



Supervision, support
and safety:
Annual report of the
Local Supervising
Authority (LSA)
including Annual Audit
Report of the LSA
in Wales

2014-
2015

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Foreword

I have pleasure in presenting this 2014 - 2015 annual report on the quality assurance of the Local Supervising Authority (LSA) for Wales. On behalf of Welsh Ministers and the citizens of Wales, Healthcare Inspectorate Wales (HIW) fulfils the function of the LSA and is therefore responsible for ensuring that statutory supervision of all midwives is exercised to a satisfactory standard across Wales.

This annual report looks back at the LSA and supervisory activities during 2014 -2015 as well as looking forward to the changes ahead. This year's annual report will provide insight into the impact of the implementation of the new model of supervision which came into being on the 4th August 2014. The Nursing and Midwifery Council (NMC) Quality Assurance Review, undertaken in December 2014, reported the new model to be innovative and effective. The NMC reported¹ the model as an example of excellent change management which involved relevant stakeholders within maternity services, HIW and service users' representatives. The NMC confirmed professional standards for statutory supervision are being met in Wales.

I am confident that the LSA in Wales is in a stronger position as a result of seeking a new and better way of providing supervision of midwives. This assurance is important given the issues raised by the [Kirkup Report](#) (March 2015)² around the need for the NMC and Department of Health to act upon the recommendations of the [Kings Fund](#)³ in regards to risks identified around statutory supervision. As a result of the changes in Wales, the LSA is well placed to maintain the delivery of supervision whilst legislative changes are made.



A handwritten signature in blue ink, appearing to read 'K. Chamberlain'.

Kate Chamberlain
Chief Executive

¹ NMC (2015) HIW LSA-Monitoring review of performance in mitigating key risks identified in the NMC Quality Assurance framework for local supervising authorities for midwifery supervision.

² Kirkup (2015) The Report of the Morecambe Bay Investigation
https://www.gov.uk/government/.../47487_MBI_Accessible_v0.1.pdf

³ NMC Council paper to accept Kings Fund recommendations <http://www.nmc.org.uk/news/news-and-updates/nursing-and-midwifery-regulator-calls-for-supervision-to-be-removed-from-its-legislation/>

Introduction and Background

To ensure safe and effective midwifery practice, the Nursing Midwifery Council (NMC) is required, by the [Nursing and Midwifery Order 2001](#)⁴, to maintain a register of qualified midwives and establish rules and standards of proficiency.

The Nursing and Midwifery Order 2001 also sets out a statutory requirement that all midwives are subject to supervision. The fundamental purpose of supervision is to enhance the protection of women and babies by actively promoting and supporting safe standards of midwifery practice.

Healthcare Inspectorate Wales (HIW), on behalf of Welsh Ministers, fulfils the function of the Local Supervising Authority (LSA) for Wales. It is therefore responsible for ensuring that statutory supervision of all midwives, as required in the Nursing and Midwifery Order (2001) and the Nursing and Midwifery Council (NMC) Midwives rules and standards (NMC 2012), is exercised to a satisfactory standard across Wales.

Our role as the LSA for Wales and how we fulfil it

The LSA for Wales has a responsibility to:

- Be available to women if they wish to discuss any aspect of their midwifery care that they consider has not been addressed through other channels
- Provide a framework of support for supervisory and midwifery practice
- Receive Intention to Practise data for every midwife practising in the LSA
- Ensure that each midwife meets the statutory requirements for practice
- Provide initial and continuing education and training for supervisors
- Investigate cases of alleged misconduct or lack of competence
- Determine whether to suspend a midwife from practice, in accordance with Rule 14⁵ of the Midwives rules and standards (NMC 2012)
- Lead the development of standards and audit of supervision.

⁴ Nursing and Midwifery Order 2001 (The Order). <http://www.legislation.gov.uk/uksi/2002/253/contents/made>

⁵ Rule 14 of the NMC Midwives rules and standards (2012) relates to the suspension from practice by a local supervising authority.

The LSA for Wales



LSA Midwifery Officers

To enable it to deliver against the above responsibilities HIW has appointed two Midwifery Officers (LSA MOs), whose responsibility it is, on behalf of HIW, to:

- Lead the development of standards and audit of supervision throughout the LSA
- Appoint Supervisors of Midwives (SoMs)
- Provide a formal link between midwives, SoMs and the statutory bodies
- Provide a framework for supporting the supervision of midwives and midwifery practice within its boundary
- Participate in the development and facilitation of programmes of preparation and ongoing development of SoMs
- Ensure that SoMs are capable of meeting the competencies set out in the Standards for preparation of supervisor of midwives [(PoSoM) NMC 2014⁶]
- Work in partnership with other agencies and promote partnership working with women and their families.

The LSA MOs represent the LSA for Wales at the United Kingdom (UK) LSA Midwifery Officers' forum and at NMC/LSA MO Strategic Reference Group, ensuring that Welsh issues and perspectives are fully considered. They also have a responsibility for maintaining good working relationships with the Welsh Government Nursing Officer responsible for maternity policy, the Chief Nursing Officer for Wales, the Professional Adviser at the Royal College of Midwives UK Board for Wales, the all Wales Heads of Midwifery Advisory Group and the Lead Midwives for Education (LME) Group in Wales.

The LSA MOs have been allocated responsibility for overseeing the delivery of supervision across specific Health Boards and geographical areas of Wales, as set out below;

LSA MO Julie Richards covers:

- Betsi Cadwaladr University (BCU) Health Board
- Powys Teaching Health Board
- Cardiff and Vale University (C&V) Health Board
- Cwm Taf University Health Board

⁶ NMC 2014 Standards for the preparation of supervisor of midwives

<http://www.nmc.org.uk/globalassets/siteDocuments/NMC-Publications/NMC-Standards-for-preparation-of-supervisors-of-midwives.pdf>

LSA MO Vinny Ness covers:

- Hywel Dda University Health Board
- Abertawe Bro Morgannwg University (ABMU) Health Board
- Aneurin Bevan University (AB) Health Board

Vinny Ness completed her planned four year tenure as a secondee to the Welsh Government and returned to the NHS in May 2015. Her successor as the LSA MO covering the same geographical patch is Sue Jose who took up her post full time on 1st April 2015. Sue was previously a supervisor of midwives appointed to the revised model of supervision which enabled her, following the offer of appointment, to shadow the LSA MOs during January to March 2015 in preparation for the handover.

1. The delivery of effective supervision

In the LSA's annual report for 2013-14 the LSA described the very important work it had been doing to modernise and re-shape the provision of statutory supervision in Wales. This was as a result of the work presented in an options appraisal paper, 'The Case for Change', to Directors of Nursing (DoNs) from NHS Wales in April 2013, which set out challenges and risk to the provision of safe and effective statutory supervision of midwives across Wales. These challenges and risks included;

- Lack of NHS resources to support SoMs to adapt to the LSA change agenda
- Impossible challenge for SoMs in balancing the increasing SoM role with the increasing demands of their substantive position
- Inconsistencies in the application of NMC standards across all areas of SoM activity
- Increasing public awareness creates increased public expectation but no capacity to respond
- Large numbers of SoMs spread across a wide geographic area militates against team cohesion and effective two way communication with the LSA
- The challenge of balancing the SoM accountability to the LSA for all matters relating to statutory supervision and their responsibility to their employer
- The lack of impartiality of supervision from the contractual obligations of the SoM
- The potential for conflict of interest between the SoM and employment role, particularly for managers of maternity services
- Increasing leave of absence and de-selections by SoMs from the SoM role owing to increasing pressures on home/work life balance
- Significant and serious delays to the completion of supervisory investigations with concomitant delays to implementing remedial action for midwives and implementing lessons learnt for the organisation
- A wide variation in the skills and abilities of SoMs to conduct a robust investigation and write a strong report that could stand up to external and legal scrutiny
- An inability of all SoMs to be able to demonstrate effective compliance with all NMC standards for the practice of a SoM
- Failure to comply with 100% completion of the annual supervisory review.

The challenges, and risks identified, weakened the supervisory function, which posed significant risks to the main purpose of statutory supervision, that being the protection of women, babies and their families. As a result, the DoNs challenged the LSA with devising a sound model of statutory supervision that included three main elements, namely; an Assurance Framework, a detailed workforce plan and a fully costed model of supervision that would ensure maternity services in Wales were meeting their statutory requirements in line with the Nursing & Midwifery Order (NMO) 2001 and the Midwives rules and standards (NMC 2012). The revised model became known as Future Proofing Supervision (FPS). A steering group was convened to

deliver this programme of work which was extended to include the provision of an 'Accountability and Responsibility' framework to ensure the LSA and health boards would meet their respective duties in this regard.

There was also concern expressed about where the LSA function was currently hosted and work was undertaken with Welsh Government (WG) lawyers to find a suitable alternative host for the LSA outside of HIW. This second element of concern was more complex as it required a change to the Nursing & Midwifery Order to enable Welsh Ministers to delegate their powers. However, since the publication of the [Kings Fund report to the NMC](#)⁷ in January 2015, this work stream has been halted, as ultimately the LSA function will be disbanded. Further detail on this significant change is set out later in this section of the report.

The LSA and DoNs worked with lawyers from NHS Shared Services and Welsh Government to devise a Collaboration Agreement, Role Profile and a Service Specification, all of which have been adopted. This documentation serves to ensure SoMs are clear about their role and the lines of accountability to the respective organisations whilst working with the LSA but continuing to be employed by their respective health boards.

The FPS model went 'live' on 4th August 2014 with the overarching aim of improving the quality of statutory supervision in Wales through the appointment of supervisors, to work full time as SoMs, for a rotational 18 month period. The SoMs are dedicated to the role of supervision thereby increasing their visibility and accessibility to midwives and service users.

There is 24 hour access to a SoM via an all Wales on-call number (0300 062 8049), for advice on issues relating to supervision and professional standards. Midwives are benefitting from a more robust annual supervisory review process through group supervision and sharing of best practice. Evaluation of group supervision to date has been very positive with midwives reporting increased learning from their peers. The LSA audit process in year has focused on the lay reviewers 'testing' group supervision and its contribution to enhanced midwifery care, which is described in detail in the annual audit report attached at appendix 2.

The FPS model is being evaluated by a Monitoring and Evaluation Group which meets quarterly to assess progress against the key performance indicators which are as follows:

- **KPI 1** The LSA to review, and update, workforce planning forecasts

⁷ NMC 2014 Kings Fund independent review into the regulation of midwives.

http://www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/council-2015/kings-fund-review.pdf?_t_id=1B2M2Y8AsgTpgAmY7PhCfg%3d%3d&_t_q=kings+fund&_t_tags=language%3aen%2csiteid%3ad6891695-0234-463b-bf74-1bfb02644b38&_t_ip=46.254.200.66&_t_hit.id=NMC_Web_Models_Media_DocumentFile/_9406792f-f891-484d-895f-f95dcd5fb82e&_t_hit.pos=1

- **KPI 2** The LSA database will be used to monitor SoMs' completion of relevant CPD
- **KPI 3** 100% of SoMs will have an ASR & an organisation IPR
- **KPI 4** 100% of midwives are compliant with the Annual Supervisory Review (ASR) process – LSA random audits of quality
- **KPI 5** 100% of student midwives will be able to report meeting with a SoM at least twice a year
- **KPI 6** 100% of newly qualified midwives will meet a SoM at least twice within six months and three times by 12 months to agree and monitor preceptor-ship programme
- **KPI 7** SoM record keeping & storage
- **KPI 8** Random audits of SoM on call response times – trends and themes assessed in order to inform service developments
- **KPI 9** Monitoring timeliness and quality of the whole investigation process

The remainder of this report should be read in the context of the provision of supervision in a very different way to that which is provided elsewhere across the UK. The SoM to midwife ratios for example are calculated with a specific formula, based on whole time equivalent (WTE) SoM hours per head count, rather than the simple division of numbers of SoMs into the number of midwives employed. The workings of how SoM to midwife ratios are calculated in Wales can be seen in appendix 1.

1.1 Wider political and regulatory context of statutory supervision

In 2013 the Parliamentary and Health Services Ombudsman (PHSO) for England published a report, *Midwifery supervision and regulation: recommendations for change*⁸. The report raised concerns about the public protection allowed by the unique arrangements for midwifery regulation. The Ombudsman recommended to the NMC that the regulatory role of statutory supervision should be separated from that of the supportive function and the NMC should be in direct control of regulatory activity.

As a consequence of the PHSO report the NMC commissioned the Kings Fund to conduct an independent review of midwifery regulation and make recommendations to the NMC. The review concluded in December 2014 and a report was presented to Council in January 2015. The Kings Fund found *'there was a lack of evidence about the safety and efficacy of different approaches to regulation and current midwifery regulation did not appear to be more or less safe for mothers and babies than other regulatory approaches'*.

⁸ Parliamentary & Health Service Ombudsman (2013) *Midwifery supervision and regulation: recommendations for change*. The Stationery Office, London England

The report went on to find that ‘the current extra layer of regulation for midwives was confusing for patients and the public and leads to a lack of clarity for maternity service providers in regard to responsibilities when things go wrong with duplication of investigations’.

The Kings Fund recommended to the NMC that ‘the additional layer of regulation in place for midwives should end’ but also recommended that ‘the elements of supervision and professional development that were found useful should be considered by the governments of the four countries seeking ways to ensure these valuable functions were picked up within the health system’.

The NMC accepted the report of the Kings Fund and the recommendations made therein. However in order to enact the changes recommended there will need to be a significant re drafting of the legislation, set out within the Nursing and Midwifery Order (2001). It is anticipated that, given the various stages that such change to legislation will need to pass through, it is unlikely there will be any new law passed for between 18 months and two years. During this time the NMC have stressed that whilst the legislation remains on the statute books it will be business as usual for midwifery supervision.

Wales believes it is in a strong position to retain the status quo, having been through a significant period of change management to introduce the revised model. SoMs are secure in their rotation to the model knowing they have a substantive post to return to. The LSAMOs are also seconded to the role and are therefore equally protected. However, most importantly, the LSA in Wales had identified many of the risks and challenges reported by the Ombudsman a year earlier and the revised model was implemented to address them.

1.2 SoM to Midwife Ratio

The LSA for Wales is responsible for appointing an adequate number of SoMs to ensure that all midwives practising in Wales have access to supervision. The NMC Midwives rules and standards Rule 9⁹ requires that the SoM to midwife ratio will not normally exceed 1:15 but must, at the very least, reflect local need and circumstances, without compromising the safety of women. As of 31 March 2015, 16 full time SoMs were in post, and 1,786 midwives had notified the LSA of their Intention to Practise (ItP) midwifery in Wales during 2014 -15. Using the adjusted ratio calculation shown at appendix 1 the average all Wales ratio was 1:11. Table 1 sets out the actual ratio for each of the seven Health Boards in Wales

⁹ Rule 9 of the NMC Midwives rules and standards (2012) sets out the Local supervising authority’s responsibilities for supervision of midwives

1.3 Table 1 - Ratio of SoMs to midwives in Wales as of 31 March 2015

Health board	Midwives	SoM wte	SoM hours per month	Adjusted ratio
Abertawe Bro Morgannwg	300	2.2	265 hrs	1:12
Aneurin Bevan	300	2.4	289 hrs	1:11
Betsi Cadwaladr	405	3.0	360 hrs	1:12
Cardiff and Vale	282	2.2	265 hrs	1:11
Cwm Taf	210	1.6	192 hrs	1:12
Hywel Dda	205	1.8	216 hrs	1:10
Powys	43	0.4	48 hrs	1:11

1.4 Appointment of SoMs, de-selection, resignation and leave of absences

In August 2014 13.6 WTE SoMs (16 head count) were appointed across Wales. All appointees came from the pool of SoMs who had been through a rigorous selection process in January 2014 in readiness for the FPS model.

Table 2 - Appointment and de-selection trends for the past three years

No. of SoMs	2012-2013	2013-2014	2014-2015
Appointed in year	8	7	16 (13.6wte)
Removed from post (LSA de-selection)	0	0	0
Resignation (self de-selection)	21	27	85
Suspension from role (LSA suspension)	0	0	0
Suspension from role (self suspension)	0	0	0
Commenced preparation course (September)	9 (2012)	0 (2013)	5 (2014)
Leave of absence	9	13	2
Total number of SoMs in post	130	101	16

Table 2 above demonstrates the number of SoMs de selecting from the role. The significant increase in de-selections was an inevitability following the planned implementation of the FPS model. During this practice year 85 SoMs resigned from the previous role and two SoMs appointed to the new model have taken a leave of absence, one following a period of extended sick leave and the other for maternity leave. The pool of SoMs-in-waiting provided the necessary backfill for these changes without causing any undue pressure on the forward planning.

In order to ensure that SoMs meet the requirements of Rule 8¹⁰, the LSA is committed to ensuring all SoMs appointed in Wales are able to access 6.5hrs minimum continuing professional development (CPD) annually and have opportunities to update their practice. All newly appointed SoMs in the revised model attended a Masters module with the University of Swansea to help them prepare and develop into the new role. This meant they met well in excess of the minimum CPD standard in completing this programme. There was a specific emphasis on the particular areas of risk identified in the previous model as set out above including; additional training on the facilitation of group supervision as a means of delivering proactive learning through the ASR process; and a scenario based session on learning from events and devising effective learning objectives. The LSA is grateful to Swansea University for their flexibility in supporting the SoMs to adapt to the requirements of the revised role.

