East of England

Local Supervising Authority

Annual Report to the Nursing and Midwifery Council

1 April 2008 – 31 March 2009

Joy Kirby
LSA Midwifery Officer
East of England

September 2009

Contents Page

East of England
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 report follows the guidance set out by the Nursing and Midwifery Council (NMC) – Guidance for Local Supervising Authority Annual Report submission to the Nursing & Midwifery Council (NMC) for practice year 1 April 2008 – 31 March 2009. The report is submitted to the NMC in fulfilment of Rule 16 of the NMC Rules and standards.

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.

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. As of 31st March 2009, 2832 Intention to Practice forms were uploaded onto the LSA database (2644 in 07/08).This is a 3.2% rise from 2008.These notifications were sent electronically to the NMC in mid April 2009 as required.

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 184 Supervisors of Midwives (SoMs) currently appointed within the east of England LSA. This is an increase of 9.7% on 07/08. The average SoM to midwife ratio across the east of England is 1:15. SoMs 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 student midwives. 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, Cardiotocograph(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.

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's and also through the SHA reporting process (NMC 2004).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 review of guidelines which support practice.

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 13 maternal deaths throughout the East of England LSA during the reporting year (15 in 2007/08). There is no significant rise in the direct maternal deaths across the east of England. 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 Centre for Maternal and Child Enquiries (CEMACE). The cause of direct maternal death in the east of England included overwhelming infection and embolism.

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 midwifery programmes 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 25 enquiries from individuals interested in Returning to Midwifery Practice (RtP). Encouraging and supporting midwives to return to practice is an important part of the SHA strategy for increasing the midwifery workforce. The Workforce development team have reviewed the funding for RtP in order to support returnees and to encourage Trusts to support practice placements.

Sharing good practice is encouraged through ongoing learning opportunities funded by the LSA. 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, Accountability, and Excellence in report and statement writing.

Complaints

No complaints were received by the LSA in the year 2008/09 in regard to the discharge of the supervisory function.

Trends

The EoE vision document; *Towards the best, together* (E0E2009) sets out a clinical vision for Maternity and Newborn Care in the East of England including a set of key proposals for delivery by 2011. Maternity Matters forms one element of the Maternity and Newborn Clinical Programme Board implementation plan. SoM will be key to influencing local services to ensure that they reflect the recommendations identified in *Towards the best, together*.

The birth trend shows an overall rise in the number of women delivered over the last five years (8336). In this reporting year, all but 2 units in the east of England have seen an increase in women delivered ranging from 5 – 380, a 2.4% rise overall (4.6% in 07/08). This is however set against an increase in midwife numbers of 154 full time equivalents and a commitment by the SHA to further increase the midwifery workforce in the coming year.

Midwife Only Care

The number of births conducted by midwives varies from 75% to 55% and has remained static for the last three years. To enhance midwife led births, the east of England has proposed that there will be a co-located Midwife Led Birthing Unit (MLBU) in each acute Trust by 2011. Currently 47% of Trusts have co-located midwife led birthing units, with the remaining Trusts developing plans for future implementation. The SHA milestones for delivery for provider Trusts to have a co-

located midwife led birthing unit is 25% by September 2009, 50% by June 2010 and 75% by March 2011.

Caesarean Section

The caesarean section rate in units across the EoE stands at 24.52%. This is against a rate of 23.0% in 06/07 and 24.0% in 07/08. The reduction of the caesarean section rate is included in the performance framework and the target for the east of England for 09/10 is 23.4%.

LSA Priorities for 2009/2010

The priorities identified for the LSA for the year 2009-10 will be:

- Working with local SoM to ensure all Trusts meet the SoM:Mw ratio of 1:15
- Encourage and support SoMs to ensure that protected time to undertake the role is taken
- To link more closely with commissioners of maternity services to continually improve the quality and safety of maternity services in the east of England
- Enhance the quality assurance of SoM in east of England
- Provide support and education for SoM in relation to undertaking supervisory investigations and completing reports to ensure that the process is robust and protects women and their babies
- To provide further analysis of outcomes of investigations to ensure learning takes place across the east of England
- To continue to implement strategies which encourage more engagement with women and users in the work of the LSA.

Conclusion

Statutory supervision of midwives has operated in the UK for over 100 years and is now an integral part of clinical governance for maternity services. Effective use of the supervisory framework leads to improvements in standards of care and better outcomes for women and their babies. It has developed into a modern regulatory system and is a means by which midwives are supported in practice.

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.

Joy Kirby
LSA Midwifery Officer
NHS East of England
Victoria House
Capital Park
Fulbourn
Cambridge CB1 5XB
Tel: 01223 597 568
e-mail: joy.kirby@eoe.nhs.uk

Sir Neil McKay
Chief Executive
NHS East of England
Victoria House
Capital Park
Fulbourn
Cambridge CB1 5XB
Tel: 01223 597 500
e-mail: neil.mckay@eoe.nhs.uk

1.0 INTRODUCTION

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

1.2 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.

1.3 The Nursing & Midwifery Council (NMC) published Midwives Rules and standards in August 2004 which set 54 standards to be met by LSA's 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. The report demonstrates the ways in which the LSAMO and Supervisors of Midwives have monitored the practice of midwives and the environment of care.

1.3.1 This report follows the format set out by the Nursing and Midwifery Council (January 2009) Guidance for Local Supervising Authority (LSA) Annual Report submission to the NMC for practice year 1 April 2008 – 31 March 2009.

1.4 On receipt of the annual report the NMC use a risk scoring framework to assess the compliance of LSA's with the 54 NMC standards for LSA's. Three risks were identified by the NMC for the East of England (EoE) for the reporting year 2007/08, giving a score of 39, in a range of 0 – 185 (0 low) which is consistent with the majority of the LSA's across England. Following submission of the last report the identified risks were:

- SoM /Midwife (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

1.4.1 The identified risks have been the focus of the work of the LSAMO in this reporting year and progress has been made:

- The ratio of SoM:Mw has improved with the average ratio across the EoE now meeting the 1:15 recommendation set by the NMC. 70% of individual Trusts also meet the ratio as against 52% last year.
- The number of births in the east of England has increased by 2.4% on last year. The commitment from the SHA that midwife numbers will increase to meet the rising demand has resulted in an increase of 154 full time equivalents. The EoE SHA also met its Department of Health targets in terms of increasing midwife numbers.
- Service users continue to be actively encouraged to participate at both a local and LSA level in activities supporting supervision.

1.5 Local Context

1.5.1 Geography

1.5.2 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.

1.5.3 There were a total of 69,507 births throughout the east of England during the reporting year. This is an increase of 1683 (2.4%) on the last reporting year.

1.6 Population

1.6.1 There are around 5.6 million people living in the east of England. The region is relatively affluent; however, there are significant areas of deprivation (*Towards the best, together* E0E 2009).

1.6.2 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 2009).

1.6.3 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.

1.6.3.1 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.

1.6.4 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 access to services, providing information in relevant languages and availability of interpretation services (Maternity Workstream Group 2007).

1.6.5 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).

1.7 Public Health Profile

1.7.1 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) (EoE 2008).

1.8 Future Plans

1.8.1 *'Towards the best, together - A Clinical Vision for our NHS (East of England), now and for the next decade'* (2009), remains the guiding vision of the SHA and there are 11 pledges. A number of pledges relating to maternity services are incorporated in the document 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 and recruit the necessary number of additional midwives to do this.

1.8.2 Other related maternity indicators include: 80% of women by 2009/10 having their first appointment with maternity services by the twelfth completed week of pregnancy (an existing vital sign), a reduction in caesarean section rates of 2% per annum unless set by PCT Commissioners, an increase in breastfeeding initiation rates and breastfeeding prevalence rates at 6-8 weeks

by 2% year on year (national target for breastfeeding initiation) and smoking at time of delivery.

1.8.3 A Maternity and Neonatal Clinical Programme Board (CPB) has been established in the last year and work to implement the TTBT pledges and Maternity Matters is well under way. Supervisors of Midwives have been key to moving this work forward.

1.8.4 The LSAMO has been the Chair of the Quality sub group of the CPB and a number of quality metrics have been developed relating to maternity services. Trusts are monitored through the performance framework on the metrics which relate to the key indicators of Maternity Matters, TTBT and the other maternity indicators.

1.8.5 A monitoring tool has been developed by the LSAMO to assist maternity commissioners in measuring 1:1 care in labour. The tool has been rolled out across the East of England to provide a benchmark for all maternity units in relation to this vital quality indicator.

