that the Scottish trigger list for supervisory reviews is implemented across NHS Highland.</td>
<td></td>
<td><strong>Partially Met</strong></td>
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<tr>
<td>Management meetings and SoM present. Use of DATIX and Trigger Form for reporting.</td>
<td>process for identifying cases and reporting by SoM to LSAMO /onto LSA database.</td>
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<td>[[Updated_Trigger_Form_May_15[2].docx]]</td>
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<thead>
<tr>
<th>NHSH Trigger form in use. Cross reference to Supervision Trigger List and SoM undertakes chronology for onward reporting to LSA Midwife.</th>
<th>Whilst the system of notifying SoMs when a review was required worked well in the early part of the year it is notable that the number of reviews for NHS Highland undertaken by SoMs is not comparable with the knowledge of triggers amongst the SoM team present and on further discussion with the SoM team it was accepted that further work in this area is required to give assurance that ALL triggers are being reviewed timeously by a SoM.</th>
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</thead>
<tbody>
<tr>
<td>[[SOP_LSA_TriggerReview__UpdatedSept2016_NHSH_SoM[1][1].docx]]</td>
<td>[[SOP_LSA_TriggerReview__UpdatedSept2016_NHSH_SoM[1][1].docx]]</td>
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<tr>
<td>[[SOM%20LSA%20Trigger%20Rota%202016-2017(1).xlsx]]</td>
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Risk management meetings are held in localities on a regular basis. SoM on group membership.
These are followed by Maternal Morbidity and Perinatal Mortality meetings to allow discussion between multidisciplinary team members – SoM input and review of cases / complaints at all of these meetings.

SoM investigations carried out when practice is below what is normally expected or required.

SoMs utilise LSA Review and Investigation processes in relation to undertaking an investigation.

Support and guidance of the LSAMO & LSA Midwife

SoMs maintain accurate records of investigations and forward reports to LSAMO. They are verified for content and standards.

SoM minutes are circulated amongst the group who further disseminate to local
Maternity Dashboard can identify trends and changes in activity within each locality

SAER / Clinical incidents – learning points discussed & shared, standing agenda item on SoM forum

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**Standard Five**

6. **Supplementary Evidence of Statutory Supervision Representation by SoMs:**
   - SoM representation at clinical governance meetings
   - Som representation at clinical guideline development

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<tr>
<th>SoM team self assessment, comments and supporting evidence</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Operational Units have Quality &amp; Patient Safety / Clinical Governance meetings.</td>
<td>Evidence supplied highlighting the input of SoMs within clinical governance meetings and</td>
<td><strong>MET</strong></td>
<td></td>
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</tr>
</tbody>
</table>
SoMs present / invited to meetings.  
SoM representative on NHSH CG Committee  

NHSH Clinical Guideline Group – SoM representation from across NHSH teams on this group  
SoM representation at Maternity Clinical Risk Meetings (Raigmore / Inner Moray Firth and N&W OU)  

involvement of individual and the team of SoMs when new clinical guidelines are being developed and current guidelines are being reviewed.

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<thead>
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<th>Standard Six</th>
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<tr>
<td>7. Supplementary Evidence to demonstrate SoM effectiveness in ensuring safe practice</td>
</tr>
<tr>
<td>• SoM interface with audit activities</td>
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<tr>
<td>• Evidence to demonstrate SoMs are involved in networking activities</td>
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Record Keeping Audits

Workforce Planning – review of establishment setting – supporting safe staffing levels. Workload tools outcomes discussed at SoM forum.

Support with case reviews and midwifery practice across operational units.

SoM on membership of NHSH Nursing Midwifery Allied Health Professional Leadership Committee

SoM on membership of the NHSH Revalidation Working Group

Networking through NHSH Lead Midwives Committee and Maternity & Neonatal Services Strategy and Co-ordination Committee.

Evidence supplied highlighting role and input of SoMs when audits are undertaken across NHS Highland.

Documentation reviews routinely undertaken when a SoM is involved in reviewing care following an adverse event.

MET
**Standard Seven**

8. **Supplementary Evidence to demonstrate SoM development of leadership skills**

- SoM involvement in identifying and encouraging future SoMs to undertake preparation programme
- SoM involvement in providing mentorship, support and preceptorship for student midwives, student SoMs and newly qualified SoMs
- Leadership on SoM initiatives across the Board

<table>
<thead>
<tr>
<th>SoM team self assessment, comments and supporting evidence</th>
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<tbody>
<tr>
<td>SoMs have undertaken mentorship training and identified SoM for support to student midwives.</td>
<td>Evidence supplied of SoM involvement in West of Scotland University pre-registration midwifery programme. SoM involvement noted in planning to develop a preceptorship programme for newly qualified midwives. SoM involvement in Compassionate connections work noted. Evidence supplied of leadership demonstrated by SoMs when providing advice and support to women and midwives around issues where women’s choices are outwith parameters for low risk care in a low risk setting.</td>
<td>MET</td>
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</tbody>
</table>
### Standard Eight
#### 9. Supplementary Evidence to demonstrate SoMs interface with users of maternity services

