Review of University Hospitals of Morecambe Bay NHS Foundation Trust

Date of review: 18-20 July 2011
Date of report: 11 October 2011
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Introduction

We are the nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands. We exist to safeguard the health and wellbeing of the public. We set standards of education, training, conduct and performance for nurses and midwives and the Local Supervising Authority (LSA). We establish standards for the exercise by LSA’s of their functions and may give guidance to LSA’s on these matters.

We hold the register of nurses and midwives who have qualified and meet our standards. We provide guidance and advice for nurses and midwives, and we have clear and transparent processes to investigate and deal with nurses and midwives who fall short of our standards. We may inspect the premises where midwives practise to monitor standards and methods of practice and to inspect records.

Role of the LSA in protecting the public

LSAs are organisations that hold statutory roles and responsibilities for supporting and monitoring the quality of midwifery practice at a local level. This is done through the mechanism of statutory supervision of midwives which is delivered in line with the standards we set. The LSA has a pivotal role in clinical governance and a responsibility to ensure there is a local framework to provide equitable, effective statutory supervision for all midwives. The primary responsibility of an LSA is to safeguard and protect the public.

LSAs sit within strategic health organisations, and the type of organisation varies in each country of the UK. The chief executive of the authority is responsible for the LSA. In England, the LSAs sit within the Strategic Health Authority (SHA); in Wales, the Healthcare Inspectorate Wales; and in Northern Ireland, it is the Public Health Agency. In Scotland, the functions of the LSAs are provided by the health boards which are arranged into three regions: the North of Scotland, the South East of Scotland and the West of Scotland. As of 1 April 2010 there were 26 LSAs across the UK with 16 appointed local supervising authority midwifery officers (LSAMOs).

Each LSA must appoint a practising midwife to the role of LSAMO who is responsible for exercising its function in relation to supervision of midwives. We set the statutory requirements of the LSAMO role, and these requirements cannot be delegated to another person or role. The LSAMO has a pivotal role in clinical governance by ensuring that the standards for supervision of midwives and midwifery practice meet our requirements.

The LSAMO has a professional leadership role, and discharges the LSAs’ responsibility for the protection of women and babies by influencing both the quality of the local midwifery services, and also the wider NHS agenda. Safety for mothers and babies can only be achieved if local trusts, health boards and health authorities are engaged with the supervision framework, and act on maternity matters brought to their attention by the LSAMO.

To support us in monitoring LSAs and obtaining assurance that our standards are being met, an LSA review process is in place which includes reviewing every LSA on a two to
three-year cycle. There is a standardised review process to ensure consistency and equity for all LSA reviews across the UK. The North West LSA is scheduled for review at the end of October.

Every LSA provides us with a quarterly, quality monitoring report to verify that the LSA is meeting the required standards and to enable review of any concerns that may impact upon the safety of women and their families. This will include a review of key themes highlighted by us for investigation and if necessary verification in relation to the Midwives rules and standards (NMC 2004). The quarterly monitoring report is both formative (an aid to development) and summative (a check that the required standards are being met).

Additionally, under Rule 16 of the Midwives rules and standards LSAs are required to produce and submit an annual report to the NMC’s Council containing detailed information and analysis relating to the activity of the LSA and supervisors of midwives. These are published on our website www.nmc-uk.org

The review of University Hospitals of Morecambe Bay NHS Foundation Trust was conducted by the Nursing and Midwifery Council (NMC) and the Care Quality Commission (CQC) over a period of three days 18, 19 and 20 July 2011.

It was an unannounced visit and followed a number of concerns and complaints regarding midwifery practice and the supervisory activities at the University Hospitals of Morecambe Bay Trust which were raised from a member of the public. These resulted in meetings with the bereaved family and the North West Local Supervising Authority.

We note there have been a number of internal and external investigations undertaken by the local supervising authority and the trust which have resulted in recommendations and action plans. These will be followed up by the relevant bodies that requested them.

Both the Health Care Commission and more recently the Care Quality Commission have been monitoring the work of the strategic health authority in relation to the action plans from their reports.

There has been a recent coroners case (June 2011) which raised a number of actions under Rule 43 Coroners Rules (1984) concerning the standards of midwifery practice.

The ombudsman had also been involved in reviewing the standards of supervisory activity at the Trust and the role of the local supervising authority.

A separate NMC Quality Assurance review will be undertaken on 18 October to review the standards for pre-registration midwifery students by the Trust and its education providers.

The trust provides midwifery care in a range of settings, within two acute units, Furness General Hospital and the Royal Lancaster Infirmary, a midwife led unit at Kendal and community settings.
Following discussion with colleagues at the [Care Quality Commission](https://www.cqc.org.uk) (link to report) it was agreed to undertake a joint review in order to minimise the disruption to the services that such an event causes.
Executive summary

This review has been conducted jointly between the NMC local supervising authority (LSA) review team and the CQC. The NMC LSA review team considered whether the supervision of midwives was meeting the required NMC standards within University Hospitals of Morecambe Bay NHS Foundation Trust.

Supervisors of midwives (SoMs) are experienced practising midwives who are appointed by the LSAMO for a specific LSA after completing additional education and training through a preparation of supervisors of midwives (PoSoM) programme. Following appointment to the role, they are accountable to the LSA for their supervisory activities, not their employer. The SoM provides support, advice and guidance to women and midwives 24 hours a day to increase public protection. Every qualified midwife will have a named SoM who will offer guidance and support in developing skills and expertise throughout their career. The SoM has a duty to bring to the attention of the LSA any practice or service issue which may affect midwives’ ability to care for women and their babies, and could directly impact on the safety and protection of the public.

They protect the public through the support they provide to midwives to ensure that the care offered is safe and appropriate for the mothers and their babies in their care.

They act as positive role models for midwives, guiding and supporting them in their personal and professional development as well as developing additional skills and expertise specific to their role. If a midwife requires additional education, training and support in practice, a supervisor would be expected to recommend a formal programme of supervised practice.

SoMs can directly support women by advocating about any concerns a mother may have about the care she received or her experience giving birth. They will also provide advice and support to a mother and her midwife about care choices and promote safe practice to ensure the best possible outcome for the mother and her baby.

SoMs have the authority to investigate concerns relating to health, competence, behaviour or misconduct of midwives. They will also address issues such as staff attitudes and behaviour. Supervisors can implement remedial action through supervised practice or referral to the LSA and the Nursing and Midwifery Council.

All nurses and midwives have a professional duty to report any concerns from the workplace which put the safety of the people in their care or the public at risk. We would expect SoMs to lead by example and consider and act on any issues that may put mothers and babies at risk and take appropriate action.

Effective supervision is demonstrated by strong leadership, effective risk management, appropriately raising concerns and challenging poor and ineffective policies and practice.
We would expect the LSAMO to ensure that the statutory role of supervision is represented from board level to ward level. This should include making sure expectant mothers understand how supervision supports them to have a safe birth experience.

We were concerned to note a culture at Furness General Hospital Maternity Unit of supporting midwives and past midwifery practice, rather than focussing on what needs to be done to fulfil the primary purpose of supervision which is protecting mothers and babies. This culture was not found at Kendal maternity led unit or at Royal Lancaster Infirmary. Neither was this evident in the attitudes of senior midwives who work across the sites. Our concerns have been raised with the LSAMO who is now taking steps to address these through the action plan (Annexe 2).

The profile, activities and value of statutory supervision of midwives needs to be raised both within University Hospitals of Morecambe Bay NHS Foundation Trust and to users of the maternity services. Additionally supervisors need to ensure that risks and concerns that are raised through the supervisory framework are appropriately discussed and actioned through robust trust governance processes and where appropriate, reflected on the maternity risk register. The NMC will be seeking to raise awareness of midwifery supervision and how supervisors can support mothers through the distribution of Support for parents, How supervision and supervisors of midwives can help you.

We would expect that the LSAMO will support the supervisors of midwives to address the issues and recommendations that we have identified within our report and provide advice to inform the maternity risk strategy in regard to statutory supervision. Additionally, we would like to see rotation and succession planning for the role of the contact supervisor.
Overview

This review considered how the statutory function of the NMC *Midwives rules and standards*, *The code: Standards of conduct, performance and ethics for nurses and midwives* (the code) and the standards relating to the practise and supervision of midwives is reflected within the organisation in safeguarding the health and wellbeing of the public.

The report identifies a number of areas for improvement and includes action plans with a total of 19 recommendations for the Trust board, the local supervising authority and the supervisors of midwives. The recommendations address concerns about Trust policies and procedures relating to governance, risk management, collaborative working and leadership which are integral to ensuring high standards of safe and effective care.

