WEST MIDLANDS
LOCAL SUPERVISING AUTHORITY

ANNUAL REPORT

TO THE

NURSING AND MIDWIFERY COUNCIL

APRIL 2006 TO MARCH 2007

WENDY NOBLE
LSA MIDWIFERY OFFICER
JUNE 2007

DISCHARGE OF THE STATUTORY FUNCTION OF THE LOCAL SUPERVISING AUTHORITY

Report to the Nursing and Midwifery Council
Wendy Noble, LSA Midwifery Officer – June 2007

PART 1

1. INTRODUCTION

1.1 The statutory functions of the Local Supervising Authority (LSA) for the Supervision of Midwifery Practice are designated in the Nursing and Midwifery Order 2001, and the NMC Midwives rules and standards (NMC 2004). The primary purpose of the LSA function is the protection of the public. Responsibilities include setting standards for the general supervision of all midwives in its area, the appointment and coordination of supervisors, and investigating and reporting to the council, any midwife whose fitness to practise is impaired.

1.2 For this purpose supervisors of midwives are appointed in each Trust by the Local Supervising Authority Midwifery Officer (LSAMO) following the successful completion of an approved degree module and each supervisor has a direct line of communication with the LSAMO.

1.3 Statutory supervision covers all midwives practising in the LSA boundary, whether employed in the NHS, in higher education, employed by general practitioners, through agencies or the private sector, in prisons, armed forces or in independent practice.

1.4 Supervisors of midwives contribute to the clinical governance framework by supporting the professional development of midwives, and participating in local risk management systems.

2. THE LSA MIDWIFERY OFFICER

2.1 The LSA Midwifery Officer for the West Midlands is Wendy Noble (now retired) who carries out the function on behalf of the West Midlands Strategic Health Authority (SHA). She is supported by two Link Supervisors who are experienced senior midwife managers /supervisors and there is a Contact Supervisor in each unit.

3. GEOGRAPHICAL AREA

3.1 The West Midlands LSA covers the area from the Staffordshire border with Cheshire and Lancashire in the north to the southern borders of Herefordshire, Worcestershire and Warwickshire, and Wales in the West to Derbyshire and Leicester in the East. The population of approximately 5 million people live in both rural and densely populated inner city areas, including the second city of Birmingham.

3.2 There are 19 consultant maternity units, and 6 midwife led units in 15 Acute Trusts, and 17 Primary Care Trusts. The consultant units vary in size from 1846 births in Hereford to 7120 births in the Heart of England Foundation NHS Trust in Birmingham. This represents a 2% increase of births across the LSA.

4. STATISTICS

Births:	69162 - an increase of 1329 from last year
Number of midwives:	2882 (head count) – a reduction of 61 from last year
Number of supervisors:	225

Supervisors in training:	10 midwives commenced training in March 2007 and a further 13 are provisionally booked to commence the course in September 2007.

5. CONTACT DETAILS

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PART 2

RULE 16 – ANNUAL REPORT

Each year every local supervising authority shall submit a written report to the Council by such date and containing such information as the Council may specify.

LOCAL SUPERVISING AUTHORITY STANDARD

A written, annual local supervising authority report will reach the Midwifery Committee of the NMC, in a form agreed by the Nursing and Midwifery Council, by the 30th of September each year.

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

The report will include but not necessarily be limited to:

- Numbers of supervisors of midwives appointments, resignations and removals.
- Details of how midwives are provided with continuous access to a supervisor of midwives.
- Details of how the practice of midwifery is supervised.
- Evidence that service users have been involved in monitoring supervision of midwives and assisting the local supervising authority midwifery officer with the annual audits.
- Evidence of engagement with higher education institutions in relation to supervisory input into midwifery education.
- Details of any new policies related to the supervision of midwives.
- Evidence of developing trends affecting midwifery practice in the local supervising authority.
- Details of the number of complaints regarding the discharge of the supervisory function.
- Reports on all local supervising authority investigations undertaken during the year.

(Midwives Rules and standards, NMC 2004)

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

The LSA is currently pursuing having the report and other LSA documents put on the Health Authority web site. This report will be distributed to Directors of Nursing, Heads of Midwifery and Contact Supervisors of Midwives, and MSLC chairs.

2. Numbers of supervisors of midwives appointments, resignations and removals.

2.1

	06/07	05/06	04/05	03/04	02/03
Number of supervisors appointed:	26	19	15	12	34
Number of supervisors resigned:	15	10	17	11	11
Number of supervisors removed:	1	0	1	1	0

See Appendix A for details of supervisors by unit and Appendix B for ratios of supervisors to midwives.

2.2 The NMC recommends that there is a ratio of 1 supervisor to 15 midwives and within the West Midlands there are now only 2 units where the ratio is more than 15 midwives to each supervisor. These ratios are 18 and 21 respectively. Following a successful recruitment campaign 8 midwives from these two units are either awaiting results from the September 2006 training programme or have just commenced a course in March 2007.

2.3 Three supervisors are currently on leave of absence for personal reasons in accordance with LSA guidelines relating to taking time out.

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

3.1 Newly appointed midwives are allocated to a supervisor and may change at a later date if they wish. All other midwives are allocated to supervisor of their own choice within the agreed numbers per supervisor. Ballots for changes are often held when a new supervisor is appointed. Individual supervisors are audited every 3 years by means of a questionnaire to a random selection of their midwives. Questions on choice of supervisor and relationships are included. Midwives are also aware of how to change supervisors if they wish. Midwives are aware that they can contact any supervisor for advice not just their named supervisor.

3.2 Independent Midwives and midwives employed by agencies are advised to select a named supervisor who is responsible for undertaking the annual review. A summary sheet is provided in addition to the main review documents and a copy of this summary sheet is provided to supervisors in the geographical area where the midwife has clients.

