agic Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales hiw

amddiffyn y cyhoedd trwy oruchwyliaeth statudol o fydwragedd

protecting the public through statutory supervision of midwives

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

1 April 2016 – 31 March 2017

2016-2017

May 2017

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications and Facilities Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: **hiw@wales.gsi.gov.uk**
Fax: 0300 062 8387
Website: **www.hiw.org.uk**

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

OGL © Crown copyright 2017 WG30952 Digital ISBN 978 1 4734 9767 2

Contents

1. Foreword 4
2. Introduction and background 5
Our role as the LSA for Wales and how we fulfil it 5
The LSA for Wales 6
LSA Midwifery Officers 7
3. Section 1 9
3.1 The delivery of effective supervision 9
3.2 Wider political and regulatory context of statutory supervision 9
3.3 SoM to Midwife Ratio 10
3.4 Appointment of SoMs, de-selection, resignation and leave of absences 11
3.5 Supervisor of midwives initial and continuing professional development 12
(CPD) 12
3.6 Mechanisms for continuous access to a supervisor of midwives 13
3.7 Engaging with Approved education institutions 15
4. Section 2 16
4.1 Involving service users in supervision 16
4.2 Overview of LSA audit activity 17
4.3 National and local policies related to supervision 18
5. Section 3 19
5.1 Ensuring investigations into sub-optimal practice are undertaken 19
5.2 Complaints in relation to the discharge of the supervisory function 21
6. Section 4 22
6.1 Notable and Innovative Practice 22
6.2 Sharing good practice 23
6.3 Looking to the future 23

1. Foreword

I have pleasure in presenting this final 2016-2017 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) fulfilled the function of the LSA and has, therefore, been responsible for ensuring that statutory supervision of all midwives was delivered to a satisfactory standard across Wales.

This annual report looks back at the LSA and supervisory activities during 2016 - 2017, as well as looking forward to the future for midwifery supervision in Wales with a new employer led model of Clinical Supervisor's for Midwives (CSfM) following the cessation of statutory supervision on the 31st March 2017.

The LSA's introduction, in 2014, of a revolutionary model of supervision ensured the values of statutory supervision became well embedded within the maternity services. Working with key stakeholders has ensured that the successes of this model, including the support for newly qualified midwives in their first year of qualification, with the development of an All Wales Preceptorship Passport and support for midwives during the implementation of Revalidation and the innovative group supervision model, paved the way for the development of a new model of Clinical Supervision for Midwives.

The LSA has made significant contributions to the new model of supervision following the establishment of a taskforce by the Chief Nursing Officer (CNO). The purpose of the Taskforce was to develop and implement a new health board model ensuring that all of the best aspects of statutory supervision have been incorporated, as a means of ensuring midwives continue to be supported in their practice whilst removing the regulatory aspects of the role.

As of 1st April 2017, the LSA will cease to function and all health boards in Wales will appoint CSfMs to lead and support excellence in midwifery practice. The role of the CSfM will be based on the core principles of statutory supervision. Delivery of these principles will be monitored via the implementation of key performance indicators, ensuring good practice and lessons learned continue to be shared.

Kate Chamberlain - Chief Executive

2. Introduction and background

To ensure safe and effective midwifery practice, the Nursing Midwifery Council (NMC) was required, by the Nursing and Midwifery Order (2001)[1], to maintain a register of qualified midwives and establish rules and standards of proficiency.

The Nursing and Midwifery Order (2001) also set out a statutory requirement that all midwives were 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, fulfilled the function of the Local Supervising Authority (LSA) for Wales. It was, therefore, responsible for ensuring that statutory supervision of all midwives, as required in the Nursing and Midwifery Order (2001) and the NMC Midwives Rules and Standards (2012)[2], was exercised to a satisfactory standard across Wales.

