Nursing and Midwifery Council review of University Hospitals of Morecambe Bay NHS Foundation Trust

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Title Nursing and Midwifery Council review of University Hospitals of Morecambe Bay NHS Foundation Trust

NMC review team Carmel Lloyd (NMC Assistant Director Standards) Verena Wallace (NMC LSA reviewer) Sally Williams (NMC LSA reviewer) Helen Pearce (NMC Midwifery Adviser)

NMC department Policy and Standards

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Contact details

Nursing and Midwifery Policy and Standards Nursing and Midwifery Council 23 Portland Place London W1B 1PZ 020 7681 5692

Website: www.nmc-uk.org

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1 Executive summary

1.1 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 for education and maintain the register of nurses and midwives. We have fair processes to investigate and deal with those whose fitness to practise is called into question.

Local supervising authorities (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.

1.2 Scope of review

The focus of our review is to assess that all requirements regarding statutory supervision of midwives are in place at University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) and are effective in supporting safe midwifery practice, identify and respond to poor and unsafe practice.

Outside of the scope of this review is education for student midwives and any other areas of nursing practice.

1.3 Focus of review

This report concerns the findings of our second review to consider the progress made by University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) against the action plan of the NMC extraordinary review 18-20 July 2011 (http://www.nmc-uk.org/Documents/MidwiferyExtraordinaryReviewReports/NMC_Review-of-University-Hospitals-of-Morecambe-Bay-NHS-Foundation-trust.pdf).

The first NMC review meeting (15 December 2011) demonstrated that whilst the UHMBT had made progress meeting recommendations in relation to dignity of mothers and babies and the storage of records, the majority were ‘work in progress’ (http://www.nmc-uk.org/Documents/Special-Reports/NMC-Action-plan-University-Hospitals-Morecombe-Bay-NHS-Foundation-Trust-2012.pdf). Evidence of these findings have also been presented to Cumbria Health and Well-being Scrutiny Committee 9 May 2012.

Since the extraordinary review the NMC has continued to monitor the performance of the trust through regular reports from the North West Local Supervising Authority, participation in meetings and discussions with the Care Quality Commission (CQC), Monitor and the General Medical Council (GMC). In addition there have been meetings with key stakeholders including the commissioners of services.

NMC rules and standards were used to inform the framework for the review.
1.3 Review findings

The review established that statutory supervision is effective with a motivated and increasingly confident group of supervisors of midwives. Progress was monitored against 15 recommendations, eight were met, six were partially met and one was not met. The recommendation not met, related to the trust governance systems and processes which need to be addressed by University Hospitals Morecambe Bay NHS Foundation Trust.

In response to our review the trust established a ‘Maternity services guideline sprint group.’ As a result of their outputs the recommendation related ‘to have an effective database for the management and review of all maternity guidelines including the process for uploading to the intranet’ has been amended from ‘partially met’ to ‘met’ and ‘to gain agreement for trust wide maternity guidelines’ has been amended from ‘not met’ to ‘met’.

The trust has therefore met ten recommendations with five considered partially met.

1.4 Recommendations

We will publish this report on the NMC website at www.nmc-uk.org. North West Local Supervising Authority will continue to monitor the effectiveness of statutory supervision within the trust and will agree an action plan to address the concerns that we have raised.

2 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 for education and maintain the register of nurses and midwives. We have fair processes to investigate and deal with those whose fitness to practise is called into question.

The NMC is empowered to carry out these functions by the Nursing and Midwifery Order 2001 (the order).\(^1\)

The NMC wishes to know of any concerns that may impact upon the health and wellbeing of women and families, such as poor midwifery practice. Also of concern to the NMC would be where the clinical environment was not a safe and supportive place for the provision of care or as an appropriate learning environment for pre-registration midwifery students.

2.1 Acknowledgements

The NMC would like to thank everyone who participated in the review.

\(^1\) The Nursing and Midwifery Order 2001, SI 2002 No 253
3 Interpreting the report

The 15 recommendations made following our review in July 2011 have been themed under the following sections: governance, policy and guidelines, incident and complaint reporting, interface between supervisors of midwives (SoM) and service users, the profile and effectiveness of supervision.

The table at the beginning of each section states the recommendation and whether it was met, partially met or not met with a short summation. There follows narrative providing further detail of our findings.

