East of England

Local Supervising Authority

Annual Report to the Nursing and Midwifery Council

1 April 2007 – 31 March 2008

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East of England

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Contents

East of England
Local Supervising Authority (LSA)

1.0 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 (EoE SHA) 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 – Guidance for Local Supervising Authority (LSA) Annual Report submission to the Nursing & Midwifery Council (NMC) for practice year 1 April 2007 – 31 March 2008.

Substantial improvements have been made in the reporting year against the risks identified by the NMC in the last reporting year, particularly in relation to the supervisor to midwife ratio (Appendix I).

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 2008, 2644 midwives notified to the EoE LSA. This is 103 (3.8%) more than in 2007. These notifications were sent electronically to the NMC in mid April 2008.

In accordance with the NMC standards the LSA maintains a database of midwives practising within its boundaries and submits any new intention to practice 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 166 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.

SoMs work in all areas of practice and offer 24 hour support to the midwives using an on-call system. They are available for ongoing support for midwives and students. They are able to observe, coach and encourage evidence-based practice.

- **Quality Indicators**

Documentation is of vital importance and SoMS 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 of the midwifery, obstetric and paediatric teams.

The LSA Midwifery Officer (LSAMO) issues guidance, based on the NMC Midwives rules & standards (2004) and national guidance formulated by the National Forum of LSA Midwifery Officers (United Kingdom).

- **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 15 maternal deaths throughout the EoE LSA during the reporting year (14 in 2006/07). There is no significant rise in the direct maternal deaths across the EoE. The reporting and investigation of the deaths were carried out by Supervisors of Midwives. 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 & 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.

Over the time period of the report the LSA office had 24 enquiries from individuals interested in Returning to Midwifery Practice. Funding for RtP now rests with PCT's and can be accessed through the Work force development team. Encouraging midwives to return to practice is part of the strategy being used by the SHA to increase the midwifery workforce.

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 2007/08 in regard to the discharge of the supervisory function.

- **Trends**

The birth trend shows a consistent rise in the number of women delivered over the last five years. In this reporting year, all but 2 units in EoE have seen an increase in women delivered ranging from 34 – 530 (4.6% rise overall). This is however set against an increase in midwife numbers, (2006/07): 2541 mw, 2007/08: 2639 mw (3.8%) and a commitment by the SHA to further increase the midwifery workforce in the coming year. The consistently rising birth rate has also played a role in the capacity and staffing issues leading to temporary unit closures.

- **Midwife Only Care**

The number of bookings for midwife only care has increased from 41.99% in 06/07 to 49.70% in 07/08, an overall increase of 7.71%. Three units were unable to provide this information but will be collecting the data for 08/09. 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 varies from 75% to 55%, the latter being in a high-risk tertiary centre.

- **Caesarean Section**

2007/08 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. However, in spite of this, the caesarean section rate has risen from 23.28% 06/07 to 24.44% (07/08) an overall increase of 1.16%. 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**

70% of women across the EoE initiate breast feeding and the Primary Care Trusts have a target for increasing breast feeding rates by 2% as part of the public health agenda.

Conclusion

There has been a continued commitment to the role from the SoM, midwives and others within the LSA during the reporting year. 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

The LSAMO will continue to support SoM to exercise leadership within their local service and to actively influence both the local and national agenda relating to maternity services.

Systems to ensure timely collection of accurate data in relation to clinical activity and relevant reporting data will continue to be developed with input from local SoM and taking into account advice and guidance from the NMC.

In view of the increase in the number of supervisory investigations taking place, there will be continued education and support for SoM from the LSA to ensure that the process is robust and protects women and their babies.

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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East of England
Local Supervising Authority (LSA)
Annual Report 2007-2008

2.0 Introduction

2.1 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.

2.2 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.

2.3 The Nursing & Midwifery Council published Midwives Rules and standards in August 2004 which set 54 standards to be met by LSAs and SoM. Rule 16 requires an annual report to be submitted to the NMC and to be made available to the public within the LSA boundaries.

2.3.1 This report follows the guidance set out by the Nursing and Midwifery Council (June 2008) Guidance for Local Supervising Authority (LSA) Annual Report submission to the NMC for practice year 1 April 2007 – 31 March 2008.

2.4 On receipt of the annual report the NMC use a risk scoring framework to assess the non compliance of LSA's with the 54 NMC standards for LSA's. Only three risks were identified by the NMC for the EoE for the reporting year 2006/07, giving a score of 39 in a range of 15 – 193 , following submission of the last report:

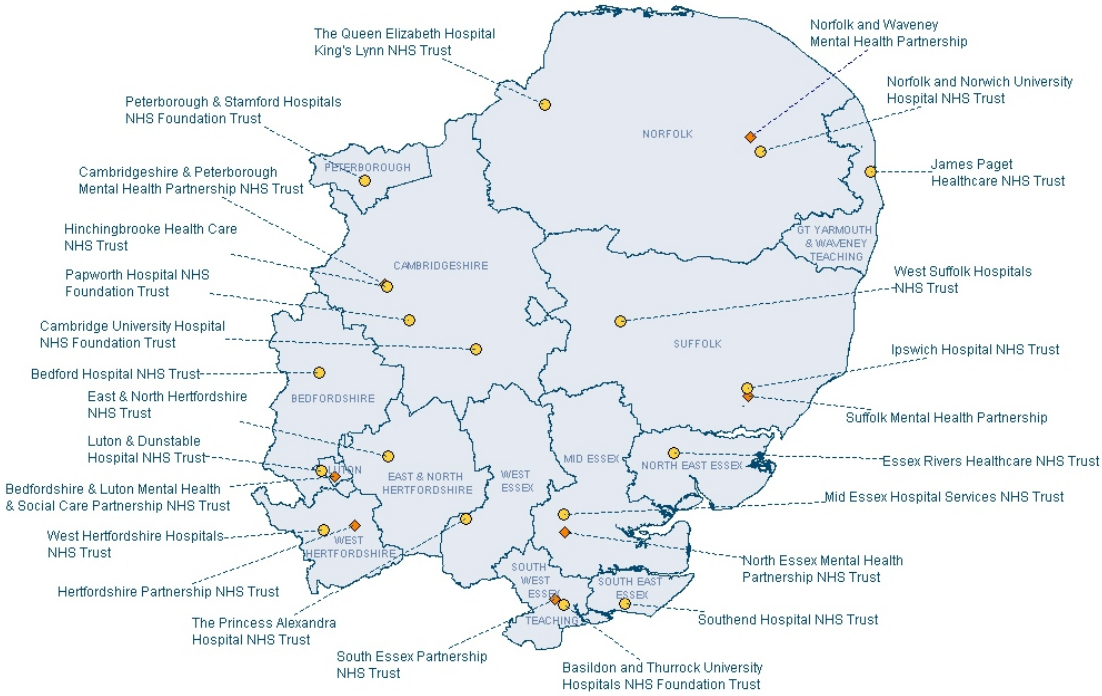
- SoM /Mw ratio above 1:20 within individual services across the LSA
- Public User Involvement in supervision audits not described
- Evidence to suggest increasing births across the LSA of over 5-10% or increase in midwife to birth ratio (Appendix 1).

