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DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

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protecting the public through statutory supervision of midwives

Supervision, support and safety: Annual report of the Local Supervising Authority (LSA)

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1. Foreword

I have pleasure in presenting this 2013 - 2014 annual report on the quality assurance of the Local Supervising Authority (LSA) for Wales. On behalf of Welsh Ministers and the citizens of Wales, HIW fulfils the function of the LSA and therefore is 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 2013 - 2014 as well as looking forward to the changes ahead. As in previous years this annual report provides an account of how the LSA ensured that standards of supervision were delivered to midwives across Wales. It also provides insight into the changes that have been planned with Nurse Executives and Heads of Midwifery to implement a new model of supervision that will be fit for purpose and stand the test of changing demands and pressures within the NHS.

The publication of the Parliamentary & Health Service Ombudsman for England's report on Statutory Supervision of Midwives (PHSO 2013)[1] highlighted a number of concerns in regard to midwifery regulation. In particular it identified the potential muddling of the supervision and regulatory roles of supervisors of midwives and the possibility of a perceived conflict which the proposed model in Wales will address. In light of the Nursing & Midwifery Council's plan to review midwifery regulation there has never been a better opportunity for supervision to come to the fore and demonstrate its true worth. The future is an exciting one for supervision in Wales and we expect the rest of the UK will be looking to the outcomes of our work as there appears to be a ground swell of opinion that change is needed and that the status quo is not an option.

Kate Chamberlain

Chief Executive for Healthcare Inspectorate Wales

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

2. Introduction and Background

To ensure safe and effective midwifery practice, the Nursing Midwifery Council (NMC) is required, by the Nursing and Midwifery Order 2001,[2] 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[3]), is exercised to a satisfactory standard across Wales.

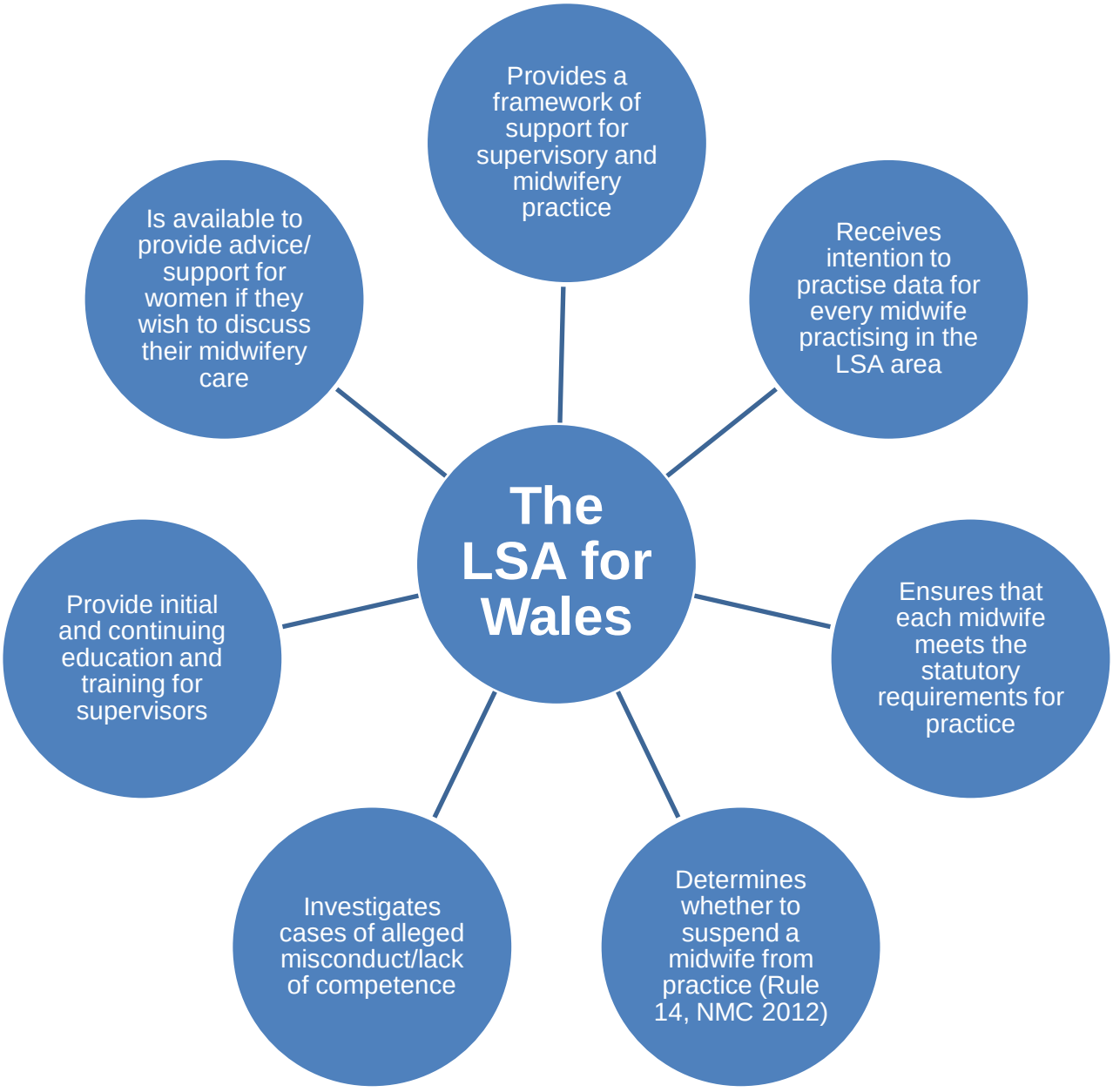
Our role as the LSA for Wales and how we fulfil it

