



Nursing & Midwifery
Council

NMC

Supervision, support and safety:

Analysis of the 2008–2009 local supervising
authorities' annual reports to
the Nursing & Midwifery Council

The Nursing & Midwifery Council exists to safeguard the health and wellbeing of the public.

- We register all nurses and midwives and ensure that they are properly qualified and competent to work in the UK.
- We set the standards of education, training and conduct that nurses and midwives need to deliver high quality healthcare consistently throughout their careers.
- We ensure that nurses and midwives keep their skills and knowledge up to date and uphold the standards of their professional code.
- We ensure that midwives are safe to practise by setting rules for their practice and supervision.
- We have fair processes to investigate allegations made against nurses and midwives who may not have followed the code.

Contents

Executive summary	2
Introduction	4
Rule 16 standard 1: Each LSA will ensure their report is made available to the public	8
Rule 16 standard 2: Numbers of supervisors of midwives appointments, resignations and removals	10
Rule 16 standard 3: Details of how midwives are provided with continuous access to supervisor of midwives	18
Rule 16 standard 4: Details of how the practice of midwives is supervised	22
Rule 16 standard 5: Evidence that service users have been involved in monitoring supervision of midwives and assisting the LSAMO with the annual audits	28
Rule 16 standard 6: Evidence of engagement with higher education institutions in relation to supervisory input into midwifery education	32
Rule 16 standard 7: Details of any new policies related to the supervision of midwives	36
Rule 16 standard 8: Evidence of developing trends that may impact on the practice of midwives in the LSA	40
Rule 16 standard 9: Details of the number of complaints regarding the discharge of the supervisory function	44
Rule 16 standard 10: Reports on all LSA investigations undertaken during the year	48
Conclusions	53
Summary of recommendations	54
Appendix 1	56
Glossary	57

Executive summary

This report is an analysis of the information provided by local supervising authorities (LSAs) to the Nursing & Midwifery Council (NMC) for the 2008–2009 practice year. The data and trends shared in these reports affect the safety of women and babies using the maternity and midwifery services across the UK. As in previous years, the NMC will make the individual LSA reports available online at **www.nmc-uk.org**

There have been increases in midwifery ratios in some areas and good practice regarding service development for some of the most vulnerable families.

However there are concerns regarding:

- the continued rise in birth rates and increasing complexity of births in many LSAs
- the increasing numbers of experienced midwives and supervisors of midwives (SoMs) who may leave the workforce as they approach retirement age
- the quality and variability of maternity data which is used to monitor trends and public health outcomes, and which is collected either manually or by a plethora of maternity information systems
- the increased numbers of midwives recommended to undertake a period of supervised practice
- the areas of practice that need further improvement including assessment of the fetal condition, fetal heart interpretation in labour, record keeping, communication skills, drug errors, assessment of the maternal condition and appropriate referral to more experienced personnel.

Reconfiguration of maternity services and plans for service mergers continued to be a theme across the UK during 2008–2009. Maintaining safe and woman-centred services during such challenges is supported by the supervisory framework. LSA reports provide evidence that supervision of midwives is an effective method of public protection, as poor practice is identified and action taken with individuals and services to support improvement. The LSAs engagement with public safety is an important aspect of their function.

LSAs' have reported that they have conducted an annual audit of all maternity services in their geographical areas against agreed LSA standards. LSAs have demonstrated that midwives have continuous access to a SoM and that there are no concerns regarding SoM response times. The involvement of service users in monitoring the statutory requirements continues to improve. There is continued evidence of engagement with approved education institutions (AEIs) and further LSA collaboration regarding the review and updating of LSA guidelines to promote consistency of practice. The LSA database is in use in all but one LSA consortium and this one will be coming on board from early 2010.

Introduction

The core function of the Nursing & Midwifery Council (NMC) is to establish standards of education, training, conduct and performance for nurses and midwives, and to ensure those standards are maintained, thereby safeguarding the health and wellbeing of the public (the Nursing and Midwifery Order 2001). The NMC is required to set rules and standards for midwifery (*Midwives rules and standards*, 2004) and for the local supervising authorities (LSAs) responsible for the statutory supervision of midwives. The NMC *Midwives rules and standards* are currently being reviewed and the date for completion is 2011.

Practice years run from 1 April to 31 March. Rule 16 of the NMC *Midwives rules and standards* requires that each year, every LSA has to submit a written report to the NMC by the deadline date, and that the report contains any information specified by the NMC (NMC circular 01/2009). All LSA reports were received by the NMC within the due timeframe.

The NMC has a duty to monitor that the LSAs are meeting its requirements and the annual report helps the NMC to do this. It is one opportunity for each LSA to inform the NMC and the public about its activities and key issues.

LSAs are organisations that hold statutory roles and responsibilities for supporting and monitoring the quality of midwifery practice through the mechanism of statutory supervision of midwives. The LSA has a pivotal role in clinical governance and public safety by ensuring the standards for the supervision of midwives and midwifery practice meet the requirements set by the NMC.

LSAs sit within strategic organisations such as an NHS authority and the type of organisation varies in each country of the UK. In England, the LSAs are the Strategic Health Authorities (SHAs); in Wales, the Healthcare Inspectorate Wales; and in Northern Ireland, it was the four Health and Social Services Boards (HSSBs). Since 1 April 2009 the LSA function in Northern Ireland has been held by the Public Health Agency. In Scotland, the functions of the LSAs are provided by the health boards, which are arranged into three regions or consortia: the West of Scotland, the North of Scotland and the South East of Scotland. The chief executive officer (CEO) of each organisation is ultimately responsible for its LSA function. As of 1 April 2009 there were 26 LSAs across the UK with 16 appointed local supervising authority midwifery officers (LSAMOs) (see table 1).

Table 1 UK local supervising authorities 2009

England	Northern Ireland	Scotland	Wales
East of England SHA	Public Health Agency	North of Scotland consortium	Healthcare Inspectorate Wales
East Midlands SHA		NHS Grampian	
London SHA		NHS Highland	
North East SHA		NHS Orkney	
North West SHA		NHS Shetland	
South Central SHA		NHS Tayside	
South East Coast SHA		NHS Western Isles	
South West SHA		South East of Scotland consortium	
West Midlands SHA		NHS Borders	
Yorkshire and the Humber SHA		NHS Fife	
		NHS Forth Valley	
		NHS Lothian	
		West of Scotland consortium	
		NHS Ayrshire and Arran	
		NHS Dumfries and Galloway	
		NHS Greater Glasgow and Clyde	
		NHS Lanarkshire	

The LSAMO puts the responsibilities of the LSA into practice and this work cannot be delegated to another person or another role. The LSAMO is a practising midwife who provides leadership, support and guidance on a range of matters. The LSA is responsible for the protection of the women and babies using midwifery services in its area. Safety for mothers and babies can only be achieved if local trusts, health boards and health authorities are engaged with the supervision framework and act on maternity matters brought to their attention by the LSAMO.

Supervisors of midwives (SoMs) are experienced midwives who have undergone additional education and training in the knowledge and skills needed to supervise midwives. They can only be appointed by an LSA, not by an employer, and act as an impartial monitor of the environment of care and the safety of midwives' practice. They are accountable to the LSA for all their supervisory activities. By appointing a SoM, the LSA ensures that support, advice and guidance are available for women and midwives 24 hours a day to increase public protection. SoMs have a responsibility to bring to the attention of the LSA any practice or service issues that might jeopardise midwives' ability to care for women and their babies.

As part of the NMC LSA risk framework, individual LSA risk profiles were provided to each LSA. The LSA reports made reference to their individual risk scores and provided information about what steps they had taken to improve them. During 2008–2009, five LSAs with the highest risk scores were reviewed. A sixth LSA with the lowest risk score was also reviewed to test the framework. The reports of these reviews are available at www.nmc.org.uk. Action plans were developed by LSAs in response to any recommendations arising from these reviews and progress against these actions were reported in their latest annual report. A further six LSAs are being reviewed by the NMC during the 2009–2010 year: Healthcare Inspectorate Wales, West Midlands, Yorkshire and the Humber, South West, South East of Scotland consortium and East of England. It is expected that any recommendations arising from these reviews will have action taken by the LSA and reported in their annual report for 2009–2010. The NMC review framework is moving from a risk assessment model to one of quality measurement.

An update on the progress of the recommendations set for the NMC in the previous year 2007–2008 can be found in appendix 1.



Rule 16 standard 1:

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

Guidance

Please provide details of how and when your LSA makes the report available and accessible to the general public and key organisations.

All LSAs identified that their report would be placed on the public domain of their website which was cited as that of the local SHA or health board. Most have a dedicated LSA section although a few are still under construction. All reports provided a website address or link. Links from these sites to the LSAMO forum UK website www.midwife.org.uk were also described.

Some also placed the report on the websites of the universities who run the Preparation of Supervisors of Midwives (PoSoM) course. Reference was made to the fact that the reports will also be placed on the NMC website www.nmc-uk.org

Alongside publication on websites, copies were distributed electronically at strategic and local level.