2.4.1 Significant progress has been made in relation to the identified risks:

- The ratio of Supervisor of Midwives : Midwives has improved, with the average ratio across the EoE meeting the recommendations set by the NMC.
- Births continue to increase in the EoE but there is a recognition and commitment from the SHA that midwife numbers will increase to meet the rising demand.
- Service users are actively encouraged to participate at both a local and LSA level in activities supporting supervision.

2.5 Local Context

2.5.1 Geography



2.5.2 The East of England LSA covers Essex, Bedfordshire, Hertfordshire, Norfolk, Suffolk and Cambridge. There are 250 miles of coastline and four major ports, as well as two international airports. There is a mixture of urban and rural communities, and three significant growth areas: the M11 corridor, the Thames Gateway and the wider Milton Keynes growth area that includes parts of Bedfordshire. The main economic sector is the service industry, but agriculture is very important accounting for 71% of all land use.

2.5.3 There were a total of 67,684 births throughout the EoE during the reporting year. This is an increase of 3,166 on the last reporting year.

2.6 Population

2.6.1 There are about 5.6 million people living in the east of England. The region is relatively affluent; however, there are significant areas of deprivation in the region.

2.6.2 The majority of people in the East of England come from a white ethnic background (92.8%). Of the ethnic minority groups, the most predominant is Asian or Asian British (3.1%). Whilst this makes the East of England one of the least ethnically diverse regions in the country, there are over 400,000 people of non-white origin who live and work in the region. It is expected that this proportion of the population will grow in the coming years (EoE 2008).

2.6.3 Within the population there are specific groups who may have the greatest need of public services including the NHS, but find it difficult to access them. These include migrant workers, Gypsies and Travellers.

2.6.3.1 There is also a small, but significant, group of women who do not access antenatal care until later on in their pregnancy, missing the opportunity to obtain screening and advice and therefore having a higher risk of poor maternal and neonatal outcomes.

2.6.4 There are a significant number of migrant workers in the East of England. Most registered migrant workers are young and intend to stay for less than a year. This provides many challenges for local maternity services including late access to services, lack of information in relevant languages and lack of available interpreters (Maternity Workstream Group 2007)

2.6.5 The East of England has the highest concentration of Gypsies and Travellers in its population, with 25% of English Gypsies and Travellers living in or passing through the region. Those who are pregnant seek healthcare support at a later stage than the average and have higher levels of maternal and infant mortality (CEMACH 2007).

2.7 Public Health Profile

2.7.1 The health of the East of England's population as a whole is relatively good compared to the national average. Life expectancy is an estimate of how long a child born today could expect to live. The life expectancy is above the national average for both men and women. For men it is 78.1 years (national average 77.2 years) and for women it is 82.0 years (national average 81.5 years).

2.8 Future Plans

2.8.1 In the recent publication, *'Towards the best, together - A Clinical Vision for our NHS (East of England), now and for the next decade'*, the SHA set out a number of pledges relating to maternity services including:

- Promotion of normal birth and to guarantee women choice on where to give birth, based on an assessment of safety for mother and baby
- Ensure all 17 Acute Trusts will keep an obstetric unit, with a co-located midwife-led unit
- Guarantee of one-to-one midwifery care in established labour

2.8.2 These pledges have been well received by all concerned with maternity services in the EoE and supervisors of midwives will be key to moving the pledges forward.

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

3.1 This 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
- The public, via the SHA website
- NHS Trust Boards
- Maternity Services Liaison Committees
- Individual service users on request.
- Primary Care Trusts

3.2 The LSA report is forwarded to all Chairs of local MSLC's with an offer for the LSAMO to attend a meeting to discuss the report. This offer is taken up by the 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.

3.3 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. The report can be accessed at http://www.eoe.nhs.uk

3.4 Hard copies of the report have been requested by the East of England Screening co-ordinator and local Trusts for CNST and HCC purposes.

4.0 Numbers of Supervisor of Midwives Appointments, Resignations and Removals

4.1 The nomination process takes place within the Trust with midwives self nominating or being nominated by their peers. They are then interviewed and midwife colleagues provide supporting statements to ensure there is support for their nomination.

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

4.3 The number of midwives within the East of England (EoE) who notified their intention to practice by March 2008 is 2644 with the ratio of supervisors to midwives varying from 1:10 to 1:26. The average ratio across the EoE is 1:15 with 52% of units achieving this ratio.

	05/06	06/07	07/08
Appointments	9	9	15
Resignations	2	6	14
Retirements	0	0	8
Suspensions	0	1	0
Removals	0	0	0

Table 1

4.3.1 14 SoM resigned over the year, 8 of these left the LSA for a substantive role outside of midwifery, 5 stood down from their Supervisory position and 1 resigned due to illness. 8 SOM retired. There are currently 166 SoM within the east of England (*Table 1*).

4.4 Taking into account the 12 SoM waiting to be appointed following successful completion of the preparation course, which commenced in September 2007, the average ratio across EoE will be 1:14 as from August 2008 with 72% of units achieving the 1:15 ratio.

4.5 The SoM : Midwives ratio for the EoE was identified as a risk by the NMC following last years LSA Annual report with only 48% of units able to achieve the 1:15 ratio. However the current average ratio is an improvement on last year and is evidence of the positive action by both SoM and the LSA MO in relation to addressing this issue (*Table 2*).

Trust	1	2	3	4	5	6	7	8	9
No. of SoM	8	7	7	9	12	9	11	13	10
Ratio	1:17	1:16	1:26	1:20	1:13	1:10	1:15	1:12	1:10
Trust	10	11	12	13	14	15	16	17	
No. of SoM	7	16	9	9	14	6	9	10	
Ratio	1:25	1:12	1:15	1:13	1:16	1:25	1:13	1:16	

e 2

4.5.1 There are 21 potential candidates due to be interviewed in July 2008 to commence the preparation course in October 2008. Of these, 6 are from those units who are currently experiencing an ongoing deficit of SoM. This is the highest number of applicants ever received by the LSA (*Table 3*).