3.3 Continuous access to a supervisor differs in each unit. Some supervisors have introduced a 24 hour on-call rota and others only have a rota for out of hours such as nights, weekends, bank holidays. Other groups of supervisors have opted not have a formal rota but telephone numbers are held by senior midwives or switchboard operators for out of hours contact. An emergency rota is used to cover home births against advice. There have been no difficulties reported and midwives have expressed satisfaction with this system. Access to a supervisor is discussed with midwives at the annual LSA visit.

4. Details of how the practice of midwifery is supervised.

4.1 All supervisors in the LSA have a copy of the LSA Standards and Guidelines which have been produced by a small working group of experienced supervisors in conjunction with the LSA Midwifery Officer. Each guideline is reviewed every 3 years.

4.2 Each supervisor attempts to meet at least annually with each of the midwives on their allocated lists. This may not always be possible due to long term sickness or lengthy maternity leave episodes. These midwives receive extra support from their supervisors on their return to work.

4.3 At the annual review midwives are helped to identify development needs in their professional practice as well as checking their eligibility to practise and registration details.

4.4 Supervisors investigate incidents where poor practice could be a contributing factor and take the appropriate action to remedy any development needs.

4.5 In cases where a programme of support or supervised practice is required the supervisor will implement the programme in conjunction with the midwife and other appropriate staff, and provide continuous support.

4.6 All supervisors audit record keeping to ensure midwives are adhering to local and national guidance.

4.7 Supervisors in each Trust have regular local meetings usually monthly and some more frequently. This gives them the opportunity to develop strategies for supervising midwives in their own units and discuss topical issues. In some units supervisors hold “away days” once or twice a year with set agendas and invited speakers.

4.8 Supervisors attend meetings held by the LSA Midwifery Officer every 2 months in January, March, May, July, September and November. Two of these meetings are held in 3 geographical areas to facilitate discussions about local issues.

4.9 Study days are held by the LSA Midwifery Officer each year and include: - 1 supervision workshop, and 2 critical incident presentation days. Other study days include: - 2 report writing days, and a “midwives on trial” day facilitated by Bond Solon legal firm, and 2 days on root cause analysis awareness. These all enable supervisors to develop their skills to supervise practice.

4.10 Apart from meetings and study days the LSA communicates with supervisors mainly by email to Contact Supervisors. In some units supervisors now have dedicated supervisor email drives which all supervisors access to share information and receive and correspondence.

4.11 In all units, supervisors are represented on working groups which develop and up-date maternity policies and procedures to ensure that midwives practise according to best evidence.

4.12 Accurate confidential records of all activities and discussions are maintained in locked cabinets in designated supervisors’ offices.

4.13 Supervisors help midwives to reflect following traumatic incidents or under stressful situations.

4.14 Supervisors participate in the selection and training of new supervisors to ensure that there are sufficient supervisors appointed and provide easy access to all midwives at all times for advice and support.

4.15 The LSA Midwifery Officer, with a team of visiting supervisors, undertakes an annual audit visit to all units. Midwifery practice and the process of supervision is assessed in each unit.

4.16 The practice of each supervisor is audited every 3 years by means of a questionnaire sent to the midwives on the named supervisor’s list.

Examples where supervision within the LSA has enhanced and supported the practice of midwives can be found in Appendix C.

5. Evidence that service users have been involved in monitoring supervision of midwives and assisting the local supervising authority midwifery officer with the annual audits.

5.1 The annual LSA visit continues to incorporate the participation of service users. This continues to be beneficial to assess their views of the service as a whole and midwifery practice. It also gives an insight into how little the users understand the role of the supervisor of midwives. There is still a lot of work required to achieve this.

5.2 The LSA Midwifery Officer is accompanied on each visit by two Visiting Supervisors of Midwives. Opportunities are given for the visiting supervisors to meet with mothers who are expecting or have recently had their babies. They are asked about their care from the midwives and others and have a discussion about supervision and what it means for them. The LSA Midwifery Officer also meets representatives of user organisations during the course of the day.

5.3 There are supervisor representatives on all Maternity Services Liaison Committees in the LSA

area. There is also evidence of an increase in user representatives in various maternity forums, e.g. labour ward forums.

5.4 An LSA leaflet is available for all users and gives details of the role of the supervisor and how women can access them. Unfortunately an audit of its use has produced some poor results. All supervisors are encouraged to make sure that midwives are providing the leaflets.

5.5 Two groups of supervisors have now got a supervision page on their Trust websites.

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

6.1 The LSA Midwifery Officer holds a quarterly meeting with the Lead Midwives for Education from the 6 universities in the West Midlands to share supervision and education issues and initiatives.

6.2 LSA Midwifery Officer is a member of the Course Management Team for the Preparation of Supervisors Course and contributes to the programme in conjunction with the course lecturer team.

6.3 LSA Midwifery Officer is an Honorary Lecturer at the University of Central England and Manchester University where the preparation programmes for supervisors are provided in rotation.

6.4 Six universities in the West Midlands involve supervisors of midwives in their midwifery education programmes. There is at least one supervisor/lecturer in each university now and this strengthens the supervisory links for midwives and students.

6.5 Student midwives in the LSA are allocated to a named supervisor of midwives so that all through their training they see how supervision can function. This is discussed with any available students during the annual LSA visits.

6.6 Supervisor/lecturers always contribute to supervised practice programmes.

6.7 Two universities provide programmes for the preparation of supervisors of midwives in the West Midlands and the North West LSAs – Manchester University and University of Central England in Birmingham. These programmes are jointly planned and run twice a year for midwives from both regions, alternating between universities. Lecturers from both sites share the sessions and both LSA Midwifery Officers input to the programme.

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

7.1 The LSA Standards for supervisors of midwives were reviewed and re-issued in July 2006.

7.2 The LSA guideline for supervisors on the scope and function of the maternity support workers was totally revised and re-issued in July 2006.