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

[2] Nursing and Midwifery Order 2001 (The Order).
[3] NMC Midwives rules and standards (2012)

- Determine whether to suspend a midwife from practice, in accordance with Rule 14[4] of the Midwives rules and standards (NMC 2012)
- Lead the development of standards and audit of supervision.



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

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 2014[5]]
- 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 meetings; 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;

[5] NMC 2014 Standards for the preparation of supervisor of midwives

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

LSA MO Vinny Ness covers:

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

3. Section 1.

The delivery of effective supervision.

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 9[6] 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 2014, 101 SoMs were in post, and 1,742 midwives had notified the LSA of their Intention to Practise (ItP) midwifery in Wales during 2013 -14. This demonstrates an all Wales average SoM to midwife ratio of 1:17. However where Health Boards had SoM to midwife ratios above 1:15 additional SoM hours were made available, dedicated to the provision of statutory supervision, and an adjusted ratio was then calculated. Taking into account the additional hours, the average all Wales ratio of SoMs to midwives, as of 31 March 2014, was 1:13.5 which meets the statutory NMC requirement. **Table 1** shows the detail of the ratio of SoMs to midwives during 2013 - 2014. As can be seen three of the seven Health Boards supported an increased number of hours to enable effective supervision to be delivered.

Table 1 Ratio of SoMs to midwives in Wales as of 31 March 201

Health Board	No. of midwives	No. of SoMs	Ratio SoMs to midwives	Adjusted ratio with extra hrs.
ABMU	311	21	1:15	
AB	293	14	1:21	Deficit 10 days /mth Gain 12 days/mth Equ. to 8 SoMs 1:13
BCU	400	13	1:31	Deficit 18 days /mth Gain 20 days/mth Equ. to 13 SoMs 1:15
C&V	287	16	1:18	Def 3 days /mth Gain 3 days/mth Equ. to 2 SoMs 1:15
Cwm Taf	209	16	1:13	
Hywel Dda	197	16	1:12	
Powys	45	4	1:11	
Independent	0			
Total (all Wales)	**1742**	**100**	**1:17**	**1:13.5**

[6] NMC Midwives rules and standards (2012)

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

During the year seven SoMs were appointed across Wales. All new appointees came from the pool of midwives who had attended the SoM preparation course during 2012 -13.

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

No. of SoMs	2011-2012	2012-2013	2013-2014
Appointed in year	11	8	7
Removed from post (LSA de-selection)	0	0	0
Resignation (self de-selection)	19	21	27
Suspension from role (LSA suspension)	0	0	0
Suspension from role (self suspension)	0	0	0
Commenced preparation course (September)	8 (2011)	9 (2012)	0 (2013)
Leave of absence		9	13
Total number of SoMs in post	**135**	**130**	**101 Inc. 1 SoM on LOA**

Table 2 above demonstrates that the LSA has continued to experience a year on year trend of an increasing number of SoMs exiting from the role. During this practice year 27 SoMs resigned from the role and each individual was offered an exit interview in line with UK Forum Guideline E[7] . **Table 3** highlights that the main reason for de-selection continues to be increasing work pressures. The Case for Change options appraisal paper[8], written to support the introduction of the Future Proofing of Supervision (FPS) model, recognised that SoMs were constantly struggling to balance the increasing workload and responsibilities of being a SoM with the increasing clinical challenges present in contemporaneous midwifery practice.