Candidates for SOM Course 2008				
Unit	**Revised ratio**	**Deficit**	**Applicants**	**Ongoing deficit**
2	1:16	1	0	1
4	1:20	3	3	0
10	1:22	4	3	1
3	1:20	3	1	2
15	1:25	4	2	2

Table 3

4.6 One of the issues identified in the previous LSA report was that midwives were reluctant to undertake the role of SoM. Midwives cited the Trusts lack of value for the role in terms of:

- Professional leadership
- On-call commitment
- Lack of remuneration

4.6.1 SoMs were frequently used to make up short-falls in staffing numbers caused by historically low staffing establishments and recruitment and retention difficulties. In most units this issue has now been addressed with the implementation of appropriate management on-call systems and improved midwifery staffing levels.

4.6.2 SoMs now report that inappropriate calls to the on-call SoM have decreased and that they are only being called into the unit to provide hands on care in extreme circumstances. Further work continues in those units where there is no management on-call system and where staffing levels remain low.

4.7. Proactive measures are being taken by the current SoM to sustain the ratio of supervisors to midwives. The value of the role is being actively promoted and midwives are encouraged to consider being nominated for selection for the role.

4.7.1 Nominees are supported in their studies with study time and course expenses paid. Support is also given from other supervisors with their studies and they are allocated a supervisor of midwife as mentor during that period. When appointed by the LSA the new SoM are supernumerary in the role for the first three months when they shadow and are supported by an experienced SoMs.

4.8 SoM in all of the Trusts, where they receive no remuneration for the role of SoM, have written papers to their Directors of Nursing and Trust Boards in relation to this issue but there are still 9 Trusts where remuneration is not provided.

4.8.1 A good model for remuneration has been adopted by one Trust who remunerate their SoM by awarding them £100 per midwife per SoM to the value of £1500 (the NMC recommended ratio for SoM:MW) This model also works pro rata for those SoM who have a smaller caseload. The SoM are also paid for being on - call and expenses such as travelling and telephone calls. This model is being promoted as the preferred model which should be adopted for all Trusts across the LSA.

4.8.2 Adopting this model for remuneration would amount to a total spend of £ 264,400 across the EoE (excluding on-call and expense payments).

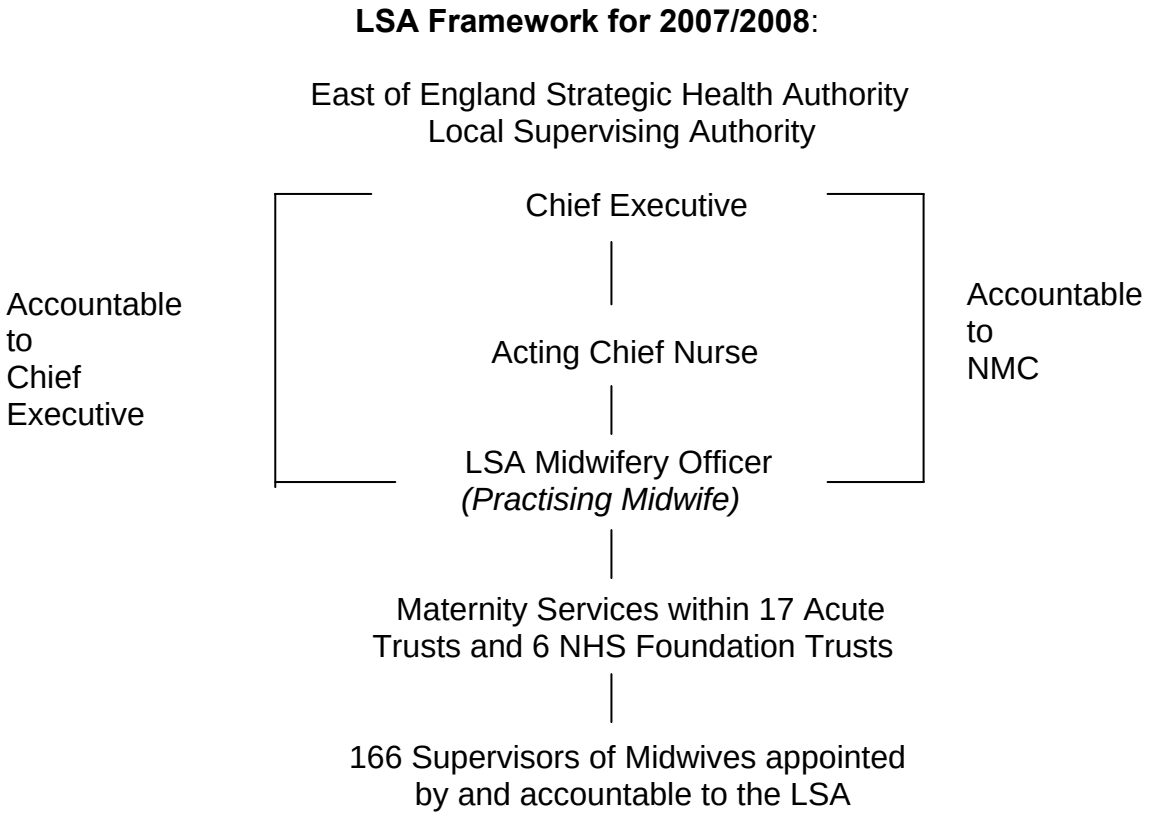
4.9 A study undertaken in 2005 (Mead & Kirby 2005) demonstrated that SoM were spending on average one day per week on supervision. This applied whether they worked part time or full time.

4.9.1 Even though time to undertake the role has been agreed by all but one Trust, due to workload the majority of supervisors continue to 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 who struggle to prioritise their supervisory role with the needs of the service.

4.9.2 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. Where supervision cannot be provided midwives cannot practice and this clearly has implications for the continuation of maternity services.

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

5.1 Framework for Statutory Supervision within EoE



5.2 Midwives are required to notify their intention to practise in the following twelve months by the 31 March each year. In March 2008, 2644 midwives completed Intention to Practice forms in the EoE LSA. This is 103 more than in 2007. These notifications were sent electronically to the NMC by mid April 2007.

5.2.1 In accordance with the NMC standards the LSA maintains a database of midwives practising within its boundaries and submits any new intention to practice to the NMC each week.

5.2.3 The LSA is responsible for the supervision of all midwives within its geographical boundary, including those working in the private sector, agencies, independent practice and prisons. This means that the midwives held on the database include those midwives working outside of the NHS.