2.0 EACH LOCAL SUPERVISING AUTHORITY WILL ENSURE THEIR REPORT IS MADE AVAILABLE TO THE PUBLIC

2.1 This report has been agreed by the Chief Executive of the NHS East of England and will be distributed as follows:

- Nursing & Midwifery Council by 30 September 2009
- East of England SHA Board
- NHS East of England Staff through intranet
- The public, via the SHA website
- East of England NHS Trusts, PCT's and Foundation Trusts
- East of England Maternity Services Liaison Committees (MSLC's)
- Organisations such as the National Childbirth Trust (locally)
- Individual service users on request
- Leads for Midwifery Education and HEI Resource centres
- Maternity Services Commissioning group
- Maternity and Newborn Clinical Programme Board
- East of England Directors of Nursing, Heads of Midwifery, Supervisors of Midwives and Commissioning managers

2.2 A hard copy of the LSA report is forwarded to all Chairs of local Maternity Services Liaison Committees (MSLCs) with an offer for the LSAMO to attend a meeting to discuss the report. This offer was taken up by 70% of the MSLCs following last years report. 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.

2.3 400 hard copies of last years report were published and were sent to Chief Executives , Directors of Nursing and commissioning managers in all acute and Primary Care Trusts in the east of England. Chief Executives of Mental Health Trusts will be added to this years circulation list . A copy of the report was also sent to individual SoM and made available in HEI libraries. Midwives

undergoing the Preparation course for SoM were provided with hard copies as part of the course reading material.

2.3.1 Further copies of the report have been requested by local Trusts for CNST purposes.

2.4 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

3.0 NUMBERS OF SUPERVISOR OF MIDWIVES APPOINTMENTS, RESIGNATIONS AND REMOVALS

3.1 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.

3.2 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.

3.3 The number of Notifications of Intention to practice received by the LSA as of 31st March 2009 was 2832 which is an increase of 3.2% on the previous reporting year. There are currently 184 SoM within the east of England which is an increase of 9.7% with the ratio of supervisors to midwives varying from 1:8 to 1:28.

3.3.1 Six SoM's resigned over the year and all but 1 left for a substantive midwifery role outside of the east of England. The LSAMO resigned as a SoM following a circular from the NMC 06/2008 which stated that there was a need to clearly delineate the differences in roles and responsibility between SoM's and LSAMOs. To this end, all LSAMOs ceased acting as supervisors of midwives from 31 March 2008. One SoM took a leave of absence for a year as she had other commitments outside of her substantive post and felt she would be unable to undertake her supervisory role in its fullest sense. A leave of absence is often facilitated to enable a SoM to return to the role rather than resign completely. (Table 1).

	05/06	06/07	07/08	08/09
Appointments	9	9	15	12
Resignations	2	6	14	6
Retirements	0	0	8	10
Suspensions	0	1	0	0
Leave of Absence	0	0	0	1
Total SoM			**166**	**184**

Table 1 (Information relating to total number of SoM EoE prior to 07/08 is not available)

3.4 Following last years LSA Annual report, despite the significant improvement in the SoM: Mw ratio this was still identified as a risk by the Nursing &

Midwifery Council. 70% of Trusts now achieve the 1:15 ratio which is an improvement on last year (52%) and is evidence of the positive action by both SoM and the LSAMO in relation to addressing this issue (*Table 2*).

Table 2: **Ratio of SoM : Mw by Trust**

Trust	1	2	3	4	5	6	7	8	9
No of MW	153	112	166	154	233	101	141	103	103
No. of SoM	11	4	11	11	16	8	15	12	8
Ratio	1:14	1:28	1:15	1:14	1:14	1:12	1:9	1:8	1:13

Trust	10	11	12	13	14	15	16	17
No of MW	185	210	147	131	247	139	94	192
No. of SoM	9	18	8	10	16	7	9	11
Ratio	1:20	1:12	1:18	1:13	1:15	1:19	1:10	1:17

3.5 The east of England has made a significant commitment to developing midwifery leadership. To facilitate this a programme has been designed to develop leadership skills for all Heads of Midwifery and Consultant Midwives and 70 Supervisors of Midwives across the region.

3.5.1 The programme will provide a holistic approach to developing the leaders of tomorrow and is comprised of four key elements; master classes, modules, action learning sets and one to one coaching, coupled with an acute understanding of individual and organisational needs.

3.5.2 A cohort of 20 SoM will begin a specifically designed programme in November 2009 with the aims and objectives for programme being:

Aims

- To increase the performance of supervisors and enhance their development as leaders now and in the future

Objectives

- To enable supervisors to be effective, visible leaders and team members who can support and facilitate change at all levels and sustain a safe high quality service for women
- To be role models and provide clinical and professional leadership
- To demonstrate the contribution that good midwifery supervision can provide to safe practice
- To enable supervisors to be champions of good practice and to use their networks to disseminate best practice

3.6 The numbers of applicants for the SoM preparation course continues to rise with 24 potential candidates (21 in the last reporting year) due to commence the preparation course in October 2009. Of these, 8 are from those units who

are currently experiencing an ongoing deficit of SoM (Table 3). One midwife who deferred from the 2008 cohort for personal reasons has automatically been offered a place for this year.

Table 3

Candidates for SoM Course 2009				
Unit	**Ratio**	**Deficit**	**Applicants**	**Ongoing deficit**
2	1:28	3	1	2
10	1:20	3	2 + I deferral	0
12	1:18	2	1	1
15	1:19	2	2	0
17	1:17	2	2	0

3.7 In order to address the ongoing deficit in some units, the SoM are being encouraged to take proactive measures to improve the ratio of supervisors to midwives. The value of the role is being actively promoted and midwives are encouraged and supported to undertake nomination for the role. These discussions often take place during supervisory reviews and at Trust mandatory training days.

3.7.1 Workforce planning for SOM is a permanent fixture on the agenda at each SOM monthly meeting and is evidenced by entries in the Action Logs completed at each meeting.

3.7.2 In Mid Essex Hospital Services NHS Trust reflective articles are to be completed by the two most recently appointed SOMs and the current student SOM for the Maternity Newsletter and the Trust staff Focus (MEHT Intranet) to publicise the course from the student SOM's perspective.
Other innovations and examples of good practice relating to recruiting SoM will be shared across the east of England via the supervisory network.

3.7.3 Nominees for the preparation programme 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 midwives 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 SoM.

3.7.4 Where there remains an ongoing deficit, discussions are taking place to explore other options such as the potential of those SoM who have retired working for the Trust purely for supervision.

3.7.5 A further short term measure being explored is cross boundary supervision. However this has met with some resistance from SoM given the complexity of maternity services and the possible unplanned physical presence of a SoM being required when they are unfamiliar with the service.

3.8 A preferred model for remuneration has been supported by the SHA and all Trusts are being encouraged to adopt the model. Discussions with Directors of Nursing in both Acute Trusts and PCT's have taken place and maternity services commissioners have also been made aware of and are supportive of

this issue. There now remains only 2 Trusts where remuneration is not provided. These Trusts have been asked by the Chief Nurse for EoE to provide plans for how the SoM: Mw ratio can be improved including the issue of remuneration and time to undertake the role. Local SoM will continue to be supported by the LSA MO to develop robust strategies to encourage more midwives to undertake the role.