[7] LSA Midwifery Officers Forum UK - National Guideline E-Voluntary de-selection from the role as a supervisor of midwives.

[8] The Case for Change; an options appraisal on the future proofing of statutory supervision in Wales. LSA Wales (2013) Internal Communication, Healthcare Inspectorate Wales

Table 3. De-selection trends the past three years

Reason for de-selection	2011-2012	2012-13	2013-2014
Change in SoM's substantive role	2	2	0
Resigned from role/moved out of Wales	5	2	3
Retirement from substantive role	4	5	3
Work pressures	6	6	20
Personal/family issues, inc. ill health	2	5	1
Did not give a reason	0	1	0
De-selection from post (self de-selection)	**19**	**21**	**27**

During the 2013 - 14 reporting year 13 SoMs took a leave of absence for a period of between six and 18 months for personal/family reasons, a change in their substantive role and/or health issues that made it difficult for them to commit to the added responsibilities of being a SoM. As reported last year, there appears to be an increasing trend in requests for leave of absence, which the LSA has supported to help retain experienced SoMs in the longer term. The LSA actively engages with individuals on a leave of absence providing support for their re-induction to the SoM role when they are ready to return. The LSA also works closely with local SoM teams to monitor the impact that periods of leave of absence have on the ongoing workload of the SoM team.

In order to ensure that SoMs meet the requirements of Rule 8[9], the LSA is committed to ensuring all SoMs appointed in Wales are able to access continuing professional development and opportunities to update their practice. All SoMs in Wales also had the opportunity to attend regional investigation workshops which were held quarterly during the year. The workshops focused on the changes in the revised NMC Midwives rules and standards (NMC 2012) with an emphasis on Rule 10,[10] recommendations from a supervisory investigation and the SoM role in closing the loop after a SoM investigation.

SoMs were also invited to attend regional information sharing events which were held as part of the communication and engagement process for the FPS

[9] Rule 8 of the NMC Midwives rules and standards (2012) sets out the requirement for continual professional development as a supervisor of midwives.
[10] Rule 10 of the NMC Midwives rules and standards (2012) sets out the LSA procedures for supervisory investigations.

model. The events centred on the Case for Change for the revised model and explored the Service Specification and Role Profile for the future SoMs. A number of SoMs benefited from attending these events and in the Mid & West Wales region of the LSA some were able to attend the concurrent NMC consultation event on the proposals for Revalidation and the Code.

A number of SoM teams were able to enhance their leadership and development skills by engaging with the expertise offered by workforce and development teams in their own Health Board. They then put this learning into practice by facilitating the SoMs annual away day. These leadership, development and information sharing days offered key opportunities for continual professional development 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.

The LSA was mindful of the potential impact of preparing for the implementation of the FPS model so deferred the Annual LSA Workshop in this practice year. Many SoMs had the opportunity to update their continual professional development portfolio by attending the UKLSA MO forum biannual conference in Nottingham, which was held in March 2014, and the RCM annual conference in Shrewsbury in November 2013.

Mechanisms for continuous access to a supervisor of midwives

Rule 9[11] 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 2013 -14, 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 2013 -14 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. At the time of reporting, 97% of midwives

[11] Rule 9 of the NMC Midwives rules and standards (2012) sets out the requirement for supervisor of midwives.

in Wales had an ASR uploaded to the LSA database which is significant progress on the 83% reported to the NMC in the previous year.

During the year quarterly meetings with Heads of Midwifery (HoMs) and SoMs have been used to monitor the compliance with the ASR process particularly in light of the Francis Report and its recommendations.[12] The report highlighted the importance of all staff being subject to an annual review of their performance. All SoMs and midwives must therefore recognise 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 SoM's that have outstanding ASRs and robust performance monitoring is instigated to ensure that they comply with the ASR process. Monitoring the compliance with the ASR process has been an important element of the preparation for the implementation of the FPS model, ensuring that FPS SoMs did not inherit additional work and that SoM records were in a fit state for hand over with up to date and relevant information.

All providers of maternity services in Wales have a 24 hour on-call rota of SoMs who can be contacted in an emergency. All midwives are informed of the location of the rota and how to access it. Normal practice is to place a copy of the rota in all departments/areas of the maternity unit/community office as well as to supply the hospital/unit telephone switch board with a copy of the rota. Records are kept of when advice is sought from a SoM, including date, time, problem and advice given. A random telephone audit of the on call response rates was undertaken by the LSA lay reviewers.