4 Review findings

4.1 Governance

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></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>
<th>Met</th>
<th>Evidence demonstrates attendance at meetings and participation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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>
<td>Partially met</td>
<td>Supervisors are appropriately investigating incidents and raising concerns. Issues remain concerning the trust risk register.</td>
</tr>
<tr>
<td>3</td>
<td>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 University Hospitals of Morecambe Bay NHS Foundation Trust to address common issues.</td>
<td>Met</td>
<td>SoM have presented information at trust board meeting and are actively promoting supervision to women and staff</td>
</tr>
<tr>
<td>4</td>
<td>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.</td>
<td>Partially met</td>
<td>There is increased knowledge amongst staff concerning the risk register and improved access. Management of the maternity risk register needs to be addressed. Divisions receive monthly reports from risk register via Ulysses which is the electronic system.</td>
</tr>
</tbody>
</table>
Findings

Progress has been made to delineate the role of supervisor of midwife (SoM) from a substantive role, although challenges remain. Midwives, student midwives and SoMs, clearly identified situations where SoMs functioned as supervisors and those in which they were demonstrably managers. Two SoMs explained that their operational role had taken precedence in recent months, because of a shortage of senior midwife leaders, such that they ‘very rarely’ contributed to meetings in their role as supervisors.

However, there is a will to develop opportunities to ensure that expert knowledge from supervision is effectively utilised. SoMs are members of key trust groups and are attending in their supervisor role.

Whilst SoMs have developed improved governance processes the effectiveness is hampered by the poor trust system. At the time of the review governance was being led by the Divisional Governance lead and the quality and safety midwives. It is apparent that the absence of a senior midwife lead for the governance team has resulted in a lack of authority and confidence to effectively manage, downgrade or archive risks. Whilst training has been provided for authorised midwives to add risks to the risk register, further work is needed to capture and score risks appropriately. Additionally, it was evident that there is a reluctance to remove risks where they have been reduced, mitigated against or been dealt with appropriately.

A major piece of work has been required to cleanse the data on the risk register and although not complete at the time of our visit, 118 identified risks had been reduced to 40. All red risks are discussed at trust board level.

The maternity and paediatrics risk registers were described as the priority by the director of nursing (DoN).

The trust has commissioned PricewaterhouseCoopers (PwC) to undertake a review of governance systems, their report was submitted to the trust board January 2012. The trust are considering at which point to request PwC to review progress against recommendations in their report. We would expect the local supervising authority to monitor and take any appropriate action to ensure new governance systems support an effective interface with supervision of midwives and compliance with NMC rules and standards.

Actions taken

A comprehensive two day multi-professional training programme in serious incident investigation has been led by the North West Strategic Health Authority’s assistant director of patient safety. The root cause analysis training utilised the National Patient Safety Agency (NPSA) model of investigation and review. It was universally well evaluated and the effectiveness is evidenced by a 100% increase since January 2011 in Obstetrics and Gynaecology incident reporting. Reporting by midwives accounts for 90% of incidents, although it was recognised that reporting amongst doctors needed to be further encouraged.
The LSA has also provided support and training to SoMs; again this has been well evaluated. We had assurance that systems were in place for supervisors of midwives to regularly review clinical incidents and identified that learning from incidents has started to be cascaded through the use of the ‘Supervision Matters’ newsletter.

The strengthened communications SoM network across the bay has led to a better understanding of supervision. There has been active participation in local media events and a ‘day in the life of a supervisor of midwives’ is planned with the North West Evening Mail.

The LSA had supported SoMs to reflect on their own effectiveness and values resulting in an understanding of how past cultures had been insular and somewhat defensive. SoMs clearly described how the new culture and vision was woman focused which they underpinned by using *NMC Midwives rules and standards (2004)* to support safe and effective midwifery practice.

Subsequent to the review the trust have appointed a maternity governance lead (27 June 2012).

