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Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

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

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Contents

Foreword

I have pleasure in presenting this 2015 - 2016 annual report on the quality assurance of the Local Supervising Authority (LSA) for Wales. On behalf of Welsh Ministers and the citizens of Wales, Healthcare Inspectorate Wales (HIW) fulfils the function of the LSA and is therefore responsible for ensuring that statutory supervision of all midwives is exercised to a satisfactory standard across Wales. This annual report looks back at the LSA and supervisory activities during 2015 -2016, as well as looking forward to the future for midwifery supervision in Wales and celebrating the successes achieved.

In August 2014 the LSA in Wales introduced an innovative model for the delivery of statutory midwifery supervision, having identified the need to evolve to ensure safe and effective delivery of its statutory function. In the two years since its inception, the new model of supervision has become firmly embedded and valued within maternity services across Wales.

Aspects of the model have been recognised as good practice including the introduction of group supervision. Its success has been recognised in the Welsh Government Green paper “Our Health-Our Health Service”, and through publication of the evaluation of group supervision in the British Journal of Midwifery. Further initiatives to be celebrated include the development of an All Wales Preceptorship Passport, supporting newly qualified midwives within their first year of practice, and a revised Annual Supervisory Review document to support midwives toward transition to revalidation with the Nursing and Midwifery Council (NMC). Both documents have been endorsed for use across Wales by the Heads of Midwifery Advisory Group and were implemented into all health boards in 2016.

There is wide interest across the UK in the model of supervision used in Wales and the LSA has continued to work in partnership with key stakeholders to provide assurance that midwifery supervision is delivered consistently and to a high standard.

Looking to the future, the LSA and supervision will not remain part of the NMC legislation. The Chief Nursing Officer has established a taskforce to transition midwifery supervision to an employer led model, to ensure supervisors of midwives continue to influence and support excellence in midwifery practice. In the meantime I am confident the LSA is well placed to maintain the delivery of statutory midwifery supervision whilst legislative changes are made.

Kate Chamberlain - Chief Executive

Introduction and Background

To ensure safe and effective midwifery practice, the Nursing Midwifery Council (NMC) is 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 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 NMC Midwives rules and standards (NMC 2012), is exercised to a satisfactory standard across Wales.

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

The LSA for Wales has a responsibility to:

- Be available to women if they wish to discuss any aspect of their midwifery care that they consider has not been addressed through other channels
- Provide a framework of support for supervisory and midwifery practice
- Receive Intention to Practise data for every midwife practising in the LSA
- Ensure that each midwife meets the statutory requirements for practice
- Provide 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[2] 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] Rule 14 of the NMC Midwives rules and standards (2012) relates to the suspension from practice by a local supervising authority.

The LSA for Wales

LSA Midwifery Officers

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

- Lead the development of standards and audit of supervision throughout the LSA
- Appoint Supervisors of Midwives (SoMs)
- Provide a formal link between midwives, SoMs and the statutory bodies
- Provide a framework for supporting the supervision of midwives and midwifery practice within its boundary
- Participate in the development and facilitation of programmes of preparation and ongoing development of SoMs
- Ensure that SoMs are capable of meeting the competencies set out in the Standards for preparation of supervisor of midwives [(PoSoM) NMC 2014[3]]
- Work in partnership with other agencies and promote partnership working with women and their families.

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

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

LSA MO Sue Jose:

- Abertawe Bro Morgannwg University Health Board (ABMU)
- 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 (AB)
- Cardiff and Vale University Health Board (C&V)
- Powys Teaching Health Board (PtHB)

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

Julie Richards completed her planned seconded tenure to the Welsh Government and returned to the NHS from September 2015. The LSA would wish to thank Julie for her vision and leadership during her time as LSA MO. Julie's successor to the LSA MO role is Maureen Wolfe who took up her post full time on 14th January 2016. Maureen was a full time supervisor of midwives in Wales prior to taking up her LSA MO role.

1. The delivery of effective supervision

The main purpose of statutory supervision is the protection of women, babies and their families. The Wales model of statutory supervision introduced in August 2014 ensures maternity services are meeting their statutory requirements in line with the Nursing & Midwifery Order (NMO) 2001 and the Midwives rules and standards (NMC 2012).

The Wales model is flexible and appoints supervisors of midwives dependant on the number of midwives who require supervision. SoMs in-waiting are appointed within each Health Board who will step into the role as necessary to sustain effective delivery of supervision and the statutory requirements. The SoMs are primarily dedicated to the role of supervision thereby increasing their visibility and accessibility to midwives and service users.

The delivery, achievement and assessment of risk in relation to midwifery supervision are reported quarterly to key stakeholders including the LSA Lay reviewers. A quarterly report is prepared against the key performance indicators (KPIs) 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 Annual Supervisory Review (ASR) & 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

1.1 Wider political and regulatory context of statutory supervision

In December 2013 the Parliamentary and Health Service Ombudsman[4] (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[5] presented its review commissioned by the NMC, 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 on 16 July 2015 that the government will change the legislation governing the regulation of midwives. The main effect of the changes will be to take midwifery supervision out of regulatory legislation. It is likely the new law will be passed by April 2017.