The telephone audit was conducted by the team of lay reviewers with each reviewer linking with the same Health Board they visited for the LSA annual audit process. Lay reviewers were asked to identify the number of on-call SoMs for each Health Board and to identify the appropriate phone numbers. Two calls were made; one during Monday to Friday, between 9am and 5pm (office hours), and the other out of hours. The reviewers reported that

[12] Francis Inquiry (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry. London: The Stationary Office

information on how to contact a SoM was readily available on all Health Board websites. The audit highlighted that the average time to contact a SoM was around 20 minutes both in and outside of office hours. The audit identified a few minor challenges with contact numbers for individual Health Boards which were immediately addressed through the HoM and the local SoM team.

LSA MOs attend regular SoM meetings to enable clear two way communication between the LSA and SoMs on all aspects of the supervisory function. The SoM meetings provide an opportunity for the LSA MOs to offer additional advice and support to SoMs in relation to service matters that may be relevant to public protection as well as allowing the LSA to oversee SoMs planning and implementing their annual work plans.

Impact on supervision of midwives working outside of maternity services

The NMC has acknowledged that an increasing number of midwives are working in non midwifery roles but continuing to maintain their midwifery registration to enable them to practice. These registrants are often working as Specialist Community Public Health Nurses (Health Visitors and School Nurses) using midwifery as their single registration. The NMC requested the LSAs to consider the impact that this additional workload of midwifery practitioners requiring the input of a SoM but not delivering midwifery services could have on the SoM to midwife ratios to inform the 13 -14 report.

In accordance with the Midwives rules and standards (NMC 2012) these practitioners must meet the practice requirements for renewal of registration by submitting an ItP form and meet with their named SoM on an annual basis. The NMC provides clear guidance for Specialist Community Public Health Nurses on the range of practice and learning they may use to evidence their midwifery Post Registration Education & Practice (PREP)[13] to maintain their midwifery registration http://www.nmc-uk.org/Nurses-and-

[13] NMC (2011) The Prep Handbook. NMC, London

midwives/Regulation-in-practice/Specialist-community-public-health-nursing/Renewing-registration-on-the-SCPHN-part-of-the-register-for-direct-entry-midwives/.

The LSA in Wales has reviewed the number of midwives who required a SoM whilst they were practising in non midwifery roles during 13 -14. The review identified that 49 of 1742 (2.8%) midwifery registrants who notified their ItP to the LSA were working in non midwifery roles. The impact on the ratio of SoMs to midwives equates to the equivalent of three SoMs across Wales.

Thirty five registrants were in Specialist Community Public Health Nurse roles with 31 of them having a single midwifery registration. The SoMs allocated to supervise these practitioners follow the NMC guidance for Specialist Community Public Health Nurses in regard to the range of practice and learning they may use to evidence their midwifery PREP and maintain their midwifery registration.

Table 4 – Analysis of midwifery registrants in non midwifery roles

Type of role	No. of midwives	Single registration	Joint registration
Specialist Community Public Health Nursing	35	31	4
Neonatal role	3	-	3
Public Health Wales such as new born screening co-ordinator, smoking cessation	2	-	2
Fertility Services	3	1	2
NSPCC	1	1	
School Nurse	2	2	
Sexual Health / Youth Liaison	3	-	3
Total (all Wales)	**49**	**35**	**14**

4. Section 2

Involving service users in supervision

The LSA in Wales appointed five lay reviewers in 2008 to support the LSA in its work. 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 lay reviewers will exit 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. The LSA ran a new recruitment process and was delighted with such a positive recruitment campaign which attracted 15 high calibre applicants. The LSA could only recruit four lay reviewers and was able to choose from an excellent range of users who were shortlisted for interview.

The four successfully recruited lay reviewers will replace the five existing lay reviewers who will exit from the role in July 14 following their five year tenure. A full day's induction and training event was held to explain the LSA audit process and what is expected of the lay reviewer role within the process. The existing lay reviewers supported the new reviewers by sharing their experiences of the role and have acted as mentors to the new reviewers. The LSA will continue to recruit future lay reviewers using the recruitment pack that has received positive feedback from the second cohort.

Direct contact from service users to the LSA or SoMs is still relatively limited. However, the lay reviewers found, during the telephone audit and the Pyramid visits, a number of examples where women are being signposted to SoMs by midwives. The Pyramid visits have been adapted by the LSA from the wider organisational quality and safety 'walkabouts' that cascade down from the Nurse Director to ward level. The LSA are given free access to any chosen area to carry out an audit visit with a specific focus on user views, evidence and visibility of supervision and ward safety.