Circulation lists were described and included:

- Department of Health maternity advisers
- chief nursing officers
- Royal College of Midwives (RCM) officers
- CEOs for maternity services at both strategic and local level
- education commissioners
- directors of nursing
- directors of workforce
- patient safety leads
- maternity and newborn clinical pathway leads
- quality improvement leads
- directors of commissioning for maternity services
- heads of midwifery

- lead midwives for education (LME)
- SoMs
- clinical governance committees
- maternity service liaison committees (MSLCs) and other user groups
- National Childbirth Trust (NCT)
- Centre for Maternal and Child Enquiries (CMACE) (formerly CEMACH)
- directors of public health
- Independent Midwives UK (formerly Independent Midwives Association [IMA])
- National Patient Safety Association (NPSA)
- President of the Royal College of Obstetricians and Gynaecologists (RCOG)
- LSA lay reviewers

Hard copies were produced and distributed to a number of key stakeholders as described above. The largest print run described was 500.

Individual hard copies were also available on request from the LSA office.

Other examples of how LSAs were making their annual report available to the public included:

- having it available in local and higher education institution libraries
- LSAMOs and SoMs presenting the content of the report to local MSLCs
- a summary of the annual report was given to user representatives who did not wish to receive a full copy of the report
- using the report in lay audit training
- tabling the report at a variety of LSA meetings, presenting at conference and study events
- giving the report to PoSoM course leaders for use in teaching.

Good practice

In Yorkshire and the Humber, the LSAMO has a notification of the report as part of the footer on their outgoing email throughout the year.

Rule 16 standard 2: **Numbers of supervisors of midwives appointments, resignations and removals**

Guidance

Please include data for the preceding three years and provide a summary of any trends and actions plans if any risks have been identified (and mitigated against):

- total number of supervisors working in your LSA
 - total number of midwives working in your LSA
 - new appointments
 - resignations
 - removals
 - ratio of midwives to SoMs across your LSA
 - ratio of midwives to supervisors for each maternity service as of 31 March 2009
 - information about your recruitment strategy to ensure you have sufficient and sustainable numbers for the future
 - SoMs who are suspended from their role for any period
 - SoMs removed from their role
 - reasons for suspensions or removals
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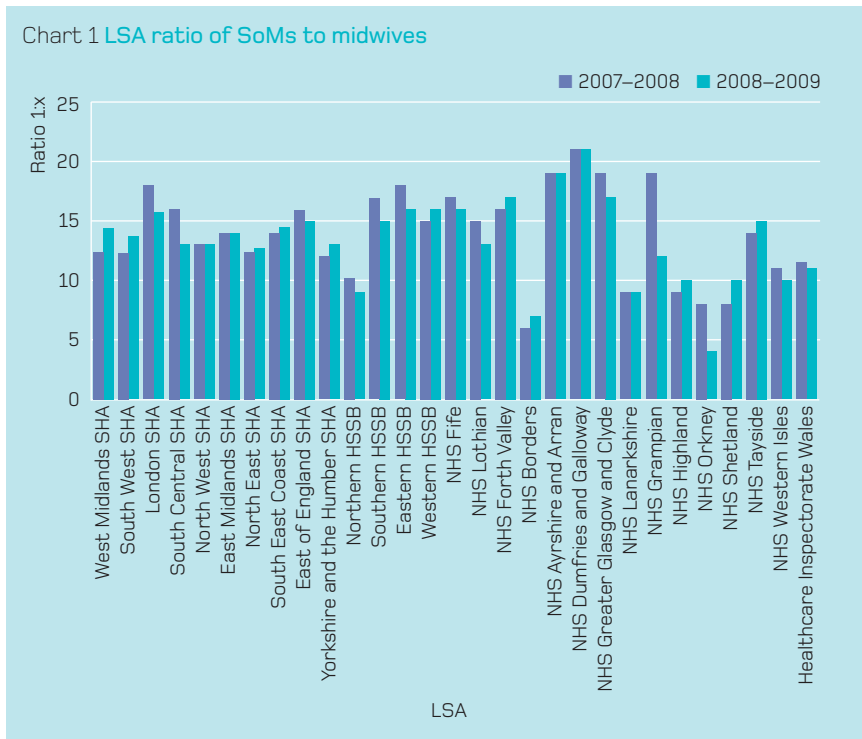
All reports except Northern Ireland provided details of the numbers of SoMs working in their LSA during 2008–2009. Clear information of new appointments, resignations, leave of absence and removals were provided for the most part. The majority gave details of the trends over the last three years relating to this standard.

Number of SoMs

The overall number of appointed supervisors has increased over the past three years. This rise needs to be considered against any increase in the number of practising midwives, whether part- or full-time, as well as other aspects of recruitment strategies such as return to practice midwives who all require a named SoM.

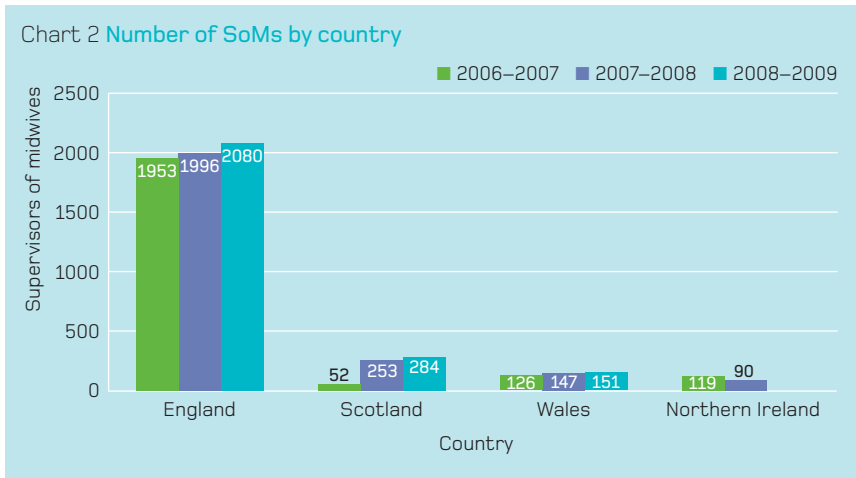
LSA ratio of supervisors to midwives

The LSA ratios of SoMs to midwives were provided in all reports. At the end of March 2009, 21 out of 29 LSAs met or were better than the NMC minimum recommended standard of 1:15, the lowest ratio being 1:4 (Orkney). Of the eight LSAs that did not meet the NMC ratio, the highest ratio was 1:21 (Dumfries and Galloway).

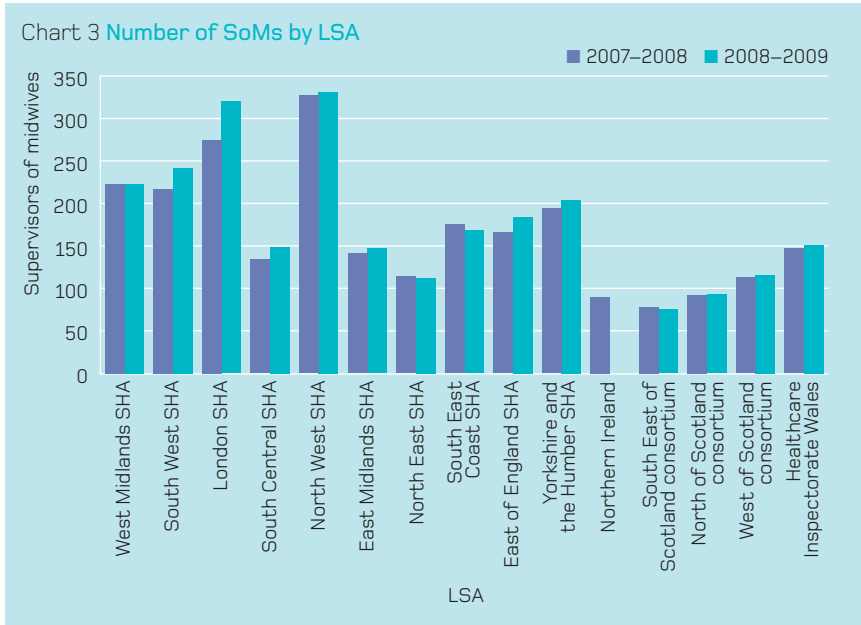


In mitigation, by the time of the annual report submission (September 2009), a number of LSAs had improved ratios as a result of recruitment strategies.

Supervision of midwives is an important governance function in any health authority. With each midwife having a named SoM, the LSA ensures that support, advice and guidance are available for midwives and women 24 hours a day to help safeguard the health and wellbeing of the public.



