East of England

Local Supervising Authority (LSA)

Report

2006/07

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East of England

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Local Supervising Authority (LSA)

Executive Summary

The Local Supervising Authority (LSA) is responsible for ensuring that the statutory function for the supervision of midwives and midwifery practice is carried out to a satisfactory level, for all midwives working within its boundaries.

The East of England Strategic Health Authority took over the function of the Local Supervising Authority from 1July 2006.

The report follows the guidance set out by the Nursing and Midwifery Council Circular 15/2006 – Guidance for Local Supervising Authority (LSA) Annual Report submission to the Nursing & Midwifery Council (NMC) for practice year 1 April 2006 – 31 March 2007.

The LSA report is forwarded to all Chairs of the Maternity Services Liaison Committee (MSLC) with an offer for the LSA Midwifery Officer (LSAMO) to attend a meeting to discuss the report. This is to help raise the profile of statutory supervision with maternity service users.

Framework for Supervision of Midwives

- **Intention to Practice**

Midwives are required to notify their intention to practise in the following twelve months by the 31 March each year. In March 2007, 2,541 midwives notified to the EoE LSA. This is 151 less than 2006. These notifications were sent electronically to the NMC by mid April 2007.

The LSA is required to maintain a database of midwives practising within its boundaries and submits any new notifications to the NMC each week.

- **Supervisors of Midwives**

Supervision is a statutory responsibility which provides a mechanism for support and guidance to every midwife in the United Kingdom. The purpose of supervision of midwives is to protect women and babies by actively promoting a safe standard of midwifery practice.

There are 188 Supervisors of Midwives (SoM) currently appointed within the EoE LSA. SoM are appointed by the LSA after successful completion of a preparation programme at master's degree level.

SoM work in all areas of practice and are available for ongoing support for midwives and students. They are able to observe, coach and encourage evidence-based practise

The SoM offer 24-hour support to the midwives by an on-call system. The trend is for midwives to call a supervisor whenever there is a high workload which is jeopardising safety for mothers and babies.

Barriers to supervision being undertaken to a high standard remains the lack of supervisors, with the on-call commitment and lack of remuneration being cited as reasons which prevent midwives from wanting to take on the role.

- **Quality Indicators**

Documentation is of vital importance and SoM lead regular record keeping audits, ensuring results are fed back to their supervisees and to all professionals within the Maternity Services.

SoM participate in the organisation and delivery of mandatory updating sessions including adult and neonatal resuscitation, CTG interpretation, risk management and skills and drills workshops for dealing with Obstetric emergencies. SoM ensure that all midwives attend regularly and that their attendance is recorded.

The LSA audit of supervision identifies an increase in both awareness and active involvement by supervisors and midwives, in activities, which support the governance agenda such as risk management, audit and learning in practice. In all Trusts, risk management and clinical governance within the Maternity Service is led by a SoM. After a clinical incident or near miss involving practice issues, a supervisor is involved in the investigation, the action planning and the support of the midwives concerned. The SoM will continue involvement by monitoring implementation of the action plan and by sharing the lessons learnt with all the midwifery, obstetric and paediatric team.

A local guidelines group has been set up facilitated by the LSAMO with presentation by SoM from each of the units within the LSA. The guidelines from the two old LSA's are currently being reviewed and amalgamated in order to obtain consistency across the EoE LSA and will be widely circulated to all SoM within the LSA on completion.

The LSA Midwifery Officer issues guidance, based on the NMC Midwives rules & standards (2004) and national guidance formulated by the national forum for LSA Midwifery Officers in England (2005).

- **Serious Untoward Incidents**

The LSAMO is informed of all Serious Untoward Incidents (SUI's) directly by SoM and also through the SHA reporting process (NMC 2004). The SHA has recently reviewed and updated its reporting policy which was disseminated to all SoM. The LSAMO and Head of Patient Safety work closely together to review and follow up Maternity SUI's which ensures that recommendations for practice are implemented. In the reporting year this has included recommendations for improving record keeping, recognising accountability and direct access to a consultant obstetrician by the midwife.

The LSAMO has actively supported SoM during investigations following serious untoward incidents. Where supervised practice has been recommended, the LSAMO participates in the development of the programme and determines that the programme has been successfully completed in consultation with the co-ordinating SoM and midwife tutor.

There were 14 maternal deaths throughout the EoE LSA during the reporting year. The reporting and investigation of the deaths were carried out by SoM. Each Trust has a maternal death co-ordinator who is responsible for the collection of information and for reporting the death to the Confidential Enquiry Maternal And Child Health (CEMACH). The cause of maternal death in the EoE included suicide, thromboembolism and heart failure.

- **Strategic Development - Education**

The LSAMO and SoM work closely with the Higher Education Institutions (HEIs) in the LSA. This is with regard to pre-registration and post-registration programme development, teaching on courses and the supervision of student midwives. Local supervisors are invited to talk to midwifery students at various stages in their programme about statutory supervision with the aim of increasing the student's awareness of supervision and its impact on practice. Feedback from both managers and SoM indicates that students are able to demonstrate a positive attitude to supervision and the role of the SoM at interview.

In order to provide students with access to a SoM, Units have identified a local SoM who acts as a link for the students to supervision. This has helped student midwives to be more aware of the role of the supervisor and the benefits of supervision. Feedback from SoM is that students are using the SoM link to discuss practice issues and gain support in their practice placements.

There were 18 enquiries for return to practice places in the report year There has been little opportunity for any midwives to Return to Practise (RtP) this year due to the allocation of RtP funding to Primary Care Trust's who are reluctant to fund RtP, and the financial constraints that do not allow Trusts to financially support returners.

Sharing good practice is encouraged through ongoing learning opportunities. Evaluation shows that the learning opportunities are valued by supervisors, both for networking and the opportunity to present their work to a wider audience. Several topics have been covered including carrying out a supervisory investigation, keeping birth normal and courtroom skills.