- SoM involvement with MLSC
- SoM accessibility to users e.g. user strategy, user involvement, user questionnaires
- SoM advocacy for women i.e. in care planning
- SoMs supporting women's choices
- SoMs proactive in the promotion of Normal Birth
- Patient Opinion input from SoMs

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<tbody>
<tr>
<td>Information leaflet on Supervision is available to all women. Notice boards with information available in Raigmore &amp; Caithness Maternity Unit. Women are given support in decision making with regard to place of birth during contact with community midwives and completing birth plans. Offered meeting with SoM. Home births, Free birth – SoM involvement – meeting with women Facebook pages – Skye &amp; Sutherland teams</td>
<td>Robust evidence supplied identifying the advocacy role undertaken by SoMs. Robust evidence supplied highlighting the role of the SoMs in supporting women’s choices.</td>
<td><strong>MET</strong></td>
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Principles of KCND supported Highland wide

Provision and evaluation of Hypnobirthing Classes.

Positive feedback from women, supporting normal birth and positive birthing experience.

Hypnobirthing Training for midwives representing all community teams within NHSH. Supporting standard provision of hypnobirthing techniques / classes as part of mainstream antenatal education programme.

Two SoM's are Responders on Patient
Opinion – links below to recent posting complimenting Midwifery Services in A&B. Similar postings have been made over the last year ranging from Breast Feeding Support, Post Natal Care in the Community, Intra Partum Care and sadly following the loss of a baby – these were from a range of maternity services within NHS Highland.

https://www.patientopinion.org.uk/opinions/328225

https://www.patientopinion.org.uk/opinions/335391

Standard Nine
10. Supplementary Evidence to demonstrate SoMs are responsible for ensuring that the LSA database is updated and maintained

<table>
<thead>
<tr>
<th>SoM team self assessment, comments and supporting evidence</th>
<th>LSA verification and comments</th>
<th>Measurement Met</th>
<th>Partially Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>The LSA audit team will review the following evidence on the LSA database as part of the audit process</td>
<td>The SoMs have demonstrated commitment and dedication whilst fulfilling their role in this challenging year and the evidence supplied through the database entries is commendable.</td>
<td>MET</td>
<td></td>
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<tr>
<td>SoM /Supervisee caseload</td>
<td>The LSA midwife highlighted that the role of the named SoM during investigations undertaken in NHS Highland is commendable and has been reflected through supervisees attending their investigation interview having fully reflected on the care they gave and many instances given of the supervisees and named SoM having already agreed and implemented an action plan to mitigate against re-occurrence.</td>
<td>ITPS are uploaded</td>
<td>Annual supervisory reviews</td>
<td>Personal details of supervisees</td>
</tr>
<tr>
<td>Category</td>
<td>Definition</td>
<td></td>
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<td>--------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Stillbirth</td>
<td>Baby born dead from 24 weeks of pregnancy</td>
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<tr>
<td>Major obstetric haemorrhage</td>
<td>Estimated blood loss ≥2500ml, or transfused 5 or more units of blood or received treatment for coagulopathy (fresh frozen plasma, cryoprecipitate, platelets). (Includes ectopic pregnancy meeting these criteria).</td>
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<tr>
<td>Eclampsia</td>
<td>Seizure associated with antepartum, intrapartum or postpartum symptoms and signs of pre-eclampsia.</td>
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<tr>
<td>Renal or liver dysfunction</td>
<td>Acute onset of biochemical disturbance, No detectable major pulse.</td>
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<tr>
<td>Cardiac arrest</td>
<td>No detectable major pulse.</td>
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<tr>
<td>Pulmonary Oedema</td>
<td>Clinically diagnosed pulmonary oedema associated with acute breathlessness and O₂ saturation &lt;95%, requiring O₂, diuretics or ventilation.</td>
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<tr>
<td>Pulmonary Embolus</td>
<td>Increased respiratory rate (&gt;20/min), tachycardia, hypotension. Diagnosed as ‘high’ probability on V/Q scan or positive spiral chest CT scan. Treated by heparin, thrombolysis or embolectomy</td>
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<tr>
<td>Acute respiratory dysfunction</td>
<td>Requiring intubation or ventilation for &gt;60 minutes (not including duration of general anaesthetic).</td>
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<tr>
<td>Cerebro-vascular event</td>
<td>Stroke, cerebral/cerebellar haemorrhage or infarction, subarachnoid haemorrhage, dural venous sinus thrombosis.</td>
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<tr>
<td>Status epilepticus</td>
<td>Unremitting seizures in patient with known epilepsy.</td>
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<tr>
<td>Anaphylactic shock</td>
<td>An allergic reaction resulting in collapse with severe hypotension, difficulty breathing and swelling/rash.</td>
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<tr>
<td>Septicaemic shock</td>
<td>Shock (systolic blood pressure &lt;80) in association with infection. No other cause for decreased blood pressure. Pulse of 120bpm or more.</td>
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<tr>
<td>Intensive care admission Coronary care admission</td>
<td>Unit equipped to ventilate adults. Admission for one of the above problems or for any other reason. Include CCU admissions</td>
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<tr>
<td>Maternal Death</td>
<td>Women who have booked for maternity services and up to one year post delivery.</td>
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<td>Unexpected Admission of a Term Baby to Neonatal ITU</td>
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