7.3 Two new guidelines have been produced:

"Guidelines for supervisors of midwives supporting midwives in caring for women involved in surrogacy" – July 2006 (Appendix D)
"Guidelines for supervisors of midwives supporting midwives involved in child protection cases" – July 2006 (Appendix E)

7.4 The following sections of the LSA Guidelines have been revised and re-issued: -

Section 1 – Local Supervising Authority

Section 2– The responsibilities of the supervisor of midwives
Section 3 – Practical guidance for supervisors of midwives.

8. Evidence of developing trends affecting midwifery practice in the Local Supervising Authority.

8.1 Supervisors help and support midwives to provide services in a number of public health initiatives across the LSA.

- Stronger support systems are in place to promote breastfeeding amongst teenagers and mothers from a low socio-economic background;
- Guidelines have been developed and training put in place to support midwives discussing domestic abuse with women in a way that is non-threatening;
- Further progress has been made to enable midwives to access children's centres around the LSA and move clinics into these centres out of GP surgeries;
- Eco-friendly cotton nappies have been actively promoted everywhere;
- Closer links between maternity services and mental health services are slowly being developed and many initiatives are led by supervisors in light of the evidence in the CEMACH maternal death reports and the incidence of mental health related deaths;
- Many PCTs involve midwives in their substance misuse programmes;
- Supervisors also contribute to the public health agenda by participating in "Healthy Start to Life" local improvement groups;
- Across Birmingham and the Black Country supervisors are involved with the collaborative work between Trusts and PCTs to develop dynamic models of care to help reduce the perinatal mortality rate;

8.2 Clinical activity – details of births, etc are included in Appendix F. These are only extracts from the annual collection of LSA workload and staffing data, which can be provided on request to the LSA Office. There have been 17 maternal deaths reported to the LSA in this 12 month period (12 last year) of which 5 (3 last year) could be attributable to direct causes. The perinatal death rate continues to be one of the highest in England and the team at the West Midlands Perinatal Institute have introduced a number of initiatives to address this issue. The lead midwife is also a supervisor.

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

9.1 The LSA received an informal complaint from a self-employed midwife about her perceived bullying by a supervisor. An investigation revealed that the supervisor had only been trying to comply with the LSA guideline for supervising self employed midwives and was seen to be too persistent by the midwife. A useful meeting was held with the self-employed midwife, her named supervisor and the LSA Midwifery Officer. As a result certain changes were recommended for the guidelines, which are due to be reviewed in 2008, and minor changes were agreed in the meantime.

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

10.1 Two LSA investigations were undertaken during the 12 month period.

- ♦ The first related to the investigation referred to in 9.1.
- ♦ The second was an investigation of the practice of an independent midwife who was subsequently referred to the NMC.

10.2 A further investigation was undertaken by the LSA Midwifery Officer into a case where the midwife had resigned before completing a supervised practice programme in which she had failed to make any progress. Due to mitigating circumstances the LSAMO felt it expedient not to refer the midwife to the NMC. The midwife is now pursuing a career in social work.

10.3 Reviews – the Healthcare Commission has undertaken two mini reviews where complaints had been received from members of the public. In both cases recommendations were made and robust action plans put into place to ensure any unsafe practice is addressed. Contributions were made by the LSA Midwifery Officer with the provision of local knowledge and the standards of the supervision in each unit.

10.4 The SHA distributes any maternity serious untoward incidents to the LSA Midwifery Officer as well as the Director of Nursing and the Medical Director. The LSA Midwifery Officer also collects data which includes serious untoward incidents and brief details of any supervisory investigation.

10.5 Supervised practice. There have been 5 incidences of supervised practice programmes during this 12 month period. One was for gross misconduct and this midwife was referred to the NMC by the LSA but not suspended from practice. The case was subsequently closed by the NMC and no further action taken. Three cases related to persistent poor practice and one for non-adherence to NICE guidelines in labour. The midwife involved in the last case has not completed the programme yet due to prolonged long term sickness.

10.6 Suspension from practice. The LSA Midwifery Officer suspended two midwives from practice and referred them to the NMC. One referral was for mismanagement of pregnancy and labour and the second was for unprofessional conduct.

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Wendy Noble on behalf of:
West Midlands SHA

Authorised by: ……

Cynthia Bower
Chief Executive
West Midlands SHA

WEST MIDLANDS LOCAL SUPERVISING AUTHORITY March 2007

APPENDIX A

TRUST	UNIT	CONTACT SUPERVISOR OF MIDWIVES	NUMBER OF SUPERVISORS OF MIDWIVES
BURTON HOSPITALS NHS TRUST	• Queens Hospital • Lichfield Victoria	Mrs L Bird	13
UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST	• City General Hospital	Mrs J Jenkinson	13
ROYAL SHREWSBURY HOSPITAL NHS TRUST	• Royal Shrewsbury Hospital • Ludlow Midwife led unit • Oswestry Midwife led Unit • Bridgenorth Midwife led Unit • Wrekin Midwife led Unit, Telford	Mrs A Hughes	15
MID STAFFORDSHIRE GENERAL HOSPITALS NHS TRUST	• Stafford General Hospital	Mrs W Hayes	10

WEST MIDLANDS LOCAL SUPERVISING AUTHORITY March 2007

TRUST	UNIT	CONTACT SUPERVISOR OF MIDWIVES	NUMBER OF SUPERVISORS OF MIDWIVES
HEART OF ENGLAND NHS FOUNDATION TRUST	• Princess of Wales Womens Unit	Mrs J Cotterrill	12
	• Solihull Hospital		
	• Good Hope Hospital	Mrs H Melville	11
BIRMINGHAM WOMENS HEALTH CARE NHS TRUST	• Birmingham Women's Hospital	Miss J Owen	24
DUDLEY GROUP OF HOSPITALS NHS TRUST	• Russells Hall Hospital	Mrs A Batty	13
ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST	• New Cross Hospital	Mrs D Moore	12