The report also recognised areas of effective practice, and notes the actions that have been taken since the review and have been implemented to improve the quality of care provided to mothers and babies.

The areas of improvement and associated recommendations are underpinned by the code and the *Midwives rules and standards* (2004).

The review team engaged with the staff and patients in University Hospitals of Morecambe Bay NHS Foundation Trust. We would like to thank all those who participated and their willingness to share information and engage with the process necessary for our review.
Summary of Recommendations

There are six recommendations for the board of directors of University Hospitals Morecambe Bay NHS Trust

To ensure good governance practices by having an effective database for the management and review of all maternity guidelines including the process for uploading to the intranet.

To actively seek out ways to ensure that midwives and medical teams, users, supervisors of midwives and senior management in University Hospitals of Morecambe Bay NHS Foundation Trust work collaboratively and effectively for the benefit of mothers and their babies. Such initiatives need to be monitored closely and embedded within the local policies and procedures in the Trust.

It is important to identify opportunities to develop a proactive solution focused approach with midwifery and medical teams, users, supervisors of midwives and senior management in to address common issues.

To ensure that the purpose of the maternity risk register is disseminated to clinical staff and that access to the live register is appropriately facilitated to support midwives to effectively manage risks associated with individual mothers and babies either directly relating to their care or to the care environment.

To gain agreement for trust wide maternity guidelines in order to ensure a consistently high level of practice and expected standards of attitudes and behaviour. This requires robust approval processes for policy and guideline control which should clearly state the way in which all maternity guidelines are managed. The Trust board must ensure that these policies and guidelines are used and are embedded in practice.

For University Hospitals of Morecambe Bay NHS Foundation Trust to provide safe and secure storage for all maternity records at the FGH site to protect the confidentiality of mothers and babies which midwives are expected to do within the code.

To provide privacy and dignity for women and babies at Furness General Hospital (FGH) who require emergency transfer to and from theatre from the delivery suite. Under the code, midwives are expected to respect the dignity of those in their care. To monitor the ongoing measures to mitigate the situation until a permanent solution is found.

There are two recommendations for the North West Local Supervising Authority

There needs to be annual rotation of the role of the contact supervisor of midwives.

For the LSAMO to provide guidance to strengthen and clarify the role of the LSA and the supervisor of midwives in University Hospitals of Morecambe Bay NHS Foundation Trust maternity risk management strategy.
There are 11 recommendations for the supervisors of midwives

When acting in their capacity as a supervisor of midwives, the supervisors are expected to clearly delineate their role as a supervisor from their substantive role, demonstrating how their expert knowledge of supervision and clinical practice protects the public. Supervisors of midwives need to ensure that risks and concerns that are raised through the supervisory framework are appropriately discussed at trust governance level and where appropriate, reflected on the maternity risk register.

To review the current draft maternity risk management strategy with the support of the LSAMO to clarify and strengthen the role of the LSA and the supervisor of midwives in line with the NMC *Midwives rules and standards*.

For supervision to demonstrate strong leadership by effectively managing risk and protect the public in producing intelligence and disseminating learning from serious incidents and to work collaboratively to enact any learning requirements or system changes necessary to improve practice.

The strategy and activities for supervision need to clearly reflect the primary importance of protection of the mother and baby as well as the proactive supportive role of the supervisors to midwives.

Supervisors need to consider how they identify and appropriately challenge processes and practices if they do not meet best practice guidance in order to proactively protect the public and set a positive cultural example of raising and escalating concerns.

For supervisors of midwives to demonstrate strong leadership by actively seek opportunities to engage with the trust board, senior trust colleagues and with the public using maternity services.

Supervisors need to effectively manage their identified time and to appropriately raise a concern if there is insufficient time to effectively undertake the role.

The strategy for supervisors should reflect the need to support medical staff and midwives to work collaboratively in order to provide safe care for women and babies. The NMC code makes clear that midwives are expected to work effectively within multidisciplinary teams and refer to another practitioner when it is in the best interests of the person in their care.

For supervisors to identify and implement opportunities to engage with users of the maternity services to inform supervisory activities. Supervisors can directly support women by advocating about any concerns a mother may have about the care she received or her experience giving birth.

For supervisors of midwives to support the need to ensure a consistent and evidence based approach to the education and support of infant feeding across the sites. Supervisors are expected to support midwives to develop their skills and expertise, making sure they are keeping up to date through continuing professional development activities.
Recently introduced effective practice identified

There were a number of recent service improvements that demonstrate commitment to providing women focused services.

We particularly noted the following:

- Support from the chief executive, the director of nursing and the newly appointed head of midwifery for a robust framework for supervision which is proactive and links with trust processes and systems.

- A central on-call system covering all of the trust, ensuring 24 hour access to a supervisor of midwives.

- The LSA are now utilising supervisors of midwives who are external to the unit to investigate concerns relating to midwifery practice.

- Involvement of supervisors of midwives in innovative training programmes.

- Effective public health initiatives providing support for vulnerable women and families in the acute and community settings.

- There was a high standard of midwifery record keeping (this reflects the quality of the content of care records rather than the concerns we had regarding the storage of old records).

Conclusion

There are some clear challenges for University Hospitals of Morecambe Bay NHS Foundation Trust and the supervisors of midwives, however we were assured by the leadership and approach demonstrated by the newly appointed head of midwifery. Prior to the review, she had already identified and had planned to address key areas that we subsequently highlighted.

Additionally the newly appointed LSAMO has also already started to address issues and is committed to working collaboratively with the SoMs and senior members of University Hospitals of Morecambe Bay NHS Foundation Trust to strengthen and enhance the framework for supervision.

There are a number of effective initiatives taking place which supervisors are able to report verbally. However, these need to be documented and evidenced within the operating framework at a strategic level to ensure the safety and wellbeing of women using the maternity services.

The framework for statutory supervision needs to be much more visible both within University Hospitals of Morecambe Bay NHS Foundation Trust and for users of the service.
A strong clinical leadership is now apparent and there is clear support for statutory supervision from both the CEO and the director of nursing.

The NMC will continue to monitor the progress of the Trust over the coming months to seek assurance that improvements are continuing to be made. Expectant mothers and their families who use the services at the Trust should be confident that the care they receive is delivered safely. This can only be ensured when the components of effective leadership, clear and accessible policies and procedures work in harmony towards the provision of consistently high standards of care.
### Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>FGH</td>
<td>Furness General Hospital</td>
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<td>LME</td>
<td>Lead midwifery for education</td>
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<td>LSA</td>
<td>Local supervising authority</td>
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<td>LSAMO</td>
<td>Local supervising authority midwifery officer</td>
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<td>NMC</td>
<td>Nursing and Midwifery Council</td>
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<td>RLI</td>
<td>Royal Lancaster Infirmary Hospital</td>
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<td>RM</td>
<td>Registered midwife</td>
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<tr>
<td>SHA</td>
<td>Strategic health authority</td>
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<tr>
<td>SoM</td>
<td>Supervisors of midwives</td>
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**Preferred terminology in report writing**

| Effective practice | Rather than good practice |

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### Morecambe Bay University Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th>Provision reviewed:</th>
<th>The functionality of the statutory framework for the supervision of midwives</th>
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</table>
| NMC LSA review team: | Helen Pearce - Midwifery Adviser  
Verena Wallace NMC LSA reviewer  
Maria Herron NMC LSA reviewer  
Roger Thompson Director of Nursing and Midwifery Policy and Standards (observer 18.7.11) |
| Date of event:      | 18-20 July 2011 |
| Date of report:     | 11 October 2011 |
Interpreting the report

This report is divided into five sections: Governance, profile and effectiveness of statutory supervision, team working, the interface with service users, and evidence base informing outcome of review.

Under NMC good governance practice, each section includes the relevant NMC rules and standards that were used to inform the framework for the review.

Section one: Governance

NMC Midwives rules and standards – Rule 6 Responsibility and sphere of practice Rule 7 Administration of Medicines, Rule 13 The LSAMO, NMC Standards for supervised practice, NMC Standards for medicines management, NMC Raising and escalating concerns, NMC Record keeping

To identify the interface and effectiveness between University Hospitals of Morecambe Bay NHS Foundation Trust governance systems and the statutory framework for supervision

<table>
<thead>
<tr>
<th>Recommendation 1</th>
<th>When acting in their capacity as a supervisor of midwives, the supervisors must clearly delineate their role as a supervisor from their substantive role. Demonstrating how their expert knowledge of supervision and clinical practice protects the public.</th>
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<tr>
<td>Recommendation 2</td>
<td>Supervisors of midwives need to ensure that risks and concerns that are raised through the supervisory framework are appropriately discussed at trust governance fora and where appropriate, reflected on the maternity risk register.</td>
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<td>Recommendation 3</td>
<td>To actively seek out ways to ensure that midwives and medical teams, users, supervisors of midwives and senior management in University Hospitals of Morecambe Bay NHS Foundation Trust work collaboratively and effectively for the benefit of mothers and their babies. Such initiatives need to be monitored closely and embedded within the local policies and procedures in the Trust.</td>
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Risk Management

- There are basic systems in place for identifying incidents to the supervisors and the governance guideline with use of the National Patient Safety Agency matrix to identify levels of risk.