Each of the FPS SoMs has had equal opportunity to attend regional and national conferences and events to ensure they broaden their knowledge base and have exposure to working at a strategic level. For example, SoMs have shadowed the LSAMOs in their bi-annual meetings with the Chief Nursing Officer, the Royal College of Midwives and the NMC Strategic Reference Group. SoMs have also had the opportunity to attend the information sharing meetings to inform the Kings Fund review, met with the Welsh Risk Pool advisors to share lesson learned across Wales and attended both the Heads of Midwifery Advisory Group and the UK LSAMO Forum where national maternity policy is discussed.

These development and information sharing events offered key opportunities for CPD for SoMs and were particularly helpful in enabling SoMs to hone the skills required to support the planned forthcoming changes across maternity services in Wales. After attending an event, each SoM is asked to complete a brief report in the Situation, Background, Action, Review (SBAR) format on the key learning which can then be shared with the whole group to ensure all SoMs benefit from the learning.

The LSA was mindful of the impact of the implementation of the FPS model so deferred the Annual LSA Workshop in this practice year. However, the current SoM team have set up a conference planning sub group which has led on the development of the forthcoming all Wales conference to be held in May 2015 which is open to all midwives and student midwives not just SoMs as in previous years. The themes of the conference are professional accountability, the NMC Code¹¹ and countdown to Revalidation¹².

¹⁰ Rule 8 of the NMC Midwives rules and standards (2012) sets out the requirement for continual professional development as a supervisor of midwives.

¹¹ Nursing and Midwifery Council (2015) The Code, Professional standards of practice and behaviour for nurses and midwives.

¹² Revalidation is a NMC process to be implemented in April 2016 that all nurses and midwives will need to engage with to demonstrate that they practise safely and effectively throughout their career

1.5 Mechanisms for continuous access to a supervisor of midwives

Rule 9 of the NMC Rules and Standards (2012) sets out the requirements for the supervision of midwives and states that the LSA shall ensure that:

- Each practising midwife within its area has a named supervisor of midwives
- At least once a year, each SoM meets each midwife for whom she is the named SoM to review the midwife's practice and to identify their training needs
- All supervisors of midwives within its area maintain records of their supervisory activities, including any meetings with a midwife
- All practising midwives within its area have 24-hour access to a supervisor of midwives.

All midwives are allocated a named SoM on commencement of their employment. In principle, midwives may choose their named SoM, but in practice they will normally be initially assigned to the SoM with the lightest caseload. If a midwife is self-employed a SoM who lives and/or works near the midwife's base, or can travel to the base, would normally be asked by the LSA to include the self-employed midwife in her supervisory caseload. All midwives and SoMs are advised that they may request to change their SoM or midwife if the relationship is not effective for either party.

During 2014 -15, the LSA continued to monitor the LSA database quarterly and on an ad hoc basis to ensure that every midwife in Wales had a named SoM. We are able to report that during 2014 -15 every midwife practicing in Wales met this requirement. The LSA also used the database to monitor, in line with standards, whether annual supervisory reviews (ASR) have taken place. An analysis of the LSA database is undertaken on a quarterly basis to monitor the compliance with ASRs. On the 31st March 2015 there was 100% compliance with the ASR process and at the time of reporting, 99.2% of midwives in Wales had an ASR uploaded to the LSA database. This a positive impact from the implementation of the new model showing an upward trend from the previous year of 97% reported to the NMC.

During the year, quarterly meetings with Heads of Midwifery (HoMs), SoMs and the LSA MOs have used a scorecard based around the KPIs of the model to monitor the compliance with the ASR process. All SoMs and midwives have ben continually reminded of the importance of complying with, and giving commitment to, the NMC requirement for a meaningful ASR. The LSA uses the database to run reports on any SoMs that have outstanding ASRs and robust performance monitoring is instigated to ensure that they comply with the ASR process. The LSA worked hard with SoM teams prior to the hand over of caseloads to ensure the FPS SoMs did not have to pick up heavy caseloads at a time of change. In the main, the handover was relatively smooth with only one organisation having made less progress than the other six.

Group supervision, to address the ASR, has been an unrivalled success winning over many midwives, and in some cases SoMs, who were sceptical about the concept. Regular evaluation following each session has identified positive aspects such as learning from others, gaining an insight into the challenges faced by different staff groups, as well as providing some rich data to inform future development. This innovation in supervisory practice is an important pre-cursor to Revalidation which will require all registrants to undertake 40hrs of CPD, 20hrs of which must be participatory. In thinking about which elements of supervision Wales might like to retain and roll out to the nursing community, group supervision could be seen as a pilot to inform and develop the way forward.

The all Wales on call rota is now working well having had several 'teething' problems with the Welsh Government on call system at the outset. All contacts, whether from service users, members of the public or midwives, are written up in SBAR format and trends and themes are collated monthly to inform service improvement or change as necessary. The trends and themes reports are collated into six monthly reports which are then monitored at the monthly SoM performance meeting. The LSA lay reviewers have done additional work on this KPI to ensure data collection can be scrutinised through further qualitative enquiry with women and midwives on whether the contact achieved the desired outcome. The LSA lay reviewers' audit report provides some interesting data on the progress with this enhanced KPI, as well as identifying further areas for development.

The telephone audit, conducted by the team of lay reviewers, was completed in year, and again at year end, as part of the annual audit process and to make comparisons between the changeover to an all Wales number. The lay reviewers broadened the remit of their end of year audit focusing particularly on how easy it was for a service user or a member of the public to find out, firstly about supervision and then how to contact a SoM. This included contacting a SoM during usual office hours, between 9am and 5pm Monday to Friday as well as out of hours and at weekends. Again the full detail of the lay reviewers' work makes interesting reading and can be found in the annual audit of supervision report attached. There were also some important recommendations for improving practice, which the LSA will take forward in an action plan as part of the 2015-16 work plan.

LSA MOs hold monthly performance management meetings with SoMs from across Wales. This monthly gathering, whilst chiefly about managing the compliance with the KPIs set out in the service specification, also enables SoMs to build a cohesive team and form a supportive network, which is vital given there are now a smaller number of SoMs who work in a very different way to the previous model.

2. Involving service users in supervision

The LSA in Wales appointed four new lay reviewers in 2013 to support the LSA in its work. These were chosen from a high calibre of 15 applicants. Each lay reviewer was supported with a robust induction plan and had an opportunity to shadow the exiting reviewers before working alone. The purpose of the lay reviewer role is to ensure the user perspective is embedded in the work of supervision of midwives. The first cohort of five lay reviewers exited on completion of their tenure in July 2014, and all have been invited to apply their skills and experience to HIW lay reviewer roles in regulation and inspection of NHS services.

LSA Lay reviewers have been involved in the LSA work during 2014-15 in the following ways:

- Participating in the recruitment of SoMs for the new model, observing SoMs in a workshop environment, and sitting on the interviewing panel. Lay reviewers assessed the SoM's attitude and approach to women's choices and individualised care
- Developing a leaflet to explain the new model of supervision in Wales, and more generally raising the awareness of the role of supervision for service users
- Participating in the LSA all Wales Monitoring and Evaluation Group set up to monitor and evaluate the evidence produced from the Key Performance Indicators (KPIs) aiming to demonstrate the value of supervision. As part of this membership, the lay reviewers put forward a proposal for the expansion of the KPI relating to service users, which was approved, and expanded into a lay reviewers audit programme as outlined in Section 1.2
- Attending the SoM monthly meetings to keep abreast of SoM activities, monitor compliance with the service specification for supervision and review progress towards achieving KPIs
- Contributing to the updated information on the new model of supervision in Wales to be included in the national hand held patient records for pregnant women
- Participating in the NMC Review in December 2014, which included a workshop with the NMC review team to share the lay reviewers perspective on progress with statutory supervision of midwives in Wales
- Interviewing SoMs in waiting who applied to join the new model of supervision and SoMs applying to participate in the SoM preparation programme at Swansea University. The Lay reviewers observed and assessed students and SoMs at the workstations and were part of the interview panel.
- Assisting the selection process of the LSA Midwifery Officer role

Direct contact from service users to the LSA or SoMs was still relatively limited prior to the implementation of the new supervisory model. However, the lay reviewers found, during the annual audit process, a number of examples where women are being signposted to SoMs by

midwives. The audit of SBAR contacts by lay reviewers, as part of the annual audit of women's perspectives on supervision, also identified an increasing number of women had made contact with a SoM since August 2014. The LSA lay reviewers' audit report, attached at appendix 2, provides the detail on this and any areas for improvement.

It has been found that the most common reason for a woman needing to speak to a SoM is when she wants to make choices outside of the normal pathways of care. There is still a need for service users to have clarity on the role of supervision, as sometimes it can be unclear whether an individual is being approached as a SoM or a manager. The lay reviewers devised an all Wales leaflet to explain the FPS model and more generally raise the awareness of the role of supervision for service users in Wales (available via <http://www.hiw.org.uk/supervise-midwives>).

Prior to the implementation of the revised model of supervision, the annual audit process had involved audit visits by the LSA, accompanied by Lay Reviewers, to each of the seven Health Boards, which included meetings, presentations and general observation walk around. This process served to get a snapshot of the implementation of supervision in each region. Given that the SoMs, are a small team of 15, now work directly with the LSA under the Collaborative Agreement this process would not be sufficiently robust or impartial in auditing the standard of supervision in Wales.

Furthermore, in December 2014, the NMC carried out a full review of supervision in Wales. The outcome of this review was wholly positive, with no areas of concern raised. It was therefore agreed that there was no value in duplicating the NMC review, but it was important to identify key areas of the new model that had not been previously scrutinised. It was noted that there was little work done in year on the user's perspective and how women felt about contacting a SoM. As a lay reviewer sits on the all Wales Monitoring and Evaluation Group, a proposal was agreed to extend the KPI relating to service user experience. The proposal identified areas of the model that could be audited by the lay reviewers as show in Table 5. The outcomes of the lay reviewers audit process are set out in the annual audit report (see appendix 2).

2.1 Table 3 – Areas of SoM provision that formed the LSA lay reviewers’ audit

Area for Audit	Overview
A1) Service User Experience	It is vital that supervision of midwives is providing appropriate advice to service users (both midwife and non midwife users), and that the users are satisfied with the service they received. This area of audit looked at both the process of providing advice via the new on-call system, and the general satisfaction of service users with the advice given by supervisors.
A2) Group Supervision and CPD	One to one annual reviews between individual midwives and their supervisor have largely been replaced under the new model with group supervision using an action learning approach. CPD plans for midwives are developed as a result of group supervision. This area of audit looked at whether these new processes are of sufficient quality to enhance public protection through validating the individual CPD of midwives and whether this improves the service offered to women and their families.
A3) Ease of Accessibility of SoMs To Women and Their Families	The new model of supervision in Wales includes a single common 'on-call' telephone number for women and their families to contact a supervisor. This area of audit looked at whether information regarding supervision of midwives in Wales is up to date, accessible and there is equitable signposting to the new on-call number.

The results of the above audit demonstrated positive satisfaction from the service users from this contact. The service users particularly valued the service provided by SoMs, including the speed of response, personal qualities of SoMs and their ability to provide emotional reassurance. The service users highlighted the ongoing issue regarding increasing awareness of the SoM service to the public. The audit highlighted positive feedback into the use of group supervision of midwives. The Lay Reviewers concluded that the group supervision concept was an effective mechanism to ensure that midwives practice is kept under review to enhance public protection, and that it allows the sharing of best practice and joint learning.

During the year, the SoM team have also worked closely with local Doulas across Wales in order to establish a service that supports the importance of working together and valuing each others role to ensure the ultimate goal of safeguarding the health of mothers and their babies. Doulas from around Wales were contacted by local SoMs and invited to attend one of the regular SoM team monthly meetings. A number of Doulas accepted this invite and in April 2015 they

attended a meeting to discuss partnership working. It was agreed by all who attend the meeting that a clear understanding of each others roles had been achieved. In order to strengthen this partnership, it was agreed that a SoM would be allocated as a named contact within each health board in Wales to support the Doulas in their role. The named SoM would ensure clear communication channels between the woman, Doula, midwife and managers in ensuring the requirements of the woman are discussed and enabled within the remit of maintaining the health and wellbeing of both mother and baby.

2.2 Overview of LSA audit activity – risk and benefit realisation

The annual audit process introduced in 2011 was considered no longer fit for purpose since SoMs are now working as part of the LSA which would be tantamount to the LSA auditing itself. As part of the initial set up of the revised model of supervision the LSA had agreed that it would need to consider how best to conduct a robust annual audit that would demonstrate transparency and avoid the potential for a perceived conflict of interest. This was considered particularly important given this would be the first audit of the revised model and all stakeholders would require a higher degree of assurance that the change to how supervision was delivered in Wales had no unintended, adverse consequences. Furthermore, recent reports had been critical of statutory supervision elsewhere in the UK finding it to be inward looking and somewhat insular or divorced from mainstream governance structures within the NHS; Wales was keen to deflect similar criticism of the revised model.

As a result, the LSA planned an audit process to replicate that which is used by the NMC, whereby an external team, made up of an LSA MO, an experienced SoM, a Head of Midwifery and a lay reviewer, all from outside of Wales would be invited to carry out the audit process using the Midwives rules and standards as the benchmark to audit against. In reality this process did not happen in this audit year because the NMC itself identified Wales for a review by the Quality Assurance team facilitated by Mott MacDonald. In essence the LSA would therefore have only been replicating the same process which did not seem a good use of time or resources. Importantly, as the audit team was selected independently of the LSA in Wales this would provide greater assurance to the public that the revised model was or was not meeting the standards set by the regulator.

The annual LSA Lay Reviewer audit report is presented in full within this document in appendix 2 and the Quality Assurance Report from the NMC can be found via http://www.nmc.org.uk/globalassets/sitedocuments/midwifery-lsa-reports/lisa-reports-2014-2015/healthcare-inspectorate-wales_9-11dec2014_lisa-review-report_final_nmc-approved.pdf . The process of the Mott MacDonald review and the key messages from their findings are reported below.

The NMC Quality Assurance Framework is the process by which the NMC ensures that LSAs continue to meet the rules and standards. Specifically, Rule 11 of the Midwives rules and standards (2012) outlines the QA framework and provides a structured means of reviewing a LSA in order to demonstrate the effectiveness of statutory supervision of midwives and good practice whilst highlighting areas of concern. Reviews take account of LSA self-reporting and factor in intelligence from a range of other sources which can shed light on potential risks associated with midwifery supervision. The NMC focus for reviews, however, is not solely risk-based. LSAs may be selected for review based on thematic or geographical factors, as was the case for the LSA in Wales, having been through a significant change management process within the reporting year. The review team report how the LSA, under scrutiny, has performed against key risks identified at the start of the review cycle. Standards are judged as 'met', 'not met' or 'requires improvement'. When a standard is not met an action plan is formally agreed with the LSA and is delivered to an agreed timeframe.

The NMC review took place over three days and the following maternity services were visited:

- Abertawe Bro Morgannwg University (ABMU) Health Board Singleton Hospital, Swansea - Maternity Services - Ward 19 and Midwifery Led Unit; Antenatal Clinic and Day Assessment Unit; Princess of Wales Hospital, Bridgend - Maternity Services - Ward 12,
- Swansea University, School of Midwifery which provides the Preparation of SoM programme.
- Betsi Cadwaladr University (BCU) Health Board: Wrexham Maelor Hospital- Maternity Services - Antenatal Clinic; Antenatal and Postnatal ward, Midwifery Led Unit, and Delivery Suite.
- Powys Teaching Health Board - Welshpool Birth Centre.

The practice visits were planned on the basis that it enabled the review team to sample as large a geographical area as possible i.e. the north and south of Wales, and to visit maternity providers who provide maternity services to rural and urban communities. The LSA team has a plan to undertake audit visits to all health board areas in Wales during 2015-16, to follow up on the recommendations from the 2014-15 lay reviewer audit process. The audit visits will monitor compliance with the key performance indicators and provide further assurance to the health boards that NMC standards are met.

2.3 Summary of public protection, context and findings

The strategic role of HIW LSA is to set the direction of the supervision of midwives in line with the midwives rules and standards (NMC, 2012). The audit findings demonstrate that the HIW LSA ensures that there are systems and processes in place to monitor the performance of the SoMs and practising midwives throughout Wales to assure public protection. The review process measured the provision of supervision in Wales against the seven relevant rules from the Midwives rules and standards (2012). The review team reported that the LSA in Wales met all seven rules, with no areas for improvement and just two areas identified for future review which were:

- The ongoing implementation of the future proofing supervision (FPS) model across Wales.
- The ratio of SoM to midwives is maintained at the recommended ratio 1:15 across the LSA.