- **Complaints**

No complaints were received by the LSA in the year 2006/07 in regard to the discharge of the supervisory function.

Challenges

The financial situation facing most Trusts has impacted on maternity services with all Heads of Midwifery being required to make savings and maintain services within tight budgets. This can add to the pressure already being felt in the service and in some areas it has resulted in:

- The number of midwives on call being reduced. This may result in a woman being requested to attend a unit for birth rather than give birth at home because a midwife may not be available.
- The number of postnatal visits undertaken by midwives or midwifery support workers being reduced. In many units women will usually only receive a maximum of three visits postnatally compared with 5-7 three years ago.
- Parent education being reduced or discontinued.

Trends

The birth trend shows a consistent rise in the number of women delivered over the last five years. All but two of the units in EoE have seen an increase in women delivered ranging from 8 – 236 in this reporting year. This is set against a falling number of midwives notifying their intention to practice (2006: 2692 mw, 2007: 2541 mw). The rising birth rate and falling midwife numbers will have played a key part in the capacity and staffing issues leading to unit closures.

- **Midwife only care**

The number of bookings for midwife only care is increasing year on year and the numbers varies across the Units from 35% to 70%. Encouraging women to make the midwife the first point of contact for care is a priority for SoM. This will enable the recommendations made around this in both the NSF and Maternity Matters to be met.

The number of births conducted by midwives only, varies from 75% to 55%, the latter being in a high-risk tertiary centre.

- **Caesarean Section**

2006/07 has seen many units adopting the Institute for Innovation and Improvement's (2006) toolkit; Focus on Normal Birth and reducing Caesarean section rates, in order to help reduce the number of caesarean sections being undertaken. Some PCT's have agreed to pay only for the percentage of elective caesarean sections equivalent to the national average. Any elective sections above this amount will have to be funded by the units themselves.

- **Breast Feeding**

The percentage of women initiating breast feeding has remained stable in all of the Units. Primary Care Trusts have a target for increasing breast feeding rates by 2% as part of the public health agenda.

Future Direction

1. The review of guidance for SoM within the EoE LSA is a priority for 2007/08. This will ensure consistency of approach and ensure one cohesive LSA for the East of England.

2. It is important to enhance the role played by service users at LSA monitoring visits and ensure they participate with supervisors of midwives in ensuring the quality of care given to mothers and babies.

3. During 2007/08 it is proposed that SoM undertake a self audit against the proficiencies developed by the NMC for SoM. On-going education will be based on the learning needs identified by the SoM ensuring that SoM are fit for purpose.

Conclusion

Supervisors have sustained high standards of practice in relation to statutory supervision. The LSAMO will continue to support SoM to exercise leadership within their local service.

Maternity Services, along with the Health Service in general, annually grow in complexity and it is imperative that statutory supervision continues to be strengthened so that mothers and babies are provided with the highest quality care and protection.

There has been a continued commitment to statutory supervision from the supervisors and midwives within the East of England LSA. Supervisors appointed by the East of England LSA continue to provide proactive supervision for midwives assuring competent and safe care for women and babies.

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East of England
LSA Report

2006/ 07

Contents **Page**

East of England

Local Supervising Authority (LSA)

Report 2006/07

Introduction

The LSAMO is pleased to present this report of the work carried out on behalf of the Strategic Health Authority, in its statutory role as the LSA.

From April 2002 to July 2006 the Norfolk, Suffolk & Cambridgeshire Strategic Health Authority, Essex Strategic Health Authority and Beds and Herts Strategic Health Authority were responsible for the statutory functions of a LSA.

However, in 2006 the three Strategic Health Authorities merged and formed the East of England Strategic Health Authority. The new organisation took over the function of the LSA from 1 July 2006.

Articles 42 and 43 of the Nursing & Midwifery Order 2001 made provision for the practice of midwives to be supervised. The LSA is responsible for ensuring that the statutory function for the supervision of midwives and midwifery practice is carried out to a satisfactory level, for all midwives working within its boundaries.

The NMC published Midwives Rules and Standards in August 2004 which set 54 standards to be met by LSAs and SoM. Rule 16 required an annual report to be submitted to the NMC and to be made available to the public within the LSA boundaries. The report follows the guidance set out by the Nursing and Midwifery Council Circular 15/2007 – Guidance for Local Supervising Authority (LSA) Annual Report submission to the NMC for practice year 1 April 2006 – 31 March 2007

1.0 Each LSA will ensure their report is made available to the public

1.1 The report has been agreed by the Chief Executive of the East of England Strategic Health Authority and will be distributed as follows:

- Nursing & Midwifery Council by 28 September 2007
- East of England SHA Executive Board
- The public, via the SHA website
- NHS Trust Boards
- Maternity Services Liaison Committees
- Individual service users on request.

1.2 The LSA report is forwarded to all Chairs of the MSLC with an offer for the LSAMO to attend a meeting to discuss the report. This offer is taken up by the vast majority of the MSLCs. Where the offer is not taken up, a local SoM is nominated to ensure the report is discussed. User members of the MSLCs are invited to contact the LSAMO to discuss any issues or concerns arising from the report.

1.2.1 The report will appear on the SHA website along with the contact details of the LSAMO for anyone wishing to seek clarification or more information relating to statutory supervision.

2.0 SoM appointments, resignations and removals

2.1 The nomination process takes place within the Trust with midwives self nominating or being nominated by their peers. They then prepare a presentation for an interview panel and midwife colleagues provide supporting statements to ensure there is support for their nomination.

2.2 SoM are appointed by the LSA after successful completion of a preparation programme at master's degree level, which is delivered over two academic semesters.

2.3 There are currently 188 SoM in the East of England, with a further 13 due to start the preparation course in October 2007 at the University of Hertfordshire.