WEST MIDLANDS LOCAL SUPERVISING AUTHORITY March 2007

TRUST	UNIT	CONTACT SUPERVISOR OF MIDWIVES	NUMBER OF SUPERVISORS OF MIDWIVES
SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST	• City Hospital Birmingham	Mrs M Bradley	6
	• Sandwell General Hospital	Mrs Y Marshall	7
WALSALL HOSPITALS NHS TRUST	• Manor Hospital	Mrs T Roberts	12

WEST MIDLANDS LOCAL SUPERVISING AUTHORITY March 2007

TRUST	UNIT	CONTACT SUPERVISOR OF MIDWIVES	NUMBER OF SUPERVISORS OF MIDWIVES
GEORGE ELIOT HOSPITAL NHS TRUST	• George Eliot Hospital	Mrs K Hawker	11
HEREFORD HOSPITAL NHS TRUST	• County Hospital	Mrs C Montgomery	7
SOUTH WARWICKSHIRE GENERAL HOSPITALS NHS TRUST	• Annie Cay Maternity Unit	Mrs A Gough	7
UNIVERSITY HOSPITAL COVENTRY & WARWICKSHIRE NHS TRUST	• Walsgrave Maternity Unit	Mrs C McCalmont	19
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	• Alexandra Hospital	Ms S Heslington	20
	• Wyre Forest Birth Centre		
	• Royal Worcestershire Hosp		

RATIO OF SUPERVISORS TO MIDWIVES

APPENDIX B

31 MARCH 2007

DISTRICT	SUPERVISORS	MIDWIVES Head Count	RATIO [2006]	RATIO 2007
Worcestershire	22	293	18.4	**13.3**
Herefordshire	7	72	11.8	**10.3**
Shropshire	15	231	17.4	**15.4**
North Staffs	13	241	18.3	**18.5**
South Staffs - Stafford	10	88	11.5	**8.8**
- Burton	13	145	14.4	**11.2**
Warwickshire - Nuneaton	11	103	10.1	**9.4**
- Warwick	7	105	15.3	**15.0**
Birmingham - Heartlands	17	271	20.9	**15.9**
- Good Hope	11	145	21.8	**13.2**
- City Hosp	6	129	15.3	**21.5**
- Women's	24	262	10.8	**10.9**
Coventry	19	206	11.2	**10.8**
Dudley	13	145	11.2	**11.2**
Sandwell	7	91	14.8	**13.0**
Walsall	12	151	16.2	**12.6**
Wolverhampton	12	147	12.8	**12.3**
Plus midwife teachers as follows:-				
University College Worcester		9		
Keele University		7		
Staffordshire University		6		
Coventry University		7		
University of Central England		18		
University of Wolverhampton		10		
Total - West Midlands	**219**	**2882**	**14.5**	**13.2**

These figures do not include:- Bank Midwives
Agency Midwives
Independent Midwives
Midwives employed by GP's
Midwives in Private Institutions
Midwives in Prison Services

APPENDIX C

EXAMPLES OF WHERE SUPERVISION WITHIN THE LSA HAS ENHANCED AND SUPPORTED THE PRACTICE OF MIDWIVES

1. A newly qualified midwife was finding it difficult to settle into working at a unit and was supported by her Supervisor of Midwives to make a successful transition to the Trust. She had experienced difficulty with the computer system and had lost confidence in her abilities. This led to her feeling isolated and insecure and she did not want to participate in the rotation that operates in the unit. The Manager had requested that the Supervisor be involved to help resolve the midwife's problems.

   Supervisory Action

   An action plan was formulated by the Supervisor that facilitated the midwife gaining the appropriate experience to rebuild her confidence. This was very successful and the midwife now feels competent to work in any of the areas within the unit. This issue did serve to highlight the difficulties that newly qualified midwives can face when they join the Trust having trained in other units, despite the fact that there is an excellent induction policy for new staff. The midwife may be completely unaccustomed to using such a sophisticated system that also includes electronic prescribing and order entry.

2. Identified Need to Improve Recovery Care Following Caesarean Section.
   Highlighted at the Supervisors' Away Day

   Recovery care was discussed and highlighted by pain relief nurse who presented an audit of immediate care of women following caesarean section. **The findings** suggested sub-optimal care and included:

   - in-frequent observations (vital signs);
   - minimal observations documented, i.e. bladder care, lochia, wound, pain relief and fluid balance;
   - haphazard documentation found in numerous places in the case notes;
   - questionable awareness about significance of major surgery regardless of method of anaesthesia used;
   - on-going care of women following caesarean section was also highlighted as in need of improvement on the postnatal ward areas.

   Action Plan

   - the integrated care pathway for elective caesarean section is already commenced – to be monitored and audited;
   - a multi-disciplinary sub-group of practitioners & supervisors will review documentation;
   - the review of all recovery guidelines is under-way;
   - development of an observation chart for vital signs is in progress;
   - develop an observation chart for bladder care, lochia, wound, pain relief and fluid balance;
   - develop awareness amongst staff and provide appropriate training;
   - re-audit to demonstrate improvement.

3. Since clinical adverse event (CAE) reporting has been more formalised through clinical governance, supervisors of midwives are recruited at a very early stage to look at

adverse events and manage the midwifery practice issues that may arise from them. An example of improving standards of practice relates to third degree tears. CAE reporting highlighted an increasing number of third degree tears sustained at normal delivery. These CAEs were discussed at supervisory meetings. Each set of case notes was audited by the clinical risk manager (a supervisor) and a colleague supervisor. Trends were monitored. It became apparent that some of the third degree tears may have been avoidable if episiotomy had been considered, however midwives in training do not perform episiotomy as routine (which is correct) therefore admit to being nervous about this. The risk manager and a supervisor have initiated an education programme about episiotomy and perineal repair and this is now standard on the induction programme for midwives. The supervisors also monitor midwives in the clinical area. The annual review form is currently being updated by 2 supervisors and there will be a specific item about episiotomy and perineal repair to discuss at annual review.

