MINUTES OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON MONDAY 5 DECEMBER 2011 AT 10.00 AM IN COMMITTEE ROOM 1, HENDON TOWN HALL, THE BURROUGHS, HENDON NW4 4BG

Present: Councillors Gideon Bull (Chair) (L. B of Haringey), John Bryant (Vice Chair) (L.B. of Camden), Alev Cazimoglu (L. B. of Enfield), Alison Cornelius (L. B. of Barnet), Maureen Braun (L.B. of Barnet) Martin Klute (L. B. of Islington), Graham Old (L.B. of Barnet), Anne Marie Pearce (L. B. of Enfield),

Officers: Mike Ahuja (L. B. of Enfield), Sally Masson (L. B. of Barnet)

Also present: Martin Machray, Liz Wise (NHS North Central London), Erik Karas, (Barnet, Enfield and Haringey Mental Health Trust (BEH MHT)).

1. **WELCOME AND APOLOGIES FOR ABSENCE (Item 1)**
   The Chairman welcomed all those present to the meeting. Apologies for absence were received from Councillor Peter Brayshaw (L.B. of Camden) and Alice Perry (L. B. of Islington)

2. **URGENT BUSINESS (Item 2)**
   There were none.

3. **DECLARATIONS OF INTEREST (Item 3)**
   Councillor Gideon Bull declared an interest that he was an employee at Moorfields Eye Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

   Councillor Alison Cornelius declared an interest that she was a Chaplain's assistant at Barnet Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

4. **MINUTES (Item 4)**

   RESOLVED:
   That the minutes of the meetings held on 31st October and 14th November 2011 be agreed.

5. **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC) – TERMS OF REFERENCE (Item 5)**

   Members discussed whether there should be one vote allocated to each borough or whether a vote should be given to each borough representative who attended the committee.

   The Committee's terms of reference stated:

   'Due to the need for recommendations and reports to reflect the views of all authorities involved in the process, one vote per authority was agreed as more

*appropriate then each individual Members being given a vote. It is nevertheless to be emphasised that decisions by the joint committee should be reached by consensus rather than a vote. Every effort should therefore have been made to reach agreement before a vote is taken.' (*Each borough is entitled to a single vote irrespective of the number of representatives present at the meeting).

RESOLVED:
That the current voting system, as outlined within the terms of reference for the Committee, be maintained.

6. TRANSFORMING CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) IN PATIENT SERVICES FOR YOUNG PEOPLE LIVING IN BARNET, ENFILED AND HARINGEY (Item 6)

Eric Karas presented an introduction to the proposed new model of service. He also addressed some of the issues that had been raised by the committee over the course of the year. Concerns from the committee have included;

- The type of clinical evidence that is needed to underpin the new proposals:
- How BEH MHT will deliver clear pathways of care including local consultations; and
- What the possible impact might be after the redesign of the service and how the service will be implemented.

National research recommended that CAMHS is most effective when it is offering community based services which have good links with other support networks with mainstream mental health care and inpatient residential services.

Minimising the length of stay in an inpatient facility and promoting an integrated return to community based services was felt to be the best way forward. There was much research to support this way of delivering care. Having patients treated within community based service provision ensures that the patient stays in touch with family and other support networks, minimising the disruption to lessons at school for instance.

The Committee felt that they should be monitoring the pilot implementation and any further developments that may result as a consequence. The Committee also felt that young people should be involved more when planning treatment programmes to be delivered through local services. There needed to be some assurance that the new plans were working before any substantial investment was committed. For instance, consideration needed to be given to whether there were enough young people accessing this model of care to make it viable and were enough young people being involved in the service design.

It was discussed as to whether Barnet could manage the financial implications of the changes and Members wanted more detail regarding the financial arrangements to come from the Mental Health NHS Trust.

Members felt that there were justified concerns around the commitment to compress the timeframes of delivery and the redeployment of staff. Members also sought feedback from the focus group which had been set up at the time of

service planning. Members of the focus group were to be invited to come to the JHOSC to share their views.

Erick Karas explained to the Committee that long inpatient stays in the Northgate and 'New Beginnings' facilities had been a problem with patients getting stuck around the transition stages. In intensive community teams, trained therapists acted as care co-ordinators through the system, drawing service users back into the community wherever possible, using assessments to provide intensive treatments at home where appropriate. Mentalisation Based Therapy was the therapeutic model which will underpin the whole service. The sorts of treatments available would be varied and include:

- Systemic Family Therapy
- Cognitive Behavioural Therapy
- Solution Focused Therapy
- Psychodynamic Therapy
- Medication and other therapy approaches.

Education will be integrated into the treatment programmes.

Members wanted to know more about the refurbishment of the Northgate site which will host acute and inpatient units. The presumption was that the average length of stay in these units should be reduced, with treatment being completed between 8 – 16 weeks depending on needs. It was noted that in Hunter Coomb Treatment Centre, which was provided by the private sector, individuals were often staying longer than would be expected for their required needs and the new model set out to ensure that no individual was staying longer than necessary, when their needs would be best addressed in a more holistic, community based setting.

Members were concerned that there was not yet a business case available for the proposed new service and felt that they could not commend fully the proposals without sight of it.

Councillor Cornelius requested further information on how the refurbishments to the Northgate Clinic, which had been closed for a total of 9 months now, were going. She also wanted to know what had happened to the Holly Oak building.

RESOLVED:

1. That BEH MHT and service commissioners be requested to bring a business case to the JHOSC meeting on 16th January to review the financial implications of the proposed changes in service delivery and how these fit in with the clinical model, such as the resourcing of out of borough placements.

2. That Members of the focus group be invited to the JHOSC to provide feedback to the Committee on service planning.

3. That BEH MHT to update the Committee on the refurbishment of the Northgate and what was happening to the Holly Oak building.

7. STRATEGIC AND QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION PLAN (QIPP) (Item 7)

Liz Wise, the Quality, Innovation, Productivity and Prevention Director, NHS North Central London gave a presentation on the QIPP Plan Performance.

Members were concerned about what would happen to the debt once the North Central London cluster disappeared. The Committee noted that any debt pre April 2011 will not be carried over to CCGs. However, any debt incurred after April 2011 would be carried over to CCG organisations. Liz Wise stressed there was a complete commitment not to hand over organisations with debt to CCGs in April 2013.

The Chair said that he would draft a letter to obtain clarity from government on what the financial arrangements would be once the NCL had been dissolved. Liz Wise said that the CCGs would be the authorisation point and the Commissioning Groups Guidance would be commissioning the spend.

Members wanted to know how the CCGs are to be organised across the 5 boroughs and how the contracts were to be managed. Members were also keen to understand how the JHOSC could get involved.

RESOLVED:

That the Chair write to the Secretary of State for Health requesting clarity on what the financial arrangements would be in place, including the treatment of any outstanding debt, once the NCL cluster had been dissolved.

8. QIPP PLAN – UNSCHEDULED CARE (Item 8)

Liz Wise Quality, Innovation, Productivity and Prevention Director, NHS North Central London gave a presentation on the QIPP Unscheduled Care aims.

The aim of the plan was to develop the way people experience and access integrated care and prevention services. A&Es needed good continuity of care and integration to avoid a perception of a chaotic service. Urgent Care Centres were needed with adequate opening hours and the right treatment for what service users needed.

The presentation detailed the following aims: to transform unscheduled care by the development and the commissioning of integrated services, increasing levels of unplanned secondary care through the enhancement of integrated working between GP practices, out of hours services, unscheduled care provision, community services and social care. The national priority was to establish a single point of access.

Liz Wise outlined the NHS 111 Service. This service was set out to assist the public with accessing urgent healthcare and to assess callers during their first contact, directing them to the right local service. The service was set to be in operation in 2013. Members wanted more information on secondary users. NCL NHS cluster agreed to provide the committee with more information.

RESOLVED:

That NHS NCL be requested to Members with more information on secondary users with regard to the new NHS 111 service.

9. QIPP PLAN - CONTINUING CARE

Members had concerns around the 'Capacity to make the Decision' section of the Continuing Care document. *'Where a personal welfare deputy has been appointed by the Court of Protection under the mental Capacity Act or a Lasting Power of Attorney with powers extending to healthcare decisions has been appointed then the PCT will consult with that person and obtain a decision from the appointed person on the preferred care option.'*

The Committee wanted to know if there was any arbitration or an independent advocate embedded into the procedure. It was felt that end of life care needed an advocate to ensure that the patients interests were represented, especially where there was not an appropriate family member to help. It was very important that an advocacy service played a part in the structuring of care, particularly where there were mental health issues. It was also felt that it was important that patients received the right kind of care at end of life and that advocacy support played a part in helping deliver that care. It was noted that the LINk was involved with this aspect of care provision.

Members wanted to see that, where there might be disagreement between carers, clinical staff and/or patients, there were clear legal pathways set out. Members also wanted to see that there were measures to deliver the right kind of care through the courts if necessary and that the process was robust.

It was noted that Continuing Healthcare is delivered through the hospitals multi disciplinary teams with GP, primary care involvement along with specialist teams for end of life care.

10. FUTURE WORK PLAN (item 10)

Members considered the Work Plan for future meetings of the Committee.

16th January 2012

RESOLVED:

1. That BEH MHT bring a business Case and members of the focus group to the Committee.

2. That the issue of specialist commissioning of TB services be discussed.

27th February 2012

RESOLVED:

1. More exploration of the Consultant/consultant rates – management of the acute contract.

2. Update on Primary care review.

3. Transition of commissioning support (CCGs) – New landscape in public health commissioning.

11. ANY OTHER BUSINESS

There was none.

……. **…….**

Chairman **Date**

MJE/JHO&SC 5.12.2011

Agenda Item 5

NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, ENFIELD, HARINGEY, **WARDS:** ALL
REPORT TITLE: Implementing Transforming Community and Adolescent Mental Health Services	
REPORT OF: Andrew Williams Borough Director Haringey NHS North Central London	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 08/01/12**

SUMMARY:
The Community and Adolescent Mental Health Services (CAMHS) item will provide members with an update on the development of the business case.

The presentation will be part of the wider agenda item that enables members to stay informed of current progress in the implementation of the new CAMHs serivice.

The business case is being jointly developed between NHS North Central London and Barnet, Enfield and Haringey Mental Health Trust.

CONTACT OFFICER:
Elizabeth Stimson
Senior Communications and Engagement Officer
NHS North Central London

RECOMMENDATIONS: The Committee is asked to note the information provided.

Andrew Williams
Borough Director Haringey
NHS North Central London

DATE: 08/01/12

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Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London Sector

16 January 2012

Maternity Services

1. Report

1.1 A recent report to NHS London has outlined issues arising from the annual report of the Local Supervising Authority (LSA) of NHS London on how standards set within the Midwives Rules and Standards (2004) have been met

1.2 A copy of the report to NHS London is attached as well as the LSA report for 2010-11 to which it refers. A presentation will be made to the Committee by officers from NHS North Central London on issues arising from the report relating to north central London.

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Board Secretary and Business Manager
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Southside
105 Victoria Street
London SW1E 6QT

NHS London Board

19th October 2011

Title:	The Local Supervising Authority Annual Report, 2010-2011		
Agenda item:	4.5	**Paper**	M
Action requested:	For information		
Executive Summary:	The purpose of this report is to inform NHS London, the Nursing & Midwifery Council (NMC) and the public how the Local Supervising Authority (LSA) of NHS London met the standards set within the Midwives Rules and Standards (2004). This report is an analysis of the information provided by the Trust teams to the Local Supervising Authority (LSA) for the 10/11 year. The focus of the report this year has been to highlight the challenges to the supervisors of midwives and report on the LSA's action in response to these. The strategic role of London LSA is to set the direction of the supervision of midwives in line with the Nursing and Midwifery Council. The LSA ensures that there are systems and processes in place to monitor the performance of the supervisors of midwives and midwives within the area. The key headlines from this year are: • The birth rate has risen but only by 0.6% compared to 2%/ year for the last four years. • There has been an increase in the funded establishment of midwives overall but a decrease in some units funded establishments • The midwifery vacancy rate has decreased from 16% last year to 12% this year. • The Pan London Maternal Death Review was published. • 18% of midwives are eligible for retirement now and a further 11% will become eligible in the next 5 years. • The caesarean section rate continues to increase. • The home birth rate has decreased by 0.2%. • Temporary suspensions of maternity services have increased and, as in the previous three years, most occur in SE London Cluster. Supervisors of midwives are emerging as leaders and catalysts in the implementation of national drivers to improve genuine choice, access, safety and satisfaction for future users of the maternity services.		

Summary of recommendations		This report is sent to the Board for information.					
Fit with NHSL strategy:		This report was produced in order to meet the requirements of Rule 16, 'The midwives rules and standards' (Nursing & Midwifery Council 2004).					
Reference to other documents:							
Date paper completed:		7th September 2011					
Author name and title:		Angela Helleur, LSA Midwifery Officer		**Director name and title:**		Trish Morris-Thompson, Chief Nurse	
Date paper seen by EMT	**28/09/11**	**Equality Impact Assessment complete?**	**no**	**Risk assessment undertaken?**	**no**	**Legal advice received?**	**no**

The London LSA Annual Report to the Nursing and Midwifery Council 2010/2011

1 Introduction

This report covers the period from 1st April 2010 to 31st March 2011 and was produced in order to meet the requirements of Rule 16, 'The midwives rules and standards' (Nursing & Midwifery Council 2004). The appendices in this report contain information related to activity of the London LSA.

The purpose of this report is to inform NHS London (NHSL), the Strategic Health Authority, the Nursing & Midwifery Council (NMC) and the public how the Local Supervising Authority (LSA) of NHS London met the standards set within the Midwives Rules and Standards (2004).

This report is an analysis of the information provided by the London Supervisors of Midwives (SoMs) to the Local Supervising Authority (LSA) for the 10/11 year. The focus of the report, this year, is to demonstrate how the London LSA is meeting the Nursing and Midwifery Council (NMC) standards for LSAs and to highlight the contribution of SoMs towards improving the safety and quality of maternity care for mothers and babies in London. It will also highlight the challenges facing SoMs and report on the LSA's action in response to these.

2 Summary of Key Headlines

This report has identified a number of key issues in relation to the statutory supervision of midwifery and for London's maternity services.

Supervisors of Midwives:

- The London LSA has increased the number of SoMs by 20 in total in the last year. This includes 36 appointments and twenty resignations, mostly due to retirement. The number of midwives applying for SoM preparation courses has increased by 50% in the last three years.
- The London SoM: Midwife ratio is 1:16; this does not meet the NMC standard of 1:15. There is variation across London in terms of the SoM to Midwife ratio.
- The LSA team is supporting SoM teams where required with SoM investigations, advice and support.
- All SoMs in London (345) are reviewed by the LSAMO or Assistant LSAMO to review performance and to discuss developmental needs.
- All SoM teams have had development in the form of team development, leadership programmes, LSA conferences, Fitness to Practice Master Classes and other programmes of development.
- The report describes how the London LSA ensures that all midwives have 24 hour access to a SoM, the practice of midwives is supervised and how it ensures that the statutory function is maintained in line with the LSA standards.
- A number of challenges for supervision have been identified; scrutiny and review from external organisations has generated a significant increase in SoM workload to ensure that action is taken to improve the safety and quality of maternity services, the performance of some SoM teams and individual SoMs has needed to be

supported, dedicated time for SoMs has been a challenge particularly for those who are clinically based, not all midwives have had an annual review in a timely manner.

Developing trends

- Activity has increased by 0.6%, 134,544 births, compared to a 2% increase in the previous three years.
- There were 31 complete suspensions of services in year. The majority of these occurred in maternity services within the North West Cluster (12) and the South East Cluster (12). There were several more partial suspensions of services e.g. home births, midwifery led units, however, this has not been reported on as not all units reported this consistently throughout the year. The system has been modified to collect this data and will be reported on in 2011/2012.
- The Caesarean section rate continues to increase; the Pan London rate for 2010/2011 is 29%, which is an increase of 0.3% in year.
- Home birth rates have decreased by 0.2% this year.
- A Pan London review of Maternal Death was undertaken and a report produced. This has been discussed previously.

Midwifery Practice

- 89 SoM investigations were undertaken involving 126 midwives.
- A number of themes in relation to concerns around practice and organisational (system) issues were identified. The most frequently identified concern around practice was failure to recognise or to take appropriate action with a deviation from the norm. The most frequently identified organisational issue was insufficient support for newly qualified midwives.
- There were 61 programmes of developmental support and 20 programmes of supervised practice undertaken by midwives. There were two suspensions from practice and referrals made to the NMC.

Midwifery Workforce

- There were 5575 midwives employed in London in 2010/11, equivalent to 4430 whole time equivalent. This is an increase of 79 whole time equivalent midwives. This gives a Pan London midwife to woman ratio of 1:31. There is significant variation across London and some units have seen a decrease in the funded midwifery establishment.
- There is little change in the pan London age profile of midwives since 2010/11 which shows that the average age of midwives in London is 43 and that 18% of midwives are eligible for retirement now. A further 11% will be eligible to retire within the next 5 years. The NHSL workforce planning team in collaboration with the LSA have used this information to scrutinise local workforce plans and to commission university places for midwifery training.

3. Next Steps

The LSA will develop an action plan from this report following the NMC's analysis and recommendations. The LSA is due to review the London LSA in October 2011.

The full report is available for information.

NHS London

Local Supervising Authorities of London

ANNUAL REPORT TO THE NURSING & MIDWIFERY COUNCIL

1ST APRIL 2010 – 31ST MARCH 2011

Angela Helleur
LSA Midwifery Officer

August 2011

Contents

Executive Summary

This report is an analysis of the information provided by the London Supervisors of Midwives (SoMs) to the Local Supervising Authority (LSA) for the 10/11 year. The focus of the report, this year, is to demonstrate how the London LSA is meeting the Nursing and Midwifery Council (NMC) standards for LSAs and to highlight the contribution of SoMs towards improving the safety and quality of maternity care for mothers and babies in London. It will also highlight the challenges facing SoMs and report on the LSA's action in response to these.

The strategic role of London LSA is to set the direction of the supervision of midwives in line with the NMC's Rules and Standards and LSA guidance. The LSA ensures that there are systems and processes in place to monitor the performance of the supervisors of midwives and midwives within the area. All maternity services in London have been subjected to a formal audit by the LSA, in addition to this, the LSAMO and Assistant LSAMO have met with individual SoMs to verify NMC PREP requirements and individual supervisory activities contributing to all five LSA standards of statutory supervision of midwives. A scorecard has been developed and piloted to monitor all supervisory activities on an individual SoM and team basis, the purpose of the scorecard is to have an ongoing account of supervisory activities and, therefore, provide an assurance framework for the LSA.

The LSA and Strategic Health Authority (SHA), NHS London play a key role in monitoring standards in London's maternity services; working closely with commissioners of services and liaising with the Care Quality Commmission (CQC) and NMC. A number of London's maternity services have been asked to make improvements and the LSA has worked closely with these services to support the development of action plans and ongoing improvements.

Last year the LSA highlighted concerns around the apparent increase in the number of maternal deaths and commissioned an extra ordinary review of all maternal deaths that occurred in London in 2009 and for the first six months of 2010. This report contains a summary of the review and a link to the full report.

Investment into maternity services has continued throughout 10/11, resulting in improvements to staffing, estate and choice for women. There has been a 30% increase in activity through London's maternity services over the last 10 years and this growth continues, although this has been at a slower rate this year, 0.6%. 134,544 women gave birth with 8274 midwives submitting their intention to practice to the London LSA. There was an increase of 227[1] whole time equivalent midwives employed in London. There has been a focus on recruitment of midwives across the capital that has resulted in a significant reduction of midwife vacancies; from 16% last year to 12% this year. Some services continue to see a growth in their midwifery workforce numbers whereas others have reduced funded establishment.

[1] Includes temporary (Bank and Agency) workforce used.

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1.0 Introduction

This report covers the period from 1st April 2010 to 31st March 2011 and was produced in order to meet the requirements of Rule 16, 'The midwives rules and standards' (Nursing & Midwifery Council 2004). The appendices in this report contain information related to activity of the London LSA.

The purpose of this report is to inform NHS London (NHSL), the Strategic Health Authority, the Nursing & Midwifery Council (NMC) and the public how the Local Supervising Authority (LSA) of NHS London met the standards set within the Midwives Rules and Standards (2004).

Angela Helleur continues to hold the post of LSA Midwifery Officer for London (LSAMO); she is supported by Jessica Read, Assistant LSAMO and Carol Walsh, LSA Administrator. This year additional support was given for six months by two full time LSA support midwives, Fiona Walkinshaw and Denise Henry and two part-time LSA support midwives, Clare Capito and Georgina Simms. This increase in resource has allowed for significant improvement in support to London's SoMs and to enable special projects to strengthen supervision for midwives and women.

Analysis from the 2010-11 LSA annual report continued to identify trends in increasing birth rates and increasing complexity of health and social need of the women who use the services. The LSA continues to raise awareness of the effects of the increasing birth rates through its annual report and through individual feedback given to maternity service providers and commissioners.

2010-11 saw significant change in Health Policy and plans to reconfigure the infrastructure of Health; Equity and Excellence, Liberating the NHS, (DH, 2011)[2]. In line with these plans London has changed the commissioning arrangements into six acute commissioning Clusters. Work has also commenced to set up Maternity Network Boards.

The workforce required to provide maternity care has remained in focus. Programmes for the leadership and development of London's midwives have continued and feedback from the first year of the Foundation Degree for Maternity Care Workers has been extremely positive.

Two of London's maternity services were asked to make improvements by the CQC, Barking, Havering and Redbridge Hospitals University (NHS) Trust and Croydon Healthcare (NHS) Trust. The LSA has worked closely with the management teams and SoMs of both services to support the development of the action plans and assisting with further improvements.

The London LSA has taken account of the recommendations from the NMC publication, Supervision, Support and Safety, an analysis of the 2009-10 LSA reports to the NMC[3] and includes evidence of this throughout this report.

[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
[3] http://www.nmc-uk.org/Publications/Midwifery-Supervision/

1.1 Demography

Since July 2006 NHS London has replaced the previous five Strategic Health Authorities (SHA) in London and is responsible for developing a sustainable quality strategy for users of maternity services in the capital. Across London there are 24 NHS Trusts, two private maternity hospitals[4] and HMP Holloway, plus a number of self employed midwives providing midwifery care outside of the NHS.

Clinical activity for all maternity services has once again increased during this reporting year. 20% of all births in England take place in London. The birth rate over the past five years in London has increased by 16% compared to the overall rate for England of 12.8%. It is anticipated that the birth rate in London is set to increase by approximately 19,000 births over the next decade, in part due to the population growth associated with the Thames Gateway and the regeneration of land in the 2012 London Olympics project. This will add up to a further 6.8% demand on the existing maternity services across London[5].

The widening ethnic and multi-cultural society is also likely to affect the birth rate when the size of family is traditionally higher than the 2.5 average. The profile of pregnant women means that London's maternity services are caring for a higher proportion of women with complex medical and social needs. Currently 53% of babies are born to mothers who themselves were born outside of Britain, having significant implications for the maternity services as these groups of women are reported as having higher rates of complications in pregnancy.

The national trend of younger women and women over 40 years giving birth is more pronounced in London. The teenage rate of pregnancy 51/1,000 is higher than the national rate of 42/1,000 and of the ten local authorities with the highest under 18 conception rates in England seven of these were London Boroughs. Teenage pregnancy rates pose a major challenge for London's maternity services and midwifery workforce because of the association between teenage parents and poorer antenatal heath, lower birth-weight babies and higher infant mortality.

The number of 'older' women giving birth over the age of 40 years is proportionally higher at 17.7/1000 compared to England and Wales of 10.4/1000. Midwifery care for such women is more demanding, due to the increased health risks to mothers and babies associated with women over 40 years having a direct Impact on the maternity services and midwifery workforce.

Currently 96.5% of births take place in maternity units in hospital (a combination of obstetric units and alongside midwifery led units), 1.5% of births take place at home and a further 2% of births in stand alone midwife led units.

Most maternity units have reported an improvement in being able to provide one to one care for all women in established labour. London has the highest midwifery vacancy rates in England[6] with an average rate this year of 12%, a significant improvement on last year's 16%. Many trusts are facing a 'retirement bulge' with 18% over the age of 55 years. London's newly qualified midwives are younger than average but many are unable to stay long term in London due to the high cost of housing and living in the capital.

[4] St John and St Elizabeth Hospital closed its maternity service in July 2010.
[5] Graham D 2007 London Maternity Services Review Progress Report NHS London
[6] RCM 2008 (March) Response to the Healthcare for London Consultation 'Consulting the Capital'

2.0 Publication of the report

A hundred and fifty bound copies of the LSA report are produced. The full report is taken to a Board meeting of NHS London and is signed off by the SHA Chief Executive. It is then sent electronically to the NMC by 31st August 2011, hard copies are then
Circulated to the following:

- Chairs of local MSLC
- Leads for Midwifery Education at all the Higher Education Institutions
- Chief Executives of Commissioning Clusters who commission Maternity services in London
- All current supervisors of midwives accountable to the London LSA
- Heads of Midwifery Services in London
- Clinical Directors of Maternity Services in London
- Directors of Nursing in London Trusts that have Maternity Services
- CMACE
- Independent Midwives UK
- NPSA
- President of RCOG
- President of RCM
- Department of Health Maternity Advisors
- London Lead for Care Quality Commission

The report is also placed in the public domain via publication on the London LSA website www.midwife.org.uk.

3.0 Numbers of SoM appointments, resignations and removals

Year	No. of Midwives	SOM Number	Appointments	Resignations	Leave of Absence	Removals	Number of Student SoMs
2010-11	5575	345	36	22	8	0	36*
2009-10	5348	325	45	11	14	0	31*
2008-09	5103	320	44	16	20	2	
2007-08	4969	275	41	26	13		
2006-07	4985	268	28	23	13		
2005-06	4590	269	34	22	15		

***42 candidates were successful at interview 2 failed the course and 4 have deferred due to personal reasons.**

The LSA team and local teams of supervisors of midwives have continued to raise the profile of supervision and there have been a number of innovations by individuals to increase the awareness and understanding of Supervision.

This year the number of supervisors has increased by 6%, which has resulted in a marginal increase in the overall ratio of SoM to midwife to 1:16.1, however, there has also been an increase in the number of midwives, whose main area of practice is London, all of whom require a SoM Expressions of interest for SoM preparation courses has increased with over 70 applicants having been processed so far in 2011. The number of SoMs is expected to increase over the next two years, in order to meet the NMC standard ratio of 1 supervisor to 15 midwives. The majority of resignations were due to retirement from employment and a change in personal or family circumstances, however, 5 SoMs resigned as they felt that they could not meet the challenge of the role in conjunction with the demands of their substantive role. Most periods of leave of absence were given for maternity leave or illness or due to increased demands from their substantive roles.

Following the NMC review of the London LSA (April 2009), a recommendation was made "The LSA should continue to develop clear strategies for "talent spotting" any midwives who may wish to become supervisors of midwives and midwives should be able to approach the LSA directly for information about how to become a supervisor". Work has been ongoing to ensure that midwives are aware of the role, how to apply and how to access support. The Contact SoMs from each team have been pivotal in ensuring that this information is disseminated to local midwives and many SoMs report identifying potential SoMs during the annual review process. The London LSA conferences are now open to any midwife who has expressed an interest in the role. Many examples of how SoM teams encourage recruitment of potential SoMs were seen as part of the LSA audit programme. These include SoM "walk abouts", SoM involvement in mandatory training with a specific focus on the role of the SoM, questionnaires of midwives views on supervision and local action plans to improve SoM recruitment. The LSA publishes a document on the London LSA website on the process for selection; http://www.londonlsa.org.uk/, this also includes a template for curriculum vitae to facilitate the process.

The ratio of supervisors of midwives to midwives remains at 1:16 in London, on 31st March 2011; this is despite an increase of 25 SoMs in 2010-11. Many Trusts who have reduced

numbers of SoMs have invested in additional supervision time from external SoMs, so whilst their ratios remain high, the actual time spent on supervision is significantly increased[7].

However, there is a significant variation in ratios in the different Trusts (see 2.1) from 1:8 at best to 1:29 at worst. The role of the LSA support midwife has been invaluable this year in ensuring that there is increased support for SoMs, particularly where there are insufficient numbers. The LSA midwives have all been able to undertake supervisory investigations, help with annual reviews, attend SoM meetings and provide 1:1 support for SoMs when required. Feed back from SoM teams has been extremely positive about the increase in support.

In Trusts where the ratio of supervisor of midwives fell short of the 1:15 standard different approaches were employed to ensure all midwives had access to a supervisor of midwives at all times. In several Trusts, supervisors of midwives who had retired from substantive posts were employed on part time contracts for the purpose of supervision. In others, the use of independent supervisors of midwives was found to be an excellent short term measure.

The LSA team has supported teams where the shortage of SoMs has been a challenge by undertaking supervisory investigations, attending SoM meetings and by facilitating support from other teams. Where this has been of particular concern the LSA has met with the Trust managers to secure additional funding for additional supervisory support and maintained a high profile within the Trust. This has been the case in the two Trusts where improvements have been asked to be made. The LSAMO has met with the SoMs and Executive teams of these Trusts to ensure that adequate focus, resource and support is given to the statutory supervision of midwives.

[7] Good practice – a number of Trusts have employed external SoMs to support teams where the SoM: Midwife ratio is high.

3.1 The Ratio of Supervisors of Midwives to Midwives Trust specific

Trust	Ratio of Midwives: Supervisors as at 31/03/2010	Number of Midwives	Number of Supervisors *	Ratio of Midwives: Supervisors as at 31/03/2011	
St. John & St. Elizabeth (Private)	8.33	12	2	6.00	↑
North Middlesex	9.83	123	13	9.46	↑
Lewisham	9.45	117	12	9.75	↓
Royal Free	9.69	139	13	10.69	↓
The Royal London	13.83	175	15	11.67	↑
West Middlesex	12.92	167	14	11.93	↑
St. George's	13.93	226	17	13.29	↑
Barnet & Chase Farm	15.50	250	18	13.89	↑
Imperial College	13.56	347	24	14.46	↓
Whittington	15.23	200	13	15.38	↓
The Portland (Private)	18.00	77	5	15.40	↑
UCLH	17.73	190	12	15.83	↑
King's College	16.94	289	18	16.06	↑
Epsom & St Helier	14.69	245	15	16.33	↓
Guy's & St. Thomas'	26.33	301	18	16.72	↑
South London		427	25	17.08	
Ealing	17.00	122	7	17.43	↓
Northwick Park & Central Middlesex	16.92	221	12	18.42	↓
Kingston	18.73	240	13	18.46	↑
Chelsea & Westminster	23.00	269	14	19.21	↑
Homerton	16.60	186	9	20.67	↓
Whipps Cross	23.11	207	10	20.70	↑
Barking, Havering and Redbridge Trust	22.00	337	16	21.06	↑
Hillingdon	18.00	153	7	21.86	↓
Newham	27.86	213	9	23.67	↑
Croydon Health Services	18.75	148	5	29.60	↓
Total	**16.37**	**5533**	**345**	**16.04**	↑

*Information taken from SoM Record

Below the standard 1:15

Source: LSA Database

3.2 Professional Development of Supervisors

All SoMs appointed to the London LSA had a meeting with the LSAMO or Assistant LSAMO to discuss their supervision portfolios. This provided an opportunity for the LSA to feedback on performance over the last year and for a discussion on specific development needs for the SoMs. Only those SoMs who were on leave of absence were not seen or their portfolios not reviewed. A development plan is expected to be formulated by the individual SoM following the meeting and is used to inform the meeting with the LSA in the following year. The LSAMO is able to identify themes for development for the SoMs and is used to inform the LSA local development plan. This year the themes from the one to one meetings included, support with supervisory investigations, programmes of supervised practice and dealing with challenging conduct and behaviour.