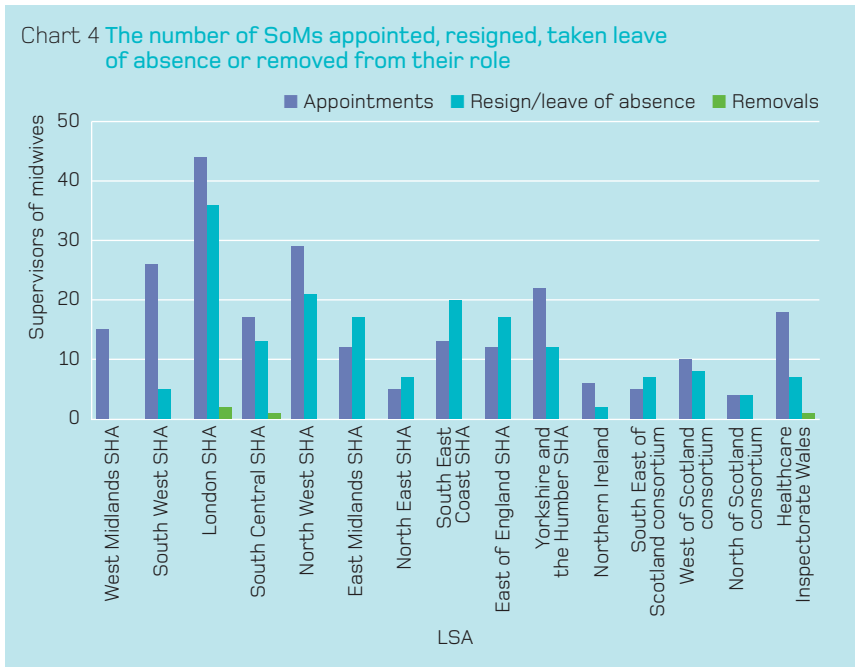
However, only two LSAs had no maternity units where the ratio of SoMs was greater than 1:15: Healthcare Inspectorate Wales and North of Scotland consortium. 54 individual maternity services (ranging from 1 to 19 services per LSA) across England and Scotland had ratios of supervisors to midwives of more than 1:15, with the highest being 1:28. Data was not provided for one LSA.



A number of reports also described high individual caseloads for some supervisors, with one example of 1:36, and a proactive approach to equitable redistribution amongst supervisory teams was recommended. Many LSAs commented that they aim for ratios of less than 1:15. Some cited 1:12 as a working target to accommodate working levels of resignation and leave of absence, acknowledging that it takes at least six months to one year to train new supervisors.

Appointments, resignations, leave of absence and removals per LSA

238 SoMs were appointed during 2008–2009 and although newly qualified SoMs were the majority, some LSAs reported a number of SoMs being reappointed either after relocation or “coming back” to supervision after a period of time out. Packages of preceptorship and support were described to support all SoMs in their role.



The number of resignations and leaves of absence continues to have an impact on any sustained increase in SoM numbers across the UK. 176 SoMs resigned or had a period of time out during 2008–2009 although some of the data regarding time out was unclear. In four LSAs and one consortium, resignations and leaves of absence appear to outnumber new appointments.

There were four removals of supervisors during the year and reasons were given in most cases. Eight supervisors were described as being suspended from their role and reasons were given.

Concerns about appointing and retaining SoMs have been highlighted in previous annual reports, and these were reiterated this year. Many supervisors give their personal time to combine the requirements of the role with busy work duties which is not sustainable, and it is one of the reasons why supervisors resign or request a leave of absence.

Approaches to supporting and remunerating SoMs remain different across the UK. Scotland and Wales have national agreements. In England it is left with individual trusts and there is variation across the 10 LSAs as to how many receive such reward. In Northern Ireland all SoMs are remunerated although the exact mechanism is unclear.

The availability of dedicated resources for supervisors is variable including private space for interviews, investigations or annual reviews, access to a personal computer at work or administrative support. This was identified by some LSAs as contributing, along with other factors, to resignations from the role.

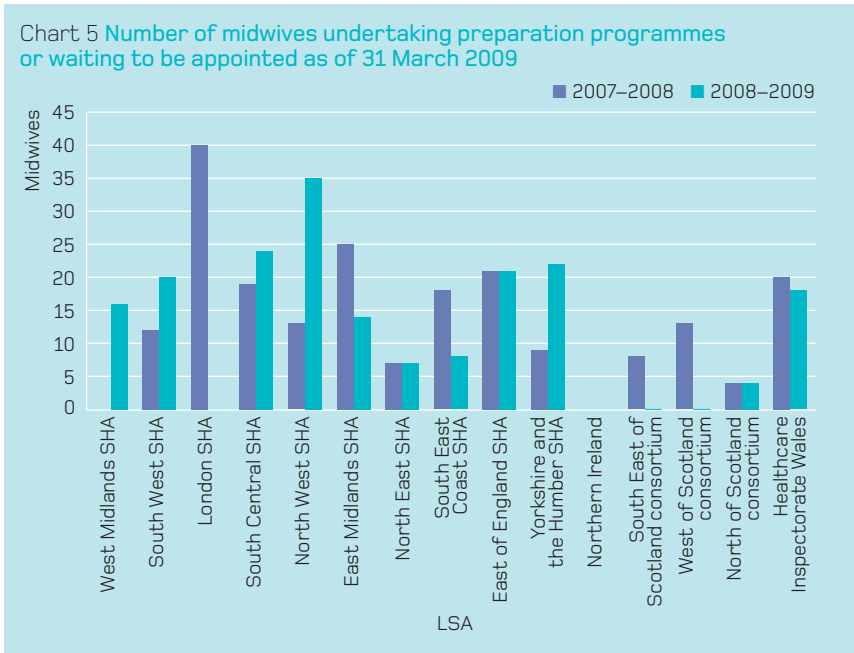
Six LSAs provided a demographic profile of their current SoMs, which indicated that 30–39 percent of them are 51 years of age or older and therefore eligible for retirement in the next 4–10 years. Many reports commented in general terms on this trend and the need for both recruitment and retention strategies to address this. Retention strategies are illustrated by the provision of investment for specific training for supervisors, which is part of their personal and professional development. Examples included leadership training and access to master classes on such topics as report writing, investigation and witness skills.

Good practice

In the East of England, the LSA is exploring with trusts the use of retired SoMs working purely for supervision so this expertise is not lost.

Preparation of midwives for appointment as supervisors of midwives

Most LSAs provided information about the numbers of midwives undertaking approved PoSoM programmes or who were waiting for appointment. The total number given for 2008–2009 was 197, a small decline on last year, and further updates were given of numbers of students recruited for programmes commencing in 2009.



Most LSAs described robust recruitment strategies for SoMs supported by the LSAMO UK guidance for recruitment and selection of SoMs (guideline C). Strategies included posters and fliers advertising the recruitment to the training and NMC SoM roadshows across the UK describing the role and what it entails. Some use LSA newsletters to advertise these opportunities. Such strategies have helped to raise the profile and promote the role. Whilst many reports described midwives keen to undertake the role, others described lack of dedicated time and a perceived lack of the value of the role as reasons why midwives would not put themselves forward.

Good practice

In the West of Scotland consortium, midwives have been encouraged to 'shadow' a SoM to further their understanding of the role as part of the recruitment strategy.

Recommendations

- LSAs should continue to monitor ratios of supervisors to midwives to support the effective performance of supervisory activities and take action to resolve concerns where they exist.
- LSAs should embed robust recruitment and retention strategies for the numbers of practising SoMs across their region in light of the future workforce challenges.

Rule 16 standard 3: Details of how midwives are provided with continuous access to supervisor of midwives

Guidance

- How do midwives contact their named SoM?
- How do midwives contact a SoM in an emergency?
- What are your contingencies if a SoM is not contactable?

Please provide evidence of how access to a SoM is audited in your LSA including:

- continuous access to a SoM
- response times from SoMs to requests for advice from midwives in challenging situations
- response times from supervisors to requests for advice from women in challenging situations
- outcomes and action plans resulting from these audits.

All LSA reports provided information on how this standard was met, and indicated that midwives were offered a choice of SoM at commencement of employment. In circumstances where the SoM's caseload was over the recommended 1:15 midwives ratio, many reports indicated that midwives were asked for a first, second and third choice. In one LSA, it was noted to be more common for midwives to have a SoM outside of their employing trust. A number of reports indicated that SoMs provide a short profile of themselves including their area of practice and/or specialist interest for midwives to assist the latter in their choice. For newly appointed midwives unfamiliar with the team, the process usually involved the midwife being allocated a SoM until they were familiar with the service and got to know the SoMs. Where student midwives had an allocated named supervisor in their training, a number would transfer to this supervisor on registration. Midwives who had been with their named

SoM for a long period of time sometimes required support with change when their named SoM either had to reduce their caseload, stepped down or resigned from supervision.

Information about supervisors for midwives was provided in a number of ways including:

- notice boards with names, photos, profiles and supervisor lanyards
- welcome letters and packs giving information and contact details
- verbal and written information at annual reviews
- information on websites and the email addresses of SoMs
- via the contact SoM.

Information on how to change a named supervisor was included in relevant documentation.

As SoM to midwife ratios improve in LSAs, this will also support access to a supervisor.

All LSAs described the process of how a midwife would contact his or her named SoM and the process for contacting a supervisor when their named supervisor is not available or in an emergency. The process is also referred to in LSA guidelines. Most LSAs have a 24-hour, on-call rota system. The rota is easily accessible, displayed and available at a minimum in the labour ward and with the switchboard of each trust, and in a number of other places. Some trusts have a list of which SoMs are available and their contact information. Most reports indicated an increasing use of email for communication.