GUIDELINES FOR SUPERVISORS OF MIDWIVES SUPPORTING MIDWIVES IN CARING FOR WOMEN INVOLVED IN SURROGACY

1. Introduction

1.1 "Surrogacy is the practice whereby one woman carries a child for another person, with the intention that the child should be handed over after the birth". (RCM 1997)

1.2 Surrogacy in the UK is controlled by the Surrogacy Arrangements Act (1985) and the Human Fertilisation and Embryology Act (1990). These Acts permit such arrangements under tightly defined circumstances, but prohibit commercial agencies organising surrogacy for profit.

1.3 Midwives involved in surrogacy will be required to care as per usual practice for the surrogate mother and baby. The duty of care to the baby remains paramount even following transfer to the commissioning parents.

1.4 This guidance has been produced for supervisors to support and advise midwives and protect the public. It is important to adhere to local policy and guidance.

2. The role of the supervisor

2.1 To have an in-depth knowledge of the law relating to surrogacy (see Appendix 1).

2.2 To ensure midwives are aware of their duty of care to the surrogate mother and baby within the surrogacy law.

2.3 To provide support and guidance for midwives.

2.4 To ensure midwives maintain strict confidentiality.

2.5 To facilitate reflection after the event.

2.6 To communicate with supervisors in the area in which the baby is going to be resident to ensure midwifery care is provided.

3. Key points

3.1 Discussion and decisions about the needs and preferences during pregnancy, labour and the puerperium should be made between the surrogate mother and the midwife as per normal practice.

3.2 The legal guardianship of the baby remains with the surrogate mother until the Court has granted a Parental or Adoption Order. This means the consent for

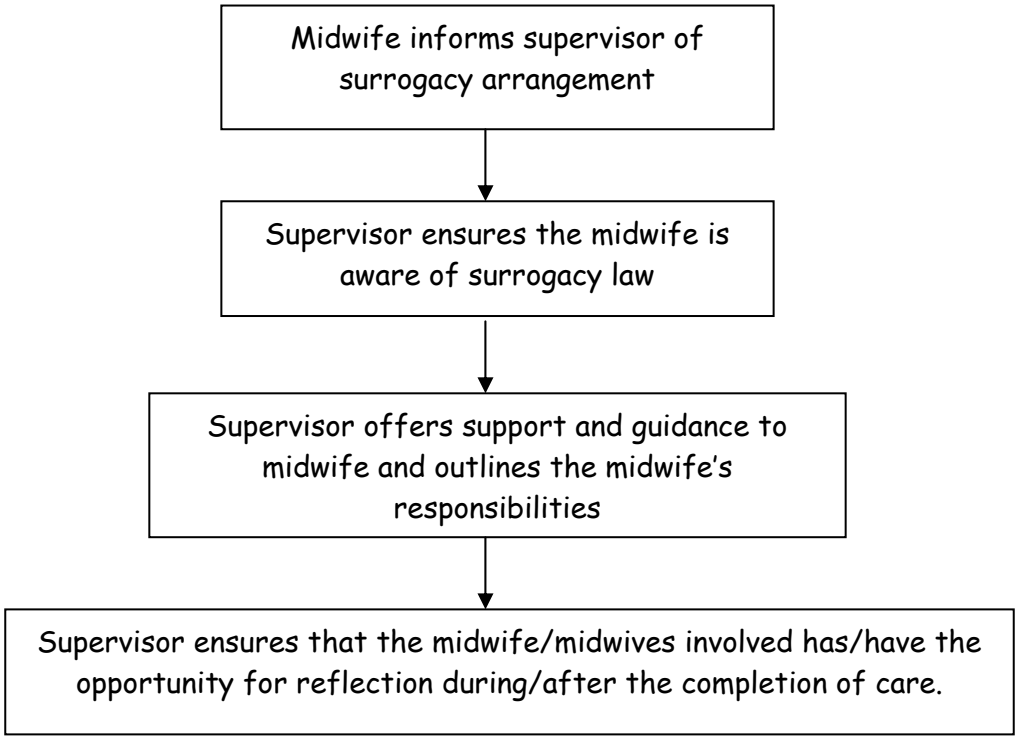
medication/screening of the baby must be obtained from the surrogate mother, even if the baby is handed over at birth.

3.3 The midwife is under no obligation to involve the commissioning parents.

3.4 In some situations a midwife may suspect a covert surrogacy arrangement. Managers and supervisors must be informed.

3.5 This guidance should be read in conjunction with the LSA guidance for supervisors of midwives supporting midwives involved in child protection events.

4. Flow chart



Appendix 1

Surrogacy – The Law

The law is very clear as to who is the legal 'mother' in any case of surrogacy:

> *The woman who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs, and no other woman, is to be treated as the mother of the child* (Human Fertilisation and Embryology Act (HFE) 1990, s27 (1)).

This position is held until the appropriate legal order is passed, enabling the passing of legal responsibility from the 'mother' to another person or couple.

In surrogacy, pregnancy can be achieved by a number of permutations:

1. Egg of surrogate with sperm of commissioning man
2. Egg of surrogate with sperm of donor
3. Egg of commissioning woman with sperm of commissioning man
4. Egg of commissioning woman with sperm of donor
5. Egg of donor with sperm of donor

In 1985 the Surrogacy Arrangements Act was passed, making commercial surrogacy illegal in the UK. The Act allows for altruistic surrogacy, through a private arrangement not an agency, with payment of expenses only. Midwives and doctors assisting in the arrangements, in the normal course of their professional involvement, are not guilty of a criminal offence unless they contravene the terms of the Act. However, most midwives were not aware of the legality of surrogacy until very recent times; perhaps because there were few cases or, quite possibly, most cases were not declared during the midwife's involvement.