As a result of the proposed legislative change the Department of Health[6] (DoH, 2015) has produced a document, "Proposals for changing the system of midwifery supervision in the UK". This sets out the position that statutory supervision must continue in its current form until the law changes, while preparing for a future model for midwifery supervision. The future model is to be based on the principles of an overarching system of midwifery supervision to be devised and put in place when statutory supervision is removed. This will provide clinical supervision for midwives in clinical practice and peer review for midwives who are not in clinical practice. The new system will be an employer led, professional model. This would enable the NMC to focus on its regulatory function (including revalidation), to protect the public

In February 2015, the Chief Nursing Officer (CNO) convened a taskforce chaired by her Midwifery Advisor to develop a robust future model for midwifery supervision in Wales, based on the principles set out in the DoH document. The taskforce, using the foundations of the current model in Wales, are working to enhance and retain the elements of supportive supervision for midwives. It is envisaged that the SoMs of the

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

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

[6] Department for Health proposal for the changing system of midwifery regulation in the UK
https://www.gov.uk/government/publications/changes-to-midwife-supervision-in-the-uk/proposals-for-changing-the-system-of-midwifery-supervision-in-the-uk

future will promote the development of reflective practitioners who embrace their professional values in line with the Code (NMC, 2015). It is expected that the taskforce will produce initial draft models for consultation in September 2016.

1.2 SoM to Midwife Ratio

The LSA for Wales is responsible for appointing an adequate number of SoMs to ensure that all midwives practising in Wales have access to supervision. The NMC Midwives rules and standards Rule 9[7] 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.

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. The workings of how SoM to midwife ratios are calculated in Wales can be seen in appendix 1.

As of 31 March 2016, 12.6wte SoMs were in post. 1,775 midwives in Wales had notified the LSA of their Intention to Practise (ItP) midwifery in Wales during 2016 -17. Using the adjusted ratio calculation shown at appendix 1 the average all Wales ratio was 1:12.

1.3 Table 1 - Ratio of SoMs to midwives in health boards in Wales as of 31 March 2016

Health board	Midwives	SoM wte	SoM hours per month	Adjusted ratio
Abertawe Bro Morgannwg	296	2.2wte	265 hrs	1:12
Aneurin Bevan	314	2.4wte	289 hrs	1:11
Betsi Cadwaladr	388	3.0wte	337 hrs	1:11
Cardiff and Vale	275	2wte	240 hrs	1:12
Cwm Taf	200	1.2wte	144 hrs	1:14
Hywel Dda	202	1.6wte	192 hrs	1:11
Powys	44	0.2wte	48 hrs	1:22

Supervision has been provided for 56 midwives employed in education, health visiting, non-midwifery roles, independent and agency midwives as required.

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

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

The model of supervision is now embedded in practice and the resignation and de-selection of SoMs evidenced in previous years has ceased. The all Wales PoSoM course was facilitated by Swansea University which enabled the LSA to appoint a proportionate number of SoMs to the all Wales model. The PoSoM students were selected through a rigorous selection process in September 2015 (Table 2).

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

No. of SoMs	2013-2014	2014-2015	2015-2016
Appointed in year	7	16	5
Removed from post (LSA de-selection)	0	0	0
Resignation (self de-selection)	27	85	4
Suspension from role (LSA suspension)	0	0	0
Suspension from role (self suspension)	0	0	0
Commenced preparation course (September)	0 (2013)	5	6
Leave of absence	13	2	0
Total number of SoMs in post	101	16	17

1.5 Supervisor of midwives initial and continuing professional development (CPD)

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

The Preparation of Supervisor of Midwives (PoSoM) programme was provided by Swansea University in 2015-16. The PoSoM students in Wales undertake education and training at Masters level (module) to help them prepare and develop into the new role in line with the NMC standards. The core elements of PoSoM student development for the role include how to support midwives to meet their statutory registration requirements, the facilitation of ASR group supervision as a means of delivering proactive learning, governance systems, report writing and investigative skills. PoSoM students have an allocated mentor who will be an experienced SoM to shadow, support

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

and guide them through the practical day to day application of supervision during training.

The comments and feedback received from the SoMs who completed the preparation programme have been overwhelmingly positive. The LSA MOs have been active participants in the delivery of the programme until the final cohort of PoSoMs commenced their training in September 2015. The taskforce convened by the CNO will consider the education and training that supervisors of midwives will need to acquire, to deliver the re-designed role of midwifery supervision in the future.

In the interim period SoMs in-waiting have been offered three stand alone formal study days to meet their CPD requirement, and to be able to step into the role if required.

In 2015-16 a number of SoMs had the opportunity to attend events at the NMC including the strategic reference group meeting for LSA MOs, Midwifery Committee meetings and NMC council meetings. Further opportunities for development included attendance at a Royal College of Midwives (RCM) debate: Manifesto for Maternity Services, "Managing Personal Change" in partnership with the RCM, a Study Day on Compassionate Care in Midwifery, Motivational Leadership training and team coaching sessions.