5.3 All midwives within the LSA are able to choose their named Supervisor of Midwives. The SoM agree the number of supervisees for each SoM based on current workload, hours worked and other commitments.

5.3.1 Below are some examples of good practice used in the Trusts in the EoE to raise the profile of the SoM:

- 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.
- 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.
- All midwives are reminded regularly that they have the option to change their Supervisor at any time.
- All student midwives are allocated a Supervisor of Midwives (SoM) during their training. They are then given the opportunity to remain with their allocated SoM upon qualifying as a Midwife or to change to another SoM.
- When midwives join the organisation they have a tailored orientation programme which includes attendance at mandatory study days. Supervision is a mandatory session. They are also allocated to a Supervisor and introduced. It is preferred practice for the new midwife and Supervisor to meet in the orientation period.
- Supervisors also wear identification on their name badges so that midwives can approach opportunistically. Photographs of SOMs for identification purposes are on the notice board.
- If any Supervisor of Midwives takes maternity leave, the caseload of that Supervisor is temporarily re-allocated to ensure all midwives have a named supervisor of midwives at all times. The names of the Supervisors and area of practice are held within all clinical areas.

5.4 Contacting a Supervisor of Midwives

5.4.1 Midwives can contact their own or any other SoM for information, advice and support when required through a variety of methods including:

- All usual forms of communication: telephone, mobile phone, e-mail, in person and by mail. Contact details are also available throughout the switchboard and delivery suite for all SoMs. SoM participate in a 24 hour on-call rota which ensures that midwives have continual access to a supervisor.
- Supervisors within the unit have their status as a supervisor annotated on their security/name badge.
- Midwives are able to access any supervisor directly if they do not wish to or are unable to contact their named supervisor.

5.4.2 All the above meet the requirements of the guidance outlined in Rule12 of the Midwives rules and standards (NMC2004).

5.5 Auditing Access

5.5.1 The systems in place are audited by both the LSA through the LSA audit process and evidenced by speaking to midwives during the audit visit. Examples of good practice are:

- Failure to contact the on-call Supervisor is audited through the incident reporting system.
- Calls to Supervisors of Midwives are recorded and then discussed at Supervisor of Midwives meeting.
- A spread sheet has been added to the supervisors shared drive to add details of all contacts when on-call for information and audit purposes.
- Individual SoM keep a record of the reasons that they have been contacted for supervisory issues (including when they are on call) on a proforma and these are discussed at the monthly meetings as a way of auditing supervisory practice within the Unit.

5.5.2 In the last year only one unit identified one incident where a Supervisor on call was not contactable due to an error on the rota. Another Supervisor was successfully contacted. All SoMs are aware of the need to maintain an accurate on call rota.

6.0 Details of How the Practice of Midwifery is Supervised

6.1 Process for Effective Supervision - Eligibility to Practice

6.1.1 Within the EoE each midwife completes an Intention to Practice Form on an annual basis which are signed by the midwife's named SoM before being entered on to the LSA data base. The ITP information forms part of the midwives eligibility to practice and contains information relating to PREP and the annual supervisory review.

6.1.2 All SoMs across the EoE are now using the database for electronic recording of the ITP information. The information is then uploaded to the LSA and then on to the NMC.

6.2 Supervisory Reviews

6.2.1 Each Midwife has a nominated Supervisor of Midwives and they are required to meet at least once a year, at which time an annual review is undertaken. This is an opportunity for the Supervisor to enable the midwife to identify any learning or practice needs. Following discussion with the Supervisor, a plan is made to enable the midwife to work towards her personal and professional needs. The SoM is able to discuss training opportunities, both mandatory and other available opportunities, including Obstetrics Study Day and Drills and Skills which will enable professional development.

6.2.2 The annual supervisory review is an opportunity to audit, with midwives, one or more sets of their own documentation for discussion and reflection purposes. During the review Supervisors encourage midwives to reflect on a case they have been involved in which helps to promote positive professional development and safety of the maternity service. This evidence builds part of the midwives professional portfolio and competencies and provides evidence of continuous professional development.

6.2.3 Many units use a standard review form which covers the 3 year registration period. The document is used to record the content of the review and has triggers for discussion. This enables the midwife and Supervisor to review study for PREP requirements as well as the achievement of the previous year's practice objectives. The form is partially completed by the midwife prior to the meeting.

6.2.4 Some SoM also maintain an annual review "reminder list" that is updated frequently; this includes issues to discuss with the midwives such as new guidelines and audit topics, including record keeping audit. The review forms are regularly reviewed by the Supervisors to ensure they are relevant and pertinent to practice.

6.2.5 Follow-up meetings, to ensure issues raised during Supervision interviews are addressed, are also undertaken by a number of SoM.

6.2.6 It is anticipated that all SoM across the EoE will be using the LSA database by September 2008 to record annual reviews. This ensures complete confidentiality of the information and allows the midwife to access a copy of the review form electronically.

6.2.7 The LSA Audit demonstrated that 92% of midwives had received a Supervisory review within the last 12 months, with some units achieving as high as 98% uptake. Some of the reasons given by those supervisors who did not achieve 100% were:

- Increased supervisory and practice workload
- Midwife on long term sick leave or maternity leave
- Failure by the midwife to attend despite encouragement.

6.2.8 Those midwives who did not receive an annual review have been identified by their named SoM and are being followed up on an individual basis. The importance and value of the supervisory review has been reiterated to both SoM and midwives with the intention of achieving 100% attendance.

6.3 Strategy for Supervision

6.3.1 All SoM teams have produced a supervision strategy which outlines the objectives to be achieved in relation to supervision. The strategies cover a three year period and are regular standing agenda items at the local SoM meetings.

6.3.2 The strategies are also developed to reflect the evidence of achievement of the LSA standards. The strategies are widely distributed throughout the Trust including midwives and other key stakeholders.

6.4 Communication and Dissemination of Information – The Role of the Contact Supervisor of Midwives

6.4.1 Each unit has an identified Contact Supervisor of Midwives (CSOM) who acts as a conduit between the supervisor of midwives within the Trust, the LSA, and other appropriate agencies. Information sent by the LSA is forwarded onto individual Supervisor of Midwives via the e-mail system. Relevant documentation needing further discussion and action is placed on the agenda for the monthly Supervisor of Midwives meeting.

6.4.2 The role of the CSOM is rotated through all members of the supervisory team for varying lengths of time ranging from three months to one year. In some units the CSOM produces a monthly report for the senior staff meeting which is then disseminated to all clinical areas.

6.4.3 Regular communication takes place between supervisors within the East of England Trusts and is often utilised to share best practice and for benchmarking purposes. Opportunities for networking takes place across the LSA at learning opportunities and study days.