In 1990, this Act was amended by section 36 of the Human Fertilisation and Embryology Act, in line with the earlier Warnock Report's recommendation, by the inclusion of a section stating that the arrangement was unenforceable. Hence, the mother (the woman bearing the child) could not be forced to release the baby, nor could the commissioning couple be forced to take the baby. In any case of dispute, courts would have to decide in the best interests of the child.

In 1997, Margaret Brazier, Professor of Law, led a small team in reviewing surrogacy. In October 1998 the report was presented to Parliament: *Surrogacy. Review for Health Ministers of Current Arrangements for Payments and Regulation*. With regard to payments, reasonable expenses only can be claimed, to prevent any suggestion of the baby being

'bought' or any other commercial element. Generally, midwives do not need to know the detail; however, if caring for a surrogate mother who requires advice, the Brazier Report suggested a list of items (see Brazier Report or Jones & Jenkins 2004, p146). With regard to regulation, the report proposed three options; the committee's preference was the development of a Code of Practice, which could also be referred to in the guidance issued by the HFEA and professional bodies. In view of the committee's findings, it also recommended the development of a new Surrogacy Act, to incorporate its other recommendations. In the spring of 1999 a consultation exercise was carried out, looking at whether payments should be made to surrogates and whether such payments should be regulated. At the point of writing there has been no new legislation in this field, nor has there been the publication of any form of Code of Practice, so the Surrogacy Arrangements Act 1985, as amended by the HFE Act 1990, is the current legislation.

A midwife's duty of care in the case of surrogacy arrangements, is to the surrogate mother (the woman bearing the child), and then includes the baby once born – as in any other childbearing situation. The wishes of the surrogate mother are paramount and only when she has given permission for the commissioning couple to take, or be involved with the baby, does the midwife have any duty to them. The duty then is to inform, advise and support them in the care of the baby during the neonatal period, as a midwife's duty of care for the neonate continues, regardless of its location. Appropriate transfer arrangements must be made to a midwife and health visitor in the couple's area of residence, to ensure that care, screening and health surveillance can continue. While involvement with a case of surrogacy might be novel, even exciting for some, it is important to remember the sensitivity of the situation. Maintaining confidentiality for all parties is very important and disclosure should be on a 'need to know' basis.

The notification of birth must be completed with the surrogate's details, as she is legally the mother. If she is a married woman and her husband was in agreement with the arrangements made, then he is the father until the legal transfer of parental rights takes place. In all other cases the father would be recorded as 'unknown', regardless of whose gametes (egg/sperm) have been used to create the baby. The legal process for the commissioning couple depends on the form of surrogacy that was undertaken. If the genetic makeup of the baby comes from either or both of the partners (as in examples 1, 3 & 4 above), then they can apply to the court for a 'parental order', which enables the child to be treated as if a child within a marriage. The application must be made within six months of the child's birth, with the child in their custody, living in the UK, Channel Islands or Isle of Man, and with the consent of the surrogate parent(s) (HFE Act, s30). In cases of surrogacy where

gametes from either commissioning partner have not been used (as in examples 2 & 5 above), the couple must apply for an adoption order to acquire parental responsibility.

(Adapted from Jones S R & Jenkins R (2004) The Law and the midwife, 2nd edn, p145 – 147. Oxford, Blackwell Publishing)

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HFE Authority (2005/6) Guide to Infertility. London, HFEA

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(a case study about surrogacy)

S R Jones, February 2006

GUIDELINES FOR SUPERVISORS OF MIDWIVES SUPPORTING MIDWIVES INVOLVED IN CHILD PROTECTION CASES

1. Introduction

1.1 Child Protection is securing the wellbeing of children [born or unborn] by protecting them from all forms of harm [i.e. abuse, neglect or exploitation].

1.2 Child protection is governed by statute and the relevant Law is The Children Act 1989. Section 47 of the Act states that other agencies have a duty to assist lead services in child protection cases [see appendix]. The process depends crucially on effective information sharing, and collaboration and understanding between agencies. (Also Children Act 2004, which received Royal assent on 15 Nov 2005, some of which came into being immediately).

1.3 Child protection is dependent upon all care providers being alert to signs and symptoms of abuse, clear and timely record keeping and communication.

1.4 It is recognised that child protection has become increasingly a part of midwives' working lives.

1.5 Therefore this guidance has been produced primarily for the use of supervisors who support midwives in child protection issues.

1.6 The supervisor should have attended appropriate training [level 3 or equivalent] and have a sound knowledge of legislation, responsibilities and principles which underpin the work of Child Protection Services in promoting and safeguarding children's welfare, and assessing children's needs.

1.7 It is important that the supervisor understands and acknowledges the potential distress and possible pressures arising from midwives' involvement in child protection cases.

1.8 The supervisor will ensure that appropriate support and guidance is available for midwives if required.

1.9 This guidance should be read in conjunction with the following LSA Guidelines:

- Guidelines for Supervisors of Midwives Supporting Midwives in Caring for Women Involved in Surrogacy.
- Guideline Section 3.7: Home Births.
- Guidance for Supervisors of Midwives on the Scope & Function of the Role of the Maternity Support Worker.
- Guidelines for Supervisors of Midwives Supporting Midwives in Court Cases.

- Trust Policies on Lone Workers and Domestic Violence, and Child Protection Guidance.