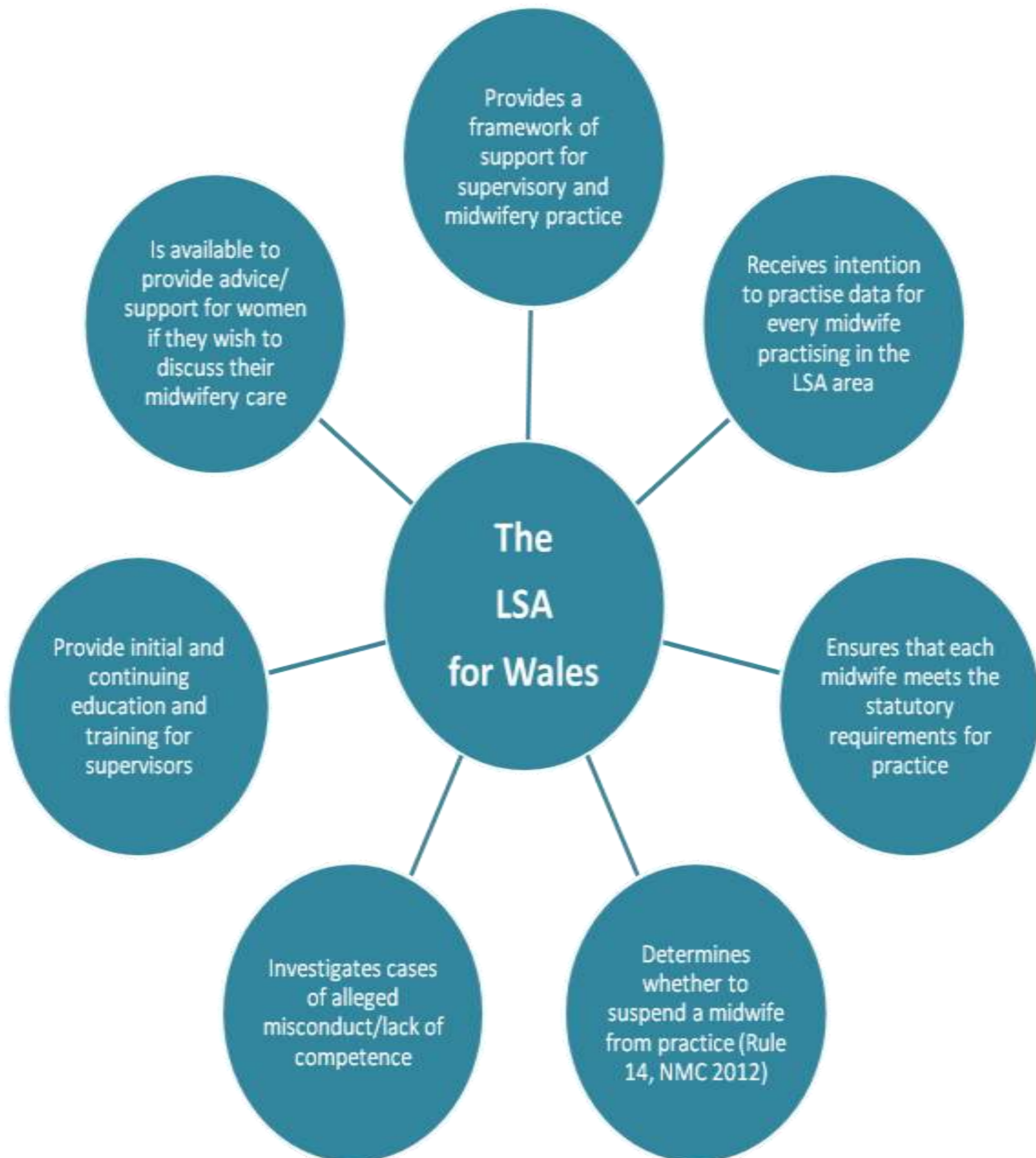
Our role as the LSA for Wales and how we fulfil it

The LSA for Wales had a responsibility to:

- Be available to women if they wished to discuss any aspect of their midwifery care that they considered had 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 met the statutory requirements for practice
- Provide continuing professional development for supervisors
- Investigate cases of alleged misconduct or lack of competence
- Determine whether to suspend a midwife from practice, in accordance with Rule 14[3] of the Midwives Rules and Standards (NMC 2012)
- Lead the development of standards and audit of supervision.

[1] Nursing and Midwifery Order 2001 (The Order). http://www.legislation.gov.uk/uksi/2002/253/contents/made
[2] Nursing & Midwifery Council 2012, Midwives Rules & Standards NMC
[3] 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 appointed two Midwifery Officers (LSA MOs) whose responsibility on behalf of HIW, was 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 were capable of meeting the competencies set out in the Standards for Preparation of Supervisor of Midwives [(PoSoM) NMC 2014[4]]
- Work in partnership with other agencies and promote partnership working with women and their families.

The LSA MOs represented 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 were fully considered. They also had a responsibility for maintaining good working relationships with the Welsh Government Nursing Officer responsible for maternity policy, the Chief Nursing Officer for Wales, 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 had been allocated responsibility for overseeing the delivery of supervision across specific health boards and geographical areas of Wales, as set out below;

LSA MO Sue Jose (until October 2017) followed by LSA MO Lindsey Hilldrup:

- Abertawe Bro Morgannwg University Health Board (ABM)
- Betsi Cadwaladr University Health Board (BCU)
- Cwm Taf University Health Board (CT)
- Hywel Dda University Health Board (HD)

LSA MO Maureen Wolfe:
- Aneurin Bevan University Health Board (ABU)
- Cardiff and Vale University Health Board (C&V)
- Powys Teaching Health Board (PtHB)