**Monitoring**

The North West Local Supervising Authority will monitor new trust governance systems, to ensure that there are effective reporting systems for supervision of midwives raising any public safety concerns to us.
### 4.2 Policy and guidelines

<table>
<thead>
<tr>
<th></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>
<th>Partially met (at review)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The new heritage system can be difficult to navigate and more than one database exists (separate anaesthetic database)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Met (amended)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>September 2012</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maternity services</td>
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<tr>
<td></td>
<td></td>
<td>guideline sprint group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>commissioned to address areas of concern</td>
</tr>
<tr>
<td></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>
<td>Partially met</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LSA will need to review strategy once the revised governance reporting systems are available</td>
</tr>
<tr>
<td></td>
<td>To gain agreement for trust wide maternity guidelines</td>
<td><strong>Not met (at review)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guidelines identified as a priority by the NMC in July 2011 are not agreed and finalised</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Met (amended)</strong></td>
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<td>September 2012</td>
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<td></td>
<td></td>
<td>commissioned to address areas of concern</td>
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</tbody>
</table>

Concerns remain about the process for the review, development and the database for clinical guidelines. An extensive exercise to cleanse the data and transfer hundreds of guidelines from across two databases has taken place, guidelines have been themed into different sections, but retrieval issues remain. Staff reported to us that unless every specific form of words were used, guidelines could be difficult to locate. More than one database for guidelines remains. We appreciate that the heritage system is new and that it will take time to embed and refine but there is a risk that midwives may not access the most recent guideline.

Whilst capable, the current midwifery governance team lacks the authority to drive the review of the guidelines, exercise version control and hold senior clinical staff to account for delivery, ratification and compliance. Hence key guidelines, for example concerning care of newborn babies are out of date, are in draft or lack identified medical input.

The newly appointed senior midwives provided examples of where they had challenged guidelines that they felt did not reflect current best practice.
There was a sense that non rotating medical staff needed to update their knowledge and clinical practice.

The team heard of a good example about developing guidelines from the anaesthetists who already involve their junior staff in the preparation of background research to inform anaesthetic guidelines. Whilst medical participation in guidelines is outside of the NMC remit it does impact upon effective and safe midwifery practice if outdated guidelines are being accessed by midwives. The clinical director informed the review team that medical staff would be held to account for their participation in guidelines and other governance issues.

There is an opportunity to involve student midwives (as well as doctors in training) in guideline development. One student midwife highlighted an error to us in the guideline on breech delivery (the subject of her dissertation); another concluded that the guidelines relating to stillbirth were not nearly as robust as they needed to be (again, this was her dissertation topic).

Whilst we were assured that the risks concerning guidelines were on the risk register, issues do not appear to be accurately defined as there is one guideline related risk on the register (Risk 571: guidelines not applied and adhered to consistently across all 3 sites). There is a need to develop a process for guideline development, to identify the lead author, timescale and hold contributors to account.

Evidence was provided concerning the absence of a link pharmacist for maternity and the impact upon clinical care and standards. There are issues relating to medication management which remain, namely still providing epidural in two different ways and inconsistency in prescribing regimes across units. The head of midwifery is aware of the challenges in this area.

There are plans for the new post of deputy head of midwifery to have line management responsibility for governance, which should improve the situation, but it is of concern that an effective interim response had not been made.

**Actions taken**

A successful national recruitment programme has resulted in the appointment of thirteen additional midwives (with seven at a senior clinical grade) who are being encouraged to share guidelines and good practice from other units. The trust has also developed positive links with another trust in Liverpool and guidelines are being shared. Staff told us that all areas of the maternity services were actively seeking critical review of processes and practice from new staff. This is to be encouraged.

Post our review the trust identified resource (Maternity services guideline sprint group) to fast track guideline review and ratification, this is now complete and the evidence submitted to ourselves and CQC.

Through this initiative, seven new guidelines were ratified and six out of date guidelines were reviewed. We received evidence that the principle guideline relating to the care of the newborn infant had been agreed, finalised and uploaded to the intranet.
There has been a review of the library management system for the storage and management of guidelines and they are all now accessed through one database (Heritage system).

A communication strategy and library support package was agreed to inform staff about the changes to the guideline system.

**Monitoring**

Immediately, following our review, verbal feedback was given to the North West LSA and the trust in relation to guideline development, management and adherence. The LSA responded by agreeing an urgent action plan with the trust.

As a result, action was taken and evidence to demonstrate the results provided to us. We are now satisfied that an appropriate response has been made in relation to managing guidelines.