2. Principles

The Framework for assessment for children in need (DOH 2000) report, states that:

"The midwife and health visitor are uniquely placed to identify risk factors to a child during pregnancy, birth and the child's early care"

2.1 Statutory supervision recognises that all midwives are accountable and must be competent to practice in a range of settings to provide a safe and responsive service to mothers and babies. Supervisors therefore must recognise their important role in the continual professional development of midwives and maintain their knowledge base in order to support midwives.

2.2 Supervisors play a pivotal role in safeguarding and enhancing the quality of midwifery care provided to mothers and babies and, therefore, ensure that midwives provide a duty of care to all families involved in child protection cases in line with NMC regulations and local Trust guidelines.

2.3 Supervisors will support midwives professionally through the difficult process of child protection.

2.4 Supervisors are aware of their responsibilities in empowering midwives to adapt to constantly changing professional practice and the complexities within the field of child protection.

3. Role of the Supervisor

3.1 The supervisor needs to be able to support midwives by acting as a resource for midwives, advising midwives and giving practical support to meet the needs of the individual midwife (NMC 2002).

3.2 The supervisor needs to ensure that her knowledge base has sufficient information to support a midwife. However, child protection is a specialist field and the supervisor may need to direct the midwife to other experts. It is recognised that supervisors may require support.

3.3 Supervisors should be aware of current national guidance relating to training for midwives and network with appropriate members of the Trust to ensure that training is provided.

3.4 Advisory Support

The supervisor should:

- Ensure that midwives liaise with the named midwife for child protection ("There should be an identified Named Midwife for Child Protection within all Maternity units" p17 Royal College of Paediatrics and Child health 2006).
- Be familiar with child protection guidance issued by the Safeguarding Children Board.
- Ensure that the midwife understands her role and responsibilities within child protection; in particular that the midwife has a duty to participate in these procedures, including providing her professional opinion. The supervisor needs to remind the midwife of her individual accountability and that the midwife will need to justify her decisions in all aspects of the child protection process.
- Ensure that the midwife is familiar with other relevant policies that impact upon child protection work, such as any lone worker policies
- Reinforce the issues of confidentiality and record keeping.

3.5 Practical Support

The supervisor should:

- Facilitate the reflective process to enable the midwife to learn from the process.
- Identify risks with regard to the information provided by the midwife and undertake the necessary follow up action:
  1. Risk of violence to midwife. Support the midwife in informing management, devising a specific plan to protect the midwife including, if necessary, accessing the police.
  2. Compromise of health and emotional wellbeing of the midwife. The supervisor needs to assist the midwife in obtaining the necessary support from relevant professionals.
  3. Training issues. If a training need is identified then the supervisor must support the midwife in accessing the relevant training.
  4. If there is a clinical risk identified then the supervisor must follow the process for clinical governance and support the midwife through this process.
- Support the midwife in the preparation of statements required as part of the child protection procedures.
- Help the midwife to prepare for participation in a case conference or providing evidence in court.

4. References

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5. Reading list

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APPENDIX

CHILD PROTECTION – THE LAW

The law pertaining to today's child protection rules and regulations comes from the Children Act 1989, which came into force in October 1991, and the Children Act 2004, which received Royal assent on 15 Nov 2004, and some of which came into being immediately. The guiding principal of this Act is that the best place for a child to be cared for is within its own family. The courts expect that proceedings take place in a timely manner and that any delays are minimised. Therefore the local authorities should have done everything possible to help families stay together, whilst protecting the child's safety, before court proceedings are commenced.

The key themes of the Children Act are:

- The child's welfare is the main priority.
- Whenever possible children are best brought up within their families.
- Unwarranted interference in family life should be avoided.
- Local authorities need to provide services for children and families in need.
- Local authorities, parents and children should work in partnership.
- Courts should manage children in a different way to adults.
- Appeals can be made against court decisions.
- Parental rights are preserved when local authorities are looking after children.
- All children looked after by local authorities should receive a good standard of care.

Child Protection Conferences.

Section 47 of the Act allows professionals to make enquires into a child's safety through child protection conferences. These conferences can be called when "*a local authority-*

A *are informed that a child who lives or is found in their area –*

i *is the subject of an emergency protection order; or*

ii *is in police protection or*

B *have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm,*

The authority shall make, or cause to be made, such enquires as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare".

The phrase 'significant harm' is further explored in section 31 of the Act.

"*Harm means ill treatment or the impairment of the health and development; development mean physical, intellectual, emotional, social behavioural development; health means physical or mental health; and ill treatment includes sexual abuse and forms of ill treatment which are not physical.*

Where the question of whether harm suffered by a child is significant turns on the child's health or development, his health or development shall be compared with that which could reasonably be expected of a similar child".

Therefore the Act does not supply a list of situations that may result in a child receiving significant harm warranting enquires from the local authority. Instead it interprets the phrase 'significant harm', leaving the professionals to make a decision as to whether the situation the child is in, will lead to significant harm.

Family Support Conferences.

It shall be the general duty of every local authority (in addition to the other duties imposed on them by this part) –

A To safeguard and promote the welfare of the children within their area who are in need; and

B so far as it is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs".

When partnership with parents and joint planning is achievable to safeguard children, the authorities may initiate section 17 of the Act, through a family support conference. This section allows for the safeguarding of children whilst the children remain at home with their parents, by providing an appropriate range of services.

<u>The Children Act: Court Orders.</u>

Police Protection Orders

This order allows the police to take a child away from a dangerous situation or to *stop a child being removed from a place of safety, such as a hospital.*

Police Protection Orders are only used in emergencies and only last for a maximum of 72 hours.

If the concern about the child is not resolved in this period of time, Social Care & Health may then decide to apply to the Court for an Emergency Protection Order or an Interim Care Order.

Whilst a child is under Police Protection, he/she will normally be accommodated by Social Care & Health.