Despite the strong outcome from the NMC review process, the Monitoring and Evaluation group, set up to oversee the ongoing work of the LSA through the revised model, felt that there had been a limited focus on the user perspective since the introduction of the new model. It was therefore agreed that the lay reviewers would conduct a discreet piece of audit work to compliment the NMC review and ensure the user perspective was considered. The findings from their work are presented in the Annual Audit Report as part of this document (appendix 2).

2.4 Engaging with higher education institutions

There are four Higher Education Institutions in Wales (HEIs), each providing pre and post registration midwifery education. During the year, SoMs were actively engaged with all HEIs to ensure that students are familiar with the concept and importance of supervision in preparation for registration as a midwife. Students were offered a number of opportunities to experience supervision in action, such as students shadowing their third year mentor when they met their named SoM for a supervisory discussion.

Key Performance Indicator six, within the Service Specification, concentrates on the contact between SoMs and students, meeting in excess of the minimum requirement within the Midwives rules and standards Rule 9 1.1.2¹³. KPI 6 requires 100% of newly qualified midwives

¹³ Rule 9 of the NMC Midwives rules and standards (2012) states that the LSA must have a framework to support for student midwives to enable them to have access to a supervisor of midwives.

will meet a SoM at least twice within six months and three times by 12 months to agree and monitor their preceptor-ship programme. This closer contact with student midwives has enabled SoMs to monitor concerns within the clinical environment which could have had an adverse effect on the student training programme.

The LSA was made aware of two such concerns raised by students through the local SoM and also one further concern regarding future student numbers identified by the Lead Midwives for Education (LMEs). This prompted the LSA MOs to meet with HoMs and to write formally requesting an action plan to address the concerns if they were found to be legitimate. The HoMs were able to provide adequate assurance that, where there had been staffing issues previously, appropriate plans were in place to address this. They were also able to demonstrate to the LSA what action had been taken with examples of positive feedback from students as a result. The NMC, through the quarterly quality monitoring process and the Quality Assurance team, were made aware of these concerns before quality assurance framework review the visit in order for them to validate the corrective action taken.

The LSA has regular contact with LMEs across Wales which includes attendance at the quarterly Heads of Midwifery Education (HoMEd) group. The LMEs and the Senior lecturer responsible for the Preparation of Student SoMs are represented on the LSA Monitoring and Evaluation group. The all Wales ASR documentation requires SoMs to discuss with midwives the NMC requirements for education and check that midwives are compliant with the required “sign off mentor status”. This ensures they are fully conversant with their roles and responsibilities when mentoring and supporting student midwives or midwives who require additional support in practice.

The Preparation of SoM programme is provided by Swansea University with very positive comments and feedback received from the SoMs who attended the development programme to support their transition into the revised model of supervision. The forthcoming programme has been set up to support both student SoMs and the next cohort of SoMs in waiting, in readiness for the first step off/on process due to take place in August 2015. The LSA MOs have been actively involved in the curriculum planning and have been active participants in the delivery of the programme.

The HEI representative on the LSA Monitoring and Evaluation group has been actively involved in supporting the LSA to seek resources for the formal evaluation of the FPS model. It has been agreed with the Welsh Government policy advisor that further in depth evaluation of the group supervision element of supervision should be undertaken, as this model could help to inform the future revalidation process for all NMC registrants. HIW has agreed to fund a small scale evaluation, to be carried out by Professor Susanne Darra from Swansea University, which will focus on group supervision as a specific element of the Future Proofing Supervision model.

3. Trends impacting on or which may impact on the future practice of midwives

3.1 Midwifery workforce requirements and acuity

Following the Report of the [Francis Inquiry](#)¹⁴ and the [Berwick Review](#)¹⁵ into Patient Safety, NICE was asked by the Department of Health and NHS England to produce guidelines on safe staffing capacity and capability in the NHS. This led to a multidisciplinary consultation on midwifery staffing in maternity settings from February to March 2014. In February 2015, NICE published the guideline [Safe midwifery staffing for maternity settings](#)¹⁶. The recommendations set out:

- Responsibilities of hospital managers and actions organisations should consider as part of their midwife staff planning
- The ongoing process that senior registered midwives should use to determine whether there are sufficient staff to provide for the needs of women and babies
- Red flags that warn when immediate action is required.

The NICE (2015) guideline does not cover national or regional level workforce planning or recruitment, although the content should inform these areas. Maternity services in Wales use Birthrate Plus¹⁷ as required by [Welsh Risk Pool](#)¹⁸. Although Birthrate Plus attempts to address complexity and models of care within maternity services, the calculation for number of midwives required is complicated. With increasing social and medical complexities within maternity services together with maintaining quality, the 18 year old Birthrate Plus tool may underestimate all aspects of the midwife's role (Tolofari, 2014)¹⁹. In 2013 there was a 2% fall in the birthrate in Wales from 35,952 compared with 35,238 in 2001 (Royal College of Midwives (RCM), 2013a)²⁰. Despite this fall, demands on maternity services are increasing. There are many factors which give rise to increasing care complexity. In Wales, since 2001 - 2011 there was a 64% rise in women aged 40 years and greater giving birth (RCM, 2013a). Increasing rates of obesity, multiple pregnancies and women with existing co-morbidities add to the demand and intensity of care required ([Royal College of Obstetricians and Gynaecologists, 2013](#))²¹.

¹⁴ Francis Inquiry (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry.

<http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report>

¹⁵ Berwick (2013) A promise to learn – a commitment to act Improving the Safety of Patients in England. National Advisory Group on the Safety of Patients in England <https://www.gov.uk/government/publications/berwick-review-into-patient-safety>

¹⁶ NICE (2015) Safe midwifery staffing for maternity settings. <http://www.nice.org.uk/guidance/ng4>

¹⁷ Ball, J. A. Washbrook, M. (1996) Birthrate plus: A framework for workforce planning and decision making for midwifery services. Books for Midwives Press: Cheshire.

¹⁸ The Welsh Risk Pool <http://www.wales.nhs.uk/sitesplus/955/page/52730>

¹⁹ Tolofari, M. (2014) Counting midwives. *Midwives*, 1, pp. 60 – 61.

²⁰ Royal College of Midwives (2013a) State of Maternity Services.

²¹ Royal College of Obstetricians and Gynaecologists (2013) Reconfiguration of Women's Services in the UK. Good Practice No.15. December.

There is lack of evidence about what outcomes Birthrate Plus influences, therefore, the effectiveness and cost effectiveness of Birthrate Plus is not known (NICE, 2015). It is also unknown whether other toolkits or methods for determining staffing requirements are better (or worse) than Birthrate Plus (NICE, 2015).

The implementation of the revised model of statutory supervision in Wales in August 2014 was accompanied by the majority of midwives accessing their Annual Supervisory Review in a group setting. This has allowed greater opportunity for peer discussion and support amongst midwives. Without exception, a consistent issue raised by midwives across Wales is the increased frequency with which midwives are deployed from their own workplace to another clinical area due to insufficient staffing levels. Some midwives report this movement may occur several times during the same shift resulting in fragmented care provision which is associated with increased clinical risk. [The RCM Heads of Midwifery Survey \(2013b\)](#)²² reflects this picture as:

- 94.5% of Heads of Midwifery reported they had to deploy midwives to cover essential services
- 38.5% of Heads of Midwifery stated that community midwives and midwives providing postnatal care were moved at least once a week to provide intrapartum care in the hospital setting
- 68.5% of Heads of Midwifery reported that on-call community midwives had to be called in to cover the labour and delivery suite.

https://www.rcog.org.uk/globalassets/documents/guidelines/reconfiguration_good_practice_no.15_corrected_february_2014.pdf

²² Royal College of Midwives (2013) Submission to NHS Pay Review Body.

<https://www.rcm.org.uk/content/unit-closures-restricted-services-and-falling-budgets-shows-survey-of-senior-midwives-29-09>

There is increased clinical risk and potential for errors when there is deployment of staff to clinical areas where they do not feel confident or competent to work. [The NHS Wales Staff Survey \(2013\)](#)²³ reports that midwives (23%) were the highest group of healthcare professionals who felt they had been inappropriately deployed.

The image of increased demands on maternity services and a mobile workforce is mirrored by another aspect of the NHS Wales Staff Survey (2013), with 67% of midwives feeling that they had insufficient time to carry out all of their work. Statutory supervision during 2014 -15 has played a key role in highlighting to midwives how the revised NMC Code (implemented 31st March 2015)²⁴ requires midwives to escalate any concerns they may have about patient safety or the level of care women/babies are receiving in their workplace.

The revised Code has been influenced by major reviews into patient safety, such as the Francis Report into care failings at Mid Staffordshire NHS Foundation Trust, which can be transferrable to maternity services. Supervision plays a key role in raising awareness in midwives that the revised NMC Code is a tool designed to enhance their professionalism and is not just a means for disciplinary processes.

3.2 1000 Lives Plus

[1000 Lives Improvement](#)²⁵ is the national improvement programme which supports organisations and individuals to deliver the highest quality and safest healthcare for the people of Wales. The following maternity work streams are currently a component of the 1000 Lives Plus improvement programme.

²³ NHS Wales Staff Survey 2013 National Overview

<http://gov.wales/topics/health/publications/health/reports/survey/?lang=en>

²⁴ Nursing and Midwifery Council (2015) The Code, Professional standards of practice and behaviour for nurses and midwives.

²⁵ 1000 Lives Plus <http://www.1000livesplus.wales.nhs.uk/home>

3.3 All Wales Maternity Network

The Transforming Maternity Services Mini-collaborative²⁶ which was part of the 1000 Lives Plus ended in March 2014. Set up in March 2011, the overall aim of the Mini-Collaborative was to improve the experience and outcomes for women, babies and their families within the maternity services in Wales. The All Wales Maternity Network²⁷ (Public Health Wales) was set up in 2014. Stakeholders consist of a wide range of multidisciplinary healthcare professionals, a Supervisor of Midwives and service user groups. In maternity services in Wales common objectives are to reduce variation of care, reduce waste of resources and improve outcomes for both pregnant women and their babies. The All Wales Maternity Network plans to utilise the benefits of a clinical network by:

- Education and shared knowledge management
- Better risk management through partnership working
- Sharing best practice and lessons learned
- Collating information which allows benchmarking and the setting of improvement objectives.
- Improving clinical outcomes and service delivery
- Integrated and standardised care across Wales, supporting the reduction of inequalities.

3.4 Welsh Initiative for Stillbirth Reduction

The [Welsh Initiative for Stillbirth Reduction](#)²⁸ (WISR) set out to implement an All Wales Growth Assessment Programme (GAP) for maternity services in Wales. The aim of GAP is to enhance antenatal recognition of fetal growth problems improving the chance that babies are born in good condition, reducing perinatal mortality and morbidity, resulting in fewer stillbirths and neonatal deaths and fewer cases of cerebral palsy in Wales. Undiagnosed intrauterine growth restriction (IUGR) is strongly linked to perinatal mortality and life-long morbidity. Health boards in Wales, on a phased basis during 2014, have purchased and implemented the Growth Assessment Programme from Birmingham Perinatal Institute (West Midlands) as recommended in the WISR.

²⁶ Transforming Maternity Services Mini-collaborative <http://www.1000livesplus.wales.nhs.uk/maternity>

²⁷ All Wales Maternity Network <http://gov.wales/topics/health/cmo/professionals/officechiefnursing/cno-publications/maternity-network/?lang=en>

²⁸ Welsh Initiative for Stillbirth Reduction <http://www.1000livesplus.wales.nhs.uk/maternity-services-stillbirth>

3.5 All Wales Clinical Pathway for Normal Labour Care

A revised version of the All Wales Clinical Pathway for Normal Labour (AWCPNL)²⁹ was implemented in Wales during 2014, accompanied with training for midwives within the health boards' maternity services. Midwives however share differing degrees of uncertainty around practice and documentation when using the AWCPN. This uncertainty is compounded for midwives who work in both low risk and high risk settings. One of the factors giving rise to this is that the AWCPNL requires midwives to document 'variance' only compared to the 'full story' of labour in the intrapartum record of the high risk women. A focus of discussion within the Annual Supervisory Review group sessions has been on how midwives should use the AWCPN when caring for a woman in normal labour whilst at the same time ensuring correct documentation.

3.6 Maternity strategy and indicators

Following the publication of the Welsh Government (2011) Strategic Vision for Maternity Services in Wales³⁰ a set of maternity indicators were developed to monitor progress. Work to collect the appropriate data from health boards to underpin these indicators is currently undertaken by Public Health Wales and NWIS³¹. An interim reporting tool for use in supporting the Maternity Strategy was developed with six monthly performance meetings taking place with Welsh Government and health boards to monitor their maternity services progress. Plans are in place to develop a national maternity dataset to provide data for an All Wales surveillance tool with reporting down to health boards and local authority level. It is anticipated that this will include the Maternity Strategy indicators as well as a set of early years indicators which have been piloted with Aneurin Bevan University Health Board.

3.7 Reducing caesarean section rates

There continues to be emphasis on reducing intervention in labour to increase women's chances of a normal birth. This work is aided by maternity services in Wales using the findings of the national Birth Place Study (NPEU, 2011)³² which reports that low risk women who birth in a high risk labour ward have a higher incident of intervention with morbidity.

²⁹ All Wales Clinical Pathway for Normal Labour 2014. Clinical Pathway for Normal Labour has been developed to reduce unnecessary intervention in normal labour and birth

³⁰ Welsh Government (2011) A strategic vision for maternity services in Wales.

³¹ Early Years Surveillance Public Health Wales' Early Years Programme website: <http://www.wales.nhs.uk/sitesplus/888/page/64302#WG>

³² National Perinatal Epidemiology Unit (2011) Birthplace Study <https://www.npeu.ox.ac.uk/birthplace/birthplace-follow-on-study>

The proportion of hospital births by caesarean section rose from 24% in 2004-05 to 27% in 2013-14 (Welsh Government (WG), 2014)³³. An estimate of the national caesarean section rate would include home and other births, making the Wales rate 26% during 2013-14 compared to 27% in 2012 (WG, 2014). Health boards have met with Welsh Government on a six monthly basis to discuss their maternity services action plan and progress in reducing the caesarean section rate.

3.8 National and local policies related to supervision

Nationally

During 2014 the LSA MO Forum UK reviewed and updated all the national policies and guidelines to reflect the changes and developments set out in the NMC Midwives rules and standards (NMC 2012). National policies and guidelines are written in order to support LSA MOs and SoMs in their role. The UK focus is to ensure equity and consistency in process and outcome wherever the supervisory activity is undertaken. The updated national policies and guidelines were ratified in April 2013 and were published on the LSA MO Forum UK website at www.lsamoforumuk.scot.nhs.uk. A policy review plan is in place to highlight when relevant policies and guidelines are due for a three year review or after significant amendments to statute or NMC standards.

The UK forum will be reviewing all LSA MO Forum guidance to ensure it is in line with the newly introduced Code (NMC, 2015).

During the year there have been further improvements to the local guidance documents relating to supervision in Wales:

Locally

The LSA has implemented guidance on the use of the all Wales Annual Supervisory Review (ASR) document in a question and answer format to support group supervision approach to ASRs. This has been amended during 2014-15 to take into account the Code (NMC 2015) which came into use March 2015.

Healthcare Inspectorate Wales' website has been developed to include the local guidance documents to support the introduction of the Wales model of midwifery supervision. The documents include the Standard Operating Procedure for On Call, the ASR process, and the

³³ Public Health Wales Observatory website: <http://www.wales.nhs.uk/sitesplus/922/page/75041>

local templates to support the LSA MO Forum UK policy for the investigation process. All contacts made to the Supervisor on call are logged on a SBAR telephone record. These calls are audited on a monthly basis, themes and trends have been shared in a 6 monthly audit with Heads of Midwifery and the Supervisory team in order to inform organisational planning to ensure all learning opportunities are used their full potential.

4. Ensuring investigations into sub-optimal practice are undertaken

The LSA is formally notified of serious untoward incidents where sub-optimal midwifery practice may have been a contributing factor via the national LSA database. Guidance on what type of incident should be reported is set out in the 'LSA Incident Reporting Trigger List' which ensures that only those incidents relevant to the role of the LSA are reported.

All serious clinical incidents are subject to a supervisor of midwives' case review using the LSA MO Forum Decision Tool Kit. If the tool kit indicates that the acts or omissions of any midwife may have contributed in a negative way to the clinical incident, or their practice was not in line with the Midwives rules and standards or the NMC Code, a SoM will then undertake a full supervisory investigation in line with LSA MO Forum UK guidance. A supervisory investigation may also be initiated following a routine audit of records or through the complaints mechanism where midwifery practice standards are called into question.

Forty two investigations were formally notified and commenced within the LSA in 2014-15 compared to the previous year's figure of 48. All 42 investigations were conducted in line with LSA MO Forum UK guidance.

SoMs, in year, continue to find it a challenge to complete investigations within the 45 working days recommended by the LSA MO Forum UK, or in a timely manner as required under the revised Midwives Rules (NMC 2012). Of the 42 investigations undertaken there was some evidence of improvement in timeliness mid year. The first quarter report (Q1) of 2014 (April – June 2014) only 20% (2 in 10) concluded within 45 working days. The remaining quarterly reports evidence the percentage number of investigations completed in a timely manner as following; Q2- 70%, Q3-75% and Q4- 48%. The overall annual completion of reports within 45 working days is 49%.