Sue Jose completed her planned seconded tenure to the Welsh Government and returned to the NHS in October 2016, on her successful appointment as Deputy

---

[4] NMC 2014 Standards for the preparation of supervisor of midwives
http://www.nmc.org.uk/globalassets/siteDocuments/NMC-Publications/NMC-Standards-for-preparation-ofsupervisors-
of-midwives.pdf

Head of Midwifery in ABM. The LSA would wish to thank Sue for her valuable contribution during her time as LSA MO. Sue’s successor to the LSA MO role was Lindsey Hilldrup who took up her post full time on 15th August 2016. Lindsey was a full time supervisor of midwives in Wales and a clinical midwife prior to taking up her LSA MO role.

3. Section 1

3.1 The delivery of effective supervision

The LSA was responsible for delivering effective statutory supervision based on the 'Futureproofing' model introduced in Wales in August 2014. The key function in protecting women and babies was to ensure that maternity services were meeting their statutory requirements in line with the Nursing & Midwifery Order (NMO) 2001 and the Midwives Rules and Standards (NMC 2012).

To achieve this, the delivery, achievement and assessment of risk in relation to midwifery supervision was reported quarterly to key stakeholders including the LSA Lay reviewers. A quarterly report was prepared against the key performance indicators (KPIs) which were as follows:

- **KPI 1** The LSA to review, and update, workforce planning forecasts
- **KPI 2** The LSA database will be used to monitor SoMs' completion of relevant CPD
- **KPI 3** 100% of SoMs will have an Annual Supervisory Review (ASR) and an organisational Personal Development Review
- **KPI 4** 100% of midwives are compliant with the Annual Supervisory Review 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 preceptorship programme
- **KPI 7** SoM record keeping & storage (Safe 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

3.2 Wider political and regulatory context of statutory supervision

In December 2013 the Parliamentary and Health Service Ombudsman[5] (PHSO), published their findings following the completion of three investigations into complaints from three families which related to midwifery supervision and regulation in Morecambe Bay NHS Foundation Trust. The PHSO report proposed a change to the system of midwifery regulation based on two principles:

- That midwifery supervision and regulation should be separated
- That the NMC should be in direct control of regulatory activity.

In January 2015 the Kings Fund[6] presented its review commissioned by the NMC,

[5] PHSO report 2013
http://www.ombudsman.org.uk/__data/assets/pdf_file/0003/23484/Midwifery-supervision-and-regulation_-recommendations-for-change.pdf

which recommended the NMC should have direct responsibility and accountability for the core function of regulation. It further recommended the LSA structure should be removed from statute as it pertains to the NMC. The NMC accepted the report recommendations in full. The Secretary of State for Health announced in July 2015 that the government would support change to the legislation governing the regulation of midwives.

In December 2016, following public consultation, the Department of Health confirmed this decision[7]. Consequently, the Section 60 Order was amended in Parliament in March 2017, the Midwifery Order was revoked together with the Midwives Rules and Standards (NMC 2012) including reference to statutory supervision. The new model of Clinical Supervision for Midwives (CSfM) was introduced in Wales by Welsh Government[8] on the 1st April 2017 as an employer led model of support for midwives, building on the essential elements implemented in the 'Futureproofing' model of Supervision of Midwives in 2014 in Wales.

The main effect of the changes was to take midwifery supervision out of regulatory legislation. All four countries had been tasked with developing their own model of supervision to be implemented from 1st April 2017, the principles being to provide an overarching system of midwifery supervision to be put in place when statutory supervision was removed.

An All Wales Taskforce was convened in February 2015, chaired by the Midwifery Advisor on behalf of the Chief Nursing Officer (CNO), and included key stakeholders to draft a new model of supervision. The new model will provide clinical supervision for midwives in clinical practice and peer review for those midwives who are not in clinical practice but have maintained their registration. The new system would be an employer led, professional model and will enable the NMC to focus on its regulatory function (including revalidation), to protect the public. The Taskforce was able to utilise the foundations of the 'Futureproofing' model in Wales, to enhance and retain the elements of supportive supervision for midwives. It was envisaged that the SoMs of the future would promote the development of reflective practitioners who embrace their professional values in line with the NMC Code (2015)[9]. The new model of supervision, based on Clinical Supervision of Midwives received Cabinet Secretary approval in December 2016, with an implementation group convening in February 2017. Wales was, therefore, well placed to successfully implement the new model of Clinical Supervision for Midwives on the 1st April 2017.