Conference attendance was shared among the SoMs throughout the year and included:

- Wales Royal College of Midwives (RCM) conference
- CNO Wales conference
- Student Society conference
- British Journal of midwifery "birth choices" conference
- RCM legal birth conference
- LSA North east Conference
- Maternity Network conference.

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

The LSA and SoM team planned and delivered the "Local Supervising Authority Annual Spring Conference" on 20th May 2015. The theme of the conference was professional accountability: Using the NMC Code[9] and Revalidation[10] to support midwives; sharing

[9] Nursing and Midwifery Council (2015) The Code, Professional standards of practice and behaviour for nurses and midwives.
[10] Revalidation (2016) https://www.nmc.org.uk/globalassets/sitedocuments/revalidation/how-to-revalidate-booklet.pdf

lessons from events and good practice across Wales. The conference held at the Royal Welsh Showground in Mid Wales was a successful event attended by midwives and student midwives from across the Principality. The CNO for Wales opened the conference, followed by presentations from key stakeholders including a lay reviewer, the NMC, RCM, midwifery leaders from service and a Lead Midwife for Education (LME). A standing ovation was given to a midwife who presented her journey and experience of undergoing a recently completed LSA Practice Programme.

1.6 Mechanisms for continuous access to a supervisor of midwives

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

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

All midwives are allocated a named SoM on commencement of their employment. 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 to take on this midwife as part of her caseload by the LSA MO. All midwives and SoMs are advised that they may request to change their SoM or supervisee if the relationship is not effective for either party.

During 2015-16, 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 2015-16 every midwife practicing in Wales met this requirement. The LSA also used the database to monitor whether annual supervisory reviews (ASR) have taken place. An analysis of the LSA database is undertaken on a quarterly basis to monitor the compliance with ASRs. On the 31st March 2016 there was 100% compliance with the ASR process.

Group supervision, implemented to address the completion of all ASRs, has been an unrivalled success, winning over many midwives who were initially sceptical about the concept. Regular evaluation following each session has identified positive aspects such as learning from others, gaining an insight into the challenges faced by different staff groups, as well as providing some rich data to inform future development. This innovation in supervisory practice has also proven to be an important element of supporting revalidation.

During the year, SoMs have monthly meetings with their respective Head of Midwifery (HoM). Each quarter the meeting includes the LSA MO who report on activity against the KPIs through a quarterly monitoring report. Discussions are held around health board issues that impact on midwifery practice including midwives' compliance with NMC regulatory requirements, ongoing supervisory investigations and restoration programmes. The LSA uses the database to run reports on SoM activities enabling robust performance monitoring.

There is 24 hour access to a SoM via an all Wales on-call number (0300 062 8049), for service users and midwives, for advice on issues relating to supervision and professional standards. The all Wales on call rota continues to be effective. The trends and themes of calls are collated into six monthly audit reports which are then reviewed at the monthly SoM performance meeting and shared with all HoMs. An addition to the on-call template is the request for callers to be contacted at a future date and time for audit purposes, to monitor the effectiveness of the on call advice and service provided. A further development of the on-call template is to ask service users their preferred language of Welsh or English for communication with the LSA to manage their contact. There are currently five supervisors of midwives who can speak Welsh. If a caller would prefer to converse and communicate in Welsh an offer is made to return the call within forty eight hours.

The SoMs are 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 is on the whole positive. The LSA MOs have received one piece of negative feedback and work is being undertaken to address the issues identified. The students have the opportunity to attend group supervision sessions, record keeping tea parties and discussions on professional standards and revalidation requirements.

LSA MOs hold monthly performance management meetings with SoMs from across Wales. The meeting is chiefly concerned with managing the compliance with the KPIs set out in the service specification, and provides SoMs the opportunity to develop team working and to utilise the supportive network that the All Wales SoM team provides. As a result of the success of group supervision for midwives, the SoMs have included action learning sets into alternate all Wales meetings for shared learning and team building.

1.7. Overview of LSA audit activity

The NMC Quality Assurance Framework[11] is the process by which the NMC ensures that LSAs continue to meet the rules and standards. The Quality Assurance Framework

[11] The NMC Quality Assurance framework

provides a structured means of reviewing a LSA in order to demonstrate the effectiveness of statutory supervision of midwives and good practice whilst highlighting areas of concern. NMC reviews take account of LSA self-reporting and factor in intelligence from a range of sources which can shed light on potential risks associated with midwifery supervision.

In 2015-16, LSAs were selected for review by the NMC based on concerns raised in quarterly reports submitted to the NMC, or via exception reporting by an LSA MO. Although there were no concerns raised within the quarterly reports in Wales in 2015-16, an exception report was submitted for Betsi Cadwaladr University Health Board[12] (BCU) in June 2015. As a result, an NMC review was held in July 2015 over a period of three days and the programme was based on rules four, six, seven, eight, nine, ten and fourteen from the Midwives rules and standards (2012). The NMC review team report how the LSA, under scrutiny, has performed against key risks identified at the start of the review cycle. Standards are judged as 'met', 'not met' or 'requires improvement'. When a standard is not met an action plan is formally agreed with the LSA and is delivered to an agreed timeframe. Two standards were determined by the NMC as not met;

- Rule 7- The LSA had not completed an annual audit of supervision at that time
- Rule 9- ASR compliance was 97%, not the required 100%.