The above data demonstrates the challenges of ensuring compliance with the reasonable timeframes expected prior to the introduction of the FPS system. During the year, the timeframe for SoM investigations remained under close scrutiny and the LSA continued to emphasise the importance of timely investigations and conclusion to assist effective restoration where required.

The main cause of delay was the time taken between completing the interviews and finalising the reports, owing to various challenges such as getting signed notes returned, midwife engagement (for example sickness episodes), and prior to August 2014, balancing report writing with the demands of a substantive post. This is clearly unacceptable as it delays

restorative practice for the midwives involved, prevents lessons from being learnt at the earliest opportunity as well as leaving the LSA and the health boards open to challenge. While significant improvement was evidenced mid year in Q2 and Q3, the Q4 position demonstrates the need for the LSA to maintain focus in order to prioritise report completion.

In 2014 -15, the outcomes of the investigations conducted were no further action for 27 midwives, 58 midwives undertook a Local Action Plan (LAP), for Reflection or Continuing Professional Development relevant to the issues that caused concern, and 10 LSA Practice Programmes (LSAPP) were recommended.

In this reporting year, two midwives were suspended from practice by the LSA and referred to the NMC as a result of significant deficits in their fitness to practice. One referral was made to the NMC in tandem with a midwife self referral as she recognised due to competing demands, she would be unable to complete a recommended LSAPP.

4.1 Improving the supervisory investigation process

The LSA uses both the LSA MO Forum UK database and a local workbook to monitor investigations and their progress to completion. As referred to earlier, this is a particularly challenging area for SoMs on many levels. The LSA MOs provide initial advice and guidance on completing a review of clinical records and the use of a decision tool kit to inform whether an investigation appears to be warranted. The LSA MOs support SoMs in devising an interview schedule if required. The LSA MOs have developed and revised an Investigation Resource book which, along with the LSA website, contains all the templates and examples of letters, interview planning, schedule of questions etc. to support SoMs in preparing for the investigation. There are also example reports in the resource book for SoMs to follow before drafting their report.

The LSA MOs receive draft reports from SoMs to review, and these should be with the LSA within 30 days. Comments or tracked changes are emailed back to SoMs. In some cases, one to one meetings take place where it is apparent the SoM needs additional support. The LSA are now monitoring the number of iterations of reports received to help identify whether training has been effective or where it is apparent further training is required.

When the LSA is content with a report and the recommendation made, the SoM is given clearance to upload this to the LSA database and the case is marked as closed. The LSA aims for SoMs to conclude the report writing and upload it to the LSA database within 45 days as recommended by the LSA MO Forum UK. The investigating SoM sends a referral form to a named SoM who is asked to support the midwife with a Local Action Plan of Reflection, or required learning in Continuing Professional Development, and this includes an expected date for return. The LSA workbook does not consider the case is closed until the SoM reports back that any recommended restoration has been successfully completed and also uploaded to the

LSA database as evidence of learning. At the end of the full investigation process the investigating SoM and the midwives involved in an investigation are asked to complete an evaluation of the process. Monitoring of evaluations aims to support the LSA in reviewing policies and processes and providing SoMs with further training or guidance as required.

As highlighted elsewhere in this report, investigations have been a particular area of risk for the LSA in Wales, and this is therefore a high priority for the FPS model going forward. All SoMs have had, and will continue to receive, further training from the LSA, including direct mentoring and coaching throughout the investigation process, as well as from experts in the field such as Bon Solon.

In response to the Francis and PHSO Reports, the SoMs working in the FPS model in Wales will no longer conduct investigations into incidents that occurred in their substantive place of employment. This aims to avoid actual or perceived conflicts of interest, brings a fresh eyes approach to custom and practice in any organisation, demonstrates openness and transparency in a learning organisation and enhances all Wales learning from events. The Key Performance (KPIs) identified in the FPS Service Specification are set out in full in the final section of this report.

The LSA expects to report more positive compliance rates with all targets at all stages of the investigation process within the next six months. In the FPS model, there are a number of changes aimed at improving the quality and timeliness of the investigation process. The actions listed below are those already identified and in place, but this is a dynamic process which will be kept under continual review:

- The SoMs will not conduct an investigation into any matter which has occurred in their employing health board. This ensures greater openness and transparency, avoids conflict of interest and enhances opportunities for all Wales learning from incidents. The investigating SoM will work with the relevant health board's designated SoM to identify records, forge links with any management investigation being conducted simultaneously, arrange venues for meetings, arrange note taking and support other practical issues
- Where possible the SoM will conduct the supervisory investigation in tandem with any management process, albeit retaining the impartiality of the supervisory process. The health board's active SoMs and SoM in waiting will support midwives involved in an incident to review their care and record keeping in order that they are properly prepared for the investigation meeting and are supported at that meeting
- The investigation report will be read by a 'buddy SoM', who may or may not be the designated health board SoM, with a particular emphasis on proofing and testing the

findings of the investigation before it is submitted to the relevant LSA MO for review. Using the health board active SoM or SoM in waiting for this activity could be advantageous in 'testing' any specific issues relevant in that organisation but care must be taken to retain transparency in the process. This buddying system will improve quality and consistency of reports over time as well as enhancing SoM learning and providing peer support

- Following an investigation, if there is any learning or remedial action required for individual midwives, the health board's active SoM, or SoM in waiting, and the midwife will work with the investigating SoM to receive feedback on the investigation report and to devise Local Action Plans as appropriate. The active SoM or SoM in waiting will support and oversee the completion of the remediation, reporting back to the investigating SoM on completion to enable closing the loop on lessons learnt. Any wider learning and good practice will be discussed at the LSA monthly SoM meeting to ensure this is shared across Wales
- Midwives and Investigating SoMs will be asked to complete an evaluation of the process after each investigation. Trends and themes identified by both parties in this evaluation will be used to make improvements to the training of SoMs, the investigation process, or to feedback to HoMs if there were organisational issues that impacted on the investigation process at any stage
- The investigating SoM will arrange to present the full supervisory report to the HoM with specific emphasis on systems and clinical governance concerns. This will enable discussion to take place regarding the report and its recommendations, and allow subsequent action planning to ensure governance and systems issues are addressed. Organisational action plans will be reviewed with HoMs at each health board, the active SoM and the LSA MO at quarterly meetings. Any challenges with service improvement will be escalated to the Nurse Director by the HoM and LSA MO at bi-annual meetings or more immediately as required.

Key Performance Indicator (KPI) 9 aims to gather both quantitative and qualitative data to demonstrate whether local intervention and restoration of midwives is effective in supporting them in their practice whilst supporting the referral to the regulatory body of those midwives who continue to be a risk. KPI 9 aims to continually monitor the timeliness and quality of the whole investigation process. The benchmarks will be:

- 30 days for 1st draft report to LSAMO
- 45 days for completion of the report, feedback to midwives and setting objectives as required and feedback to HoM with organisational issues

- Appropriate monitoring, via the LSA Workbook and LSA database, of sign off of the completed objectives including uploading to the LSA database and closure of the investigation
- Number of iterations of reports seen by the LSAMO before final agreement, including agreeing report quality and recommended sanctions to the LSA. This will inform training needs and support required by individual SoMs
- Improvement in midwife and SoM feedback on investigation process, in particular midwives reporting the investigation as helpful and positive rather than punitive
- Decrease in numbers of the same midwives who repeatedly require support for similar and/or unrelated practice issues linking this to the ASR discussion and group supervision
- Numbers of midwives subject to an LSA Practice Programme who are subsequently referred to the NMC and the reasons for the referral
- The number of midwives who, following a successful LSA Practice Programme, go on to further development within the service.

4.2 Complaints in relation to the discharge of the supervisory function

Complaints against the LSA and or LSA MOs are dealt with in accordance with the Welsh Government's complaints procedures or through the LSA appeals process as appropriate. The process of dealing with complaints and appeals is described in the [LSA MO Forum UK](#) policy³⁴, Complaints against a supervisor of midwives or LSA Midwifery Officer. The LSA received two formal complaints in 2014-15 regarding historical actions of the LSA. An in-depth review of a series of complaints made about the actions of the LSA that was started in 2011-12 and is still on-going. The Complaints Unit of the Welsh Government continue to assist HIW with this case.

³⁴ LSA MO Forum UK (2013) Policy for the complaint against a Supervisor of Midwives or LSA Midwifery Officer
<http://www.lsamoforumuk.scot.nhs.uk/policies-guidelines.aspx>

5. Notable and Innovative Practice

The NMC review team found that the new FPS model of statutory supervision for Wales is innovative and effective and its implementation is an example of excellent change management which had involved relevant stakeholders within the maternity services, HIW and service user representatives. The team found that midwifery supervision is appropriately and well resourced, and that all possible eventualities had been considered and addressed during the planning and implementation phases of the change. It was also noted that the innovation has already been shared widely through publication of a paper in the British Journal of Midwifery (April 2014) but is considered that it was also worthy of further dissemination in light of its early success.

Under the Future Proofing Model of supervision, all innovative and notable practice is reflected across the whole of Wales with all Midwives accessing standardised process and models of delivery which include:

- Group Supervision, which is a formal and supportive group to ensure midwives' completion of the Annual Supervisory Review document; SoM's use action learning set at structured discussions for midwives to learn from others and their own experiences. This is an opportunity to update midwives on local themes and trends and also update on NMC guidance and the revised Code (NMC 2015).
- An all Wales telephone number to access a SoM on call 24hrs a day, 7 days a week. All contact is recorded and a monthly report is produced to reflect all contact across Wales, ensuring those challenging and difficult calls can be discussed in the monthly performance meeting and also locally at each Health Board.
- Record keeping group sessions presented in a tea party environment for midwives to attend to support their requirement for completion of a record keeping audit. During the group setting midwives work in pairs to look at a set of notes and complete an audit of those notes and then feedback to the group and share the learning.
- HIW CEO participated in an NMC panel debate at the national RCM Conference in November 2014 to discuss the new model of Supervision.
- Two SoM's have presented their poster presentations at the Chief Nursing Officer's Conference, they showcased the record keeping tea parties and Group Supervision.

- SoM's are writing a two part article for the British Journal of Midwifery reflecting on the concepts and outcomes of group supervision.

5.1 Sharing good practice

During the year, there have been a number of occasions where the LSA in Wales has involved other LSAs in their work such as;

- LSA MO from South West LSA has been part of the FPS implementation group
- LSAMOs presented the implementation of the new model and the early indicators at the London LSA conference in October 2014
- A SoM from Wales has attended the LSA Midwives forum in November 2014 to present the model to LSA Midwives from across the UK
- LSAMO and a SoM attended a SoM meeting in February 2015 with the Wye Valley Trust West Midlands LSA to discuss the model and cross border working with neighbouring LSA
- LSAMO and a SoM from Wales presented the case for change and outcomes for the model at South West LSA Conference in March 2015
- A LSAMO attend a workshop in Northern Ireland in April 2015 to contribute to the Northern Ireland review of supervision of midwives
- LSAMOs from Wales have undertaken appeals for two other LSAs which related to a SoM investigation and a recommended LSA Practice Programme. The opportunity to consider appeals is always seen as a chance for learning and benchmarking work within the LSA.

During 2015-16, the LSA has committed to being involved with other LSAs in their work as follows:

- Full time SoM from Yorkshire and Humberside to shadow a full time SoM in Wales (July 2015)
- SoMs to present group supervision concept to Head of Midwifery and SoM team in Oxford (August 2015)
- LSAMO and SoM to share the model of group supervision and discuss the process and documentation with Highland SoMs with a video conference to Scotland (August 2015)

- SoM from Wales presented the case for change and outcomes for the model at Northern Ireland LSA Conference (September 2015)

5.2 Key issues for the LSA in 2014-15 and looking to the future

Without doubt the biggest challenge to the provision of statutory supervision across the UK will be to sustain the momentum and commitment to the role whilst the NMC resolve the legislative changes needed. The LSA in Wales believes it is in a stronger position although we are not complacent, recognising that we will need to work hard at keeping SoMs within the role when alternative opportunities arise. However, we are confident we have a high calibre team who joined the model because they wanted to make a difference for women and families who use the maternity services in Wales, but also for midwifery colleagues who may be facing significant service reconfiguration in the coming months.

The role of the SoM going forward will be to support midwives in the management of change to ensure service provision remains seamless and delivered by a highly motivated midwifery workforce that meets the statutory requirements laid out in the Midwives rules and standards and the NMC Code. Over the next twelve months, the LSA has committed to continue to work closely with HoMs and workplace representation across Wales to align the SoM investigation process closer with the organisational governance and management process. This direction of travel is a step forward to share the skills and expertise from the SoM investigation process. This will also help health boards to prepare for the exit from SoM investigation process once legislative changes are made. A key priority will also be a robust information governance process for the safe storage of SoM records particularly the investigation process which is required to be archived for 25 years.

SoMs will play a pivotal role in embedding revalidation into the practice of midwives but more importantly they will look to share their knowledge and expertise to with nursing colleagues those grappling with. SoMs already have expertise in professional discussion and confirmation elements of the revalidation process which are the backbone of the SoMs work. The evaluation report from Swansea University and the success to date of group supervision will also be invaluable in supporting other disciplines to address the need to improve the annual appraisal compliance and effectiveness

The LSA looks forward to working with all our colleagues towards the aim of improving professionalism and enhancing public protection and thanks everyone for their support to date.

Appendix 1- SoM Equivalent Ratio in Wales

Traditional model

1786 midwives = 1:15 ratio

116 SoM

116 SoMs x 10.5hrs per month = 1,218 hrs of supervision per month

New model

1,950 SoM hrs per 52 Week year - 26% headroom = 1,443hrs actual hours worked per WTE
 SoM x 13.8 WTE SoMs = 19,913 hrs per yr ÷ 12 mths = 1,659hrs of supervision per month

1,659 ÷ 10.5 hrs = equivalent of 158 SoMs

1779 (+7 Health Visitors & Independent Midwife)

1786 midwives ÷ 158 SoMs = adjusted ratio of 1:11

Table 1 - Health Board Specific Calculations Updated - Q4 2014-15

Health board	Midwives	SoM wte	SoM hours per month	Adjusted ratio
Abertawe Bro Morgannwg	300	2.2	265 hrs	1:12
Aneurin Bevan	300	2.4	289 hrs	1:11
Betsi Cadwaladr	405	3.0	361 hrs	1:12
Cardiff and Vale	282	2.2	265 hrs	1:11
Cwm Taf	210	1.6	192 hrs	1:12
Hywel Dda	205	1.8	216 hrs	1:10
Powys	43	0.4	48hrs	1:11

ABMU

$1443\text{hrs} \times 2.2\text{wte} = 3175\text{hrs per yr} \div 12\text{mths} = 265\text{hrs per month}$
 $265 \div 10.5 = \text{equivalent of } 25 \text{ SoMs}$
 $300 \div 25 \text{ SoMs} = \text{adjusted ratio } 1:12$

Aneurin Bevan

$1443\text{hrs} \times 2.4\text{wte} = 3463\text{hrs per yr} \div 12\text{mths} = 289\text{hrs per month}$
 $289 \div 10.5 = \text{equivalent of } 28 \text{ SoMs}$
 $300 \div 28 \text{ SoMs} = \text{adjusted ratio } 1:11$

BCU

$1443\text{hrs} \times 3\text{wte} = 4329\text{hrs per yr} \div 12\text{mths} = 361\text{hrs per month}$
 $361 \div 10.5 = \text{equivalent of } 34 \text{ SoMs}$
 $405 \div 34 \text{ SoMs} = \text{adjusted ratio } 1:12$

Cardiff and Vale

$1443\text{hrs} \times 2.2\text{wte} = 3175\text{hrs per yr} \div 12\text{mths} = 265\text{hrs per month}$
 $265 \div 10.5 = \text{equivalent of } 25 \text{ SoMs}$
 $282 \div 25 \text{ SoMs} = \text{adjusted ratio } 1:11$

Cwm Taf

$1443\text{hrs} \times 1.6\text{wte} = 2309\text{hrs per yr} \div 12\text{mths} = 192\text{hrs per month}$
 $192 \div 10.5 = \text{equivalent of } 18 \text{ SoMs}$
 $210 \div 18 \text{ SoMs} = \text{adjusted ratio } 1:12$

Hywel Dda

$1443\text{hrs} \times 1.8\text{wte} = 2597\text{hrs per yr} \div 12\text{mths} = 216\text{hrs per month}$
 $216 \div 10.5 = \text{equivalent of } 21 \text{ SoMs}$
 $205 \div 21 \text{ SoMs} = \text{adjusted ratio } 1:10$

Powys

$1443\text{hrs} \times 0.4\text{wte} = 577\text{hrs per yr} \div 12\text{mths} = 48\text{hrs per month}$
 $48 \div 10.5 = \text{equivalent of } 4 \text{ SoMs}$
 $43 \div 4 \text{ SoMs} = \text{adjusted ratio } 1:11$

Appendix 2 - Supervision of Midwives in Wales

LSA Lay Reviewers Audit Report - April 2015

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Executive Summary

The Local Supervising Authority (LSA) lay reviewers are key to the LSA audit process as they are responsible for seeking the views of maternity service users and assessing their awareness of supervision from an independent perspective. The involvement of the lay reviewers in supervision of midwives in Wales during 2014-15 has been extensive and has included participating in interviewing, monitoring and evaluation, awareness raising and the Nursing & Midwifery Council (NMC) review. The audit process for this year was developed by the lay reviewers and involved auditing the following areas of supervision of midwives in Wales:

- Service user experience
- Group supervision and continuing professional development (CPD)
- Accessibility of Supervisors of Midwives (SoMs) to women and their families.