The supervisors continued to use the benchmarking exercise using the Skills Development Workbook introduced for newly appointed supervisors in their preceptorship period. This is

based on work undertaken by the LSA in conjunction with the University of Hertfordshire in the development of the new preparation course for student supervisors.

The Fitness to Practice Master classes have continued throughout 2010-11, with a further 143 SoMs having accessed them this year. This brings the total to 253 SoMs now having had this development. The quality of supervisory investigations has increased significantly since the inception of these workshops. They continue to be well evaluated.

The LSA recognises the important contribution of the role of Contact SoM towards the function of the SoM teams and the Contact SoM meetings have increased in number and duration to incorporate training and development to reflect this. Training on equity and diversity, the Department of Health white paper, the London Maternal Death review and antenatal and neonatal screening are among the topics presented this year.

The LSA team also attended a number of SoM team development days to present the topics of; supervised practice programmes, dealing with challenging conduct and behaviour, escalating concerns and influencing the quality and safety of maternity services.

The LSAMO, Assistant LSAMO and LSA Midwives spoke at local and National Conferences where SoMs formed part of the audience.

As in previous years two conferences were held in London for the supervisors of midwives in May and October 2010. The May conference was the same as the October 2009 programme where the London LSA worked together with Bond Solon Training Ltd to increase the SoMs knowledge of their role in regulation and the legal process. The October Conference focussed on Maternal Death. Both conferences were extremely well evaluated (see **Appendix 1 and 2** for conference agendas).

In addition, several SoM teams had team development programmes and in some cases a bespoke leadership programme.

4.0 Details of how midwives are provided with continuous access to a Supervisors of Midwives

All midwives have a named supervisor of midwives and know how to contact them for advice and guidance and for planning their annual reviews. More and more use is being made of e-mail facilities provided for midwives by the Trusts. In addition midwives may access supervisors of midwives with a specialised expertise for specific advice regarding practice situations.

Newly qualified or newly appointed midwives are introduced to the supervisory team during their period of orientation. They are informed about the role of a supervisor and how to contact a supervisor at all times. All London Trusts also have this information available for Agency Midwives.

Regardless of employment status, all midwives have access to a supervisor of midwives through published 24 hours on-call rosters. Midwives working out-with the NHS are able to access this information by telephoning the labour and delivery suites for the name and contact details of the ‘on call’ supervisor of midwives for that locality.

Many teams of supervisors have designed innovative ways of publishing ways in which they may be contacted. This ranges from a simple bookmark given out to women at booking and to midwives on joining the Trust to the development of posters and wall charts.

In the unusual event of a midwife not being able to contact a supervisor of midwives, there is twenty four hour access to the LSAMO or Assistant LSAMO. With contact details available on the NMC and LSA websites.

In Trusts where there is a significant reduction in the number of supervisors, in order to always cover the 24 hour 'on-call' rota supervision cover from adjacent trusts has been arranged.

On call supervisors have now reported receiving a number of calls from women and families seeking advice and guidance, especially in Trusts where supervision is widely published and included on their web sites pages.

Some supervisory teams have implemented robust arrangements for their bank and agency staff who work at night, to enable these midwives to access a supervisor for specific or ad hoc support, in house 'skills and drills', group supervision and reflection. In some cases medical students have now joined these sessions

Midwives may have a named supervisor of their choice subject to the size of the supervisor's caseload. Supervisory caseloads are reviewed on an annual basis and midwives may change their supervisor subject to this. It is becoming more common for midwives to have a named supervisor who is not part of the midwifery workforce in the Trust that they themselves are employed in.

Each cohort of student midwives is allocated a named supervisor of midwives who contributes to their professional development and support through group supervision and structured reflection. In the practice areas student midwives have access to all supervisors in the same way as midwives. It is now more common for supervisors to be actively involved in educational matters with the HEI from whence they receive their student midwives.

All Trusts are subject to an annual LSA audit and evidence of compliance against the LSA standards for the statutory supervision of midwives (2005). Standard 4.1 states that "there is 24 hours access to Supervisors of Midwives for all midwives irrespective of their employment status" All Trusts audited by the London LSA, in the period covered by this report, met this standard in full. The evidence submitted often contains supervisors of midwives on- call rotas and call logs of when a supervisor has been contacted. In addition to this the LSA audit team meets with a representative sample of midwives and users and the question of accessibility to a supervisor is asked. No concerns have been raised by Midwives or women in relation to response times from supervisors of midwives. Many examples of when supervisors of midwives were involved in challenging situations were given to the LSA audit team. In addition to this the LSA team undertook a random audit of all SoM teams during September 2010 to establish the length of time taken to contact a SoM by telephone. Some calls were made in working hours and others at night and at weekends. The results were encouraging with 86% of SoMs answering within 5-10 minutes, 6% within 10-20 minutes, 4% within 30- 60 minutes and only 4% (two SoMs) not responding at all. On further exploration it was clear that the switchboard for this SoM team had incorrect information on who was on call that night. All SoM teams have been asked to clarify the processes for contacting a SoM to ensure that the correct information is available at all times.

4.1 Details of how the practice of midwives is supervised

The London LSA is responsible for ensuring that the statutory supervision of midwives happens as set out in the Nursing and Midwifery Order (2001). Rule 12 – The supervision of midwives (Midwives rules and standards 2004) sets the standards for the supervision of midwives.

This year each SoM team was asked to prepare an Annual Report for the LSA and in addition an individual SoM scorecard has been developed and piloted to monitor supervisory activity. Further work is ongoing with the scorecard to ensure it is fit for purpose.

Rule 3 - Notification of intention to practise

It is a midwife's responsibility to notify his/her intention to practise (ITP) midwifery in the London LSA area when he/she intends to practise midwifery. This notification process is there for public protection as the system enables the LSA to check that the midwife is eligible to practise and so protects the public by ensuring that only eligible midwives practise midwifery.

Currently midwives submit their ITP to their named SoM and this information is entered onto the London LSA database. A SoM must only sign the ITP if she can confirm that to the best of her knowledge that the information contained on the form is correct and the midwife has provided the SoM with the evidence that he/she has met the NMC PREP requirements to maintain registration as a midwife. PREP is a set of NMC standards and guidance which describes how much clinical and educational activity is required in each registration period. The NMC PREP Handbook was reissued in June 2008 (and is available online at http://www.nmc-uk.org/aDisplayDocument.aspx?documentID=4340)

Rule 4 - Notifications by LSA

The LSA published the date and the name and address of the LSAMO to whom the midwife must give notice under rule 3 (1). The SoMs send the notifications to the LSA via the web based electronic database and this information was uploaded to the NMC in March 2011 and subsequent notifications were thereafter uploaded weekly. This notification system enabled London LSA and the NMC to keep an updated record of all practising midwives.

The online system continues to be managed locally by the supervisors of midwives and is monitored by the LSAMO. The ITP upload failures are reported back to the LSA by the NMC and acted upon by the LSAMO once the report is received. There are very few upload failures (0.001% of all ITPs notified) and the two main reasons for a failure notice was an incorrect date of birth being entered onto the LSA system or the midwife's registration payment had not been processed by the NMC before the ITP was submitted. The LSAMO made certain that all the failure notices were acted upon immediately in order to protect the public to ensure that only midwives who had current registration status were practising midwifery.

It was the responsibility of the named SoM to also carry out checks on the NMC website to ensure that midwives who are part of their caseload have had their ITPs successfully uploaded. This notification system identifies those midwives who are entitled and those who are not able to provide midwifery care.

Employers, SoMs and the public may verify a midwife's registration and entitlement to provide midwifery care status on the NMC online register. This verification system supports public protection. This register can be accessed via the NMC's website http://www.nmc-

uk.org/aNewSearchRegister.aspx. Only the details of those registrants with effective registration will be displayed.

Rule 5 - Suspension from practice by a Local Supervising Authority
If anyone (service users, colleagues and managers) has concerns about a midwife's ability to practice safely and effectively this must be reported to a supervisor of midwives or directly to the LSAMO. Any concerns raised were investigated and through this process it will identify those midwives who may need additional support, supervised practice or on the rare occasion, need to be suspended from practice by the LSAMO in the interest of their own, or public safety. Section 10 in this report details the investigations, suspension and outcomes carried out in the 10/11 year and details how the public were protected.

Rule 6 – Responsibility and sphere of practice
The standards within this rule define what would be reasonably expected from someone who practices midwifery.

Rule 7 – Administration of medicines
SoMs audit individual records related to the administration of medicines and controlled drugs. Evidence of this is provided at the annual LSA audits. The audits show whether midwives are meeting standards and if any improvements to every day practise are needed. The NMC has produced new *Standards for medicines management* in 2008 and this document has been disseminated to all SoMs within the London LSA (available on line at http://www.nmc-uk.org/aDisplayDocument.aspx?documentID=4585.

Rule 8 - Clinical trials
There were very few midwifery clinical trials in London LSA and any that were in progress had been approved by the relevant ethics committee.

Rule 9 – Records
The SoMs must audit clinical records with their supervisees at their annual reviews. This exercise enables the SoM to have an open discussion about the standards for recordkeeping. SoMs also audit records annually in a variety of ways. During investigations the SoM will review records to ensure that an appropriate standard of care has been given and this is based on current evidence. Many SoM teams discuss recordkeeping at the mandatory training day in Trusts.

The pitfalls of poor record keeping was a topic presented at both London LSA conferences this year.

The NMC has updated the guidance issued to Nurses and Midwives in July 2009 (available online at http://www.nmc-uk.org/aDisplayDocument.aspx?DocumentID=6269).

Rule 10 – Inspection of premises and equipment
SoMs must monitor standards and methods of practice and this includes reviewing records, equipment and place of work. Evidence of compliance for this standard was examined as part of the LSA audit.

Rule 11 - Eligibility for appointment as a supervisor of midwives
The London LSA has published information on the appointment of SoMs; this is in line with rule 11 and can be found at http://www.midwife.org.uk.

Rule 12 - The supervision of midwives
All midwives should meet with their named SoM at least once a year for the purpose of statutory supervision. This provides the midwife with an opportunity to discuss their professional development needs. The LSAMO can now monitor the percentage of annual reviews achieved via the LSA database.

68 per cent of midwives had an annual review by their named SoM this year, which is a decrease from 2010-2011, however, when asked the SoMs insisted that this was because they had not entered the Annual review on to the LSA database and not because they had not been done. Once again, the most common reason stated for a midwife not having attending for an annual review is clinical demand or when the review was due she was not at work because of long term sickness, taking a career break or being on maternity leave.

Methods of communication with supervisors
Each SoM has the means to contact the LSA MO (electronic, mobile or telephone). The LSA acts as 'communication centre' receiving and transmitting information from the NMC regulatory body, Department of Health, Royal College of Midwives and locally from the SHA, Trusts, PCTs and from the supervisors. Information flows in both directions allowing the national bodies to be aware of local issues affecting maternity services and ensuring that supervisors of midwives have information distributed directly to them.

The following forums facilitate the LSA communication network: -

National
- The NMC/ LSA Strategic Reference Group - one of the main functions of this group is to assist in advising the Midwifery Committee on any proposals to make, amend or revoke rules relating to the supervision, practice and education of midwives.
- The Local Supervising Authority Midwifery Officer Forum UK (LSAMO Forum UK) - this forum meets every 2 months and was established to provide all the LSAMO with support and to also make sure that supervision across the UK developed in consistent direction. The Forum has a website and published a strategy for the next 3 years. This document can be viewed at http://www.midwife.org.uk/.
- RCM England Heads of Midwifery network.

Strategic
- The Contact Supervisors of Midwives forum meeting – the aim of this group is that this is a forum meeting with a representative from each Trust.
- London Heads of Midwifery (HoMs) meeting – LSAMO attends.
- LME and HoMs meeting
- Maternity Implementation Network.
- London Directors of Nursing meeting – LSAMO attends and has presented on two occasions this year.

Trust/HEI meetings
- Local Trust Supervisor of Midwives meetings – the SoMs in each Trust meet on a regular basis and the LSAMO attends on an ad hoc basis.
- LME/HEI meetings with Trusts

LSA Conferences

Supervisors who continue in the role are required to undertake a minimum of six hours relevant learning in each year of appointment. This is in addition to the 35 hours required to renew professional registration. There were 2 conferences held in the 10/11 practice year.

Rule 13 – The Local Supervising Midwifery Officer
In this year the role of LSAMO has been undertaken by Angela Helleur. The LSAMO ensures that the processes of statutory supervision are in place for the area. The LSAMO acts as an essential point of contact for supervisors of midwives to consult for advice on all aspects of supervision, and for advice with especially difficult or challenging situations.

The LSA has completed 25 annual audit and monitoring visits of the practice and supervision of midwives within the LSA area to ensure the requirements of the NMC are being met. Where NHS Trusts provide maternity services at more than one site, each site was visited. Dates of LSA audit visits can be found in **Appendix 3** the *Midwives Rules and Standards* (2004) set broad principles for supervisors of midwives. These audit standards are published at; www.midwife.org.uk.

Challenges identified by the London SoMs that impede effective supervision

- Two teams had significant challenges due to external scrutiny by the Care Quality Commission. This increased their workload significantly as the public confidence in these services was reduced and women requested support from the SoM teams. Morale amongst midwives at these units was low and the SoM teams were pivotal in ensuring that communication to midwives was ongoing and that they were available for support. In addition to this both teams were involved in developing the action plans and supporting the improvements to the services. This has had an impact on the time they spend on supervision, particularly in one team where the numbers are very low. The LSA team has supported the teams; attending as many SoM team meetings as possible, being available for support and advice, liaising with Trust Executive teams and assisting with practical tasks such as assisting with SoM investigations.

- Conflict within SoM teams appears to be less of an issue this year but has been identified in some teams. As before, this seems to occur when there is a lack of understanding and application of supervisory processes. A number of teams have had team development programmes and this appears to support good team working and is strongly encouraged by the LSA. Overall, the SoM teams appear to be working well together and most are highly productive and provide a high standard of supervision.

- Dedicated time for supervision continues to be a challenge for some teams. Whenever this was identified the LSA fed back to Trust Executive teams that this was an issue and in many cases additional time was secured for the SoMs. The SoM teams are also asked to monitor this closely. Additional time for supervision has been negotiated by the SoMs to undertake investigations if required. In some cases, even though dedicated time has been agreed SoMs do not take it as they feel that clinical work takes priority.

- Achieving 100% of annual reviews for all midwives. The LSAMO has instructed SoMs to record the annual review on the LSA database so that this can be monitored and to inform the LSA if this continues to be a problem. This is monitored by the LSA and discussed at the Annual audits.

Rule 14 – Exercise by a LSA of its functions
The NMC has a duty to verify that the standards set for the LSA are being met and has therefore developed a system for reviewing LSAs and this is contained in the document available on the NMC website online at
http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=3085.

The aim is to ensure that the rules and standards for statutory supervision of midwives and the function of the LSA are being met and to highlight any concerns around protection of the public. The NMC midwifery department have reviewed all the LSA profiles via the LSA annual reports and have decided which LSAs.

The London LSA was reviewed in April 2009 and the full report from this review can be viewed on http://www.nmc-uk.org/aArticle.aspx?ArticleID=258. The London LSA has responded to the recommendations made from this view and the updated action plan can be found at www.londonlsa.org.uk.

Rule 15 – Publication of Local Supervising Authority procedures
The National LSA Forum website contains guidelines for the LSAMOs and Supervisors of midwives across the United Kingdom at www.midwife.org.uk.

The annual audit reports are published at www.midwife2.org.uk.

Rule 16 – Annual report
This report is the evidence of compliance with rule 16. The NMC guidance document is available to the public on the NMC website at
http://www.nmc-uk.org/aDisplayDocument.aspx?documentID=5290

5.0 Evidence that service users have been involved in monitoring supervision of midwives and assisting the local supervising authority midwifery office with the annual audits.

This year service users have been involved in all LSA audits. All Trusts in London have maternity service user forums, such as Maternity Services Liaison Committees, and members of these forums were invited to form part of the audit team. As part of each audit, a number of recent service users were asked about their general views on their experience and also about supervision of midwifery.

As part of all LSA audits evidence of user involvement is reviewed. In most SoM teams there is clear evidence that SoMs are actively encouraging women to access the SoMs when required. SoMs have demonstrated leadership and initiative in ensuring that “hard to reach groups” are involved in the planning and provision of local maternity services. One SoM team has a regular forum for women to access a SoM and another has developed a social networking site for women. The LSA was impressed by the efforts made by SoMs to increase the profile of supervision locally. A number of initiatives have been undertaken to ensure that women and midwives have access to SoMs.

Last year the process for the selection of potential supervisors was reviewed and now includes a group exercise which is observed. User representatives form part of the selection process and assist the LSA to determine how participants respond in groups. They are also involved in the evaluation of each candidate at the end of the selection process and ultimately in the decision to select a candidate for SoM training. This has proved to be a very valuable and worthwhile exercise.

A business case was submitted to NHSL by the LSA to fund additional user involvement in the LSA function, and has now been approved. This resource will be available from May 2011 and will be used to pay expenses to users for supporting the LSA function, particularly in LSA audit.

6.0 Evidence of engagement with higher education institutions in relation to supervisory input into midwifery education.

There are eight HEIs that provide midwifery education in London. They are:

- London South Bank University
- West London University
- St Georges' University
- University of Hertfordshire
- King's College University
- Middlesex University
- University of Greenwich
- City University

And four which provide courses for the Preparation for the Supervision of Midwives (POSOM) they are:

- St Georges / Kingston University
- West London University
- Kings College London
- University of Hertfordshire

The London LSAMO and HEIs work in close collaborative partnerships to ensure that pre and post registration midwifery education programmes are developed, planned and delivered to meet the future midwifery workforce and to ensure that current midwives are prepared for contemporary practice. There are several forums at both strategic and operational levels to ensure this is achieved. These include:

- The annual NMC/LSA/LME Strategic reference group where all UK LSAMOs meet with the Lead Midwives for Education (LME) for the purpose of debate and discussion at national level.
- London Higher Education Institution (HEI) Forums. Each university holds regular quarterly midwifery and education strategy group meetings; the London LSAMO is on the membership for each along with the Lead Midwives for Education (LME's), Heads of Midwifery, Lecturer Practitioners and SoMs. These forums provide a valuable opportunity to strategically direct the future education and development pre and post registration midwifery education.
- Twice yearly meetings between London LSA / HEI leads of POSOM courses. The purpose being to give/receive information from each course leader regarding each of the POSOM courses, to facilitate LSA involvement in planning and management of POSOM courses and to ensure LSA involvement in quality assurance including practice environments and support for development from local and supervisory teams

The LSAMO attends the Universities regularly to lead specific teaching session on modules which include learning outcomes relating to the statutory functions of supervision and professional issues.

LMEs and midwife teachers work collaboratively where programmes of supervised practice have been recommended by the LSAMO, to ensure the academic standard meets those set within the NMC document *Standards for the supervised practice of midwives* (NMC 2007)

LSA / HEI partnership working in relation to the LSA selection of student SoMs; four selection days are planned throughout the year (two in the spring, and two in the summer) which coincides with the commencement dates of the POSUM courses and facilitates improved recruitment to all London POSUM courses. Over the past two years there has been significant development in the structure of the selection days whereby all HEIs offering the POSUM course are involved in the selection process. In addition to this, users of maternity service and users of SoM have been involved in selection to ensure that future SoMs have the necessary qualities for the role as identified in the Midwives Rules (2004). The selection process consists of three aspects, a written element assessed by a SoM educationalist, an individual interview assessed by the LSAMO/ HoM and group discussion on a given trigger assessed by and educationalist, user and newly qualified midwife or SoM Each element is assessed and the selection panel meet together at the end of the interviews to share their feedback score sheets, thus the triangulation of the feedback provides a more comprehensive assessment of the student's potential for the role. Evaluations for student SoM applicants have been positive; they report that the process helps them to be more knowledgeable about the various London POSUM courses and this enables them to make an informed choice of HEI.

SoMs engagement with HEIs
The SoMs continue to contribute to the development, teaching and assessment programmes of education leading to registration and the continuous professional development of all midwives. The SoM involvement is monitored by the LSA at the annual audit visit. Supervisors of midwives have set up systems of support within the Trusts they work to ensure the continued support of student midwives. In most HEIs, SoMs are involved in the final assessment of student midwives.

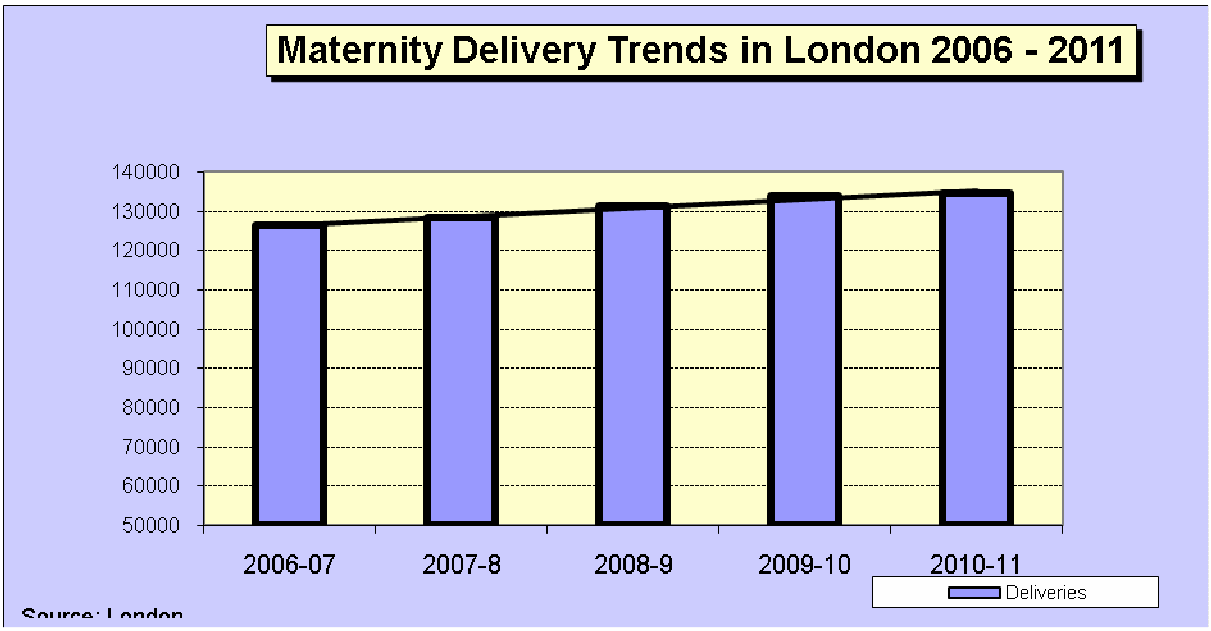
7.0 Evidence of developing trends that may impact on the practice of midwives in the local supervising authority

The trend analysis in this section is based on data provided directly from individual maternity units, the LSA database and other published information. The workforce and clinical activity data is requested directly by the LSA office from the Heads of Midwifery using a standardised form. This data is submitted on a monthly basis. Information derived from the LSA database has been entered by Supervisors of Midwives.

7.1 Birth Rates

Activity	**2006-07**	**2007-8**	**2008-9**	**2009-10**	**2010-11**	3 Year change (%)
NHS	122,905	124,914	127,842	131,081	131,824	3.1%
Non NHS	3,288	3,406	3,375	2,612	2,720	-19.4%
TOTAL	**126,193**	**128,320**	**131,217**	**133,693**	**134,544**	2.5%
Year on Year change		1.7%	2.3%	1.9%	0.6%	

London continues to see a rise in the birth rate which is in line with birth projections which estimate the increase to be 2.9% over the next ten years. Clinical activity has increased overall by 0.63% in this year; this demonstrates a slower growth than has been seen in recent years. The activity profile has changed over the year with some units experiencing an increase in deliveries and others a small decrease. The SHA is monitoring the trends in activity and is working closely with commissioners and providers to ensure that the capacity and manpower required to meet the increase in demand is met.



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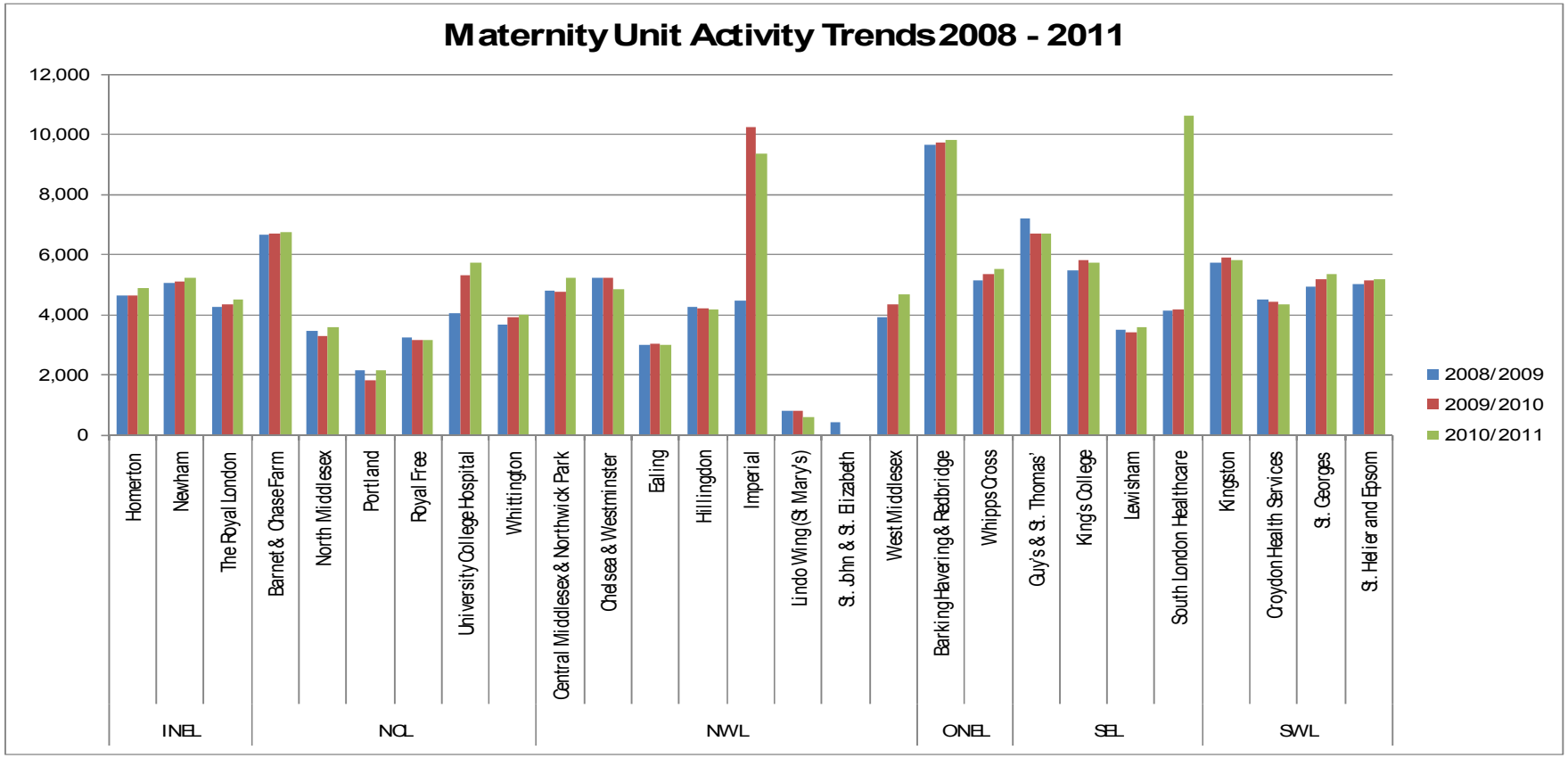


[8] N.B. Imperial (NHS) Trust is the merged organisation of what were formally St Mary's (NHS) Trust and Queen Charlotte's (NHS) Trust. The activity for Imperial is a combination of both sites.

7.2 Demand Management

Thirty-one complete suspensions of maternity services were reported via the LSA database, this is an increase of 9 suspensions from 2009-10. Merged organisations (BHRT, Imperial, Barnet and Chase Farm and South London) are managing their activity across sites so that full suspension of services is avoided. The main reason for suspension was insufficient beds followed by insufficient staff; other reasons included issues with the estate (such as fire, flooding etc). Most suspensions lasted for a few hours and all were for no longer than 24 hours.

A number of Trusts also reported partial suspension of services; this may range from suspension of one site, a midwifery led service, homebirth service or postnatal visiting. From April 2011, all Trusts have been asked to report all partial suspensions of services as this can have a detrimental effect on women's experiences and should be monitored in the same way as complete suspensions.