6.4.4 All supervisory teams produce an annual report which is distributed to a wide audience including Supervisor of Midwives, LSA, MSLC, Chief Executive and Director of Nursing / Governance. Copies are also displayed on the Supervisor of Midwives notice board.

6.4.5 There are supervision boards which SoM use as a means of communication with both midwives and service users. The boards include photographs of local SoM to help identification by both midwives and women and the minutes of the monthly meetings, minus any confidential information. NMC information documents are also available to staff and the public.

6.5 Communication with Midwives

6.5.1 Methods of communication with midwives by SoM are on an individual basis at annual supervisory reviews, SoM facilitated reflective forums and by email. SoM also contribute to a Supervision of Midwives page in newsletters produced within the maternity department. The newsletters are also used by SoM to promote new guidelines.

6.5.2 Supervisors facilitate, on a rotational basis 'drop-in' or 'Supervision Surgeries'. All new midwives as part of their induction are allocated to attend one of these sessions to be informed of the process of supervision and how to access it.

6.6 SoM Local Meetings

6.6.1 All supervisory teams hold regular monthly meetings where all business related to supervision is discussed, with many using a pre-formatted agenda which demonstrates compliance with the LSA standards and provides a focus for the meetings.

6.6.2 The meetings are generally well attended with some units achieving a 99% attendance rate throughout the year. The chair of the meetings rotates through all the members of the SoM team and provides a learning opportunity for those SoM who may not have had much experience of chairing meetings. All SoM have an opportunity to contribute to the agenda prior to the meeting

6.6.3 Any specific problem areas or practice issues are highlighted, with action plans formulated where action needs to be taken. There is an opportunity for SoM to feed back from meetings that they have attended as a supervisor representative.

6.6.4 In some Trusts there are a designated number of meetings a year attended by invited guests such as the General Manager, Risk Manager, Education Representative, Practice Development Midwife, Practice Educator Midwife and Director of Nursing. This enables the SoM to engage with a wider audience to promote and discuss supervision issues.

6.6.5 The LSAMO has a standing invitation to all local SoM meetings and attends at least one meeting per quarter. This gives the opportunity for the LSAMO to provide updates on topical supervision issues, to disseminate strategic information and to provide advice and support to the SoM.

6.6.6 Notes and action points made at meetings are circulated to all Supervisors of Midwives and the LSAMO

6.7 Consistent Approach to Supervisory Functions

6.7.1 The development of the LSA Standards for supervision have been a major influence in ensuring that all SoM have a clear picture of what is expected from them in terms of their role. Compliance with the standards is audited by the LSA.

6.7.2 The use of one Supervisory Review form within units helps to ensure that all midwives are asked the same questions in relation to practice to ensure there is a consistent approach to supervisory systems.

6.7.3 A set meeting agenda template ensures all areas of supervision are discussed at monthly meetings and minutes and actions are accurately recorded.

6.7.4 A meeting record pro forma has also been developed by a SoM within the LSA and is used by many of the units to record notes of the local meetings. The form enables easy identification of actions, by whom, and when, and allows actioned items to be removed.

6.8 Challenges to Effective Supervision

6.8.1 The success of supervision in most Trusts relies on the commitment of the supervisors many of whom are unable to obtain protected time to fulfil the duties and have to 'fit it in' around their substantive post. While all but one of the Trusts has agreed allocated time for supervision (usually one day a month), it is increasingly problematic for the SoM to take the time away from clinical and managerial commitments. This appears to be particularly difficult for clinically based SoM who are unable to be released from their clinical commitments.

6.8.2 In those units where protected time has been agreed the SoM have been encouraged to identify the time for supervision as a priority and to ensure it is taken.

6.8.3 The Trust cited in 6.8.1 is the only unit in the EoE where protected time has not been agreed. Support is being provided by the LSAMO to enable SoM to obtain protected time for supervision

6.8.4 The supervisor to midwife ratio within the 28% of units that do not achieve the 1:15 recommended by the NMC provides a challenge to effective supervision.

6.8.5 Proactive measures are being taken by the current SoM to sustain the ratio of supervisors to midwives. The value of the role is being actively promoted and midwives are encouraged to consider being nominated for selection for the role.

6.8.6 The increasing birth rate has led to an increase of the midwife to birth ratio which in some units is as high as 1:42. This has proved to be a challenge in providing effective supervision. Midwives are providing care not only to an increasing number of women but also for caseloads of increasing complexity and risk.

6.8.7 Two of the pledges of the EoE SHA in relation to maternity services are:

- Promotion of normal birth and to guarantee women choice on where to give birth, based on an assessment of safety for mother and baby
- Guarantee of one-to-one midwifery care in established labour

In order to achieve the above there is a commitment by the SHA to work with local health communities to increase the number of midwives to achieve a midwife to birth ratio of 1:30 across the EoE. This proposal has been welcomed by all involved in maternity services across the SHA.

6.9. Risk Management

6.9.1 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.

6.9.2 The risk manager reports trends and areas of concern to the group of supervisors at each monthly meeting. Supervisors take a proactive approach using evidential research to evaluate risk and plan how to provide best care.

6.9.3 In the event of a midwife being involved in a clinical incident her supervisor is informed through the risk manager and a review of the incident will take place. Learning needs may be identified and the supervisor will monitor and evaluate progress.

6.9.4 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.

6.9.5 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.

6.9.6 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.

6.9.7 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 happening are the workshops on shoulder dystocia and waterbirth, both identified as potential risks in practice.

6.10 Audit

6.10.1 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.

6.11 Skills Development

6.11.1 SoMs participate in the organisation and delivery of mandatory updating sessions, ensuring all midwives attend regularly, recording their attendance. They have also been key in leading 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.

6.11.2 All Trusts have now developed training packages to 'up-date' midwives and medical staff understanding and interpretation of 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 anonymous.

6.11.3 Issues arising from annual reviews are discussed at the monthly SOM meetings and help to inform education planning advice for the Practice Development Midwife and Head of Midwifery. Many units have developed a database of all midwives' educational profiles which is updated annually.

6.11.4 Each SoM has a role in educating Midwives through teaching at practice level or through education at mandatory in house study days. The SoMs act as effective role models to Midwives and are a valued learning resource

6.11.5 One Trust provides a one year preceptorship programme, facilitated by the Practice Development Midwives for newly qualified midwives. During this time they work towards achieving their competencies supported by the Supervisor of Midwives.

6.12 Quality

6.12.1 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.