All service users surveyed reported satisfaction with their SoM contact. Pregnant women in particular value the service provided by SoMs, including the speed of response; personal qualities of SoMs and their ability to provide emotional reassurance. Now that the new model is fully embedded some refresher training for SoMs would be beneficial and some minor improvements to the systems and processes have been identified.

The overall findings from the audit of group supervision are that this is an effective mechanism to ensure that the practice of midwives is kept under review, thereby enhancing public protection; it allows the sharing of best practice and joint learning. To maximise the benefits of group supervision for all midwives, the barriers to their participation, highlighted through the audit process, need to be addressed by SoMs and Heads of Midwifery (HoMs). The incorporation of women's feedback into the CPD process is an area which requires some attention, and this will be particularly pertinent in light of the new revalidation requirements.

A telephone audit of health boards found good results in terms of signposting to the national on-call SoM number. However, online results were mixed and further work needs to be carried out to ensure consistency in maintaining electronic media across Wales. Many health boards provide information for women via printed media, notice boards etc. though further sharing of good practice could improve the quality and consistency of messages.

1. Lay Reviewers Involvement and Audit Proposal

1.1 Overview of lay reviewers' involvement during 2014-15

The LSA lay reviewers are key to the LSA audit process as they are responsible for seeking the views of maternity service users and assessing their awareness of supervision from an independent perspective. The four current lay reviewers have now been in post for 16 months, and have been extensively involved in LSA activities during the year as the new model has been implemented.

The lay reviewers have a clear focus on the user perspective in line with NMC Midwives rules and standards (2012) Rule 7: 2.3, which states; 'involve women who use the services of midwives in assuring the effectiveness of the supervision of midwives'.

Lay reviewer involvement in LSA work in Wales during 2014-15 has included:

- participating in the recruitment of SoMs for the new model, observing SoMs in a workshop environment, and sitting on the interviewing panel. Lay reviewers assessed the SoM's attitude and approach to women's choices and individualised care
- developing a leaflet to explain the new model of supervision in Wales, and more generally raising the awareness of the role of supervision for service users
- participating in the LSA all Wales Monitoring and Evaluation Group set up to monitor and evaluate the evidence produced from the Key Performance Indicators (KPIs) aiming to demonstrate the value of supervision. As part of this membership, the lay reviewers put forward a proposal for the expansion of the KPI relating to service users, which was approved, and expanded into a lay reviewers audit programme as outlined in Section 1.2
- attending the SoM monthly meetings to keep abreast of SoM activities, monitor compliance with the service specification for supervision and review progress towards achieving KPIs
- contributing to the updated information on the new model of supervision in Wales to be included in the national hand held patient records for pregnant women
- participating in the NMC Review in December 2014, which included a workshop with the NMC review team to share the lay reviewers perspective on progress with statutory supervision of midwives in Wales
- interviewing SoMs in waiting who applied to join the new model of supervision and SoMs applying to participate in the SoM preparation programme at Swansea University. The Lay reviewers observed and assessed students and SoMs at the workstations and were part of the interview panel.
- assisting the selection process of the LSA Midwifery Officer role

1.2 Proposal for audit of the new model of supervision In Wales

The 2013-14 LSA Annual audit concluded by stating that:

Most importantly the LSA would like to show that supervision of midwives really does add value to midwives, women and even to the SoMs themselves. Furthermore the model will aim to examine and demonstrate the additional value supervision brings to the midwifery profession and maternity services, over and above the existing governance framework and thereby enhances public protection.

During the lay reviewers' audit planning meeting with the LSA Midwifery Officers (LSAMOs) in January 2015, the previous audit process was discussed and reviewed in light of the new model of supervision in Wales. Prior to the implementation of the new model, the annual audit process had involved a self assessment plus audit visits by the LSA team to each of the seven health boards; this included meetings, presentations and general observation walk-arounds. This process served to provide a snapshot of the effectiveness of supervision in each region

As a result there were provisional plans in place to set up an external review team from other parts of the UK, supported by the lay reviewers in Wales, to conduct the 2014-15 annual audit process. However in December 2014, the NMC carried out a full review of supervision in Wales. The outcome of this review was wholly positive, with no areas of concern raised. It was therefore agreed that there would be no value in duplicating the NMC review in year, but it was important to identify key areas of the new model that had not previously been scrutinised.

The overall objectives of carrying out the annual audit remained, that is to validate that statutory supervision was contributing to the governance mechanisms for safeguarding the health of women and their families who use maternity services in Wales. The annual audit also monitors that statutory supervision of midwives is exercised to a satisfactory standard in accordance with the standards set by the NMC.

As part of the lay reviewers membership of the all Wales Monitoring and Evaluation Group, a proposal for extending the KPI relating to service user experience had already been drafted, identifying areas of the model that could be scrutinised by the lay reviewers. This document was developed into a firm proposal for audit and presented to the LSA for approval.

The following table provides a brief overview of the evaluation carried out by the lay reviewers:

Area for Evaluation	Overview
A1) Service user experience	It is vital that supervision of midwives is providing appropriate advice to service users (both midwife and non midwife users), and that the users are satisfied with the service they received. This area of audit looked at both the process of providing advice via the new on-call system, and the general satisfaction of service users with the advice given by SoMs.
A2) Group Supervision and Continuing Professional Development (CPD)	One to one annual reviews between individual midwives and their SoMs have largely been replaced in the new model with group supervision using an action learning approach. CPD plans for midwives are developed as a result of group supervision. This area of audit looked at whether these new processes are of sufficient quality to: <ul style="list-style-type: none"> ▪ enhance the protection of the public (through validating the individual CPD of midwives) ▪ improve the service offered to women and their families.
A3) Ease of accessibility of SoMs to women and their families	The new model of supervision in Wales includes a single common 'on-call' telephone number for women and their families to contact a SoM. This area of audit looked at whether information regarding supervision of midwives in Wales is up to date, accessible and there is equitable signposting to the new on-call number.

2. Lay Reviewers Audit 2014–15 Outcomes

2.1 Evaluation of service user experience

2.1.1 Objectives

Objective 1	To measure the satisfaction of service users with the SoM contact.
Objective 2	To assess the quality and appropriateness of advice and actions of SoMs in response to service user contact.
Objective 3	To ensure that the new on-call system is providing an appropriate and effective platform for receiving and responding to service user requests for SoM assistance.

2.1.2 Evaluation questions

The key questions to answer were:

- Are SoMs being contacted for the right reasons?
- Do service users understand the role of SoMs?
- Is the process of receiving and recording SoM contacts working effectively, from both an on-call and non on-call perspective?
- Is this system enhancing the protection of the public appropriately?
- Is the process of referral of contacts from the on-call system working effectively?
- Is data cross referenced, and outcomes linked?
- Are themes and trends in contacts being identified and addressed appropriately?
- Are there any challenges with the on-call system which need to be addressed?
- Are users reporting satisfaction with the process and the advice received from SoMs?

2.1.3 Methods

The evaluation was carried out in two parts as follows:

- Reviewing the on-call system including scrutinising contact documentation, carrying out further follow up on a sample of contacts and surveying the SoMs
- Identifying service users (both women and midwives) and using a questionnaire to evaluate their satisfaction with the service.

Full details of the methodology used are available from HIW on request.

2.1.4 Confidentiality

Participants were given pseudonyms and any quoted references to personally identifiable information were anonymised. The service users had given their consent to their material being used but were assured it would remain confidential. They are referred to as service user 1, 2, 3, etc.

2.1.5 Objective 1: Findings and discussion

Objective 1: To measure the satisfaction of service users with the SoM contact.

To analyse this we looked at the following question:

- Are users reporting satisfaction with the process and the advice received from SoMs?

We used two questions in the **User Contact Survey** to address this quantitatively, illustrated below (see fig. 1 and fig. 2):

Fig. 1

If a pregnant friend or relative had concerns about the care she was receiving from her midwife, I would:

Answered: 9 Skipped:2

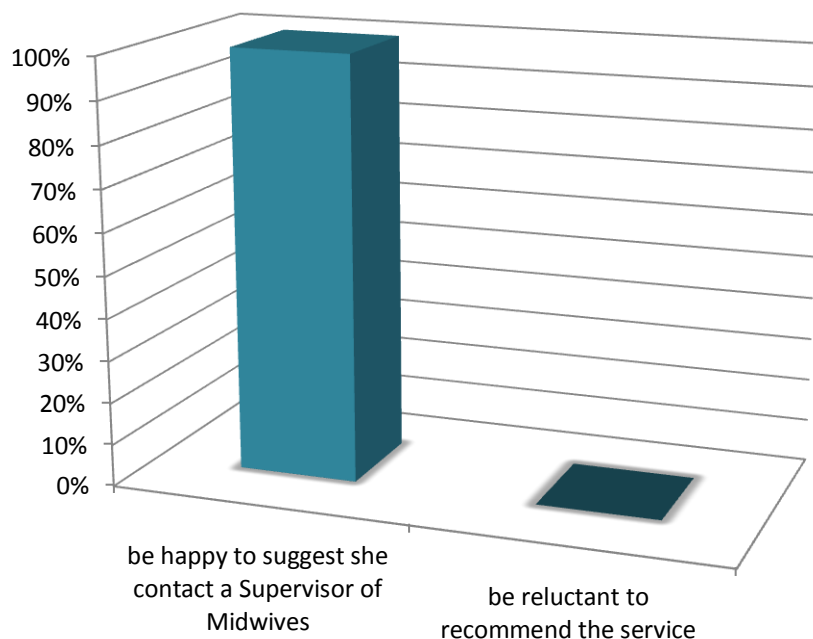
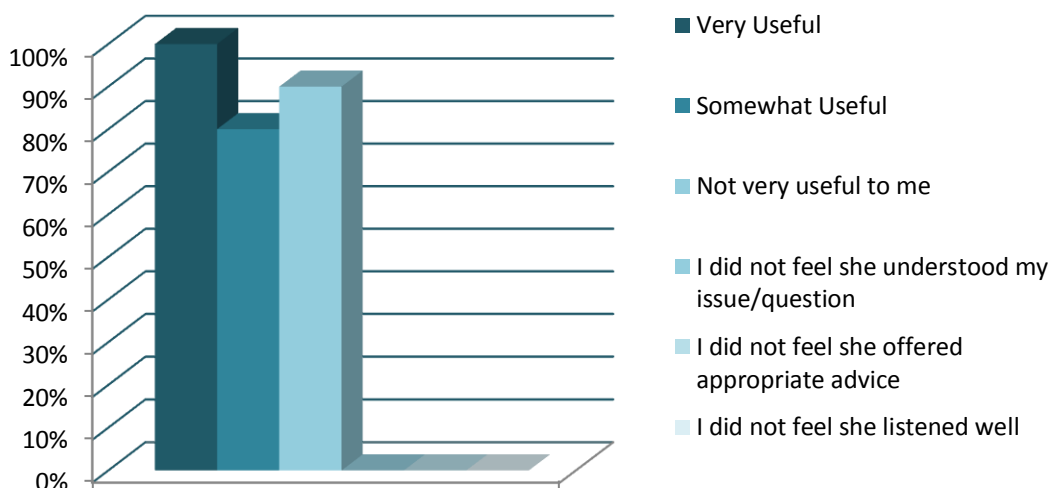


Fig. 2

How would you describe the conversation you had with the Supervisor of Midwives? Please tick any statements that apply:

Answered: 10 Skipped: 1



Given that all **Service User Contacts** reported satisfaction with their SoM contact, it was agreed that this objective would be better explored through qualitative analysis addressing which elements of the SoM contact are valued by service users.

Our more in-depth analysis of service users' comments demonstrated the following themes:

Theme 1: Women value the **accessibility** of the service, particularly the **speed of response**.

One service user, when asked how the service could be improved, said:

'It couldn't. A call was made and within the hour everything had been resolved :). Great work'. (Woman 4)

Women also wanted the service to be more accessible than it already is:

'This should be given as a contact in the first instance of contact with the midwife, I have spent most of my pregnancy unhappy with my midwife not knowing who to approach, my mother found the SoM on the Internet but not everyone has the access or knowledge of what to look for'. (Woman 5)

Theme 2: Women believe the SoMs have the **ability to create change**, and this is valuable:

I was anxious, scared, worried, at being [clinical detail omitted]. After I made the call I was put at ease, assured I would get seen and that the supervisor would make all the calls needed. I was seen within the hour. All the stress was taken off me. Great service.

(Woman 4)

The service user above pinpoints her SoM contact as pivotal in her getting the care she was requesting.

Theme 3: SoM contact can provide a useful **containment** of an issue, and use of the SoM service appears to prevent some matters from being pursued further or becoming a complaint. This service user describes receiving an outcome she did not want, but later on describes herself as very satisfied with her SoMs advice, and willing to recommend the service to a friend or relative. Describing the outcome of her call she says it:

'Made me see there was no way I was allowed to have a scan which the rest of great Britain are allowed' [due to different rules applying in Wales which were explained to her by the SoM] *(Woman 3)*

As noted above, despite the disappointment with the outcome of the contact, she still rated her satisfaction with the call and the service very highly.

Theme 4: The SoM's **personal qualities** in relating with the service user are of positive value:

'The SOM was welcoming and listened to my concern'. *(Woman 1)*

'She was understanding'. *(Woman 3)*

'I think that the supervisor I contacted was very professional, supportive without being patronising, and was open to any form of communication available to me. Her door was always open, and I felt that I could share my concerns and that they would be listened to sympathetically'. *(Midwife 3)*

'Prompt reply, professional, appropriately confidential, good signposting to additional support, very approachable'. *(Midwife 1)*

SoM qualities valued by the service users came out in almost all of the more in-depth responses. These included listening skills, warmth and supportiveness.

Theme 5: We also noted that the SoM's **ability to empower** is important. Midwife 3 above (in referencing that she did not feel patronised) and Woman 2 below (who had previously felt against a 'them' of healthcare professionals) both indicate feeling empowered by the contact.

The advice empowered the service user, where her contact with other healthcare professionals had been difficult. This led to a better outcome:

'This was first time I heard I can contact someone about any problems or concerns, until now I felt I was alone against health staff. The option to talk to someone, and the knowledge there is someone to listen needs to be told readily to all pregnant women'. (Woman 2)

Theme 6: Women described the contact with the SoM as providing **emotional reassurance** and support, and that this had a positive benefit to their pregnancy and birth experience.

'I don't believe there is any more that could have been done. Extremely happy after speaking with supervisor xx'. (Woman 4)

'I was worried and nervous about the up coming birth of this baby due to how things were handled by hospital last time. The supervisor let me talk through all the issues and was very sympathetic to my concerns. I now feel I can relax about the birth and actually look forward to it'. (Woman 2)

'I felt more supported and the result was a much happier pregnancy and birth experience. I honestly believe that her input contributed to my wellbeing as during my previous pregnancy I had been depressed and frightened'. (Woman 7)

Theme 7: Service users believe increased **awareness** of the SoM service is required. A number of the service users stated that they had not been given information about a SoM early in their pregnancy. The details about the SoM service are now included in the woman's hand-held record, therefore further interviewing/ auditing of views may be indicated to find out why this information isn't perceived as being easily accessible by service users.

'This should be given as a contact in the first instance of contact with the midwife, I have spent most of my pregnancy unhappy with my midwife not knowing who to approach, my Mother found SoM on the Internet but not everyone has the access or knowledge of what to look for'. (Woman 5)

'I'm not sure there are any. It was a great service. Maybe provide all mums to be with the number - save googling. But other than that - top service'. (Woman 4)

2.1.6 Objective 2: Findings and discussion

Objective 2: To assess the quality and appropriateness of advice and actions of SoMs in response to service user contact. To analyse this, we looked at the following questions:

- Is the process of receiving and recording SoM contacts working effectively?
- Is this system enhancing public protection public appropriately?
- Is the process of referral of contacts from the on-call system working effectively?
- Is data cross referenced, and outcomes linked?
- Are themes and trends in contacts being identified and addressed appropriately?