	02/03	03/04	04/05	05/06	06/07
Appointments	12	5	11	9	9
Resignations	9	10	9	2	6
Suspensions	0	0	0	0	1
Removals	0	0	0	0	0

Table 1

2.3.1 One SoM is currently suspended from the role following a disciplinary hearing. The SoM will remain suspended for one year when her reinstatement will be reviewed.

2.3.2 Of the six SoM who resigned, four left their Trusts, one retired and one changed her substantive role to one outside of midwifery.

2.4 In 2004, the NMC set the ratio of SoM: midwives as 1:15. Within the EoE the ratio of supervisors to midwives varies from 1:10 to 1:27 with the units within the old Eastern Region West having the highest ratios.

2.4.1 One of the issues identified during the LSA audit visit is that increasingly midwives are reluctant to undertake the role of SoM.

2.4.2 Midwives were asked what it was that would stop them from undertaking the role and the on-call commitment was cited in the majority of cases.

2.4.3 The SoM offer 24-hour support to the midwives by an on-call system. Midwives are made aware of the rota and how to contact a supervisor. This is audited by the LSAMO as part of the annual review for each Trust.

2.4.4 SoM are frequently used to make up short falls in staffing numbers caused by historically low staffing establishments and recruitment and retention difficulties. This is an inappropriate use of SoM and must be addressed.

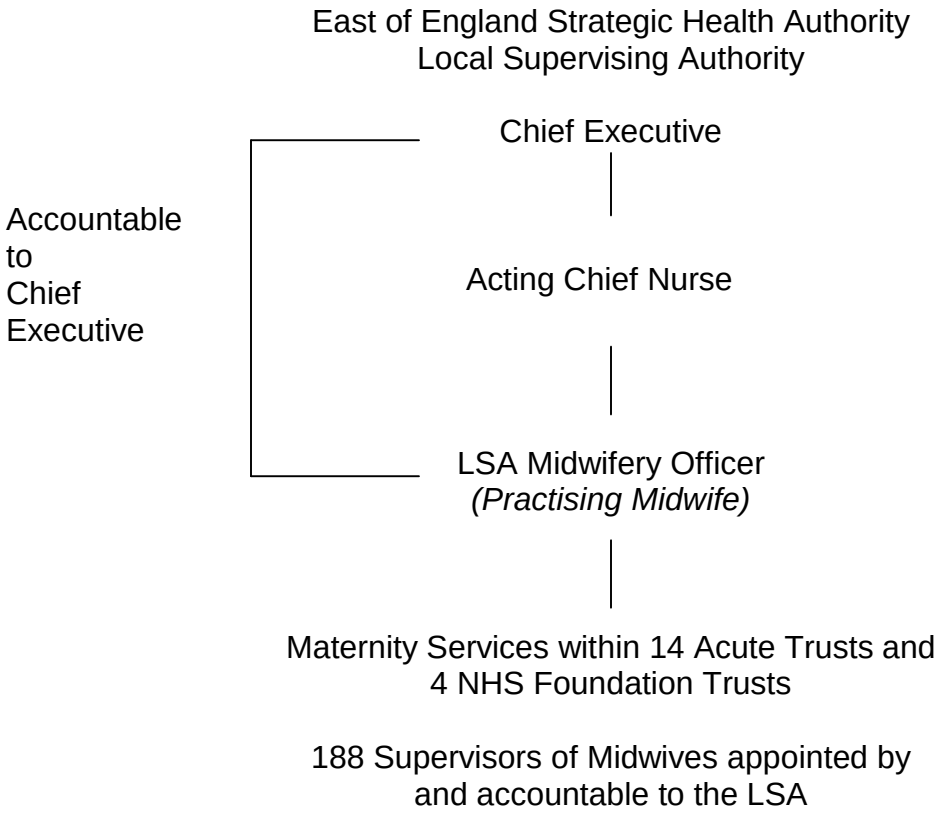
2.5 Even though time to undertake the role has been agreed by most Trusts, due to workload the majority of supervisors find it difficult to set aside time to carry out their supervisory duties, particularly annual reviews. This appears to be more difficult for clinically based SoM.

2.6 The Nursing and Midwifery Order 2001 states that all midwives must have access to statutory supervision to support them in practice and the Trusts have a responsibility to support SoM in their role. Many of the SoM have been unable to secure remuneration for their additional responsibilities although this has been agreed in a small number of Trusts. Lack of remuneration for the additional responsibilities and workload was also cited as a reason for midwives not wanting to undertake the role. Where supervision cannot be provided then midwives cannot practice and this clearly has implications for the continuation of maternity services.

3.0 How are midwives provided with continuous access to a SoM?

3.1 Framework for Statutory Supervision

LSA Framework for 2006/2007:



Intention to Practice

3.2 Midwives are required to notify their intention to practise in the following twelve months by the 31 March each year. In March 2007, 2541 midwives completed Intention to Practice forms in the EoE LSA. This is 151 less than in 2006. These notifications were sent electronically to the NMC by mid April 2007.

3.2.1 The LSA is required to maintain a database of midwives practising within its boundaries and submits any new intention to practice to the NMC each week.

3.3 All midwives within the LSA are able to choose their named supervisor of midwives. The SoM agree a caseload number for each SoM based on current workload, hours worked and other commitments. A letter is sent to individual midwives detailing the names and contacts of those SoM within their unit. The midwives are then given the opportunity of a 1st, 2nd and 3rd choice. Those midwives who do not request a particular SoM are allocated to a supervisor who has space in her caseload.

3.3.1 New midwives joining the Trust are allocated a SoM to allow them to have access to a named SoM until they get to know the SoM available. They are then able to choose their SoM providing she has space in her caseload.

3.4 When a midwife's named SoM is not available the midwife may access the on-call supervisor. All SoM participate in a 24 hour on-call rota which ensures that midwives have continual access to a supervisor. The systems in place are audited through the LSA audit process and evidenced by speaking to midwives during the audit visit.