In response to the NMC extraordinary review, a full audit programme was planned for the seven health boards in Wales through October and November 2015. The template for the LSA audit programme was a mirror of the extraordinary review template; to gain assurance all health boards were meeting the NMC standards for the provision of statutory supervision. The full report for each health board can be found on the Healthcare Inspectorate Wales website[13].

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https://www.nmc.org.uk/globalassets/sitedocuments/edandqa/nmc-quality-assurance-framework.pdf?_t_id=1B2M2Y8AsgTpgAmY7PhCfg%3d%3d&_t_q=quality+assurance+framework&_t_tags=language%3aen%2csiteid%3ad6891695-0234-463b-bf74-1bfb02644b38&_t_ip=46.254.200.2&_t_hit.id=NMC_Web_Models_Media_DocumentFile/_545731fd-0c8e-449e-bd8d-dfea109d162f&_t_hit.pos=1

[12] Extraordinary LSA review Healthcare Inspectorate Wales, LSA within Betsi Cadwaladr University Health Board https://www.nmc.org.uk/globalassets/sitedocuments/midwiferyextraordinaryreviewreports/2015/extraordinary-lsa-review-of-performance---hiw-english.pdf?_t_id=1B2M2Y8AsgTpgAmY7PhCfg%3d%3d&_t_q=extraordinary+review&_t_tags=language%3aen%2csiteid%3ad6891695-0234-463b-bf74-1bfb02644b38&_t_ip=46.254.200.2&_t_hit.id=NMC_Web_Models_Media_DocumentFile/_bc9fee6f-c1d4-4365-8f80-1fb77dc205c5&_t_hit.pos=8

[13] Healthcare Inspectorate Wales Website
http://hiw.org.uk/reports/lsareports/?lang=en

The SoM team in BCU achieved and maintained 100% compliance for completion of midwives ASR from August 2015 to the time of completing the annual report.

The Monitoring and Evaluation Group for the Wales model of supervision continued until December 2015. The decision was made at that point to focus on the All Wales taskforce, working toward the transition from statutory supervision to an employer led model. The monitoring and evaluation of the KPIs has continued on a quarterly basis with the preparation of a report for dissemination to key stakeholders. A lay reviewer has been invited to the All Wales SoM monthly meetings in July, October, and January 2017 to receive the quarterly monitoring feedback report.

1.8 Summary of public protection, context and findings

The strategic role of HIW LSA is to set the direction of the supervision of midwives in line with the midwives rules and standards (NMC, 2012). The audit findings demonstrate that the HIW LSA have ensured that there are systems and processes in place to monitor the performance of the SoMs and practising midwives throughout Wales to assure public protection. The audit process measured the provision of supervision in Wales against the seven relevant rules from the Midwives rules and standards (2012).

1.9 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 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 attending notes audit tea parties and during their third year of training attending a group supervision session as an observer.

KPI 5, within the Service Specification, concentrates on the contact between SoMs and students, meeting in excess of the minimum requirement within the Midwives rules and standards Rule 9 1.1.2[14]. This closer contact with student midwives has enabled SoMs to monitor concerns within the clinical environment which could have had an adverse effect on the student training programme. The LSA was made aware of such a concern

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

raised by students through their AEI. Following the extraordinary review of the AEI education provision and BCUHB learning environment in July 2015, student midwives were removed from hospital placements in Ysbyty Glan Clwyd and were redeployed to the community and other maternity units within the health board.

SoMs will continue to provide support to newly qualified midwives as they experience their first year as registered midwives. KPI 6 requires a SoM to meet 100% of newly qualified midwives at least twice within six months and three times by 12 months to agree and monitor their preceptorship programme.

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. The LMEs and the Senior lecturer responsible for the Preparation of student SoMs were represented on the LSA Monitoring and Evaluation group and more recently on the taskforce group.

2. LSA lay reviewers annual report for 2015-16

The work of the lay reviewers in 2015-16 has focused on the following key areas:

- Auditing of midwifery supervision within Health Boards
- LSA MO and SOM recruitment
- Participation in the All Wales Monitoring and Evaluation Group
- Participation in the Maternity Network Women's Forum
- Representation on the taskforce group working toward the new model of non statutory midwifery supervision
- Attending and presenting at the LSA Spring Conference in 2015.

This work has seen the lay reviewers' role evolve from one traditionally focused on the experience of service users to a more strategic role, focused on all aspects of midwifery supervision.

<u>The audit process</u>

During the 2015-16 audit visits, the lay reviewers aimed to follow up on the findings of the 2014-2015 audits which looked at 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.