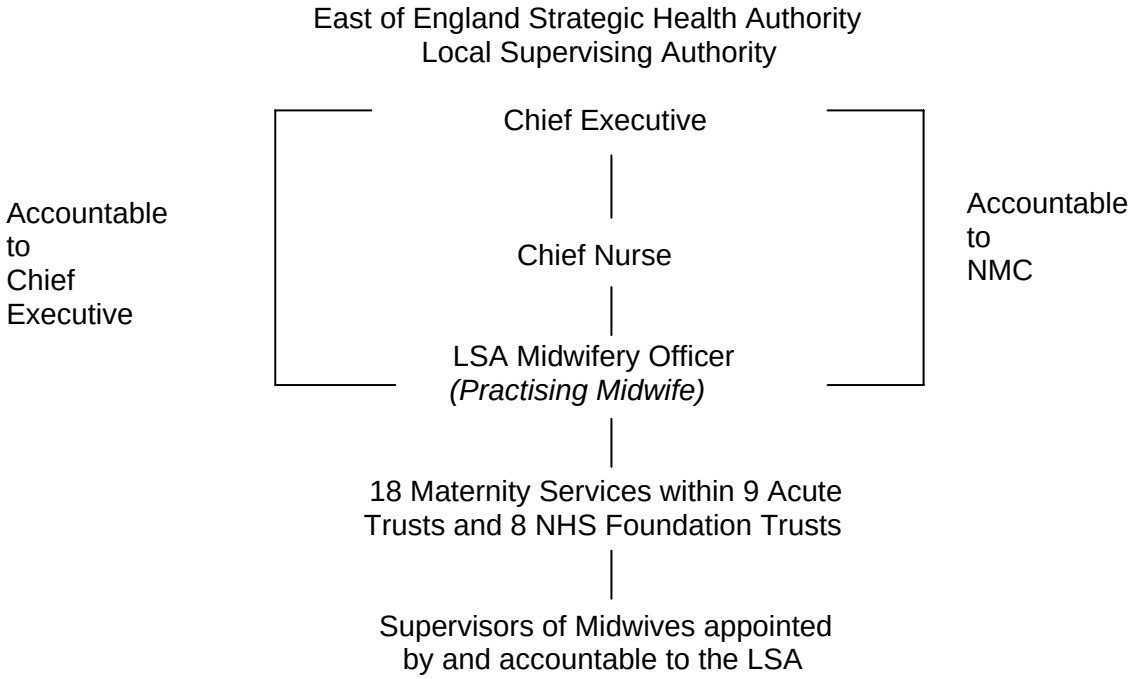
3.8.1 Time to undertake the role remains problematic even though this has been agreed. Due to workload the majority of supervisors continue to find it difficult to set aside time to carry out their supervisory duties, and this appears to be more difficult for clinically based SoM who struggle to prioritise their supervisory role with the needs of the service. The preferred remuneration model recommends that SoM are allocated time to undertake the role and that their substantive post is backfilled. It is anticipated that this will help to address the issue.

3.9 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.

4.0 DETAILS OF HOW MIDWIVES ARE PROVIDED WITH CONTINUOUS ACCESS TO A SUPERVISOR OF MIDWIVES.

4.1 Framework for Statutory Supervision within EoE

LSA Framework for 2008/2009:



4.2 Midwives are required to notify their intention to practice (ITP) in the following twelve months by the 31 March each year. In March 2009, 2832 midwives completed ITP forms in the EoE LSA. This is 3.2% more than in 2008. These notifications were sent electronically to the NMC by mid April 2009.

4.2.1 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. The number of ITP's held on the database will not be equal to the number of midwives employed by NHS Trusts as the data base includes those midwives working outside of the NHS but within the east of England. As of 31st March 2009 the number of ITP's received where the midwife identified her main area of practice as an NHS Trust within the east of England were 2451. ITPs were also received from 101 midwives working outside of NHS Trusts within the east of England.

4.2.2 Expansion of the LSA database has been ongoing throughout the year and a common core of information has been agreed by all LSA. The ability to be able to track midwives from one United Kingdom Country to another or from one LSA to another will enhance public protection and provide a quicker and more efficient communication network in circumstances where speed is essential. The LSA Co-ordinator for the east of England is currently a member of the Database national steering group.

4.2.3 The LSA is responsible for the supervision of all midwives within its geographical boundary, regardless of their employment status. This includes those working in the private sector, agencies, independent practice, GP practices and prisons. Midwives working outside of the NHS all have a named SoM and have equal access to supervision as those employed in the NHS.

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

4.3.1 Below are some examples of good practice used in the Trusts in the east of England to raise the profile of the SoM:

- Supervisors of Midwives are chosen by a ballot process. Each midwife is sent a nomination form with the names of the supervisors of midwives available. They then have a 1st, 2nd and 3rd choice of supervisor. If the midwives do not return their completed ballot form they are then allocated an appropriate supervisor
- All midwives are regularly reminded in the Supervision page of the maternity newsletter that they have the option to change their Supervisor at any time
- 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 there is space in the supervisors caseload
- All midwives are reminded regularly that they have the option to change their Supervisor at any time
- All student midwives are allocated a SoM who contributes to their professional development. In the practice areas students have access to SoMs in the same way as midwives. 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
- A number of units now have posters which have the photos all of the SoM on them and are displayed throughout the clinical and public areas. This helps women and others to recognise and access SoM. Supervisors also wear identification on their name badges so that midwives can approach opportunistically

Contacting a Supervisor of Midwives

4.4 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.
- Each midwife is given the mobile telephone number and Trust e-mail of their named Supervisor. These are usually recorded on the midwife's Annual Review Form. The midwife is also made aware of their named Supervisor's regular pattern of off duty as required. Some S0M are equipped with long range pagers and mobile phones.
- Midwives are able to access any Supervisor directly if they do not wish to, or are unable to, contact their named Supervisor.
- In West Herts NHS Trust an audit of supervisory activity of 5 SoM was undertaken during one week in November 2008.This showed that SoM spent a total of 2 hours discussing issues pertinent to midwives practice and 10 hours providing support for midwives. It is the intention of the team to repeat this audit three times a year.

4.4.1 All the above meet the requirements of the guidance outlined in Rule12 of the Midwives Rules and Standards (NMC2004).

4.5 Auditing Access

4.5.1 The systems in place are audited by the LSA through the LSA audit process . Examples of good practice are:

- Failure to contact the on-call Supervisor is audited through the incident reporting system.
- Calls to SoM are logged 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.
- Each SOM maintains a personal log of all contacts made with midwives or women, within their role of SOM. This provides documentation of date and

time of contact, who made the contact, reason for contact, advice given and action taken. There is a "call pad" available for SOMs to use.

- "Issues arising from on-calls" is an agenda item for the monthly SOM meeting. This presents the opportunity to discuss on-call contacts, discuss actions taken and explore different ways of handling situations in a safe and confidential environment. This provides a way of auditing on-call contact responses and is a valuable learning opportunity to members of the SOM team.

4.5.2 In the last year no units identified incidents where a Supervisor on call was not contactable. All SoMs are aware of the need to audit this on an ongoing basis.

5.0 DETAILS OF HOW THE PRACTICE OF MIDWIFERY IS SUPERVISED

5.1 Process for Effective Supervision - Eligibility to Practice

5.1.1 Within the east of England each midwife completes an Intention to Practice Form (ITP) on an annual basis which is signed by the midwife's named SoM confirming that a supervisory review has taken place during the year, 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 post–registration education and practice (PREP) and the annual supervisory review. The LSA audit process ensures that robust systems are in place for confirming the eligibility of midwives to practice prior to them working in the maternity services.

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

5.2 Supervisory Reviews

5.2.1 Each Midwife has a named SoM whom 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 Obstetric Study Days and Drills and Skills which involve practical scenarios for serious midwifery and obstetric emergencies, which aid professional development.

5.2.2 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.

5.2.3 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.

5.2.4 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.

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

5.2.6 The LSA continues to work towards all SoM using the electronic database for recording the annual review. Currently 50% of SoM use the database to record annual reviews with the remaining 50% continuing to use a paper based version. The aim is to achieve 100% of SoM using the database. This will encourage equity across the LSA and aid less experienced SoM in the review process. It also ensures complete confidentiality of the information and allows the midwife to access a copy of the review form electronically.

5.2.7 The LSA Audit demonstrated that 86% of midwives had received a Supervisory review within the last 12 months (92% last year), with 77% of SoM achieving 100%. 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.

5.2.8 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.

5.3 Strategy for Supervision

5.3.1 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.

5.3.2 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. The strategies are also accessible to the public on the Trust web sites.

5.3.3 Action plans related to the strategies and annual report are developed by all supervisory teams to ensure that supervision moves forward.

5.4 Communication and Dissemination of Information

5.4.1 Communication between LSA Midwifery Officers continues on a UK national basis with meetings held regularly over the year. Supervisory practice is shared and common challenges discussed and support and solutions offered. The forum is regularly accessed in an advisory capacity by national external bodies such as Centre for Maternal and Child Enquiries, National Patient Safety Agency, Care Quality Commission, Department of Health, Royal College of Midwives and Nursing & Midwifery Council.

5.4.2 Meetings take place regularly with the DH Midwifery Advisor, the HoM at the NMC and President of the RCM. This wider forum allows the opportunity to discuss a broad range of professional issues which affect all of the UK countries.

The Role of the Contact Supervisor of Midwives

5.4.3 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.