4.0 How is the practice of midwives supervised?

4.1 Standards have been developed in collaboration with LSA officers for England and local supervisors (LSA 2005). The focus is on a proactive model of supervision for all midwives, who may work in a variety of settings and reflect the minimum standard of statutory supervision to be achieved.

4.1.1 There are five LSA standards that are based on the five broad principles set out by the NMC on page 29 in the Midwives Rules and Standards (2004). There are criteria attached to each standard. Evidence of achievement of the criteria is used by the LSAMO as evidence that the NMC requirements are met in respect of statutory supervision

4.2 The LSAMO undertakes an annual audit visit to assess performance against the standards and to audit the evidence of compliance. The audit panel consists of the LSAMO, a SoM from another part of the LSA and a student SoM, currently undertaking the preparation course for SoM.

4.2.1 The involvement of SoM in the audit process provides greater opportunities for the sharing of good practice. Those taking part in past audits have provided positive feedback on the process and have indicated that it provided a useful learning opportunity.

4.2.2 Despite many attempts to include users in the audit process this has yet to be achieved with any level of success. Users were present in some Units for the feedback session following the audit visit, which was viewed as very positive by both the users and the SoM.

4.2.3 For the old Eastern Region West LSA the audit visit took a slightly different format this year. It was agreed that the visit by the panel to the Unit would focus on feedback rather than evidence gathering. It would be an opportunity for the Units to present to an invited audience their annual report and for feedback from the LSAMO.

4.2.4 The new process was three phased: **phase one** took a self/peer review approach. Self/peer review is recognised as a powerful tool that stimulates professional development and decentralises power, creating awareness of personal accountability (Cheyne et al 2003, Malkin 1994).

4.2.5 The Units were asked to complete a self audit form and return it to the LSA prior to the visit. The evidence of achievement was verified by an audit panel using a targeted sampling technique.

4.2.6 **Phase two** was a questionnaire sent to all the SoM which asked questions based on a tool used by Stapleton et al (1998) which proved effective in determining the understanding of their role by SoM.

4.2.7 **Phase three** was a questionnaire sent to a random sample of midwives selected from the LSA database. The questions mirrored in many respects the questions asked of the SoM in order to compare the midwives perceptions of supervision in their unit with that of the SoM.

4.2.8 The peer review form was sent to the Units three months before the audit date, with the completed information returned one month before the audit date.

4.2.9 The audit panel members were sent the completed self audit form prior to the visit and were asked to formulate any questions they had in relation to any aspect of the standards. The panel was also given the opportunity to request any further information or evidence that the criteria had been met.

4.2.10 The panel was particularly concerned with ensuring that the evidence reflected the activities of SoM and not those of managers or others with particular responsibilities in the unit.

4.2.11 The panel met with the SoM from the Unit to seek further clarification in relation to the evidence and to hear some of the successes of supervision within the unit. This is also an opportunity for the SoM to reflect on some of the barriers to good supervision within their Unit.

4.2.12 During the last part of the visit, the panel met with midwives from the Unit, who were assured of the confidentiality of the information shared. The midwives were asked to be as honest as possible with the panel in order to ensure that their views were an accurate reflection of supervision in their unit.

4.2.13 Where standards are only partially met or not met, an action plan has been developed by the local SoM to ensure supervision moves forward and the standards are met. A report is written following the visit and the results of the audits fed back to the supervisors with recommendations for further improvement and commendations where good practice has been highlighted. The supervisors are encouraged to feedback the findings of the audit report to the Chief Executive, Director of Nursing, Trust Board and to other members of the Obstetric Directorate.

4.3 The National Forum for LSA Midwifery Officers in England have issued a National Strategy to identify their goals for 2005 to 2008. Based on these goals and the standards set by the NMC and LSA, the supervisors of midwives in each Unit have written a Strategy for Supervision with measurable action plans for achievement. These are reviewed each year and progress demonstrated to the LSAMO during the LSA audit and through minutes of local supervisors meetings.

Governance

4.4 The LSA audit of supervision has identified an increase in both awareness and active involvement, by supervisors and midwives, in activities which support the clinical governance strategy. Statutory supervision is explicit in most Trusts clinical governance strategies and where this is not the case is clearly identified in directorate/division strategies**.**

Risk Management

4.5 All Maternity units now have a robust risk management strategy in place, which, in most places, is led by a supervisor of midwives. Where this is not the case, there are processes in place, which ensure that supervisors have the opportunity to discuss the outcomes of the incident reporting forms or the analyses of the data collected, in relation to the implications for practice**.**

4.5.1 After a clinical incident or near miss involving practice issues, a SoM is involved in the investigation, the action planning and the support of the midwives concerned. The LSA is informed whenever a SoM is involved in an investigation following a critical incident (NMC 2004). This enables the LSAMO to remain aware of trends developing in relation to incidents but also to offer advice and support to the SoM undertaking the investigation.

4.5.2 The SoM will continue to be involved by monitoring implementation of the action plan and by sharing the lessons learnt with all the midwifery, obstetric and paediatric team. Clinical Audit meetings are the vehicle used to promote this. Following any incident review, the midwife's named supervisor assists them to identify any learning needs and supports, monitors and evaluates her progress.

4.5.3 The LSAMO is also actively involved in any proposed supervised practice programme. This ensures that the process is fair, equitable and enables the midwife to address the practice issues identified from the investigation.

4.6 Supervisors are also able to identify potential deficits in practice and be proactive in developing education opportunities for midwives or to review guidelines for practice in light of the information. An example of this are workshops on shoulder dystocia and waterbirth, both identified as potential risks in practice.

Clinical Negligence Scheme for Trusts

4.7 Currently 15 units in the EoE have level 2 CNST with 2 having level 1 although they are expected to gain level 2 before the end of the year. One unit is going for level 3 this year. Much of this work has been taken forward by SoM.