SoMs keep a record of calls and these are available for audit by the LSA. There is evidence of LSAs developing methodologies to log calls electronically. This will facilitate trend analysis as well as support clinical and information governance. Calls are reviewed at local SoM meetings, relevant LSA meetings and audits. Themes include complex child protection concerns, capacity of the service to meet demand and unusual clinical incidents.

Continuous access and the availability of SoMs is audited in a number of ways including rota evidence, verifying with midwives and students at audit visits, and LSAMOs phoning units at random and asking to speak to the available or on-call SoM. The contingencies for when a SoM is not available were described.

No LSAs reported any concerns about a SoM not being available and where response times were recorded, they were within 15–30 minutes and generally within a few minutes. One concern was raised regarding a response time which was linked to a lack of mobile phone signal coverage in a rural area, and LSAs are aware of the contingency of alternative land line numbers for supervisors to ensure availability. Most LSAs were planning a formal audit of response times for the 2009–2010 audit cycle.

LSAs described the availability of information for women about supervision:

- on websites
- in leaflets – both local and using the NMC information leaflet for parents
- in their maternal records
- on customised bookmarks.

These included information on how to contact a SoM, and some LSAs were seeing increasing calls from women to the supervisor or LSAMO. Although the nature of the call was not commonly described, one LSA cited that there was an increase in requests for advice in relation to homebirth against medical advice.

A number of LSAs have appointed LSA midwives as a support to the LSAMO. Some are long-standing substantive posts and others are new posts created during 2008–2009 including secondments. Although there is variation in job titles and responsibilities, there is evidence that they enable midwives and women to access a SoM.

As in previous reports, access to SoMs by self-employed midwives was described by some LSAs. The good practice of regular facilitated meetings between SoMs, LSAMOs and self-employed midwives to support communication pathways, share practice challenges, and identifying named 'liaison' SoMs for self-employed midwives is to be commended.

Recommendation

- LSAs should develop effective methodologies to monitor the frequency and nature of calls to SoMs to identify any emerging trends.
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Rule 16 standard 4: **Details of how the practice of midwives is supervised**

Guidance

How does the supervisory function work and what processes are in place for the effective supervision of midwives? This includes:

- methods of communication with SoMs
 - mechanisms to disseminate information
 - mechanisms to ensure consistency when carrying out supervisory functions
 - evidence about how your LSA has improved care to women, or enhanced and supported the practice of midwives
 - information on any challenges that impede effective supervision
 - how these challenges are being addressed
 - progress towards an electronic method of storing supervision related data.
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All reports described how the supervisory function worked within their LSA. Reference was made to the Nursing and Midwifery Order 2001 which makes provision for the practice of midwives to be supervised. The NMC *Midwives rules and standards* (2004) and LSA national and local guidelines provide the framework for statutory supervision. The detail of how the rules, standards and guidelines are put into operation at local level give structure to the framework. Practice is supervised and audited at trust level, and carried out by SoMs for that geographical area regardless of who employs the midwife. All LSAs have full-time midwifery officers in post as of March 2009 who are the lead for this work.

The LSA annual audits of maternity services are one of the main ways in which the effectiveness of the supervisory function is assessed. All LSAs carried out their audits of their respective maternity services this year, and some gave more details about the process, findings and recommendations than others. The processes relating to supervisory functions such as annual notification of intention to practise (ItP), annual supervisory review, record keeping, and investigation of practice. These are verified at the annual audit following a self-assessment undertaken by supervisory teams.

The LSA database was purchased or implemented in four more LSAs during 2008–2009. This secure, web-based tool is now in place in all but one LSA, the West of Scotland consortium, which is due to commence using it in early 2010. This enables the storage of supervisory records and other statutory supervision data, and allows the LSA to interrogate data, predict trends and raise alerts. A number of reports can be produced from the database including the number of annual reviews undertaken, incident reporting, ItP notification, age profiles of midwives and supervisors of midwives, and the ratio of part-time to full-time midwives and SoMs. Useful information regarding midwifery trends have been identified and form part of the audit process and supervision data governance. Consistency is thought to be improving as a result.

A number of reports referred to the risk scores they received from the NMC following the submission of their 2007–2008 annual report and the actions the LSA had taken. For those LSAs that had been reviewed during 2008–2009, information regarding their action plans and progress against them were included. NMC review reports are available from the NMC website www.nmc-uk.org

Communication from the LSA to SoMs is two-way, individual and through groups. As well as the information sharing facility of the database, the use of individual and group emails cascaded via the contact supervisor is common. Phone (mobile or landline), pagers, letters and memos are also used. All LSAs have contact SoM meetings and the national LSA guideline (guideline M) regarding the role of the contact SoM was developed during 2008–2009.

Following review, one LSA has identified particular competencies relating to the role of contact SoM. There are also opportunities for communication at local audit visits, conferences and study days. Personal face-to-face meetings also take place and video or telephone conferencing is used especially where there is great geographical distance. There was evidence of SoMs using a variety of information technology tools to share information. For example, Wales LSA uses a PBWiki website.

National and local LSA guidance and standards are in use in all of the LSAs to promote consistency. All LSAMOs are active members of the UK forum which leads on developing and updating the national guidelines and standards. All SoMs are given a copy of these guidelines or referred to the website www.midwife.org.uk and their local website for the latest versions to support their practice. Local and national guidelines are regularly reviewed and updated as appropriate. In relation to supervised practice, reference is made to the NMC *Standards for the supervised practice of midwives* (2007). A number of agreed templates for reports, investigations and meeting agendas have been described to further support the consistency of supervision. If concerns are raised about inconsistent advice or practice, LSAMOs investigate and will share these concerns both nationally and locally with their supervisory peers.

All reports described ways in which supervision improves care to women and supports midwives. Descriptions of service developments for vulnerable women and their babies led by SoMs were evident throughout reports. This includes services for young parents, women with poor mental health, women who do not have English as a first language and may be new to the country, a refugee or asylum seeker, women with substance misuse or alcohol problems, and women where there are safeguarding concerns for them or their unborn child.

Many examples of SoMs supporting services to promote normal birth and working in partnership with women were also described, including the opening of midwifery-led services in Londonderry and Downpatrick in Northern Ireland, and the 'keeping childbirth natural and dynamic' (KCND) initiative in Scotland.

Women are also supported by SoMs managing clinical risk proactively. LSA support for mandatory training and updating, to ensure midwives are appropriately trained to deal with maternity emergencies and other practice needs, is evident throughout reports. However, some LSAs highlighted concerns that training is cancelled due to increased clinical activity. SoM involvement in all clinical governance activities contributes to the quality and safety of the service. If there is a concern regarding a midwife's practice, effective supervisory processes – including investigation – can help with early identification of concerns which can be addressed. Following investigation, there can be a range of outcomes including structured reflection, further training, developmental support, and in some instances supervised practice.

Amalgamation or change of some services took place in 2008–2009, namely in Wales and Northern Ireland. Planning is underway regarding mergers in the North West region of England and the Greater Glasgow and Clyde Health Board in Scotland. SoMs were a key source of support and guidance during these and other changes.

A number of reports described the support by SoMs for midwives returning to practice, which is an essential part of midwifery recruitment plans.

The most frequently cited challenges that impede effective supervision are:

- the competing demands on SoMs which prevent them using allocated protected time to undertake all supervisory activities
- insufficient administrative support for these functions which includes dedicated secretarial support, access to computers in a private setting to record supervisory activities, access to a private room to undertake supervisory reviews and investigations, and adequate locked storage for supervisory records
- increasing birth rates
- more complex births
- high midwife to SoM ratios in a number of maternity units

- recruitment and retention of sufficient SoMs to undertake all their statutory functions
- raising the profile of supervision with women and their engagement with it
- variation in recognition of the value and benefits of supervision within individual trusts.

LSAs have highlighted a number of strategies to address these challenges. These include the following:

- LSA discussions with SoMs and CEOs to highlight where there are concerns regarding the requirements for midwifery supervision to ensure safety for women and their families and support for individual SoM teams.
- Comprehensive recruitment and retention strategies for SoMs to ensure recommended ratios. This includes recruitment roadshows and LSAs identifying inequities in remuneration packages across the region which are believed to negatively impact on recruitment and retention. Maternity providers have indicated a willingness to address these concerns where they exist.
- LSAs are using a variety of methods to increase user engagement with supervision.
- LSAs are supporting midwifery recruitment strategies across the region to improve midwife to birth ratios and improve care for women.
- LSAs are supporting further improvements to comprehensive supervision data collection of a high quality which are effectively electronically stored and archived.

Good practice

Yorkshire and the Humber LSA communicate information about supervision via a monthly electronic briefing to all SoMs for dissemination to all their supervisees and within their own trusts. It is sent to others on request including LMEs, student SoMs, some SHA staff and some directors of nursing within the region. It contains a mixture of national, regional and local news including key publications, sharing of best practice and notice of LSA events.