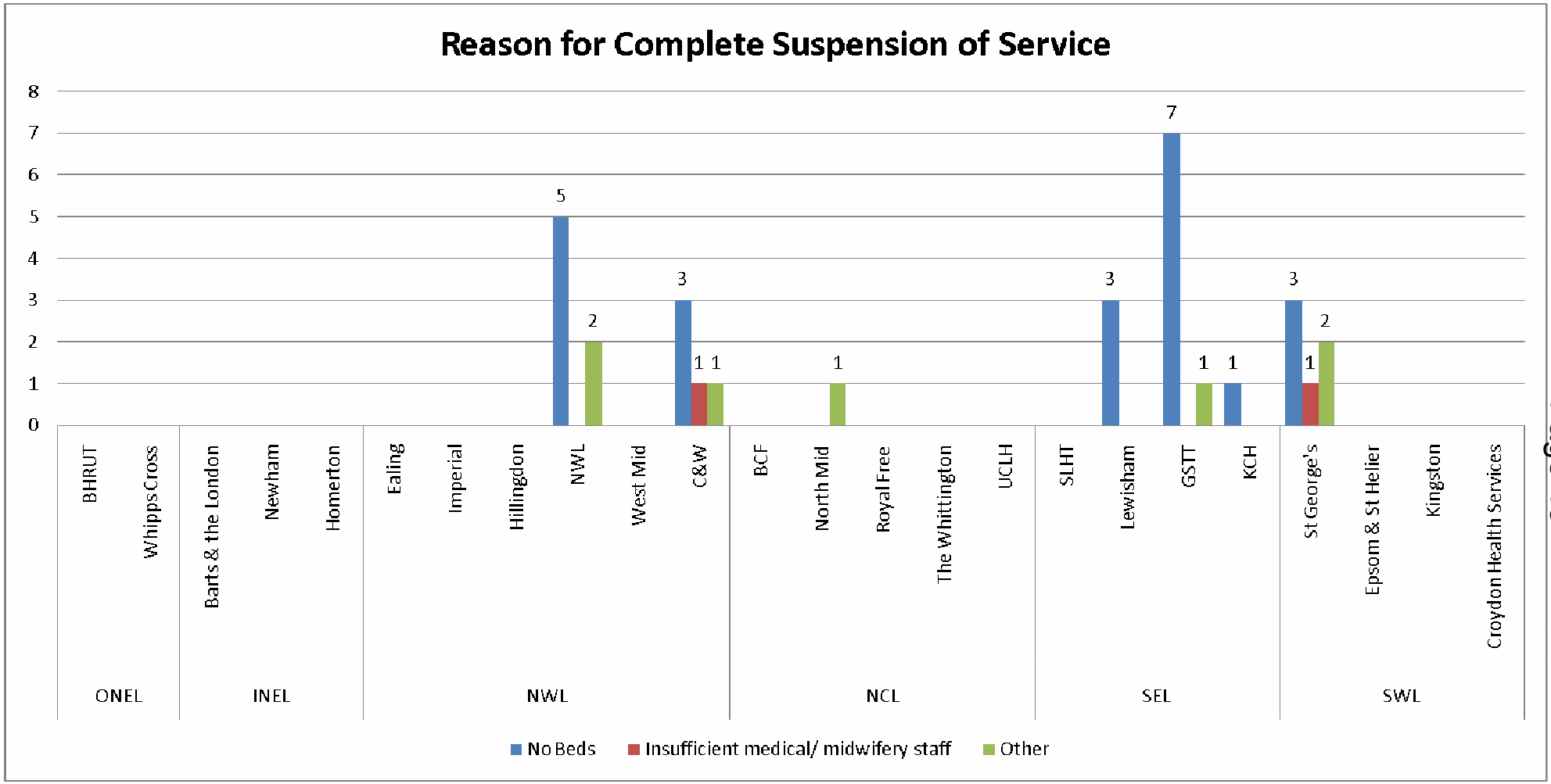
For the third year running most complete suspensions of maternity services took place in SE London, with insufficient capacity being quoted as the main reason. SE London and NE London are the areas of London which has the greatest projected increase in the number of births for the next ten years. Therefore, capacity planning is of particular relevance in these areas.

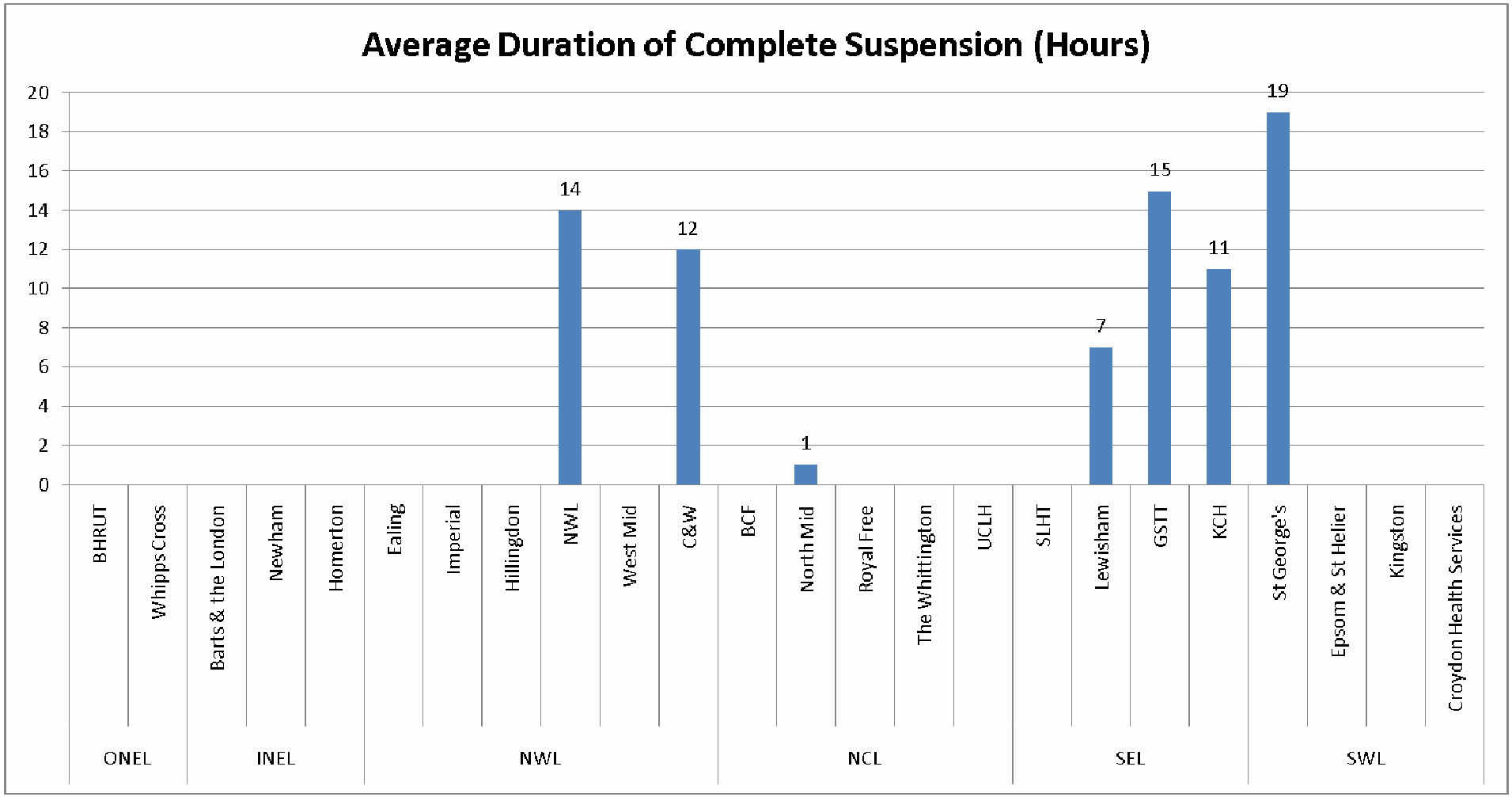
In addition to the successful suspensions there were a further 3 attempted suspensions of maternity services where suspension was not possible due to the neighbouring units not being able to accept women.

All suspensions and attempted suspension of services are classified as a serious untoward incident (SUI), by the SHA. The full report from the SUI is shared with the SHA and with the main commissioner of the service.

In partnership with the SHA and the London Ambulance Services, the LSA launched a Pan London suspension of services guideline in October 2010. This was developed to support services at times of high activity or when they needed to suspend services. The process appears to be working well and most maternity units have had cause to suspend services.
A formal evaluation of this process will be undertaken in 2011.

From 2011 the London LSA will also collect information on partial suspension of services e.g. home birth or midwifery led unit suspensions.


Reason for Complete Suspension of Service
8
7
6
5
4
3
2
1
0
5
2
3
1 1
1
3
7
1
1
3
1
2
BHRUT
Whipps Cross
Barts & the London
Newham
Homerton
Ealing
Imperial
Hillingdon
NWL
West Mid
C&W
BCF
North Mid
Royal Free
The Whittington
UCLH
SLHT
Lewisham
GSTT
KCH
St George's
Epsom & St Helier
Kingston
Croydon Health Services
ONEL
INEL
NWL
NCL
SEL
SWL
No Beds
Insufficient medical/ midwifery staff
Other

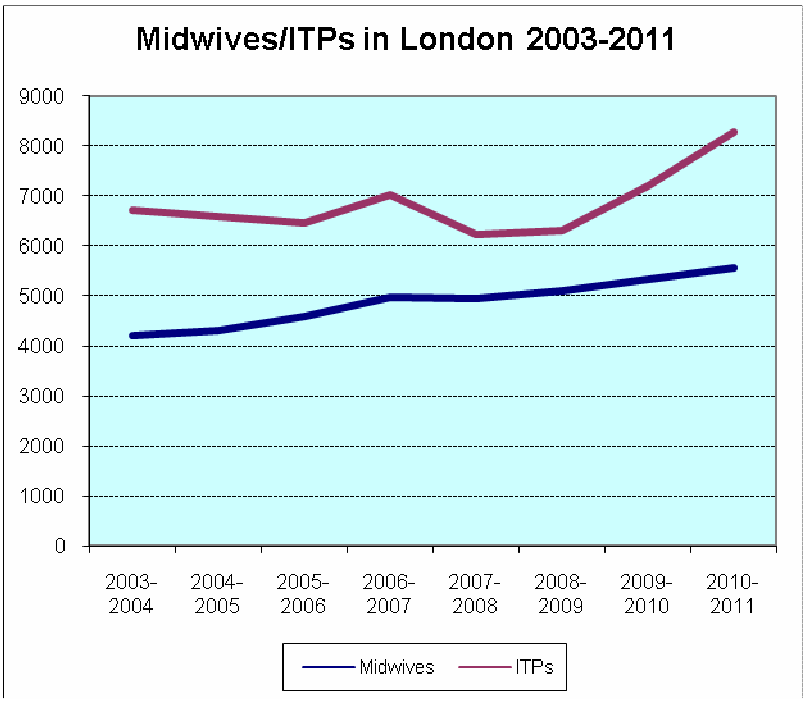

Average Duration of Complete Suspension (Hours)
20
18
16
14
12
10
8
6
4
2
0
14
12
1
7
15
11
19
BHRUT
Whipps Cross
Barts & the London
Newham
Homerton
Ealing
Imperial
Hillingdon
NWL
West Mid
C&W
BCF
North Mid
Royal Free
The Whittington
UCLH
SLHT
Lewisham
GSTT
KCH
St George's
Epsom & St Helier
Kingston
Croydon Health Services
ONEL
INEL
NWL
NCL
SEL
SWL

7.3 Midwifery Workforce

This year 5575 whole time equivalent midwives were employed to provide care to women in London, which is an increase of 221 from 2009-10. Based on the total number of deliveries of 134,554 this gives a ratio of 1 midwife to 25 deliveries, however, this figure does not include self employed midwives or the number of deliveries conducted by them. The mean ratio of midwife to delivery is 1:31.

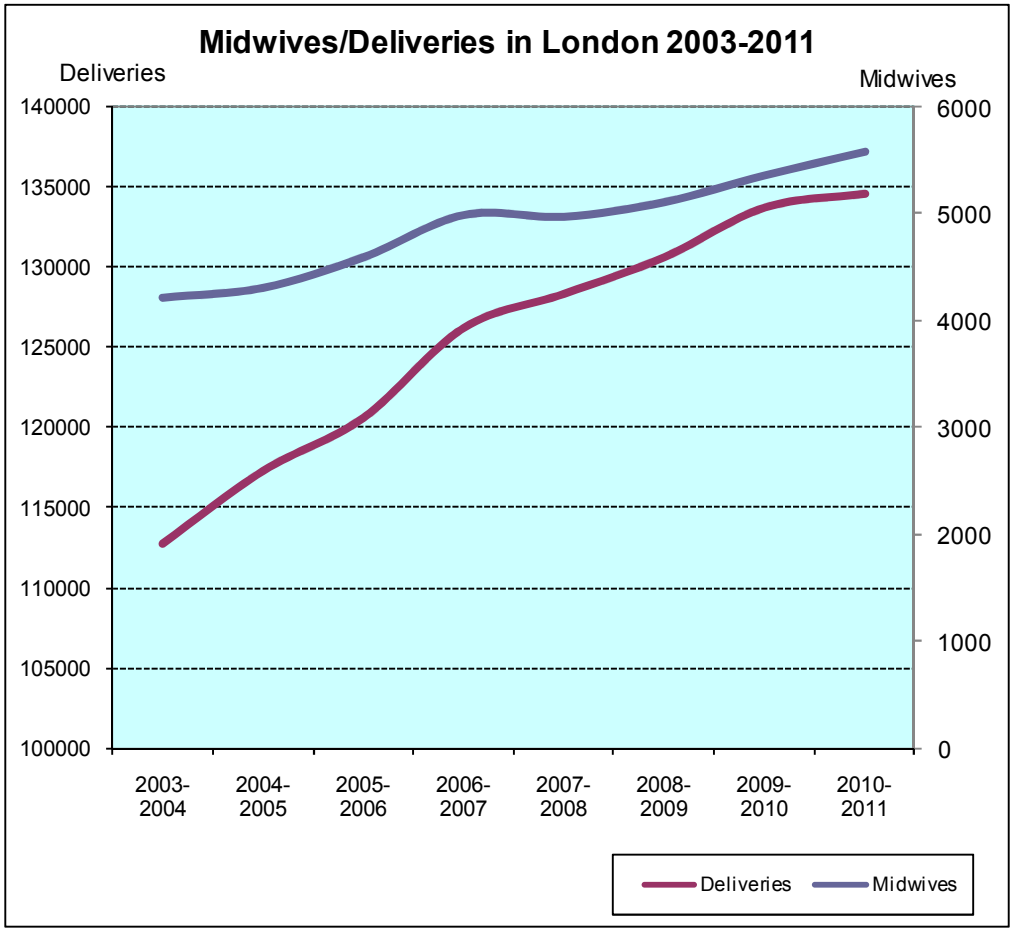
Midwives/ITPs in London 2003 to 2011		
Year (April-March)	**Midwives**	**ITPs**
2003-2004	4214	6722
2004-2005	4306	6581
2005-2006	4590	6456
2006-2007	4985	7022
2007-2008	4969	6236
2008-2009	5105	6323
2009-2010	5348	7201
2010-2011	5575	8274

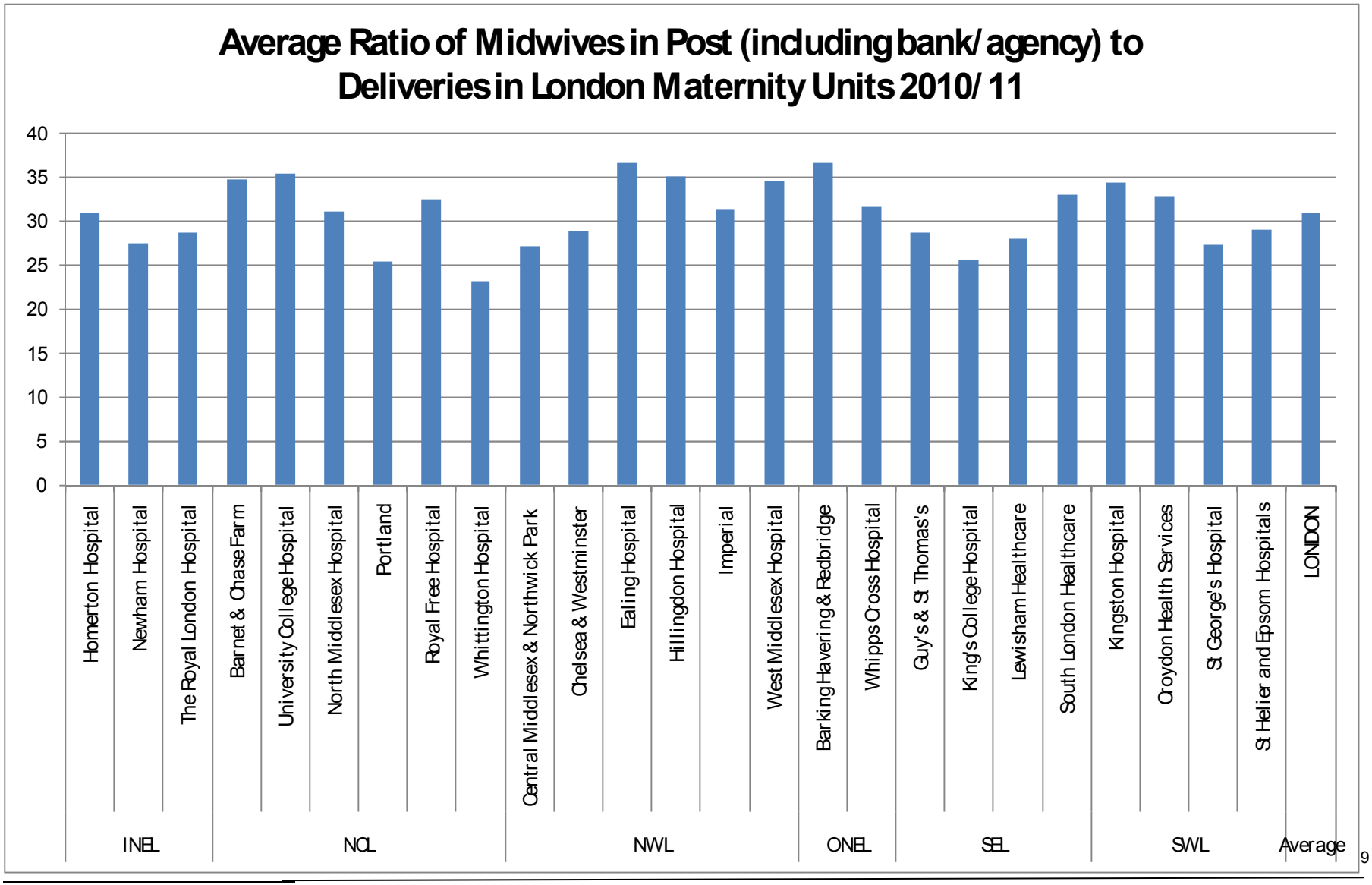
Source: LSA Database



Midwives/Deliveries in London 2003 to 2011		
Year (April-March)	**Midwives**	**Deliveries**
2003-2004	4214	112760
2004-2005	4306	117288
2005-2006	4590	120598
2006-2007	4985	126193
2007-2008	4969	128320
2008-2009	5105	130604
2009-2010	5354	133693
2010-2011	5575	134554

Source: LSA Database (2007-2011 deliveries taken from Clinical Activity returns)



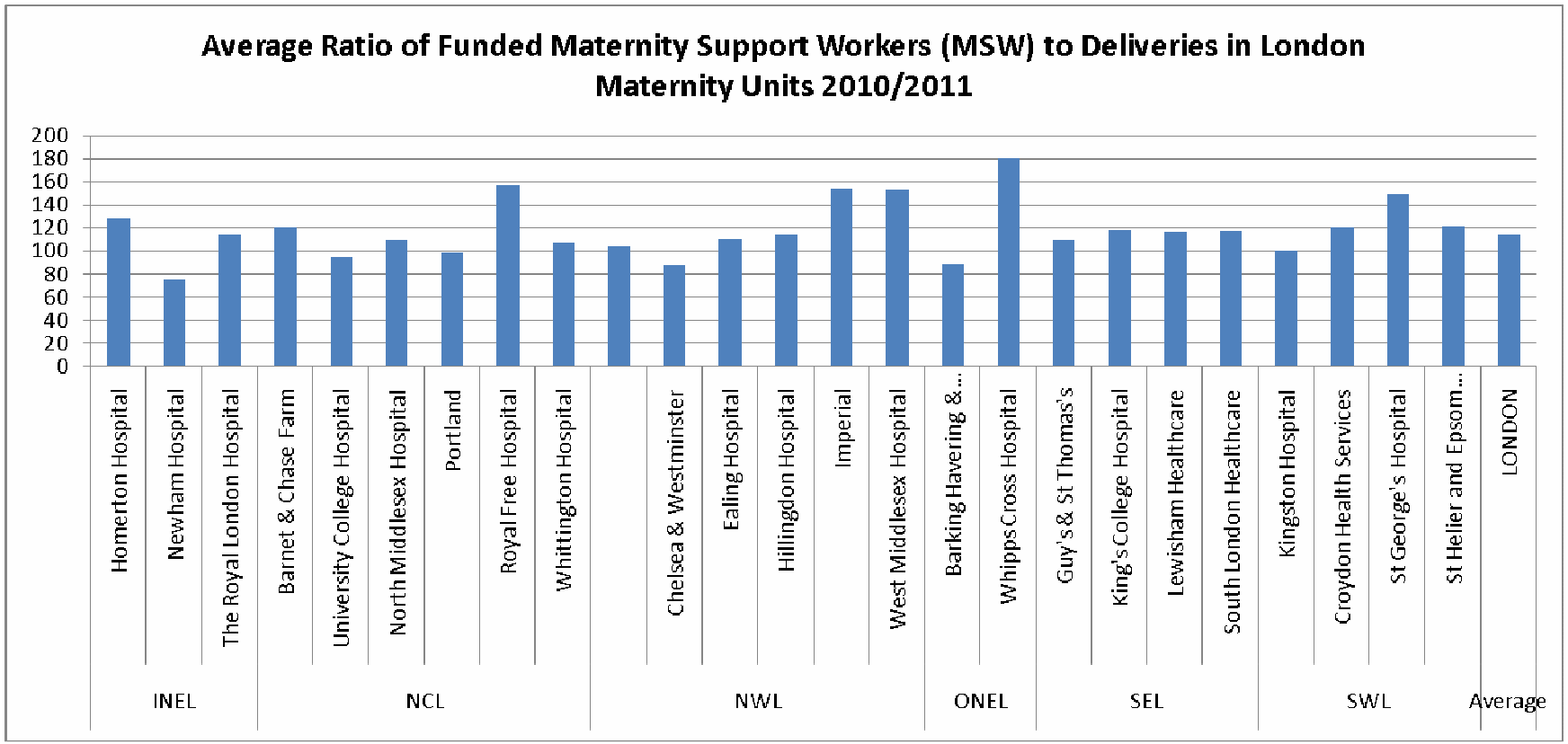

Average Ratio of Midwives in Post (including bank/agency) to Deliveries in London Maternity Units 2010/11
40
35
30
25
20
15
10
5
0
Homerton Hospital
Newham Hospital
The Royal London Hospital
Barnet & Chase Farm
University College Hospital
North Middlesex Hospital
Portland
Royal Free Hospital
Whittington Hospital
Central Middlesex & Northwick Park
Chelsea & Westminster
Ealing Hospital
Hillingdon Hospital
Imperial
West Middlesex Hospital
Barking Havering & Redbridge
Whipps Cross Hospital
Guy's & St Thomas's
King's College Hospital
Lewisham Healthcare
South London Healthcare
Kingston Hospital
Croydon Health Services
St George's Hospital
St Helier and Epsom Hospitals
LONDON
INEL
NCL
NWL
ONEL
SEL
SWL
Average

Sector	Maternity Service	Midwives in Post : Deliveries
INEL	Homerton Hospital	31
	Newham Hospital	27
	The Royal London Hospital	29
NCL	Barnet & Chase Farm	35
	University College Hospital	35
	North Middlesex Hospital	31
	Portland	25
	Royal Free Hospital	32
	Whittington Hospital	23
NWL	Central Middlesex & Northwick Park	27
	Chelsea & Westminster	29
	Ealing Hospital	37
	Hillingdon Hospital	35
	Imperial	31
	West Middlesex Hospital	35
ONEL	Barking Havering & Redbridge	37
	Whipps Cross Hospital	32
SEL	Guy's & St Thomas's	29
	King's College Hospital	26
	Lewisham Healthcare	28
	South London Healthcare	33
SWL	Kingston Hospital	34
	Croydon Health Services	33
	St George's Hospital	27
	St Helier and Epsom Hospitals	29
Average	**LONDON**	31

There has been significant investment in additional midwifery posts across London and many Trusts have been successful in their efforts to recruit midwives to London the vacancy factor continues has decreased from 16% to 12%. The actual number of midwives employed has increased by 4.7%. **Appendix 4** shows changes in funded establishment

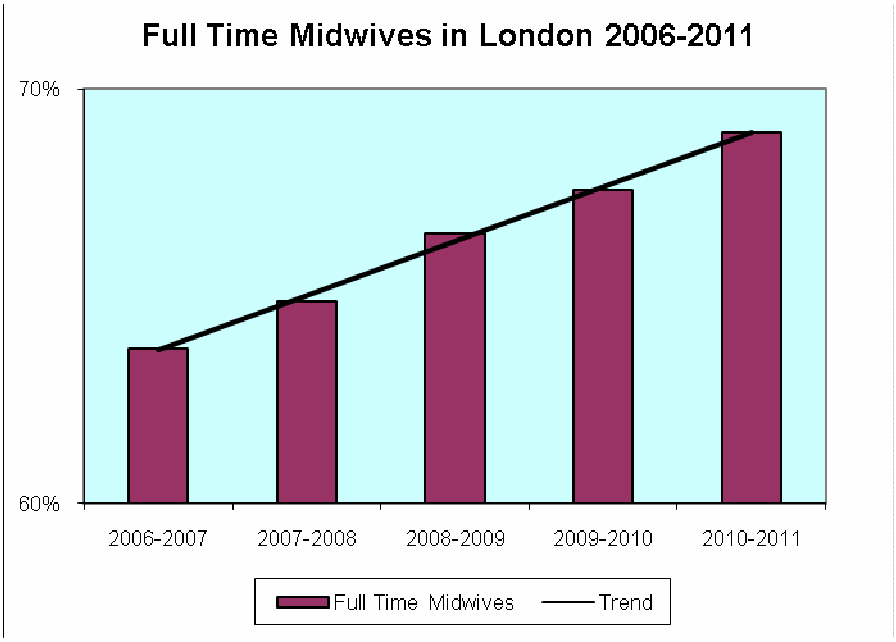
Sector	Maternity Service	Vacancy %
		2010-2011
INEL	Homerton Hospital	16%
	Newham Hospital	8%
	The Royal London Hospital	6%
NCL	Barnet & Chase Farm	23%
	University College Hospital	2%
	North Middlesex Hospital	5%
	Portland	10%
	Royal Free Hospital	16%
	Whittington Hospital	5%
NWL	Central Middlesex & Northwick Park	13%
	Chelsea & Westminster	18%
	Ealing Hospital	21%
	Hillingdon Hospital	12%
	Imperial	9%
	West Middlesex Hospital	10%
ONEL	Barking Havering & Redbridge	20%
	Whipps Cross Hospital	5%
SEL	Guy's & St Thomas's	15%
	King's College Hospital	10%
	Lewisham Healthcare	12%
	South London Healthcare	11%
SWL	Kingston Hospital	16%
	Croydon Health Services	24%
	St George's Hospital	4%
	St Helier and Epsom Hospitals	17%
Average	**London**	**12%**

The London LSA values the contribution of maternity support workers in supporting midwives in the care of women and their families. Significant work has been done to train maternity support workers in skills which support the role of the midwife and evidence suggests that the use of maternity support workers significantly increases midwifery time. In 2009, NHSL and The London Southbank University collaborated on developing a foundation degree for maternity support workers the first year has been well evaluated and has been welcomed by participants and employers alike.


Average Ratio of Funded Maternity Support Workers (MSW) to Deliveries in London Maternity Units 2010/2011
200
180
160
140
120
100
80
60
40
20
0
Homerton Hospital
Newham Hospital
The Royal London Hospital
Barnet & Chase Farm
University College Hospital
North Middlesex Hospital
Portland
Royal Free Hospital
Whittington Hospital
Chelsea & Westminster
Ealing Hospital
Hillingdon Hospital
Imperial
West Middlesex Hospital
Barking Havering &...
Whipps Cross Hospital
Guy's & St Thomas's
King's College Hospital
Lewisham Healthcare
South London Healthcare
Kingston Hospital
Croydon Health Services
St George's Hospital
St Helier and Epsom...
LONDON
INEL
NCL
NWL
ONEL
SEL
SWL
Average

There has been a slight increase in the number of full time midwives compared to the number of part time midwives again this year, which may indicate an increase in midwifery hours in London.

Full/Part Time Midwives in London 2006 to 2011					
Year (April-March)	**Full-Time Midwives**	**(% of total)**	**Part-Time Midwives**	**(% of total)**	**Total**
2006-2007	3175	63.74%	1806	36.26%	**4981**
2007-2008	3223	64.86%	1746	35.14%	**4969**
2008-2009	3396	66.52%	1709	33.48%	**5105**
2009-2010	3618	67.58%	1736	32.42%	**5354**
2010-2011	3844	68.95%	1731	31.05%	**5575**



7.4 Age Profile of Midwifery Workforce

London LSA	Number of Midwives by LSA	Number of ITPs by LSA
Totals	**5575**	**7291**

Full time/Part time number by practice type		
Practice Type	**Full-time Midwives**	**Part-time Midwives**
NHS (inc. Bank)	3609	1553
Private Hospital/Services	67	30
Agency	33	87
Higher Education Institution	60	20
Self Employed (Independent m/w)	27	9
Other	40	32
TOTAL	**3836**	**1731**

Average Age by Full Time / Part Time		
Year	**Average Age (Full Time)**	**Average Age (Part Time)**
2008/2009	41	42.86
2009/2010	41.22	43.52
2010/2011	41.13	43.61

Average Age by Year	
Year	**Average Age**
2010/2011	43.14

Age Profile of Midwives as of 31/03/2010	
Age	**Number of Midwives**
Under 21	0
21 to 25	224
26 to 30	535
31 to 35	661
36 to 40	667
41 to 45	841
46 to 50	960
51 to 55	697
56 to 60	503
61 to 65	337
Over 65	150
TOTAL	**5575**

Number of Midwives/ITPs by Practice Type (as at 31/03/2011)*

Practice Type	Number of Midwives	Number of ITPs
NHS (inc. Bank)	5169	5559
Private Hospital/Service	97	133
Agency	120	1308
Higher Education Institution	80	99
Self Employed (Independent m/w)	36	109
Other (Specify)	72	86
Total	**5575**	**7294**

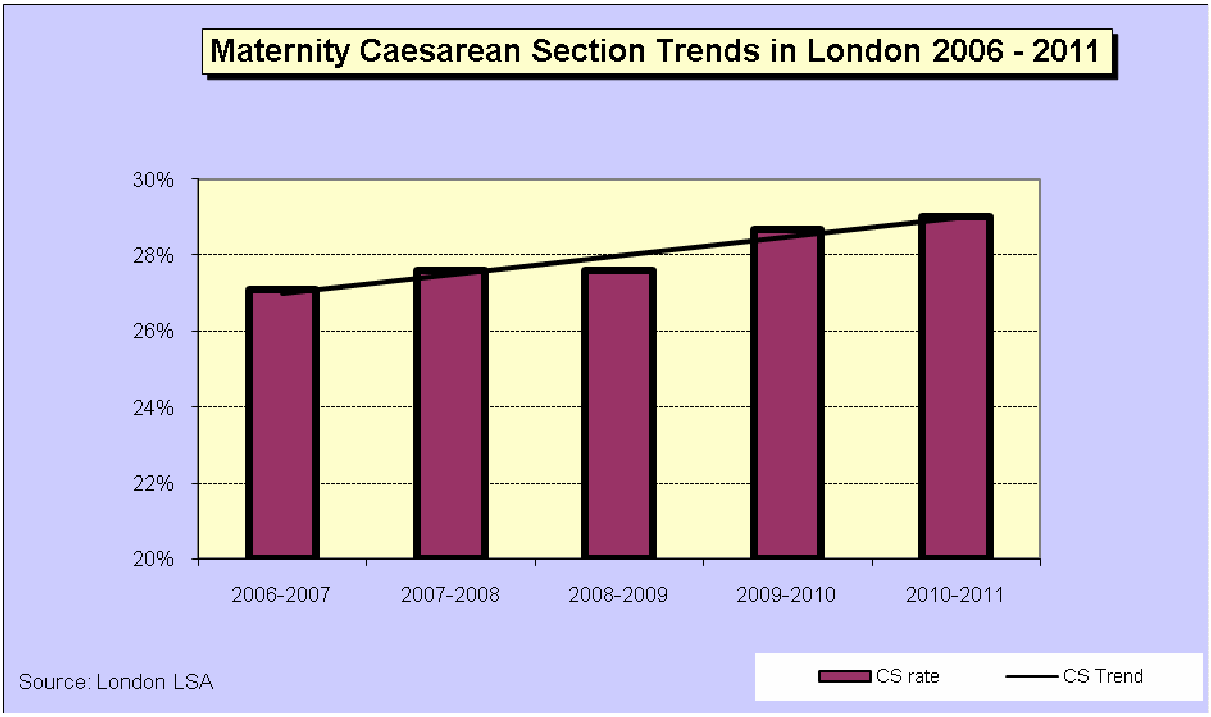
*The Number of Midwives is calculated from a midwife's "main" place of work.