- Whilst there is a supervisor of midwives on the risk management steering group, her contribution as a supervisor rather than in her substantive role is not apparent. There is a need for the supervisor of midwives to be really clear when attending a
meeting or acting in her capacity as a supervisor of midwives (as distinct from a participant who was present by virtue of their substantive role).

- Supervisors of midwives need to raise their profile within the organisation by clarifying how their role as a supervisor and their expert knowledge of supervision, informs and supports effective midwifery practice and the safety and wellbeing for women and families.

- We would expect the supervisor to be clearly articulating any relevant NMC midwifery rules, the code, standards, guidance and regulatory frameworks and demonstrating current knowledge of supervision as well as midwifery practice issues.

- We would expect the supervisor to be utilising supervisory networks to examine and discuss practice issues with other supervisors from outside University Hospitals of Morecambe Bay NHS Foundation Trust so that they can enrich the discussions, debate and information in their own workplace.

- It is important to identify opportunities to develop a strategic approach to ensure effective team working between midwifery and medical teams in University Hospitals of Morecambe Bay NHS Foundation Trust. Supervisors of midwives and senior managers are in a position to support an environment to enable this to happen.

- There is an upcoming opportunity for the supervision framework to be presented to the board, and to further consolidate closer links between supervision and governance.

### The maternity risk register

<table>
<thead>
<tr>
<th>Recommendation 4</th>
<th>To ensure that the purpose of the maternity risk register is disseminated to clinical staff and that access to the live register is appropriately facilitated.</th>
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- There was a lack of knowledge from senior medical and midwifery staff, including supervisors of midwives, about what was on the live maternity risk register.

- Supervisors were not able to demonstrate how any concerns that had been raised through the supervisory framework (such as the privacy and dignity issue that was highlighted in their annual report) were reflected on the risk register.

- It is poor practice that access to a copy of the current maternity risk register appeared dependent on a staff member who was on annual leave. Whatever the formal process, it is significant that this is what staff believe (senior medical and midwifery). Additionally, the review team was not able to access a copy of the live risk register whilst undertaking the review.
• For there to be such restricted access and lack of knowledge about identified risks on the register is indicative of a failure to appropriately recognise the value and purpose of a risk register which poses a risk to the public.

• It is important that processes critical to the mitigation of risks identified on the risk register are supported by the relevant updated and uploaded guideline (escalation process for staffing).

• Risks identified through supervision need to be discussed through the appropriate governance processes led by the supervisor of midwives on the governance group. If the issue is considered to be of significance this should be on the maternity risk register.

• There is a dissonance in processes if the matter is considered serious enough to be highlighted in the annual supervisor of midwives report to the LSA and the same concerns are not reflected on the maternity risk register.

• Concerns seen by us or described to us (privacy/dignity in transfer to theatre, availability of rest area / shower facilities for midwifery staff on delivery suite) were not reflected on the risk register (either maternity or corporate).

Policy and guidelines

<table>
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<tr>
<th>Recommendation 5</th>
<th>To have an effective database for the management and review of all maternity guidelines including the process for uploading to the intranet.</th>
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<tr>
<td>Recommendation 6</td>
<td>To review the current draft maternity risk management strategy with the support of the LSAMO to clarify and strengthen the role of the LSA and the supervisor of midwives</td>
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<tr>
<td>Recommendation 7</td>
<td>To gain agreement for trust wide maternity guidelines in order to ensure a consistently high level of practice and expected standards of attitudes and behaviour. This requires robust approval processes for policy and guideline control which should clearly state the way in which all maternity guidelines are managed. The Trust board must ensure that these policies and guidelines are used and are embedded in practice.</td>
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<tr>
<td>Recommendation 8</td>
<td>For the LSAMO to provide guidance to strengthen and clarify the role of the LSA and the supervisor of midwives in the trust maternity risk management strategy.</td>
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• A number of trust guidelines given to us were in draft format (Maternity risk management strategy, Maternity Services Staffing Levels Contingency Plans and Escalation Policy for Staffing and Unexpected High Capacity) and also guidelines
that were for review in 2009 (Transfer of mother to another unit following regional transfer of baby) in 2010 (Protocol for the Transfer of Postnatal Mums and Babies into the Community, Protocol for postnatal transfer of mothers to another unit within Morecambe Bay).

- There was additionally some conflict between two lists that we were given relating to which guidelines had been updated and approved and which were still awaiting approval:
  - CNST Policies / Guidelines (RAG rated) List with Approved Dates and Expiry Dates (Dated 1/5/11)
  - Guideline Review Groups allocation of Guidelines {list of Guidelines issued toFGH, RLI and HCMU/Paeds} – which had incomplete information and was not clear who would be updating the guidelines or when draft or completion date was expected.

- Some of the listed documents were more recent than the hard copies of similar topics we had been given.

- The system appeared to be reliant on one member of staff (who was on annual leave) therefore access to some of the guidelines on one of the lists identified as approved, was not possible.

- There needs to be adherence to a robust system for updating and approving maternity guidelines in a systematic manner. This needs to include an accurate central database of maternity guidelines requiring updating and where they sit in the approval process. The system must ensure that approved guidelines are efficiently uploaded to University Hospitals of Morecambe Bay NHS Foundation Trust intranet site so that access to the updated guideline is universal.

- We were unable to determine from the oral or documentary evidence specifically how the supervisor influences the development and dissemination of policy and guidelines within University Hospitals of Morecambe Bay NHS Foundation Trust. This is a concern as it creates the potential for confusion amongst staff and could risk the safety of mothers and babies.

- University Hospitals of Morecambe Bay NHS Foundation Trust maternity risk management strategy is currently in draft form. Whilst the process appears satisfactory the role of the LSA in particular and the supervisor of midwives in general, could be strengthened and clarified. We would recommend that the LSAMO could support in meeting this objective.

- The review team was made aware that there were significant tensions between consultant groups of medical staff and that it was difficult and in some cases there was a failure to gain approval for guidelines across the two consultant led units. The NMC code makes clear that midwives are expected to work effectively within multidisciplinary teams and refer to another practitioner when it is in the best interests of the person in their care.
• Rule 6 NMC Midwives rules and standards 2004 states that midwives are expected to familiarise themselves with their employer’s policies and failure to do so is a serious matter. Midwives are being encouraged to work in different ways with midwives from the community working in the acute unit and other midwives working across the Bay in different units. It is therefore important that agreement is reached to ensure guidelines are standardised across University Hospitals of Morecambe Bay NHS Foundation Trust to minimise the risk of error and ensure equity for all users of the service. Additionally, it is important that there are robust induction programmes to ensure midwives working in unfamiliar environments are safe and competent to do so.

• Evidence was heard that access to guidelines had been improved through the new hospital library system where they are catalogued.

• Staff were also appreciative of the global email system for informing them when new guidelines had been agreed and a summary of the changes.

Incident and complaint reporting

• Completed incident forms are electronically sent to all supervisors of midwives across University Hospitals of Morecambe Bay NHS Foundation Trust and these include gynaecology and maternity related incidents.

• Supervisors review all the incidents in their inbox and pick out those that they either know about, or relate to one of their supervisees. There is no apparent system to demonstrate how incidents are signed off and closed by supervisors of midwives. Supervisors appeared to rely on midwifery managers for guidance about the organisation of reviewing and investigating incidents related to supervision.

• The absence of a robust incident reviewing and sign off system for supervisors of midwives has been identified by the new head of midwifery who has allocated a midwife to take the lead. The need to urgently map this process is supported by our findings.

• There is a risk that incidents are not responded to in an appropriate and timely manner by supervisors of midwives. More effective leadership in this area is needed to effectively manage risks that may impact on the care being delivered to mothers and babies.

• Consideration should be given to the approach taken to disseminate the follow up of initial incidents or complaints relating to practice: currently this is done on an ad-hoc basis. Furthermore consideration of these complaints, issues and actions should be a standing item at the supervisor of midwives meeting and regularly shared with management.