Audit

4.8 Audit of practice is widely accepted as part of the supervisor's role and the active involvement of supervisors and midwives in audit has increased over the last year. Supervisors present at multidisciplinary audit sessions and audits looking at the rising number of BBA's (babies born before the arrival of the midwife), record keeping , caesarean section and bladder care following birth have resulted in changes to practice and revision of clinical guidelines.

Skills Development

4.9 SoM participate in the organisation and delivery of mandatory updating sessions, ensuring all midwives attend regularly and recording their attendance. They have also been key in leading forward the 'skills and drills' sessions, which involve practical scenarios for serious midwifery and obstetric emergencies, such as shoulder dystocia and massive haemorrhage. These sessions enable the supervisors to implement the recommendations of the confidential enquiries. Many of the supervisors are ALSO (UK) trained.

4.9.1 All Trusts have now developed training packages to up-date midwives and medical staff in understanding and interpreting Cardiotocograph's. Many include an assessment test which is performed both pre and post session for the purpose of assessing knowledge gained and highlights those midwives and medical staff who require further training. Results from the test have shown a vast improvement where they are not anonymised.

Lifelong Learning

4.10 Midwives needs in relation to practice are identified through the annual supervisory review and in most instances inform the education provision. However, the current deficits in funding are having an impact on the kind of education that midwives can access. This is affecting post graduate courses at both degree and postgraduate level in particular. For example, those midwives that are ALSO and NALS trained are having difficulty in accessing updating courses in order to maintain ongoing competence. This is currently being negotiated through the Workforce Development Directorate in order to address this issue.

Quality

4.11 Supervision has contributed to the quality agenda ensuring that services that are responsive to the needs of local women, remain central to midwifery care. The statutory supervision of midwives and practice is the framework for quality assurance.

4.11.1 Record Keeping study sessions have been formally developed in all units and are proving very beneficial in improving the quality of record keeping. A record keeping audit tool was developed by the LSAMO some years ago and while this has been adapted to ensure that it meets the requirements of both the Trust and CNST, it is used by SoM in undertaking audit of records with their supervisees.

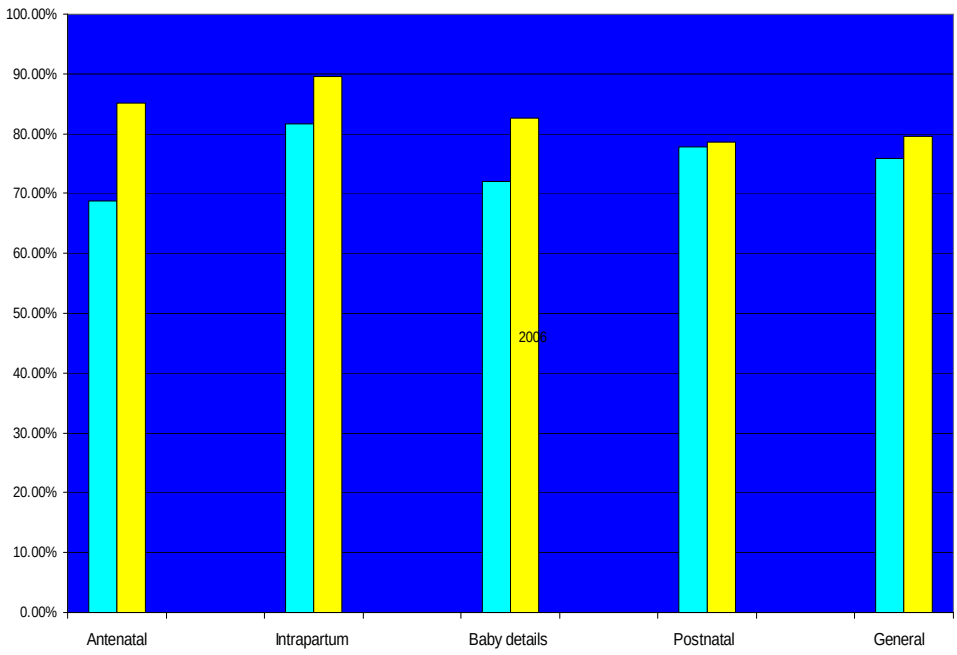


Table 2 shows record keeping results from 1998 and 2006

4.11.2 SoM are involved in a number of other groups who evaluate education and practice and look at ways of improving the quality of care:-

- Policy Steering Group
- Labour Ward Forum
- Maternity Services Liaison Committee (MSLC)
- Normal Labour Group
- Postnatal Forum.

4.11.3 The Labour Ward Forum provides multidisciplinary participation and peer review influencing intrapartum care for women. An additional role for the SoM on the forum is to support the lay member of the group ensuring she has access to documentation and related commentary, which explains any issues requiring clarification.

Collaborative working

4.12 The LSA have facilitated a collaborative approach to working between the supervisors in all Trusts. This has been achieved through better networking opportunities now available to supervisors and has resulted in an improved support framework and increased development for supervisors including the opportunity to participate in investigations in Trusts other than their own.

4.12.1 Collaborative work on guidelines for practice is also taking place. The guidelines used across the two old LSA consortia are currently being reviewed, updated and amalgamated to ensure consistency across the whole of the EoE LSA.

4.12.2 The implementation of the Children, Young People and Maternity National Service Framework (NSF) and Maternity Matters (2007) will provide a focus for future collaborative work between the supervisors of midwives. Priorities include the midwife as the first point of contact for women, keeping birth normal and supporting women in making informed choices for place of birth.

5.0 Service user involvement in monitoring SoM and assisting the LSAMO

5.1 Despite a more proactive approach to user involvement in the audit of supervision, to date this has not occurred. Contacts with users on local MSLC's have proved positive although to date none have been available to participate in the audit process. SoM have also been engaged to encourage wider user participation from other groups such as labour ward forums and guideline development groups.