3.3 SoM to Midwife Ratio

---

[6] The King's Fund (2015) Midwifery Regulation in the United Kingdom

[7] The Nursing and Midwifery Council - amendments to modernise midwifery regulation and improve the effectiveness and efficiency of fitness to practise processes https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582494/Consultation_report.pdf

[8] Clinical Supervision for Midwives http://gov.wales/docs/dhss/publications/170405whc015en.pdf

[9] Nursing and Midwifery Council (2015) The Code, Professional standards of practice and behaviour for nurses and midwives.https://www.nmc.org.uk/standards/code/read-the-code-online/

During 2016-2017, the LSA for Wales was responsible for appointing an adequate number of SoMs to ensure that all midwives practising in Wales had access to supervision. The NMC Midwives Rules and Standards Rule 9[10] required that the SoM to midwife ratio would not normally exceed 1:15 but must, at the very least, reflect local need and circumstances, without compromising the safety of women. The SoM to midwife ratios 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.

As of 31 March 2017, 12.9wte SoMs were in post. 1872 midwives in Wales had notified the LSA of their Intention to Practise (ItP). Of these, 55 midwives were working within education, health visiting or private practice and also had access to statutory supervision during 2016 -17. (Table 1)

Using the adjusted ratio calculation, the average all Wales ratio was 1:12.

Table 1 - Ratio of SoMs to midwives in health boards in Wales as of 31 March 2017

Health board	Midwives (previous year)	SoM wte	SoM hours per month	Adjusted ratio
Abertawe Bromorganwg	340 (296)	1.9	228	1:15
Aneurin Bevan	329 (314)	2.2	265	1:12
Betsi Cadwaladr	401 (388)	3.0	361	1:11
Cardiff & Vale	309 (275)	2.2	265	1:12
Cwm Taf	229 (200)	1.6	192	1:12
Hywel Dda	214 (202)	1.6	192	1:11
Powys	50 (44)	0.4	48	1:12

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

Without doubt, the biggest challenge to the provision of statutory supervision across the UK during the past 12 months has been to sustain the momentum and commitment to the role whilst the NMC legislative change takes effect. A final PoSoM course was once again, successfully hosted by Swansea University following a rigorous selection process in April 2016. All SoMs were appointed throughout the year to replace those de-selecting, having successfully been appointed to more senior roles and, therefore, evidencing the professional development opportunity provided by the SoM role. The flexibility of the role was utilised towards the latter part of the year with some cross border working to ensure sufficient SoM cover was provided in all health boards.

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

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

No. of SoMs	2014-2015	2015-2016	2016-2017
Appointed in year	16	5	5
Removed from post (LSA de-selection)	0	0	0
Resignation (self de-selection)	85	4	6
Suspension from role (LSA suspension)	0	0	0
Suspension from role (self suspension)	0	0	0
Commenced preparation course (April)	5	6	5
Leave of absence	2	0	0
Total number of SoMs in post	16	17	17

3.5 Supervisor of midwives initial and continuing professional development

(CPD)

In order to ensure that SoMs met the requirements of Rule 8[11], the LSA was committed to ensuring all SoMs appointed in Wales were able to access 6.5hrs minimum continued professional development (CPD) annually and have opportunities to update their practice.

The PoSoM course provided the prospective SoMs development opportunities in relation to supporting midwives to meet their statutory registration requirements. This included facilitating the Annual Supervisory Review (ASR) and group supervision as a means of promoting proactive learning. Further opportunities in relation to health board governance systems were facilitated together with workshops to develop report writing and investigative skills. PoSoM students also had the opportunity to shadow a nominated mentor to support and guide them through the practical day to day application of supervision during training.

SoMs 'in waiting' were also provided with CPD opportunities, specifically in relation to report writing and facilitating group supervision and action learning with a view to developing these skills once statutory supervision ceased.

There have been significant CPD opportunities for all SoMs throughout the year, over and above the minimum requirement of 6.5 hours per annum. These have included:

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

- Skills workshops
- Investigation Workshop
- Report Writing Workshop
- Facilitating Action Learning and group supervision
- CTG/STAN Masterclass

National conferences including:
- RCM Conference, Harrogate 'Safety, Standards, Experience'
- RCM Legal Birth Conference
- Florence Nightingale Annual Conference
- Applying and Adhering to the Duty of Candour
- BJM Birth in Contemporary Society Conference
- Obs Cymru Launch
- Safer Pregnancy Launch

SoMs have also made significant contribution to the All Wales work streams as part of the work being undertaken by the Maternity Network. These opportunities have included a SoM presence in relation to the Sepsis, Postpartum Haemorrhage and Stillbirth reduction work streams aimed at standardising care across Wales based on improving safety and outcomes for mothers and babies.

The LSA and SoM team planned and delivered the annual LSA Conference in Builth Wells with the theme being 'Mind the Gap', focusing on the cessation of statutory supervision and ensuring that the new model continues to offer support for midwives in a way that ensures public safety is maintained.