  • Staff have access to trigger lists for raising concerns about serious incidents and for contacting supervisors of midwives on-call (provides detail about whether on-call should be made immediately, next day or during working hours).
• The mechanism for staff feedback following incident reporting or the escalation of concerns, is not always clear to staff who told us that they felt disheartened when they failed to have a response or see any changes (lack of shower facility for female staff in labour ward in FGH, length of time taken to complete records of care).

• Whilst reporting of near misses and serious incidents is fed into training programmes, we would support the proposal by supervisors to additionally, commence drop in sessions to provide feedback of the lessons learnt and the actions that arise. This will support trust processes and provide contemporaneous feedback for staff.

• It is important to enhance the practice educator’s links with supervisors and any learning outcomes from investigations, annual reviews or training needs analysis.

• Supervisors of midwives are not explicitly involved in reviewing user complaints. This is being addressed by the head of midwifery.

• Consideration of issues, trends and action plans arising from complaints, incidents and concerns and should be a standing item at supervisor of midwives meetings. These need to inform supervisory activities.

**Support for trust actions identified prior to this review**

• We would wish to monitor the progress made by the head of midwifery in mapping and implementing an appropriate system for supervisors of midwives to manage incident reports in a timely and systematic manner.

• The head of midwifery is also addressing the need to ensure that complaints and concerns are addressed appropriately through action plans. These where appropriate, will include supervisors of midwives.

**To review learning from serious incidents**

| Recommendation 9 | For supervision to demonstrate strong leadership by effectively managing risk and protect the public in producing intelligence and disseminating learning from serious incidents and to work collaboratively to enact any learning requirements or system changes necessary to improve practice. |

• Concerns have previously been raised relating to the quality of documentation. The West Midlands Perinatal Institute notes have now been introduced across all three sites.

• The NMC review team audited randomly selected records from across all three sites. All were of a high standard and showed evidence of clear discussions with women about their choices for care, consent for interventions and appropriately highlighted babies who required enhanced observation post delivery. Appropriate neonatal recordings were documented.
• Additionally we saw comprehensive templates for booking and reviewing women with particular needs from the ‘Substance misuse or blood borne virus senior midwife’ and the ‘mental health senior midwife’. These demonstrated a woman and family centered approach to care and promoted focused communication with the wider multi-disciplinary team.

• There were enhanced vigilance chart for neonates for babies who required increased surveillance. These were appropriately completed and actions taken.

• There is a traffic light system on the delivery suite which clearly identifies women with increased risk factors. The system assists obstetricians and midwifery workforce planning and is felt by senior midwifery staff to be working well.

• There have been training programmes for midwives in the care of babies in the postnatal period who require increased surveillance and these continue, if necessary on an individual basis. There are no formal transitional neonatal areas in any of the units. Babies requiring interventional therapies (intravenous medication, tube feeding) are returned to the neonatal unit for the intervention which is administered in the neonatal unit.

• Continuity of carer has been improved and is monitored. A pilot is being undertaken to determine the effectiveness of the ‘situation, background, assessment, recommendation (SBAR) tool’ to improve the quality of handover information between professionals.

• There is an increased emphasis on public health. There is a senior midwife with the lead for public health. There is a family team group comprising, health visitors, children’s nurses, public health midwives and clinical support workers. This appears to be working well.

• There are systems for identifying at risk families with formal professional reviews and feedback to midwives and the community and safeguarding nurse.

• Evidence was provided demonstrating a high standard of service from members of the family team which extends from the hospital to the community and takes an individual and holistic approach for vulnerable women and their baby. There is an emphasis of ensuring ongoing support with decisions being made on an individual basis to continue to provide support until effective community systems are in place.

• Junior doctors responding to a call or request by a midwife are monitored by consultants when reviewing records for example during the cardiotocograph review meetings. If the notes indicate that the doctor was called several times before reviewing the woman, it is followed up with the individual concerned.

• There is a template to be completed for transfers which details which documents have been photocopied and sent.

• Whilst there was evidence about changes in practice that have resulted from learning following serious incidents, the role of the supervisor of midwives in those
changes and how the intelligence informs supervisory activity were not clearly demonstrated.

To evaluate how statutory supervision is supporting learning from incidents

| Recommendation 10 | The strategy and activities for supervision need to reflect the primary importance of protection of the mother and baby as well as the proactive supportive role of the supervisors to midwives |

- At trust board level, user stories are an intrinsic feature of Board meetings. Supervisors of midwives need to consider how they can replicate this culture within their own meetings to ensure that they uphold the principle of supervision which is the protection of the public and to consider the NMC code to ‘make the care of people your first concern, treating them as individuals’.

- Whilst many midwives were able to clearly articulate how supervisors provided support to midwives (reflection and training) we did not hear any evidence of how supervision had supported families. Whilst the NMC’s *Support for parents, How supervision and supervisors of midwives can help you* is put into the booking packs, there needs to be more evidence of how feedback from users informs supervisory activities.

- We were concerned by a number of comments from supervisors which indicated a focus on the defense of midwifery practices and practitioners. Empowering midwives and midwifery students to practise safely and effectively needs to be undertaken by prioritising protection of the public.

- Supervisors were not able to clearly articulate or provide documented evidence to show how supervision was informing training programmes, leaflets, guidelines, systems, service or environmental changes.

- This is not to take away from the fact that there is learning from incidents but this appears to be undertaken by supervisors who are also senior midwifery staff and it therefore becomes merged with their management role. When acting in their capacity as a supervisor of midwives, the supervisors are expected to clearly delineate their role as a supervisor from their substantive role.

- There are plans in place from the LSAMO and the head of midwifery for supervision to be more proactive. There is both commitment and support from the CEO and director of nursing for this approach.

- Using supervisors of midwives from other units to lead supervisory investigations and for root cause analysis are effective initiatives which we would support.

- There is a ‘lessons learned bulletin’ which is circulated. We would encourage supervisors of midwives to contribute to this initiative.
Raising and escalating concerns

| Recommendation 11 | Supervisors need to consider how they identify and appropriately challenge processes and practices if they do not meet best practice guidance |

- A concern relating to the time taken to complete maternity records was raised to the review team by staff. Although supervisors and managers were well aware of staff concerns it is important that staff appropriately use local managerial and supervisory systems to formally raise and escalate concerns.

- The review team heard evidence that all midwives had recently received a global email from University Hospitals of Morecambe Bay NHS Foundation Trust reiterating the process for raising concerns.

- We observed poor midwifery practice in the reuse of cardiotocograph belts which had been washed and left in the sluice to dry (FGH). This would be an infection risk. We would expect all midwives, particularly supervisors of midwives, to challenge poor practice and manage risk in line with the code.

- Staff were able to clearly articulate that they would take any concerns to their line manager. Staff felt that they could easily escalate concerns to a more senior member of staff if they were not satisfied with the response from their line manager. The senior midwifery team was highly visible and was felt to be approachable.

Storage of records

| Recommendation 12 | For the trust to provide safe and secure storage for all maternity records at the FGH site |

- There was an accumulation of a significant number of unsecured confidential medical records (>100) which were piled up in transport cages, on the floor and on shelves in a medical staff rest room on the delivery suite in FGH. These records dated back to 1965 and were the subject of an eight months ongoing dispute between the medical records department and the delivery suite. A lack of identified funding to address the problem was cited.

- Effective record keeping is an integral part of safe nursing and midwifery practice and the secure storage of personal patient data is an important component. Whilst University Hospitals of Morecambe Bay NHS Foundation Trust responded immediately to our concerns by providing a temporary solution, a permanent solution to the problem needs to be found.
Section two: Profile and effectiveness of statutory supervision of midwives


To review the profile and effectiveness of supervision within University Hospitals of Morecambe Bay NHS Foundation Trust

<table>
<thead>
<tr>
<th>Recommendation 13</th>
<th>For supervisors of midwives to actively seek opportunities to engage with University Hospitals of Morecambe Bay NHS Foundation Trust Board, senior trust colleagues and with the public using maternity services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation 14</td>
<td>Supervisors need to effectively manage their identified time and to appropriately raise a concern if there is insufficient time to effectively undertake the role</td>
</tr>
<tr>
<td>Recommendation 15</td>
<td>There needs to be annual rotation of the role of the contact supervisor of midwives</td>
</tr>
</tbody>
</table>

- There is an urgent need to review the profile and identity of supervision of midwives within the maternity units. There was acknowledgement that supervisors were the group that needed to lead this work and this will be supported by the LSAMO.