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 have been devising a local leaflet to explain the FPS model and more generally raise the awareness of the role of supervision for service users in Wales.

The 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 lay reviewers have been fully involved in the annual LSA audit processes including participation in quarterly Pyramid visits, the telephone audit to test out the On Call SoM rota, and are also part of the review team for the annual LSA audit visit. During the audit process, the lay reviewers also lead discussions with the Maternity Service Liaison Committees (MSLC) Chairs and Patient Experience leads.

The lay reviewers' participation in the Pyramid visits held by the LSA in each Health Board on a quarterly basis provided them with an opportunity to meet with a wider range of service users. The reviewers identified good practice and suggested areas for improvement to information boards which profile supervision and the promotion of normality. Lay reviewers gathered women's views and experiences of the service and explored their understanding of the role of a SoM. They also commented on the maternity environments of care from a user perspective. Reports were drafted by the LSA MOs following each quarterly visit and shared with the lay reviewers for comment before being sent to the HoM for information or corrective action as required.

The lay reviewers are integral to the recruitment process for student SoMs and they were part of the selection process for SoMs joining the FPS model. They observed and assessed students and SoMs at the workstations and were part of the interview panel. The lay reviewers focussed on the assessment of the SoM's attitude and approach to women's choices and individualised care. Their input was invaluable in identifying SoMs who they considered would be able to work well with women and their families. The lay reviewer's telephone audit described in section one provided information that helped shape the new on call arrangements to support the implementation of an on call process in the FPS model.

The LSA has also been meeting with Community Health Councils across Wales to explain the FPS model which has raised the profile of the LSA and improved the interface with service users from a broader perspective.

Overview of LSA audit activity – risk and benefit realisation

The annual audit process introduced in 2011 - 2012 continued in the current audit year and the LSA retained the use of a team approach. The audit process for 13 -14 was undertaken to include the quarter three Pyramid visit. The LSA lay reviewers, as part of the audit team, ensured a clear focus on the user perspective in line with NMC Midwives rules and standards (2012) Rule 7[14], which recommends involving women who use the services of midwives in assuring the effectiveness of supervision. The peer review, achieved by the use of an external SoM employed in a different Health Board from that which was subject to audit, was as an opportunity to bring a "fresh eyes" approach to service delivery and to share best practice across Wales.

In advance of the annual audit visit, the SoM team were required to submit their self assessment tool to demonstrate achievements by the supervisory team against all NMC standards. They were also expected to identify an action plan where they considered development was still required for the coming year. The SoM team were asked to focus on developments that had been identified as priority actions in the LSA audit report from 2012 - 2013 and from within their Health Board team competency tool. On the day of audit, the SoM team presented on;

•Summary of progress in delivering operational plan for 2013 - 2014
•Control measures for outstanding priority actions by the end of quarter 4 to inform 2014 -15 plan

[14] Rule 7 of the NMC Midwives rules and standards (2012) sets out the requirement for involving women who use the services of midwives in assuring the effectiveness of supervision of midwives.

•Examples of good practice and achievements of the SoM team
•Examples of local profiling of supervision

While the published audit report for each organisation will provide full evidence of the progress made, some key themes identified included:

- Further improvement is still needed in relation to the link between supervision and organisational governance arrangements
- Further alignment and joint working across management and supervisory investigation processes where there is a serious untoward incident
- Ability of SoMs to deliver proactive rather than reactive supervision owing to increasing pressures from their substantive roles and having sufficient protected time for supervision
- Full compliance with the ASR process in preparation for implementation of the FPS model
- Significant improvement needed in all aspects of the supervisory investigation process to improve timeliness and allow for quicker restorative support for midwives (see section 4 for detail).

The LSA in Wales has been working with multiple stakeholders over the past 18 months to devise a new model of supervision that we consider will enable SoMs to deliver a high standard of supervision consistently across Wales. There has been an intensive programme of development for the SoMs who will be working in the revised model which is an adaptation of the PoSoM programme at Masters level working with Swansea University as the programme provider. There has been a specific emphasis on the particular areas of risk identified in the current 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.

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.

As in previous years, SoMs were members of the interview panel for the selection of prospective student midwives. SoMs worked in collaboration with colleagues in education on the Objective Structured Clinical Examination (OSCE) process to ensure that prior to qualifying; student midwives were competent and confident to practise midwifery. SoMs continue to play an active part in delivering training for midwives and student midwives.