The South East of Scotland LSA consortium has commenced a programme of electronically scanning previous supervisory data as a means of safe, secure information storage.

The North of Scotland LSA consortium has developed a tool to record the activities of their dual and triple duty midwives in order that they can demonstrate that they have met their post-registration education and practice (Prep) requirements.

Recommendation

- LSAs should provide details of actions taken to monitor that protected time for supervision is being achieved and effective administrative support is in place.

Rule 16 standard 5: Evidence that service users have been involved in monitoring supervision of midwives and assisting the LSAMO with the annual audits

Guidance

- Service user involvement in the supervision of midwives.
 - Progress against action plans to improve service user involvement.
 - Evidence of service users assisting with the annual audits of practice.
 - Training provided to service users involved in the supervision process.
-

All LSAs gave examples of the further development of service user and parental involvement in the supervision of midwives, and commented how valuable this dimension was. For all, it was an evolving process even though some have had more formal service user involvement for a number of years, while for others it was at an earlier or static stage.

At a local level, SoMs are part of well-established forums for users of maternity services in their trust or local health board. Most are members of active local MSLCs as well as other user groups such as labour ward forums and birth centre working parties. Within these groups they review feedback regarding service delivery, birth and service trends, and look at service developments or redesign such as planned birth centres. Many users will comment on information leaflets for women, look at specific services such as homebirth or services for bereaved parents. These are one source of recruitment for user involvement in specific supervisory activities such as the annual audits, recruitment and selection of supervisors.

LSAs use a number of ways to inform women about supervision including local and national websites, public notice boards within trusts and health boards, contact information in women's notes, information in bedside directories, a service user blog and specific information leaflets about supervision. One LSA website has a parents' portal.

All of the reports included action plans and strategies to improve service user involvement. Recruitment of service users came from a number of sources (including members of MSLCs, the NCT and other groups). Some LSAs had recruited a panel of LSA-approved lay reviewers. Specific advertising posters and leaflets were used. Examples were given of LSAs keeping a record of users who had contacted them in a variety of settings and who expressed an interest in being involved in future activities.

Formal training for service users was provided by the LSAs and the content described. Service users were given information about supervision, about the audit process, and in some instances a summary of the LSA annual report. In one LSA, experienced users provided one-to-one support and in some cases additional training for new service users, including opportunities for new volunteers to shadow more experienced ones.

Service users were part of the audit team in many LSAs and plans were in place for further involvement in 2009–2010 for the remaining LSAs. Their role included talking with women for assessment regarding woman-centred care. This included lay reviewers talking with women on maternity wards where appropriate and feeding their views back as part of the audit evidence. A number of LSAs had developed or were developing a structured audit questionnaire to use with women to talk about their experiences and assess their knowledge of supervision.

In a number of LSAs, service users were part of the selection panel for midwives wishing to undertake the PoSoM course, using particular observational skills to identify communication and team working skills of candidates. Service users were also involved in delivering aspects of the taught course programme especially in relation to user involvement. A number of users and lay organisations such as doula organisations gave presentations at LSA education events and conferences.

Some of the challenges to effective and sustainable user involvement were described including issues around returning to work, child care (not all LSAs pay for child care), travel and time costs.

Good practice

South West LSA SoMs work with lay groups of young and ethnically diverse groups to encourage them to consider midwifery as a career. They are given a structured placement and background information including the application process and the availability of posts. This practice has been well received.

In the West Midlands LSA, it has been arranged for a user to 'shadow' a midwife to inform her role as a lay representative.

In the Healthcare Inspectorate Wales, LSA service users commented on the draft version of the LSA annual report.

In the South Central LSA, user information is translated into other languages namely Polish and Urdu.

In the Yorkshire and the Humber LSA, the LSAMO and a service user gave a joint presentation at the NMC conference in 2008.

In the West of Scotland LSA consortium, they are working with the local community engagement officer to raise the profile of supervision and recruit service users to work with the LSAs.

South Central LSA user views were sought for National LSA guideline L which relates to the investigation of a midwife's fitness to practise.

North West LSA pay lay auditors £100 per audit visit plus a pro-rata payment of £25 and travel and childcare costs for other supervisory activities.

Recommendation

- LSAs should continue to develop innovative and sustainable ways to involve service users, particularly women from vulnerable groups, in the practice of supervision and provide robust evidence as to how this is achieved.



Rule 16 standard 6: **Evidence of engagement with higher education institutions in relation to supervisory input into midwifery education**

Guidance

- How does your LSA gain information about the clinical learning environment for pre-registration student midwives?
 - Describe the processes used to feed this back into higher education providers and commissioners.
 - List the approved education providers you use to supply preparation of SoM programmes.
 - Provide information as to how your LSA is kept informed by the LME in relation to the numbers of midwives who fail to complete the programme successfully.
 - How does your LSA determine that new SoMs are competent to undertake the role at the end of the programme?
-

As in previous years, generally robust evidence was provided in meeting this standard although there was limited detail in a few reports. All LSAs gain information about the clinical learning environment for pre-registration student midwives from a variety of sources.

All LSAs report that LSAMOs and SoMs are involved in development, delivery and monitoring of pre-registration midwifery education. SoMs are invited to give evidence regularly as part of the NMC quality assurance programme for pre-registration courses and preparation of supervisors of midwifery courses. Where return to practice programmes are run, LSAMOs and SoMs are involved. Many universities have practising SoMs based within them. All LSAs have regular, usually quarterly, meetings with LMEs where review of any education and training concerns can be raised. Involvement by SoMs in the selection of students and curriculum development is

commonplace. SoMs engage with students regularly as a named SoM for students (either individually or as a group), as well as in their role as mentors. LSA audit teams ask students their views on their clinical learning environment at annual audits, when they teach them, as well as asking their mentors, lecturers and clinical leaders such as heads of midwifery (HoM) about the practice environment. They also visit the practice environment. LSAs describe overwhelmingly positive feedback from students.

All LSAs described regular meetings with higher education providers where they give feedback regarding curriculum planning, course management and the learning environment. In one LSA these meetings had been re-established. Only some mentioned regular feedback opportunities to education commissioners, although for some LSAs, such opportunities were described in other parts of their reports when describing workforce planning initiatives. Where joint meetings between LSAs, education commissioners, education providers, senior midwifery leaders and workforce planners are in place, they have been found to be very effective.

Only one LSA report did not provide the information listing approved education providers used to supply PoSoM programmes. There are currently 18 approved courses across the UK. All LSAMOs are part of the team involved in the curriculum planning, course management, assessment, evaluation of courses and delivery of key sessions within those courses. The support for SoM mentors was described in line with NMC mentor criteria, and mentor preparation and workshops are provided.

All LSAMOs are part of the selection process for the course, and all have regular meetings and close communication with course leaders and LMEs. The majority are part of the course management team, and teach and assess on courses. This provides regular and ongoing updates for them regarding the progress of all students and provides opportunities to meet with students. Examples were given of LSAMOs viewing the portfolios of the students as part of the course assessment process and meeting students on a one-to-one basis during and at the end of the course. Most described being formally notified by the course leader of those who had passed, failed or deferred from the course. One report described recording the course outcome of the individual on the LSA database, which is good practice.

Most reports described the process by which they determine that new SoMs are competent to undertake the role at the end of the course. As the LSAMOs are involved in the course and with the students throughout the course, they are aware of their competencies. All students will have a sign-off mentor throughout the course who provide feedback and assessment regarding competency to the LSA, as do students themselves and their mentors. Reference was made to LSA national guideline C for SoMs (nomination, selection and appointment of supervisors of midwives). Most reports described LSAMOs meeting with students at the end of the course. Some described reviewing student portfolios with reference to the NMC competencies for SoMs to ensure appropriate sign-off by a SoM sign-off mentor, course leader and then the LSAMO.

Preceptorship was offered to all newly appointed SoMs; a number of self-audit and benchmarking tools are used to assess competence and influence personal development plans as a SoM. Some LSAs provide meetings for newly appointed SoMs and invite them to complete a preceptorship package which is on the LSA website. Others provide quarterly action learning sets for new SoMs. Preceptorship follows LSAMO forum guidance. Open access is provided to all SoMs, including to those newly appointed, by the LSAMO shortly following appointment to allow the LSAMO to assess progress. A number of audit and competency tools were described for self-audit by the SoM to demonstrate they meet NMC competencies. These are reviewed by the LSAMO and inform the SoM's personal development plan.

Other professional and practice development for SoMs was also provided, including the development of competency assessment tools for all SoMs however long they had been in practice. Many examples were provided of professional development for SoMs which had been commissioned by LSAs, including workshops on supervisory investigation skills, statement writing, report writing and witness skills. Much of this content is included in preparation courses.

Good practice

The West of Scotland LSA consortium and the University of the West of Scotland are developing a directory of competencies that SoMs and educationalists can use following supervisory investigations that recommend supervised practice.

The North West LSA has developed a benchmarking tool for all SoMs to demonstrate that they meet NMC competencies.