- Supervisors should take the opportunities offered to present regularly to University Hospitals of Morecambe Bay NHS Foundation Trust board.

- University Hospitals of Morecambe Bay NHS Foundation Trust board is holding an open meeting in October when the maternity services will be featured. There will be an opportunity to highlight the purpose and function of supervision at this meeting as the LSAMO will be invited. This is to be commended.

- It was evident that there was senior management appreciation and acknowledgement of the positive role of supervision. There is an opportunity to increase the profile and remit of supervision by gaining agreement for a designated supervisor of midwives to attend the ‘seniors meeting’. Supervision of midwives is not currently perceived as part of the leadership team.

- There is evidence that supervisors attend a variety of meetings at various levels but do not necessarily highlight the unique contribution of their supervision role.

- The issue is compounded by the style of minute taking which was inconsistent across the different groups with some using first names and no clear time scales for actions.
• Supervisors should develop templates for minutes and agendas to ensure there is clarity relating to actions agreed, timescales and the person responsible.

• The supervisors based in Kendal found it challenging to meet as a group due to their small numbers and their clinical commitments. This meant that they rarely met as a group more than once a year (for the annual LSA audit). We would recommend the use of video-conferencing or teleconferencing be utilised in order to ensure contributions on a monthly basis from all supervisors to a meeting.

• The review team heard from staff that supervision was previously perceived as policing, but was now seen as supportive.

• Supervisors of midwives based in the community gave examples of how they supported women in their choice of place of birth.

• There had been a recent complex case that had been managed effectively by supervisors, midwives, obstetricians, the LSAMO, midwifery managers and the family in order to effectively and safely manage the situation. All felt that this had been an extremely positive and supportive process. This is to be commended.

• A supervisor of midwives on call rota is in place across University Hospitals of Morecambe Bay NHS Foundation Trust. This is effective practice.

• Leadership development should be encouraged particularly for those supervisors who do not hold a management position thereby enhancing the non hierarchical intention of supervision. To that end, we would encourage rotation of the contact supervisor’s role.

• Supervisors should demonstrate proactive initiatives with learning and development to improve practice and to improve the user interface and involvement with maternity services. This is a clear expectation within the midwives rules and standards.

Support for trust actions identified prior to this review

• The head of midwifery is committed to ensuring that all supervisors have one day a month for supervision. It is the responsibility of supervisors to effectively manage their activities and to appropriately raise a concern if there is insufficient time to effectively undertake the role.
Section three: Team working

NMC The code, NMC Midwives Rules and Standards: Rule 6, Rule 10 Inspection of premises and equipment, NMC Raising and escalating concerns

To evaluate the effectiveness of multi-disciplinary team working and approaches

| Recommendation 16 | The strategy for supervisors should reflect the need to support medical staff and midwives to work collaboratively in order to provide safe care for women and babies |

- There are opportunities for supervision to make further improvements in supporting midwives and contributing to team working which supports the principles in the code and midwives rules and standards.

- Midwifery staff felt confident that there were effective working relationships with junior and senior medical colleagues. Any concerns or differences in opinion were appropriately resolved at a local level.

- Consultants felt that there were effective relationships with midwives who would contact them if there were any concerns about the management of a case, or professional conflicts of opinion.

- Medical staff appreciated the role of supervisors of midwives in the investigation of incidents and support for staff.

- Midwives are appropriately involved in the appraisal of junior medical staff.

- Many midwives and senior medical staff described the benefits of integrated working for community midwives who worked regular shifts in the maternity unit. This has increased the knowledge, confidence and competence of individual practitioners. It has also improved communication for community midwives when seeking medical advice for a community referral as they have developed relationships with their medical colleagues.

- Supervisors of midwives who were community midwives felt that the integrated working patterns enabled them to establish effective working relationships with medical staff so that when they had challenging clinical situations as a supervisor, they were confident to contact senior obstetric staff and gain appropriate advice and support. This evidence was supported by a consultant obstetrician.

- Consultant anaesthetists at RLI are involved in the delivery of skills and drills training for the multi-disciplinary team and support the weekly drills training on labour ward. This has highlighted the importance of calling anaesthetic assistance in maternity emergency situations. This initiative needs to be replicated at FGH.
• Paediatricians supported the ‘assessment of the newborn training’ for midwives based in the MLU in Kendal. This has improved the service for women and their families who deliver in the Kendal MLU.

• One of the specialist midwife trainers had delivered a programme for skills drills training in a home environment for community midwifery staff. This had been well evaluated and was an effective initiative.

• There is evidence of effective multidisciplinary working in a number of different areas including; the caesarean section review group, the Seniors meeting and involvement of doctors in teaching with the midwifery practice educators and skills and drills.

• Supervisors of midwives must encourage the sharing of effective practice, skills and learning across Trust through multi-disciplinary meetings.
Section four: Interface with service users

NMC The code, NMC Midwives Rules and Standards: Rule 6 Responsibility and scope of practice, Rule 10 Inspection of premises and equipment, Rule 12 The supervision of midwives, NMC Raising and escalating concerns

To evaluate the interface between supervision of midwives and women using the service

<table>
<thead>
<tr>
<th>Recommendation 17</th>
<th>To provide privacy and dignity for women and babies at FGH who require emergency transfer to and from theatre from the delivery suite. To monitor the ongoing measures to mitigate the situation until a permanent solution is found</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation 18</td>
<td>For supervisors to identify and implement opportunities to engage with users of the maternity services to inform supervisory activities</td>
</tr>
<tr>
<td>Recommendation 19</td>
<td>For supervisors of midwives to support the need to ensure a consistent and evidence based approach to the education and support of infant feeding across the sites</td>
</tr>
</tbody>
</table>

Privacy and dignity

- The transfer of women and babies to and from theatre from the labour ward in FGH necessitates transfer via a public corridor. The corridor passes a number of entrances to offices, a public waiting area with refreshment dispensers, a cash machine, and the entrance to the children’s unit. Travel through this corridor raises significant privacy and dignity issues for women. Midwives told us that they ensure the woman is well covered in the bed and will often have the entonox mask on covering their face. The issue has been highlighted in the annual report from supervisors of midwives but is not evident on the maternity risk register. Midwives are required under the code to respect the dignity of those in their care.

- We heard evidence from midwives and theatre staff (via CQC inspectors) that midwives had undertaken emergency cord prolapse procedures which had necessitated the midwife travelling on the bed. Whilst the distance is not great and would take less than a minute, the health and safety for midwives needs to be considered.

- Additionally, there is a further issue in the transfer of a deceased baby from theatre to the delivery suite. Staff did report that this can be difficult as members of the public like to try to see the baby.

- Whilst there were no formal complaints from women and their families they have not been formally approached for feedback. There is a belief that nothing further could be done to manage this situation until the maternity unit is refurbished and a change made to the location of theatre. However, further improvement could be achieved by
clearing the public corridor of people prior to the transfer to and from the theatre of a mother or a baby.

- Following this suggestion by an NMC reviewer University Hospitals of Morecambe Bay NHS Foundation Trust immediately responded by adopting this proposal. There was a missed opportunity to utilise supervisors of midwives, medical staff and users with managers to generate potential solutions to this situation.

**Supervision and the user interface**

- Although information about the potentially supportive nature of supervision is available via leaflets and on some notice boards, women do not understand the function or why they would access a supervisor of midwives.

- Whilst this is not uncommon every effort should be made to proactively engage with users. The review team is aware that work is currently being undertaken to improve website information.

- There are management plans to request feedback from all women who use maternity services: this information will potentially assist the interface between supervision and service users.

- The review team met with a range of service users. All were very happy with the services they were receiving, however none were aware of any system that they could access if they had any concerns or if they were not happy with any aspect of the service.

- The feedback received from midwives indicated that women have a number of different routes to making complaints. One of the matron’s felt that there is low level of complaints as a debriefing system is embedded (although not formally) which diffuses the need to formally complain. Supervisors of midwives can discuss and debrief with mothers who are unhappy with their birth outcome or treatment.

- There is a listening service and listen to mother at FGH (however we did not see any leaflets or publicity about this). The women interviewed were not aware of any service. It therefore seems unclear how users would know about this service. We would encourage the supervisors of midwives to actively engage with and support this service across University Hospitals of Morecambe Bay NHS Foundation Trust.

- Midwives had mentioned that there is a trust complaints leaflet. The women we met said they had not seen this.

- While there was a range of (ad-hoc) user view surveys, some survey results were handwritten and did not appear to be widely distributed. There did not seem to be a protocol for using the information generated by the surveys and whether it feeds into the ‘GURU dashboard’ system.