5.4.4 National guidelines for the role of the CSOM have been developed and it recommends that the role is rotated through all members of the supervisory team. This is to ensure equity of workload but is also a good learning opportunity which should be available to all SoM. The role is undertaken 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.

5.4.5 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 which are offered on a monthly basis and the supervisors annual meeting where each supervisory team is encouraged to share at least one supervisory innovation. This day is very well attended by over half of the SoM across the East of England and evaluates very well.

5.4.6 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 acute and PCT and Chief Nurse NHS EoE. Copies are also displayed on the Supervisor of Midwives notice board and made available on Trusts intranet and via the Internet.

5.4.7 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.

5.5 Communication with Midwives

5.5.1 Methods of communication with midwives by SoM are on an individual basis at annual supervisory reviews, SoM facilitated reflective forums and by email. SoM 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.

5.5.2 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.

5.5.3 Other methods of communication with midwives include:

- SoM slot on annual midwives updating day
- SoM feedback during staff meetings
- SoM provide support in an advocate role in meetings

5.6 SoM Local Meetings

5.6.1 All supervisory teams hold regular monthly meetings where 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.

5.6.2 The meetings are well attended with SoM achieving between a 75% -100% 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

5.6.3 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, sharing good practice.

5.6.4 At the Luton & Dunstable NHS Trust 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. Confidential issues relating to practice are discussed in a closed section of the meetings.

5.6.5 The LSAMO has a standing invitation to all local SoM meetings and attends at least one meeting in each Unit 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.

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

5.7 Consistent Approach to Supervisory Functions

5.7.1 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.

5.7.2 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.

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

5.7.4 A meeting record pro forma has also been developed by a SoM within the LSA and all of the units are encouraged to use this to record notes of the local meetings. The format enables easy identification of actions, by whom, and when, and allows actioned items to be removed.

5.8 Challenges to Effective Supervision

5.8.1 The success of supervision relies on the commitment of the supervisors and this is recognised and valued by the LSA. Supervisory teams have been supported by the LSAMO to ensure that dedicated time to undertake their supervisory duties has been agreed in all Trusts. However taking the time remains problematic for some SoM and this appears to be particularly difficult for clinically based SoM who are regularly unable to be released from their clinical commitments.

5.8.2 SoM have been encouraged to identify the time for supervision as a priority and to ensure it is taken. The recommended model for remuneration identifies that SoM should be 'back filled' to enable them to have time to undertake the role effectively and this may be of benefit in ensuring the time for supervision is taken.

5.8.3 The supervisor to midwife ratio within the 30% of Trusts that do not achieve the 1:15 recommended by the NMC provides a challenge to effective supervision.

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

5.8.5 Three of the pledges of the east of England 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.
- Ensure all 17 Acute Trusts will keep an obstetric unit, with a co-located midwife-led unit.

In order to achieve the above there is a commitment by the SHA to work with local health communities to employ the correct number of midwives to achieve the pledges. Much work has been undertaken towards achieving this role and will continue in the coming year.

Examples of how supervision of midwives protects the public.

5.9 Risk Management

5.9.1 All Maternity units have a robust risk management strategy in place, which in 65% of Trusts is led by a midwife. 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.

5.9.2 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.

5.9.3 In the event of a midwife being involved in a clinical incident their supervisor is informed through a number of routes including the risk management process and a review of the incident will take place. Learning needs may be identified and the supervisor will monitor and evaluate progress.

5.9.4 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.

5.9.5 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.

5.9.6 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 happening are the workshops on shoulder dystocia and massive Post Partum Haemorrhage both identified as potential risks in practice.

5.9.7 SoM at Bedford NHS Trust hospital have been key to the unit being an Early adopter site to reduce the LSCS rate and a pilot site for the introduction of the NPSA Intrapartum Score card. The feedback from the pilot sites will inform practice across the UK.

5.9.8 At the Rosie Maternity Hospital the on-call SoM contacts the Midwifery bleep holder of the day to discuss any untoward incidents that have occurred in the preceding 24 hours. This helps to ensure that SoM are aware of clinical incidents that have occurred, to be proactive in commencing a supervisory investigation should one be required and to offer support to any of their supervisees that may have been involved in the incident. This model will be encouraged for all supervisory teams across the East of England.

5.10 Audit

5.10.1 Audit of practice is widely accepted as part of the supervisor's role and the active involvement of supervisors and midwives in audit has continued to improve. Supervisors have presented the following audits at multidisciplinary audit sessions:

- Stillbirths
- record keeping
- skin to skin
- caesarean section
- 3 degree tears
- Breast feeding

The audit process has resulted in changes to practice and revision of clinical guidelines.

5.11 Skills Development

5.11.1 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.

5.11.2 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.

5.11.3 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.

5.11.4 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 SoMs.

5.12 Quality

5.12.1 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**.**

5.12.2 SoMs are leaders and experts in ensuring that best practice environments are sustained. They take an active part in various forums which also inform education and practice and ensure 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

5.12.3 Increased participation at various forums has enabled SoM to become more influential in the strategic vision for shaping local maternity care.

5.12.4 Some supervisors also undertake birth afterthoughts sessions with women and their partners; this provides valuable insight into how users view standards within the unit.

5.12.5 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 .This has proved very helpful for those women who choose to have their maternity care provided by an independent midwife.

5.12.6 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.

5.12.7 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 can be challenging. The role of the SoM is to support the midwives by developing an action plan to ensure that transfer and emergency care, should it be needed is appropriate and timely.

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

5.12.9 In one Trust, as a result of clinical incident reporting, two specific guidelines were developed 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.

5.13 Governance

5.13.1 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.

5.13.2 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.

5.14 Reflection opportunities

5.14.1 SoM have been proactive in developing new opportunities for reflective practice have been created by SoM which are available by a variety of means.

5.14.2 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.

5.14.3 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.

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

5.15 External Networks that Support Women and Enhance Practice

5.15.1 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.

5.15.2 Many SoM have established links with the Lead Nurses within local Primary Care Trusts 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.

5.15.3 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.

5.15.4 Following several recent documents highlighting the rising body mass index (BMI) in pregnant women, one Supervisors of Midwives has taken the lead, in conjunction with an anaesthetist, in holding a regular BMI clinic where all relevant issues relating to the risks for pregnant women are discussed. In view of the risks surrounding raised BMI and pregnancy this model will be promoted throughout the LSA.

6.0 EVIDENCE THAT SERVICE USERS HAVE BEEN INVOLVED IN MONITORING SUPERVISION OF MIDWIVES AND ASSISTING THE LOCAL SUPERVISING AUTHORITY MIDWIFERY OFFICER WITH THE ANNUAL AUDITS.

6.1.1 Service user involvement and increasing public awareness of the role of supervision in protecting the public happens in both the LSA and other health organisations.

6.1.2 Gaining user involvement in the work of the LSA has been a priority for the LSAMO during the reporting year. Despite a more proactive approach the response has not been encouraging. Information about the East of England LSA is on the SHA website and further work is underway to include information about how users can contribute to the work of the LSA.

6.1.3 Contacts with users on local MSLC's have proved positive although to date none have been available to participate in the LSA audit process. However, local MSLC users were asked to review the findings of the LSA audit particularly Standard 1 which relates to Women Centred Services. Their feedback was valuable in ensuring the report reflected the views of local women.

6.2 A user was also invited as a member of the selection panel for midwives undertaking the Preparation of SoM programme. This was evaluated very positively by both the midwives and the user.

6.3 SoMs have been engaged to encourage wider user participation in other groups such as labour ward forums and guideline development groups.

6.3.1 User representation on the Maternity and Neonatal Clinical Programme Board has been facilitated and supported in order to ensure that the work of the board reflects the views of women and their families.