3.6 Mechanisms for continuous access to a supervisor of midwives

Rule 9 of the NMC Rules and Standards (2012) set out the requirements for the supervision of midwives and stated 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 were allocated a named SoM on commencement of their employment. If a midwife was self-employed, a SoM who lived and/or worked near the midwife's base, or could travel to the base would normally be asked to take on this midwife as part of her caseload by the LSA MO. All midwives and SoMs were advised that they may request to change their SoM or supervisee if the relationship was not effective for either party. As part of their own professional requirement, all SoMs accessed a SoM from outside their respective Health Boards.

During 2016-17, the LSA continued to monitor the LSA database quarterly, and on an adhoc basis, to ensure that every midwife in Wales had a named SoM. We are able to report that during 2016-17 every midwife practicing in Wales met this requirement. The LSA also used the database to monitor whether annual supervisory reviews (ASR) had taken place. An analysis of the LSA database was undertaken on a quarterly basis to monitor the compliance with ASRs. On the 31st March 2017 there was evidence that the SoM teams had not met 100% compliance with this standard. The main reason for this was reported as being some dis-engagement with supervision, mainly from midwives working within educational institutions, or where a SoM had been on unplanned sick leave in the last two months of statute.

Group supervision and action learning has continued to be regarded as a complete success and supports peer learning and support as well as Revalidation[12], with the emphasis being on taking this component forward in the new model of Clinical Supervision for Midwives post statute.

During the year, SoMs had monthly meetings with their respective Head of Midwifery (HoM). Each quarter the meeting also included the LSA MO who reported on activity against the KPIs through a quarterly monitoring report. Discussions were held around Health Board issues that impacted on midwifery practice including midwives' compliance with NMC regulatory requirements, ongoing supervisory investigations and restoration programmes. The LSA used the database to run reports on SoM activities enabling robust performance monitoring.

There was 24 hour access to a SoM via an all Wales on-call number, for service users and midwives, for advice on issues relating to supervision and professional standards. The trends and themes of calls had been collated into six monthly audit reports which were then reviewed at the monthly SoM performance meeting and shared with all HoMs. The on call template included a request for callers to be contacted within 48 hours if they preferred to converse in Welsh. The last 6 monthly audit report demonstrated a significant reduction in the number of calls taken by SoMs, the majority of which were appropriate and not a request for clinical advice as had been the case previously.

The Autumn supervision audit in each health board demonstrated an improvement in local websites signposting to Supervision of Midwives and access to the on call number. However, it was disappointing that the lay reviewer calls requesting to speak to a SoM via switch boards met with some confusion. In some cases there was a complete lack of awareness despite an action plan being put into place to address this issue a year previously. These, however, were immediately addressed through the HoM and the local SoM teams.

The SoMs were invited to meet with student midwives at the four approved education Institutes (AEI): Bangor University, Cardiff University, Swansea University and the University of South Wales. The feedback from the student midwives and the University lecturers was on the whole positive. The SoM teams recognised that there

[12] Revalidation https://www.nmc.org.uk/globalassets/sitedocuments/revalidation/how-to-revalidate-booklet.pdf

was no standardisation of issues being discussed and a SoM working group was therefore formed resulting in a devised plan of key issues relevant to supervision that was implemented to ensure equal opportunity for student midwives throughout Wales. This included in some cases, the development of 'teaching' plans to be shared by the SoMs as a tool of reference when meeting with students.

LSA MOs held monthly performance management meetings with SoMs from across Wales. The meetings were chiefly concerned with managing the compliance with the KPIs set out in the service specification, and provided SoMs the opportunity to develop team working and to utilise the supportive network that the All Wales SoM team provided.

3.7 Engaging with Approved education institutions

There are four Approved Education Institutions in Wales (AEI's), each providing pre and post registration midwifery education. During the year, SoMs were actively engaged with all AEI's to ensure that student midwives were familiar with the concept and importance of working within the Code (NMC 2015) in preparation for registration as a midwife. Students were offered a number of opportunities to experience supervision in action, such as attending a group supervision session with other midwives and meeting with a SoM twice a year in the university settings.

Following the NMC Extraordinary Review in 2015 in Betsi Cadwaladr University Health Board (BCU)[13], student midwives were removed from the clinical environment in Ysbyty Glan Clwyd. The LSA and the SoM team offered support to midwives in practice as well as to the Head of Midwifery and the LME, with a gradual re-introduction of students since September 2016.

SoMs have continued to hold recordkeeping 'tea parties' with student midwives and have continued to support student society events and have undertaken teaching sessions in collaboration with health board initiatives to which student midwives have attended. The LSA MOs had also met with students during the audit process, at quarterly visits to the health boards and in collaborative workshops for SoMs and SoMs in waiting as part of ongoing CPD.