- It was noted that University Hospitals of Morecambe Bay NHS Foundation Trust has plans to capture patient information from all mothers as they use the maternity services.
• Information on the internet for women wanting to use maternity services in University Hospitals of Morecambe Bay NHS Foundation Trust is very basic. We heard that there are plans for improvement, however on the home page there is a link to ‘how can we help you?’ section which identifies how people can make their concerns known, including who can complain, how to complain, time limits and contact details of patient advice and liaison service (PALS), the ombudsman and the independent complaints advocacy service. The website also has a copy of the complaint leaflet (dated January 2011).

• It is important that supervisors are involved in encouraging user feedback whether it is through complaints or planned surveys or ad-hoc interviews. There is an opportunity for supervisors to get involved in University Hospitals of Morecambe Bay NHS Foundation Trust user questionnaire which is undertaken every 3 years, the next one is due 2012.

• University Hospitals of Morecambe Bay NHS Foundation Trust have indicated that maternity services liaison committees (MSLC) will be rejuvenated in all three areas. We would expect supervisors to nominate a lead for each area to sit on the MSLC.

• Supervisors should demonstrate proactive initiatives with learning and development to improve practice and to improve the user interface and involvement with maternity services. This is a clear expectation within the midwives rules and standards.

Evaluating the availability of the necessary support for choice of place of birth and birth plans

• A leaflet on ‘Birth choices’ is available however; consideration should be given to involving users in the design and dissemination of information.

• University Hospitals of Morecambe Bay NHS Foundation Trust feedback (October 2010) concerning choice from service users was generally effective ‘midwife continually listened and offered choices when I need them’ but also included some comments on lack of choice: ‘choice is limited’ and ‘locations too far away for there to be a choice’.

• University Hospitals of Morecambe Bay NHS Foundation Trust user feedback (November 2010) included positive experiences and happy mothers however some negative comments regarding busy postnatal ward and a number of women felt they did not get the support they needed with breastfeeding.

• Breastfeeding is recommended to women and there are some effective initiatives such as the use of maternity assistants and peer supporters in support of breastfeeding. However, we saw evidence that knowledge and support is not consistently available, leaving some women feeling unsupported. Breastfeeding training is not currently part of the maternity mandatory training programme.

• We would expect to see evidence from University Hospitals of Morecambe Bay NHS Foundation Trust feedback mechanisms discussed at supervisors meeting and
reflected in training, guideline development and discussion with midwifery managers as appropriate.

- We saw evidence that many mothers use the opportunity to outline their own birth plans in University Hospitals of Morecambe Bay NHS Foundation Trust pregnancy records.

- There are effective links via family centres for women to mental health, breastfeeding and antenatal programmes.

- The use of patient stories at trust board meetings is to be commended.

- Supervisors need to support women by making it clear when it is appropriate to contact a supervisor of midwives.
Section five: Evidence base informing outcome of review

Documents reviewed at monitoring event

Samples of full set of case notes showing different sections: green (antenatal), yellow (intra partum), purple (post natal), teal (any antenatal admissions) and computer generated notes (which are generated after birth)

- Cause for concern form (pink booklet) and summary duplicate sheet
- The effects of domestic abuse on children – a four week course at Westgate Children’s Centre
- Parent education for the Lancaster and the Morecambe Bay areas
- Tongue tie presentation
- Heads of service meeting minutes
- Senior management team meeting minutes
- Divisional management team meeting minutes
- Minutes of obstetric and gynaecology seniors meeting (latest notes Mon 18 July 2011)
- Minutes of Cross Bay senior midwives meetings (latest notes 19 April 2011)
- Family team minutes family services division – notes about vulnerable women and teenagers (May 2011)
- Modernisation of maternity services (16 Nov 2010)
- Keeping Mothers Safe leaflet – University Hospitals of Morecambe Bay
- Midwifery action plan ‘Forward Together’ agenda 26 January 2011
- Westgate Children’s Centre midwife drop in sessions
- Proposal and evaluation oral glucose tolerance tests in a community setting (Jan – April 2011)

Supervision file

- Your Choices for Maternity Care (June 2011) – leaflet
- NW LSA and supervisors of midwives how can we help you? (March 2007)
- Records audits form
- SoM rota sheets
• Terms of reference for SoMs at RIL
• Thank you letter from Lisa Bacon LSAMO thanking all midwives and SoM for high standard professional working
• Feedback from LSA audit June 2011
• Homebirth term +30 days communication
• Minutes of meetings supervisors of midwives
• Audit midwives views on supervision
• Records audit form to be used for CNST, supervision, midwifery and medical audits of records standards four and five antenatal and postnatal care
• Records audit form to be used for CNST, supervision, midwifery and medical audits of records standards two and three intra partum care
• Minutes of community midwives (available 24 June 2011)

**ANC Folder**

• communications
• audits
• statistics for infection screenings
• guidelines and referral forms
• Minutes of Meetings (available 11 July 2011)

**Morecambe Bay ultrasound scanning information:**

• Minutes of Cross Bay Ultrasound meeting 22 April 2010
• Scan guidelines
• Audit of scanning services in Morecambe Bay

**Teenage Information Minutes; handouts**

• The young woman’s guide to pregnancy
• Teenage pregnancy report 2010
• Role of teenage clinical support worker
• Teenage pregnancy midwifery referral pathway
Check list for positive pregnancy test

**RLI screening meetings 2009**

Includes draft management of screening and diagnostic test results during pregnancy, birth and the puerperium (Jan 2010)

**Maternity User Feedback questionnaires**

- User views on local maternity services May 2010
- Maternity user comments October 2010
- User views (handwritten notes) Nov 2010
- Audit of effects of domestic violence on children July 2010
- User evaluation of birth, bump and beyond parent education July 2010- May 2011
- Public health questionnaire ‘*How can we help you?’* work in progress via parent education
- Current ongoing audit user feedback questionnaire

**Mental Health Folder including**

- Mental health guidelines for maternity services
- Draft perinatal mental health guidelines for maternity services November 2010
- Mental health midwife 2011

**Off Duty Folder including**

- CDS off duty register (including names and addresses of mums on the home birth list)
- Ward 17
- Off duty roster ante natal
- Improving outcomes and ensuring quality – a guide for commissioners and providers of perinatal infant mental health services
- When and how to contact a supervisor of midwives
- Terms of reference (November 2010) with flowchart referral process into family team meetings
- A preceptorship programme for newly registered midwives
• Transfer of information form

• Record keeping slides (NMC) delivered 19 July 2011

• New baby notes – reminder to midwives (not dated)

• Maternity and neonatal notes review April 2009 and training list of community midwives

• Preliminary notes audit 201009 mother and baby Notes

• Memo dated 05 January 2010 From Jane Heath to Alison Mayor re some areas that need work re new post natal notes

• Guidelines for completing perinatal institute records agreed 04 December 2009

• Draft guideline development policy maternity services December 2010 review 2013 includes (p6) The consultation and approval process for clinical guidelines

• UH of Morecambe Bay NHS policy and guidelines review forums terms of reference draft document valid from Aug 2011

• Protocol for the transfer of postnatal mums and babies into the community September 2007 review date: September 2010 (under review)

• Transfer of mother to another unit following regional transfer of baby June 2006 review Date: June 2009 (under review)

• Contingency plans and escalation policy for staffing and unexpected high capacity October 2007 review date: October 2009 (under review)

• Draft maternity services staffing levels contingency plans and escalation policy for staffing and unexpected high capacity (Dated Feb 2011 but still in draft format and not yet publicly available)

• CNST policies and guidelines (RAG rated) list with approved dates and expiry dates (only a few hardcopies of policies and guidelines available to review team)

• Guideline review groups – allocation of guidelines {list of guidelines issued to FGH, RLI and HCMU/Paeds} – incomplete information;

• Records audit forum used for CNST, supervision, midwifery and medical audits of records

• Antenatal liaison form
Terms of reference for:

- Family services clinical Governance Group
- Clinical incident panel
- Labour ward forum
- Maternity risk management group
- Senior midwives forum
- UHMB supervisors of midwives meetings
- Policy and guidelines review forums
- Family services newsletter
- NHS North West NHS care records service

Interviews with

- The Chief Executive, Director of Nursing, Head of Midwifery
- Matrons for maternity inpatients, community, OPD, neonatal services
- Associate medical director, obstetrics and gynaecology
- Consultant obstetrician
- Senior midwives with specialist roles, substance misuse/blood borne virus, training co-ordinators, infant feeding co-ordinators and mental health
- Delivery suite co-ordinators
- Supervisors of midwives
- Clinical midwives
- Users on the postnatal ward
## Recommendations for University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBNSHT) board