6.4 SoM have also developed a number of ways to raise the profile of supervision with users and the public. These include:

West Suffolk

- Lay members of the MSLC have attended the east of England recruitment day and the NHS Innovation Adopter Site Forum
- Presently Supervisors of Midwives are involved in the Trusts "Your Shoes" initiative which involves lay members of the public voicing their experience within hospital. The aim is to improve service provision by viewing from the eyes of the user

West Herts

- A SOM has developed a leaflet about Supervision of Midwifery for users of maternity services detailing the role of SOM and how women can contact them. This is also available via the Trust website

Peterborough

- Contact details for SoM's are on hand held records

Harlow

- User members of the bereavement group are actively involved with developing maternity guidelines, policies and leaflets. They also speak on the bereavement study day offered at the Trust
- Supervisors of Midwives are working closely with local Primary Care Trusts (PCT's) to attend out-reach clinics and forums in the community setting to actively recruit members for the MSLC and to gain service user's views on and needs of the maternity services

Ipswich

- Chair of MSLC spent 3 days in the Maternity Unit at the hospital, observing and asking users for comments about the service
- MSLC involved in collating user surveys and producing action plans

Basildon

- The Patient and Public Involvement Forum (PPI) also have regular contact with Maternity Services and the Chair of the MSLC is a member of the PPI Forum

Hinchingbrooke

- MSLC consulted on Service user tracker, which is a tool to gauge patient experience and satisfaction
- Financial remuneration given to users to enable them to actively participate in local forums and conferences and finance provided for childcare, travel etc
- Presentation of HCC users survey to MSLC resulting in joint action planning and identified areas for audit over the following year

East & North Herts

- Service Users were invited to participate in the reconfiguration of the maternity services at East and North Herts. This included attending the design meeting for the New Midwifery Led Unit and Consultant Led Unit
- There has been a local media campaign to encourage more service user members to participate in MSLC meetings. This successful MSLC recruitment day was attended by a SoM

Southend

- Users involved on the 'Pathways to Success' reducing the caesarean section rate multidisciplinary meetings
- 'Blog' on website for service users to leave their comments

James Paget

- Complaints received through Complaints Service and the Patient Advice and Liaison Service (PALS) Feed back to the complainant includes measures taken through supervision to prevent reoccurrence

Bedford

- Users have been invited and attended Clinical Audit and Effectiveness meetings and have contributed to the Reducing Caesarean Section Initiative which is being led by a Supervisor of Midwives
- The bedside directory has details of the function of Supervision

Cambridge

- The profile of supervision has been raised by displaying large posters around the Trust with photographs of all current SoM and the LSAMO. The poster briefly details the role of the Supervisor and how to contact them if required

6.1.2 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 enables the views of these women to directly influence services. This is a model which is proving effective and is encouraged throughout the LSA.

6.1.3 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.

7.0 EVIDENCE OF ENGAGEMENT WITH HIGHER EDUCATION INSTITUTIONS (HEI'S) IN RELATION TO SUPERVISORY INPUT INTO MIDWIFERY EDUCATION.

7.1.1 There are three Universities that provide midwifery Education within the east of England**:**

- Anglia Ruskin University
- University of East Anglia
- University of Hertfordshire

7.1.2 All three Universities have midwifery and education strategy groups . The membership is made up of the Lead Midwives for Education (LME's), Heads of Midwifery, Lecturer Practitioners, SoM and the LSAMO. This forum provide a valuable opportunity to think and plan strategically the future education and development of midwives and students. It also ensures that there is a recognised forum where SoM can ensure that the clinical learning environments are enhanced.

7.1.3 The LSAMO and SoMs work closely with the HEIs 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. The feedback from the sessions are that it enables student midwives to have a clearer view of how supervision relates to everyday midwifery practice and the benefits of supervision in clinical situations in the practice environment

7.1.4 Other examples of how SoM are involved in aspects of HEI activity are:

- Curriculum development and planning teams
- Validation of midwifery programmes of education
- Selection panels for prospective students
- Midwifery education and examination boards

- Liaising with midwifery lecturers' to ensure that issues identified by supervisors are reflected in changes in education programmes.

All of the activities undertaken by SoM in relation to the HEI's ensure that supervision is not seen in isolation but is a continual thread throughout the midwifery educational programmes.

7.1.5 All Units have identified a local SoM who acts as a link for the students to access 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.

7.1.6 A small number of units have provided student midwives the opportunity to have a named SoM. The student may then choose to stay with that SoM on qualifying or may change. However, this model only works well where SoM have caseloads smaller than the recommended 1:15

7.2 The LSAMO has input into the post registration education programmes particularly in modules concerning advancing midwifery practice, clinical governance and risk management. The University of Hertfordshire offers a Legal & Ethical Study day to student midwives, student nurses and student SoM , on an annual basis The LSAMO has presented a session on the Statutory framework and professional conduct for the last three years. This has evaluated very well.

7.3 The Preparation Course for Supervisors of Midwives is currently offered at the University of Hertfordshire. The Preparation course team are active participants in the selection process for student SoM and ensure that students receive the appropriate support during the programme to enable them to meet the proficiencies for SoM prescribed by the NMC (NMC 2006).

7.3.1 The LSAMO is an active member of both the curriculum planning team and course management team. The course continues to be evaluated and developed to meet the changing demands on SoM. Feedback from students is an essential part of the review and this has helped to ensure that on completion of the programme SoM are appointed that are fit for purpose.

7.3.2 Each student undertaking the preparation programme has a SoM mentor. The mentors are invited to a half day workshop which enables them 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. The mentors for student SoM all meet the standards for 'sign-off' mentors prescribed by the NMC

7.4 Encouraging and supporting midwives to return to practice is an important part of the SHA strategy for increasing the midwifery workforce. The Workforce development team have reviewed the funding for RtP and every successful candidate to the programme receives course funding and a lump sum of £2000 with a further £1000, going to the maternity unit to support the practice placement.

7.4.1 The LSA office remains the contact point within the SHA for information pertaining to RtP. Speculative enquiries are forwarded to HoM and the Lead Midwife for Education at the relevant HEI. The situation in relation to

mentorship and support in practice has improved in the reporting year and all returnees have secured contracts in the Trust of their choice.

7.4.2 Over the time period of the report the LSA office had 25 enquiries (24 last year) 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. (Table 4).

Year	Enquiries	Completed Course	Currently Employed
2006/2007	28	n/k	n/k
2007/2008	24	3	2
2008/2009	25	5	5

Table 4

While the numbers currently remain small, it is hoped that the changes in funding will encourage more midwives to return in the coming year.

7.5 Ongoing Education for SoM

7.5.1 SoM are required to undertake 6 hours of study in relation to statutory supervision in each year. In order to facilitate this a number of learning opportunities specifically for SoM have been provided by the LSA during the last year which includes:

Learning Opportunity	Number Attending
Excellence in Statement Writing	11
Clinical Responsibility & Accountability	11
Undertaking an Investigation	18
Excellence in Statement and Report Writing	13
EoE Supervisors Forum	72
Clinical Responsibility & Accountability	14
Witness Familiarisation Skills	13
Excellence in Statement and Report Writing	14
PG Certificate in Supervision of Midwifery Practice (University of Herts) Sept-June	21

Table 5

The learning opportunities evaluate very well and 60% of Som within the east of England attended one or more learning opportunity during 2008/09. The LSA has funded learning opportunities for Som relevant to supervision outside of the east of England. This provides an opportunity for SoM gain a broad view of supervision and practice issues which can be shared with Supervisor colleagues both within their own Trust and across the whole east of England. (Table 5).

7.5.2 There has been a focus on improving the understanding for SoM on undertaking a supervisory investigation. The workshop day enables the Som to undertake a 'real time' investigation of a clinical incident as if they were the investigating SoM. The day is facilitated by the LSAMO and evaluates extremely well. The SoM report that they feel more confident and better equipped to undertake an investigation and there has been an improvement

of the quality of the investigations and reports. The workshop day has now been incorporated into the preparation programme for new SoM.

7.5.3 SoM have undertaken a self assessment against the competencies identified by the NMC for SoM. The learning opportunities offered for 2009/10 will be based on the learning needs identified by the SoM in their self assessment.

8.0 DETAILS OF ANY NEW POLICIES RELATED TO THE SUPERVISION OF MIDWIVES.

8.1 Two types of policies / guidelines are in place to support SoM in the east of England LSA.

8.1.1 National guidelines, which are developed by the LSAMO's Forum UK, are provided where it is important that consistency is achieved across the whole of the UK. The national guidelines can be accessed at www.midwife.org.uk

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

8.2 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. The local guidelines can also be accessed at www.eoe.nhs.uk

8.2.1 Terms of reference for the group are regularly reviewed and the SoM representative on the group gains feed back from their own local SoM team. Student SoM are encouraged to attend the group as a development opportunity and to ensure that they are actively engaged in supervision processes.

8.3 Both National and local guidelines are available on the SHA website at http://www.eoe.nhs.uk/page.php?page_id=67

A list of both national and local guidelines can be found in **Appendix II**.

9.0 DEVELOPING TRENDS

Maternal Death

9.1 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.

9.1.1 There were 13 maternal deaths reported to the LSA throughout the east of England during the reporting year. Table 6 shows the classification of the deaths.