SoMs continued to work in partnership with relevant education colleagues, supporting training and continuous professional development workshops. For example SoMs were involved in a collaborative conference which resulted from the challenges facing midwives and SoMs in normalising birth. The conference focused on raising the profile of normal birth with a key note speech from Cathy Warwick, Chief Executive of the RCM, on the Birthplace Study. The conference featured a very lively debate on midwife and SoM dilemmas in managing women's choices outside of guidance, fielded by Legal & Risk, Royal College of Midwives and the LSA. Other SoMs across Wales have worked in partnership with HEI colleagues to host Denis Walsh's Normal Birth and Dianne Garland's Water Birth skills workshops.

The LSA gains information about the clinical learning environment by meeting with a number of student midwives as part of the quarterly Pyramid visits and the annual supervisory audit process. The LSA MOs have both contributed to teaching sessions and have spoken at conferences held by HEIs during the

year. In this practice year, student midwives have been establishing student midwife societies and the LSA MOs have been invited to take part in area launches and as guest speakers at the society meetings. Such engagement with students provides opportunities to enhance the students' understanding of the LSA function, the LSA MO role and further promote the role of supervision.

The LSA has regular contact with Lead Midwives in Education (LMEs) across Wales which includes attendance at the quarterly Heads of Midwifery Education (HoMEd) group. As in previous years, the LSA invited a representative from the HoMEd/LME group to attend meetings of the LSA/contact SoM forum. General issues relating to the clinical learning environment for student midwives were shared and discussed at these meetings. No issues of concern were highlighted during the year regarding the clinical learning environment for pre-registration student midwives. 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 students in the first cohort regarding the innovative, work-based learning approach which was developed around the LSA competency tool. The LSA MOs have been actively involved in the curriculum planning and have been active participants in the delivery of the programme.

In turn an HEI representative has been part of the steering group and selection process for SoMs to deliver the FPS model. This involvement has included Swansea University leading on a midwives' survey to gather views and experiences of supervision from across Wales. Within the Service Specification for the FPS model, there is a specific key performance indicator to ensure SoMs meet the NMC requirement for student midwives to have

access to them[15]. The aim is that 100% of student midwives will be able to report meeting with a SoM at least twice a year. LMEs in Wales have agreed to develop the student portfolio to record the SoM contacts which will support measurement of this KPI.

5. Section 3

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

Workforce trends

The LSA has continued to note a steady trend in the increasing ratio of part time to whole time equivalent midwives over the past three years. Whilst the appointment of part time midwives enables greater flexibility within the workforce and retains experienced midwives who may otherwise retire, this also presents additional challenges for the service and the SoM team. An increased head count means an increased workload for SoMs in maintaining the 1:15 ratio required by the NMC. Furthermore an increasing part time workforce taxes service delivery in having to allow all staff, regardless of the hours worked, sufficient time to access continuous professional development and the demanding mandatory training agenda.

Birth trends

In Wales there continues to be an emphasis on reducing intervention in labour to increase women's chances of a normal birth, although caesarean section rates are still reported as continuing to be high at 27.9%. Welsh maternity services meet with Welsh Government on a six monthly basis to review the performance indicators within the Maternity Strategy, a Strategic Vision for Maternity Services in Wales[16]. Providers of maternity services with caesarean

[15] Rule 9 standard 1.1.2 of the NMC Midwives and Standards (2012)
[16] Welsh Assembly Government (2011) A strategic vision for Maternity Services in Wales http://wales.gov.uk/topics/health/publications/health/strategies/maternity/?lang=en

section rates above 25% are required to report on local delivery plans and their intentions to reduce high caesarean section rates.

The all Wales Perinatal Survey[17] reports the stillbirth rate within Wales for 2012 as 4.5 per 1000 births. During 13 -14, many SoMs were involved with the 1000 Lives[18] mini collaborative on a national stillbirth programme which focused on reducing preventable stillbirths in Wales. The mini collaborative set up the Welsh Initiative for Stillbirth Reduction (WISR) to consider several practical steps, particularly around reduced fetal movements, fetal growth, perinatal review and perinatal pathology. The 1000 Lives programme completed its work in March 2014 with a number of all Wales interventions such as standardising the management of women who present with reduced fetal movements, an all Wales growth assessment programme and standardising the information given to women. Full information on the WISR programme can be accessed via http://www.1000livesplus.wales.nhs.uk/maternity-services-stillbirth

SoMs are continuing to report their input to supporting women and midwives in complex births who wish to give birth outside a high risk setting against medical advice. The SoMs role is to advise and support midwives to ensure their advice and care planning is in line with NMC rules and standards as well as recognising and recording consideration of all relevant local and national guidance. This protects women and helps them to make appropriate informed choices based on up to date; evidence based information as well as supporting the midwife to deliver a high standard of care based upon regulatory and statutory guidance.