<table>
<thead>
<tr>
<th>Recommendations for the trust board</th>
<th>Action planned</th>
<th>Achievement date</th>
<th>Responsibility for action</th>
<th>Evidence of completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide privacy and dignity for women and babies at FGH who require emergency transfer to and from theatre from the delivery suite. To monitor the ongoing measures to mitigate the situation until a permanent solution is found.</td>
<td>Interim arrangements in place to clear route. Risk assessment completed Sept 11 Verbal information provided to women in ante natal period with immediate effect. Written information in draft to add to antenatal information. User feedback surveys to capture experience of women. Alternative route identified. Modifications</td>
<td>Immediate July 2011 Sept 11 Complete July11 Complete and on going Oct 11 Commence September 11 Complete by 21 Sept 11</td>
<td>Head of Midwifery/Mat Risk Manager</td>
<td>Evidence of interim arrangements in action. Risk assessment document/risk register-Complete Feedback from women-on-going Evidence of information On-going evaluation of user feedback 7 October 2011 Information provided to all</td>
</tr>
</tbody>
</table>

Note: covered in CQC action plans, outcome 10
- For the trust to provide safe and secure storage for all maternity records at the FGH site.

Note; covered in CQC action plans, outcome 21

<table>
<thead>
<tr>
<th>Action</th>
<th>Date</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records secured immediately with lock to room.</td>
<td>July 2011 Complete</td>
<td>Associate Director of Operations</td>
</tr>
<tr>
<td>Records removed to alternative secure storage <strong>Complete</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff undergo information governance training as part of mandatory training each year.</td>
<td>On-going 2011/12</td>
<td></td>
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</tbody>
</table>

women about the transfer to theatre and the new route
Evidence of safe storage. **Complete**
Moved to permanent storage
Monthly Monitoring reports.
Monthly monitoring reports.
<table>
<thead>
<tr>
<th>To ensure that the purpose of the maternity risk register is disseminated to clinical staff and that access to the live register is appropriately facilitated.</th>
<th>Multi-disciplinary Risk workshops for all disciplines being held for all staff across all sites Oct 11 onwards</th>
<th>Oct 2011 onwards</th>
<th>MD exec lead/ governance manager</th>
<th>Risk registers are in place in common format, live, accessible and up to date. Clinical staff can state the top risks for their area. Evidence of linkages between, departmental, divisional and corporate risks. 7 October 2011 Risk register is available to view for all staff, special access to senior divisional clinicians with authority for updating the risk register.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: covered in CQC action plans, outcome 16.</td>
<td>Trust's revised Draft Risk Strategy in place and to be endorsed at Oct 11 Board as part of NHSLA programme</td>
<td>Scheduled for Oct 11 Board</td>
<td>MD exec lead/governance manager</td>
<td>Evidence in Board minutes</td>
</tr>
<tr>
<td></td>
<td>Revised draft Maternity Risk Strategy is in place and to be approved by Board in October 11 (CQC outcome 16 action plan)</td>
<td>Scheduled for Oct 11 Board</td>
<td>MD exec lead/Maternity Risk manager</td>
<td>Evidence in Board minutes</td>
</tr>
<tr>
<td>Task</td>
<td>Time</td>
<td>Responsible Party</td>
<td></td>
<td></td>
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<tr>
<td>----------------------------------------------------------------------</td>
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<td>----------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LSA giving advice re supervision in relation to Maternity Risk strategy.</td>
<td>End Sept 2011</td>
<td>Head of Midwifery/ Maternity Risk Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common template for department risk registers to be implemented at launch risk workshops following approval of Risk Strategy.</td>
<td>Oct 2011</td>
<td>Maternity risk manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Management Team in addition to IRSC to review Divisional risk registers from Oct 11. Review the Trust current /existing database and work with Library services to administer database.</td>
<td>Agenda for HMT Oct 11</td>
<td>Director of Ops and Performance (chair of HMT)/ Associate Dir of Ops MD exec lead/Governance manager /Maternity Risk Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of LSA advice within Maternity Risk Strategy.</td>
<td></td>
<td>Evidence of common template in place for risk registers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of common template in place for risk registers.</td>
<td></td>
<td>HMT minutes.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- To have an effective database for the management and review of all maternity guidelines including the process for uploading to the intranet.

<table>
<thead>
<tr>
<th>Trust wide guidelines group was established in July 11 and replaced the former arrangement where guidelines were endorsed at Maternity risk management group. 2 meetings to date; July and Aug 11.</th>
<th><strong>Complete and on-going meetings</strong></th>
<th>Maternity Risk Manager</th>
<th>Progress report CNST programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Trust policies, maternity guidelines are on Trust intranet Policies /Maternity page currently Staff to be reminded of how to access.</td>
<td>October 11</td>
<td>Maternity Risk Manager</td>
<td>Evidence of up to date database.</td>
</tr>
<tr>
<td>Existing schedule for guidelines review to be reviewed as part of CNST programme- (ongoing work as part of CNST programme) by Oct 11</td>
<td>Oct 11</td>
<td>Maternity Risk Manager</td>
<td>Evidence of schedule of guidelines review</td>
</tr>
<tr>
<td>Protocol for uploading guidelines to be reviewed</td>
<td>Oct 11</td>
<td>Maternity Risk Manager</td>
<td>Audit reports showing compliance with guidelines.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Minutes of guideline groups and Maternity</td>
</tr>
</tbody>
</table>
To gain agreement for trust wide maternity guidelines.

**Updated October 2011**: To gain agreement for trust wide maternity guidelines in order to ensure a consistently high level of practice and expected standards of attitudes and behaviour. This requires robust approval processes for policy and guideline control which should clearly state the way in which all maternity guidelines are managed. The Trust board must ensure that these policies and guidelines are used and are embedded in practice.

Trust wide maternity guidelines group was established in July 11 and replaced the former arrangement where guidelines were endorsed at Maternity risk management group. 2 meetings to date; July and Aug 11.

Audits of maternity records occur every month since Sept 10 and this is where compliance levels with guidelines is tested. On-going and part of CNST programme.

2 meetings in new format July and Aug 11

Completed

Clinical governance group

The Maternity guideline group has now met three times.

Audit findings reports to demonstrate compliance with Trust wide guidelines.

Audit reports to demonstrate compliance.
- To actively seek out ways to ensure that midwives and medical teams, users, supervisors of midwives and senior management in University Hospitals of Morecambe Bay NHS Foundation Trust work collaboratively and effectively for the benefit of mothers and their babies. Such initiatives need to be monitored closely and embedded within the local policies and procedures in the Trust.

<table>
<thead>
<tr>
<th>October 2011 New recommendation</th>
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<tbody>
<tr>
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</tbody>
</table>
## Recommendations for supervisors of midwives (SoMs)

<table>
<thead>
<tr>
<th>Recommendations for SoMs</th>
<th>Action planned</th>
<th>Achievemen\nt date</th>
<th>Responsibility for action</th>
<th>Evidence of completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• When acting in their capacity as a supervisor of midwives, the supervisors must clearly delineate their role as a supervisor from their substantive role. Demonstrating how their expert knowledge of supervision and clinical practice protects the public.</td>
<td>Amend ToR for all meetings attended by supervisors of midwives to clearly demonstrate their role and attendance. Ensure that each SOM is aware that they are attending in supervisory capacity. All of the above to be included and cross referenced in the Maternity Risk Management and Supervision Strategies.</td>
<td>October 31\textsuperscript{st} 2011</td>
<td>Governance Lead for Maternity/SOM (JAP) Matron/CNST Lead/SOM (SH)</td>
<td>Maternity Risk Management Strategy</td>
</tr>
<tr>
<td>• Supervisors of midwives need to ensure that risks and concerns that are raised through the supervisory framework are appropriately discussed at trust governance fora and where appropriate, reflected on the maternity risk register.</td>
<td>Supervisory Issues to be a Standing item at Maternity Risk Management Meetings and Divisional Clinical Governance Group Meetings. Dedicated SOM to represent and highlight supervisory concerns at above meetings.</td>
<td>October 31\textsuperscript{st} 2011</td>
<td>Governance Lead for Maternity/SOM (JAP) Interim Divisional Clinical Governance lead/Matron/SOM (SK)</td>
<td>Maternity Risk Management Strategy</td>
</tr>
<tr>
<td>• To review the current draft maternity</td>
<td></td>
<td>October 31\textsuperscript{st} 2011</td>
<td></td>
<td>Minutes from all risk and governance fora</td>
</tr>
</tbody>
</table>
risk management strategy with the support of the LSAMO to clarify and strengthen the role of the LSA and the supervisor of midwives.