On the majority of audit visits, the lay reviewers found awareness of supervision among service users remained low with most being unaware of the term; however, service users in two health boards had improved levels of awareness than previously found. The lay reviewers did not audit the experiences of women who had contacted a supervisor during this audit, however they did find evidence from SoMs themselves and from a Maternity Service Liaison Committee (MSLC) chair, that SoMs are meeting with women to discuss their needs and concerns.

In terms of accessibility, during the 2015-16 audit visits, the lay reviewers found that information about supervision was publicly available in all areas of maternity services. Some of the information given was, however, out of date or incorrect. Lay reviewers made calls to the switchboards of all health boards to ask for the 24-hour on call number. In several cases incorrect information was given and it was felt awareness training of switchboard staff was needed. Similarly, information on health board websites was not always easy to access and was in some cases, incorrect.

One of the key focuses of the 2015-16 audit was group supervision and following up on challenges identified during the previous audit; namely, ensuring a consistent approach and making sure all midwives were able to attend the sessions. The lay reviewers also obtained feedback from midwives about group supervision. The audit visits found that the majority of midwives spoken to had attended an annual supervisory review within a group supervision session within the past 12 months. On the whole, the feedback received indicated that midwives preferred the new model of group supervision to the previous one-to-one meetings. Midwives cited the opportunities for shared learning and greater understanding of their colleagues' roles as well as the chance to share concerns.

Revalidation

Overall, lay reviewers found there was a good awareness of the revalidation process and the new portfolio requirements.

Lay reviewer participation in the Betsi Cadwaladr Extraordinary NMC visit

In July 2015, as part of the unscheduled NMC visit to the BCU health board, a lay reviewer was requested to be interviewed by an NMC lay reviewer. The interview took place over the telephone and included discussions about the lay reviewers' involvement in audit activities over the previous 12 months.

All Wales Monitoring and Evaluation Group

The lay reviewers continued to participate in and contribute to the All Wales Monitoring and Evaluation Group (Which was set up to oversee the performance of the Welsh supervision model against KPIs). In light of the move to non-statutory supervision, the group met for the final time in July 2016, as this meeting was superseded by the taskforce meetings. Lay reviewers were invited to attend the taskforce and SoM meetings in the interim period, to review performance of supervision in Wales and to inform the new model.

Maternity Network Women's Forum

The network was established with the aim of standardising maternity services across Wales, focusing on quality, safety and the experiences of service users. One of the main aims of the Network is to establish an All-Wales women's forum. In November 2015 an event was held to discuss how such a forum could enable women's voices to help shape maternity services in Wales. A lay reviewer attended the event alongside MSLC chairs and other key stakeholders, including the LSA and Welsh Government. Ideas were shared about the challenges, opportunities and practicalities of setting up a forum. The lay reviewer present was able to share information about the lay reviewer team's role during discussions about lay participation in national groups and forums.

Recruitment

Lay reviewers took part in the recruitment process for a new LSA MO and for prospective SoMs. This provided the opportunity to help assess the candidates from a lay, service user perspective.

LSA Spring conference 2015

The LSA Spring Conference 2015 was an opportunity for the lay reviewers to present the qualitative data gathered in the previous year's audit, with a special emphasis on service users' perspectives on the role of supervision of midwives. A number of participants asked questions about this area of the lay reviewer team's work and commented that they had benefited from hearing this perspective.

Lay reviewer participation in discussions relating to the future of supervision

More recently the lay reviewers have contributed their perspective to discussions about the future model for non-statutory supervision in Wales. A member of the lay reviewer team was invited to take part in the taskforce group set up to explore the idea of a mandatory supervision model in Wales, led by the Midwifery Advisor to the Chief Nursing Officer. As those involved in the taskforce were primarily looking at the model from a clinical perspective, the lay reviewers felt it was important to look at the model from the point of view of service users. With this in mind, the lay reviewers considered the draft supervision model proposal in detail and put together their initial comments for presentation to the taskforce.

Going forward

Having played an active role in so many different aspects of the LSA's work, the lay reviewers look forward to continuing their work until the expected end to statutory supervision in March 2017. In the months ahead they will take part in the final round of the LSA audit of supervision in the health boards, building on the findings of their previous audit. They will also continue to be involved in contributing their thoughts and ideas on proposals for the new model of supervision in Wales from a lay perspective.

3. National and local policies related to supervision

3.1 National

During 2015-16 the LSA MO Forum UK reviewed and updated all of their national policies and guidelines. 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 national policies and guidelines are published on the LSA MO Forum UK website[15].

3.2 Local

The LSA has updated the investigation workbook and restoration programmes to ensure compliance with the Code (NMC, 2015).

Further updates in 2015-16 include a Standard Operating Procedure for the intention to practice process, which has been developed for agency midwives who provide midwifery care in North Wales.

4. Ensuring investigations into sub-optimal practice are undertaken

A supervisory investigation may be 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 are called into question.

All serious clinical incidents are subject to a supervisor of midwives case review. The SoM will record the case review using a SBAR[16] format, or the LSA UK Forum case review template, whichever they consider is appropriate to capture information pertinent to the incident.