Regular contact with the LMEs had been maintained through a number of engagement activities including the quarterly Heads of Midwifery Education group and particularly as part of the Taskforce group, when planning the new model of Clinical Supervision for Midwives.

[13] https://www.nmc.org.uk/globalassets/sitedocuments/midwiferyextraordinaryreviewreports/2015/extraordinary-review-of-performance-bangor-university-english.pdf

4. Section 2

4.1 Involving service users in supervision

The work of the lay reviewers during 2016-17 has focused on the following areas:

- Auditing of supervision across all Health Boards in Wales
- Attending and presenting at the LSA Spring Conference in 2016
- Representation on the Taskforce group working toward the new model of non statutory midwifery supervision.

The audit process 2016-17 focused on the following areas:

- The service users' experiences of supervision
- The accessibility of supervisors to service users
- The effectiveness of group supervision and CPD including a review of midwives awareness of the NMC revalidation process
- The awareness of midwives in relation to the cessation of statutory supervision and the planned new model of Clinical Supervision for Midwives
- The concerns of current SoMs in relation to the planned changes.

Once again, awareness amongst service users of supervision remained low with the majority being unaware of supervision. There was some evidence of service users accessing a SoM, particularly with reference to birth choices outside of recommended schedules of care. However, it is worthy to note that many of the health boards currently have other processes in place to support women in these circumstances, such as Consultant Midwife clinics.

In terms of accessibility, the lay reviewers were able to report some progress having been made to the availability of supervision notice boards in the clinical areas with the majority displaying the on call number. However, despite the recommendations of the previous year's audit, many of the health board switch boards appeared either confused by or unaware of the SoM 24 hour on call number.

LSA Spring Conference 2016

The lay reviewer attendance at the LSA Spring Conference in April 2016 provided an opportunity for the lay reviewers to lead a workshop to address any concerns relating to the transition from statutory supervision to an employer led model. This was used to inform the Taskforce planning the new model, ensuring that consideration was given from the user perspective in ensuring their voice continues to be heard but in a different way.

Taskforce

The lay reviewer representative at the CNO led Taskforce aimed at planning the new model of Clinical Supervision for Midwives provided invaluable insight from the user perspective.

4.2 Overview of LSA audit activity

The NMC Quality Assurance Framework[14] was the process by which the NMC ensured that LSAs continued to meet the Rules and Standards. The Quality Assurance Framework provided 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. NMC reviews took account of LSA self-reporting and factored in intelligence from a range of sources which could shed light on potential risks associated with midwifery supervision.

In May 2016 the LSA exception reported Hywel Dda UHB following a number of 'cluster events' which gave rise to a significant level of concern in relation to public protection and the safety of babies within the unit. This was following seven incidents between February and April, whereby babies were admitted to level 3 neonatal units for prescribed cooling treatment having been born in poor condition with low Apgar scores. This was followed by a further two incidents in May 2016, whereby two women experienced a stillbirth. A robust action plan was developed by the Health Board to address the issues raised as part of a multi-disciplinary review including the LSA. Formal supervisory investigations were undertaken on 4 of these cases, whilst the Health Board managed the other cases with internal 'table top' exercises supported by the local SoM team. At the time of the Exception reporting, the NMC made no recommendation for an Extraordinary Review, although a planned visit to the Health Board by the NMC was undertaken in February 2017.

The LSA continued to monitor progress with the action plan and was able to provide ongoing monitoring and evaluation of progress made and to provide reassurance to the NMC in relation to the completion of the action plan.

The annual audit process continued in 2016-17 and the LSA used the team approach, including the lay reviewers as part of the audit team. This ensured a clear focus on the user perspective in line with NMC Midwives Rules and Standards (2012) Rule 13[15], which recommended involving women who use the services of midwives in assuring the effectiveness of supervision. Peer review was undertaken with external SoMs being involved in the audit in a different health board from that which they were employed, ensuring a 'fresh eyes' approach. One health board audit was led by an LSA MO from England. This was due to the new appointment to the LSA of an LSA MO who had hitherto, been a SoM within that health board immediately prior to the audit being undertaken. This would ensure greater objectivity when completing the audit.

SoMs were given the opportunity prior to the audit to review their own evidence of compliance with NMC standards, with the emphasis on reviewing the recommendations of the previous year's audit. They were asked, in particular, to showcase any notable practice within their own health board to be shared with the audit team and the organisational representatives, as well as evidence of

---

[14] The NMC Quality Assurance framework

[15] Rule 13 of the Midwives Rules & Standards (NMC 2012) recommends that service users are involved in monitoring supervision of midwives and assisting with annual audits

collaborative working as a means of progressing through the transition period into the employer led model.

The full report for each health board can be found on the Healthcare Inspectorate Wales website[16].