The LSA will continue to monitor the effectiveness of supervisory activities through their reporting systems.
4.3 Incident and complaint reporting

<table>
<thead>
<tr>
<th>8</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met</td>
<td>SoMs are developing their role and are extremely well supported by the LSA, director of nursing and head of midwifery</td>
</tr>
</tbody>
</table>

The local supervising authority midwifery officer has worked with SoMs to set up cross bay working arrangement including on-call systems. This initiative meets the requirements of *Midwives rules and standards (NMC 2004)* Rule 12 to provide a local framework to ensure that equitable, effective supervision is available for midwives.

Cross bay working was well evaluated with a number of positive examples cited such as demonstrating the value of a fresh perspective, sharing good practice, guidelines and developing networks across the three sites.

Additionally, SoMs were developing relationships with midwives who were working in other sites and community areas which was beneficial if the midwife needed support or advice from the on-call SoM.

The clinical incident reporting system provides an automatic notification of an event to the SoM. However, the system does not appear to be sensitive to the category of incident and therefore maternity, paediatric and gynaecology events are notified in a blanket approach to everyone on the cascade list.

There has been a significant increase in risk reporting and the reporting of near miss events, with a corresponding decrease in the significance of the incident. It was evident that there is greater understanding by all staff about the importance of appropriately raising concerns. The trust is already identifying an improvement in investigative reviews.

When the supervisor on-call for their ‘hot week’ we heard that SoMs reviewed clinical incidents and were part of multi-disciplinary Monday clinical case review meetings. Whilst this is a new initiative, feedback has been positive. SoMs now need to develop processes to review user complaints.

SoMs are taking a proactive approach to governance issues and receiving dedicated time when a supervisory investigation is required. The ‘hot week’ has facilitated a more collaborative approach with other professionals and is facilitating the appropriate sharing of information from supervisory activities. Examples were given demonstrating how findings from supervision have informed management decisions and investigations. This is to be encouraged.

SoMs described themselves at better at sharing lessons learnt from incidents through the use of the newsletter ‘Supervision Matters’. A range of staff positively reported the newsletter.
SoMs also use email, 1:1 feedback to staff and sometimes a reflective piece of work is recommended. We were provided with an example of a midwife who had submitted an incident that she had missed herself which illustrates an improved, cultural change to the reporting processes. This is to be commended.

Leadership was evidenced by SoMs leading the changes in culture and their involvement in; guideline development, providing evidence to inform management decisions, regular skills drills training and practice sessions, multi-professional training sessions, clinical investigations and record keeping audits. Further development is required to demonstrate how the outputs from supervisory activity protect mothers and babies.

Student midwives, preceptor midwives and new starters to the trust all felt that SoMs were approachable and knowledgeable. Three of the staff interviewed by the review team indicated that they would like to become a SoM, one had previously held the position in another LSA. This is very positive and will be acted upon by the LSA midwifery officer.

It was encouraging to learn that a SoM had been involved in the selection and recruitment process for a non-executive member of the trust board.

The LSA midwifery officer reported that SoMs were now contacting her appropriately and in a timely manner to discuss concerns. Investigations were commenced when required. This provides assurance that SoMs are reporting and communicating to the LSA midwifery officer who is able to provide further practical support through the LSA midwife if required. The relationship with the LSA was positively evaluated by the SoMs and members of the trust executive team.

**Monitoring**

There are no NMC monitoring recommendations. The LSA will continue to examine the effectiveness of supervisory activities through their monitoring systems.
4.4 Interface between supervisors of midwives and service users

<table>
<thead>
<tr>
<th></th>
<th>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</th>
<th>Met</th>
<th>Vision for supervision consistently demonstrated in written and verbal evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>For supervisors to identify and implement opportunities to engage with users of the maternity services to inform supervisory activities</td>
<td>Partially met</td>
<td>Information boards in clinical areas provide information for users and visitors. There are areas requiring development.</td>
</tr>
<tr>
<td>10</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>
<td>Met</td>
<td>Supervisors are supporting good infant feeding practices.</td>
</tr>
</tbody>
</table>

Whilst the SoMs were enthusiastic and committed to engaging proactively with service users there is an absence of mechanisms by which service users are contacted on a regular, structured and formalised basis. It is fundamental that supervisors of midwives are approachable and accessible for women so that they are able to offer guidance and support to women accessing maternity services (Rule 12 Midwives rules and standards 2004).