6.12.2 SoMs take an active part in various forums which inform 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.
- Control of Infection as a representative for the Maternity Department.
- Children's Commissioning Forum
- Perinatal Mortality/Morbidity meetings
- Daily Labour Ward reflective reviews
- Safeguarding Children Forum
- Joint Education Forum with local Universities
- Home Birth Reviews

6.12.3 Increased participation at various forums has enabled Supervisors of Midwives to become more influential in the strategic vision for shaping local maternity care.

6.12.4 Some supervisors also undertake birth afterthoughts sessions with women and their partner, this provides valuable insight into how user groups view standards within the unit.

6.12.5 One unit has developed a communication letter sent to women informing them about Supervision and the role of the SOM, advising them of the SOM contact details for those women who choose to have their maternity care provided by an independent midwife.

6.12.6 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.

6.12.7 SoMs are able to offer support to midwives who may be supporting women in difficult circumstances such as the woman who requests a waterbirth at home during a Vaginal Birth After Caesarean (VBAC). Supporting midwives to enable women to make informed choices in relation to place of birth, particularly those women with medical or previous obstetric complications who have chosen to give birth at home, the role of the SoM is to support the midwives by ensuring that an action plan is in place to ensure that transfer and emergency care is appropriate and timely.

6.12.8 Supervisors in most instances lead on the development of evidence-based policies and guidelines. Groups may be midwife specific or multidisciplinary.

6.12.9 In one Trust as a result of clinical incident reporting two specific guidelines were developed with by Supervisors of Midwives. These were the Antenatal Care Policy and the Validation and Communication of Blood Results. These guidelines have supported midwifery practice and ensured a consistent and safe approach by staff.

6.13 Governance

6.13.1 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 Trust's clinical governance strategies and, where this is not the case, is clearly identified in directorate/division strategies.

6.13.2 In most Trusts there is a Clinical governance newsletter every month and there is a section of this news letter to provide specific information to midwives pertinent to supervision and changes to practice.

6.14 Reflection opportunities

6.14.1 The LSA audit identified that many midwives did not have the opportunity to attend reflective sessions or to be facilitated in using reflection as a means of learning. However, SoM have been proactive in developing opportunities for reflection which are available by a variety of means.

6.14.2 One team of SoMs have developed a reflection form which is available in all the clinical areas. Midwives and student midwives are encouraged to utilise these as a method of reflection for practice issues and are then encouraged to discuss these with the supervisor either at the time or at annual reviews.

6.14.3 In another unit a designated supervisor organises reflection and support group meetings for all new starters to inform them about supervision and the many ways it can used for support and in practice.

6.14.4 Supervisors of Midwives in almost all units facilitate reflective reviews with groups of midwives following critical incidents.

6.15 External Networks that Support Women and Enhance Practice

6.15.1 A rise in the number of babies on the Child Protection Register (particularly in Essex and Norfolk) has encouraged SoM to forge strong links with local Social Services Departments.

6.15.2 Many SoM have established links with the Lead Nurses within local Primary Care Groups and other primary care agencies to which the maternity services relate, such as the Community Mental Health Team and Sure Start. Much has been achieved in relation to health promotion issues directly affecting maternity services, e.g. smoking cessation, teenage pregnancy, postnatal depression and mental health.

6.15.3 Education for midwives regarding domestic violence is in place, in line with the National Service Framework for Maternity Services. In this way supervision is able to promote the needs of pregnant women in the development of health improvement programmes.

6.15.3 Following several recent documents highlighting the rising body mass index (BMI) in pregnant women, one of the Supervisors of Midwives has taken the lead, in conjunction with one of the anaesthetists, to hold a regular BMI clinic where all relevant issues are discussed.

7.0 Evidence that service users have been involved in monitoring supervision of midwives and assisting the Local Supervising Authority Midwifery Officer with the annual audits.

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

7.1.2 The LSA and SoM locally will continue to encourage users to participate in LSA 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.

7.1.3 SoMs 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 included in the hand held records and 'Bounty' books.

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

8.0 Evidence of engagement with Higher Education Institutions (HEI's) in relation to supervisory input into midwifery education.

8.1 The LSAMO and SoMs 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.

8.1.1 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.

8.2 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.

8.3 The Preparation Course for Supervisors of Midwives is currently 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.

8.3.1 The course is continually evaluated and changed to meet the changing demands on SoM. The course has successfully been reviewed, with the focus on ensuring that potential SoM are enabled to meet the proficiencies for SoM prescribed by the NMC (NMC 2006).

8.3.2 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.

8.4 Funding for RtP now rests with PCT's and can be accessed through the Workforce development team. Encouraging midwives to return to practice is part of the strategy being used by the SHA to increase the midwifery workforce. Over the time period of the report the LSA office had 24 enquiries from individuals interested in Returning to Midwifery Practice. Table 4 shows the number of midwives currently employed following successful completion of a return to practice course.

Year	Enquiries	Completed Course	Currently Employed
2006/2007	28	n/k	n/k
2007/2008	24	3	2

Table 4

8.4.1 Speculative enquiries are forwarded to HoM and the Lead Midwife for Education at the relevant HEI. However, feedback from local HoM indicates that the numbers of RtP midwives are small with difficulties surrounding mentorship and support in practice. There is also reluctance amongst HoM to provide support for return to practice midwives when they are unable to offer those midwives jobs upon successful completion of a return to practice programme.

8.4.2 This issue will be partially addressed through the pledge, by the SHA, to increase substantially the midwifery workforce over the coming year.

8.5 Ongoing Education for SoM

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

Learning Opportunity	Number Attending
Normal Birth Study Day	23
Good Practice Midwifery Conference	2
Sharing Good Practice	21
West Herts Supervisors Away Day	12
RCM Supervisors Conference	1
Witness Familiarisation Skills Course	46
Saving Mother's Lives (CEMACH one day course)	1
MSc Course - contribution towards costs	1
PG Certificate in Supervision of Midwifery Practice (University of Herts) Sept-June	13
Promoting Normality Study Day	8
Auditing Practices to Support Breastfeeding Course	1
In-House Delivery of Breastfeeding Information	1
Carrying out an Investigation	20

Table 5

8.5.2 Increasingly the SoM are asking for access to the Witness Familiarisation Skills Course. This is provided to enable them to have an understanding of the process following referral of a midwife to the NMC. The course has evaluated well and the SoM report that they have felt more confident and prepared when called to attend at an NMC hearing. New opportunities will be offered in the coming year based on the identified needs of the SoM.

9.0 Details of any new policies related to the supervision of midwives

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

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

9.1.2 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.

9.2 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 review is an ongoing process and all SoM receive both electronic and paper versions of new guidelines.