Emergency Protection Orders (EPO)

This order places the child under the care of the local authority for a maximum period of 8 days, it will only be granted in extremely urgent cases. In exceptional circumstances the court may extend the order for a further 7 days.

There is no right of appeal against the order, however the child's carers can apply for the order to be discharged after 72 hours, if the court is in agreement. The order allows the authority to remove the child from its parents to other safe accommodation, and allows time for the initiation of any actions necessary to safeguard the child in the future. On expiry the child must be returned to the parents unless a care order has been granted.

Care Order.

This order places the child under the care of the local authority until the age of 18, unless the court discharges the order earlier, due to a change in the child's circumstances. The local authority takes on the power of parental responsibility, which it shares with the parents, wherever the child is residing. If a dispute over the arrangements for the child arose, the authority would have the final say, and would have the power to remove the child from its place of residence.

The court can make an interim care order, if the full facts of the child's situation are unknown at the time of application. This order lasts for 8 weeks with an extension of 4 weeks in exceptional circumstances.

Supervision Order

When the authority does not need parental responsibility, but needs to ensure access to the child, it will apply for a supervision order. The appointed supervisor (local authority officer) has three specific duties.

1. To advise, assist and befriend the child.
2. To take all reasonable steps to ensure that the order is effected.
3. To apply for a variation or discharge of the order.

The order lasts up to 1 year but can be extended for 3 years. The order gives to supervisors the power to impose requirements on those with parental responsibilities for the child, or any other person with whom the child is residing.

Assessment Order

The purpose of this order is to allow an assessment of the child's needs to take place. These orders are seldom used, and are for non-emergency situations when the co-operation of the parents cannot be achieved. The order lasts for 7 days and can be appealed against.

Powers available to the court.

- **A residence order.** This order requires the child to live with a specified person, and that person may exercise parental responsibility.
- **A contact order**. Requires the child's carer to allow the child to have contact with a named person under any terms dictated by the court.
- **A prohibitive steps order.** Prevents a named person form doing certain activities, which might affect the child.

Parental responsibility

Section 3 "*Means the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to a child and his property".*

Parental responsibility automatically goes to married parents and unmarried mothers. Unmarried fathers would have to gain a parental responsibility agreement with the mother or a court order to obtain parental responsibility.

The local authority gains parental responsibilities through the above court orders. These orders then limit the parental responsibilities of the parents. The parent will only lose all parental responsibilities when an adoption order is made.

The Human Rights Act 1988

Article 3

The Act guarantees that no individual shall be subjected to torture or to inhuman or degrading treatment or punishment. Therefore the onus is on the professional to safeguard children's rights including their right to life, and if any one knows of a child at risk they have to take appropriate action.

Article 8

Everyone has the right to respect for his private and family life. There shall be no interference with this right by a public authority with the exercise of this right except such as in accordance with the law.

Magistrate's court

The majority of the child protection work is dealt with in these courts. There are grounds for appeal to higher courts. Child protection cases are confidential and held in closed court. This is not a criminal court and therefore is not concerned with finding a guilty party, however they will serve orders in the child's best interests. Very rarely will a midwife be asked to give evidence at either criminal or care proceedings, but if so an insight into court proceedings is advisable.

The unborn child

An unborn child has no legal rights within the English judicial system. However as a professional you can set systems in place to protect the child once born as the Children Act allows the authority to apply for court orders where the child is exposed to a "likelihood to suffer significant harm".

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Trudie Roberts, May 2006

MATERNITY WORKLOAD STATISTICS
31 MARCH 2007

APPENDIX F

DISTRICTS	TOTAL BIRTHS	BIRTHS PER M/W	NORMAL DELIVERIES		CAESAREAN SECTIONS				EPIDURALS/SPINALS		EXAMINATION OF NEWBORN	
			Number	% of total births	Emergency	Elective	Total	% of total births	Number	% of total births	M/Ws trained	M/Ws perform
Worcestershire	5792	30.3	3449	59.55	903	653	1556	26.86	2485	42.90	23	18
Herefordshire	1846	36.5	1201	65.06	251	183	434	23.51	640	34.67	4	2
Shropshire	5081	30.3	3896	76.68	388	223	611	12.03	1399	27.53	42	32
North Staffs	5434	32.3	3955	72.78	591	689	1280	23.56	1576	29.00	23	14
South Staffs - Stafford	2384	32.7	1508	63.26	233	145	378	15.86	671	28.15	8	8
- Burton	3532	32.8	1614	45.70	435	298	733	20.75	1444	40.88	4	4
Warwickshire - Nuneaton	2530	34.5	1848	73.04	390	234	624	24.66	977	38.62	0	0
- Warwick	2641	37.0	1652	62.55	385	275	660	24.99	977	36.99	5	4
Birmingham - Heartlands *	7120	37.5	4738	66.54	1120	572	1692	23.76			14	14
- Good Hope	3355	37.1	2463	73.41	465	372	837	24.95	669	19.94	15	15
- City Hosp.	3481	34.1	2273	65.30	675	271	946	27.18	1253	36.00	8	6
- Women's	6835	32.2	4316	63.15	1057	623	1680	24.58	2520	36.87	1	1
Coventry	5194	35.1	3199	61.59	728	494	1222	23.53	1857	35.75	5	5
Dudley	4269	40.9	2751	64.44	613	591	1204	28.20	873	20.45	16	14
Sandwell	2543	28.8	1619	63.66	460	296	756	29.73	827	32.52	5	0
Walsall	3764	33.0	2377	63.15	623	330	953	25.32	957	25.43	33	27
Wolverhampton	3361	29.5	2077	61.80	579	313	892	26.54	1331	39.60	11	5
WEST MIDLANDS TOTAL	**69162**		**44936**	**64.97**	**9896**	**6562**	**16458**	**23.80**	**20456**	**29.58**		

* information not available for number of epidurals