5.1.2 The LSA and SoM locally will continue to encourage users to participate in audit activities when possible and any users identified who are happy to participate in the LSA audit will be given training and be appropriately remunerated for their time and expenses including child care.

5.1.3 SoM are encouraged to include information about supervision and contact details on local Trust websites. Many have developed information leaflets for women which are included in the booking pack and some have information about SoM include in the hand held records and 'Bounty' books.

5.1.4 In some Trusts, midwives have been identified to carry particular caseloads of traditionally hard to reach women such as travelers', teenage mothers and asylum seekers. This is a model which is proving effective and should be encouraged throughout the LSA.

6.0 Engagement with higher education institutions in relation to midwifery education programmes

6.1 The LSAMO and SoM work closely with the HEIs in the LSA with regard to pre-registration and post-registration programme development, teaching on courses and the supervision of student midwives. Local supervisors are invited to talk to midwifery students at various stages in their programme about statutory supervision with the aim of increasing the student's awareness of supervision.

6.1.1 In order to provide students with access to a SoM most Units have identified a local SoM who acts as a link for the students to supervision. This has helped student midwives to be more aware of the role of the supervisor and the benefits of supervision. Feedback from SoM is that students are using the SoM link to discuss practice issues and gain support in their practice placements.

6.2 The LSAMO is a member of the midwifery strategy groups at three Universities and has input into some of the post registration education programmes. There is specific input from the LSAMO into modules concerning advancing midwifery practice, clinical governance and risk management.

6.3 The Preparation Course for Supervisors of Midwives is only offered at the University of Hertfordshire. The LSAMO is an active member of both the curriculum planning team and course management team. A very effective and close working relationship has been built up with the team at University of Hertfordshire gaining the preparation course National recognition.

6.3.1 The course is continually evaluated and changed to meet the changing demands on SoM. The course was successfully revalidated in January 2007, with the focus on ensuring that potential SoM are enabled to meet the proficiencies for SoM prescribed by the NMC (NMC 2006).

6.3.2 The needs of mentors for student SoM are met through an identified session which enables mentors to gain a thorough understanding of the programme and the outcomes that student SoM are required to meet. Support for mentors is provided by the SoM in the HEI and the LSAMO.

6.4 There has been little opportunity for any midwives to RtP this year due to the allocation of RtP funding to Primary Care Trust's who are reluctant to fund RtP, and the financial constraints that do not allow Trusts to financially support returners.

Ongoing education for SoM

6.5 A number of learning opportunities for SoM have been provided by the LSA during the last year which includes:

Learning Opportunities	Number of SoM attending
Excellence in Statement and Report Writing	25
Courtroom Skills	16
Swimming in Concrete (Resolving Bullying)	38
Patient Safety and Root Cause Analysis -	12
Carrying out a Supervisory Investigation	28

Table 3

6.5.1 The learning opportunities have evaluated well with the workshop on carrying out a supervisory investigation obtaining very positive feedback from the SoM who carried out an investigation following the workshop. New opportunities will be offered in the coming year based on the identified needs of the SoM. Their needs will be assessed following the completion of the competency benchmarking tool.

7.0 New policies related to the SoM

7.1 Two types of guidelines are in place to support SoM in the East of England LSA.

7.1.1 National guidelines, which are developed by the LSAMO's for England, are provided where it is important that consistency is achieved across the whole of England.

7.1.2 These guidelines are reviewed on a bi-annual basis and changes made based on the best available evidence or circulars from the NMC where appropriate.

7.2 A local guidelines group has been set up facilitated by the LSAMO with representation by SoM from each of the units within the LSA. The guidelines from the two old LSA's are currently being reviewed and amalgamated in order to obtain consistency across the EoE LSA and will be widely circulated to all SoM within the LSA on completion.

7.3 Both National and local guidelines will be available on the SHA website at www.eoe.nhs.uk from 1 October 2007. National guidelines can also be accessed by all SoM at www.yorksandhumber.nhs.uk/nationalguidelinesforsupervisorsofmidwives. A list of both national and local guidelines can be found in **Appendix 1**.

8.0 Developing trends affecting midwifery practice in the LSA

Data Collection

8.1 Data in relation to Maternity unit statistics have not been routinely collected across the whole LSA in the reporting year. This is however in place for the year 2007/08. An agreed format will be used across the LSA to be completed by a designated SoM. The data will relate to the fiscal year and contain data relating to both clinical activity and staffing.

Maternal Death

8.2 The definition of maternal death is a death of a woman while pregnant or up to one year after abortion, miscarriage or birth. Indirect deaths are those deaths resulting from previous existing disease and not due to direct obstetric causes. Direct deaths are deaths resulting from Obstetric complications during pregnancy, labour and postnataly.

8.2.1 There were 14 maternal deaths throughout the EoE LSA during the reporting year. Table 4 shows the classification of the deaths. It is likely that the rise in maternal deaths is attributable to better reporting systems than in previous years.

Year	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007
Direct	1	1	1	3	2
Indirect	9	4	4	2	10
Unknown	3	3	3	2	2
Total	13	8	8	7	14

Table 4

8.2.2 The reporting and investigation of the deaths were carried out by SoM. Each Trust has a maternal death co-ordinator who is responsible for the collection of information and for reporting the death to the Confidential Enquiry Maternal And

Child Health (CEMACH). The cause of maternal death in the EoE included suicide, thromboembolism and heart failure.

Unit Closures

8.3 Data relating to the temporary closure of maternity units has not been collected consistently throughout the LSA for the report year. Temporary closure most often relates to staffing and capacity issues. Data relating to closure is currently being collected by the LSA and will be available for the report year 2007-08. Temporary unit closures may mean that a unit is closed for anytime between 1 - 24 hours.