There is little change in the pan London age profile of midwives since 2010/11 which shows that the average age of midwives in London is 43 and that 18% of midwives are eligible for retirement now. A further 11% will be eligible to retire within the next 5 years. The NHSL workforce planning team in collaboration with the LSA have used this information to scrutinise local workforce plans and to commission university places for midwifery training.

7.5 Clinical Outcomes

7.5.1 Caesarean Section Rates

Pan London Caesarean Section Rates					
Strategic Health Authority	**2006-2007**	**2007-2008**	**2008-2009**	**2009-2010**	**2010-2011**
London Average	**27.1%**	**27.6%**	**27.6%**	**28.7%**	**29.0%**

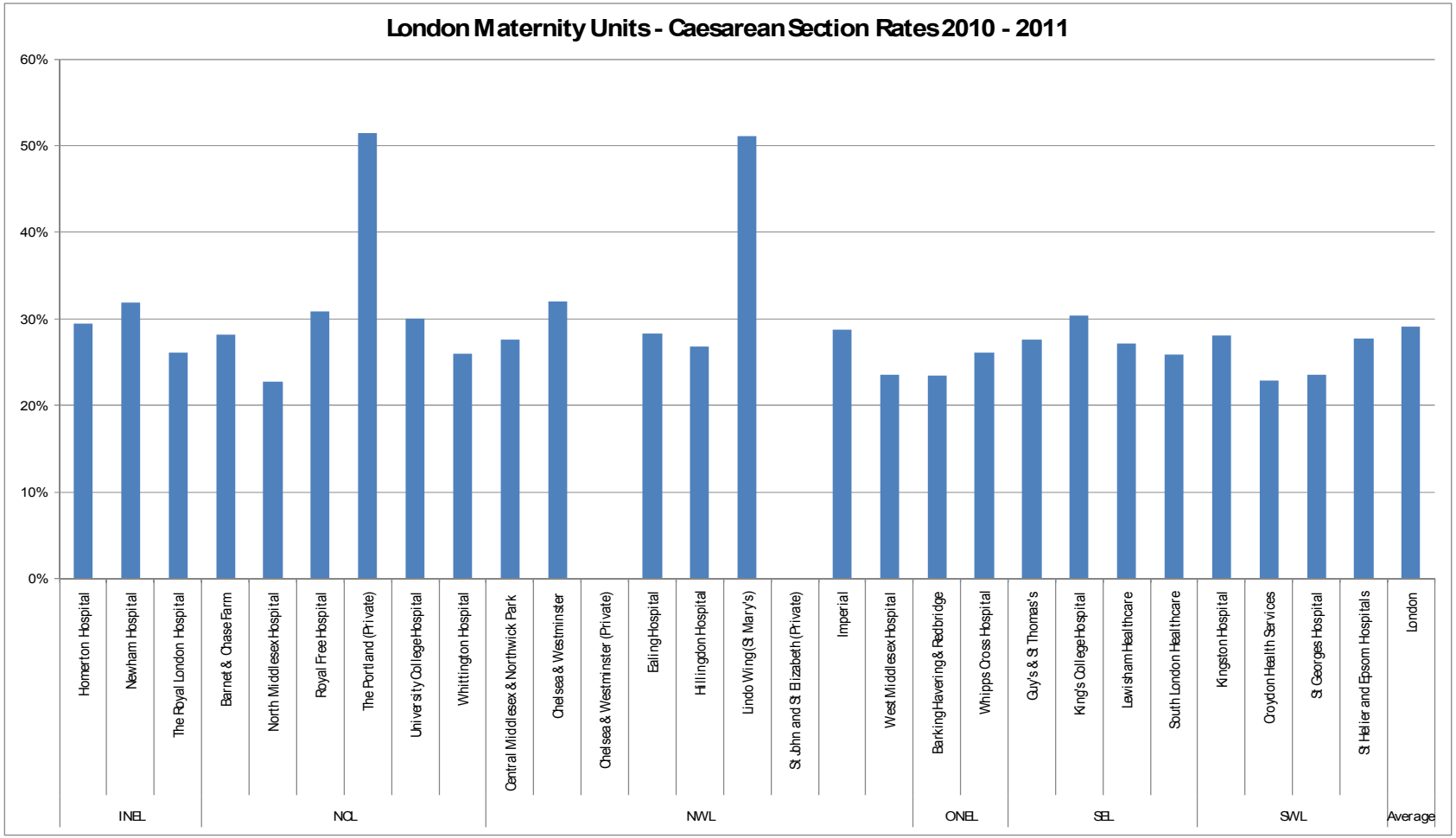


Caesarean section (CS) rates have increased by 0.3% this year. All units report ongoing audit into caesarean section and this rate continues to be monitored closely by commissioners, NHSL and the CQC. The CQC issues outlier reports to services when rates appear higher than expected. When this occurs the service is expected to respond with a detailed explanation of the rate and details of any actions being taken to reduce this. The LSA has sight of these responses and this information is used to support SoMs to reduce unnecessary intervention. There continues to be significant variation across units, some of which can be explained by the specialist nature of the services at that Trust. Commissioners of services have agreed a number of CQUINS (local agreements to improve clinical outcomes; commissioning for quality and improvement) in relation to reducing caesarean section rates.

The private units continue to have the highest caesarean section rates which may reflect women's choice.

A number of London maternity units have used the NHS Institute for Innovation and Improvements toolkit for reducing caesarean sections - full details; http://www.institute.nhs.uk/quality_and_value/high_volume_care/focus_on:_caesarean_section.html .

Supervisors of midwives are increasing the profile of normality in a number of areas, in particular, leading Vaginal Birth after Caesarean Section (VBAC) services, using reflection as a tool to reduce unnecessary midwifery intervention and by supporting women in their choice of birth. All London NHS services have VBAC clinics that are led or supported by SoMs.



Caesarean Section Rates in London Maternity Units

Sector	Trust/Year	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
INEL	Homerton Hospital	25%	28%	28%	28%	29%
	Newham Hospital	29%	29%	29%	30%	32%
	The Royal London Hospital	25%	29%	29%	25%	26%
NCL	Barnet & Chase Farm	26%	26%	26%	27%	28%
	North Middlesex Hospital	20%	22%	22%	21%	23%
	Royal Free Hospital	28%	29%	29%	28%	31%
	The Portland (Private)	50%	53%	53%	54%	51%
	University College Hospital	31%	34%	34%	31%	30%
	Whittington Hospital	24%	23%	23%	25%	26%
NWL	Central Middlesex & Northwick Park	28%	24%	24%	26%	28%
	Chelsea & Westminster	28%	37%	37%	27%	32%
	Chelsea & Westminster (Private)	45%	N/A	N/A	N/A	N/A
	Ealing Hospital	26%	27%	27%	33%	28%
	Hillingdon Hospital	24%	23%	23%	26%	27%
	Lindo Wing (St Mary's)	47%	50%	50%	49%	51%
	St John and St Elizabeth (Private)	25%	34%	34%	n/a	n/a
	Imperial	28%	23%	23%	31%	29%
	West Middlesex Hospital	22%	23%	23%	23%	24%
ONEL	Barking Havering & Redbridge	22%	24%	24%	23%	23%
	Whipps Cross Hospital	26%	27%	27%	30%	26%

SEL	**Guy's & St Thomas's**	30%	27%	27%	31%	28%
	King's College Hospital	23%	23%	23%	24%	30%
	Lewisham Healthcare	31%	30%	30%	29%	27%
	South London Healthcare	21%	22%	22%	24%	26%
SWL	**Kingston Hospital**	26%	25%	25%	24%	28%
	Croydon Health Services	23%	23%	23%	24%	23%
	St Georges Hospital	24%	22%	22%	24%	24%
	St Helier and Epsom Hospitals	27%	29%	29%	29%	28%
Average	**London**	**28%**	**28%**	**28%**	**29%**	**29%**

7.5.2 Home Birth Rates

There has been a reduction in the home birth rate from 1.7% last year to 1.5% this year. Many services attribute this reduction to women being able to access midwifery led units; however, maternity units continue to work closely with their commissioners to improve home birth rates to ensure choice of place of birth. All NHS maternity services offer home birth as a real choice for women.

Trust Maternity Units	Home Births 2010 to 2011		
	Total Women Delivered	Home Births	Home Birth %
Barking Havering & Redbridge	9,831	108	1.1%
Barnet & Chase Farm	6,746	78	1.2%
Central Middlesex & Northwick Park	5,224	31	0.6%
Chelsea & Westminster	4,839	37	0.8%
Ealing Hospital	2,975	25	0.8%
Guy's & St Thomas's	6,700	160	2.4%
Hillingdon Hospital	4,164	46	1.1%
Homerton Hospital	4,868	121	2.5%
Kings College Hospital	5,729	300	5.2%
Kingston Hospital	5,821	45	0.8%
Lewisham Healthcare	3,598	36	1.0%
Croydon Health Services	4,352	80	1.8%
Newham Hospital	5,232	67	1.3%
North Middlesex Hospital	3,590	14	0.4%
Queen Elizabeth Woolwich Princess Royal Bromley (South London Healthcare Trust)	10,599	134	1.3%
Royal Free Hospital	3,178	300	9.4%
St Georges Hospital	5,371	31	0.6%
St Helier and Epsom Hospitals	5,166	14	0.3%
Imperial	9,342	34	0.4%
The Royal London Hospital	4,526	116	2.6%
University College Hospital	5,730	80	1.4%
West Middlesex Hospital	4,691	10	0.2%
Whipps Cross Hospital	5,533	68	1.2%
Whittington Hospital	4,019	91	2.3%
TOTAL NHS	**131,824**	**2,026**	**1.5%**

7.5.3 Maternal Death

In the first six months of 2010 there had been the same number of maternal deaths as there had been for the whole of 2009. This was a serious cause for concern so an external review of all maternal deaths, in 2009 and the first six months of 2010, was commissioned.

The work was undertaken by the centre for Maternal and Child Enquiry (CMACE) who were responsible for producing the triennial national confidential report on maternal death in the UK. The purpose of the review was to identify any specific themes and trends, identify learning opportunities and to ensure the continuation of safe maternity care in London.

A comprehensive review of thirty four deaths was undertaken by multidisciplinary panels and a report produced on the findings. A number of recommendations were also made.

This review has identified a number of key issues for London's maternity services.

- During the period under review the London Maternal Death rate was 19.3/ 100,000 maternities compared to the national rate of 8.6/ 100,000 maternities. This is statistically significant.
- Haemorrhage was the leading cause of direct maternal deaths and diseases of the neurological system the leading cause of non-direct deaths.
- Older and younger women appear to be more at risk.
- 66% of the women who died were from Black and Minority ethnic groups.
- 58% of the women who died were born outside of the UK.
- 52% were from the lowest two quintiles of the scale of deprivation
- Body mass index was found to be a significant factor with 50% of the women either in the overweight or underweight category.
- 36% had previous pregnancy complications (the most common being caesarean section).
- 17% had pre existing, or developed during pregnancy, mental health issues.
- 35% of women booked late for antenatal care in pregnancy (second and third trimester).
- 23 out of the 34 women had their baby delivered by caesarean section.
- 26 babies survived the death of their mother.
- 26 of the 34 deaths reviewed had avoidable factors identified
- Care was said to be poor in aspects of care in approximately 50% of the cases.

A number of recommendations and points for learning were made. A number of actions were taken immediately following the publication of this report; all maternity services were advised to have an external Obstetrician and midwife on any maternal death serious incident panel, service specific recommendations were reported to those maternity services where a maternal death had occurred during the period of review, the Executive summary of the report was sent to all Trust and Cluster Chief Executives. It is expected that this will be discussed at the Trust's own Clinical Governance Boards.

The Chief Nurse and Local Supervising Authority Midwifery Officer has written to all Cluster Chief Executives asking for assurance on minimum requirements of staffing in maternity units and to give evidence of the systems they have in place to monitor the quality and safety of the maternity services that they commission.

A steering group from the Chief Nurse Directorate and Medical Directorate has been established to take forward the recommendations from this review. There are a number of far reaching recommendations that require changes to the education and training of midwives and obstetricians, leadership development and the organisation of London's maternity services. It is proposed that this will be taken through London's Clinical Senate Group. A presentation on the findings was given to the Senate in June and it is expected that

further work will be undertaken through this forum. This presentation has been given to the London Chief Executive forum and the London Directors of Nursing.

In addition to this a number of workshops will be delivered throughout London so that opportunities for learning from this review can be maximised. This is organised in the Clusters and will be open to a wide range of stakeholders.

It is clear that women from BME and deprived backgrounds are at greater risk and there must be a focus on engaging with local groups to improve communication and opportunities for health education. There are a number of services in London who have undertaken exemplary work in engaging with "hard to reach" groups and it is proposed that their approached is shared on a Pan London basis as part of the workshops.

The full report can be accessed at
www.london.nhs.uk/webfiles/Independent%20Reports/London%20MDR%20Report.pdf

All maternal deaths are subject to internal review and meet the NHSL criteria of Serious Untoward Incident. This year has seen more Trusts moving towards external panels and using a wider expertise in their enquiries to increase opportunities to consider alternative system changes and lessons that can be drawn from these sad and untimely events. All such deaths are entered on the LSA database by the supervisors of midwives to inform the LSAMO. This year saw the cessation of CMACE and at the time of writing this report no national solution for a confidential enquiry has been established to continue this work. It is understood that the Department of Health along with key stakeholders are working towards this.

Thirty one maternal deaths were reported to the LSAMO in this reporting year, nine more than reported in 2009-10.

Of the 31 deaths[10], 6 appear to be due to causes directly related to pregnancy/childbirth and 23 were indirect deaths and one incidental. The causes of these deaths reflect the causes found in the Pan London review. Only basic analysis has been possible without further information from CMACE.

Ethnicity of the women who died is as follows; 8 Asian, 5 Black, 12 White, 2 Mixed, 2 were said to be 'Other' and one was not recorded. These statistics are reflective of the Pan London review and highlight the vulnerability of women from Black and minority ethnic groups.

The LSA team has developed a maternal death calculator that monitors maternal death across London and forms part of the NHSL Organisational Health Intelligence Tool; this is shared with services and commissioners and is in the public domain.

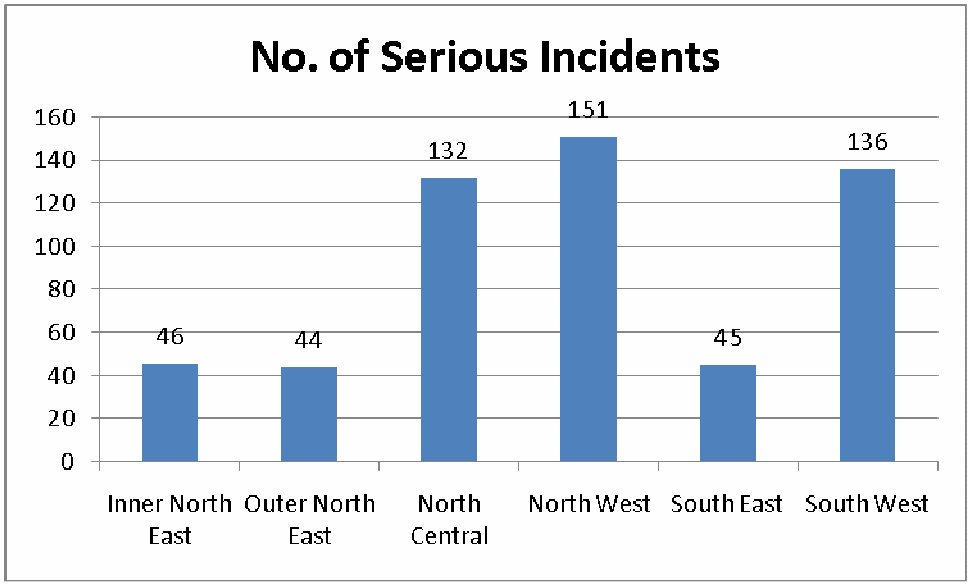
7.5.4 Serious Incidents (SIs)

The SHA has an agreed policy for the escalation of SIs which includes a number of circumstances which automatically categorise an incident as an SUI. Details of this can be found at
http://www.london.nhs.uk/publications/tools-and-resources/serious-untoward-incident-sui-reporting-guidance.

[10] Information from LSA database, not verified from any other source since cessation of CMACE.

There has been further change in the reporting and categorisation of maternity SIs in line with national guidance. The table and graph below provide the number of maternity service SIs reported on StEIS between 01/04/10 and 31/03/11, by sector.

The LSA team forms part of the review process for SI reports and any concerns around midwifery practice are escalated to the LSA team.



8.0 Reports on all local supervising authority investigations undertaken during the year.

The LSA is informed of serious incidents (SI) via the Patient Safety Team at the SHA. The LSAMO and Assistant LSAMO are involved in reviewing the SII reports and in making further recommendations to the maternity service. The LSAMO is informed of all supervisory investigations prior to their commencement via the LSA database.

8.1 The number of investigations undertaken during the year by supervisors of midwives.

All SoM teams in London have had professional development in relation to undertaking supervisory investigations, in the form of workshops.

London SoMs and the LSA had previously identified confusion around the process and lack of knowledge and clarity around when a supervisory investigation was necessary. All SoMs in London are expected to undertake supervisory investigations in line with guideline L (a) and L www.midwife.org.uk. The LSAMO reviews all supervisory investigations before the final recommendation is made.

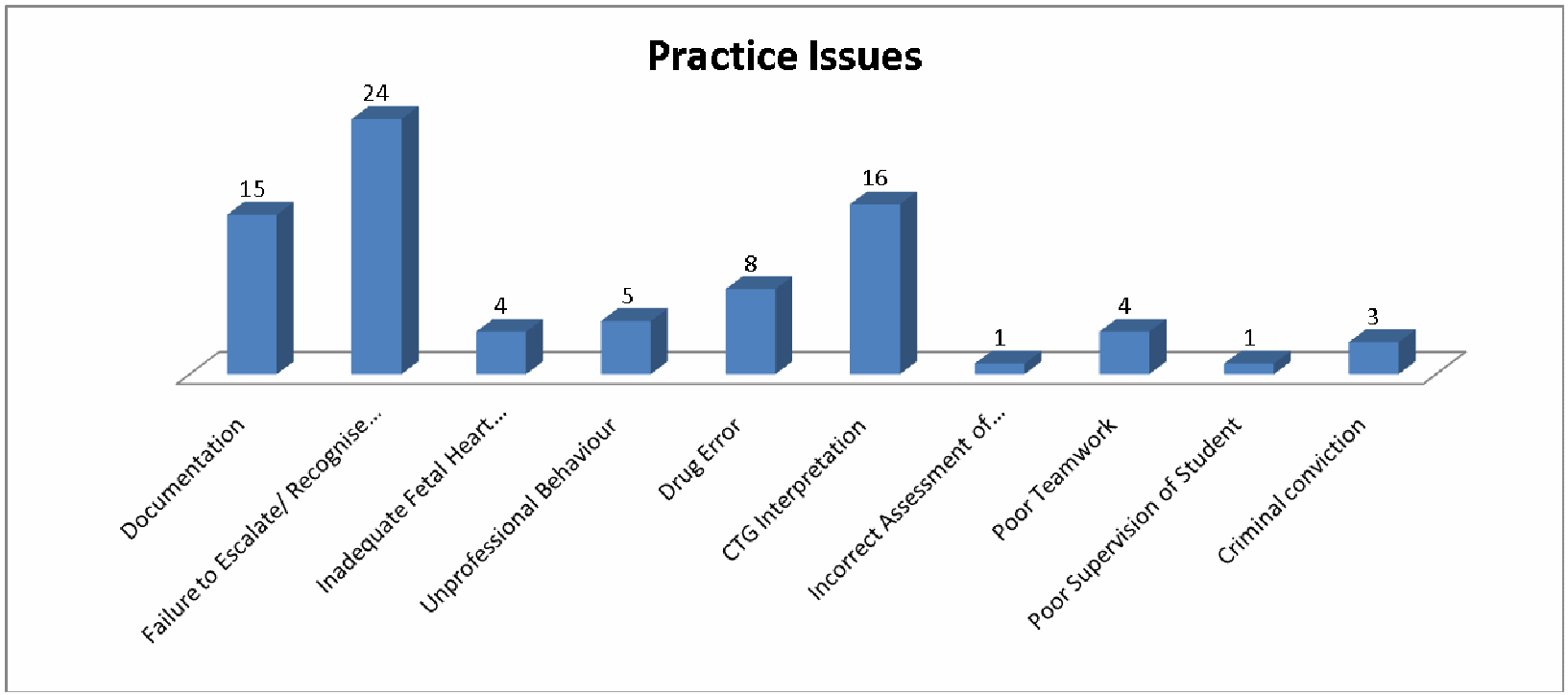
This year, SoMs of midwives reported on 89 investigations, involving 126 midwives, which is a similar number to last year. The following charts show the concerns around practice themes, organisational issues identified and the outcome from these investigations.

An audit was undertaken of SoM investigations in London and the full report can be found in **Appendix 5**. The most significant finding of this audit was the delay in commencing SoM

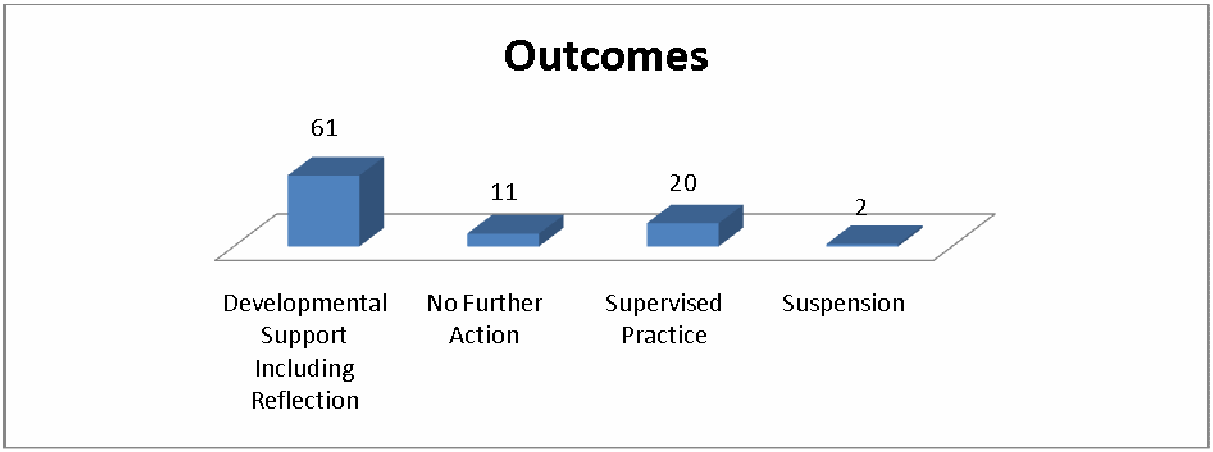
investigations. The following recommendations have been made and are being monitored through all SoM teams.

- All SoMs should attend ‘Investigation Master Class Training’ to gain a clear understanding of the investigation process and the use of root cause analysis within an investigation.
- Each SoM team should review the process of how they are made aware of incidents within their unit.
- Prompt action must be taken to commence investigations and time should be allocated to ensure that the investigation can realistically be completed within 20 working days. Completion of the team ‘Dashboard’ should be used to monitor team performance in meeting this goal.
- LSAdb should be completed at the time of commencing investigations and closed with the addition of a completion date at the end of the investigation, to provide a clear audit trail of investigations.

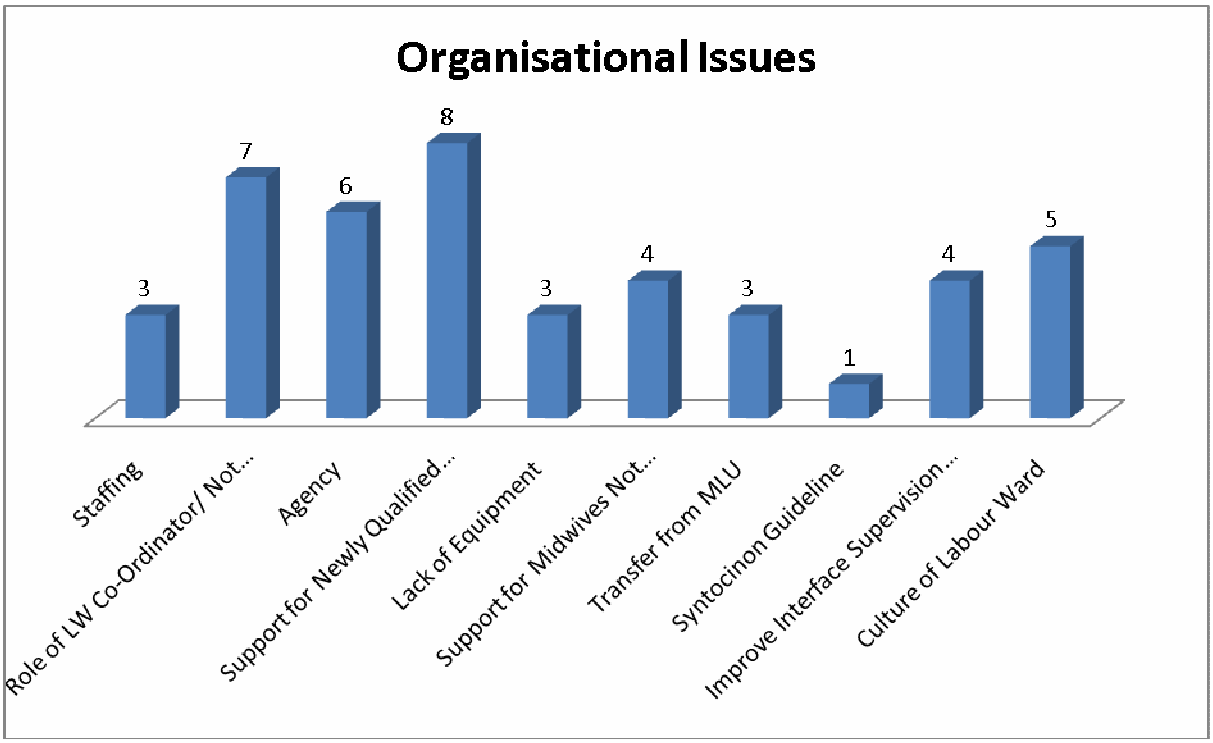
The themes emanating from these investigations are highlighted below;



Whilst there has been a significant increase in the number of investigations; the recommendations from them have shown a decrease in the number of supervised practice programmes and an increase in developmental support, which demonstrates a proactive approach to supervision.



In addition, each supervisory investigation identified a number of organisational issues which contributed to the trigger for the investigation. A summary of each investigation report is sent to the Head of Midwifery and if organisational issues have been identified an action plan to address these is requested and monitored by the SoM team. Assurance is also sought by the LSA team to ensure that identified concerns have been addressed, as part of the LSA audit. If the concerns identified are serious or require urgent attention, the LSAMO meets directly with managers from the Trust and the NMC is informed.



Following analysis of the themes from SoM investigations last year a number of SoM teams undertook development with their midwives and a number of examples of good practice have been identified;

- Barts and the London team of SoMs led on a zero tolerance to poor standards of behaviour which has led to a reduction in the number of complaints from women
- SoMs have used the information to input on the mandatory training for midwives
- SoMs have led on reviews of clinical guidelines to ensure they are fit for purpose and meet national guidance.
- Additional equipment has been purchased where necessary
- A number of SoM teams have escalated concerns directly to their Executive teams.

8.2 The Number of Investigations Undertaken Directly by the LSAMO

Profile of Midwife	Practice Issues	Outcome
NHS employed	Breach of Rule 6. Breach of Code of Conduct	Dismissed from employment & referred to NMC. Suspended from practice. Interim orders – suspension order for 18 moths – case pending
Self employed	Breach of Rule 6.	Programme of supervised practice – successful.
NHS employed	Breach of Code of Conduct	Programme of supervised practice – pending outcome
NHS employed	Breach of Rule 6 Breach of Code of Conduct	Health issues – supported back to work with support of SoM and reasonable adjustments.
NHS employed	Breach of Code of Conduct	Suspended from practice for criminal allegations. Referred to NMC, case pending.

In addition to this, the LSAMO received three letters of complaint from women about the care they received. In all cases a full investigation was undertaken, a full report was given to the women. The midwives involved in two cases were given a programme of developmental support and in the third a formal reflection with her SoM.

All LSA investigations were conducted by the LSAMO for London. In addition, the London LSAMO undertook a review of a LSA investigation for the South Central LSA.

8.3 Supervised Practice programmes which have not been implemented due to employer dismissal or refusal by the midwife.

Three programmes of supervised practice were unable to be commenced within the year as it was not possible to find services able to facilitate the programmes. All three midwives were employed by Agencies or dismissed by their employer at the time of the incident. It is becoming more difficult to find supervised practice placements for unemployed midwives as many services do not wish to take the risk of providing an honorary contract for a midwife who has been dismissed elsewhere or is currently unemployed.

The London LSA was asked to find a placement for a midwife from a different LSA but this was not possible.

8.4 Details of the number of complaints regarding the discharge of the supervisory function

The LSA received two complaints regarding the discharge of the supervisory function this year.

The complaints received all related to the process of supervisory investigations and came from the midwives whose fitness to practice was subject to the investigation. In each case, the LSA reviewed the process of the supervisory investigation by meeting with the investigating supervisor of midwives, the midwife and by looking at the documents related to the investigation. In the first case, the complaint was unfounded. In the second case there was some cause for concern around the process of the investigation and an external LSAMO was asked to review the investigation. The recommendation from each investigation remained the same but in the second case some of the allegations were no longer upheld and recommendations were made to the investigating SoM. Both SoMs undertaking the investigations were given feedback and further development in relation to the process of investigation including undertaking a supervisory investigation with an experienced SoM.

8.5 Communication with the NMC on matters of concern regarding midwifery practice.

The LSAMO raised concerns directly with the NMC regarding the two maternity services that were asked to make improvements to their service. The NMC advisors attended the LSA audit of one of the Trusts and there has been ongoing and regular communication with the NMC in relation to these services.

Since January 2011, the London LSA has participated in the NMC quarterly monitoring of LSAs. This is a formal process to ensure that the NMC is kept informed of any matters affecting midwifery practice and maternity services.