A limited number of service users were available for the review team to meet. There was engagement with the public using maternity services via new posters about supervision which were seen at sites visited by the NMC team. Only one of four service users that we spoke to had heard about supervision.

The trust have a continual patient feedback survey, SoMs could encourage women to complete information and arrange to access results to inform supervisory practice.

It appeared that the development of the maternity services liaison committee (MSLC) had stalled pending agreement and support from the primary care trust. The inaugural meeting of the North Lancashire MSLC meeting has subsequently been held on 16 August 2012 and there was a SoM and student SoM present. We understand that this will continue on a bi-monthly basis and the PCT and trust are working together to develop this group.

We are aware of plans to restore the maternity services liaison committee (this is a commissioning for quality and innovation target), to expand the ‘listening to mother service’ and use the ‘Picker’ system to capture user views. However, there is clearly a need for SoMs to establish a good network of users to effectively assess that midwives make the care of women and their families their first concern NMC Code (2007).
Monitoring

The local supervising authority will be working with supervisors of midwives to ensure that a structured approach is taken to proactive engagement with women and families.

4.5 The profile and effectiveness of supervision

<table>
<thead>
<tr>
<th></th>
<th>Supervisors need to consider how they identify and appropriately challenge processes and practices if they do not meet best practice guidance</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Verbal and written evidence consistently demonstrated compliance</td>
<td></td>
</tr>
<tr>
<td></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>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>Identified time given and a process if further time is required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>The strategy for supervision has been reviewed and is of a high standard</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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</td>
<td>Partially met</td>
</tr>
<tr>
<td></td>
<td>Engagement with women and families needs to be developed</td>
<td></td>
</tr>
</tbody>
</table>

We are assured that SoMs are gaining confidence in appropriately raising and escalating concerns and challenging poor or outdated practice (NMC Raising and escalating concerns 2010). We heard how external supervisors are being used to investigate complex incidents. There were other examples of good links with supervisors from outside the region, particularly Liverpool. SoMs had plans to induct new trust board members about the role of supervision and a SoM was involved in the initial meeting to discuss future clinical strategy.

The networks developed by supervisors of midwives with the trust board, the director of nursing, head of midwifery, governance systems, external supervisors and the LSA raises the profile of supervision, its value and purpose. Therefore, we have confidence that when SoMs raise concerns these will be heard and acted upon.

As previously discussed, structured processes for engaging with service users need to be addressed as a priority.

Some staff perceived supervisors to be experiencing difficulties in terms of carrying out all the activities required of supervision, particularly investigations, within the time allocated (one day per month). We are aware of the supportive response from both the director of nursing and head of midwifery to requests from SoMs for time to undertake
their statutory role. There is also an escalation process to the LSA if sufficient time is not available.

We heard from SoMs that the ‘victim culture’ has gone and staff have faced up to the challenges and are now much more reflective. The newly recruited staff unanimously described the Furness Hospital as ‘a happy place’, with staff being ‘very welcoming and positive’ and with none of the resistance to change that might have been anticipated. SoMs have been working with midwifery managers and senior medical staff to drive cultural improvements.

A tangible example of listening and responding to staff views and collaborative management and supervisory activity is ‘The Lancaster Project’ and ‘the letterbox’ system. This encourages all grades of staff to communicate their views and or concerns to managers and SoMs. We did see evidence of changes on the ward as a result of this initiative.

The SoM meeting has a chair and the attendance target is 75%. Only SoMs currently receive the minutes from meetings, which might mean a missed opportunity in terms of showcasing their work and demonstrating the benefits of supervision. We suggest that minutes of supervisors meetings are made public with the proviso to ensure that matters of a confidential nature are discussed within a closed, confidential session. Additionally, user complaints are not routinely discussed at SoM meetings and we would like this to be a standing agenda item. It would also be interesting to invite a service user(s) to SoM meetings.

Evidence was provided demonstrating how SoMs supported women with complex birth plans but there was little to show how proactive engagement informed guidelines, or feedback on the quality and safety of midwifery practice. The views, experiences and opinions from users must clearly inform supervisory activities. SoMs need to establish local networks of users.