- For supervision to take the lead in producing intelligence and disseminating learning from serious incidents and to work collaboratively to enact any learning requirements or system changes necessary to improve practice.
The strategy and activities for supervision need to reflect the primary importance of protection of the mother and baby as well as the proactive supportive role of the supervisors to midwives.

Supervisors need to consider how they identify and appropriately challenge processes and practices if they do not meet best practice guidance.

<table>
<thead>
<tr>
<th>Action</th>
<th>Date</th>
<th>responsible Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated item for supervision feedback on Maternity Newsletter.</td>
<td>October 2011</td>
<td>All SOM’s</td>
</tr>
<tr>
<td>Development of a Supervision newsletter to disseminate lessons learned</td>
<td>December 2011</td>
<td>newsletter</td>
</tr>
<tr>
<td>Review and update the current Strategy for Supervision to reflect the importance of protecting mothers and babies, as a primary aim of supervision.</td>
<td>October 31st 2011</td>
<td>All SOM’s</td>
</tr>
<tr>
<td>Strategy to reflect the ‘NW LSA Guidance for Supervisor of Midwives’ and the National Standards for Supervision, with a corresponding action plan</td>
<td>October 31st 2011</td>
<td>All SOM’s</td>
</tr>
<tr>
<td>Dedicated SOM member of Guideline review Group.</td>
<td>October 31st 2011</td>
<td>All SOM’s</td>
</tr>
<tr>
<td>Record Keeping audits by all SOM’s and referral of midwifery practice issues from Band 7 midwives audits to SOM’s.</td>
<td>October 2011</td>
<td>All SOM’s</td>
</tr>
<tr>
<td>User feedback from Questionnaire</td>
<td></td>
<td>User feedback from Questionnaire</td>
</tr>
<tr>
<td>Minutes of meetings</td>
<td></td>
<td>Minutes of meetings</td>
</tr>
</tbody>
</table>
For supervisors of midwives to actively seek opportunities to engage with the trust board, senior trust colleagues and with the public using maternity services.

Supervisory concerns as standing agenda item on appropriate multidisciplinary forums to promote collaborative working, develop and improve understanding of midwifery supervision with medical colleagues to gain an understanding of the impact it has in best practice and how that governs a midwives practice.

Use of incident reporting and escalation process to highlight deficiencies in care.

SOM’s to present at 19 October Public Trust Board meeting and to divisional clinical management team 12 October.

Annual report to Trust Board reflecting progress on action plans from LSA Audit and NMC Report.

Senior Trust board members invited to attend cross Bay Supervisors meetings.

Supervision leaflet currently included in all booking packs.

<table>
<thead>
<tr>
<th>Date</th>
<th>Responsible Person</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2011</td>
<td>Maternity Risk Manager (JAP)</td>
<td>Audit results and actions</td>
</tr>
<tr>
<td>October 2011</td>
<td>All SOM’s</td>
<td>Incident reporting minutes</td>
</tr>
<tr>
<td>October 2011</td>
<td>All SOM’s</td>
<td>Risk Register</td>
</tr>
<tr>
<td>October 2011</td>
<td>All SOM’s</td>
<td>Trust Board Minutes</td>
</tr>
<tr>
<td>April 2012</td>
<td>All SOM’s</td>
<td>Board report</td>
</tr>
<tr>
<td>December 2011</td>
<td>All SOM’s Directors</td>
<td>Minutes of cross bay SOM Meetings</td>
</tr>
<tr>
<td>In place</td>
<td>All SOM’s</td>
<td>Evidence from units</td>
</tr>
</tbody>
</table>
- Supervisors need to effectively manage their identified time and to appropriately raise a concern if there is insufficient time to effectively undertake the role.

- The strategy for supervisors should

<table>
<thead>
<tr>
<th>Action</th>
<th>Due Date</th>
<th>Stewards/Team</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision posters in units to be updated and reviewed to strengthen the understanding of the role of a supervisor</td>
<td>October 31&lt;sup&gt;st&lt;/sup&gt; 2011</td>
<td>All SOM’s</td>
<td>Intranet</td>
</tr>
<tr>
<td>Supervision Web Page to be developed.</td>
<td>December 2011</td>
<td>Trust IT Department</td>
<td>Business plan</td>
</tr>
<tr>
<td>Dedicated time for each supervisor agreed by Maternity Management Team in principle</td>
<td>September 2011</td>
<td>All SOM’s (OM) (SW)</td>
<td>Staff rotas</td>
</tr>
<tr>
<td>Matrons have scoped impact of time on clinical midwifery activity.</td>
<td></td>
<td>HOM Divisional Team</td>
<td>Business plan</td>
</tr>
<tr>
<td>Business case outlining proposal to Divisional management Team and CEO Group</td>
<td>October 31&lt;sup&gt;st&lt;/sup&gt; 2011</td>
<td>All SOM’s</td>
<td>Incident reports Risk Register</td>
</tr>
<tr>
<td>Impact of new process to be monitored via the incident reporting system and escalated onto Maternity Risk Register if appropriate.</td>
<td>December 2011</td>
<td>All SOM’s</td>
<td>Diary Sheets Extraction from the Incident</td>
</tr>
<tr>
<td>Introduction of LSA Diary Sheet to monitor activity</td>
<td></td>
<td>All SOM’s</td>
<td></td>
</tr>
</tbody>
</table>
reflect the need to support medical staff and midwives to work collaboratively in order to provide safe care for women and babies.

- For supervisors to identify and implement opportunities to engage with users of the maternity services to inform supervisory activities.

<table>
<thead>
<tr>
<th>Task</th>
<th>Due Date</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Supervision Strategy to ensure this process is reflected and implemented.</td>
<td>December 2011</td>
<td>All SOM’s Comms Team</td>
</tr>
<tr>
<td>To agree an external and Internal Communications plan – to include -Supervision of Midwives Leaflets included in all booking packs. -Establishment of MLSC meetings on ALL sites. - Supervision posters in units to be updated and reviewed to strengthen the understanding of the role of a supervisor. - Supervision Web Page to be developed.</td>
<td>December 2011</td>
<td>All SOMs</td>
</tr>
<tr>
<td>SOM’s to explore widening of current Listen to Mother Service</td>
<td>December 2011</td>
<td>All SOM’s</td>
</tr>
<tr>
<td>Supervisors of Midwives to encourage working towards, and achieving Baby Friendly '10 Steps'.</td>
<td>December 2011</td>
<td>All SOM’s HOM</td>
</tr>
</tbody>
</table>

December 2011

All SOM’s

Evidence of delivering milestones of the communication plan

Infant Feeding Guidelines
| SOM’s working in conjunction with the HOM to ensure effective and equitable commissioning of infant feeding specialist across all three sites | December 2011 |   |   |
### Recommendations for the North West Local Supervising Authority

**Recommendations for the LSA**

<table>
<thead>
<tr>
<th>Action planned</th>
<th>Achievement date</th>
<th>Responsibility for action</th>
<th>Evidence of completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Named Contact Supervisor Of Midwives (SOM) and named Deputy in place</td>
<td>30.09.11</td>
<td>Contact SOM and LSA MO</td>
<td>List of North West Contact SOM and LSA website</td>
</tr>
<tr>
<td>2. Meet with SOMs to discuss draft strategy and work with SOMs on</td>
<td>31.01.12 and 31.01.13</td>
<td>Contact SOM and LSA MO</td>
<td>List of North West Contact SOM and LSA website</td>
</tr>
<tr>
<td>completion of same.</td>
<td></td>
<td>Contact SOM</td>
<td>Notes and attendance list of Contact SOM and LSA meetings</td>
</tr>
<tr>
<td>Deputy will shadow Contact SOM and work alongside her in readiness to take on</td>
<td>31.01.12</td>
<td>LSA MO</td>
<td>Attendance of LSA MO at cross bay extraordinary SOM meeting</td>
</tr>
<tr>
<td>this role</td>
<td></td>
<td></td>
<td>26.09.11 to review strategy.</td>
</tr>
<tr>
<td>For the LSAMO to provide guidance to strengthen and clarify the role of the</td>
<td>30.09.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LSA and the supervisor of midwives in the trust maternity risk management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>strategy</td>
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</tbody>
</table>

- There needs to be annual rotation of the role of the contact supervisor of midwives.
- For the LSAMO to provide guidance to strengthen and clarify the role of the LSA and the supervisor of midwives in the trust maternity risk management strategy.