Year	2004/ 2005	2005/ 2006	2006/ 2007	2007/ 2008	2008/ 2009
Direct	1	3	2	3	4
Indirect	4	2	10	10	5
Unknown	3	2	2	2	4
Total	8	7	14	15	13

Table 6

9.1.2 The reporting and investigation of maternal deaths are carried out by SoMs. Each Trust has a maternal death co-ordinator who is responsible for the collection of information and for reporting the death to CEMACE. Causes of direct maternal death in the east of England include overwhelming infection and embolism. Causes of indirect maternal death include road traffic accidents and deaths relating to pre-existing conditions.

9.1.3 Any maternal death is automatically reported as an SUI either to the SHA through the PCT route or through the LSA. Any direct maternal death will be routinely investigated by a SoM. Indirect maternal deaths are reviewed by a SoM to ensure that no practice issues can be identified.

9.1.4 The Guidelines for Maternal Death have been revised during the reporting year and the role of the SoM in coordinating the investigation and reporting of maternal deaths has been strengthened. This is to ensure that maternal deaths are reported to CEMACE in a timely manner and learning identified from the investigation is identified and actioned appropriately.

9.2 The LSA and the patient safety team work closely together and a direct link between the two directorates have been established to ensure that both areas are aware of maternal deaths and other reported SUI's. The LSA also works in close liaison with the CEMACE co-ordinator for the east of England.

9.3 Birthrate Trends

Unit	2005	2006	2007	2008	2009	Trend
Basildon	4040	4063	4257	4548	**4553**	**↑5**
Bedford	3035	3010	2947	3075	**3103**	**↑28**
Colchester	3508	3516	3694	3858	**3880**	**↑22**
E&N Herts	5094	5301	5309	5889	**5927**	**↑38**
Hinchingbrooke	2202	2199	2363	2473	**2601**	**↑128**
Ipswich	3536	3616	3704	3806	**3884**	**↑78**
James Paget	2076	2050	2209	2243	**2307**	**↑ 64**
King's Lynn	2030	2145	2229	2286	**2341**	**↑ 55**
Luton & Dunstable	4513	4728	4780	5127	**5299**	**↑172**
Mid Essex	3835	3767	3882	4265	**4300**	**↑35**
N&NUH	5055	5324	5455	5600	**5720**	**↑120**
Peterborough	3494	3505	3760	3808	**4153**	**↑345**
Princess A H	2822	3013	3252	3596	**3646**	**↑50**
Rosie	4990	5020	5119	5330	**5710**	**↑380**
Southend	3486	3532	3768	3761	**3868**	**↑107**
West Herts	5265	5186	5254	5566	**5630**	**↑ 64**
West Suffolk	2483	2416	2623	2593	**2585**	**↓ 8**
Total women delivered	61,651	62,737	64,133	67,824	**69,507**	
Total rise/fall	**480 ↑**	**1086 ↑**	**1396 ↑**	**3691↑**	**1683↑**	

Table 7 *2009 relates to April 2008 – March 2009*

9.3.1 The birthrate trend (Table 7) shows an increase of 8336 women delivered over the last five years. All but one Trust in the east of England has seen an increase in this reporting year ranging from 5 – 380 . This is a 2.4% increase on last year but is less significant than the 4.6% increase in reporting year 2007/08.

9.2.2 However, the commitment of the SHA to increasing the midwifery workforce means that alongside the 2.4% increase in the birth rate the number of midwives has increased by 154 full time equivalents.

9.3 Unit Closures

9.3.1 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. All units have robust escalation plans which involve calling into the unit all staff including community staff and managers. However, many of the closures have been related to capacity issues and not staffing and this is reflective of the increase in births over the last five years.

9.3.2 Data relating to the temporary closure of maternity units has been entered onto the LSA database by SoM. The robustness of the data collection has improved considerably in the last reporting year.

9.3.3 There were 60 temporary unit closures reported as against 24 reported closures last year. However of the 60 reported 26 were from one unit with only 9 units reporting temporary closures from the 17 Trusts.

9.4 Clinical Activity

9.4.1 The EoE vision document ; *Towards the best, together* (E0E 2009).sets out a clinical vision for Maternity and Newborn Care in the East of England including a set of key proposals for delivery by 2011. Maternity Matters forms one element of the Maternity and Newborn Clinical Programme Board implementation plan. SoM will be key to influencing local services to ensure that they reflect the recommendations identified in the above report.

9.4.2 Maternity services have been identified as one of the national priorities for improvement by the Department of Health and successful implementation of this policy is expected to be achieved by December 2009 through the local commissioning framework. The Maternity Matters policy commitment is to provide all women with a range of choices, access and continuity of care in a safe service.

9.4.3 A forum for maternity commissioners was established in January 2009 to facilitate joint working, share good practice and identify development needs. A regional conference to promote Maternity Matters was held in March 2009 and has been followed up with workshops on maternity tariffs and maternal mental health.

9.4.4 A number of key performance targets have been agreed with the PCT's and Trusts. Included in these are the percentage of women seen by a health professional before the 12th completed week of pregnancy and smoking cessation. Figures demonstrate that currently on average 82% of women are seen by a health professional (usually a midwife) before the 12th completed

week of pregnancy. Trusts vary between 69% - 100%. All Trusts have been set a target figure which demonstrates an increase in the percentage but all must achieve a minimum of 80% by March 2010. target

9.4.5 Smoking at time of delivery is also a target area with on average 15.3% of women smoking at the time of delivery. This is in fact an increase on the same quarter last year which was 14.6%. SoM will be key contributors in supporting midwives to implement strategies to reduce this figure and the significant harm that smoking has on babies and their mothers' health.

9.4.6 The number of deliveries conducted by midwives varies from 75% to 55% and has remained unchanged over the last three years. To enhance midwife led births, the east of England has proposed that there will be a co-located Midwife Led Birthing Unit (MLBU) in each acute Trust by 2011. Currently 47% of Trusts have co-located midwife led birthing units, with the remaining Trusts developing plans for future implementation. The SHA milestones for delivery for provider Trusts to have a co-located midwife led birthing unit is 25% by September 2009, 50% by June 2010 , 75% by March 2011.

9.5 The caesarean section rate in units across the EoE stands at 24.52%. This is against a rate of 23.0% in 06/07 and 24.0% in 07/08. The reduction of the caesarean section rate is included in the performance framework and the target for the east of England for 09/10 is 23.4%.

9.5.1 Many units are using the Maternity Clinical Dashboard to identify trends particularly month on month increases in caesarean section rates.

9.5.2 SoM in Bedford NHS Trust have led a series of workshops using the 'Pathways to Success Toolkit' and the service has seen a reduction in the Caesarean section rate of 2.1% in the last year.

9.5.3 As part of the work of the Clinical Programme Board there is a sub group led by a HoM which is focusing on normality. This group has identified a number of key issues which units will be recommended to focus on in the coming year in order to reduce the caesarean section rate.

9.5.4 Supervisors are monitoring the Vaginal Birth After Caesarean Section Rates (VBAC) and many SoM are leading this service. The number of women achieving VBAC is increasing in units where this service is offered. This is one of the many strategies in place which may contribute to a reduction in the caesarean section rate over time.

9.5.5 At Princess Alexandra NHS Trust , SoM and obstetric consultants review all perinatal mortalities using a locally produced tool. The result of the audit and the National data from CEMACE is disseminated to staff at the perinatal mortality and morbidity meetings.

9.5.6 Many units have seen an increase in the number of large post partum haemorrhage (PPH). Following audit this has been identified as the change from Syntometrine to Syntocinon as per NICE guidelines for management of the third stage as a possible cause of this.

9.5.7 At the Rosie Maternity Hospital monitoring throughout the year of clinical outcomes via the incident reporting system is carried out and reported

monthly to the maternity risk management group and also to the Supervisors of Midwives group. During 2008 this reporting system identified an increase in postpartum haemorrhage greater than 1500mls following the adoption of the use of Syntocinon 10 iu for the active management of the third stage in line with the recommendations of the NICE Guidance on Intrapartum Care. This trend was then analysed in greater detail and the resulting report presented to these groups, with the result that there was a return to the use of Syntometrine. Feedback has been provided to NICE.

9.5.7.1 At Peterborough and Stamford Hospitals NHS Foundation Trust the SoM also carried out an audit into management of the third stage of labour. Along side the issues surrounding the use of Syntocinon the audit identified specific trends in relation to an increase in birth weight and longer labours which may contribute to uterine inertia. There was also a failure to identify those women deemed at risk. Guidelines have been developed to assist midwives in practice and additional skills and drills sessions are being implemented to ensure that the guidelines are embedded in practice.