9.0 Additional LSA activities

9.1 Self Employed midwives

The LSA continues to facilitate quarterly meetings with self employed midwives and those midwives who are privately employed. The purpose of the meeting is to share information and to provide a forum for discussion.

There were a number of invited speakers and the meetings were well evaluated.

9.2 Collaborative Working between the LSA and Safety organisations

The LSAMO and Assistant LSAMO met quarterly with the CMACE co-ordinator until January 2011, when the organisation was disbanded. Data on Maternal deaths was shared and compared for accuracy. Updates on local reporting were discussed and strategies for improvements were made and then disseminated via the supervisors of midwives and Heads of Midwifery.

The LSAMO has worked with the CQC when concerns have been raised about maternity services in London.

The LSA team has been invited speakers and facilitators at a number of National Patient Safety Agency, CMACE and NHS Institute of Innovation and Improvement events.

Local Supervising Authority Midwifery Officers' Forum (UK)

Annual Report for 2010 - 2011.

Introduction

The aim of this report is to provide an update on the LSA Midwifery Officers' (LSAMO) Forum (UK) "The Forum" activity during 2010-11. The purpose of the Forum is to enable the LSAMOs to work collaboratively with each other and with key stakeholders to ensure that there is a consistent and equitable United Kingdom (UK) wide approach to achieving the standards set by the Nursing and Midwifery Council (NMC). The Forum consists of the fifteen LSAMOs from across the UK and is currently working to a four year strategy, which describes the work plan until the end of 2011. The Forum meets six times annually at different venues across the UK, hosted by the local LSA. In 2010-11 the meetings were;

- May 2010 NHS London
- July 2010 NHS West Midlands
- September 2010 NHS London
- December 2010 Cancelled due to adverse weather
- January 2011 Healthcare Inspectorate Wales
- March 2011 NHS London

The Forum is chaired by a LSAMO; the Chair and Vice Chair are elected for a period of one year with the Vice chair becoming the Chair the following year. This year the period of Chair has been changed to reflect the practice / fiscal year.

Stakeholder Involvement

The following stakeholders were invited to meetings in 2010-2011;

- Department of Health (January, May, October)
- Chief Nursing Officers
- Care, Quality Commission (May)
- NHS Litigation Authority (October)
- Nursing and Midwifery Council (January, March, October)
- Royal College of Midwives (March)

LSA Midwifery Officer Engagement

LSAMOs represent the LSAMO Forum (UK) as members of other forums;

- NMC /LSAMO Strategic Reference Group
- Midwifery 2020
- Midwives rules and standards consultation
- Midwife Supply Orders working group
- NMC review of Midwives rules and standards steering group
- NMC review of the Standards for the supervised practice of midwives
- NMC Revalidation
- Maternity Safeguarding Alert system
- NICE consultations
- MINT Project
- Review of the Centre for Maternal and Child Enquiries
- LSA Database Steering Group

Work of the Forum

The Forum meetings include identifying, developing and progressing future work which in 2010-11 included the development of new and updated LSA National Guidelines - available at www.midwife.org.uk

- Guideline B: Information Governance including the transfer of confidential information relating to statutory supervision; March 2011.
- Guideline H: Transfer of records from self employed midwives; July 2010.
- Guideline K: Completion of the intention to practise form by a registered midwife; April 2010.
- Guideline N: Record Keeping, July 2010
- Guideline O: The role of the Supervisor of Midwives in raising awareness of the inappropriate use of social networking sites, March 2011.

LSA National Conference

The Forum held a national UK conference *"Supervision in action"* in April 2010, which was attended by over 500 Supervisors of Midwives and midwives from LSAs across the UK. The conference included high profile keynote speakers with Seminars sharing areas of good practice developed by Supervisors of Midwives. This conference is held bi-annually and is due to be held again in January 2012.

Conference Attendance

The Forum aims to have an exhibition stand at high profile conferences each year, in 2010-11 these included;

- Royal College of Midwives conference
- LSAMO Forum (UK) conference *"Supervision in action"*

The Forum exhibition stand at conferences enables midwives, student midwives and others to engage with the LSAMOs and raises the profile and consistency of statutory supervision. These contacts provides an ideal opportunity for the LSAMOs to demonstrate leadership and distribute a number of printed information documents regarding statutory supervision for the midwives to share with other colleagues within their practice areas.

LSA Annual Audit

The Forum has developed a portfolio of audit methodologies to fulfil the 54 standards from the 'Midwives rules and standards' (NMC 2004). There is ongoing discussion and learning within the forum to identify a best practice approach to audit.

Supervisory Investigations

The Forum has worked to enhance the consistency and quality of supervisory investigations across the UK to uphold the safety of women and babies. This included:

- Guideline L (a) Supervisory Investigation Decision Toolkit to determine when and what to investigate
- Definitions and templates
- Interface between supervision and management
- Information for the public on supervisory investigations

- Training tools for supervisors of midwives
- Capturing conduct / behaviour /attitudes in supervisory investigations
- Governance and supervision

LSA Database

The LSA Database is utilised across the UK and enables consistency of the Intention to Practise process, the confidential storage of supervision records and data collection. It allows seamless, electronic transfer from one supervisor to another, as midwives move their area of practice around the UK. It is constantly updated and improved.

LSA Website

This last year has seen further development of the Forum website www.midwife.org.uk which contains all the LSA national guidelines, templates and other core documents and also provides access to the LSA database.

LSA Midwifery Officers' Forum (UK)
August 2011.

10.0 Conclusion

The birth rate continues to rise in London and although funding for midwives has increased in some areas, this has not been consistent. Despite the significant challenges faced by SoMs they continue to demonstrate their significant contribution to improving the safety and quality of our maternity services.

There is clear evidence that SoMs are applying proactive measures to ensure that concerns about individual practice are supported early on to enable development. The SoMs and midwives are developing and introducing new initiatives to support the public health agenda, more choice and increased access for women to continually improve the care for women within London
.
The number of supervisory investigations and midwives undertaking supervised practice has increased therefore increasing the workload of the supervisors of midwives. The supervised practice programmes and suspension from practice, although small in number are very time consuming, however, this further supports the protection of our mothers and babies from poor practice.

There is clear commitment from SoMs to support the provision of excellent care for local women and their families.

In this time of change and financial uncertainty supervision of midwifery continues to be the foundation of support for women and midwives and must continue to be valued, appreciated and recognised.

Appendix 1: LSA Conference Programme: 17th May 2010

LSA CONFERENCE
FOR SUPERVISORS OF MIDWIVES IN LONDON

Monday, 17th May 2010
Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, Regent's Park, LONDON, NW1 4RG

"Essential Law for Supervisors of Midwives"

PROGRAMME

09:00	**Arrival, registration & coffee**	
	• ***Morning Session Chair – Angela Helleur***	
09.30	Welcome and Introduction	Angela Helleur, LSAMO
09:45	Maximising Statutory Supervision	Jessica Read, Assist. LSAMO
10:30	**Coffee**	
10:45	Records – A sure foundation for safe practice	Andrew Andrews, Medical Director Medico-Legal Group, Bond Solon
11.45	Complaints Handling: Resolution and beyond	Isabel West, Solicitor Head of Expert Witness Group, Bond Solon
12:45	Questions to Panel	
13:00	**Lunch**	
	• ***Afternoon Session Chair – Jessica Read***	
14:00	Thinking inside the box – How to give effective evidence in court	Mark Solon, Managing Director Bond Solon Training Ltd
15.00	Undertaking Supervisory Investigations	Angela Helleur, LSAMO Elke Hancock, SoM, Chelwest
15.30	**Tea Break**	
15:45	Report Writing. What is a Good Report?	Isabel West, Solicitor Head of Expert Witness Group, Bond Solon
16:45	Complete Evaluation Form, Closing Comment	Angela Helleur, LSAMO

Appendix 2: LSA Conference Programme: 25th October 2010

LSA CONFERENCE
FOR SUPERVISORS OF MIDWIVES IN LONDON

Monday, 25th October 2010
The Kings Fund
11-13 Cavendish Square, London W1G 0AN

"One too many…….Maternal Death in London"

PROGRAMME

09:00	**Arrival, registration & coffee**	
	• ***Morning Session Chair – Angela Helleur***	
09:30	Welcome and Introduction to the day	Angela Helleur, LSAMO
10.00	Sepsis, an increasing challenge	Austin Ugwumadu Consultant Obstetrician
10:45	**Coffee**	
11.00	Obstetric Haemorrhage	Amanda Mansfield
11.30	Update from CMACE / Claire's story	Rachel Thomas
12:15	Questions to panel	
12.30	**Lunch**	
	• ***Afternoon Session Chair – Jessica Read***	
13.30	Perinatal Psychiatric Disorders	Margaret Oates
14:30	Supervision in Action	Sue Stock Croydon Health Services NHS Trust
15.00	**Tea Break**	
15:15	When Lightening Strikes Twice	Alison Huggett
16.00	Questions to panel	
16:15	Closing comments and evaluation	Jessica Read

Copies of Presentations will be e-mailed to Contact SOMs
*** *** ***

Appendix 3: LSA Audits

April 2010-March 2011
LSA AUDIT DATES

March 2010
3rd Ealing

April 2010
21st Chelsea & Westminster
28th Homerton

May
26th West Middlesex

June
9th BHRUT
23rd UCLH

July
14th North West London
21st Croydon

September
1st Lewisham
8th Newham
15th Epsom & St. Helier

October
6th Whittington
27th North Middlesex

November
3rd Kingston
10th Imperial College
24th Guy's & St. Thomas'

December
1st Kings College
9th Royal Free

January 2010
12th Queen Mary's Sidcup/ Princess Royal
19th Queen Elizabeth
26th Portland

February
2nd St Georges
9th Barts and the London
23rd Whipps Cross

March
9th Ealing
16th Barnet and Chase Farm
30st Hillingdon

Appendix 4: Changes in funded Midwifery establishment

	Budgeted MW Establishment (WTE)				
Hospital trust	2007-2008	2008-2009	2009-2010	2010-2011	Year Change %
Barnet & Chase Farm	193	192	214	215	1%
Central Middlesex & Northwick Park	169	173	188	188	0%
Chelsea & Westminster	138	150	192	188	-2%
Ealing Hospital	84	87	90	100	11%
University College Hospital	120	131	158	166	5%
Guy's & St Thomas's	253	254	254	246	-3%
Barking Havering & Redbridge	240	279	291	308	6%
Hillingdon Hospital	114	114	123	123	0%
Homerton Hospital	141	147	158	158	0%
King's College Hospital	166	173	210	219	4%
Kingston Hospital	133	162	173	174	1%
Lewisham Healthcare	108	114	120	127	6%
Croydon Health Services	125	137	141	142	0%
Newham Hospital	147	189	193	184	-5%
North Middlesex Hospital	98	111	110	112	2%
Portland	36	42	47	58	23%
South London Healthcare	114	127	118	323	175%
Royal Free Hospital	104	97	104	106	2%
St George's Hospital	155	158	175	179	3%
St Helier & Epsom Hospitals	153	166	180	183	2%
Imperial	266	268	294	297	1%
The Royal London Hospital	128	154	164	167	2%
West Middlesex Hospital	101	118	129	134	4%

Whipps Cross Hospital	136	141	151	180	19%
Whittington Hospital	128	143	147	153	5%
Total	3782	4058	4351	4430	2%

Appendix 5 – Investigation Audit

LSA Investigation Audit

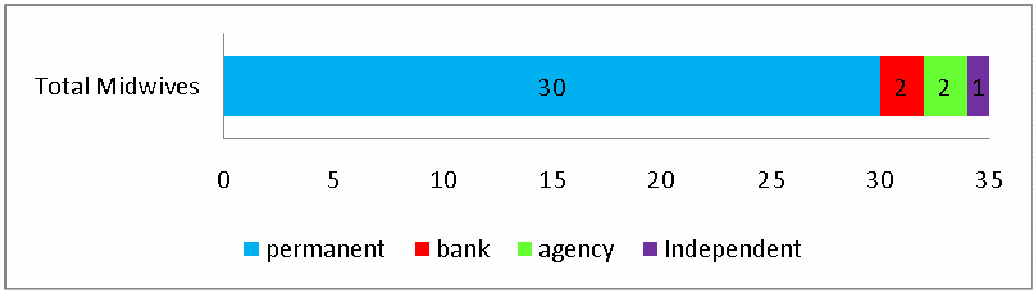
Introduction
Statutory supervision of midwives and midwifery practice promotes the development and maintenance of safe practice to support the protection of mother's, babies and their families. In line with this overall purpose, supervisors of midwives meet regularly with midwives to support them in their practice; promoting best practice, preventing poor practice and intervening in unacceptable practice.

A supervisory investigation will be carried out on all untoward incidents, allegations of professional misconduct and/or concerns in relation to lack of midwifery competence / fitness to practice. It is imperative for all involved that the process of investigation is thorough, equitable and transparent and to ensure this, the use of Guideline L and other supporting documentation available on the LSA website must be clearly demonstrated within the structure of the investigation report.

An audit of all supervisory investigations undertaken within London Strategic Health Authority (SHA) on behalf of London LSA, over a six month period in 2010 was carried out. This was benchmarked against the investigation process used within Guideline L (LSA Forum UK, 2008).

Purpose of the Audit
The purpose of this audit was to assess the quality of supervisory investigations by auditing the adherence to the investigatory process, as set out within Guideline L. In addition it is anticipated that the audit will where appropriate, highlight areas of good practice or areas that require specific attention which will be fed back to SoMs.
Methodology
The supervisory investigation audit tool (appendix 1) was used to collect the data for the audit. The audit tool reflects the guidance detailed within Guideline L and was designed to measure adherence to the investigation process set out within this guideline.
All supervisory investigations that were **commenced** (irrespective of when the incident took place) within the **six month period of June – November 2010** and whose recommendations had been agreed by the London LSAMO at the time of commencing the audit were included. Data was collected from completed supervisory investigation reports filled with London LSA and from the LSA data base (LSAdb).
This totalled 33 investigation reports and involved 35 midwives.
Demographics
During this period, supervisory investigations were carried out in 64% (14/22) of Trusts based within London SHA. In addition there was one investigation from the independent setting. 35 midwives were subject to investigation within the 33 reports. 91% of these midwives were contracted to work in the unit where the incident occurred (permanent plus bank midwives) and only 6% were contracted with midwifery agencies.

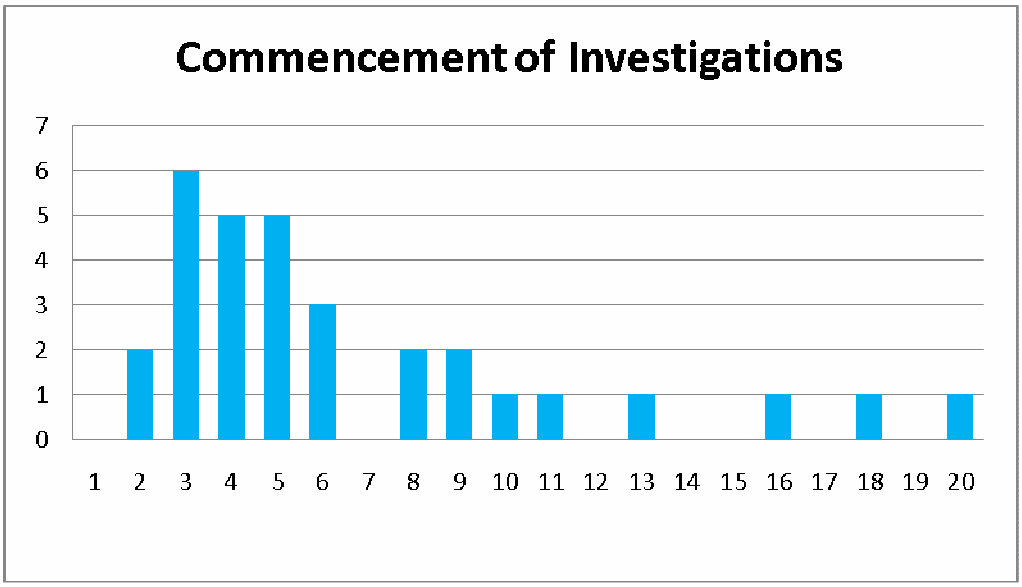
The table below demonstrates the employment status of the midwives subject to investigation at the time of investigation



Basic Investigation Principles

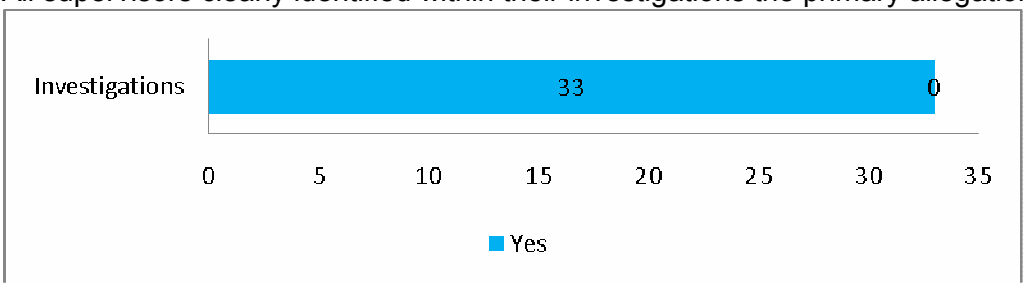
1. **How soon after this incident was an investigation commenced?**

This was measured in weeks and the results were wide ranging. Two investigations were commenced either on the day of the incident or the following day which demonstrated good communication between midwives and SoMs, as well as the SoMs ability to act promptly. At the other end of the range one investigation did not start until 20 weeks after the event which is very concerning. The mean length of time from incident to the investigation commencing was 6.3 weeks.



2. **Is the primary allegation that led to the commencement of this investigation clearly identified within the investigation?**

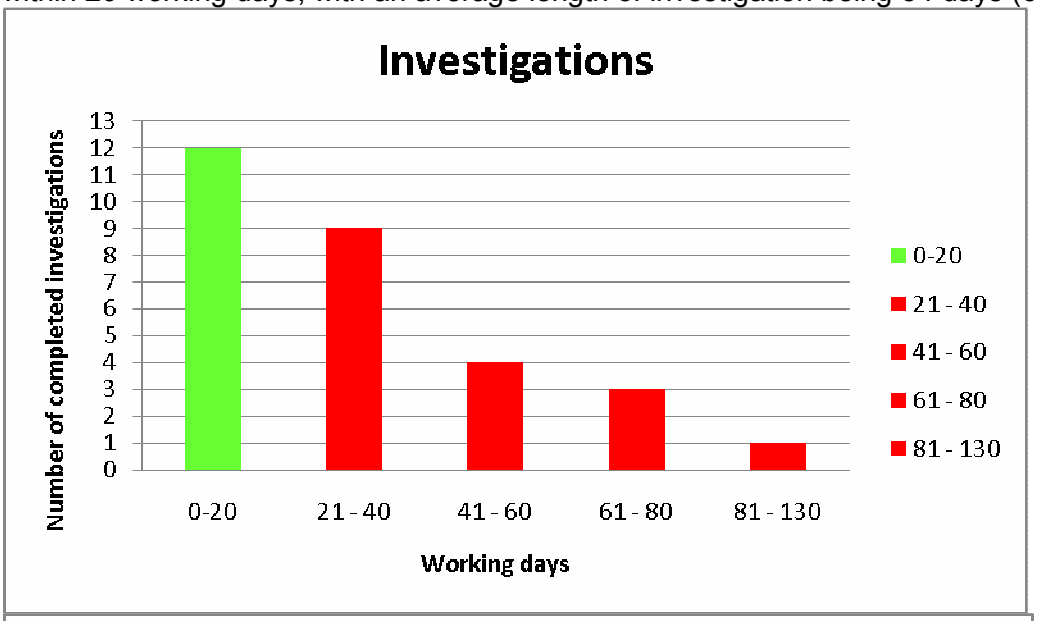
All supervisors clearly identified within their investigations the primary allegation.

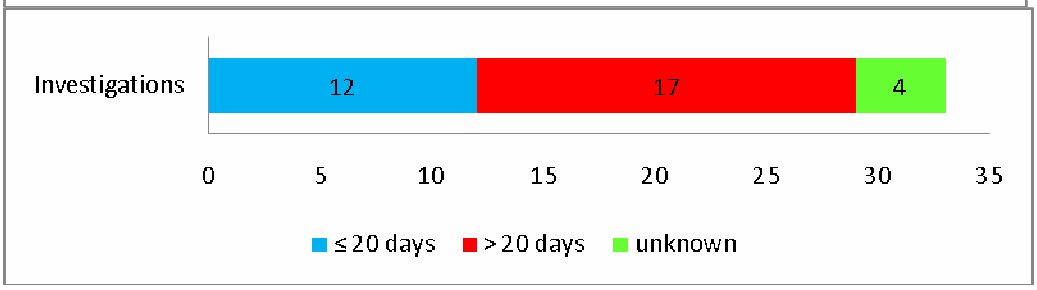


3. **From commencement of the investigation how long did it take to complete?**

The length of time for the investigation to be completed once commenced was calculated in working days. The standard for completion of an investigation is set out within Guideline L as 20 working days (4 weeks). There were four investigations where no completion date was recorded within the reports or on the LSAdb. From the remaining 29 investigation reports,

completion ranged from 6 to 130 days. Only 34% (10/29) of investigations were completed within 20 working days, with an average length of investigation being 34 days (6.8 weeks).

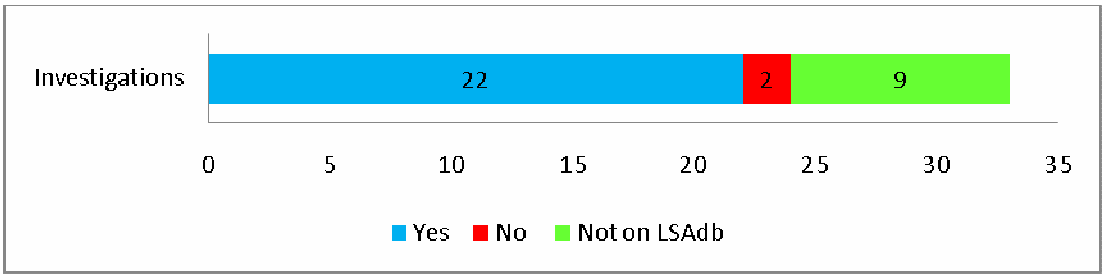




Process for supervisory investigation into a midwife's fitness to practice
Decision for investigation

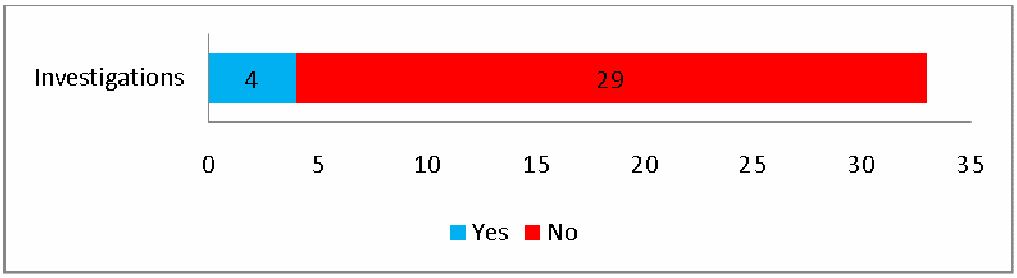
4. **Was the LSAdb correctly completed to inform the LSAMO of the commencement of the investigation?**

Of the 33 investigations reviewed, 67% (22/33) were correctly added to the LSAdb. 2 were added but with inadequate information and 27% (9/35) were not added. Within the 9 investigations that were not added, all had demonstrated within their investigation that they had spoken or emailed the LSAMO to inform her of their intention to commence the investigation but had omitted to carry out the primary notification process of completing the database.



5. **Is there evidence that the Supervisory Investigation Tool Kit was used to assist in decision making on whether to commence an investigation?**

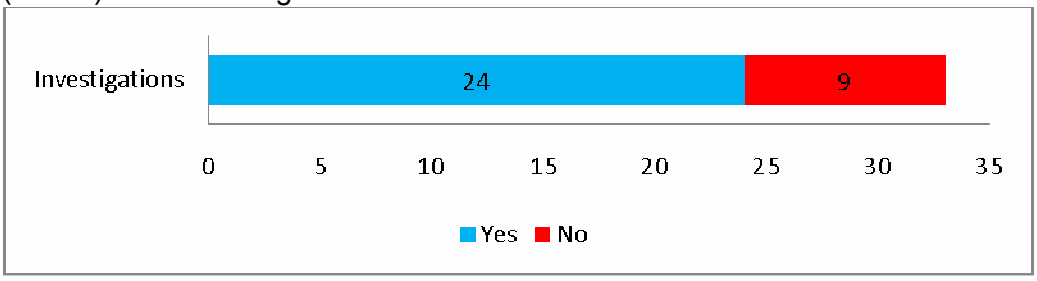
Although there is clear guidance that the decision making tool kit should be used to assist with the decision making process on whether to commence an investigation, disappointingly its use was only demonstrated within 12% (4/35) of investigations.



Identification of those involved in the incident

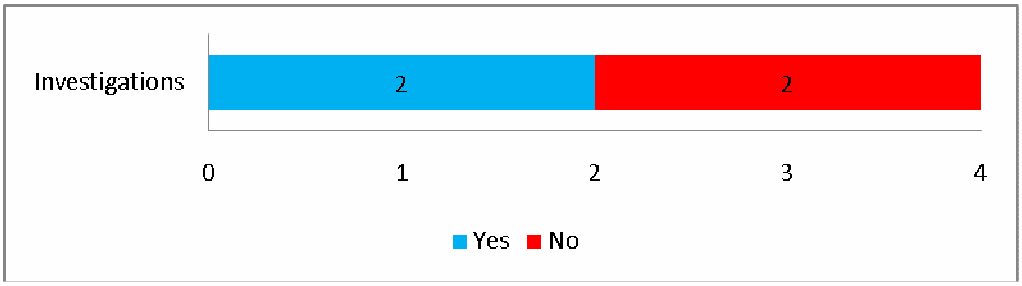
6. **Have statements been requested from all midwives involved?**

Although it is seen as best practice to request statements from all staff involved in investigations to support the investigation process, this could only be demonstrated in 73% (24/ 33) of the investigations.



7. **If a student midwife was involved, was the university contacted to discuss the best way forward?**

The majority of investigations did not involved student midwives. Of the 4 investigations that had student involvement, two could demonstrate that their university link had been contacted and two showed no evidence of this.

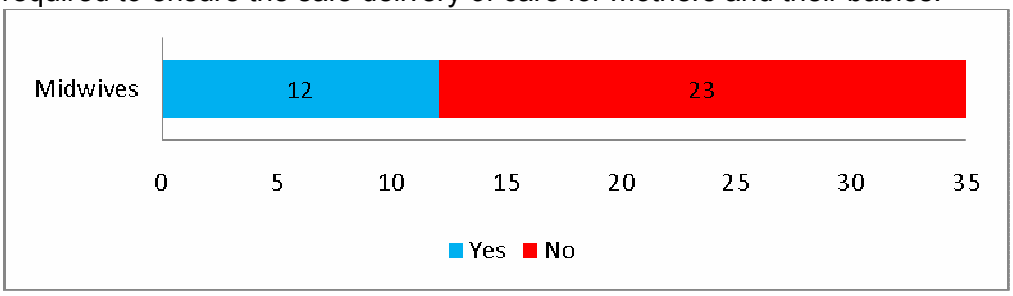


Continuance at work

8. **Is there any evidence within the investigation that options for working during the investigation were discussed with the midwives manager e.g. continuance at work / supervision in the workplace /removing the practitioner from some duties?**

As previously discussed there were considerable delays in commencing many of the investigations with 70% (23/35) not being commenced until 4 - 20 weeks after the incident. To compound this only 34% (12/35) of midwives who were subject to investigation were discussed with their managers in relation to continuance at work / supervision in the workplace /removing the practitioner from some duties, during the investigation period. This was particularly concerning to note as 77% (27/35) of midwives that were subject to investigation received final recommendations which involved them having some level of support to improve highlighted areas of weakness within their practice. (See below).Therefore omitting to discuss the above with their line manager, compounded by the delays in commencing investigations potentially resulted in several midwives working for a

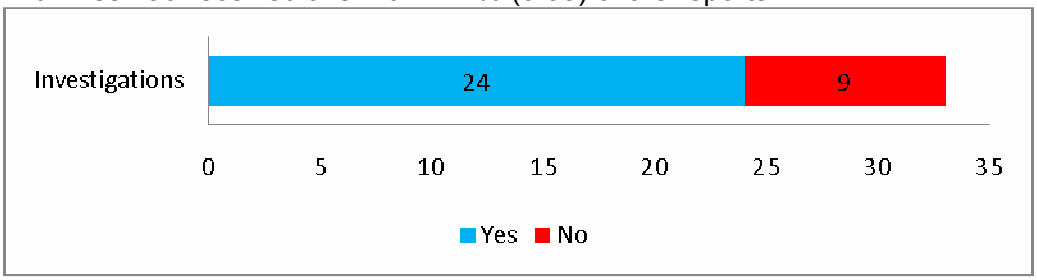
considerable time following the event without the necessary support / supervision that they required to ensure the safe delivery of care for mothers and their babies.



Informing the midwife

9. **Is there evidence that the midwife being investigated was informed formally of the process of the investigation?**

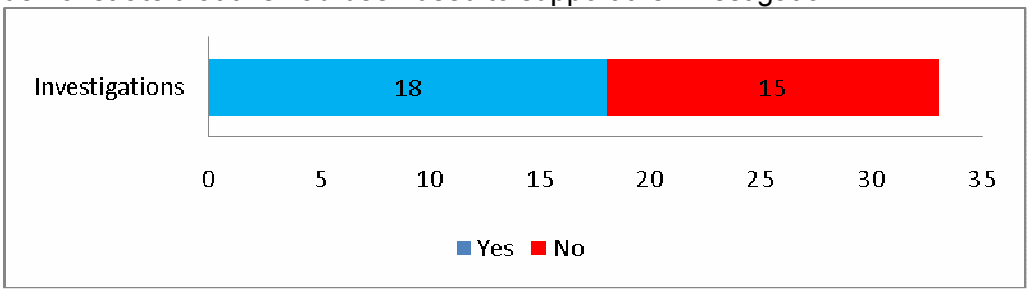
It is important to ensure midwives are aware of the formality of the investigation they are subject to and are given details of the investigatory process. There was no evidence that the midwives had received this within 27% (9/33) of the reports.