**Monitoring**

The LSA will continue to examine the effectiveness of supervisory activities through their monitoring systems.
5 The learning environment

Assurance was provided that the environment of care is vastly improved. There has been a high use of agency and bank staff but newly recruited staff are now in post and temporary staff will be phased out. There is confidence that the improved staffing levels will enable improved consistency with students.

Subsequent to our review we have assurance that mentor updates are now fully operational.

The ability to follow women from hospital to home was well evaluated with students reporting how they felt care at Lancashire was woman centred. They also identified how midwives respected each other, were appropriately assertive, acted as advocates for women, challenged and sought the opinion of others in complex cases.

Evidence demonstrated good communication with the university via the link lecturer. It is hoped that through the four practice education facilitators, improvements will be made to mentor updates.

Students valued the training and support from their mentors, the variety of placements and continuity of care. Less positive was the restricted amount of time available for reflection of events. Students would like more experience in low risk births including waterbirths and would like to attend a SoM meeting. They would also like to see greater flexibility such as allowing women’s partners to stay overnight. Students reported that medical staff were helpful and provided good educational input.

All the student midwives we met had a named SoM. They described SoMs as very supportive and felt confident about approaching any of the SoMs if their own supervisor was unavailable (however they reported a tendency to approach mentor or midwife working alongside in the first instance). Some students had worked through the incident reporting process with their SoM. The LSA midwifery officer reported that supervisors had escalated concerns about job prospects for students at the trust.

All the students would like to work at Morecambe Bay NHS Foundation Trust but there were insufficient posts. They reported the friendliness of the staff, the positive changes in the trust and the new preceptor programme as motivating factors for wanting to secure a permanent position.

6 Furness General Hospital

Two members of the NMC LSA review team who had previously undertaken a site visit visited the labour ward.

There are approximately 1300 births a year at Furness General although on the day of the visit the labour ward was quiet.

It was immediately apparent that the environmental changes provided a light, bright and welcoming environment. Everywhere was spotlessly clean, with equipment stored
neatly and labelled as checked, clean and ready for use. Emergency equipment logs were viewed demonstrating daily testing. The labour ward was tidy with laminated notices and ward boards showing for example, the ‘releasing time to care’ innovations and the new structures in the trust.

There is a new office for staff and a multi-professional rest and meeting room area with internet access. Birthing rooms had been modernised with new showers for women, wall hung ‘drop down’ resuscitaires were about to be installed and there were new Bradbury beds. Rooms were much less austere.

We saw the new arrangements for transfer of women and babies between theatre and the labour ward. These are much improved. There is a continual audit to elicit user views and so far, no problems or adverse comments have been received. Staff interviewed corroborated that the new system was working well.

The transformation achieved in 12 months was remarkable and all involved should be congratulated.

7 Trust executive team

It was anticipated that cultural workshops (which all clinical staff are expected to attend) will help support staff to accept the need to focus the service on the needs of the patient. The clinical director for obstetrics and gynaecology is monitoring attendance at the cultural workshops, and also keen to undertake 360 degree appraisals on medical staff. It was clear that all staff at all levels would be expected to demonstrate the new trust behaviours and values. This is to be welcomed.

The Interim chief executive had a good understanding of the challenges the trust has faced in terms of maternity services and about risks and governance. He explained that there was now strong clinical leadership in the divisional restructure, emphasising the role of senior clinicians to drive service improvements. Previously clinical staff had been disengaged and disempowered with a distrust of management.

The trust chair described hearing about a recent serious clinical incident within two hours of the event. He felt that governance structures which had been weak, were making progress, although he acknowledged that it was still a work in progress. He expected that two non-executive trust board directors would become very involved in maternity issues. SoMs have identified the need to inform non-executive members about the nature and purpose of statutory supervision of midwives.

Both the CEO and the chair described how important it was for the executive team to be visible to patients and staff and to be identified as steering the direction of the trust. The message was ‘the trust board is in charge’. There was recognition that this was not easy but regular walkabouts by the executive team were already proving useful.

The director of nursing would welcome formalised arrangements to meet with the contact SoM on a quarterly basis, discussing themes, trends, issues and successes that have been achieved through supervisory activity.
8 Conclusion

There are many improvements and developments to celebrate, most notably the change in culture, focus and effectiveness of supervisory activity.