9.3 Both National and local guidelines are available on the SHA website at www.eoe.nhs.uk. A list of both national and local guidelines can be found in **Appendix II**.

10.0 Maternal Death

10.1 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 postnatally.

10.1.1 There were 15 maternal deaths reported to the LSA throughout the EoE during the reporting year. Table 6 shows the classification of the deaths. There is no significant rise in the direct maternal deaths across the EoE.

Year	2003/ 2004	2004/ 2005	2005/ 2006	2006/ 2007	2007/ 2008
Direct	1	1	3	2	3
Indirect	4	4	2	10	10
Unknown	3	3	2	2	2
Total	8	8	7	14	15

Table 6

10.1.2 The reporting and investigation of the deaths are 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 & Child Health (CEMACH). Causes of direct maternal death in the EoE included suicide, thromboembolism and heart failure. Causes of indirect maternal death include road traffic accidents and deaths relating to pre existing conditions such as cancer.

10.1.3 A review of the process for reporting and recording maternal death in the EoE was undertaken by the LSA and the patient safety team. While the reporting mechanism for those maternal deaths that occurred within a maternity department was robust, this was not the case for deaths that occurred outside of maternity services. The review identified the need to ensure that all maternal deaths, wherever they occur, should be reported through the LSA. This is now reflected in the most recent guidelines issued by the SHA.

10.2 Birthrate Trends

Unit	2003	2004	2005	2006	2007	2008	Trend
Basildon	3694	3996	4040	4063	4257	**4424**	↑**167**
Bedford	2819	2876	3035	3010	2947	**3123**	↑**176**
Colchester	3248	3321	3508	3516	3694	**3858**	↑**164**
E&N Herts	5075	5173	5094	5301	5309	**5839**	↑**530**
Hinchingbrooke	2181	2222	2202	2199	2363	**2706**	↑**343**
Ipswich	3456	3625	3536	3616	3704	**3806**	↑**102**
James Paget	2132	2062	2076	2050	2209	**2243**	↑ **34**
King's Lynn	2019	2112	2030	2145	2229	**2289**	↑ **60**
Luton & Dunstable	4407	4555	4513	4728	4780	**5127**	↑**347**
Mid Essex	3570	3540	3835	3767	3882	**4265**	↑**383**
N&NUH	4801	5121	5055	5324	5455	**5600**	↑**145**
Peterborough	3427	3538	3494	3505	3760	**3895**	↑**135**
Princess A H	2797	2787	2822	3013	3252	**3596**	↑**344**
Rosie	4801	4898	4990	5020	5119	**5219**	↑**100**
Southend	3488	3500	3486	3532	3768	**3738**	↓ **30**
West Herts	5396	5266	5265	5186	5254	**5328**	↑ **74**
West Suffolk	2431	2477	2483	2416	2623	**2593**	↓ **30**
Total women delivered	59,771	61,171	61,651	62,737	64,133	**67,649**	
Total rise/fall	**1,324** ↑	**1,400** ↑	**480** ↑	**1,086** ↑	**1,396** ↑	**3,516**↑	

Table 7

10.2.1 The birth trend (Table 7) shows a consistent rise in the number of women delivered over the last six years. All but two of the units in EoE have seen an increase in women delivered ranging from 34 – 530 in the reporting year. This is a 4.6% increase on last year and for some units has contributed to the number of capacity issues resulting in temporary unit closures.

10.3 Unit Closures

10.3.1 Data relating to the temporary closure of maternity units has been entered onto the LSA database by SoM. However, this was a new data collection method for many of the Trusts this year and the quality of the data may not be as robust as expected.

10.3.2 Temporary unit closures may mean that a unit is closed for anytime between 1 - 24 hours and most often relates to capacity and staffing issues. Capacity and staffing are linked in that if the unit is full, delivery suite require more staff. At night there are limits to where these staff can be acquired from and may, therefore, account for more closures overnight.

10.3.3 There were 24 reported unit closures and 3 suspensions of the home birth service during the reporting period with one unit closing 17 times for a total of 78 hours overall.

10.4 Clinical Activity

10.4.1 Some of the challenges for the Maternity Services and Supervisors of Midwives are to increase the initiation of breastfeeding, reduce the Caesarean Section rate and assist pregnant women with smoking cessation.

10.4.2 The number of bookings for midwife only care has increased from 41.99% in 06/07 to 49.70% in 07/08, an overall increase of 7.71%. Three units were unable to provide this information but will be collecting it for 08/09. 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.

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

10.4.4 A number of units continue to experience a rise in the number of 3rd degree and 4th degree tears. A possible explanation for the rise may be better diagnosis of serious tears. This trend continues to be monitored and audited by SoM to ensure that this is not related to poor practice.

10.5 2007/08 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. However in spite of this the caesarean section rate has risen from 23.28% 06/07 to 24.44% 07/08, an overall increase of 1.16%. 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.

10.5.1 Supervisors are monitoring the Vaginal Birth After Caesarean Section Rates (VBAC) and the number of women achieving VBAC is increasing in units where this service is offered. This may contribute to a reduction in the caesarean section rate over time.

10.5.2 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 caesarean section rate remains 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.

10.6 Public Health Issues

10.6.1 All units are reporting an increase in the number of women with complex health issues accessing the maternity services. These include women who are clinically obese (BMI greater than 35), domestic violence and women with medical problems such as diabetes. Overall there has been a decrease in the number of teenage pregnancies although the number remains high.

10.6.2 Many units are seeing an increase in the number of children on the Child Protection Register with the need to put in place special measures to support these vulnerable families. There have been a number of recent appointments of Specialist Midwives for Vulnerable Women and Safeguarding Children to address the needs of specific groups of service users including teenagers, substance mis-users and women with serious mental health issues.

10.6.3 There are local areas of deprivation and midwifery input into Children's Centres is key to supporting vulnerable women and their families. The Children's Centres are used for clinics which make's for a homely atmosphere as well as providing direct links to other agencies that are based there.

10.6.5 70% of women across the EoE initiate breastfeeding. 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.

10.6.6 A number of innovative practices have been developed by SoM, in relation to the public health agenda, within the EoE.

- One stop clinic – combined booking, antenatal and post natal clinic with appointments to reduce waiting times.
- Post natal clinic held in the Family Planning Clinic (FPC). Reduction in teenage pregnancy already noticed.
- Proposed pre-conception clinic in FPC to address public health challenges found in areas of health inequalities- i.e. sexual health, diet, smoking, obesity. This will follow early intervention model in partnership with other agencies.
- Rewritten maternity notes to be more woman-centred and less medicalised.
- Advice for women on optimal fetal positioning.
- Antenatal workshops normality focused that aim to prepare the birthing partner for their important role in improving rates of normality.
- Environmental changes to the Central Delivery Suite – birthing rooms, waterbirth room.
- Mechanism of labour and ways to encourage normality on mandatory study days for midwives facilitated by a Supervisor.