9.6 Clinical activity data is shared with SoM across the LSA. This enables SoMs 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.

9.7 Home Birth

9.7.1 The home birth rate ranges from 0.8% - 7.5% and across the east of England is 3.4%. This is a decrease against 3.8% in the last reporting year. In terms of the normality agenda the number of midwife led normal births is set to rise with the advent of the SHA pledges to ensure that all women have a choice of place of birth and that every unit will have an alongside MLBU by 2012. The east of England also has five stand alone maternity units.

9.7.2 The number of suspensions of the home birth service across the EoE has decreased .However, some units have been challenged 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

9.8 Public Health Issues

9.8.1 All units are reporting an increase in the number of women with complex health issues accessing the maternity services. These include women with:

- BMI greater than 35
- Domestic violence
- Diabetes
- Mental Health Issues
- Drug and alcohol dependency
- Single unsupported women
- Learning difficulties

Overall there has been a decrease in the number of teenage pregnancies although the number remains high in certain areas. The growing number of women with very high BMI is a challenge for all units. At the James Paget University Hospital Foundation Trust, 22.5% of their pregnant population have a BMI greater than 30.

9.8.2 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.

9.8.3 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.

9.8.4 Breastfeeding is an important part of maternal and child health and across the east of England 69% of women initiate breastfeeding. However at 6-8 weeks the rate has dropped to 48%.

9.8.4.1 A Task and Finish Group facilitated by the SHA has developed a breastfeeding framework for the region and this will include the development of a quality metric to improve the longer term rates.

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

- 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.

9.9 Ethnic population

9.9.1 The ethnic population has seen a significant change across most areas of the east of England. However some units report that some high risk ethnic groups have been difficult to identify as for example Eastern European women are usually classified as white European. Many units have had to upgrade the PAS system to ensure that this data is accurately captured.

9.9.2 This increase has resulted in a number of challenges for units.

- Rising costs of interpreter services and difficulty in accessing interpreter services.
- Increasing numbers of women with associated health problems including obesity, diabetes, high blood pressure
- A high incidence of infectious diseases such as Hepatitis B and C and other sexually transmitted infections such as gonorrhoea and syphilis.

9.9.3. The impact of the increased ethnic population has been 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.

9.9.3 Some of the solutions to this growing problem that units have found are:

- Employing Polish midwives although these midwives need a lot of support in terms of communication and practice development
- Specialist midwives developed with caseloads that target vulnerable and at risk women
- Audit and benchmarking of local services to ensure they are compliant to national standards such as NICE

9.10 Workforce

9.10.1 The midwifery workforce has increased and the SHA are committed to increasing the maternity workforce further and much collaborative work with Trusts and PCT's has been undertaken. As well as increasing the whole time funded establishment across the east of England there is also a commitment to reviewing skill mix and models of service provision.

9.10.2 Information contained in the LSA database demonstrates that in the east of England, 29% of the midwifery workforce is aged between 51 and over 65. This is a substantial number of midwives who will be or are eligible to retire in the next 5 years. Strategies are being developed including phased retirement programmes to ensure that these experienced midwives are not lost to local services. (Table 8)

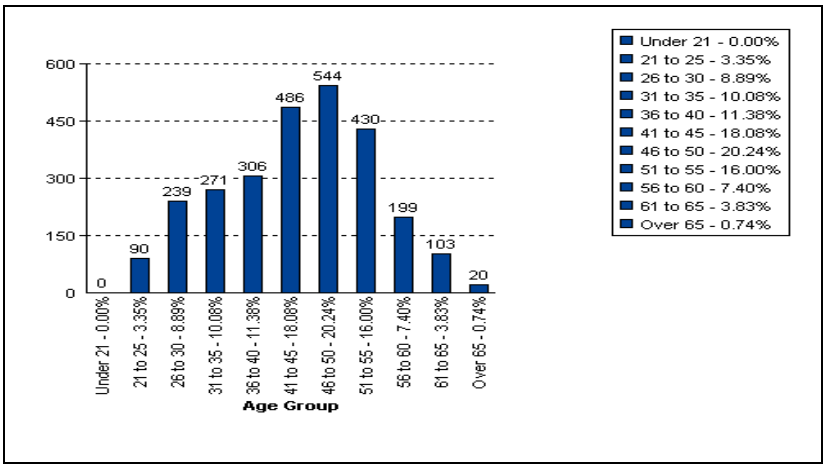


Table 8 Age profile of midwives in practice across the east of England

9.10.3 The east of England has a significant number of midwives who work part time. Table 9 shows that 58% of midwives are part time and 42% are full time. This can be viewed positively as evidence of flexible working patterns being offered for midwives but conversely poses significant problems for services in meeting the demands of the increasing birth rate and the complexity of care provision.

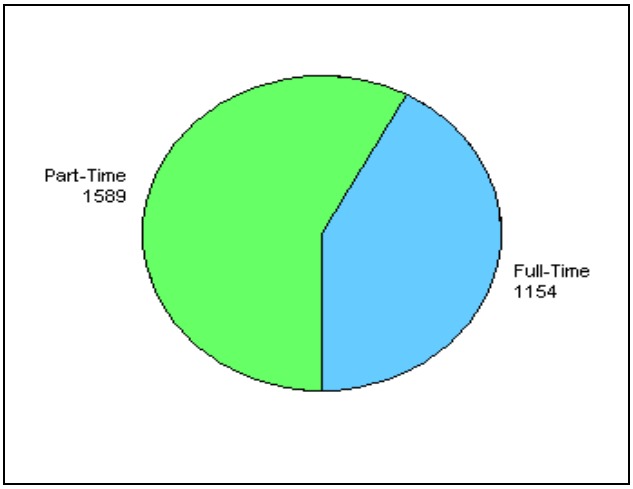


Table 9: Part time / full time by place of work

9.10.4 Midwives work in a variety of settings including HEI's, GP Practices and infertility clinics. Table 10 shows the number of Intention to Practice forms received by the LSA from midwives working in settings other than an NHS Trust. All midwives irrespective of their place of work are entitled to a named SoM. This places an additional burden on SoM based in NHS Trusts who may already have caseloads over the recommended 1:15. It is important to ensure that midwives working outside of an NHS Trust are able to choose their named SoM and to ensure that the workload is shared equitably between SoM throughout the LSA.

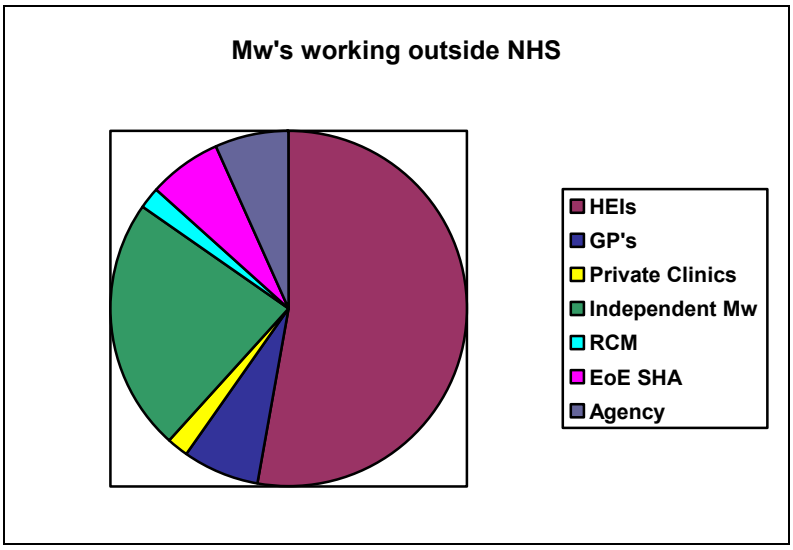


Table 10: Number of Midwives working in settings other than the NHS

9.11 Methods of Data Collection

9.11.1 The three maternity units that were identified in the last reporting year, where statistics and other data are still collected manually have been working with the Connecting for Health Team to determine their service needs. All three units are in the process of implementing an electronic maternity system in line with the east of England recommendations.