It is clear that throughout the trust, change is focused on improving the patient experience and providing safe services.

We have identified areas of concern and areas that require further development. The trust has responded promptly in relation to the management of guidelines and provided additional evidence to demonstrate that key guidelines had been reviewed and ratified and all guidelines are now located in one central database.

Governance systems remain immature and we welcome the outcomes of the trust governance review so that supervisors of midwives can actively engage with a robust and clearly defined system. We appreciate that post our review an appointment to deputy head of midwifery and governance lead has been made.

We would like to recognise the training and support for supervisors of midwives from the North West Local Supervising Authority and NHS North West SHA that have facilitated the growth of individuals and the team of supervisors.

Supervisors demonstrated renewed confidence and competence in their role and were inspirational in their energy and enthusiasm for protecting and safeguarding the public. This momentum needs to be harnessed and tangible evidence gathered to consistently demonstrate the effectiveness of supervision.

Supervisors need to develop good local networks and processes to gain views and experiences of women and families to inform supervisory activities. Users of maternity services must be the central focus for supervision and this is best demonstrated by listening and responding to their opinions.

It is clear that the focus of supervision is the protection of the public. Whilst further work is required, we have confidence in handing over the monitoring of statutory supervision to the local supervising authority. We have identified areas of particular interest that will be reported via our quarterly quality monitoring processes.
The local supervising authority

Local supervising authorities (LSAs) are organisations that hold statutory roles and responsibilities for supporting and monitoring the quality of midwifery practice through the mechanism of statutory supervision of midwives. The primary responsibility of an LSA is to safeguard the health and wellbeing of women and their families.

LSAs sit within an organisation such as an NHS authority. This varies in each country of the United Kingdom, and in:

- England the LSA is the Strategic Health Authority
- Northern Ireland the LSA is the Public Health Agency
- Scotland the LSA is the Health Boards
- Wales the LSA is Healthcare Inspectorate Wales.

The chief executive of the organisation is responsible for the function of the LSA.

Each LSA must appoint a practising midwife to the role of LSAMO. The statutory requirements for this person and role are also set by the NMC which are available at www.nmc-uk.org. The LSAMO is employed by the LSA to put its responsibilities into practice and this function 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 the requirements set by the NMC. Apart from the NMC the LSA is the only organisation that can suspend a midwife from practice and can only do so pending referral to the NMC with allegations of misconduct or persistent lack of competence.

Supervisors of midwives (SoMs) are experienced midwives who have undergone additional education and training in the knowledge and skills needed to supervise midwives. SoMs can only be appointed by a LSA, not by an employer, and as such are acting as an independent monitor of the safety of midwives’ practice and the environment of care provided by the maternity services. By appointing SoMs the LSA ensures that support, advice and guidance are available for midwives and women 24-hours a day, to increase public protection. SoMs are accountable to the LSA for all their supervisory activities and their role is to protect the public by enabling and empowering midwives to practise safety and effectively. They also have a responsibility to bring to the attention of the LSA any practice or service issues that might undermine or jeopardise midwives’ ability to care for women and their babies safely.

Every midwife practising in the UK is required to have a named SoM who is from the LSA in which she practises midwifery most each year. This LSA is described as the midwife’s main area of practice and every midwife is required to notify their intention to
practise (ItP) to this LSA each practice year. A practice year runs from the 1 April to 31 March.
The review team

Name: Carmel Lloyd
Role in review team: NMC representative
Other roles: Assistant Director, Policy and Standards

Name: Helen Pearce
Role in review team: NMC representative
Other roles: NMC Midwifery Adviser

Name: Verena Wallace
Role in review team: NMC LSAMO LSA reviewer
Other roles: LSAMO, Public Health Agency, Northern Ireland

Name: Sally Williams
Role in review team: NMC Lay LSA reviewer
Other roles:
Key people met during the review

- CEO
- Director of nursing
- FGH and WGH matrons
- Midwives
- Student midwives
- Lead paediatric consultant
- Midwife mentors
- Head of midwifery
- Service user
- Trust chair
- Healthcare assistants
- Perceptor midwives
- Obstetric clinical lead
- LME
- SoM
- Governance midwife
- Chief operating officer
- Interim practice development midwife
- RLI midwives
- Anaesthetist
Programme for the review