The SoM will assess if the incident should be escalated to the LSA using the 'LSA Incident Reporting Trigger List'. All incidents reported in line with the incident reporting trigger list require completion of the Local Supervising Authority Midwifery Officers Forum UK "Decision Tool Kit". The tool kit enables 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 will refer and discuss the incident with the LSA MO who will consider if a full external supervisory investigation in line with Local Supervising Authority Midwifery Officers Forum UK guidance is required. Supervisory investigations within Wales are conducted by a

[15] Local supervising Authority Midwifery Officer s Forum website; http://www.lsamoforumuk.scot.nhs.uk/

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

supervisor of midwives not employed by the health board in which the investigation will take place to provide a level of external scrutiny to the process.

Forty investigations were formally notified and commenced within the LSA in 2015-16 compared to the previous year's figure of 42. All 40 investigations were conducted in line with Local Supervising Authority Midwifery Officers Forum UK guidance.

Completion of the investigations in line with the 45 working days recommended by the LSA MO Forum UK guidance has proved a challenge throughout the 2015-16 period. Of the 40 investigations undertaken 46% were completed within the 45 day time frame. As a result of the failure to comply with the 45 day recommended time frame across the UK, the LSA MO Forum UK has concluded that the target set is unrealistic and have increased the timeline to 60 days from 2016. The LSA in Wales will re-structure 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.

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. All delays in report completion are unacceptable as it delays restorative action for midwives involved. The LSA will continue to monitor and scrutinise the timeliness of investigations and conclusion to assist effective restoration where required.

At the conclusion of an investigation, the investigating SoM will present an investigation report to the LSA MO. There are four possible outcomes for a midwife following investigation, as stated in the Midwives rules and standards (NMC 2012)[17]. The LSA MO must agree the outcomes reached by the investigating SoM. In 2015 -16, the outcomes of the investigations conducted were;

- No action for 34 midwives,
- Local action plan (LAP) for 59 midwives
- LSA practice programme (LSA PP) for 3 midwives
- Referral to the NMC for 2 midwives

In this reporting year, two midwives were suspended from practice[18] by the LSA and referred to the NMC as a result of significant deficits in their fitness to practice. One of the suspensions was not upheld by the NMC who placed a “conditions of practice order” for the midwife to undertake a LSAPP. The midwife’s employing organisation did not

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

[18] Rule 14 of the NMC Midwives rules and standards (2012)

support the midwife to undertake a programme and the midwife elected not to seek to undertake a programme external to her employing health board.

The following table contains the themes and trends identified and the number of investigations the identified theme or trend was present, from investigations completed in 2015-16

Table 3. Investigation themes and trends April 2015- March 2016

Theme	Number of Investigations
Record keeping not to standard of the Code (2015)	**20**
Failure to interpret CTG	**9**
Failure to auscultate the fetal heart (FH) in line with best practice	**2**
Failure of communication within the team	**12**
Failure to escalate concerns	**10**
Failure to recognise deteriorating condition of woman	**5**
Failure to follow National/Health Board guidance	**6**
Failure to refer woman for Obstetric review	**4**
Medicines management	**3**
Clinical incidents (various)	**11**

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

It remains the standard for the LSA to involve women and their families as fully as possible with the LSA investigation process. SoMs will write to women at the outset of an investigation to provide information on the investigation and invite their participation. This is in line with the NMC Duty of Candour[19] (2015) standard, introduced as a response to the Francis report[20] (2013).

[19] 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-of-candour.pdf

[20] 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

4.1 Improving the supervisory investigation process

As previously stated the issue of timeliness of investigation process is not specific to Wales, therefore the decision to increase an investigation timeline to 60 days was introduced by the LSA MO Forum UK in 2016.

The increase in administrative support available to the LSA from March 2016 will improve the level of support SoMs will receive to undertake their interviews and support the monitoring of the investigations through improved monitoring of the local workbook for investigation process. The monitoring will be managed using a Red Amber Green (RAG) rating as follows:

- Green - draft report expected at 30 days
- Amber - a second draft/near completion likely to exceed 45 days
- Red - final report expected to exceed 60 days.

The LSA will not allocate investigations to SoMs without access to the relevant I.T. systems or equipment, when stepping into the role from their substantive post. A further development to support management of investigations is the creation of a file specifically for the storage of all documents, (letters, templates, transcripts), relating to investigations to ensure SoMs can easily access and share information across a secure system with the administrative support team.

The LSA will invest in further training and education for investigation process and report writing in July and September 2016 and has undertaken a workshop in April 2016 to discuss, share and highlight issues for completion of investigations among the team.

Communication within the investigation process is vital to success. As all supervisory investigations in Wales are conducted by a SoM external to the health board where the incident/concern has been raised it is imperative that both external and local SoMs are clear of their responsibility during the process. Peer review of reports is essential prior to submitting to the LSA. Peer review can be a useful learning tool while testing the readability and testing of the findings.

The LSA MOs are clear that where appropriate, the local SoM can support reflection and learning for a midwife who has identified shortfalls in their own practice, prior to conclusion of the investigation.