SoM Advice

The following quantitative results were found from **User Contact Survey** (see fig. 3 and fig. 4 below):

Fig. 3

How would you describe the conversation you had with the Supervisor of Midwives? Please tick any statements that apply:

Answered: 10 Skipped: 1

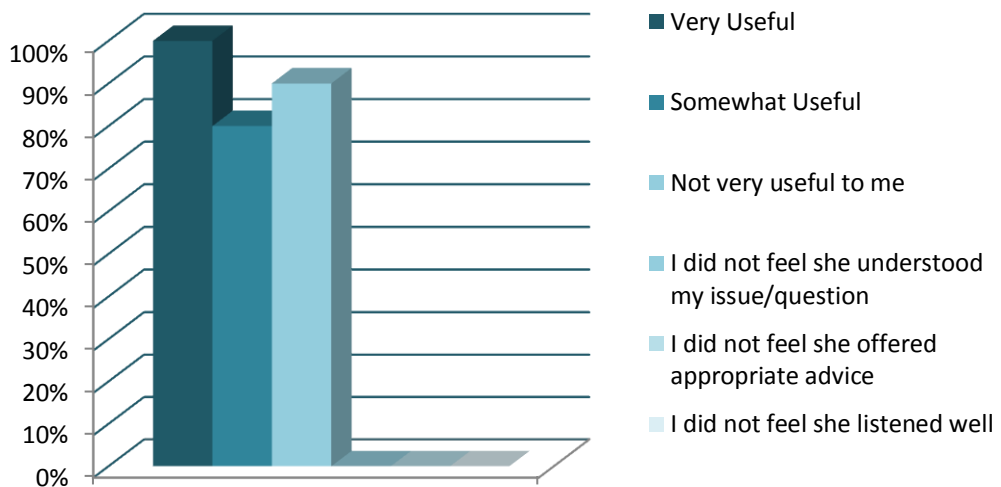
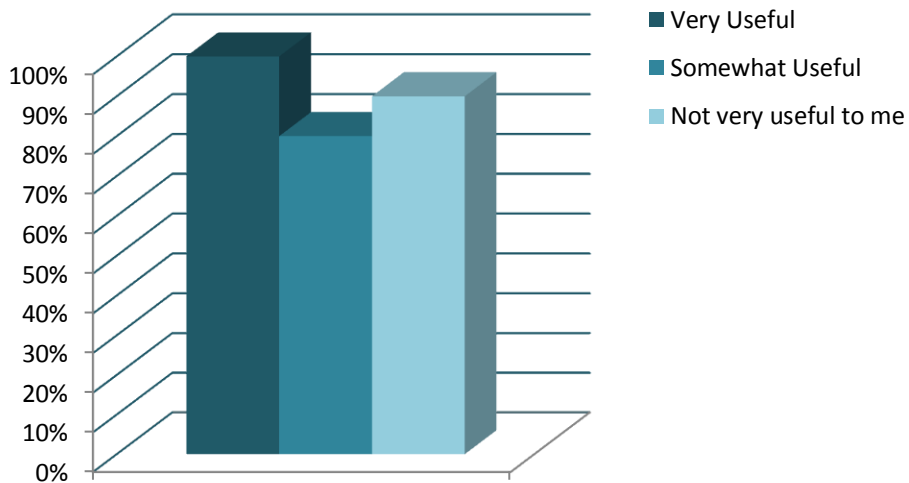


Fig. 4

How would rate the usefulness of the advice you received from the Supervisor of Midwives?

Answered: 10 Skipped: 1



There may however be a need for a refresher session on the boundaries of advice that SoMs should be providing in clinical situations, particularly as this will often now be delivered in a health board which is unfamiliar to the SoM on call:

'The supervisor advised me that it's extremely rare to be [...clinical detail omitted] and that she would make a call. I believe it was from this call that I was induced that day :)'

(Woman 4)

The quality of the advice provided by SoMs is important in enabling knowledge gaps to be filled:

'[The SoM] Made me see there was no way I was allowed to have scan which the rest of Great Britain are allowed'.*(Woman 3)*

Contact referral and SoM actions

Discussions with SoMs as part of the **SBAR Follow Up** revealed that on-call contacts are referred to a local SoM as and when required. The following was discovered with respect to the process of referring on-call contacts to another party and consequent follow up:

- Referrals take a variety of formats including emails, email attachments, telephone calls, iShare link (Welsh Government IT storage system) etc. Whilst it appears to be well recognised that the correct way to refer a contact is by providing a link to the SBAR on iShare in an email, further investigation may be required to establish why this method is not being used as standard.
- There is no formal mechanism for follow up after an on-call contact is referred to another party, and it is taken largely on trust that the required action will happen. Whilst we did not find any specific evidence of follow up not being carried out, the lack of linking future actions to the original contact makes the process of auditing the outcomes of contact via the on-call system challenging. One possible solution would be to use the original SBAR to 'close the loop' by recording any future action relating to the original call on the same document. This is further detailed in section 2.1.8.2 below. This would provide details of the whole process in one place, and would allow easy cross referencing and future evaluation.

Contact themes and trends

Review of the **On-Call Trend Reports** and attendance at the **Monthly SoM Meetings** confirmed that trends and themes are being identified and discussed. It was acknowledged that this could be further developed:

'I would like to create a reference library for SoMs while on call but this will develop over time when we identify FAQs and patterns'. (SoM 15)

2.1.7 Objective 3: Findings and discussion

Objective 3: To ensure that the new on-call system is providing an appropriate and effective platform for receiving and responding to service user requests for SoM assistance.

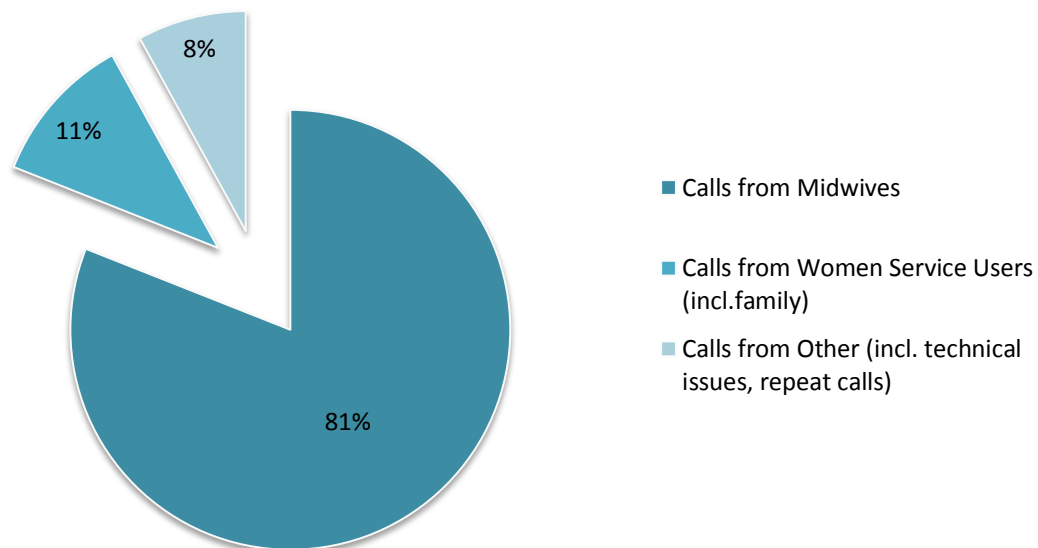
To analyse this, we looked at the following questions:

- Are SoMs being contacted for the right reasons?
- Do service users understand the role of SoMs?
- Is the process of receiving and recording SoM contacts working effectively?
- Is this system enhancing the protection of the public appropriately?
- Are there any challenges with the on-call system which need to be addressed?

Understanding the SoMs Role

During the period under review, the 84 recorded calls considered, as part of the **SBAR Review** were from the following sources:

Fig. 5



The **On Call System Survey** revealed the following quantitative results with respect to the relevance of the calls received via the on-call number (see fig. 6 & 7):

Fig. 6

Do you feel that the telephone calls received from midwives (via the New on-call number) have been relevant to your SoM role?

Answered:15 Skipped: 0

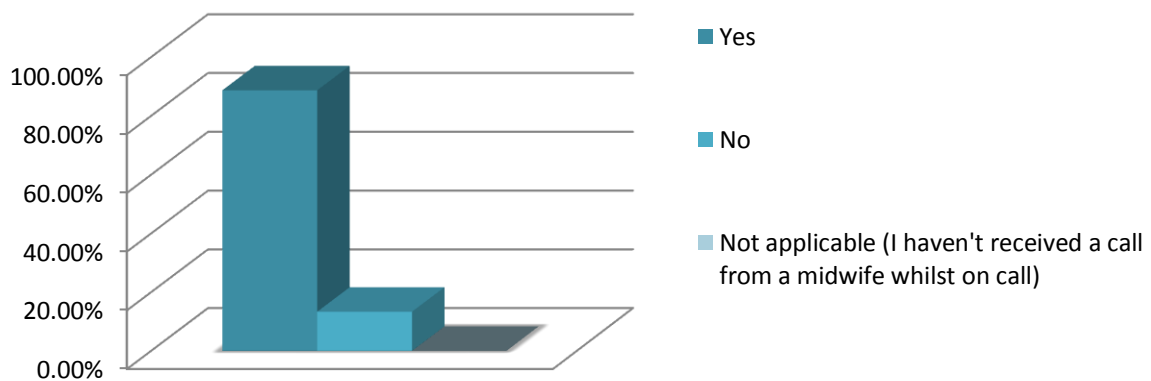
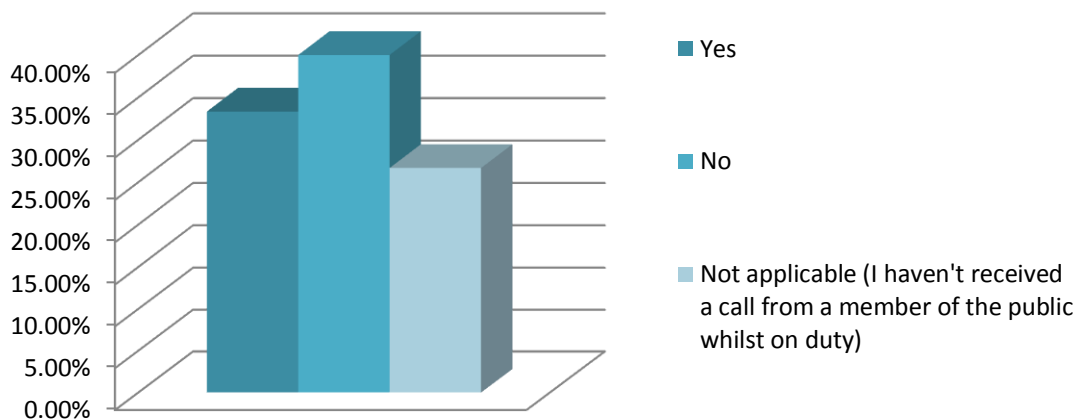


Fig.7

Do you feel that telephone calls received from members of the public (via the New on-call number) have been relevant to your SoM role?



The SoMs reported that the midwife contacts were almost entirely relevant to their role, where other service user requests were less relevant.

However, some midwives are still unaware of the new system:

'..received a telephone call from xx who was the management team on call for xx hospital. xx had called switch at xx hospital and asked to speak to SoM on call. At the beginning of the call xx believed that I was actually in the hospital working. Once I explained the new model for supervision and that I was on call for Wales, and that I was not aware of the plan of

closure in xx, she then asked for advice with regards to the need for closure in the xx hospital'. (Extract from SBAR)

'mostly [calls from midwives] are relevant, except calls re: escalation'.(SoM 1)

However, within the **SBAR Review**, the process identified a reduction in calls relating to escalation / staffing issues over the period of the review. This is further supported by the **On-Call Trends Report** thus suggesting that the understanding of the SoMs role is improving amongst health service professionals.

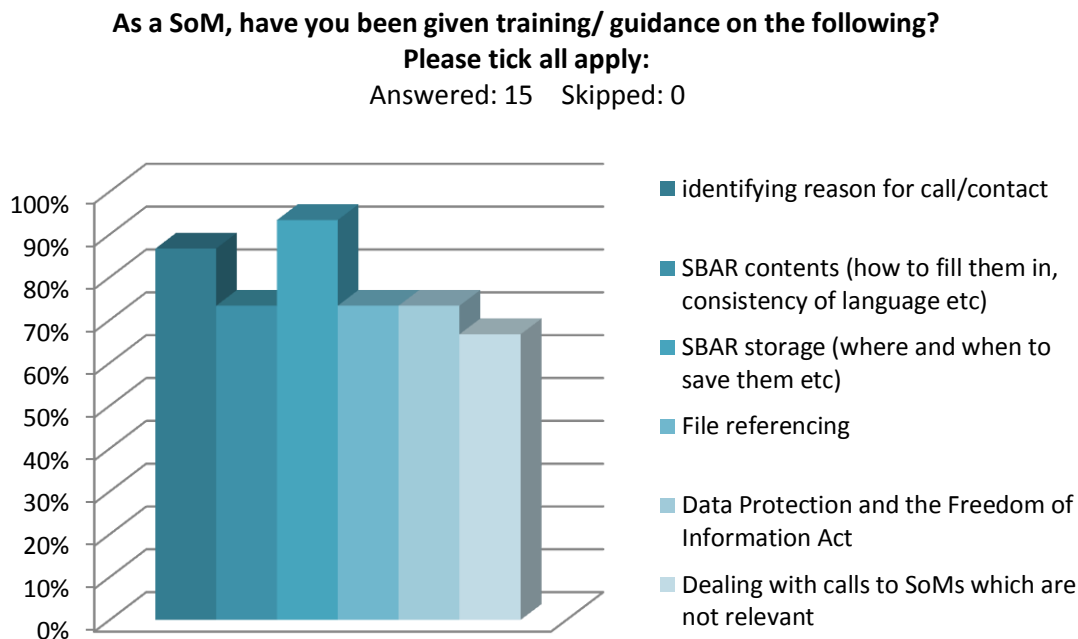
There was also an increase in the number of calls from pregnant women over the period of review, though a number of the calls from these women appeared to be less relevant to the SoMs role. This may suggest that the awareness of the existence of SoMs has increased amongst pregnant women but not necessarily the understanding of their role. This is consistent with the findings in fig 6 above.

'In my experience, calls from the public appear misdirected – they are generally looking for clinical advice out of hours or trying to get hold of a midwifery manager...'. (SoM 8)

SoM contact records

The central iShare system allows all SoM contacts received, via the central on-call number, to be captured and stored in one location, allowing easy access to all records. This provides benefits in a number of areas including data protection, easy reference, monitoring and auditing. Whilst a significant percentage of SoMs stated in the **On Call System Survey** that they had received training in a number of areas (see fig. 8 below), our **SBAR Review** found that there are still a number of areas where a revisit to training might be prudent to enable improvements in the system as 60% of SoMs themselves noted that further training is required.

Fig. 8



Areas for development identified from this part of the audit:

- where a call is from a woman, the detail recorded on the SBAR forms part of the woman's medical notes; the content should therefore be a representation of fact and avoid emotive language. Some further training may be required on consistency of language in SBARs, particularly avoiding language that may cause offense. For example the use of the word 'declined' rather than 'refused' when describing a woman's choice
- consistency in the file names of SBARs needs some refinement, including avoiding using personal data in the name of a file, consistent use of dates, capitalisation etc. The inclusion of a unique reference for each SBAR would improve future referencing and audit, along with improved compliance with the Caldicott principles for clinical record-keeping
- consistency in referral of on-call contacts (via a link to the SBAR document on iShare). Whilst discussions with SoMs appeared to suggest that they are aware of this, further review of information technology difficulties may need to be undertaken to establish what can be done to ensure the correct process is being followed
- the mechanism for 'closing out' an SBAR needs to be refined and strengthened. Unless the issue in question has been resolved completely during the course of the telephone call, it is very difficult to establish whether recommended actions have been carried out and the issue resolved. There are also duplicate SBARs for several contacts. Duplicates could be avoided by having multiple pages within the original document,

and an additional process for 'closing out' each SBAR could be established. This could include a 'complete' check box within the SBAR, and an additional element to the file name to indicate the issue is closed. This may need further evaluation of the benefits versus the resource requirements

- many contacts with SoMs are made outwith the on-call number. SoMs have told us that SBARs are sometimes generated but stored locally. It would be helpful if all SBARs (both on-call and non on-call) were recorded in the same place.

System and technical issues

A number of technical teething difficulties with the central model were raised during our audit. For example, 53% of SoMs stated in the **On Call System Survey** that they had experienced system log in problems. Other technical issues highlighted by SoMs in the **On Call System Survey** which may need to be addressed further include:

- Practicality of the laptops
- Access to the iShare system including log in / log out difficulties
- Mobile phone signal – whilst this cannot necessarily be resolved in itself, it may be helpful for SoMs to acknowledge the possibility of loss of call early in the conversation with a contact, and confirm the procedure (e.g. take the contact number immediately and confirm call back)
- The above issue is also linked to the problem of not being able to return a call when the signal drops, a message where no number is left or a missed call is received.
- During the evaluation, 27% of SoMs confirmed that they had been unable to return a missed call due to no number being stored in the phone:

'not able to call back a missed call because handset does not store incoming number'. (SoM 1)

'The voicemail system does not have a return call option and no number is recorded on the call list'. (Extract from SBAR)

- HIW's technical support department confirmed that a total of 1245 calls were made to the on-call telephone number between August 2014 and March 2015.
- Whilst the period under evaluation only extended to February 2015, only 84 SBAR reports are filed on the iShare system. This equates to 9% of the total number of calls.
- Information from the SoMs indicates that a large proportion of the remaining 91% of calls are technical checks, particularly when the system was first set up, to ensure the SoM is still logged in correctly or has effectively logged out. This amounts to approximately six test calls per 24hr period.
- It would also be useful to request a further breakdown of the number of calls on a month by month basis to assess whether the technical checks were a prominent

feature of the early implementation of the system and are now a much lesser occurrence. If not, it may be worth considering whether another procedure to test the effectiveness of the log in could be implemented, as this is a very time intensive checking procedure for the system.