Gathering information and the fact finding

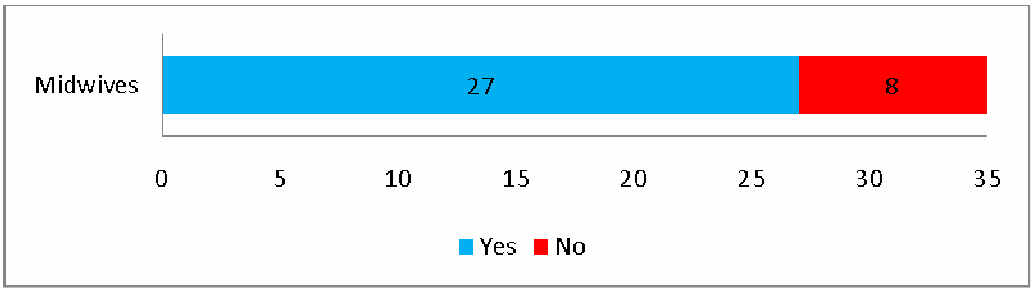
10. **Is there any evidence of root cause analysis being undertaken to support this investigation?**

Evidence of root cause analysis was weak with only 55% (18/33) of the investigations able to demonstrate that this had been used to support the investigation.



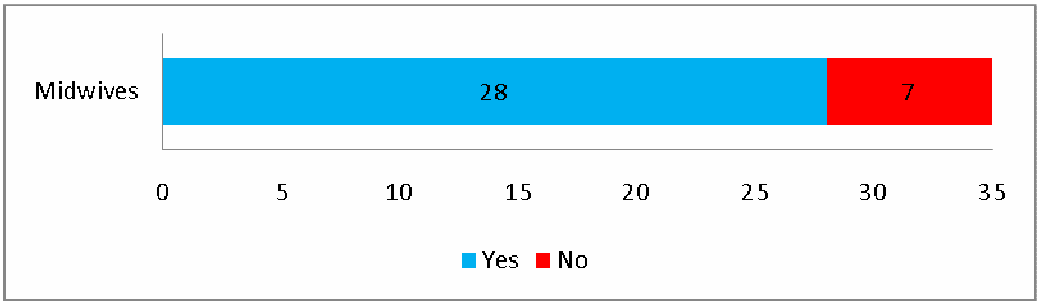
11. **Has the midwife's named SoM been contacted for additional information about this midwife e.g. Annual review, completion of actions from annual review, previous concerns with the same theme?**

77% (27/35) of midwives named SoMs were contacted for further information to support their investigation.



12. Has the practice development midwife been contacted, if appropriate to the investigation, to provide details of whether this midwife is up-to-date with all mandatory training?

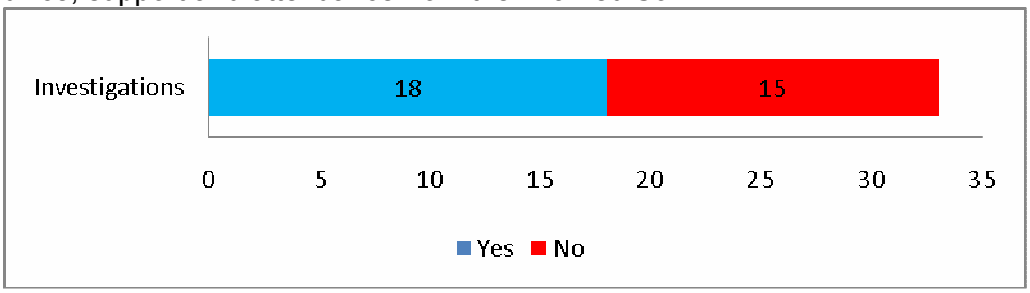
A similar number of practice development midwives, 80% were contacted for further information.



Invite for investigation interview

13. Has a formal letter been sent to the midwife inviting her to attend an interview?

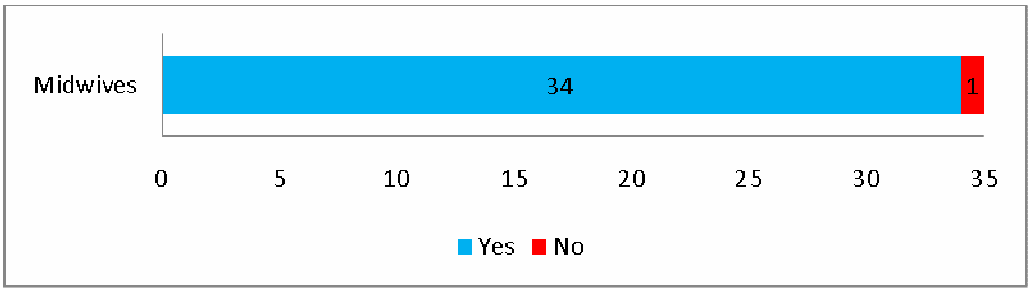
There was evidence of 54% (18/33) of the midwives being written to formally to invite them to attend an investigatory interview. In addition there was some evidence of midwives being asked verbally to attend their interview. It was therefore not clear if these midwives had been given adequate time to prepare for the interview or whether they had been able to seek advice, support and attendance from their named SoM



Conducting the interview

14. Is there evidence of fact finding being carried out during the interview? This should include some reference to self, competence and context.

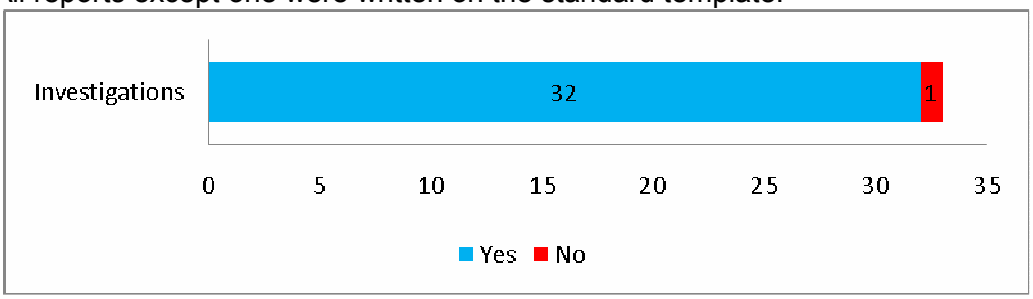
Fact finding was strong within the individual interviews and this was clearly demonstrated within all but one investigation.



Writing the supervisory investigation report

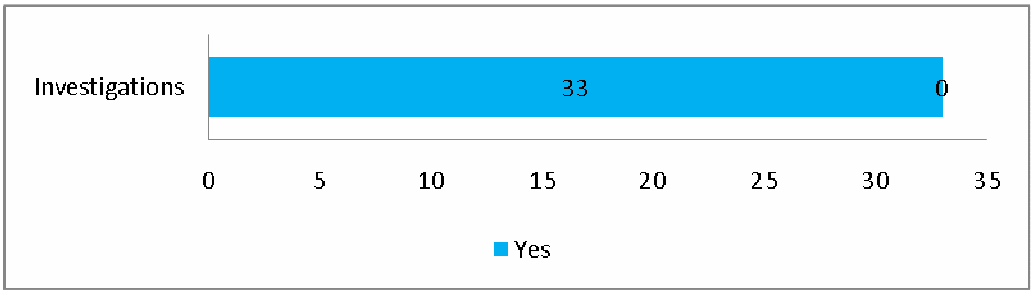
15. Has the report being written on the required standard template?

All reports except one were written on the standard template.



16. Does the report read in a clear and logical manner?

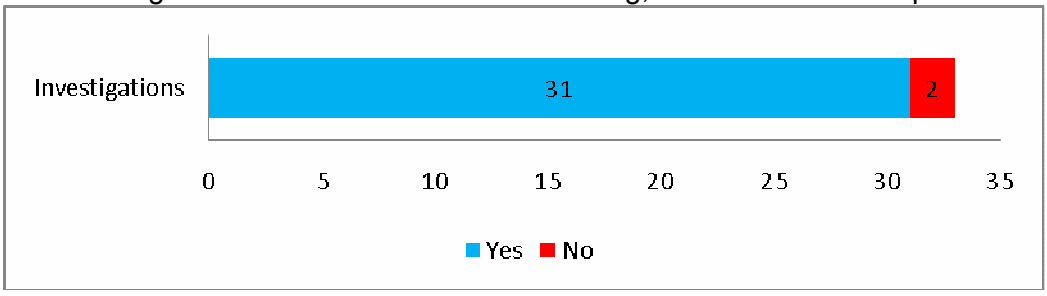
All reports were clearly written and followed a logical manner that was easy to follow and understand.



17. Does the report contain the culmination of all the work that has been undertaken by the investigating SoM?

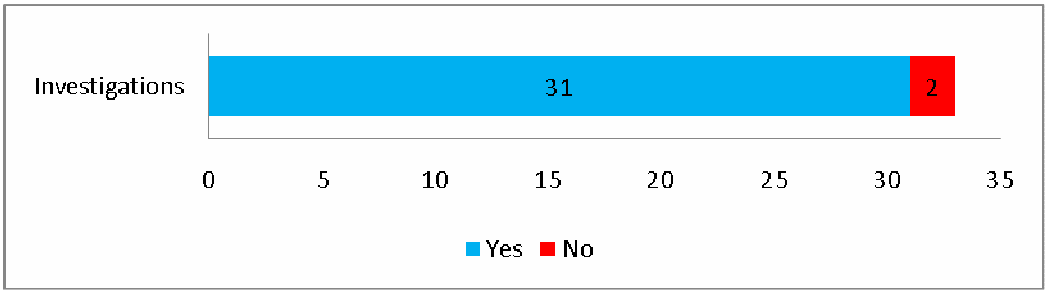
a) All necessary information about the incident?

Two investigations had some information missing, all others were complete.



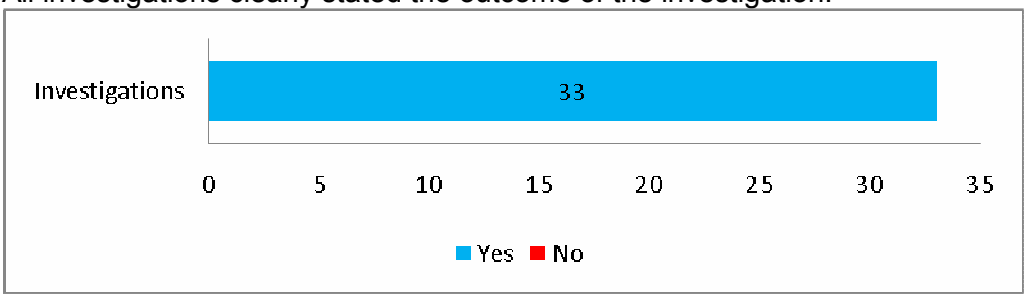
b) The investigation procedure that has been followed?

Two investigations did not clearly map the investigation procedure that they had followed.



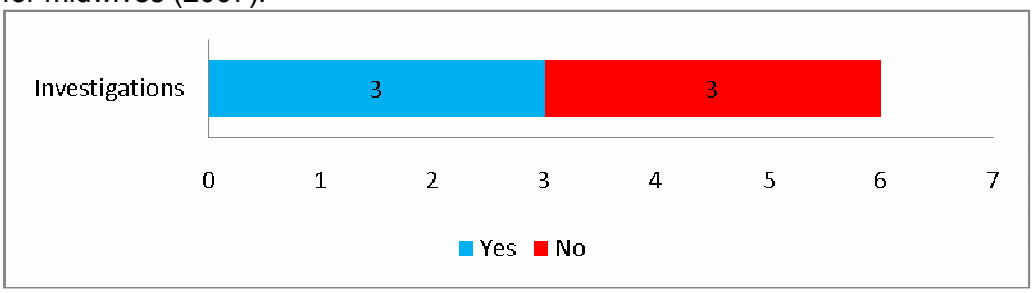
c) The outcome of the investigation?

All investigations clearly stated the outcome of the investigation.

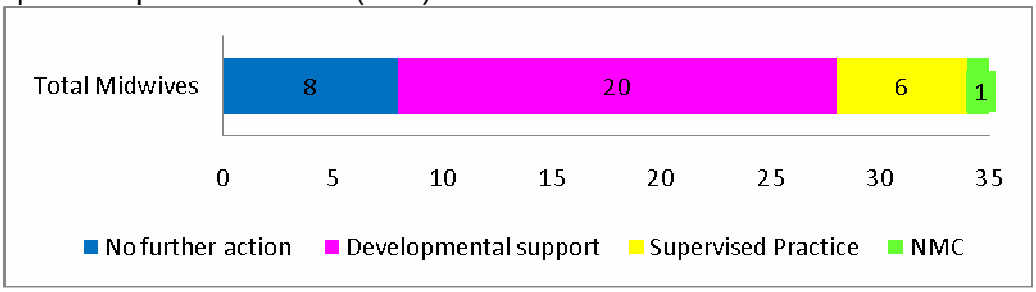


18. In the event of supervised practice being recommended, is there evidence of that the *NMC Standards for supervised practice for midwives (2007)* has been referred to?

From the 35 midwives that were investigated, 17% (6/35) were recommended to have supervised practice. Of the six that recommended supervised practice three reports (50%) demonstrated that reference had been made to the NMC Standards for supervised practice for midwives (2007).



Final recommendations following completion of investigations.
Of the 35 midwives that were subject to investigation during this period, 23% (8/35) had no further action, 57% (20/35) were recommended to have developmental support, 17% (6/35) supervised practice and 3% (1/35) a recommendation to be referred to the NMC.



Discussion

Guideline L and other supporting documents are easily accessible to all supervisors of midwives via www.midwife.org.uk and all SoMs are made aware of these documents through formal training and peer support. These documents support and guide all SoMs through the agreed process of investigation. Demonstrating that this process has been followed in all investigations carried out ensures equity and transparency for all midwives that are subject to investigation.
Overall within this sample there was good evidence of the investigation process following Guideline L. The SoMs clearly defined the primary allegation within their investigation, demonstrated fact finding during interviews and produced reports that were clear and logical, with a culmination of all the work undertaken during the investigation.
There were however some areas of weakness that needs to be improved upon. There was a notable weakness in the use of the investigation toolkit to support the decision to commence an investigation. Also the use of root cause analysis remained weak. Training on the use of both of these tools is included in the LSA Investigation Master Class which is being rolled out to the SoM teams. Not all teams have received this training as yet and these findings support the recommendation that this work should continue to remain on the LSA agenda.
Although the use of the chronology section of the investigation template was not formally reviewed within this audit. It was notable that in many of the investigations this was scantily completed and often not completed beyond notifying the LSAMO. This resulted in uncertainty in whether some areas of the investigation had taken place. It is important for all SoMs to be aware of the importance of this sheet to document chronologically the work they have carried out in relation to the investigation, with cross reference to the related documents. This provides a visual step by step summary of the process that has been followed throughout the investigation.
Most concerning was the length of delay in commencing investigations following the event, and the process of identifying / acting on issues that require investigating should be reviewed by all SoM teams. Once investigations were commenced there were further delays which compounded the concerns in relation to length of time between the event taking place and the final completion of the investigation. Guideline L states that all investigations should be completed within 20 working days. It is understandably important that midwives subject to investigation are not put under unnecessary stress caused by long delays whilst waiting for the final recommendations from the investigation. But arguably, more important is the length of time that these midwives continued to practice with no review or adaptation to their current role. It is important to note that 77% of the midwives that were subject to investigation had part or all of their allegations upheld and were recommended to have some form of support to improve their practice. This ranged from developmental support to a referral to the NMC. However in only 34% (12/35) of cases did the investigating SoM discuss with the midwives manager options for working during the investigation e.g. continuance at work / supervision in the workplace /removing the practitioner from some duties. This resulted in a concerning number of midwives continuing to practice for a considerable length of time unsupported or unsupervised prior to and / or during the investigation, that were subsequently recommended support to improve their practice, (17% requiring supervised practice). These long delays undoubtedly increased the potential risk of harm to women and their babies within their care.

Conclusion
Although many parts of the investigatory process are managed well, there is no doubt that at times the delays in identifying and completing investigations was unacceptably long if supervisors are to comply with their primary role of ‘protecting the public’. Supervisors need to acknowledge the importance of these investigations and prioritise effectively in relation to other work they are carrying out. Systems to improve identification of incidents near or at the time of an event, that may require a SoM investigation, need to be reviewed in all units as well as close working with midwifery

management to ensure that appropriate time is allocated to realistically enable investigations to be completed within the set time frame of 20 days.

Recommendations

- All SoMs should attend 'Investigation Master Class Training' to gain a clear understanding of the investigation process and the use of root cause analysis within an investigation.
- Each SoM team should review the process of how they are made aware of incidents within their unit.
- Prompt action must be taken to commence investigations and time should be allocated to ensure that the investigation can realistically be completed within 20 working days. Completion of the team 'Dashboard' should be used to monitor team performance in meeting this goal.
- LSAdb should be completed at the time of commencing investigations and closed with the addition of a completion date at the end of the investigation, to provide a clear audit trail of investigations.

References

LSA Midwifery Officers Forum UK at www.midwife.org.uk

Appendix. 1
LSA Investigation Audit Tool

The purpose of this tool is to audit the standard of investigations carried out by Supervisors of Midwives when undertaking an investigation into a midwives fitness to practice on behalf of the Local supervising Authority.
These investigations should include all untoward incidents, allegations of professional misconduct and /or concerns about lack of competence.
All investigations must be carried out to a high standard and must be able to demonstrate that they are thorough and equitable. To support this and ensure consistency with investigations Guideline L must be followed throughout the investigation and its use should be clearly demonstrated through all attached documentation.
This audit tool aims to assess the adherence of this guideline and the overall standard and quality of investigations undertaken on behalf of the LSA over the period of Jan 2010 – December 2010.

Basic investigation principles

1. How soon after this incident was an investigation commenced?
2. Is the primary allegation that led to the commencement of this investigation clearly identified within the investigation?
3. From commencement of the investigation how long did it take to complete?

Process for supervisory investigation into a midwife's fitness to practice
Decision for investigation

4. Was the LSAdb correctly completed to inform the LSAMO of the commencement of the investigation?
5. Is there evidence that the Supervisory Investigation Tool Kit was used to assist in decision making on whether to commence an investigation?

Identification of those involved in the incident

6. Have statements been requested from all midwives involved?

7. If a student midwife was involved, was the university contacted to discuss the best way forward?

Continuance at work

8. Is there any evidence within the investigation that options for working during the investigation were discussed with the midwives manager e.g. continuance at work / supervision in the workplace /removing the practitioner from some duties?

Informing the midwife

9. Is there evidence that the midwife being investigated was informed formally of the process of the investigation?

Gathering information and the fact finding

10. Is there any evidence of root cause analysis being undertaken to support this investigation?
11. Has the midwife's named SoM been contacted for additional information about this midwife e.g. Annual review, completion of actions from annual review, previous concerns with the same theme?
12. Has the practice development midwife been contacted, if appropriate to the investigation, to provide details of whether this midwife is up-to-date with all mandatory training?

Invite for investigation interview

13. Has a formal letter been sent to the midwife inviting her to attend an interview?

Conducting the interview

14. Is there evidence of fact finding being carried out during the interview? This should include some reference to self, competence and context.

Writing the supervisory investigation report

15. Has the report being written on the required standard template?
16. Does the report read in a clear and logical manner?
17. Does the report contain the culmination of all the work that has been undertaken by the investigating SoM
    d) All necessary information about the incident?
    e) The investigation procedure that has been followed?
    f) The outcome of the investigation?
18. In the event of supervised practice being recommended, is there evidence of that the *NMC Standards for supervised practice for midwives (2007)* has been referred to?

North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS**: BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL

REPORT TITLE:
NHS North Central London Transition Update Report

REPORT OF:
Helen Pettersen
Director of Transition and Corporate Affairs
NHS North Central London

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE:** 16 January 2012

SUMMARY OF REPORT:

This paper gives members an overview of the progress made in NHS North Central London Transition Programme in the transition to the new structures that will replace the roles and responsibilities of PCTs within the cluster. It provides specific information about the development of Clinical Commissioning Groups.

CONTACT OFFICER:
Amy Bray
Transition Programme Manager
NHS North Central London

RECOMMENDATIONS:

The Joint Health Overview and Scrutiny Committee is asked to

1 Note the contents of this report and consider the implications of what this might mean for the overview and scrutiny function in the future,

2 Note the process for the approval of delegation of responsibility to CCGs and the update on the current status of the delegation of responsibilities to CCGs within NHS North Central London.
.

Helen Pettersen
DATE: 5 January 2012

Key definitions for this paper

- Clinical Commissioning Groups – Formally known as GP Consortia, and based on the membership of constituent practices, but involving a broad range of clinical professionals, these organisations are designed to unleash the potential for clinical leadership.

What is this document about?

- NHS North Central London Transition activity
- Delegation of responsibility to Clinical Commissioning Groups

Why do we need change?

The Health and Social Care Bill proposes major changes within the NHS that will focus on improving quality of care, more choice and improved outcomes for patients, as well as long-term financial savings for the NHS, which will be available for reinvestment to improve care.

Amy Bray
Transition Programme Manager
NHS North Central London

North Central London

NHS North Central London Transition Update Report
Report to the Joint Overview and Scrutiny Committee

16 January 2012

1. Executive Summary

Members of the Joint Health Overview and Scrutiny Committee expressed an interest in the new structures being developed to replace the functions currently undertaken by PCTs within the cluster. This paper provides an introduction to this and gives members the opportunity to reflect on how this impacts on their role in scrutiny.

This paper gives members an overview of the national milestones in transition and the progress made so far within the NHS North Central London transition programme. It then provides specific information about the development of Clinical Commissioning Groups. There is a description of progress made to securing delegated responsibility and plans for securing authorisation in 2012. A further paper on other elements of the transition will be provided at the February meeting of the committee.

2. Transition programme

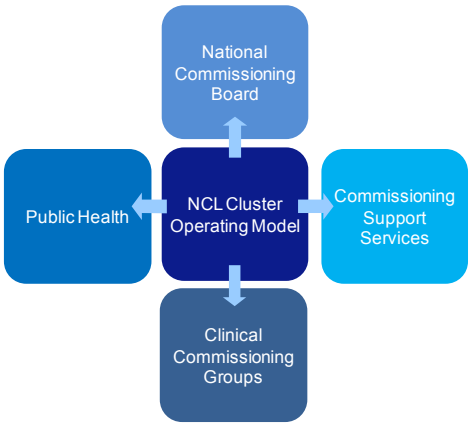
The Health and Social Care Bill proposes significant changes within the NHS that will focus on improving quality of care, more choice and improved outcomes for patients, as well as long-term financial savings for the NHS, which will be available for reinvestment to improve care.

The aims of the transition programme can be broadly described as:

1. Developing clinical commissioning groups
2. Deliver a commissioning support services, one of three in London
3. Supporting the establishment of Health and Wellbeing Boards
4. Public Health transition, locally and to Public Health England, and
5. Continuing to deliver the first year of the Commissioning Strategy and QIPP Plan

Figure 1 describes these “destinations”.

Figure 1



Known Milestones

Our current expectation of key transition milestones is as follows, subject of course to the Health & Social Care Bill receiving Royal Assent, which is presently expected to happen in May 2012:

April 2012

- Clinical Commissioning Groups have agreed their size, structure and geography
- All appropriate commissioning budgets delegated to Clinical Commissioning Groups
- Clinical Commissioning Groups have established an authorisation development plan
- Commissioning Support Services set up in shadow form
- NHS Commissioning Board functions and design agreed
- Public Health England established in shadow form

October 2012

- Clinical Commissioning Groups have identified accountable officers and senior management teams in place
- Clinical Commissioning Groups responsible for leading the 2013/14 contracting round
- Clinical Support Services have finalised their Full Business Plans
- Clinical Support Services and Clinical Commissioning Groups have service level agreements for provision of commissioning support
- NHS Commissioning Board fully operational and able to authorise Clinical Commissioning Groups
- NHS Commissioning Board operating model operational and accountable for 2013/14 contracting of its directly commissioned services
- NHS Commissioning Board has made final decision on which Clinical Support Services to host

April 2013

- Clinical Commissioning Groups become statutory entities
- All Clinical Commissioning Groups achieve full authorisation
- Clinical Commissioning Groups to be assisted by commissioning support services
- Clinical Support Services migrate to hosting arrangements with the NHS Commissioning Board
- NHS Commissioning Board becomes a statutory entity and holds Clinical Commissioning Groups to account
- Public Health England becomes a full statutory body

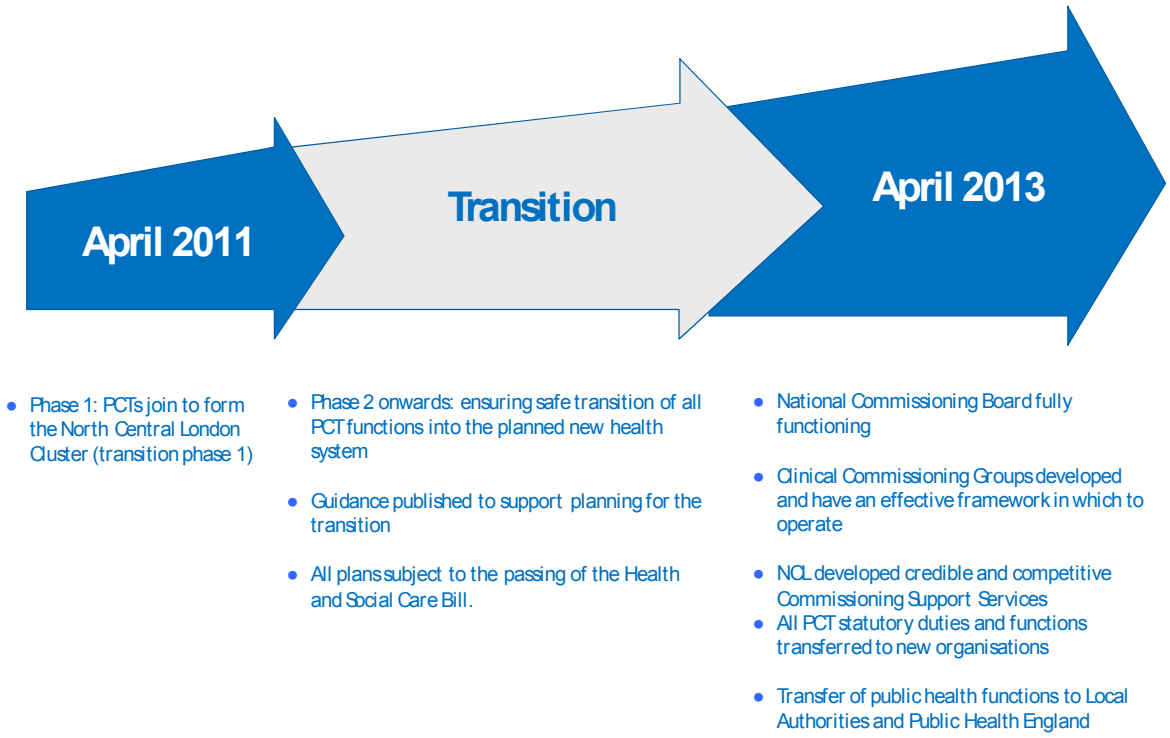
3. Overall Transition – progress update

To meet the vision set out in the Bill, and address local population needs, the north central London health landscape is changing between now and 2013 when the new nationwide system is expected to be established. As we plan for 2013, NHS North

Central London needs to develop commissioning and commissioning support services and ensure safe transition of all PCT functions into the planned new health system.

Following further progress of the Health and Social Care Bill through Parliament and publication of a number of supporting guidance documents from DH and NHS London during the Summer/Autumn 2011, North Central London undertook a preparation phase of the Transition Programme. We have now entered the delivery phase in 2012. The middle section of figure 2.

Figure 2



Local programme planning

- A small internal planning group was established, developing the outline plans and milestones for the year ahead.

Engagement & communications

- Workshops with staff to define and capture key issues for the programme and work stream plans.
- Regular updates and information to all staff and partner organisations

Nationally

- There has been ongoing development of national milestones and activities to inform internal and external stakeholders (see above). The associated guidance have increasing amounts of detail and more is expected in the coming months.

Learning from previous reorganisations

- We have been keen to learn lessons from phase one of transition (see diagram above) so that staff and our partners always as fully informed as possible in order to avoid any disruption to services.

Working with other clusters

- A dedicated CSO programme established in October with two other clusters. Outer North East London and East London and the City. The first task was to produce a prospectus and target operating model which was published on January 5th and can be found on the NHS North Central London website at http://www.ncl.nhs.uk/future-planning/developing-commissioning-support.aspx .

In the forthcoming delivery phase the programme will focus on ensuring delivery of the four 'enabling' work streams (People Transition, Governance & Finance, Stakeholder Engagement & Communications; and Infrastructure) and two 'specialist' work streams, delegation of responsibility to clinical commissioning groups (see next section) and clinical contract transfer.

Detailed updates on progress towards public health, national commissioning and clinical support will be provided at a subsequent meeting whilst the following section describes the current position regarding clinical commissioning.

4. Delegation of Responsibility to Clinical Commissioning Groups

NHS North Central London has a key role in assuring Clinical Commissioning Groups (CCGs) secure delegation of responsibility in 2012 and achieve authorisation in 2013. Guidance issued by the Department of Health during 2011 is designed to support Clinical Commissioning Groups, Clusters and other healthcare organisations in the journey. The following guidance relates directly to this area of activity and should be referred to for more detailed national information:

- Developing Clinical Commissioning Groups: Towards Authorisation (September 2011)

- Towards Establishment: Creating Responsive and Accountable Clinical Commissioning Groups (December 2011)

More information can be found at http://healthandcare.dh.gov.uk/towards-authorisation-faqs/

Within the NHS North Central London transition programme, the CCG Delegation of Responsibility work stream has focused on supporting CCGs in their journey to secure delegation of responsibility by April 2012, and on organisational development activity.

Before CCGs are fully authorised they will be established as committees of the relevant PCT. In North Central London there are currently five, coterminous with each of our boroughs. That is Barnet, Camden, Enfield, Haringey and Islington.

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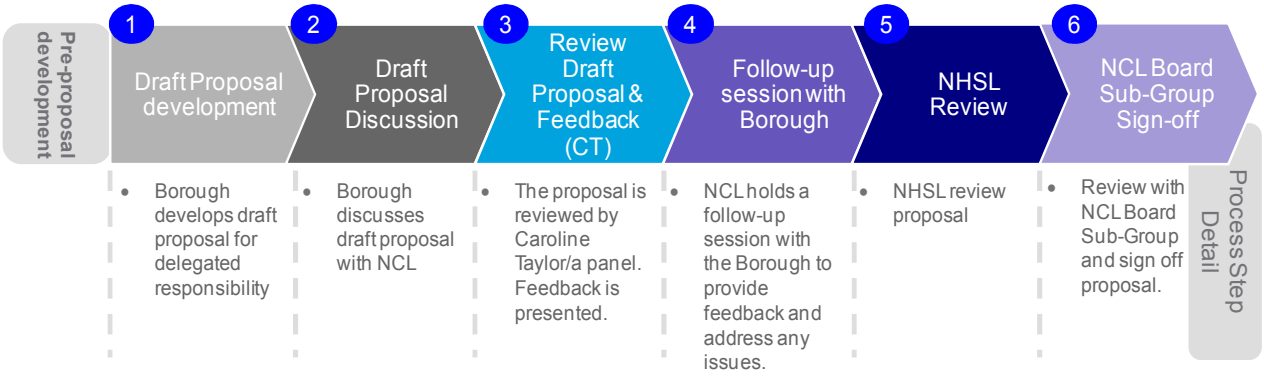
Significant progress has been made both in setting out the governance and processes for the assumption of delegated responsibilities by CCGs in NHS North Central London, and in individual CCGs working through their local approaches to delegation. Partial delegation is already in place for Islington CCG, with significant extension of scope and coverage expected across all CCGs in the first few months of 2012.