The East Midlands LSA invites newly appointed SoMs to regular meetings and to complete the preceptorship package on the LSA website.

The West Midlands LSA provides PoSoM programme curriculum details on Birmingham City University website. This website and e-learning methodology was presented and positively evaluated at the LSAMO forum national conference in 2008.

The South Central LSA hosted a joint meeting with all LMEs, senior midwifery leaders (HoMs, consultant midwives, SHA maternity leads, LSAMO), and a representative from the NMC to discuss all aspects of midwifery education. It is planned to hold this meeting twice a year and to invite the education commissioning team to plan future educational requirements and address challenges.

At Yorkshire and the Humber LSA, the LSAMO holds focus groups with student midwives and collates questionnaire responses from them related to their clinical education experience, midwifery practice and supervision practice.

Recommendation

- LSAs should continue to feedback to approved education institutions, education commissioners and the NMC any concerns related to the clinical learning environment for student midwives, and any concerns about the competency of newly qualified midwives.

Rule 16 standard 7: Details of any new policies related to the supervision of midwives

Guidance

What methods are used by your LSA to review existing policies relating to the function of statutory supervision?

It is not required to enclose new policies with the report but please provide appropriate hyperlinks so that policies can be viewed.

Most LSAs have locally established guideline groups that meet regularly, usually quarterly, to develop and review LSA guidelines. There are terms of reference for these groups and there is a three-year cycle for reviewing and updating guidelines. In the South East of Scotland and North of Scotland consortia, this guideline review process is under the remit of the Supervisors Quality Improvement Group (SQIG). Local consultation involves SoMs, HoMs and, in some instances, service users. SoMs are still given hard copies of guidelines in some LSAs but are increasingly referred to local and national websites for the most up to date version.

2008–2009 has seen more LSAs formally adopt and implement LSA national guidelines including: Northern Ireland, West Midlands, North East, London, and West of Scotland and South East of Scotland consortia. As the number of national guidelines has increased and become more widely adopted, local guidance is anticipated to decrease, which can only improve consistency of supervision of midwifery. A number of LSAs including Wales, South Central, South East Coast and South West have reviewed and updated local guidance this year and these are published on their websites. Some LSAs have classified their guidance in three sections: guidance to support midwives, rules and standards, and statutory and local guidance.

The trend for collaborative working between LSAs has continued and a number of national guidelines have been developed or updated this year, led by the LSAMO forum. National guidelines developed or updated this year include:

- guideline L – process for investigation into a midwife's fitness to practise by a SoM on behalf of the LSA
- guideline M – the role of the contact SoM
- templates of example letters and reports for SoMs to use in investigations.

All guidelines can be viewed on www.midwife.org.uk. Further collaborative working between LSAs is evidenced by those LSAs with recently established guideline development groups, including Northern Ireland and West of Scotland, sharing and adapting guidance from other LSAs for local use.

Local guidance developed or suggested in different LSAs across the UK in 2008–2009 included:

- maternity unit closure and suspension of maternity services
- guidance for births before arrival
- self-employed midwives
- safeguarding in relation to temporary residents
- escalation of concerns by a SoM to the LSA
- developmental practice
- care of the seriously ill pregnant woman
- telephone information pathways
- formal reflection processes following a critical incident
- benchmarking tools for SoMs to demonstrate their competencies
- guidelines in the event of an abducted baby
- caring for travellers and non-English-speaking women.

A number of LSAs already have guidance on many of these areas of practice, and it is hoped that these will be shared across the UK so they can be adapted for local use. Some of the topics also reflect changing birth trends in some areas and the need for guidance to support changing practice safely.

Most LSAs have other supervisory documents on their websites apart from national and local guidelines. These include: the LSA strategic direction, standards for supervision, national guidance on supervised practice programmes, LSA publications such as *Modern Supervision in Action* (2008) and, at the time of their reports, the NMC information leaflet for parents: *Support for parents: How supervision and supervisors of midwives can help you* (2009).

LSAs are aware that the NMC has commenced a consultation process to review the *Midwives rules and standards* due for completion in 2011, and it is anticipated that a complete review of local and national LSA guidance will be required following this.



Rule 16 standard 8: **Evidence of developing trends that may impact on the practice of midwives in the LSA**

Guidance

Please outline the public health picture across your LSA and include:

- workforce and birth trends that have an impact on the clinical environment in which midwifery practice occurs
 - data to support your analysis, including:
 - the midwife to birth ratio of maternity services in your LSA
 - trends that may or are impacting on the safety and protection of women or on the learning environment for students
 - a report on action taken to improve such trends by maternity services and by your LSA
 - an analysis of birth trends for respective maternity services to include information related to clinical outcomes and serious untoward incidents (if a hyperlink is more appropriate for the NMC to access this information, please place this in your report)
 - the methodology used by your offices to gather this information
 - the personnel involved in supporting this data collection
 - details of the locally agreed serious incident escalation policy
 - information on unit closures, and actions taken to ensure the safety of women and babies
 - information on collaborative working with other organisations that have a safety remit.
-

All LSA reports provided tabled or descriptive data about the workforce, birth trends and the public health profile in their area. In many cases this was supported by hyperlinks to various websites for further details. A number of trends were identified that are of concern as they impact on the safety of women and babies. These include the following:

Birth trends

- An increasing birth rate was reported from all LSAs bar one. Whilst most quoted 1–2 percent, some reported up to 5 percent and there was significant variation across maternity units. This has had a significant impact on midwife to birth ratios which are increasing and new investment is not always keeping pace.
- To address some of the capacity pressures reported from individual units and ensure women are safe, further developments of maternity triage services have been reported. In such services women are able to phone for support and can be seen for assessment.
- Caesarean section rates remain high, although some of the LSAs report encouraging early findings with the implementation of toolkits to support normal birth and reduce caesarean rates.
- Many reports describe births of increasing complexity and cite the emerging challenge of obesity and pregnancy and birth. A number of specialist services are being developed to support this group of women.
- Maternity service redesign and reconfiguration has been a continuing theme in this reporting year especially in Wales and Northern Ireland with trusts merging and a number of midwifery-led units opening. Homebirth rates remain low and are variable. There is a concern amongst some LSAs that the numbers of unattended births, including 'freebirths' is increasing and this requires further exploration.
- A significant challenge to the analysis of birth data, highlighted in many reports, is maternity data quality. The plethora of maternity information systems in use (from manual systems to, in one LSA, more than 11 different electronic systems) mean that the collation of comparable, meaningful data is not always possible. Many LSAs reported that data collection and collation was very labour-intensive in order to achieve meaningful data. Strategies to minimise the impact of duplicate requests from different agencies were described.
- Maternity unit closures or suspensions of service were reported from most LSAs across England and Wales. All LSAs have agreed escalation policies in place and they are reported on the LSA database. In some LSAs they are reported as serious untoward incidents (SUIs). LSAs have identified that clarification regarding the definitions of diverts, closure and suspension of service need to be agreed.

- Data on maternal deaths and perinatal deaths, or links to the data, are included in all the LSA reports. Trends are in line with those described in CMACE reports and all are investigated through supervisory mechanisms and lessons learnt are shared.

Public health profile

- The public health challenges being faced in LSAs have been described in previous reports. They include the particular needs in pregnancy and birth of teenagers, women with poor mental health, women with substance misuse and alcohol concerns, women subject to domestic abuse, and women who do not have English as a first language and who may also be seeking asylum in the UK. Whilst some LSAs have well-established specialist midwifery services for such groups, others have had to develop services more recently in partnership with other agencies.
- A number of reports this year highlighted the complex safeguarding needs of women and their unborn children. The further development of specialist safeguarding midwifery roles has been evident across a number of LSAs.
- Data on public health targets such as breast feeding initiation rates, smoking cessation rates and early access to services were commonly reported. Again the challenges of data quality and the resource required to collect them was noted.
- LSAs described working collaboratively with a number of organisations with a safety remit including the police, social services, primary health care teams, the NPSA, Healthcare Inspectorate Wales, safe babies initiative, CMACE and bodies such as the Health Care Commission (now the Care Quality Commission) or their national counterparts. It was noted that the increased focus on safety and quality of maternity services is bringing much needed tools and techniques to support the collection and intelligent use of data. The impact of this focus should be included in future reports.

Workforce trends

As reported in previous years significant numbers of experienced midwives and SoMs will be eligible for retirement in the next 4–10 years. Some LSAs are continuing to explore a number of strategies to address this. This includes:

- improving retention of midwifery staff
- reducing attrition from three-year and shortened midwifery courses
- increasing commissioned student places
- supporting return to practice placements with the appointment of clinical practice facilitators
- further exploring phased retirement strategies
- looking at staffing requirements for women with complex needs
- looking at staffing requirements for remote and rural areas
- further supporting maternity support worker development.

The number of self-employed midwives across the UK varies but good examples of working in partnership with LSAs were described.