Birthrate Trends

Unit	2002	2003	2004	2005	2006	2007	Trend
Basildon	3729	3694	3996	4040	4063	4257	↑**194**
Bedford	2801	2819	2876	3035	3010	2947	
E&N Herts	5011	5075	5173	5094	5301	5309	↑**8**
Essex Rivers	3266	3248	3321	3508	3516	3694	↑**178**
Hinchingbrooke	2147	2181	2222	2202	2199	2363	↑**164**
Ipswich	3174	3456	3625	3536	3753	3232	
James Paget	1979	2132	2062	2076	2050	2209	↑**159**
King's Lynn	2021	2019	2112	2030	2145	2229	↑**84**
Luton & Dunstable	4324	4407	4555	4513	4728	4780	↑**52**
Mid Essex	3585	3570	3540	3835	3767	3882	↑**115**
Norfolk & Norwich							
Peterborough	3304	3427	3538	3494	3505	3760	↑**155**
Princess A H	2641	2797	2889	3009	3222	3252	↑**30**
Rosie	4563	4801	4898	4990	5020	5119	↑**92**
Southend	3350	3488	3500	3486	3532	3768	↑**236**
West Herts	5570	5396	5266	5265	5186	5254	↑**68**
West Suffolk	2318	2431	2477	2483	2416	2623	↑**207**
Total women delivered	58,447	59,771	61,171	61,651	62,737	64,133	
Total rise/fall		**1324 ↑**	**1400 ↑**	**480 ↑**	**1086 ↑**	**1396 ↑**	

Table 4

8.4 The birth trend (Table 4) shows a consistent rise in the number of women delivered over the last five years. All but two of the units in EoE have seen an increase in women delivered ranging from 8 – 236 in the reporting year. This is set against a falling number of midwives notifying their intention to practice (2006: 2692 mw, 2007: 2541 mw). The rising birth rate and falling midwife numbers will have played a key part in the capacity and staffing issues leading to unit closures.

Clinical Activity

8.5 The number of bookings for midwife only care is increasing year on year and encouraging women to make the midwife the first point of contact for care is a priority for SoM . This will enable the recommendations made around this in both the NSF and Maternity Matters to be met.

8.5.1 The numbers vary across the Units from 35% to 70%. The number of deliveries conducted by midwives also varies from 75% to 55%, the latter being in a high-risk tertiary centre.

8.5.2 A number of units have seen an unexpected rise in the number of 3rd degree and 4th degree tears. A possible explanation for the rise may be better diagnosis of serious tears. However, this trend is being monitored and audited by SoM to ensure that this is not related to poor practice.

8.5.3 2006/07 has seen many units adopting the Institute for Innovation and Improvement's (2006) toolkit; Focus on Normal Birth and reducing Caesarean section rates, in order to help reduce the number of caesarean sections being undertaken. Some PCT's have agreed to pay only for the percentage of elective caesarean sections equivalent to the national average (13%). Any elective sections above this amount will have to be funded by the units themselves.

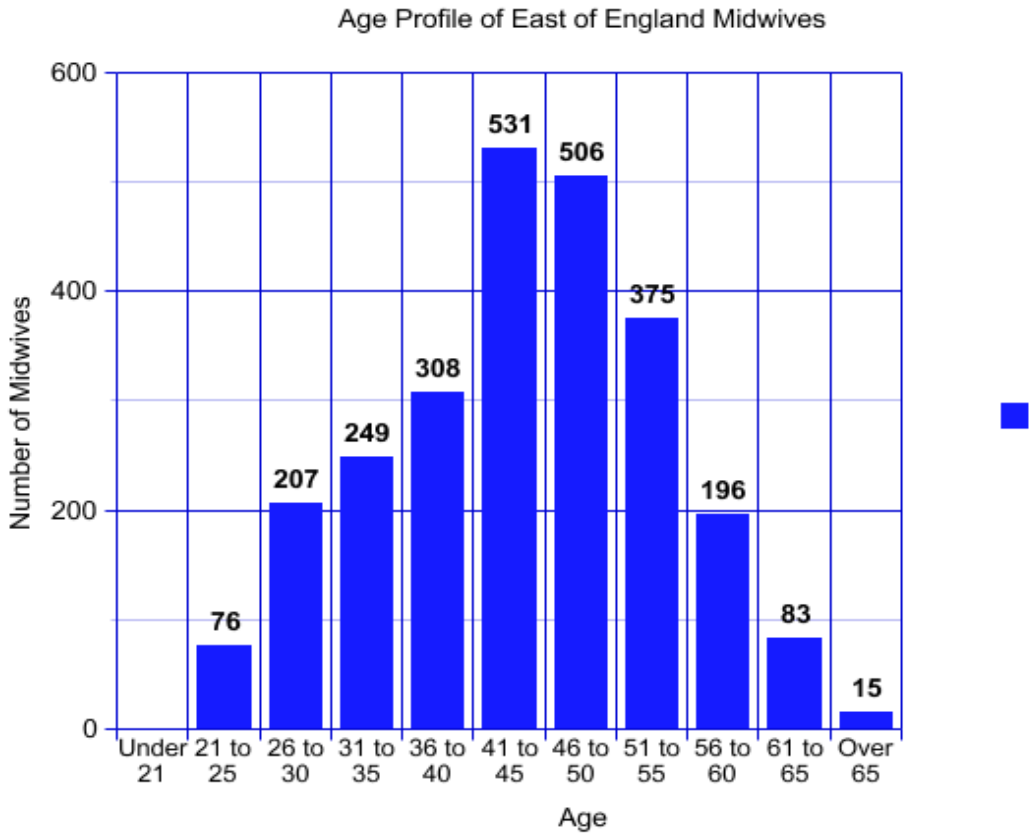
8.5.4 Clinical activity data is shared with SoM across the LSA. This enables SoM to benchmark aspects of care and identify possible trends in practice. The rising caesarean section rate is clearly of concern and SoM are working hard to promote 'normality' within their units. Much of this work is being undertaken in collaboration with medical colleagues and users of the service.