NMC LSA review framework

University Hospital Morecambe Bay Foundation Trust

18-20 June 2012

Programme

Day 1
18 June 2012

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
</tr>
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<tbody>
<tr>
<td>0915</td>
<td>FGH and WGH Matrons (</td>
<td>Teaching Room 2 Education Centre</td>
</tr>
<tr>
<td>9.45am</td>
<td>In camera session</td>
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<tr>
<td>10.00am</td>
<td>Meeting with midwives</td>
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<tr>
<td>10:45am</td>
<td>Break</td>
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<tr>
<td>11:00am</td>
<td>Meeting with student midwives</td>
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<td>Lunch</td>
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<tr>
<td>13:15pm</td>
<td>Meeting with midwives</td>
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<tr>
<td>13:45</td>
<td>Meeting with director of nursing</td>
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<tr>
<td>14:45</td>
<td>Meeting with lead paediatric consultant</td>
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<tr>
<td>15:00</td>
<td>In camera session</td>
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<tr>
<td>15:30</td>
<td>Meeting with midwife mentors</td>
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<tr>
<td>16:00</td>
<td>Teleconference with head of midwifery</td>
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Day 2
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<tbody>
<tr>
<td>0915</td>
<td>In camera session</td>
<td>VC Room/ FGH Education Centre -Teaching Rooms</td>
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<tr>
<td>10.00am</td>
<td>Meeting with service users</td>
<td>WGH Education Centre/FGH Education Centre- Teaching Rooms</td>
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<td>11:15 am</td>
<td>Teleconference with CEO</td>
<td>VC Room</td>
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<td>11:30</td>
<td>In camera session</td>
<td>VC Room</td>
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<tr>
<td>11:45</td>
<td>Meeting with trust chair</td>
<td>VC Room</td>
</tr>
<tr>
<td>12:00</td>
<td>Lunch</td>
<td>VC Room</td>
</tr>
<tr>
<td>13:15</td>
<td>Meeting with healthcare assistants</td>
<td>VC Room</td>
</tr>
<tr>
<td>13:45</td>
<td>Meeting with student midwives</td>
<td>VC Room</td>
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<tr>
<td>14:00</td>
<td>Meeting with preceptor midwives</td>
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<td>Meeting with obstetric clinical lead</td>
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<td>Meeting with LME</td>
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<td>15:30</td>
<td>Meeting with SoM</td>
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<td>16:10</td>
<td>Meeting with HoM</td>
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**Day 3**  
20 June 2012

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<tr>
<td>09:00</td>
<td>Meeting with governance midwife</td>
<td>Parent Craft Room</td>
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<tr>
<td>09:30</td>
<td>Meeting re risk register</td>
<td>Parent Craft Room</td>
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<tr>
<td>10:30am</td>
<td>Meeting with preceptorship midwives</td>
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<tr>
<td>11:00</td>
<td>Meeting with chief operating officer</td>
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<td>11:15</td>
<td>In camera session</td>
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<td>11:30</td>
<td>Meeting with interim practice development Midwife</td>
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<td>12:00</td>
<td>Concurrent session</td>
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<td></td>
<td>Meeting with RLI midwives</td>
<td>Mtg Room-Top Floor- Womens Unit/Parent Craft Room</td>
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<tr>
<td></td>
<td>Meeting with student midwives</td>
<td>Mtg Room-Top Floor- Womens Unit/Parent Craft Room</td>
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<tr>
<td>13:00</td>
<td>Meeting with anaesthetist</td>
<td>Mtg Room-Top Floor- Womens Unit/Parent Craft Room</td>
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End of day 3
Evidence viewed

- Risk management Strategy
- Risk management meetings minutes
- Governance meeting minutes
- SoM patient safety incidents
- Meeting minutes from:
  - RLI
  - FGH
  - WGH
- Maternity guideline meeting minutes
- Maternity risk management strategy
- Service user meeting minutes
- Trust board presentation
- Supervisory team presentation
- SoM meeting minutes
- SoM business plan (protected time)
- SoM diary sheets
- SoM letters to HoM