Good practice

- In Healthcare Inspectorate Wales, they are looking to merge evidence requirements of the LSA audit and healthcare standards to address some of the data collection issues.
- In Yorkshire and the Humber, the LSA facilitated labour ward master classes to further develop the skills of labour ward coordinators particularly in the context of escalation policies regarding suspension of services.
- In London LSA, the employment of the services of a local independent midwife was facilitated to ensure a woman's choice for homebirth was not compromised.

Recommendations

- LSAs should continue to monitor midwifery workforce and workload trends to ensure they do not adversely affect safety for women and babies.
- LSAs should continue to support the introduction and implementation of standardised maternity information systems to support improved data quality and meaningful data comparisons to monitor services for mothers and babies.

Rule 16 standard 9: Details of the number of complaints regarding the discharge of the supervisory function

Guidance

- Number of complaints relating to your LSA and the supervisory function in the reporting year.
- Number and outcome of investigations into such complaints.
- How your LSA ensures impartiality when dealing with such complaints.
- Data on the source of each of these complaints.
- Details on the nature of the complaints.
- Information about the length of time taken to conclude such investigations.

All but Northern Ireland LSA indicated if there had been complaints about the way the supervisory framework was carried out. Four were reported this year, which was less than last year, and there were five appeals from the previous year and two completed complaints from the previous year. In addition, there were two complaints from women regarding service provision which were resolved by the LSAMO and one LSA had implemented two recommendations from the Ombudsman from a complaint in 2006.

In the four cases from this year, three were not upheld and the fourth was investigated and resolved. In the five appeals, four were not upheld and one was upheld. Most reports referred to the complaints procedure or national guideline G in relation to ensuring impartiality. Some reports specified the use of external SoMs or LSAMOs to review complaints which is to be commended. A midwife was the complainant in all cases. The nature of the complaint in all cases was a recommendation for supervised practice and in one

there was a complaint against a whole supervisory team. Where it was stated, most investigations were concluded within 28 days. One was more than six months due to sickness and annual leave, and the other was extended due to legal processes.

A number of LSAs described using a local spreadsheet for investigations into complaints and investigations so they could track progress and timeframes.

Healthcare Inspectorate Wales	A complaint was logged against the LSA by a midwife regarding the supervisory investigation process. After investigation it was not upheld.
East Midlands LSA	A complaint was logged against the LSA regarding the supervised practice process. After investigation it was not upheld.
East of England LSA	A complaint was received against a supervisory team. After investigation it was not upheld.
London LSA	A complaint was received regarding the process of a supervisory investigation. Following investigation it was resolved.
South Central LSA	An appeal was logged against the LSA by a midwife regarding the recommendation to undertake supervised practice. The appeal was upheld and the programme changed to a developmental support programme which was satisfactorily completed.

South Central LSA	An appeal was logged against the LSA by a midwife regarding the recommendation to undertake supervised practice. An external LSAMO reviewed all the information to ensure impartiality. The appeal was not upheld. The supervised practice continued whilst the LSAMO dealt with the appeal. The midwife completed all the learning outcomes.
South Central LSA	An appeal was logged to the LSAMO about the recommendation for supervised practice. Two experienced SoMs from another organisation reviewed the information to ensure impartiality. The appeal was not upheld. The supervised practice was not completed and the case has been referred to the NMC for review at the request of the midwife.
South East Coast LSA	An appeal was logged to the LSA regarding the recommendation for supervised practice. The appeal investigation was undertaken by an external team to ensure impartiality. There were learning areas for the SoMs which have been addressed. The recommendation was for the midwife to undertake a further 150 hours of supervised practice.

**Yorkshire and the
Humber LSA**

An appeal was logged against the process of a supervisory investigation recommending supervised practice. The review was undertaken by external SoMs to ensure impartiality. The recommendation for supervised practice was overturned to developmental support. However, further concerns identified during the developmental support programme were investigated and led to supervised practice.

Recommendation

- LSAs should monitor complaints regarding the discharge of the supervisory function and ensure all aspects of the process are open and transparent.

Rule 16 standard 10: **Reports on all LSA** **investigations undertaken** **during the year**

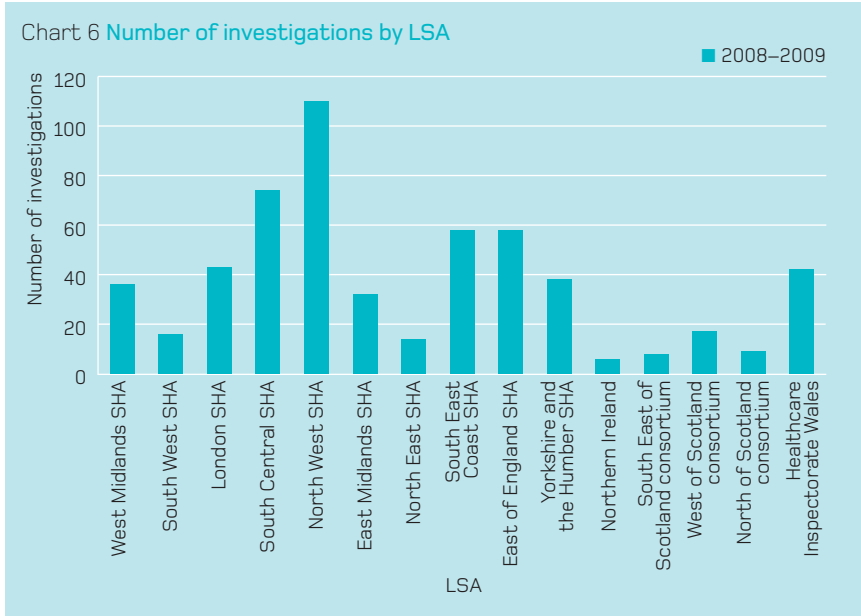
Guidance

How is the LSA informed of SUIs?

- The number of investigations undertaken during the year by SoMs, directly by the LSAMO, an external SoM or LSAMO commissioned by the LSA.
- Summary of LSA involvement in investigations by the Health Care Commission or national equivalent.
- Key trends and learning outcomes of any supervised practice programmes.
- Action taken by your LSA to reduce repeated incidents.
- Supervised practice programmes that have not been implemented due to employer dismissal or refusal by midwife.
- Follow on actions taken by your LSA.
- Concerns relating to the competence of newly qualified midwives, including their original place of training.
- How does your LSA communicate with the NMC on any matters of concern regarding midwifery practice?
- Please provide an anonymised summary of any referrals to the NMC during this reporting year.

All reports described the process of how the LSA is informed of SUIs. Many LSAMOs are part of the local patient safety team or have strong working relationships with their equivalent structures. Reference was made to LSA and NMC guidance on reporting of incidents and the use of the LSA database to facilitate this. The use of trigger lists to guide SoMs in reporting incidents is in evidence.

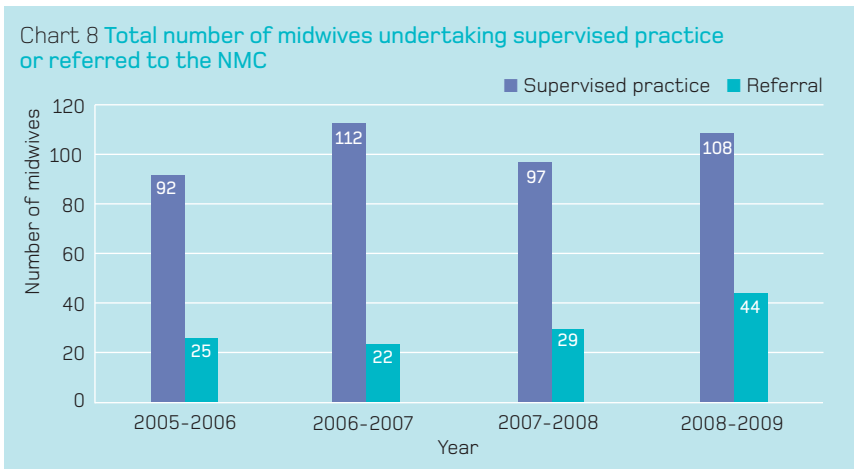
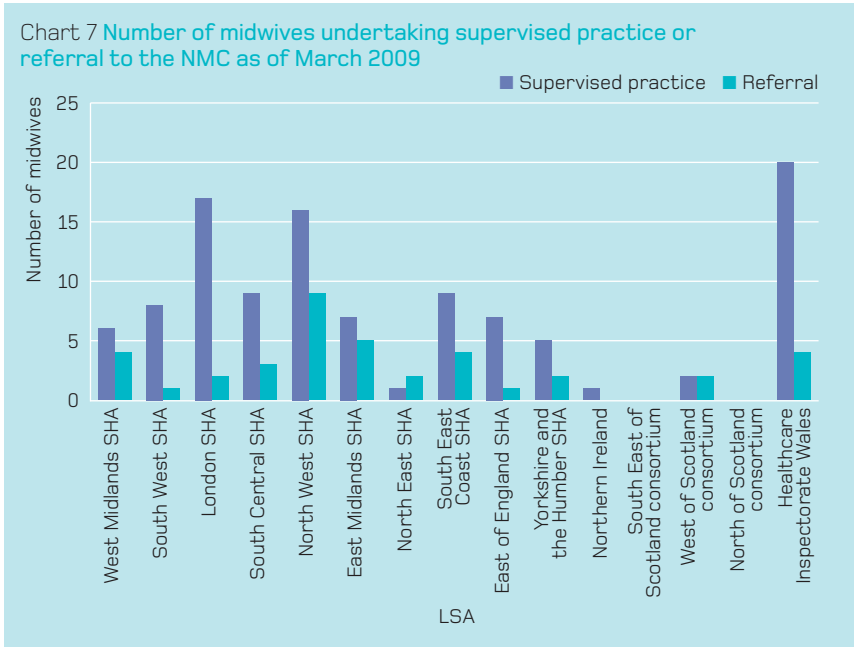
It is difficult to clarify from all reports how many supervisory investigations were undertaken by SoMs and how many by LSAs, so the figures have been combined. Chart 6 identifies the number of investigations during the reporting year.