4.3 National and local policies related to supervision

National
During 2016-17 the LSA MO Forum UK reviewed and updated all of their national policies and guidelines. National policies and guidelines were written in order to support LSA MOs and SoMs in their role. The UK focus was to ensure equity and consistency in process and outcome wherever the supervisory activity was undertaken. The national policies and guidelines were published on the LSA MO Forum UK website[17].

Local
The LSA in Wales introduced a new investigation template for SoMs with the intention of improving compliance with the recommended investigation timeframe.

[16] http://hiw.org.uk/splash?orig=/
[17] Local supervising Authority Midwifery Officer s Forum website; http://www.lsamoforumuk.scot.nhs.uk/

5. Section 3

5.1 Ensuring investigations into sub-optimal practice are undertaken

Supervisory investigations were initiated as a result of a case review, following a routine audit of records, or through the health board complaints mechanism, where midwifery practice standards were called into question.

All serious clinical incidents were subject to a supervisor of midwives case review. The SoM would record the case review using a SBAR format[18], or the LSA UK Forum case review template, whichever they considered was appropriate to capture information pertinent to the incident.

The SoM would assess if the incident needed to be escalated to the LSA using the 'LSA Incident Reporting Trigger List'. All incidents reported in line with the incident reporting trigger list required completion of the Local Supervising Authority Midwifery Officers Forum UK 'Decision Tool Kit'. The tool kit enabled the SoM to assess the midwifery practice that was provided in line with the Midwives Rules and Standards (NMC 2012,) and the NMC Code (2015). Following completion of the tool kit the SoM would refer and discuss the incident with the LSA MO who would then consider if a full external supervisory investigation in line with Local Supervising Authority Midwifery Officers Forum UK guidance was required. Supervisory investigations within Wales were conducted by a supervisor of midwives not employed by the health board in which the investigation was required to provide a level of external scrutiny to the process.

As from January 2017, following the publication of NMC guidance in relation to the transition period, incidents requiring supervisory investigation were commenced by the health board, with SoM input, as a collaborative process to ensure a seamless transition into the employer led model once statute ceased.

During the 2016-17 year, there were 19 supervisory investigations commenced with a further 4 collaborative investigations led by the individual health boards since January 2017. All supervisory investigations were conducted in line with Local Supervising Authority Midwifery Officer Forum guidance. The previous year evidenced 40 supervisory investigations, demonstrating a significant fall in total.

Completion of the investigations in line with the 45 working days recommended by the LSA MO Forum UK guidance has proved a challenge. As a result of the failure to comply with the 45 day recommended time frame across the UK in previous years, the LSA MO Forum UK increased the timeline to 60 days from 2016. The LSA in Wales re-structured its process to comply with LSA MO Forum UK guidance while continuing to focus on 45 days for completion of investigations with a maximum 60 day completion for all reports and conclusions.

---

[18] Improving clinical communication using SBAR; (Situation, Background, Assessment, Recommendation) http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/T4I%20%283%29%20SBAR.pdf

Of the 19 supervisory investigations, 32% were completed in less than 45 days, 32% were completed between 45 and 60 days and 36% were completed over 60 days. This demonstrated that overall, 64% were completed within the revised 60 day time frame which is a slight increase on the previous year. The collaborative health board led investigations were still ongoing as of the 31st March 2017.

There were multiple reasons cited for the delay in compliance with the expected timeframe for the completion of investigation reports including the availability of administrative support for note taking at interviews, typing and returning transcripts of interviews both to and from midwives, midwifery sickness and absence and SoM access to Welsh Government I.T. systems and equipment. The relative inexperience of the SoM team through the current year also had an impact on timeliness of the investigations

Rule 10[19] of the Midwives Rules and Standards cited 4 possible outcomes for supervisory investigations which were:

1. No further action
2. Local Action Plan
3. LSA Practice Programme
4. Referral to the NMC

In 2016-17 the outcomes for the midwives were as follows:

- 11 no further actions
- 26 Local Action Plans
- 5 LSA Practice Programmes
- 1 referral to the NMC

There was one midwife suspended from practice leading to the NMC referral as stated above. In addition there were a further five LSA referrals to the NMC. One involved a midwife who was referred following an investigation completed in the previous year and one midwife being referred following her resignation from her employer having disclosed serious health concerns with the potential to affect her practice. The remaining three referrals were due to midwives having retired with outstanding LSA Practice Programmes and although no longer practicing, the referrals were made due to the cessation of LSA function.

As of the 31st March 2017, two midwives were progressing through a LSA Practice Programme and a further two midwives were due to commence a LSA Practice Programme. Both were to be monitored by the health board with the responsibility being handed over to the respective Head of Midwifery.