10.7 Migrant population

10.7.1 There has been an increase in the migrant population with many units reporting a substantial number of women accessing services, although currently the definitive figure is not available. This has resulted in a number of challenges for units.

- Increasing numbers of late bookings and un-booked women
- Cascade of information to women becoming more difficult due to the volume of information needing to be given to women and the difficulty in accessing interpreter services
- An increased number of non-English speakers, asylum seekers and the need for an increased use of interpreting services.

10.7.2 The impact of this is particularly high in antenatal services. Difficulty in communication, (language barriers and cultural differences) has led to migrant women, unused to the provision of antenatal care, failing to access this service at the appropriate time.

10.8 Home Birth

10.8.1 The National home births rate is currently 2% (HCC 2008). The rate for the EoE is almost double the national average, at 3.8% (the same figure that we reported in 06/07). However, some units have struggled to maintain the home birth service at times of increased clinical activity in the delivery suite. Most units have also seen an increase in the number of primigravid women requesting home birth. This has resulted in an increase in the number of transfers in labour as might be expected.

10.8.2 There has also been an increased presence, in the last year, of Independent midwives working in the area. This has resulted in an understanding of how they work and improved communications with consultant units and Supervisors of Midwives.

10.9 Methods of Data Collection

10.9.1 All but three maternity units (where statistics and other data is still collected manually) are supported by maternity information systems such as Protos, CMIS and Istell. Those units who do not currently have access to a maternity system are being encouraged to work with the Connecting for Health Team to determine their service needs.

10.9.2 However Units report that the data collected often conflicts with Coding and HES data collected by the Trust. There is a significant amount of work still to be undertaken to resolve these issues, to recognise the work completed within maternity to achieve recommended practice outcomes and meet the PbR tariff.

10.9.3 Where monthly statistics are collected they are discussed at Supervisor of Midwives meeting and trends and implications for practice reviewed. CEMACH data is collected by the Maternity Services CEMACH Co-ordinator and forwarded to the Regional Office in Cambridge. The annual CEMACH report is received by the Head of Midwifery and discussed at Supervisors Meeting as well as in the wider Clinical Governance agenda within the Maternity Services.

10.9.4 The format for the annual reports completed by local SoM and submitted to the LSA, is based on the format specified for the LSA by the NMC. This ensures that accurate data is included in the LSA report to the NMC.

11.0 Details of the number of complaints regarding the discharge of the supervisory function

11.1 No complaints were received by the LSA in the year 2007/08 in regard to the discharge of the supervisory function.

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

11.3 Complaints against a SoM would be dealt with in accordance with the National Guidelines 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.

11.3.1 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.

12.0 Reports on all Local Supervising Authority investigations undertaken during the year

12.1 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.

12.2 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.

12.3 Supervisors of midwives carried out nine investigations into serious untoward incidents in the year 2007/08. This is a significant increase on the previous reporting year. No LSA investigations were carried out during the same year.

12.4 Seven midwives have undertaken periods of supervised practice, (complying with NMC (2007) Standards for Supervised Practice Programmes) 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.

12.4.1 Poor record keeping, communication and planning and delivery of care featured in almost all of 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.

12.4.2 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 beyond those midwives involved directly in the incident.

12.4.3 The LSA arranged a study day for Supervisors to share good practice relating to 'Supervisory Investigations'. This gave the opportunity for Supervisors who had been involved in investigations to share their experiences of what worked well, what could have been done better and to reflect on the different roles the Supervisor may be required to take; investigator, support supervisor, facilitator and academic support. Other issues discussed included confidentiality; support for colleagues involved in the investigation and those being investigated.

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

12.6 One midwife has been referred to the NMC by the LSAMO during this reporting year.

13.0 Conclusion

13.1 There has been a continued commitment to the role from the SoM, midwives and others within the LSA during the reporting year. 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.

13.3 The LSAMO will continue to support SoM to exercise leadership within their local service and to actively influence both the local and national agenda relating to maternity services.

13.4 Systems to ensure timely collection of accurate data in relation to clinical activity and relevant reporting data will continue to be developed with input from local SoM and taking into account advice and guidance from the NMC.

13.5 In view of the increase in the number of supervisory investigations taking place, there will be continued education and support for SoM from the LSA to ensure that the process is robust and protects women and their babies.

13.6 Maternity Services, along with the Health Service in general, grow year on year 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**.**

References

Nursing and Midwifery Council (June 2008) Guidance for Local Supervising Authority (LSA) Annual Report submission to the NMC for practice year 1 April 2007 – 31 March 2008.

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Institute for Innovation and Improvement (2007) Developing Quality and Value. Pathways to success. A self Improvement toolkit. Focus on Normal Birth and Reducing the Caesarean Section Rate. University of Warwick. Coventry.

DH (2005) National Service Framework for Children, Young People and Maternity.

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APPENDIX I

LSA Profile

LSA		**East of England**	**Chief Executive**		**Neil McKay** **neil.mckay@eoe.nhs.uk**		
LSAMO		**Joy Kirby**	**LSA Midwifery Officer**		**joy.kirby@eoe.nhs.uk** **01223 597568**		
Ref	**Date**	**Summary of concern / information**	**Source**	**Risk**	**Risk score**		
					Likehood	**Impact**	**Overall**
		SoM/MW ratio above 1:20 within individual services or across the LSA.		**Elements of supervisory framework unachievable or unsustainable due to lack of supervisors.**	**3**	**4**	**12** AMBER
		Public User Involvement in supervision audits not described		**Lack of user input into development of supervisory framework. Risk in meeting rules and standards.**	**4**	**3**	**12** AMBER
		Evidence to suggest increasing births across the LSA of over 5-10% or increase in midwife to birth ratio.		**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 II

Guidelines for Supervisors of Midwives East of England

Contents

Appendix III

National Guidelines (England) for Supervisors of Midwives

Contents

Nursing & Midwifery Council
NMC

Sara Howlett
East of England LSA Office
East of England Strategic Health Authority
Victoria House
Capital Park
FULBOURN
Cambs CB21 5XB
Sent via e-mail

26.09 2008

Ref: East England
Direct line: 020 7333 6530
Email: susan.way@nmc-uk.org

Dear Sara.

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