[17] All Wales Perinatal Annual Report 2012. http://awps.cf.ac.uk/awps-report-2012/download/

[18] 1000 lives Transforming Maternity services mini-collaborative Welsh Initiative for Stillbirth Reduction (WISR). http://www.1000livesplus.wales.nhs.uk/maternity-services-stillbirth

Public Health trends

Public health is a specific focus of the Strategic Vision for Maternity Services in Wales and SoMs have continued to be involved in initiatives aimed at influencing best practice in areas of public health. The Welsh maternity services six monthly meetings with Welsh Government also focus on public health targets such as reducing teenage pregnancy, managing obesity and addressing continued high rates of smoking and drinking, all of which add to the challenging agenda for maternity service provision. Maternity service providers are required to demonstrate to Welsh Government that they are taking a proactive stance to the delivery of measures which identify trends, and that they are then making changes in practice to improve care and outcomes for women and their babies.

National and local policies related to supervision

During 2013, 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.

During the year, there have been a number of local guidance documents developed relating to supervision in Wales;

- The LSA has implemented guidance on the use of the all Wales Annual Supervisory Review document in a question and answer format.

- A Standard Operating Procedure has been developed to support the move towards an all Wales On Call arrangement in the FPS model.
- The Investigation Resource book for SoMs has been updated with local templates to support the LSA MO Forum UK policy for the investigation process.

6. Section 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. If the case review indicates that the actions of any midwife may have contributed in a negative way to the clinical incident, or their practice was sub-optimal, 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 to question.

Forty eight clinical incidents or investigations were formally notified to the LSA in 2013 -14 compared to the previous year's figure of 56. Twenty five of the 48 incidents notified to the LSA were subject to a SoM investigation, in line with LSA MO Forum UK guidance.

SoMs, in year, continued to find it a challenge to complete investigations within the 45 working days recommended by the LSA MO Forum UK, or even in a timely manner as required under the revised Midwives Rules (NMC 2012). In reality, of the 25 investigations undertaken by SoMs, only six were completed within six to eight weeks. The remainder were completed between three to 12 months with an average completion time of five months. 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 and 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.

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. There still remains some historical practice of the SoMs and organisational understanding of the need for compliance with a reasonable timeframe which was challenging to manage in the prior to the introduction of the FPS system.

In 2013 -14 LSA Practice Programmes was recommended for four midwives. All four midwives successfully completed their programme in the reporting year. Local Action Plans for Reflection or Continuing Professional Development, relevant to the issues that caused concern, were recommended for 26 midwives.

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. No referrals were made to the Health Committee of the NMC in this reporting year.

Improving the supervisory investigation process

The LSA use 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 45days 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 by the Health Board, 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) nine 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 nine 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.

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 policy[19], Complaints against a supervisor of midwives or LSA Midwifery Officer. The LSA received two formal complaints in 2013 - 2014. 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. The second case was resolved through the LSA appeals process.

[19]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

7. Section 5

Notable and Innovative Practice

The all Wales ASR documentation was launched in November 2013 with champions from each Health Board attending a training event to cascade to their local SoM team for full implementation across Wales. The LSA developed the document through a task and finish group which met during 2012 -13 to review the current ASR process. The aim was to develop a document that was fit for purpose, supported a consistent all Wales approach and better informs the Individual Performance Reviews conducted by management to avoid unnecessary duplication.

The quarterly Pyramid visits, LSA audit review and regular contact during SoMs meetings highlighted numerous initiatives that were taken forward by SoMs. These are featured in the quarterly LSA newsletters to support sharing of good practice. They include, but are not limited to the following;

- Powys SoMs held learning sessions with Welsh Health Legal to review records for three complex care plans and to discuss duty of care issues
- BCU SoMs raised the local and national profile of supervision by attending the National Eisteddfod with an information booth on supervision and local services
- AB SoMs promoted normality and supporting women to achieve calm and drug free births through hypnobirthing. Community midwives are currently being trained to deliver hypnobirthing as part of parent education free of charge for women across the Health Board
- C&V SoMs have taken a fresh look at their documentation audit using women's stories to compare with the records made for care. Women have been involved in auditing their notes using a refined audit tool
- ABMU SoMs have devised a series of brief leaflets for midwives as aide memoirs to support their discussion with women in relation to the Place of Birth study and women's choices when a women falls outside the low risk birth criteria i.e. raised BMI and previous 3rd and 4th

degree trauma. This ensures midwives cover all relevant information to enable women to make an informed choice

- Cwm Taf SoM used a 60 Seconds of Fame approach at their 2013 Away Day to highlight how they had made a difference as a SoM in the last 12 months.
- Two Hywel Dda SoMs and a midwife won the Royal College of Midwives (RCM) Annual Award of the National Maternity Support Foundation for their work to improve services for bereaved parents of stillborn babies.