Variation remains but a number of actions were described to improve consistency regarding supervisory investigations including the updating of national LSA guideline L (investigation of a midwife's fitness to practise) and increased use of external SoMs to undertake investigations. The increasing number of supervisory investigations is partly reflective of the greater confidence and skills of SoMs to undertake them. There is increasing evidence of the minimum outcome from an investigation being structured reflection and templates being developed to support this.

Only one LSA was involved in an investigation of a maternity unit placed on special measures by the national inspection body. The LSAMO was actively involved and lessons learnt were shared with all other SoMs in the region. The special measures had been lifted at the time of the report.

Chart 7 identifies the numbers of midwives undertaking a period of supervised practice or referred to the NMC Fitness to Practise (FtP) directorate. Chart 8 shows the total number of midwives undertaking supervised practice or referred to the NMC in the past four years.



The use of supervised practice remains variable across LSAs from a range of zero midwives in the North of Scotland to 20 midwives in Healthcare Inspectorate Wales. In five LSAs the numbers have increased from the previous year. Consideration has to be given to birth activity and relevant number of midwives in each LSA. Work is ongoing to look at the use of supervised practice within the LSAMO UK forum, through external SoM review, and through guidance development and audit. The NMC will require diversity data in relation to the use of supervised practice to see if there are trends that require further investigation. The themes of the incidents that have led to supervised practice programmes are similar to previous years and include concerns relating to assessment of fetal condition, fetal heart interpretation in labour, record keeping, communication skills, drug errors, assessment of maternal condition and referral to more experienced personnel. Structures to share learning from these incidents are in place in all LSAs, and many LSAs are working with other organisations to further develop continuing professional development initiatives to focus around these issues and reduce re-occurrence.

The majority of supervised practice programmes were completed successfully. In instances where they were not, midwives were suspended from practice and referred to the NMC. Some midwives had been dismissed from employment and LSAMOs had varying success in finding placements for them to undertake their supervised practice in other maternity services. Some midwives declined supervised practice and indicated they did not wish to practise midwifery in the future. The use of the LSA database to record this decision, in case the midwife wished to return to midwifery practice in the future, is seen as good practice to ensure safety. The NMC should also be informed of this decision so that it can be flagged on the register.

Only one LSA reported a concern about the competence of a newly qualified midwife and this was addressed locally with developmental support and feedback given to the AEI. All LSAs described a variety of methods of communicating with the NMC, particularly the FtP directorate and the Midwifery department, in relation to midwifery practice concerns. Such communication was generally on a case by case basis. As well as phone, email and face-to-face opportunities, all LSAMOs are active members of the NMC strategic reference group which is facilitated by the Midwifery department.

The total number of referrals to the NMC has increased from last year and includes 11 referrals from others including employers, the police and parents. Reasons for LSA referrals included non-completion of supervised practice, misconduct, lack of competence and ill health.

Good practice

The South East Coast LSA has commenced a formal audit of all supervised practice programmes since 2005 which has both a qualitative and quantitative element to it. The findings and recommendation will be included in next year's annual report.

Recommendation

- LSAs should monitor and review supervisory investigations and their outcomes to promote consistency across the UK.

Conclusions

All reports received this year provided information about the LSA compliance with rule 16 of the *Midwives rules and standards* during practice year 2008–2009 although there was variation in the level of analysis. All LSAs completed annual audits of their local maternity services. The LSA annual audit of maternity services is one of the main ways in which data is gathered about the effectiveness of the supervisory function and its impact on maternity clinical governance.

As well as acknowledging the many challenges that LSAs have in carrying out their statutory function, the reports cited numerous examples of good practice. This is especially where SoMs have enhanced practice for the care of vulnerable pregnant women and babies, and involved service users in auditing services and monitoring supervision of midwives. The NMC will expect to see evidence of robust evaluation of the impact of all the good practice described in future reports.

Challenges remain for maternity services across the UK to continue to improve midwifery numbers and woman-centred midwifery practice that LSAs are well placed to support. Communication between LSAs and the NMC continues to improve.

The NMC would like to thank the LSAs for the open and transparent information provided within their annual reports which has enabled the production of this fourth report to Council for the 2008–2009 practice year.

Summary of recommendations

Recommendations for LSAs

- LSAs should continue to monitor ratios of supervisors to midwives to support the effective performance of supervisory activities and take actions to resolve concerns where they exist.
- LSAs should embed robust recruitment and retention strategies for the numbers of practising SoMs across their region in light of the future workforce challenges.
- LSAs should develop effective methodologies to monitor the frequency and nature of calls to SoMs to identify any emerging trends.
- LSAs should provide details of actions taken to monitor that protected time for supervision is being achieved and effective administrative support is in place.
- LSAs should continue to develop innovative and sustainable ways to involve service users, particularly women from vulnerable groups, in the practice of supervision and provide robust evidence as to how this is achieved.
- LSAs should continue to feedback to approved education institutions, education commissioners and the NMC any concerns related to the clinical learning environment for student midwives, and any concerns about the competency of newly qualified midwives.
- LSAs should continue to monitor midwifery workforce and workload trends to ensure they do not adversely affect safety for women and babies.
- LSAs should continue to support the introduction and implementation of standardised maternity information systems to support improved data quality and meaningful data comparisons to monitor services for mothers and babies.
- LSAs should monitor complaints regarding the discharge of the supervisory function and ensure all aspects of the process are open and transparent.
- LSAs should monitor and review supervisory investigations and their outcomes to promote consistency across the UK.

Recommendations for the NMC

- The NMC will advise LSAs on the content of their annual report for the practice year 2009–2010 by 31 January 2010.
- The NMC will take account of the findings of the report and the relevance of rule 16, as it is currently written, to improve the health and wellbeing of women and their families receiving midwifery care when reviewing the *Midwives rules and standards*.
- The NMC will monitor complaints made against LSAs, their staff and the supervisory function, and use the learning from such investigations to inform standards and policy and escalate concerns where necessary.
- The NMC will implement the action plan arising from the recommendations of the internal audit of the NMC LSA review process.
- The NMC will expect to see evidence of robust evaluation of the impact of all the good practice described in future reports.

Appendix 1

Progress on recommendations for the NMC in previous report 2007–2008.

The Nursing & Midwifery Council will:

<p>1. Advise LSA on the content of their annual report for practice year 2008–2009 by 31 January 2009.</p>	<p>Completed.</p>
<p>2. Use feedback from the supervision process relating to competency of newly qualified midwives to inform its Quality Assurance monitoring of midwifery pre-registration education programmes.</p>	<p>Ongoing. NMC to monitor through referrals to Fitness to Practise.</p>
<p>3. Alert the relevant national inspecting organisations, health authorities, health departments and government to any concerns it has about the safety of women and babies using maternity services in the UK.</p>	<p>Ongoing. LSA risk framework in place. NMC developing further systems to alert organisations about any concerns.</p>
<p>4. Issue alert letters to relevant health authorities, inspecting bodies and departments of health about any concerns relating to numbers of supervisors in LSAs.</p>	<p>Completed. Alert letters issued 2009.</p>
<p>5. Ask lead midwives for education to monitor and report the length of time taken and the success rate of midwives undertaking the PoSoM programme.</p>	<p>Completed. Information requested as part of LSA annual report 2008–2009.</p>
<p>6. Monitor complaints made against the LSAs, their staff and the supervisory function, including length of time to conclude investigation and outcome of process, as well as learning from such investigations.</p>	<p>Ongoing. Information requested as part of LSA annual report 2008–2009.</p>

Glossary

AEI – approved education institution

CMACE – Centre for Maternal and Child Enquiries

CEO – chief executive officer

CNO – chief nursing officer

DH – Department of Health

DNS – directors of nursing

HoM – head of midwifery

LME – lead midwife for education

LSA – local supervising authority

LSAMO – local supervising authority midwifery officer

MSLC – maternity service liaison committee

NCT – National Childbirth Trust

NPSA – National Patient Safety Association

PoSoM – Preparation of Supervisors of Midwives

RCM – Royal College of Midwives

RCOG – Royal College of Obstetricians and Gynaecologists

SoM – supervisor of midwives

Further information

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