In the future, wherever possible SoMs will conduct the supervisory investigation in tandem with any management process, albeit retaining the impartiality of the supervisory process.

4.2 Complaints in relation to the discharge of the supervisory function

Complaints against the LSA and or LSA MOs are dealt with in accordance with the Welsh Government's complaints procedures or through the LSA appeals process as appropriate. The process of dealing with complaints and appeals is described in the LSA MO Forum UK policy[21], Complaints against a supervisor of midwives or LSA Midwifery Officer. The LSA received one formal complaint in 2015-16 regarding the outcome of a supervisory investigation. The LSA appeals process has been followed and remains ongoing at the time of writing this report. The Legal Department of the Welsh Government are assisting with this case due to requests for the statements and transcripts of witnesses involved in the investigation.

Two informal complaints were raised with regards to the supervisory investigation process and these were resolved following meetings between the midwife, their staff side representative, SoM and LSA MO.

5. Notable and Innovative Practice

Aspects of the Wales model for supervision have been recognised as good practice.

The All Wales SoM team have developed an All Wales Preceptorship Passport, in order to support newly qualified midwives within their first year of practice following transition from student to midwife. The document has been introduced across Wales and encompasses both clinical and self development for the knowledge and skills required of a midwife in practice in the NHS today.

An all Wales task and finish group was convened to develop a revised Annual Supervisory Review document to support midwives toward Revalidation with the Nursing and Midwifery Council (NMC). The document includes all the information a midwife is required to prepare in order to meet the revalidation requirement for a three year period. The inclusion of a midwife's employing health board annual organisation performance review template, allows for the completion of the separate processes while preventing duplication for shared professional standards monitoring. The document was commended during the recent NMC review visit to BCU.

Both of the documents indicated above have been endorsed for use across Wales by the Heads of Midwifery Advisory Group (HoMaG) and have been implemented into all health boards in 2016.

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[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

Group Supervision is now firmly embedded across Wales. Midwives have evaluated group supervision as an effective development for the sharing of best practice. In 2014 HIW funded a small scale evaluation of group supervision, carried out by Professor Susanne Darra from Swansea University. Professor Darra and two full time SoMs from BCU published papers in the British Journal of Midwifery in March and April 2016 which have been widely circulated across the UK. The Health Minister in Wales has cited the success of group supervision in the Welsh Government Green paper "Our Health-Our Health Service" with a view to its likely benefit if available for all registered health professionals in Wales.

The RCM and LSA have worked in partnership to deliver leadership study days "Managing Personal Change" for RCM representatives, SoMs, and senior midwives. The events were a great success and enjoyed by all who attended.

Lay reviewers during the LSA audit process for 2015-16 focused on the 'testing' of midwives awareness and preparation for the Revalidation process. A positive response was received providing assurance that midwives are in the main Revalidation ready.

Two SoMs presented a poster to showcase the success of their "record keeping tea parties" at the CNO conference in 2015. The poster was well received.

5.1 Sharing good practice

The following initiatives have been introduced by SoMs;

- SoMs provide the Head of Midwifery, Senior Midwives and Midwives a themes and trends report from the ASR process maintaining midwives' confidentiality where appropriate
- SoMs provide a summary of all incidents and lessons to be learnt from SoM investigations on a monthly basis to the leads from each Health Board.
- SoMs have been instrumental in the creation of the All Wales Preceptorship programme
- SoMs have fostered a robust link between the SoM team and governance forums
- SoMs have effective links/visibility with Universities around Wales and regularly attend training sessions specific to Supervision and professionalism
- SoMs continue to provide effective engagement with newly qualified midwives, offering an ongoing group supervision session throughout the year
- Health Board website pages relating to Supervision are much more focused on

information appropriate to a woman and her family and provide the correct on-call number

- ABMU SoMs have devised a session for the annual mandatory training which involves the midwives in attendance reviewing a complaint or concern to demonstrate how the lessons learned link to the NMC Code (2015). This initiative has been recognised as a valuable learning tool that should be shared with midwives across Wales
- ABMU SoMs have devised a visual reference checklist on the lessons to be learnt from the Kirkup Report[22] (2015) toward assurance that the same issues did not apply locally. This was recognised as being a simple method of quickly conveying the key messages of the report
- AB SoMs have played a central role in the Nursing and Midwifery Council Pilot project for Revalidation. Their contribution through group supervision of portfolio creation and development and explanations of the requirement to revalidate has prepared midwives for the transition. The AB SoMs have shared their learning with the All Wales team to cascade the learning across the country
- The AB SoM team has been nominated as Health Board team of the year 2015
- BCU SoM team have been instrumental in the development of "Notes Audit tea parties" across Wales. The other Health Boards are modelling their annual note audit process on this innovation
- C&V contributed to a project to streamline care for women receiving elective caesarean sections to improve quality and safety and patient experience
- CT initiative to implement a Vaginal Birth After Caesarean (VBAC) clinic at both CT maternity service hospital sites led by SoM team.