The assurance process

A 6-step process for the approval of delegation has been set out, illustrated in figure 3:

Figure 3

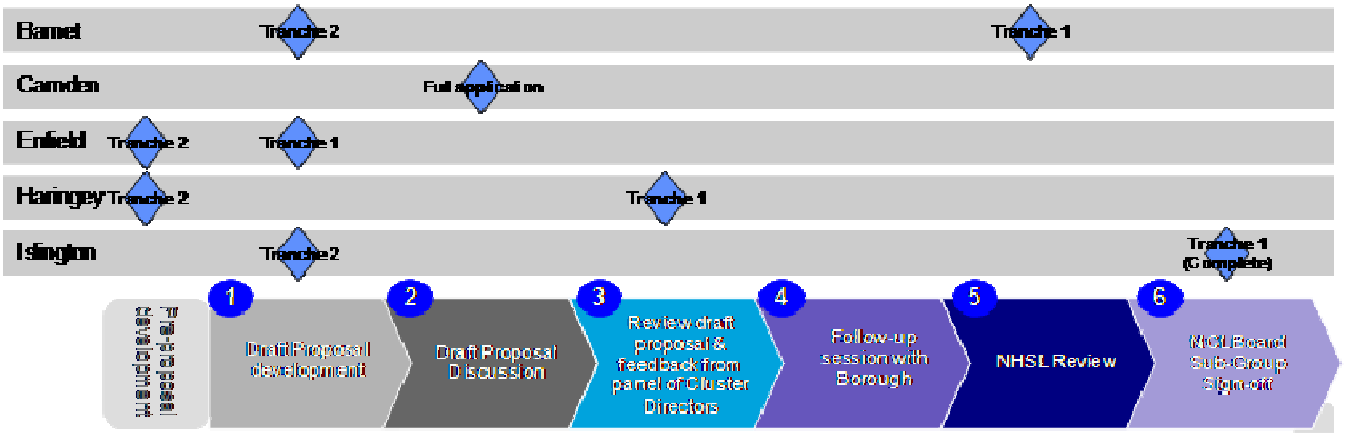


5 Current position of each CCG

For the CCGS in North Central London the next diagram (figure 4) describes how far along the journey each is.

Delegated responsibility comes in two tranches, the first is for partial responsibility and the second is for full delegation. Camden CCG has chosen to go for full delegated responsibility from the outset.

Figure 4



- **Barnet CCG** is proposing to take delegated responsibility for primary care prescribing services in the first instance, and then other eligible services in a single second tranche thereafter. The initial application is now under review by NHS London are approval is expected in due course. Drafting of the second tranche application is underway and scheduled for NHS North Central London Director Panel review in February.

- **Camden CCG** proposed to take delegated responsibility for all eligible services in one tranche. Iterative discussions have taken place between the CCG and NHS North Central London teams, and a draft application is now under review. The NHS North Central London Director Panel review is scheduled for late January and sign off from NHS London is anticipated in early March.

- **Enfield CCG** is proposing to adopt the Prescribing budget in the first tranche of delegation. The application for tranche one is currently underway, and review is likely in mid-January. NCL review is expected in early February. Delegation of remaining eligible services will follow in due course.

- **Haringey CCG** is proposing to take on delegation for Prescribing, Planned Care and Accident and Emergency minors in the first tranche application, with all remaining eligible services in a single second tranche. The tranche one application will be ready for review in early February. It is expected the drafting of tranche two will be undertaken in parallel, commencing in late January.

- **Islington CCG** is proposing to take delegated responsibility for primary care prescribing and adult community services budgets in the first instance. Their application was submitted to NHS London and for review and confirmed as successful in early December 2011. The CCG is proposing to take responsibility for the remainder of eligible services, acute and joint commissioning budgets, in a single second tranche, on track to be reviewed by a panel of NHS North Central London Directors in early February and approved by NHS London later the same month.

6 Implications of delegation in the future

Following authorisation in April 2013, Councillors can expect CCGs to have adopted a genuine partnership with their local authorities the commissioning of services. The Health and Wellbeing Board will be a statutory function of the Local Authority. It will play a strategic co-ordinating role, joining up commissioning across the NHS, adult social care, children's services, public health, the third sector and other services that directly relate to health and wellbeing, in order to improve outcomes for the local population.

During the period of delegated responsibility, starting in April 2012 (in shadow-running form) for the majority of NHS North Central London's CCGs, there will be a focus on creating robust relationships between local authorities, the CCG, local health and social care professionals, the voluntary sector and residents. The aim will

be to achieve the integration that will be necessary for a cohesive system and integrate service delivery vertically within health and horizontally across health and social care.

7 Recommendations

The Joint Health Overview and Scrutiny Committee is asked to

1 Note the contents of this report and consider the implications of what this might mean for the overview and scrutiny function in the future,

2 Note the process for the approval of delegation of responsibility to CCGs and the update on the current status of the delegation of responsibilities to CCGs within NHS North Central London.

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NHS NORTH CENTRAL LONDON	**BOROUGHS:** CAMDEN, ISLINGTON BARNET, ENFIELD, HARINGEY, **WARDS:** ALL
REPORT TITLE: Tuberculosis: developing services for the future for North Central London	
REPORT OF: Lynn Atlass North Central London TB Network Manager London Health Programmes TB Projects Lead	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 08/01/12**

SUMMARY:

The reports detail the current tuberculosis (TB) service provision, and an update on the review and development of services for TB across North Central London cluster

CONTACT OFFICER:
Terence Joe
TB Project Manager
NHS North Central London

RECOMMENDATIONS:

- To note the process of service development adopted to date
- To comment on the proposed North Central London TB model of care

NHS North Central London

DATE: 08/01/12

North Central London Joint Health Overview and Scrutiny Committee

16 January 2012

North Central London and Tuberculosis – current picture

Please note:

- 2011 data downloaded from the London TB Register, HPA London 3 January 2012. Data is provisional.
- 2011* - all information is based on provisional 2011 data unless otherwise stated.
- TB numbers and rates are based on calendar years rather than financial years.
- Rates are expressed as rate per 100,000 population.

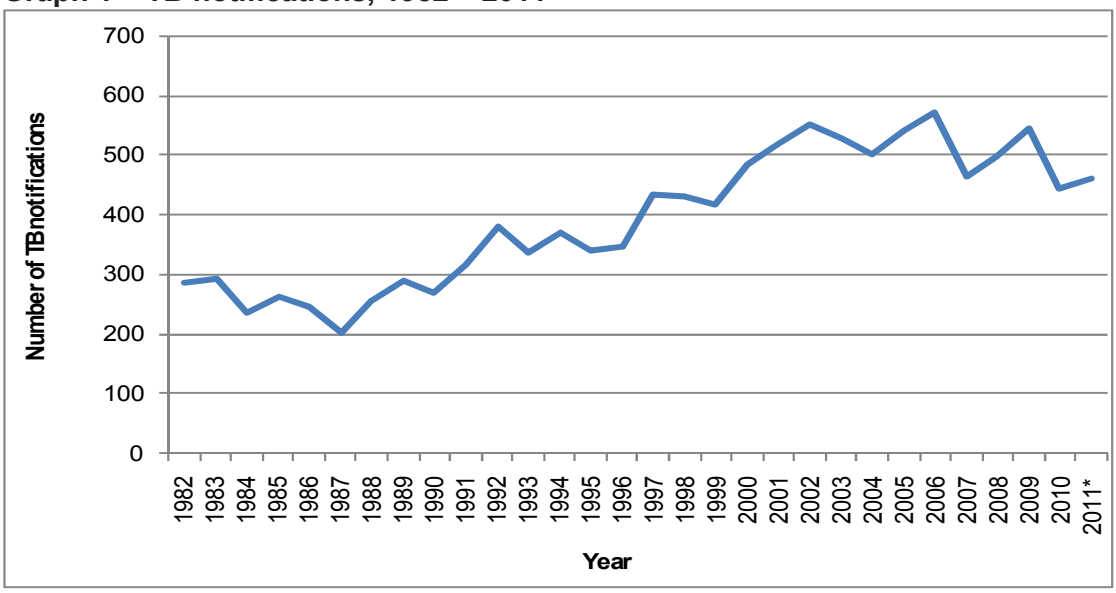
Tuberculosis (TB) is an infectious disease caused by the *Mycobacterium tuberculosis* transmitted through coughing and sneezing. TB is treatable and curable with treatment free of charge to all TB patients.

Key messages:

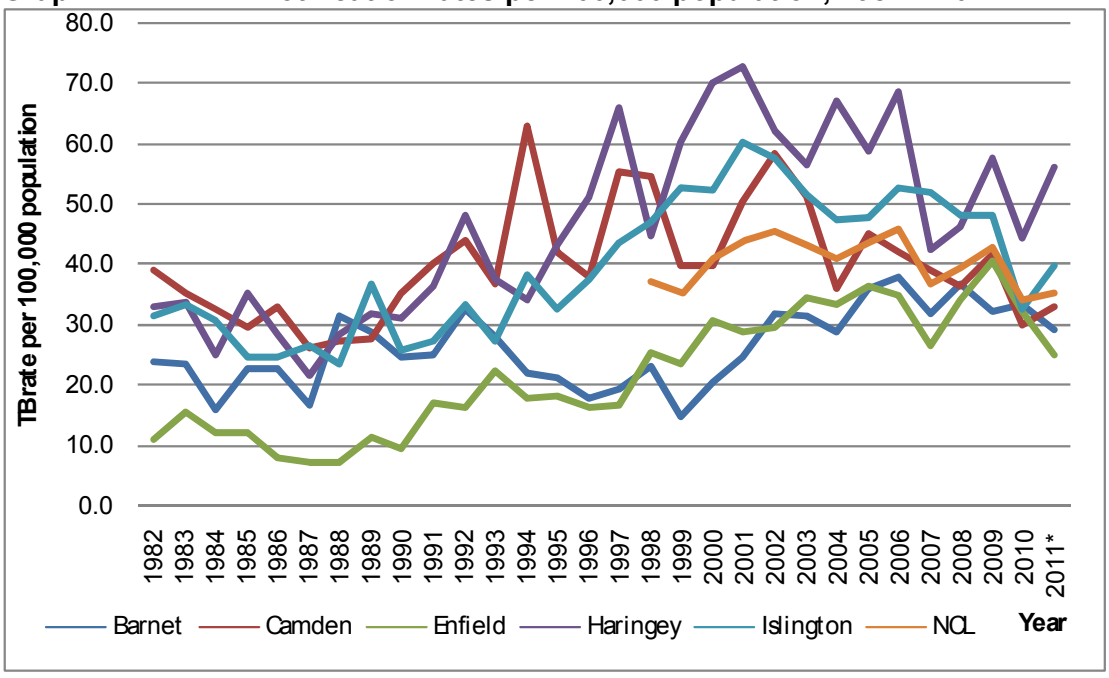
- Overall TB notification numbers and rates have been going down in North Central London (NCL) since about 2002 with 464 TB cases in 2011* (graphs 1 and 2), a reduction of approximately 20% from the 2003/2006 peaks whereas 3 of the other London clusters have been steadily increasing (graph 5)
- The overall incidence in NCL was 35.6/100,000 down from 45.6/100,000 in 2006
- Haringey had the highest rate in 2011 at 56.3/100,000 but a substantial decrease on 5 years ago and Barnet had the lowest rate at 29.1/100,000
- This number of TB notifications generates about 20,000 outpatient attendances – TB treatment is for a minimum of 6 months usually requiring monthly appointments
- 20.2% TB patients have one or more social risk factors – the highest in London (London average 12.3%)
- Highest percentage of patients on treatment for longer than six months due to drug resistance and social risk factors
- 41% of London's TB cases with a history of imprisonment were resident in NCL
- 56% TB patients in NCL have pulmonary TB (infectious TB) – the highest across London (London average 46%, range 68% - 29%)
- 78% TB patients were born abroad (London average 86%)
- Year of entry to the UK was recorded in 87.7% cases notified in 2011, of which only 4.9% had arrived in the UK during this same year
- 14% developed TB within 2 years of entry to the UK with 44% developing TB more than 10 years after entering the UK (graph 14)
- 60 countries of birth were recorded for NCL TB patients in 2011
- The largest numbers of cases were reported in patients born in the UK, Somalia and India in 2011
- 2011 saw increases in TB notifications in people from Pakistan, Romania, Philippines, Congo, Eritrea, Uganda, Nepal, Poland, Jamaica, Mauritius and Bulgaria with decreases in people from Somalia, Turkey, Afghanistan and Zimbabwe
- Paediatric patients (0 – 15 years) were 3.5% of the total which is a substantial decrease on previous years

- 75% of paediatric TB patients were Black African of which the majority had been born in the UK
- Drug susceptibility testing was carried out in 47% total TB cases and resistance to any first line drugs was recorded in 14.7% of those cases. Multi-drug resistant TB (MDRTB - resistant to at least Rifampicin and Isoniazid) was recorded in 2.3% of these cases and Isoniazid resistant TB was recorded in 12.4%. MDRTB is 1.1% of total TB cases and Isoniazid resistant TB is 5.8%.
- **NCL TB services are different – single team for sector from 2007**

Graph 1 – TB notifications, 1982 – 2011*



Graph 2 – NCL TB notification rates per 100,000 population, 1982 – 2011*

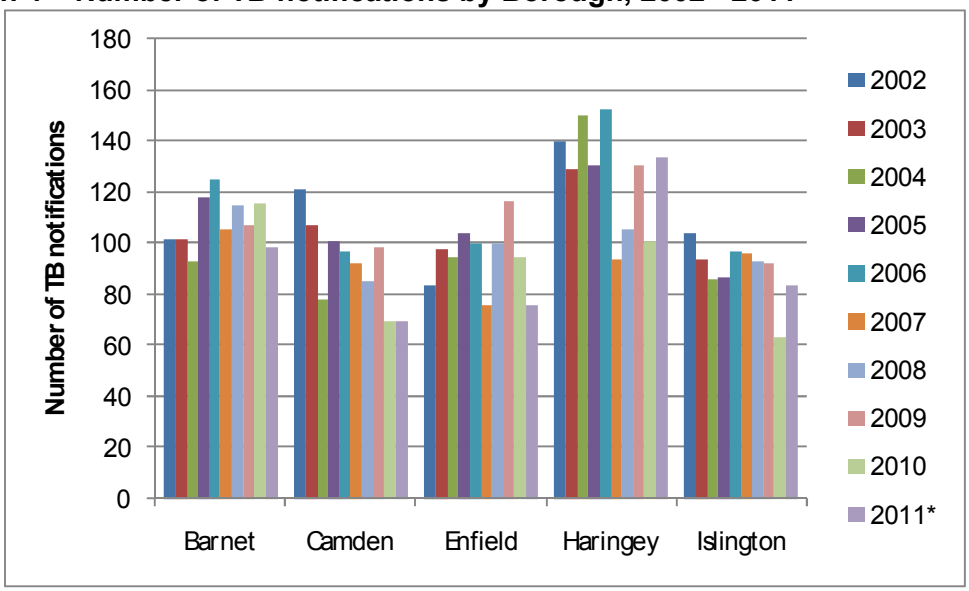


4 of 5 of NCL Boroughs TB rates are now regularly below 40 per 100,000 population. This is the level described by the World Health Organisation as high incidence requiring focussed action to decrease TB.

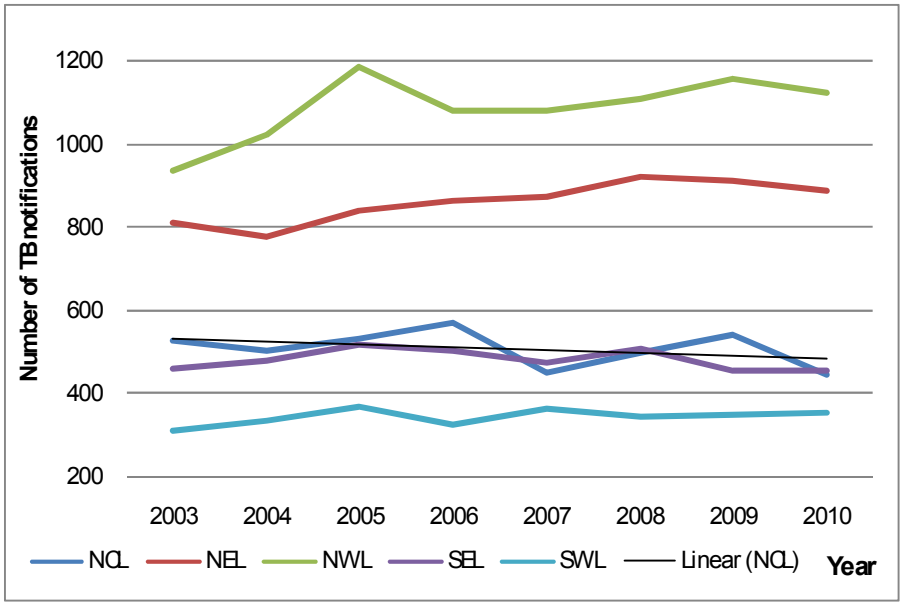
Table 1 – NCL number of TB notifications, 2002 to 2011*

Borough	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011*
Barnet	102	102	93	118	125	106	115	107	116	99
Camden	121	107	78	101	97	92	85	99	70	70
Enfield	84	98	95	104	100	76	100	117	95	76
Haringey	140	129	150	131	153	94	106	131	101	134
Islington	104	94	86	87	97	96	93	92	63	84
NCL	551	530	502	541	572	464	499	546	445	463

Graph 4 – Number of TB notifications by Borough, 2002 - 2011



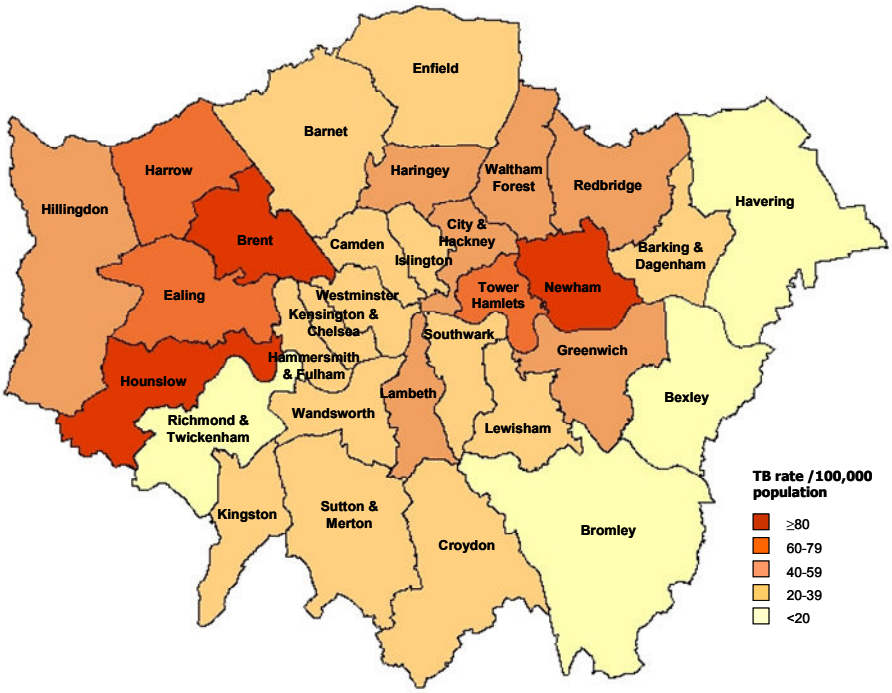
Graph 5 - How does NCL compare to other parts of London?
TB notification numbers 2003 - 2010



The decreasing trend in TB numbers and rates in NCL is markedly different to the other TB sectors in London which generally show increasing trends.

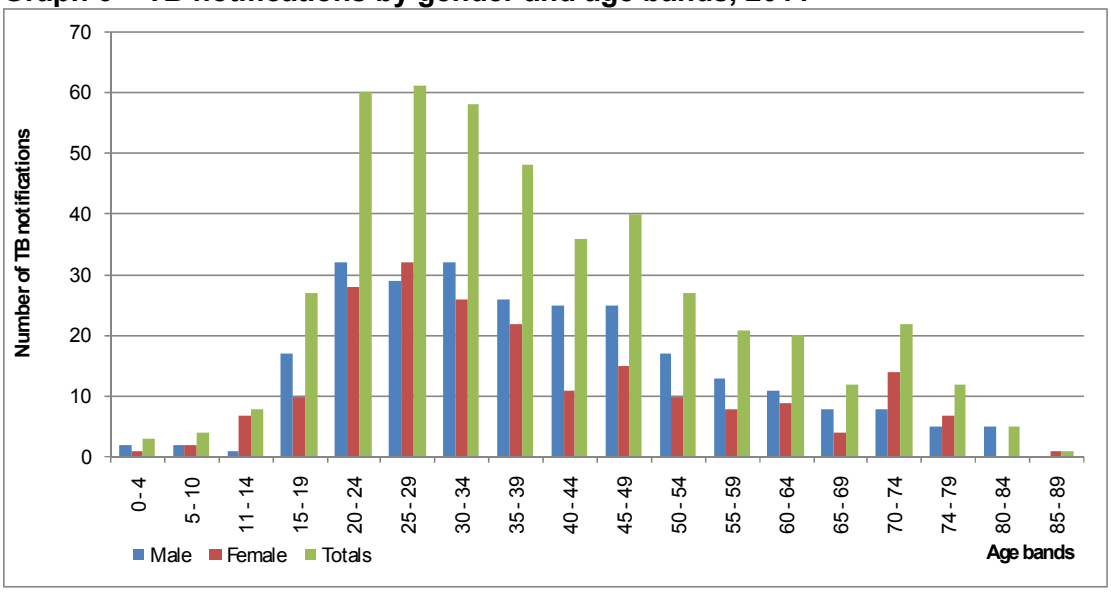
NCL TB services are managed differently to other London TB services. There is a single non inpatient TB team for NCL which includes nurses, social care support workers and admin staff working with the TB doctors and other services at each of the sites to provide a TB service.

Map 1 - TB rates by borough of residence, 2010



Demographics of TB in NCL

Graph 6 – TB notifications by gender and age bands, 2011

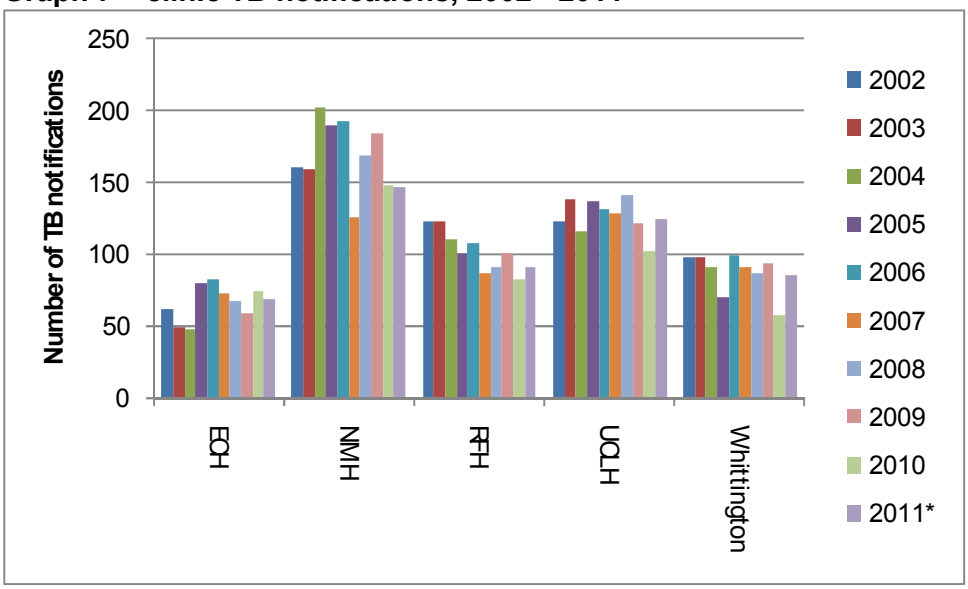


Nearly 50% TB notifications are aged between 20 – 39 years. Children 15 years and under were only 3.5% of the total. This is important as TB in young children is seen as a marker of recent transmission.

Of the total TB notifications 55% were male. This increases to 64% in the 40 – 59 year age group.

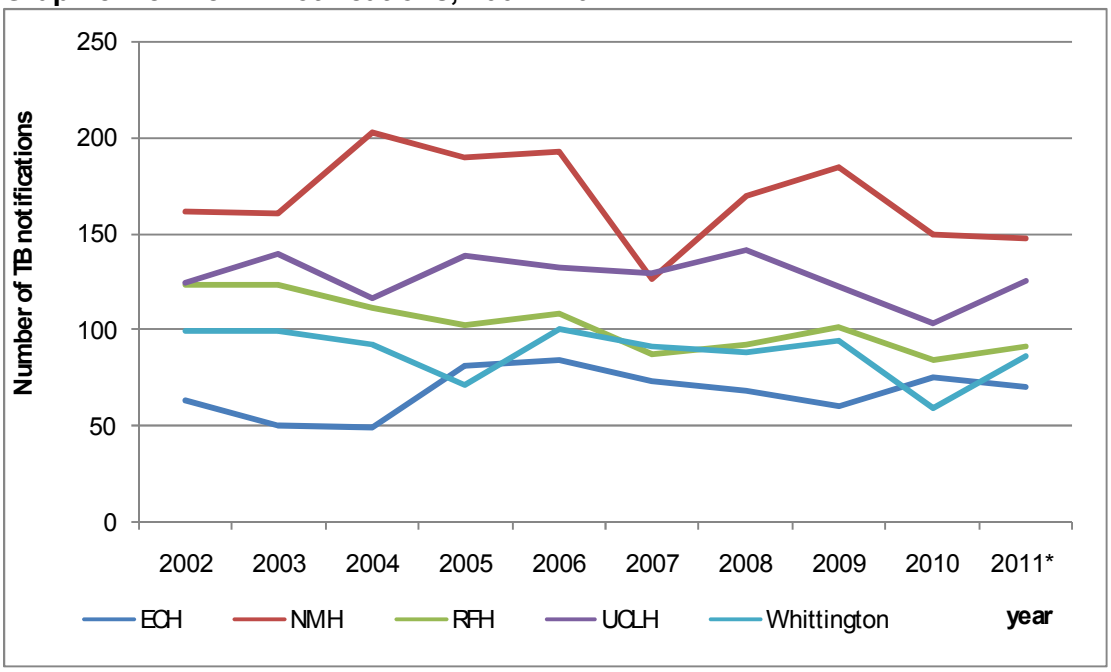
TB clinic activity

Graph 7 – clinic TB notifications, 2002 - 2011

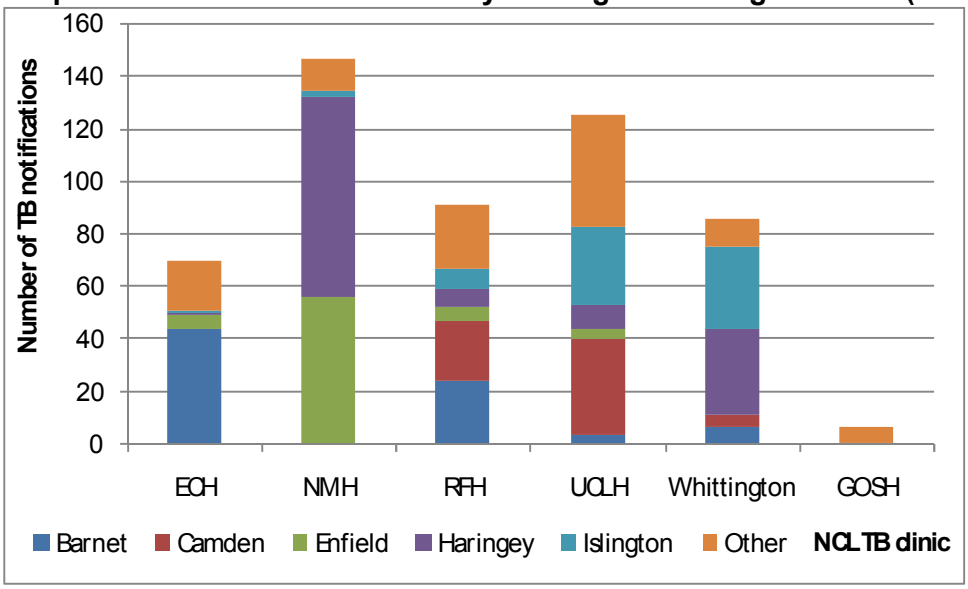


Most marked decreases in TB notifications is at the Royal Free Hospital and the Whittington Hospital.

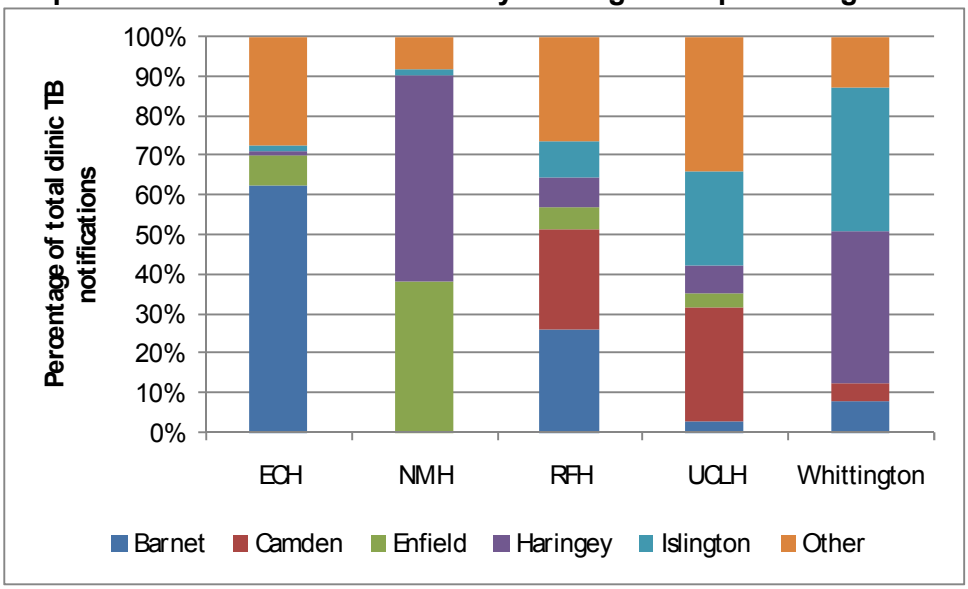
Graph 8 – clinic TB notifications, 2002 - 2011



Graph 9 – Clinic TB notifications by Borough including non NCL (other)



Graph 10 – Clinic TB notifications by Borough as a percentage of clinic totals

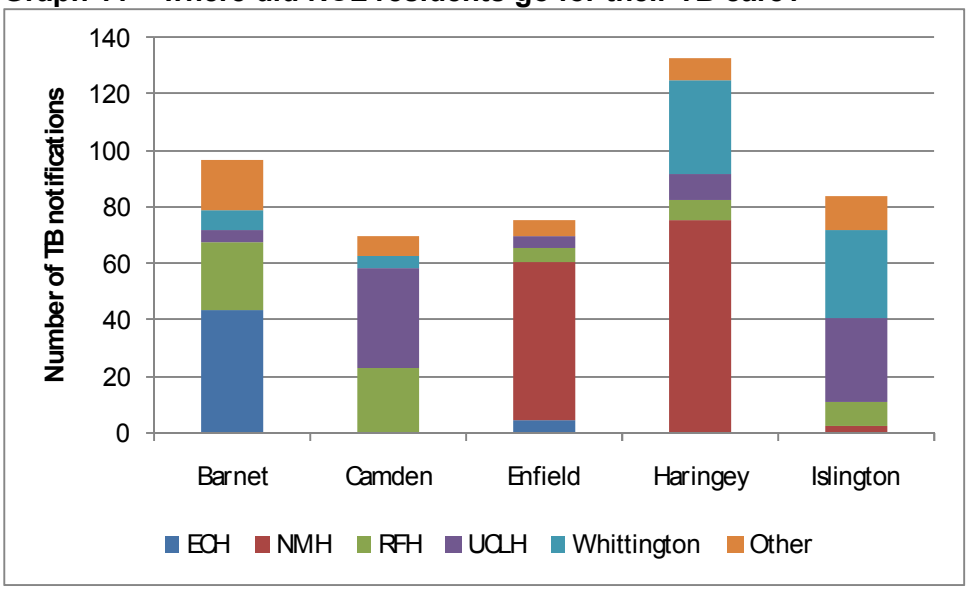


21.7% of TB clinic notifications are non NCL residents but only 11% NCL residents with TB go to non NCL TB clinics.