All restorative processes required ongoing SoM support as well as monitoring within the health boards. Head of Midwifery support was required particularly where more serious concerns were highlighted resulting in a LSA Practice Programme. The LSA continued to promote a more collaborative process of restoration, partly in anticipation of the transition and handover to the health boards. Collaborative

[19] Rule 10 of the NMC Midwives rules and standards (2012)

processes also, aimed at expediting the process for midwives in restoring practice as well as strengthening existing governance arrangements aimed at reducing further risks to mothers and babies.

The main themes and trends identified in this year have been in relation to:

- Recognition of a deteriorating CTG (fetal wellbeing)
- Failure to escalate concerns appropriately
- Failure to recognise a deteriorating condition of the mother
- Poor record keeping
- Failure to communicate effectively with colleagues and women
- Failure to seek obstetric support
- Working outside scope of practice

All supervisory reports were shared with the relevant HoM with specific emphasis on systems and clinical governance concerns. Discussion about ongoing investigation and restoration programmes were held monthly at a local level between the HoM and SoM team while organisational action plans could be monitored at quarterly meetings when the LSA MO was present.

It remained the standard for the LSA to involve women and their families as fully as possible with the LSA investigation process. SoMs would write to women at the outset of an investigation to provide information on the investigation and invite their participation. This was in line with the NMC Duty of Candour[20] (2015) standard, introduced as a response to the Francis report[21] (2013).

5.2 Complaints in relation to the discharge of the supervisory function

Complaints against the LSA and or LSA MOs were 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 policy[22] 'Complaints against a supervisor of midwives or LSA Midwifery Officer'. There were no formal complaints made to the LSA during 2016-17.

One informal complaint was raised with regards to the supervisory investigation process and this were resolved following meetings between the midwife, their staff side representative, SoM and LSA MO.

---

[20] Openness and honesty when things go wrong. The professional duty of candour.
https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-ofcandour.
pdf

[21] Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry. Chaired by Robert Francis QC
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

[22] 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

6. Section 4

6.1 Notable and Innovative Practice

- In ABU there is good evidence of collaborative working, particularly in supporting newly qualified midwives and the 'tri-partite' review with the Preceptorship programme
- ABU SoMs use of a 'checking book' as a means of 'closing the loop' on any restorative actions for midwives
- BCU SoMs have co-hosted an 'away day' for newly qualified midwives, supported by HIW
- BCU SoMs have presented at the Health Board Better Births Conference
- C&V SoMs have initiated an all Wales record keeping tool to ensure consistency throughout Wales
- C&V SoMs have regularly presented at the Health Board mandatory training days discussing the key themes highlighted in The Morecambe Bay Report[23]
- An all Wales SoM team has developed a standardised programme for planned sessions with student midwives to ensure equality of information is shared
- CT SoMs have been working in partnership with the safeguarding team to improve birth notification issues for cases of free-birthing.
- C&V SoMs have provided presentations to midwives regarding key issues of concern identified by midwives in their Health Board. These have included, 'Working with Doulas' and 'Supporting women requesting care outside of recommended guidelines'. These presentations were shared with the all Wales SoM team
- HD SoMs have co-hosted a session with the RCM
- ABM SoMs have been working closely with the practice Development midwife addressing key training issues for midwives
- Powys SoM has been noted as being flexible, supportive and adaptable in spite of large geographical area covered
- The audit reports recognised the improved collaborative working of all the SoM teams within the Health Boards, particularly within clinical governance
- The SoM teams were all noted to have significantly increased their visibility and accessibility to midwives within their respective Health Boards
- The SoMs have made a significant contribution to the Taskforce, in developing a new model of Clinical Supervision for Midwives, ensuring that the key elements of the 'Futureproofing' model have been incorporated into the employer led model.

[23] The report of the Morecambe Bay investigation. Bill Kirkup CBE. March 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.p

6.2 Sharing good practice

During 2016-17, the LSA has undertaken two external appeals on behalf of the LSA Midwifery Officers Forum UK and an external LSA Midwifery Officer undertook the annual audit in one health board in Wales providing an opportunity to share good practice.

6.3 Looking to the future

As from the 1st April 2017 the LSA ceased to function with the health boards taking over the responsibility for the Clinical Supervision for Midwives. The last year has been dominated by maintaining the role and function of the LSA in accordance with NMC standards, whilst at the same time, preparing for the legislative change that took effect on the 1st April.

The new model will ensure that midwives continue to be supported in their everyday practice in order to ensure public protection is maintained without the competing demands placed upon them in undergoing supervisory investigations.

The LSA would like to thank all stakeholders who have worked with and supported the LSA and the SoMs and look forward to moving to the new model which will secure the future for midwifery supervision in a way that is meaningful and supportive for midwives to promoting excellence in professional standards that will enhance public protection.