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

- Full time SoM from Yorkshire and Humberside attended BCUHB to shadow a full time SoM in Wales (July 2015)

[22] 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.pdf

- SoMs presented the concept of group supervision to the Head of Midwifery and SoM team in Oxford (August 2015)

- LSA MO and SoM shared the model of group supervision and discussed the process and documentation with Highland SoMs with a video conference to Scotland (August 2015)

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

6.0 Key issues for the LSA in 2016-17 and looking to the future

Without doubt the biggest challenge to the provision of statutory supervision across the UK will be to sustain the momentum and commitment to the role whilst the NMC resolves the planned legislative changes. The LSA in Wales believes it is in a strong position to ensure the continuing quality of the delivery of supervision within the current statutory framework.

The LSA in Wales has a number of key priorities for the remainder of the time for the statutory function and include;

- Continued partnership working with the LSA MO Forum UK and NMC to set the strategic professional agenda for the transition of supervision during legislative change
- Continued partnership working and effective communication with the Head of Midwifery in each health board, the Lead Midwives for Education and Royal College of Midwives throughout the transition period
- Continued partnership working with the Maternity Network to support the delivery of evidenced based midwifery practice
- Maintain robust succession planning for supervisors of midwives following cessation of the preparation of supervisors of midwives (PoSoM) education
- Full participation with the CNO taskforce to transition midwifery supervision to an employer led model with a focus on midwifery development and support
- Prepare for the transition to the new model for supervision, with closer links to employment led governance systems and processes for investigating midwifery practice issues and preparing restoration plans for continuation beyond April 2017.
- Continue to plan and work with the LSA lay review team for the 2016-17 audit cycle with an emphasis on transition and preparation for change.
- Plan a standardised approach to delivering SoM lectures within the AEI for Student midwives
- Ensure continued provision for service users access to SoMs

- Ensure archiving of all SoM records related to the investigation process and restoration are achieved within Welsh Government for the required 25 year timeframe.

The LSA looks forward to working with all our colleagues towards the aim of securing a future for midwifery supervision that is meaningful and supportive for midwives to promote professional standards that will enhance public protection.

The LSA would wish to thank all stakeholders for their ongoing and continued support to date.

Appendix 1- SoM Equivalent Ratio in Wales

Traditional model

1786 midwives = 1:15 ratio
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116 SoM

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

New model

1,950 SoM hrs per 52 Week year - 26% headroom = 1,443hrs actual hours worked per WTE SoM x 12.6 WTE SoMs = 18,181hrs per yr ÷ 12 mths = 1,515hrs of supervision per month

1,515 ÷ 10.5 hrs = equivalent of 144 SoMs

1730 midwives ÷ 144 SoMs = adjusted ratio of 1:12

Table 1 - Health Board Specific Calculations Updated - Q4 2015-16

Health board	Midwives	SoM wte	SoM hours per month	Adjusted ratio
Abertawe Bro Morgannwg	296	2.2wte	265 hrs	1:12
Aneurin Bevan	314	2.4wte	289 hrs	1:11
Betsi Cadwaladr	388	3.0wte	337 hrs	1:11
Cardiff and Vale	275	2wte	240 hrs	1:12
Cwm Taf	200	1.2wte	144 hrs	1:14
Hywel Dda	201	1.6wte	192 hrs	1:11
Powys	44	0.2wte	48 hrs	1:22

ABMU

1443hrs x 2.2wte = 3175hrs per yr ÷ 12mths = 265hrs per month
265 ÷ 10.5 = equivalent of 25 SoMs
296 ÷ 25 SoMs = adjusted ratio 1:12

Aneurin Bevan

1443hrs x 2.4wte = 3463hrs per yr ÷ 12mths = 289hrs per month
289 ÷ 10.5 = equivalent of 28 SoMs
314 ÷ 28 SoMs = adjusted ratio 1:11

BCU

1443hrs x 3wte = 4329hrs per yr ÷ 12mths = 361hrs per month
361 ÷ 10.5 = equivalent of 34 SoMs
388 ÷ 34 SoMs = adjusted ratio 1:11

Cardiff and Vale

1443hrs x 2.0wte = 2886hrs per yr ÷ 12mths = 240hrs per month
240 ÷ 10.5 = equivalent of 23 SoMs
275 ÷ 25 SoMs = adjusted ratio 1:12

Cwm Taf

1443hrs x 1.2wte = 1732hrs per yr ÷ 12mths = 144hrs per month
144 ÷ 10.5 = equivalent of 14 SoMs
200 ÷ 14 SoMs = adjusted ratio 1:14

Hywel Dda

1443hrs x 1.6wte = 2308hrs per yr ÷ 12mths = 192hrs per month
192 ÷ 10.5 = equivalent of 18 SoMs
201 ÷ 18 SoMs = adjusted ratio 1:11

Powys

1443hrs x 0.2wte = 289 per yr ÷ 12mths = 24hrs per month
24 ÷ 10.5 = equivalent of 2 SoMs
44 ÷ 2 SoMs = adjusted ratio 1:22