A number of SoMs were recognised for their achievements locally such as the BCU SoM team, which received a Director of Nursing award for "Rising Stars", in recognition of the implementation of group supervision for the midwives annual review process. SoMs have also been active in presenting their innovations in supervision through three seminar presentations from Wales at the LSA MO Forum UK conference in March 2014 and AB Health Board SoMs were selected to present the "Top Ten Hits" aide memoirs for improved clinical practice at the International Confederation of Midwives Conference in Prague.

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 steering group

- SoM from London LSA who works full time shared her experience and challenges to help shape the Role Profile and Service Specification for the FPS model
- A full time SoM and another SoM from Yorkshire and Humberside attended the information sharing events as part of the consultation process for devising the FPS model

- The LSA MO from East of England took part in the three day selection of FPS SoMs event sitting on the interview panel for consistency of views
- London LSA shared their framework for group supervision to help inform and develop the group supervision concept for Wales.
- Both 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.

Key issues for the LSA in 2013-14 and looking to the future

In April 2013 the LSA presented an options appraisal paper, The Case for Change, to DoNs from NHS Wales setting 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 charged 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). A steering group was convened to deliver this programme of work within the timeframe set as September 2013. Feedback planned for October 2013 was subsequently delayed by HoMs until January 2014.

DoNs were invited, along with all other interested parties, to the Future Proofing of Supervision stakeholder group on January 16th 2014. The consensus of opinion was that the proposed model was the appropriate way forward and DoNs signed up to the implementation of the model in principle. However, there were a few remaining issues that they required further assurance on before they could agree to a revised ‘go live’ date which was muted at that time as being 1st May 2014. The LSA addressed the concerns with the provision of an Accountability and Responsibility flow chart and worked with Welsh Government (WG) lawyers to find a suitable new host for the LSA outside of HIW. This second element of concern is more complex as it requires a change to the Nursing & Midwifery Order to enable Welsh

Ministers to delegate their powers and is therefore ongoing at the time of this report.

The LSA have 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 shared with DoNs for review and to enable them to seek an independent legal opinion. The DoNs signed up to the documentation following legal advice on 29.7.14. An overarching Memorandum of Understanding between the NMC, the LSA and the Local Health Boards has yet to be put in place.

It was agreed with the Chief Nursing Officer and DoNs that the FPS model would be implemented from the 4th August 2014. The overarching purpose of the model is to improve the quality of statutory supervision in Wales through the appointment of supervisors, to work full time as a SoMs for a rotational 18 month period. The SoMs will be dedicated to the role of supervision, increasing their visibility and accessibility to midwives and service users.

There will be 24 hour access to a SoM via an all Wales on-call number for advice on issues relating to supervision and professional standards. Midwives will benefit from a more robust annual supervisory review process through group supervision and sharing of best practice, which has been piloted in two organisations as the LSA moved towards the implementation of the model. Evaluation of group supervision to date has been very positive with midwives reporting increased learning from their peers.

The FPS model will be evaluated through key performance indicators which are 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 ASR & IPR

KPI 4 100% of midwives are compliant with the 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

Key 6 100% of newly qualified midwives will meet a SoM at least twice within 6 months and 3 times by 12months to agree and monitor preceptorship 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 LSA are keen to ensure that they can demonstrate effective evaluation of this path finder work. We are acutely aware that the rest of the UK is looking to Wales for outcomes, particularly in light of the Parliamentary Health Service Ombudsman's Report in England and the resultant work of the Kings Fund[20] who are conducting a review of midwifery regulation commissioned by the NMC.

The LSA will continue to report on the quantitative measures as a requirement of the quarterly quality monitoring to the NMC. The KPIs, identified in the FPS Service Specification, aim to add to the existing quantitative data and with regard to the supervisory investigation process aim to introduce some elements of qualitative outcomes.

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.

The LSA looks forward to working with all our colleagues towards this important aim and thanks everyone for their support to date.

[20] NMC 2014 Kings Fund independent review into the regulation of midwives. http://www.nmc-uk.org/media/Latest-news/The-Kings-Fund-to-undertake-independent-review-of-midwifery-regulation/