8.5.5 Breast feeding initiation remains fairly stable although the percentage is variable among the units. Primary Care Trusts have to raise breast feeding rates by 2% as one of the targets of the public health agenda. The establishment of Children's Centres where midwives and health visitors will be working more closely will hopefully enable women to receive more informal and accessible support, impacting on the number of women initiating and continuing to breast feed.

Midwifery Workforce

8.6 Recruitment and retention continues to be a problem in some areas but appears to have eased throughout the LSA. Robust recruitment and retention strategies have been developed by those Trusts where this continues as an issue. Units are currently managing to employ local students even if this is only on a temporary contract basis in some places.

8.6.1 The LSA database is able to identify the age profile of midwives in EoE LSA and it identifies that 26% of midwives employed are aged 50 and over. (Graph 1).



Graph 1

8.6.1 All units are aware of their age profile and both medium and long term plans have been put in place to address this including increasing student midwife numbers and the development of the Maternity Support Worker (MSW) role.

8.6.2 All Units have implemented a programme of training for MSW support workers who can assist midwives in the operating theatre and the community. They offer additional help for women who are breast feeding and can act as female support for women in labour. Some units have had MSW in pace for a number of years. They provide essential support to both midwives and women.

Challenges

8.7 The financial situation facing most Trusts continues to impact on maternity services with all Heads of Midwifery required to make savings and maintain services within tight budgets. In some areas this has resulted in:-

- The number of community midwives on call being reduced. This may result in a woman being requested to attend a maternity unit to give birth rather than give birth at home because a midwife may not be available.

- The number of postnatal visits undertaken by midwives or midwifery support workers being reduced to three visits compared with 5 -7 three years ago. This pattern of postnatal visiting does not enable midwives to fully meet the NICE guidelines for postnatal care which advocate that women should be involved in planning the timing and content of each postnatal care contact so that care is flexible and tailored to meet her and her babies needs (NICE 2006).

- Parent education reduced and additional services such as baby massage and aromatherapy discontinued. As a consequence some women may be less well prepared for birth and may require additional support during labour particularly around choice of pain relief.

8.8 The Maternity Units continue to report that on occasions, during periods of peak activity, even after calling in midwives from the community it is not always possible to offer women 1:1 care in labour. This often means that midwives are providing care for two or even three women where the expected standard would be 1:1 care.

8.8.1 All units have in place an escalation policy which is initiated when women's safety is thought to be compromised. The escalation policy culminates in the closure of the maternity unit until such time as clinical activity and staffing levels allow it to be re-opened. During the time the unit is closed, women are redirected to other local units.

9.0 Complaints regarding the discharge of the supervisory function

9.1 No complaints were received by the LSA in the year 2006/07 in regard to the discharge of the supervisory function.

9.2 Complaints against the LSAMO are dealt with through the SHA complaints procedure as the LSAMO is an employee of the SHA.

9.3 Complaints against a SoM would be dealt with in accordance with the National Guidelines (England) for Supervisors of Midwives - Poor Performance and Removal from Appointment of Supervisors of Midwives. The LSAMO will notify the NMC following investigation that the supervisor is to be removed from the LSA database as a practising SoM. Reinstatement of supervisory status is only possible by re-application.

9.3.1 The SoM concerned has the right of appeal against the decision made by the LSAMO. In the event of an appeal, the case will be reviewed by another LSAMO and an experienced SoM. The appeal should be received within three weeks of the date of the initial meeting with the LSAMO. This decision will be final.

10.0 LSA investigations undertaken during the year

10.1 The LSAMO is informed of all SUI's directly by SoM and also through the SHA reporting process (NMC 2004). The SHA has recently reviewed and updated its reporting policy which was disseminated to all SoM. The LSAMO and Head of Patient Safety work closely together to review and follow up Maternity SUI's which ensures that recommendations for practice are implemented.

10.2 Any SUI notified to the Trust board or to the SHA will require a supervisory investigation (NMC 2004). Support and guidance is given by the LSAMO during the course of the investigation and discussions take place in relation to the appropriate recommendations.

10.3 Supervisors of midwives carried out nine investigations into serious untoward incidents in the year 2006/07. No LSA investigations were carried out during the same year.

10.4 Seven midwives have undertaken periods of supervised practice during the reporting year with objectives and learning outcomes relating to the following:-

- Decision making
- CTG Interpretation
- Communication
- Accountability
- Record keeping
- Planning and delivery of care.

10.4.1 Poor record keeping, communication and planning and delivery of care featured in almost all the investigations while poor CTG interpretation featured in more than 50% of the investigations. However, systems failures in terms of inappropriate or non-existent guidelines that do not support midwives in practice were often cited as mitigating circumstances.

10.4.2 The LSAMO is currently working with SoM throughout the LSA to address the guideline issue and to ensure that wider learning takes place from clinical incidents than for just those midwives involved in the incident.

10.5 Access to the NMC for advice on matters relating to midwifery practice occurs through letter, telephone and most commonly by e-mail.

10.6 One midwife has been referred to the NMC during this reporting year, by her employing Trust, not by the LSAMO.

11.0 Conclusions

11.1 There has been a continued commitment to the role from the SoM, midwives and others within the LSA despite rising workloads and lack of remuneration and recognition for the role by some Trusts.

11.2 Supervisors have sustained high standards of practice in relation to statutory supervision and are actively involved in all aspects of the supervisor's role throughout the LSA.

11.3 The LSAMO will continue to support SoM to exercise leadership within their local service.

11.4 Supervisors have also taken an active part in influencing the midwifery agenda at both a local and national level.

11.5 Maternity Services, along with the Health Service in general, annually grow in complexity and it is imperative that statutory supervision continues to be strengthened so that mothers and babies are provided with the highest quality care and protection.

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Appendix 1

Guidelines for Supervisors of Midwives

East of England

(Currently under review)

Contents

National Guidelines (England) for Supervisors of Midwives

Contents