9.11.2 Much work has been undertaken to ensure that the data collected within maternity units is robust. Many Units report that the data collected often conflicts with Coding and HES data collected by the Trust. A significant amount of work has been undertaken to ensure that the data collected is comparable and robust. This has been particularly successful around staffing and establishment figures where a tool has been developed by the HoM and implemented through the workforce directorate. This enables accurate and meaningful benchmarking to be undertaken across the east of England.

9.11.3 Clinical statistics are regular agenda items at local SoM meetings where trends and implications for practice are reviewed. CEMACE data is collected by the Maternity Services CEMACE Co-ordinator and forwarded to the Regional Office in Cambridge. The annual CEMACE 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.

9.11.4 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.

10.0 DETAILS OF THE NUMBER OF COMPLAINTS REGARDING THE DISCHARGE OF THE SUPERVISORY FUNCTION.

10.1 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.

10.1.1 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.

10.2 One complaint was received by the LSA in the year 2008/09 with regard to the discharge of the supervisory function by a team of SoM. The complaint related to a midwife who was dismissed from employment at the Trust and referred to the NMC. The midwife was dismissed in relation to a serious drug error and the case is currently awaiting a final decision at the NMC.

10.2.1 The complaint was against the whole team of SoM in relation to supervisory support. The complaint was investigated as per the National Guidelines and was not upheld.

10.2 Complaints against the LSAMO are dealt with through the SHA complaints procedure as the LSAMO is an employee of the SHA. No complaints have been received against the LSAMO in the reporting year.

11.0 REPORTS ON ALL LOCAL SUPERVISING AUTHORITY INVESTIGATIONS UNDERTAKEN DURING THE YEAR

11.1 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 regularly reviews and updates its reporting policy which is made available 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. A total of 24 SUI's have been received in the reporting year.

11.2 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.

11.2.1 A supervisory investigation need not arise from an SUI and any SoM may contact the LSAMO for advice about the need to carry out a supervisory investigation. This has been encouraged by the LSAMO, particularly in relation to those units where undertaking supervisory investigations has not been the norm, in order to ensure that identified practice issues are addressed.

11.2.2 The LSAMO has raised, through the Directors of Nursing Forum facilitated by the SHA, the importance for supervisory investigations and reiterated the additional time needed by SoM to undertake them. A recent analysis of the investigations carried out by SoM in the EoE in the reporting year demonstrates that an investigation takes between 70 and 90 hours to complete. Historically, many of these hours were in the supervisors own time and this is not acceptable or sustainable. Increasingly SoM are being given the appropriate time to undertake investigations and this is proving positive in terms of the quality of the investigation and report.

11.3 During this reporting year much work has been undertaken in order to ensure that the LSA has a robust process for the logging and tracking of supervisory investigations. This also ensures accurate follow up of investigation outcomes and the implementation of the recommendations.

11.4 Supervisors of midwives carried out 57 supervisory investigations in the reporting year 2008/09. This is against 27 in the previous reporting year and represents a significant increase. However, analysis of the investigations concludes that all the investigations were appropriate as all related to practice issues and only 5 of the investigations undertaken resulted in no issues identified.

11.3.1 One investigation was carried out by the LSAMO for another LSA during the reporting year.

11.3.2 Table11 shows the breakdown of the main features of the investigations undertaken. Poor record keeping, communication and planning and delivery of care featured in almost all of the investigations while poor Cardiotocograph (CTG) interpretation featured in more than 50% of the investigations. This is reflective of the wider analysis of supervisory investigations undertaken across the UK and reported at the LSA National Forum in July 2009.

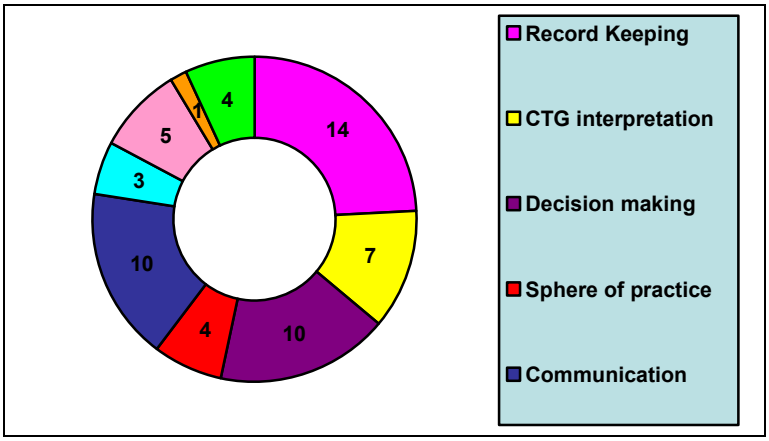


Table 11

11.3.2.1 Currently**,** many of the issues identified by the analysis of the investigation are included in midwives mandatory updating programmes. The programmes have in the main been developed 'in house' and vary greatly in content. They tend to be delivered by a variety of professionals including practice development midwives, consultants and supervisors of midwives. This format has arisen through the lack of HEI provision for mandatory updating, the reduction in funding for post registration education and the inability to release large numbers of staff from the clinical areas to go to a venue off site. However despite midwives attending mandatory updating as required the analysis of the investigations does not reflect a significant change in practice. This is particularly evident in relation to CTG interpretation. CNST standards require that midwives (and doctors) are able to access education on a six monthly basis in relation to CTG interpretation. This is operationalised by teaching sessions on interpretation (mostly given by consultant obstetricians), undertaking the K2 on line learning package and attendance at various meetings where interpretation of CTG's is included, such as labour ward forums and early morning labour ward teaching sessions where cases from the previous 24 hours are discussed in detail.

11.3.3 The LSAMO in collaboration with the workforce directorate has been successful in a bid to the Department of Health for money to develop an evidence based education package which will try to address the main issues identified by the investigation review. Local HEI's have been asked to work together to develop an evidenced based learning package related to the main areas of concern ie: CTG interpretation, communication, decision making and record keeping. The intention is that the programme will be rolled out across all Maternity Units in the East of England. This will encourage consistency of approach, quality and delivery of a programme of education which will help to ensure that the number of incidents in relation to these issues is reduced. It is planned that the programme will be ready to move forward in early 2010.

11.4 Seven midwives have undertaken periods of supervised practice, (complying with NMC (2007) Standards for Supervised Practice Programmes) during the reporting year which is the same as the previous reporting year. Objectives and learning outcomes relating to the following were identified:

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

11.4.1 The programmes of supervised practice have been rigorously overseen by the LSAMO and SoM supported throughout the process. All midwives undertaking supervised practice programmes have been successful.

11.5 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.

11.6 One referral to the NMC has been made by the LSAMO during this reporting year. The midwife was referred on health grounds for issues related to drug dependency. The midwife continues to be the subject of an interim suspension order.

12.0 LSA PRIORITIES FOR 2009 - 10 PRACTICE YEAR.

LSA Priorities for 2009/2010

The priorities identified for the LSA for the year 2009-10 will be:

- Working with local SoM to ensure all Trusts meet the SoM:Mw ratio of 1:15
- Encourage and support SoM to ensure that protected time to undertake the role is taken
- Continue to link more closely with commissioners of maternity services to continually improve the quality and safety of maternity services in the east of England
- Enhance the quality assurance of SoM in east of England
- Provide support and education for SoM in relation to undertaking supervisory investigations and completing reports to ensure that the process is robust and protects women and their babies
- To provide further analysis of outcomes of investigations to ensure learning takes place across the east of England
- To continue to implement strategies which encourage more engagement with women and users in the work of the LSA

Conclusion

Statutory supervision of midwives has operated in the UK for over 100 years and is now an integral part of clinical governance for maternity services in the UK. Effective use of the supervisory framework leads to improvements in standards of care and better outcomes for women and their babies. It has developed into a modern regulatory system and is a means by which midwives are supported in practice.

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.

Joy Kirby
LSA Midwifery Officer
East of England

September 2009

References

Nursing and Midwifery Council (May 2009) Guidance for Local Supervising Authority (LSA) Annual Report submission to the NMC for practice year 1 April 2007 – 31 March 2008.

Nursing & Midwifery Council (2004) Midwives rules and standards. NMC. London.

Local Supervising Authority (2005) LSA Standards for Statutory Supervision. London.

NHS East of England (2009) Towards the best, together - A Clinical Vision for our NHS now and for the next decade.

East of England Maternity Workstream Group (2007) East of England.

Confidential Enquiry into Maternal and Child Health (2007). Saving Mothers Lives.

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.

DH (2007) Maternity Matters.

APPENDIX I

LSA Profile 2007/08

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 (UK)
for Supervisors of Midwives

Contents