2.1.8 Conclusion and recommendations

Pregnant women value the SoM service for the following reasons; **speed of response; ability to create change; containment; personal qualities; use of power; emotional reassurance.** However, they also believe increased **awareness** of the SoM service is required.

Our audit recommendations with respect to service user satisfaction are:

- that further evaluation should be carried out to establish why women are not aware of SoM details from their hand held notes
- more publicity about the role of the SoM in a user friendly format should be made available
- since the online survey has now been created and additional users are still completing it, we would suggest that as part of the next audit round, lay reviewers can continue to analyse and feedback the relevant data and themes to the LSA.

SoMs provide appropriate and good quality advice although the following should be further considered:

- a refresher session should be offered on the boundaries of advice that SoMs should be providing in clinical situations.

Referral of on-call SoM contacts is appropriate/effective though two improvements are suggested:

- all referrals should be shared via a link to the SBAR on iShare
- the mechanism for 'closing out' a contact via the iShare SBAR system should be refined, formalised and implemented.

Themes and trends from SoM contacts are being identified and discussed, but it is recommended that:

- These should be further identified and reviewed to aid the sharing of best practice.

Relevance of calls to the SoM number from midwives is generally high, though calls from service users are often less relevant but they are increasing in number. It is recommended that:

- awareness raising amongst service users continues and the impact on the number of calls received is monitored.

The central recording of all SoM on call contacts has many benefits, and it is recommended that:

- some small improvements in the consistency of recording and storing data as outlined under 'SoM contact records' above are implemented.

The new on-call system has a number of beneficial elements to facilitate delivery of the SoM service, however it is recommended that:

- the technical issues outlined under 'system and technical issues' above need to be brought to final resolution as swiftly as possible.

2.2 Audit of group supervision and continuing professional development

2.2.1 Objective

To ensure group supervision and CPD processes are of a sufficient quality to enhance public protection by ensuring midwives remain fit to practice, thereby improving the service offered to women and their families.

2.2.2 Audit questions

The key questions to answer were:

- Is it possible for midwives to “hide” in group supervision and thereby escape notice and avoid addressing areas of concern?
- Do midwives feel they can raise concerns in group supervision?
- How does the new supervision format facilitate concerns about individual practice – either about one's own practice or that of colleagues?
- Does group supervision facilitate the sharing of best practice?
- Can we identify any examples that show that group supervision has improved the protection of the public or the quality of the service provided?
- Is there evidence that the agreed development needs of individual midwives reflects individual or collective concerns and/or women's feedback on service improvement?

2.2.3 Methods

The audit was carried out in three parts:

- a review of NMC and LSA regulation and guidance on supervision and CPD requirements for midwives
- observation of group supervision sessions
- interviews with midwives and SoMs.

Full details of the methodology used are available from HIW on request.

2.2.4 Confidentiality

The purpose of the audit was to look at processes so all interviews were conducted anonymously and comments are reported without reference to who or what role they have. Although the plan included reviewing midwives' CPD plans, this did not take place, although interviews on how they determined their CPD priorities did. This enabled us to comment on the process and approach which was the intention.

2.2.5 Findings and discussion

Quantitative findings

The sample size is small so the following should be considered in that context, and alongside the KPIs set relating to annual supervisory reviews (ASR). During the audit, the following data was obtained:

Relating to the NMC Midwives rules and standards rule 9b:

- 100% of midwives we spoke to had an up to date ASR
- 100% of midwives had attended a supervision meeting in the last year.

Relating to the NMC Midwives rules and standards rule 9 standard 1.5:

- 60% of SoMs and midwives were familiar with the ASR Guidance Q&A.

Relating to Wales the LSA ASR Guidance (Q&A) encouraging midwives to evaluate and reflect on their practice through multiple sources such as women, colleagues and their employer:

- 20% of SoMs & midwives were able to give an example of where women's feedback had informed CPD.

Relating to Wales LSA ASR Guidance (Q&A) Ensuring midwives are aware of their responsibilities regarding registration, Intention to Practice (ITP) notification and renewal of registration:

- 83% of SoMs and midwives mentioned revalidation as a topic covered in group supervision (this was not asked as a direct question).

Qualitative results and findings

The interviews provided much information about how SoMs and midwives are experiencing the reality of group supervision. Given the remit of this audit we looked to identify emerging themes on how group supervision addresses:

- enhancing public protection
- improving service quality
- incorporating feedback from women.

In addition we looked at the benefits and challenges presented by the delivery of group supervision.

The second area of interest was CPD, again themes were identified under three headings:

- the role of the SoM
- incorporating women's feedback
- the effectiveness of the process.

Theme: Enhancing Public Protection

The content of group supervision sessions is addressing issue of enhancing public protection as the topic of revalidation, and what that entails, was repeatedly referred to:

'[In] one to one – [you] get the PDR competency investment but within the group session [you] get that in less detail and [you] get the opportunity to talk about new information such as the new code'.

'helps to break it (revalidation) down a little and made it a bit more user friendly'.

'better understanding of revalidation'.

Significant and detailed discussion about revalidation was observed, which clearly allowed the midwives present to begin to think about what the challenges were going to be for them in meeting the revalidation requirements and what they can do now to prepare.

A specific example was given showing how the group format had enabled an issue relating to the protection of the public to be raised and followed through. It was felt that this might not have become apparent in the one to one ASR format, as once it was raised in group supervision others also provided supporting examples and that the SoM's involvement had ensured it was addressed.

Several interviewees felt that the model of group supervision allowed for greater honesty and encouraged the asking of questions.

'group 3 of us – but more open and honest – previously I worked with my SoM so sometimes difficult to raise issues – (in group supervision) could say what our grievances were without worrying about it'.

The benefits of gaining support from others experiencing the same issues was identified:

'Like group supervision – prefer to one to one – feel freer to say if there is anything troubling you and normally someone else has the same issues and egg each other on'.

And the inclusion of everyone in the discussion.

'Everyone contributed – wouldn't have been possible to hide in that situation'.

The culture of openness was witnessed during the observation of a group supervision session and it was particularly encouraging to hear midwives talking about how they are aware of needing to ask about things they don't know and acknowledging that the greater their experience the more they realise there are things they don't know.

There are indications that the model could potentially become one of a number of mechanisms for ensuring harmful cultures do not develop within teams:

'trying to encourage cross border group supervision – good to see how other colleagues work – cultures can be challenged through mixing and learning from each other'

'break down cultures and try and get different midwives all having contact with each other – mix of grades.'

There were no concerns raised about group supervision.

Improving service quality

The potential for improved service provision was identified from the interviews. Several people referred to the opportunity to learn from each other and in a similar vein the benefits of meeting with a more diverse group of midwives. This seems likely to deliver improved services as a culture of learning:

'Yes, learnt from others – useful from that point of view'.

'...gives us a chance to all come together and I learnt something from midwife X now'.

along with greater awareness of other midwives' roles:

'X seen as cinderella [service] and with group supervision a chance to meet with wider colleagues and get a better understanding of our and their roles'.

In the main, most interviewees were able to identify something they had learnt during a group supervision that they would go on to use in their practice:

Using SBARs in more detail but not getting too lost – focusing on the appropriate things on that situation – clarity’.

‘Writing up more contemporaneous reflections on everyday situations – e.g. complex case in antenatal clinic’.

although this was not a universal experience:

‘Nothing specific discussed re: good practice might adopt’.

Incorporating women's feedback

The Q&A document referred to in the methodology for this audit (Wales LSA Annual Supervisory Review (ASR) Guidance), states ten professional values on the front page. Two of these make reference to gaining feedback from women and one is about support to women to make choices about their care. The remainder of the document is silent on the role of women in the continuous development of midwives through ASRs. For example, Q8 which lists what can count as CPD, Q10 which suggests how you can self reflect and Q11 about record keeping evaluations make no mention of gaining and reflecting on women's feedback. Similarly, Q17 addresses the areas covered by group supervision but there is no reference to women's feedback.

Whilst it is recognised that incorporating feedback from women is not currently a requirement of supervision, it is included in the Wales LSA Annual Supervisory Review Guidance document, and will become part of the impending NMC Revalidation process. We therefore felt it was valid to look at current practice in relation to incorporating women's feedback as part of this audit.

Two interviewees were able to give instances when women's feedback had been discussed as part of group supervision. The first was a response to feedback from a woman which was discussed at the session, and the midwife said at the end of the session:

‘I'm really glad I know about that’.

The second was a discussion about using feedback, which then generated some reflection on an area to possibly seek feedback on:

'[Feedback] Not discussed before in supervision process, useful discussion (context revalidation) on getting information from women'.

then following group supervision the midwife said she is:

'reflecting on the way we greet women'.

The latter occurred in the group supervision observed by a lay reviewer, and may have been as a result of the lay reviewer's visit the previous week when midwives were asked about how women's feedback is used and the forthcoming revalidation requirement. Prior to this, it had been observed that on the whole, there was a lack of clear mechanisms for midwives to gather feedback. Furthermore, the questions about how feedback from women is discussed in group supervision elicited responses indicating that it isn't:

'Don't remember women's feedback being included'.

'Currently it doesn't'.

Any discussion of feedback mechanisms was limited to complaints and compliments being passed on, and therefore was ad hoc and dependent on women taking the time to feedback and name midwives. Neither a mechanism to systemically support midwives to continuously develop from women's feedback nor any mechanism for the involvement of women in notes evaluations were identified.

Benefits and challenges in the delivery of group supervision

The NMC requirements include the publishing of guidelines to deliver consistency in how ASRs are undertaken. We found descriptions by interviewees suggest that there is consistency in approach, albeit with some issues about attendance discussed below. Facilitators perceived that they had had no "formal" training in facilitating group supervision, even though they had received MSc level training as part of the development course completed before entering the role, which included facilitating action learning sets. There was acknowledgement that:

'experience from Betsi Cadwaller [was] passed on in a really positive way'.

'group supervision would like to know how everyone else is doing it and I believe my standard is good but are we all doing the same thing – I feel we are all doing things in a more standardised way now'.

The greatest challenge in delivering group supervision appears to be ensuring all midwives are able to access group supervision. In trying to set up attendance at two group supervisions, one was cancelled due to staff shortages and the second didn't take place as midwives were unavailable (although they were being asked to undertake their ASR a month early). Identifying

midwives to interview was again difficult as many had attended a session which was initially set up as group supervision, but where they had ended up being the sole attendee. This was reflected in some of the comments from the interviewees:

'can't attend when on duty as short of staff'.

'ASR on one to one basis – no-one else able to attend'.

The majority of interviewees were positive about group supervision where sessions have multiple attendees:

'Definitely a positive step and seemed a lot better'.

'Better with more people'.

with only one person preferring the previous format:

'[I] Would prefer [a] one to one relationship with someone who knows you rather than someone you don't know very well'.

It is possible that if the scheduling of group supervisions could be resolved, midwives would consider attending more than once a year:

'Will aim to attend 2 or 3 a year'.

Themes emerging around CPD

The role of the SoM

The perception of the interviewees, in the main, was that the role of the SoM in supporting CPD has reduced with the introduction of group supervision.

'Just discussed what we were hoping to achieve next year – what our plans are'.

'Not having one to one personal chat....that was a slight negative....not having that chat about where I wanted to go forward'.

Or that they had prepared for their CPD without any SoM input:

'This year, no role played by SoM'.

'Group supervision didn't play any role - thinking [had been] done beforehand'.

Although one interviewee felt the input had increased this year:

'SoM better help re CPD this time'.

Whilst the general perception was of a reduced role for the SoM in planning CPD, it was noticeable that SoMs are playing a significant role promoting the use of portfolios and improving their quality:

'Need more facilitation and guidance as to what a helpful/ constructive portfolio should look like and that's where (SoMs) come in as we link to the health board portfolio'.

'Give guidance on range of CPD opportunities [using] something in daily life'.

This resulted in:

'more inclined to write up now as a reflection for inclusion in portfolio. Will result in more contemporaneous reflection and better quality of portfolio'.

Discussion of best practice in portfolio development was observed. Health board templates for portfolios were shared and the midwives began to talk about how something that had happened on shift that morning could be written up as an SBAR and reflection. They talked about where they could keep the forms to help facilitate regular and timelier reflections on events.

Incorporating women's feedback (and colleague/ peer feedback)

The findings for CPD were very similar to those for group supervision. The use of feedback is at present rarely part of the process and in the absence of specific examples to relate to, interviewees hypothesised that they would use feedback from complaints if they had been through this process.

'Mechanisms not in place to gather feedback from women and colleagues'.

'Not immediately think of when women's feedback has been used to shape CPD'.

'Try to follow through if a woman has complained.....if there had been something might use this in CPD'

Effectiveness of the process

The perception of the quality of the process at present is that there is significant room for improvement in the quality of CPD plans:

'Plans quality are poor generally'.

'Quality of CPD – very average – a lot of people don't complete their future plan – just delighted they have achieved the hours they needed'.

and in the way portfolios are put together:

'people have a drawer where they have thrown their things'. (discussion about portfolios)

and what preparation they do for their ASR:

'being forced to sit and knowing that your annual review is coming up – and need to put something in this box.'

The approach to CPD seems to be consistent with the focus being on identifying areas of interest to develop:

'CPD focused on what they are really interested in'

'CPD is what inspires you and gets you excited – aspiration – get them interested in a certain area'.

'Think how far into qualification what direction do I want to go in, what interests have I got, thinking how the last year has gone'.

Although for newly qualified midwives the focus can be more on developing competence:

'Newly qualified midwives focus more on developing competence'.

The impact of looking at CPD within a group was difficult to assess as a number of our interviewees had one to one sessions to complete their ASRs, although there is some indication that the group setting may improve the process by:

Providing greater enthusiasm for midwives to undertake CPD through sharing positives with their peers:

'Last few (ASRs) one to one – crossing Ts and dotting Is rather than doing anything constructive – the group will help you go forward'.

'Too early to see if group supervision has influenced CPD plans – some midwives very proactive and will have done the RCM I-learning and it's not me preaching – midwives helping each other grow and develop and be interesting to see next year that develops'.

It may yet be too early to tell but one interviewee felt things are changing:

'Preliminary impressions are that group supervision is changing how midwives think about their CPD'.

and enabling a clearer differentiation of roles between supervision and the organisational PDR process:

'Generally the organisation would review if they have invested in someone to attend something and they would share learning so more organisational than supervision'.

The organisational process picked up some of the discussion one midwife felt was missing in her ASR this year:

'Separate PDPs with managers – hoping alongside what I have done that this will be my opportunity to say this is where I want to go forward with things'.

2.2.6 Conclusions

The overall conclusion of our observations is that group supervision is an effective mechanism to ensure that midwives practice is kept under review and thereby will enhance public protection. There are initial indications that it may be a better mechanism than the previous one to one ASR process.

Our evaluation looked to address six evaluation questions as identified in section 2.2.2 above. Our conclusions on each of the questions are:

- group supervision does enable midwives to raise concerns and there is no evidence that midwives can 'hide' within the group; to the contrary our data suggests it may be a more open and transparent process than its predecessor
- it is clear that midwives still have access to SoMs on a one to one basis if they wish to raise concerns about their own or a colleagues' practice

- we identified two specific examples of the sharing of best practice which suggests group supervision does and can facilitate this but it was unclear if this is systemically embedded within the approach
- we were able to identify several examples of how group supervision could support improved service quality and one where an issue of protection of the public had been addressed as a result of group supervision. It is possible this may not have been apparent under the old format
- we were not able to establish if the individual or collective feedback from women is used to inform CPD plans, although we did find that this is not systemically supported and there are a number of opportunities to improve this aspect, particularly in preparation for the introduction of revalidation.

2.2.7 Recommendations

Identified good practice which we recommend is continued and if possible extended:

- the recent outreach by SoMs to look at a greater variety of times for group supervision to facilitate access for midwives from all departments
- encouraging a diversity of midwives by location and role to attend group supervision
- the focus on developing better quality portfolios through promotion of regular portfolio updating and a wide range of CPD activities.

We also identified other areas where there is potential for improvement.

- to maximise the benefits of group supervision for all midwives, the barriers to their participation (predominately staff shortages and not being able to be released whilst on shift due to pressure of work) need to be addressed by SoMs and HoMs
- the Q&A ASR could be reviewed to see if it is appropriate to include more reference to using feedback from women and other sources
- some consideration should be given to whether current approaches to women's feedback could more systemically support midwives reflection and notes evaluations. This would be particularly helpful given the requirements of Revalidation
- LSAMOs to facilitate a review with SoMs on consistency of approach across Wales and to determine if the sharing of best practice is embedded within the model. If it is not embedded in the model to identify how this could be done.

2.3 Evaluation of accessibility of SoMs

2.3.1 Objectives

Objective 1	To ensure that the correct information on how to contact a SoM (particularly the new 24-hour on-call number) and information about their role is available via health board websites and other relevant online sources of information.
Objective 2	To check whether the correct contact information for SoMs can be obtained by ringing hospital switchboards.
Objective 3	To find out whether GP surgeries have been updated with the new on-call number.
Objective 4	To evaluate whether the on-call number is effective in putting callers straight through to a SoM.
Objective 5	To find out what literature about SoMs is given to service users and what information is provided on notice boards in public areas and whether this has been updated with the new on-call number.

2.3.2 Methods

To assess the accessibility of SoMs to service users we evaluated the following sources of information:

- online resources (including websites and Google search results)
- other resources (including maternity department notice boards and leaflets)
- telephone (including hospital switchboards and GP surgeries).

We also conducted a telephone audit of the actual on-call number by ringing it at three different times of the day.

Full details of the methodology used are available from HIW on request.

2.3.3 Findings and discussions

Health Board websites

Health Board	Good Practice	Areas for Improvement
Aneurin Bevan UHB	The information is given in the form of a Q&A about SoMs and their role. The section on how SoMs can help women is accurate and comprehensive. There is a contact number given for the LSAMO.	There is a link to download contact information for SoMs. It does not list the correct on-call number but instead gives contact information for the contact supervisor for the health board, Grace Thomas or the liaison supervisor Kerry Philips.
Abertawe Bro Morgannwg UHB	The information about SoMs is focused on how they can support service users. It includes a photograph of the three SoMs, which is a nice personal touch. The correct on-call number is given.	No contact number given for the LSAMO.
Powys THB	The correct on-call number is given.	<p>There is one sentence of information in the last section of the maternity services page which does not mention supervision of midwives but says the midwives offer a 24-hour seven day a week on call service and gives on call number to ring if you require urgent care. This does not give any indication of the existence of SoMs or their role and suggests the number can only be rung in emergency situations. No contact information is given for the LSAMO.</p> <p>There is a separate side bar on the maternity services page specifically about supervision. This contains a very brief description of the SoM's role, which does not fully describe the support they can provide to service users.</p>

Betsi Cadwaladr UHB	There is comprehensive information on SoMs and how they can support service users and a link to the 'Are We Delivering?' leaflet which includes contact information for the LSAMO. There is also a summary in bullet points of the new model for supervision. The correct on-call number is given.	
Hywel Dda UHB	The health board website gives a good explanation of supervision including how SoMs can help women. The 'Are We Delivering?' leaflet is clearly linked with contact information for the LSAMO and the correct on-call number is given.	
Cwm Taf UHB		The numbers on the web pages are for the maternity services at each of the hospitals rather than the on-call number. The description of supervision is very much focused on midwives until the final sentence, which just says if a member of the public wants to contact a supervisor call The LSAMO details are not available on the website.
Cardiff and Vale UHB	The correct on-call number is given. There is a link to the HIW page with LSAMO contacts and the 'Are We Delivering?' leaflet.	The information given is all about the SoMs' role in relation to midwives, until the final sentence which just says "If a member of the public wants to contact a supervisor call...."

Health Board websites – recommendations

- all health board websites should be updated with the correct on-call number for SoMs and the contact details for the LSAMO
- there should be a universal description of the role of SoMs that can be used on all health board websites in Wales. Currently there is inconsistency in the descriptions used and in whether they focus more on midwives or service users. The focus should be primarily on the SoMs' role in supporting service users. The agreed statement should include the information from the 'Are We Delivering?' leaflet

- as many service users do not know about supervisors and the support they can provide, they would not know to look in the section on supervision to find information on who to contact regarding concerns about their care. Perhaps the information could be provided under a different heading, such as; 'What to do if you have concerns about your maternity care'
- currently information about SoMs is restricted to the maternity services sections of the websites. A link to information about SoMs could perhaps also be provided in each health board website's 'how to make a complaint' section. This may be where service users look first when finding out how to flag up concerns about their maternity care.

Google searches

- Searches under Supervisors of Midwives (then the name of each health board) each brought up a direct link to the health board pages containing information on SoMs in the top ten results, except for Powys.
- it was noticeable that the page about SoMs on the Abertawe Bro Morgannwg Health Board website was listed in the top ten results for five out of the ten searches carried out. This was not the case for other health boards except under the Supervisors of Midwives search.
- most results for other searches either led back to the maternity pages of the health board websites or to news stories about problems or Ombudsman's reports.
- general searches without specifying a location resulted in a lot of Mumsnet discussions about experiences. One or two participants mention SoMs but the vast majority of participants are unaware of the role a SoM could play in resolving the problems women are experiencing.
- the www.which.co.uk/birthchoices site came up a number of times and does have useful and clear information about how to negotiate your care including linking to the NMC page and leaflet on how SoMs can help women.
- even when search terms included 'complain' it was rare for the complaints page of the health board website to be listed in the search results.
- For Aneurin Bevan, under the search How Do I Change My Midwife?, there is a link to a health board maternity services page which says to contact SoMs on the main switchboard number 01633 234 234 so the page must be out of date.
- Several searches brought up links to a 'Where Can my Baby be Born' leaflet for Aneurin Bevan and a link to a page on the Abertawe Bro Morgannwg Health Board website about birth choices but neither contain any information on SoMs.

Google searches – recommendations

- To raise the profile of supervision in Wales by ensuring that information about it comes up in relevant Google searches, some work should be put into the wording of

information about SoMs on health board websites. For instance, there could be examples of when a service user might want to contact a SoM. If the right keywords are used on Health Board websites, then SoMs are more likely to be listed in Google search results.

- Some further evaluation could be carried out into why the SoMs page on the ABM Health Board website comes up more frequently than others in Google searches.

Mumsnet

- No results came up for any of the individual health board areas under the search term supervision of midwives.
- Using the search terms Supervisor of Midwives Wales, in the Mumsnet Talk section, there were at the time the search was carried out, two discussions in which a woman in Wales had raised a query about her care in Wales and she was advised to speak to a Supervisor of Midwives. In neither case did the replies mention a contact number for the SoM.
- There is no information about SoMs in the Mumsnet Local pages for the different areas of Wales.
- In the pregnancy section of the Mumsnet website there is a page accessed via the pregnancy homepage entitled 'Your Legal Rights During Pregnancy and Childbirth' put together by the Birthrights charity. This mentions several instances of when a service user might want to contact a SoM. It does not contain contact information however.

Mumsnet – recommendations

- Given how popular Mumsnet is as an online resource for parents it would be a very effective medium for raising the profile of supervision. As discussions in the Mumsnet Talk section seem to come up as results for searches about supervision, perhaps a SoM could either reply to a discussion started by a service user in Wales (if a relevant one is found) or start a discussion, perhaps under the title: 'Are you concerned about your care/midwife in Wales' or 'do you know how supervisors of midwives can help you in Wales'.
This could be in the main site or in the Mumsnet local section.
- In the Mumsnet local section there are pages for each area of Wales. There is a listing section for each area with a specific pregnancy and postnatal section that contains information on antenatal classes, doulas etc. This would be a great place to post information about supervision of midwives with the all-Wales on call number to ring.

Facebook pages for health boards and Maternity Services Liaison Committees (MSLCs)

Cwm Taf	A Facebook page was found for the Health Board as a whole and sending a private message asking for the on-call number got a response within the hour with details of how to contact the Head of Midwifery.
Cardiff and Vale	There is a Facebook group for the Cardiff and Vale MSLC, which had no results for a search for Supervisors of Midwives. It was not possible to send a message.
Hywel Dda	There were no Facebook or MSLC sites identified.
Powys	There is a Facebook page called Bump Talk for the Powys MSLC. A message sent enquiring about the on-call SoM number received an answer with the correct number within an hour.
Aneurin Bevan	The Aneurin Bevan Health Board has a maternity services Facebook page. A message sent to enquire about the on-call number for SoMs received a reply with the correct telephone number within four days.
Betsi Cadwaladr	There is a Facebook page for the health board. A message was sent on March 14 asking for the SoM on call number. No reply had been received at the time of this report having been written.
Abertawe Bro Morgannwg	There is a Facebook page for the health board but no way to get in touch to enquire about SoMs and no relevant information on the page.

Facebook pages for Health Boards and MSLCs – recommendations

- Look into the possibility of setting up an all-Wales supervision of midwives Facebook page as a resource for both midwives and service users. If this was set up service users could contact SoMs through messaging with any concerns they had.

Other sources of information

All Wales:

- in the all Wales hand-held notes, there is a paragraph about supervision of midwives.
- there is also a section about supervision of midwives in the Bump, Baby and Beyond booklet in the section about where to give birth. It gives the all Wales on call number.

- the 'Are We Delivering?' Leaflet about supervision in Wales is available as a link on some health board websites. It is also available for service users to pick up in some antenatal clinics or maternity departments.

Betsi Cadwaladr:

- there is a notice board at the entrance to the maternity wards and posters about supervision are displayed in all areas with the correct on-call number
- there are bed cards about supervision provided on each patient's bedside table. These give comprehensive information on the role of the SoM
- in the antenatal clinic area there is a PowerPoint slide show about SoMs for waiting patients to see
- the SoMs have also been given permission for a designated, more visible notice board in the antenatal clinic.

Cwm Taf - Prince Charles Hospital:

- There are notice boards dedicated to supervision in the labour ward, postnatal and antenatal wards and the antenatal clinic. All provide the correct all-Wales on-call number.

Hywel Dda - Glangwili Hospital:

- There are notice boards about supervision in the labour ward, midwife led unit and the antenatal clinic. All display the correct on-call number.

Abertawe Bro Morgannwg:

- There are notice boards about supervision throughout ABMU's maternity departments. The notice boards have been updated with the correct on-call number. They also feature photographs of the supervisors accompanied by their direct work telephone numbers
- 'Are We Delivering?' leaflets are provided in the antenatal clinic.

Aneurin Bevan:

- There are notice boards about supervision in the antenatal clinics and antenatal and post-natal areas of Ystrad Fawr, Royal Gwent and Nevill Hall. All feature the correct on-call number
- women are not yet routinely offered leaflets on supervision in Aneurin Bevan.

Cardiff and Vale:

- Each area in Cardiff and Vale features a standardised notice board about supervision. The areas where noticeboards are displayed include: the delivery suite, postnatal ward and antenatal clinics both at UHW and Llandough and the 24 hour triage unit. The SoM leaflets are placed in both clinics.

Powys:

- There are standardised notice boards about supervision in Brecon, Llandrindod wells, Newtown, Llanidloes and Welshpool birth centres. Leaflets about supervision are also available in limited numbers in the birth centres.

Other sources of information – recommendations

- That good practice adopted by Betsi Cadwaladr Health Board is shared and adopted in other areas, particularly the use of bedside information cards and the PowerPoint presentation about supervision in the antenatal waiting area. The use of photographs of the SoMs on notice boards within Abertawe Bro Morgannwg University Health Board is also a practice other health boards could adopt.
- If possible there should be a consistency of approach in terms of what information is available to women in paper form. All women are provided with the Bump, Baby and Beyond leaflet and information in the all-Wales hand-held notes. However, it is not clear whether there is the same availability of leaflets about supervision across different areas.

General telephone audit

Health Board	Hospital / Birth Centre / GP Surgery	Findings
Aneurin Bevan	Royal Gwent Hospital	Put through to the midwifery department. Correct number given
	Nevill Hall Hospital	Given correct number at switchboard
	Hereford Road Surgery, Abergavenny	Did not know about SoMs and could not provide a contact number
Powys	Brecon War Memorial Hospital	Given correct number by switchboard
	Llandrindod Wells County Memorial Hospital	Put through to birth centre. Correct number given
	Victoria Memorial Hospital	Told by switchboard to ring 01874 622 443
	Welshpool Health Centre, Welshpool	Given number for birth centre in Welshpool
Betsi Cadwaladr	Wrexham Maelor Hospital	Put through to labour ward. Correct number given
	Glan Clwyd	Given correct number by switchboard
	Ysbyty Gwynedd	Put through to delivery suite. Correct number given
	Caritas Surgery, Wrexham	Did not know about the role and could not provide a number
Abertawe Bro Morgannwg	Singleton Hospital	Put through to labour ward. Correct number given
	Princess of Wales Hospital	Given correct number by switchboard
	Neath Port Talbot Hospital	Given correct number by switchboard
	Brunswick Health Centre, Swansea	Given the number of the community midwife to call for information

Health Board	Hospital / Birth Centre / GP Surgery	Findings
Cwm Taf	Royal Glamorgan Hospital	Switchboard operator initially said they could not give number out due to confidentiality. Consulted with supervisor who put call through to post-natal ward. They did not have number so put through to labour ward where the correct number was given
	Prince Charles Hospital	Given correct number by switchboard
	Taff Vale Practice, Pontypridd	No number given and advised to call antenatal ward
Cardiff and Vale	University Hospital of Wales	Given a local number by switchboard and told this was the number for the SoM
	Station Road Surgery, Penarth	Didn't know about SoMs and couldn't give a contact number
Hywel Dda	Glangwili General Hospital	Given correct number by switchboard
	Bronglais General Hospital	Put through to community midwife who then gave the correct number
	Withybush General Hospital	Given correct number by switchboard
	The Surgery, Margaret Street, Ammanford	Receptionist said she didn't know if she could give the number out and suggested ringing the midwife in Ammanford instead

There were good results from the telephone audit of hospital switchboards with the correct number obtained in all but one case. GP surgeries however did not provide the correct number.

General telephone audit – recommendations

- It may be useful in a future audit, if evaluation could be done of what literature is available in GP surgeries about supervision. Posters or the 'Are We Delivering?' leaflet provided in waiting rooms would be a good way of communicating with women awaiting antenatal appointments or at baby clinics or appointments with health visitors or GPs.

Audit of on-call number

Monday March 23 rd at 21.40	Call answered straight away by SoM
Friday March 27 th at 09.00	Call answered straight away by SoM
Monday March 30 th at 14.15	Call answered straight away by SoM

The calls were answered straight away by a SoM. The audit was undertaken using a mobile phone and found in each case that there was no dialling tone during the brief moment before the call was answered. This could prove confusing to callers who may think the number hasn't worked and could hang up before it is answered.

2.3.4 Conclusion and recommendations

- Work should be done to ensure information about SoMs is accurate and comprehensive across health board websites in Wales. A more consistent approach to what information is available would be helpful. It would also be helpful to include a link to the 'Are We Delivering?' leaflet from all websites
- there is plenty of information available on notice boards in public areas of hospitals and birth centres with the on-call number displayed for service users to see
- in terms of leaflets about supervision it was not possible to build a complete picture of whether these are available in all areas. Ideally they should be available to service users in wards, birth centres and antenatal clinics
- the telephone audit showed the on-call number is successful in putting service users through to a SoM straight away
- we were able to obtain the correct on-call number from all but one hospital switchboard, which shows the information about the correct on-call number has been successfully disseminated. We were not able to obtain the on-call number by ringing GP surgeries so perhaps some work is needed to communicate this information

- some work needs to be done on how the profile of supervision can be raised through social media. This could be a really useful tool for getting information to service users about the role of the SoM, examples of how they have helped women, and contact information
- a survey of service users to find out how many actually know about the role of the SoM and how to contact a SoM could be carried out
- the accessibility of SoMs in other parts of the country could be evaluated to see whether any successful practices could be used in Wales.

3. Overall conclusion

The audit process for this year was developed by the lay reviewers and involved auditing three areas of supervision of midwives in Wales which were:

- service user experience
- group supervision and continuing professional development (CPD) and
- accessibility of SoMs to women and their families.

The lay reviewers specifically focused on the user perspective, in line with NMC Midwives rules and standards, as an area that had not been audited, in depth, through the NMC Quality & Safety audit carried out in December 2014. The NMC review explored the statutory areas of supervision, in particular in light of the revised model of supervision in Wales, introduced in August 2014. The NMC findings were, without exception, very positive and reassuring in regard to public protection and the lay reviewers were pleased to find their audit findings, in relation to the service user experience of and access to supervision and SoMs, concurred with those of the NMC review team.

As with any new model there is always room for improvement and the audit highlighted some areas of provision which had clearly experienced teething problems from the outset some of which still need attention. The audit also found other areas of the supervisory process that would benefit from further development and or a refresh of the initial training provided to SoMs as part of the model's implementation plan. Recommendations have been made as appropriate throughout this report.

It is clear that pregnant women, their families and midwives too value the support and guidance provided by SoMs, and more importantly like their impartiality which means women and midwives feel more comfortable approaching a SoM for advice. Obviously there is more work to do in raising the profile of supervision and the role of the SoM with service users and the public at large however the caveat to this is the need to avoid raising public expectation when supervision is planned to be removed. It will therefore be important that the NMC, Welsh Government and the LSA consider how best to ensure such support and guidance continues to be available after the disbandment of the statutory function of supervision in Wales and across the UK.

The lay reviewer team would like to thank all those women, families, midwives and SoMs who contributed to the audit process and say how much we have enjoyed working with you all.