The majority of this activity comes from:

- Edgware Community Hospital (ECH) – Brent, Harrow and Hertfordshire
- North Middlesex University Hospital (NMH) – Waltham Forest and City & Hackney
- Royal Free Hospital (RFH) – Brent and Hertfordshire
- University College London Hospital (UCLH) – Brent, Southwark, Westminster
- Whittington – City & Hackney

Graph 11 – where did NCL residents go for their TB care?



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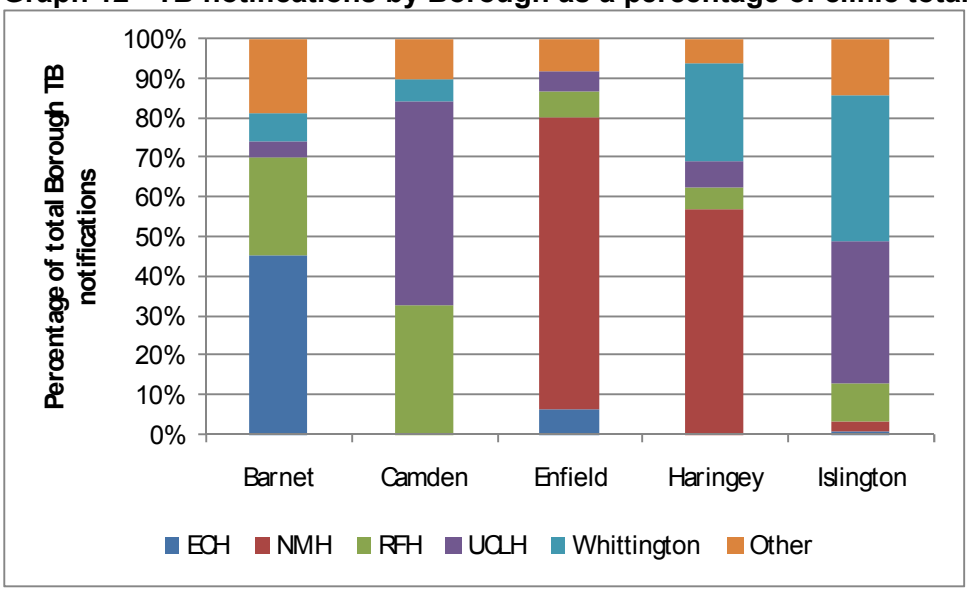
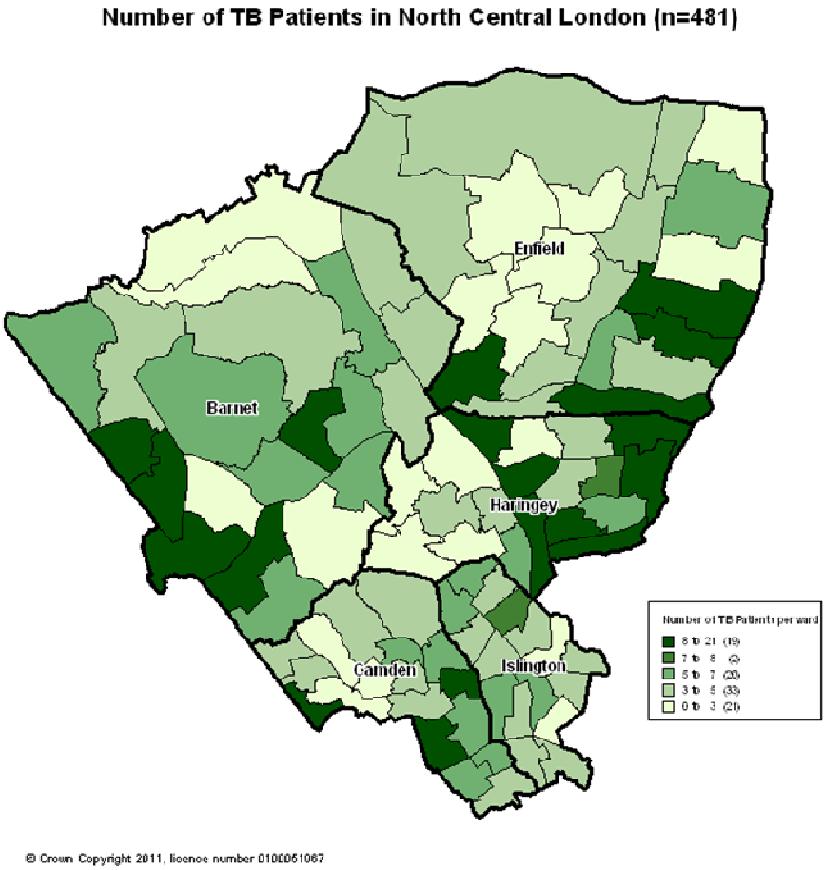
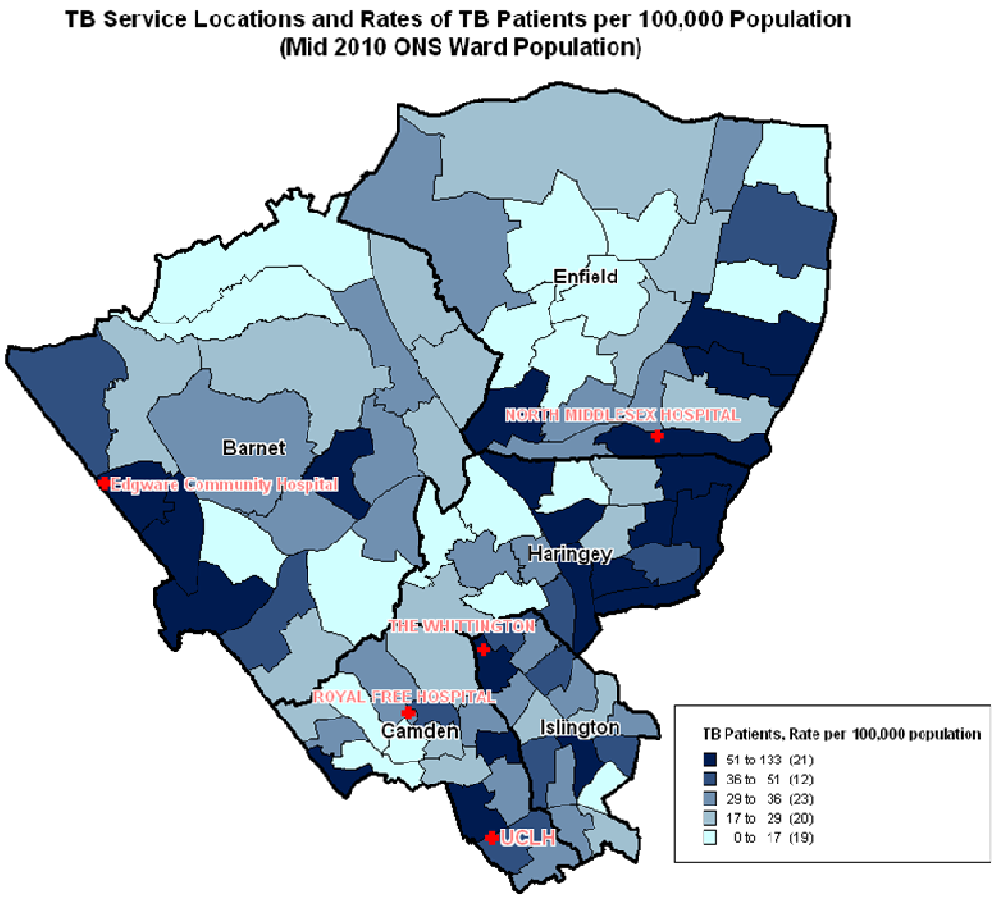
Graph 12 - TB notifications by Borough as a percentage of clinic totals



Maps 2 and 3 – where do people with TB live, 2010?

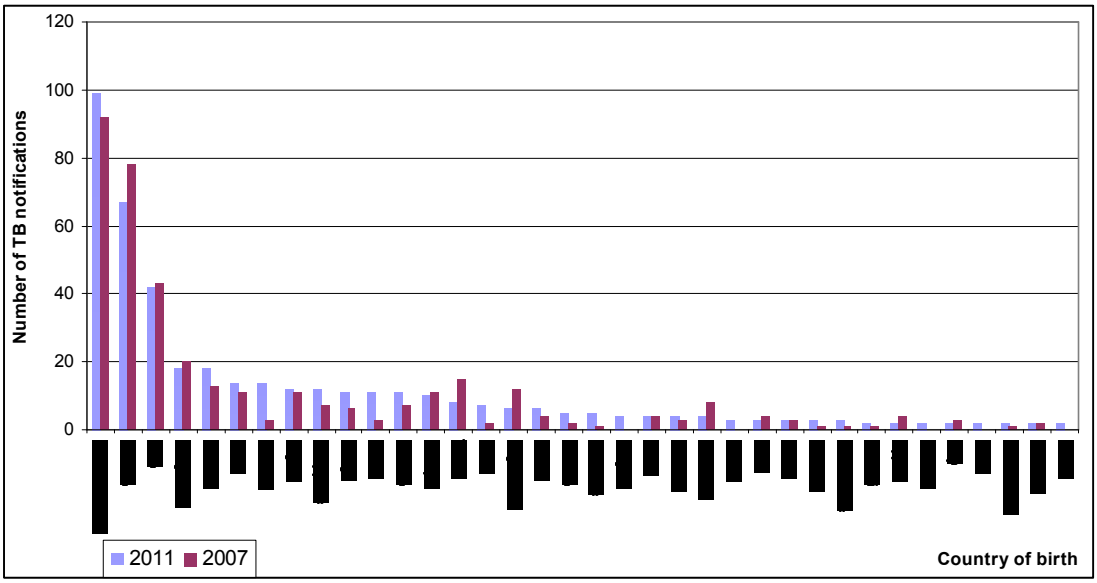




Maps 2 and 3
These maps highlight where focussed work with local communities and primary care is required. Part of this work includes developing primary care based active case finding using a blood test which can identify people with latent TB before they develop active TB disease. If they are aged 35 years or under a short course of anti-TB treatment can be offered to treat the latent TB.

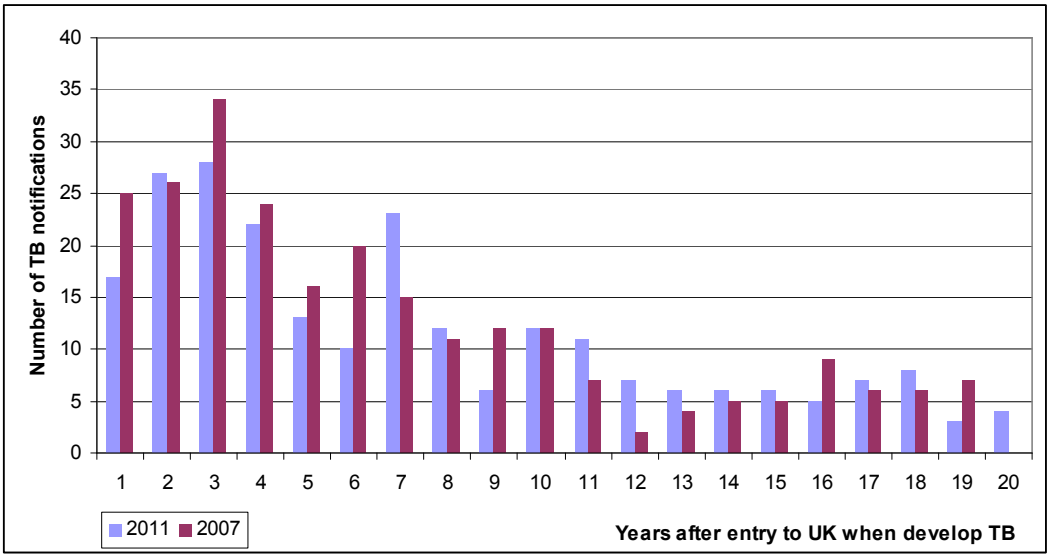
TB Alert is being supported by the Department of Health to work with local services and local community organisations and third sector organisations to raise awareness of TB and encourage those organisations to be proactive within their communities in recognising TB and destigmatising it.

Graph 13 – Country of birth



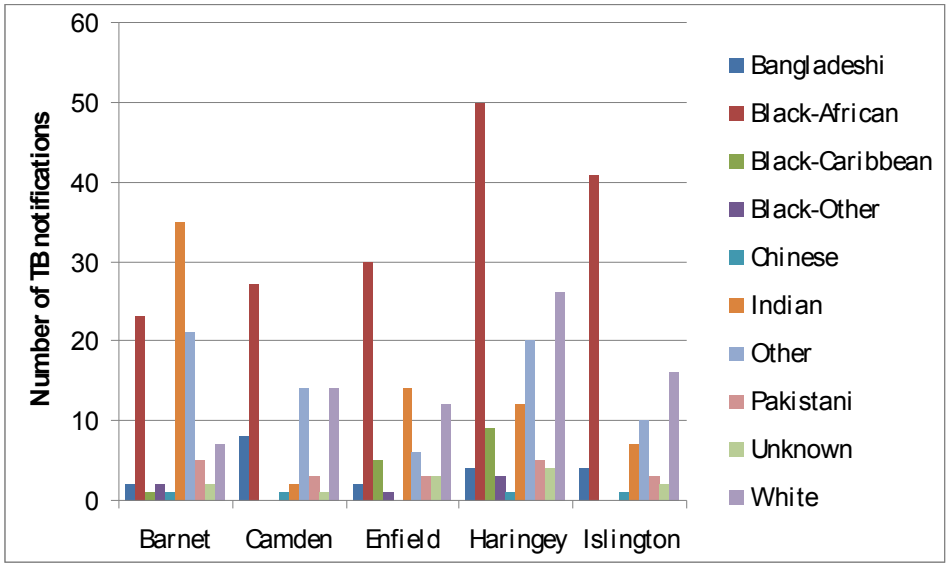
Graph 13 shows countries of birth with 2 or more TB notifications and compares 2011 with 2007 to highlight changes i.e. TB notifications from the Black African community have decreased except for Uganda and the Congo. There have been increases in TB notifications from people born in Eastern Europe, Nepal, Jamaica and Mauritius.

Graph 14 – how long has someone been in the UK before they develop TB?

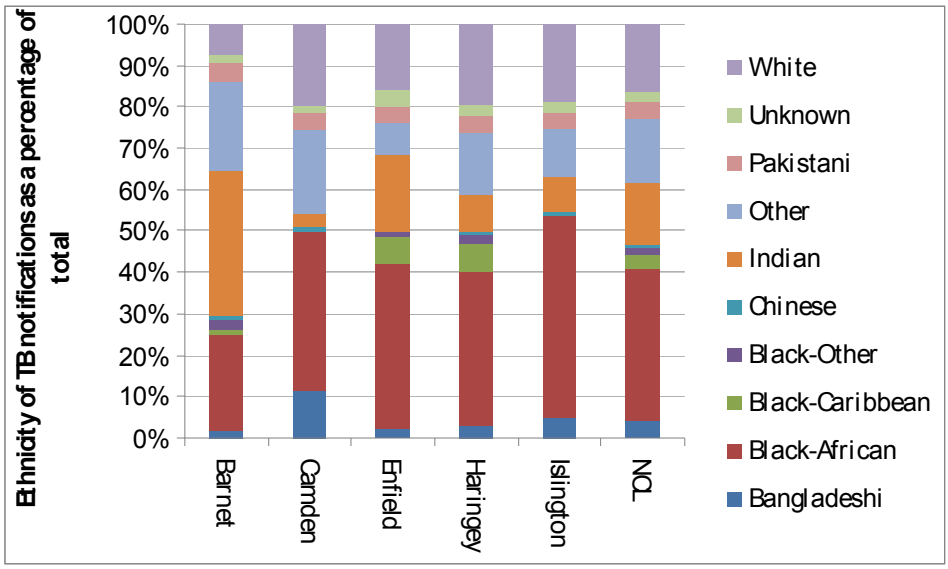


This graph compares 2007 with 2011. The percentage of people developing TB within 1 year of entry to the UK has decreased.

Graph 15 – Ethnicity of TB patients by Borough



Graph 16 – Ethnicity of TB patients as percentage of Borough total



Graphs 15 and 16 show the ethnicity of TB across NCL and the differences between Boroughs. Islington has the largest percentage of Black African residents with TB whereas Barnet has the largest percentage of Indian residents with TB.

What are we doing in NCL to improve TB service provision?

Directly Observed Therapy (DOT)
NCL currently uses clinic and community DOT for 16% TB patients. This is the highest rate in London. However, to meet the needs of the NCL TB patients, the team is looking at its workforce to increase that percentage through different ways of working. DOT is used for TB patients who have been assessed as likely to default on their treatment and require additional support.

Cohort Review
Cohort review is the quarterly review of TB patients. It is a multi-disciplinary forum which evaluates and reviews the management of each TB case including accountability. The aims of cohort review are to:

- Ensure implementation of appropriate case management for all TB patients
- Improve promptness of interventions
- Maintain reliability of data
- Analysis of treatment outcomes
- Compare local efforts against London and national TB control targets
- Follow up on case management issues
- Ongoing training and education
- Forum for open discussion

The cohort review process enables staff to review how they cared for patients and what improvements they can make to service provision. The first cohort review was held in June 2010, and have been held quarterly since then. This is an innovation by NCL with observers coming from other London teams and outside of London prior to setting up cohort review in their areas. North West London and North East London commenced cohort review in 2011 with South East London and South West London commencing in 2012.

NCL TB social care team
The NCL social care team arm of the TB service is now fully staffed supporting TB staff and TB patients in ensuring appropriate care is given. This team is part of the NCL multi-disciplinary TB team providing care to vulnerable people with complex health and social care needs, such as homelessness, drug and alcohol dependence, mental health or people who are refugees or asylum seekers
For the homeless this support can include ensuring access to stable housing during treatment leading to longer term sustained housing and re-engagement with other services. For hostel dwellers the social care support team ensures TB patients are accessing the full range of available services.
In addition the NCL TB Network Manager has supported the team in moving TB patients with 'no recourse to public funds' out of hospital into hostel or bed and Breakfast accommodation for the duration of their TB treatment and care. This model has been successfully used elsewhere across London and has been incorporated into the proposed London TB model of care as a risk sharing pan-London accommodation fund.

Commissioning of TB services
NCL
TB services are commissioned and performance managed by NHS North Central London (NHS NCL). Currently commissioners are working with TB services to develop a NCL collaborative model of care that includes reconfiguring the TB services currently at RFH, UCLH and Whittington to one site - site to be agreed - so that patients can be offered a flexible and improved service. The TB services at NMH and ECH would remain as currently located and NCL model of care improvements would be implemented at those sites. The services have to change and work differently to provide a patient focussed service to ensure continued decrease in TB numbers and to be more cost effective.

NCL TB services and commissioners are innovators for a number of proposals that have been incorporated into the London TB model of care.

London:

A London TB model of care has been developed and the proposal includes:

- Improving detection and diagnosis
    - Latent and active TB case finding through GP new registrations health checks questionnaire (new registrations who come from countries with TB rates of ≥150/100,000)
    - Raise awareness in health and social care workers
- Improving commissioning
    - Pan London commissioning - collaborative commissioning across CCGs / commissioning support organisations - to improve commissioning and remove service provision variability (NCL has commissioned TB services on a sector wide basis since 2004)
    - Funding temporary accommodation for 'no recourse to public funds' TB patients. Currently a business case has to be drafted for each patient that is NRPF where it would be more cost effective for the NHS and patient if the TB patient was placed in appropriate B&B or hostel accommodation for the duration of TB treatment rather than kept in an acute bed - NCL has pioneered this approach.
- Addressing variability of service provision
    - Sector lead provider based delivery boards to ensure TB services are delivered to pan London standards
    - Delivery boards would be responsible for ensuring TB patients are risk assessed for likelihood of treatment completion, use of DOT and that cohort review is implemented (NCL was the first one in the UK to do cohort review and is the model for other parts of London and the UK)
    - Review workforce variability linking recommendations to local need.
- BCG
    - Commissioners to proactively performance manage current uptake of neonatal BCG Review uptake in boroughs with TB rates below 40/100,000.

Lynn Altass, NCL TB Network Manager and London TB Commissioning Lead
Jenny Gough, Deputy Director of Public Health, Camden

16 January 2012

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Tuberculosis: developing services for the future for North Central London

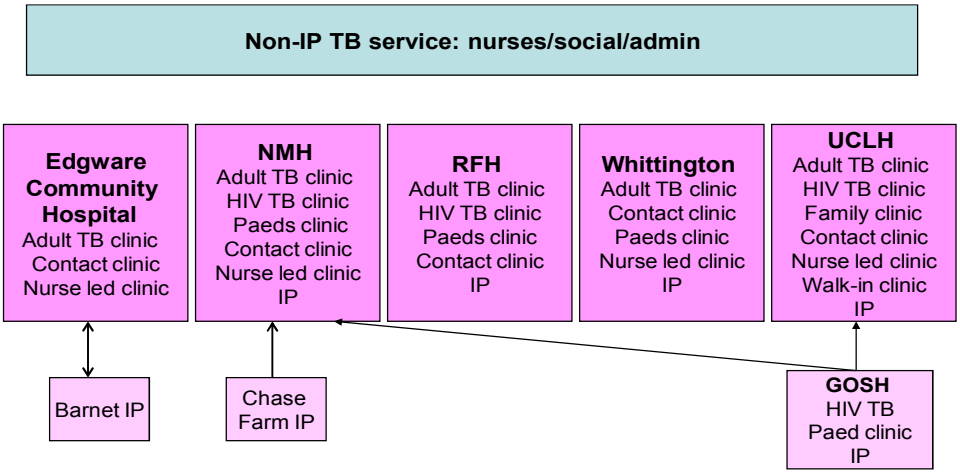
Introduction

This report is to update the Joint Health and Overview Scrutiny Committee (JHOSC) on the review and development of services for tuberculosis (TB) across North Central London cluster. The paper describes the approach to meeting the public health needs.

1 Background

North Central London non inpatient TB services are currently hosted at the Royal Free Hospital. The team provides TB nursing, social care and administrative staff working out of five acute hospital Trusts.

Current Model of TB Care in NCL



The current arrangements are fragmented and need to be arranged to better focus on current and future needs of TB patients.

2 Work to date

Engagement with TB services

A TB project steering group was set up:

- To develop a collaborative, dynamic, progressive and innovative service model providing high quality treatment and care for people with known or suspected TB

- To be accountable for the direction, outputs and outcomes of the North Central London TB services project
- To provide an overview on capacity, service planning, future problems working towards the optimal service model
- To reach a consensus on the best location for services in the south of the cluster
- To develop an implementation plan for the development of the future service, structure, standards and outputs of TB services.

Subsequently, a series of planning group meetings also contributed to the process by focusing on quality measures and developing the model of care. Extensive work has been carried out focusing on developing the model of care for North Central London. This collaborative approach has included lead TB consultants and their teams, hospital management, UCL Partners and the nursing, social care and administrative staff from all five sites. An Equalities Impact Assessment was carried out with the support of the NCL Equalities Lead (appendix 1).

Engagement with service users

Patient questionnaires were distributed in each of the clinics across the cluster and further patient engagement included interviews and patient focus groups. This work has shown that location, good transport links and being seen quickly are the most important issues for TB patients and TB patient contacts.

Crucially, patients felt incorporating the best practice from each of the services on phlebotomy and pharmacy was essential. Patients felt that any future service changes needed to demonstrate patient accessibility. Patients have also contributed to the development of the factors and weighting for the site appraisal process.

3 Model of care

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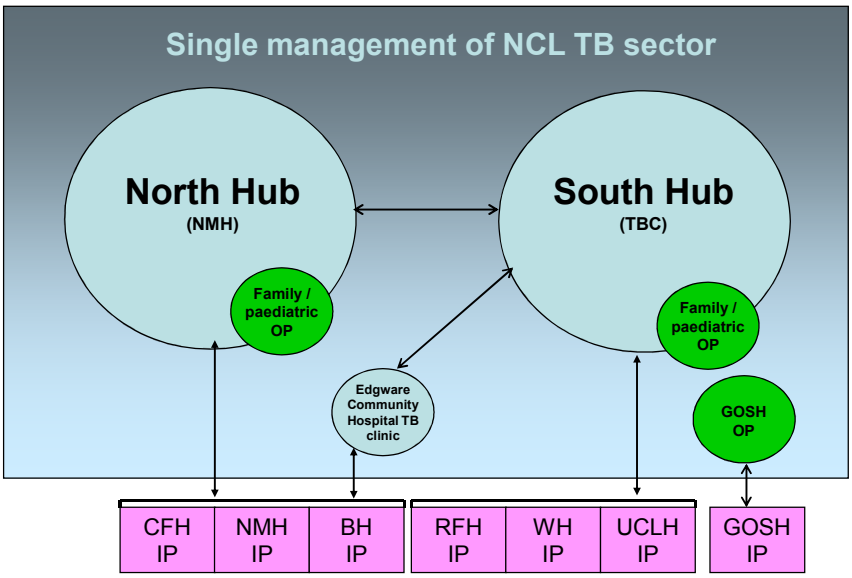
Proposed Model of TB Care in NCL



The proposed model sets out a service in which the nursing, administrative and social care team continue to be employed by one provider. It is proposed that the majority of TB treatment and care should take a community focused approach. The prospective service provider will need to have strong links with the community and will need to maintain strong links with the acute trusts to ensure seamless care between the acute and community services including meeting the needs of socially and medically complex patients.
The proposed model of care is based on two hubs where the nursing, administrative and social care team will be based with optional outreach spoke to acute and other sites.

The north hub will continue to be based at the North Middlesex Hospital and provide a comprehensive TB service providing more flexible working practices to meet patient need.

The south hub will provide consultant led clinics, nurse led clinics, rapid access, out of hours clinics, social care, outreach to the local prisons (HMPs Pentonville and Holloway) and full administrative support. It is proposed that the south hub will continue to support a weekly outpatient clinic at Edgware Community Hospital.

The proposed model includes a reactive team, which will manage contact tracing, screening when incidents and outbreaks occur and community Directly Observed Therapy (DOT) across the sector. This proposed service model will strengthen the provision of core services with the opportunity to expand, innovate and develop services further within a more cost effective, efficient and patient focused model.

4 Site Appraisal Criteria and Weighting

As part of the work stream on securing an appropriate location for the south hub factors, detailed in the table below, were weighted and agreed as the criteria to score for each of the proposed sites.

Location, mode of travel and travel times relate to patient accessibility and it was strongly felt that this was a key factor in the decision making process and amounting to 40% of the weighting. Clinic facilities and environment need to be fit for the development of an innovative and progressive service seeking to implement a series of initiatives to continue to reduce and ultimately eliminate TB. It was essential that the potential location could meet these service aspirations and be sustainable for the next 10 years. Access to support services is important for staff seeking to get rapid diagnosis and results for patients and is also essential to patients who often need further diagnostics or appointments. Close proximity to the recommended service location of X-ray facilities, pharmacy and transport is important. Information Technology and the ability to network and link to the systems across North Central London to ensure the service works efficiently and effectively.

The TB project group which included all the providers developed and agreed the criteria and weighting and were consulted on the content and style of the site descriptions. The scoring of the sites was undertaken by an independent panel providing expertise in finance, procurement, public health, nursing, health protection, medical and service development. The patient panel included patients from each of the proposed locations and an independent patient.

Factors	Weight of factor
Location • Where the centre is? • What floor? • Disabled Access? • Lighting?	**15**
Mode of Travel • Importance of bus access due to low income of most patients • How close to tube & train stations • Bicycle bays • Parking for cars	**10**
Travel Times This will be informed by Transport for London system and will grade the travelling times for patients to each of the services.	**15**
Clinic Facilities and Environment What can be provided from the centre? How many: • Clinical treatment rooms • Waiting area/s • Paediatrics facilities • Office areas for staff • Toilets for patients and staff Is there a: • Negative pressure room	**28**

Factors	Weight of factor
• Bloods (Phlebotomy) • Kitchen and staff facilities • Parking spaces • Infection control requirements • Health and safety issues including airflow • Security	
Access to Support Services Diagnostics, including: • X-ray facilities • Microbiology - testing for TB • Pharmacy • Transport • links to other key services in the hospital	**20**
IT • The extent of networking in place? • What further work required? • Link between different systems?	**12**

5 Next steps

The Joint Health Overview and Scrutiny Committee is asked:

- To note the process of service development adopted to date
- To comment on the proposed North Central London TB model of care

Appendix 1

EQIA screening

Proposed North Central London TB model of care

Author /editor/assessors	*At least one of the people carrying out an EQIA must be the person responsible for the policy/function/service*	Terence Joe
Partners/decision-makers/ implementers	*Identify who else will need to be involved. This can be decision-makers, frontline staff implementing the policy, partner/parent organisations, etc.*	All five affected Trusts, UCL Partners, NCL
Start date	*The EQIA should be started prior to policy/service development or at the design stages of the review and continue throughout the policy development/review. For an existing policy/service, any changes identified have to be implemented.*	9th August 2011
End date	*The EQIA will need to inform decision-making so the date should take this into account.*	1st June 2012
Due regard, proportionality and relevance in relation to the following characteristics • Gender including gender reassignment • Race/ethnicity • Disability • Age	*Has due regard been given to equality (i.e. promote equality of opportunity between communities, eliminate discrimination that is unlawful, promote positive attitudes towards communities) for this proposal/policy/function?* *Due regard has two linked elements: **proportionality and relevance**. The weight given to equality should therefore be proportionate to its relevance to a particular function. The greater the relevance of a function/policy/proposal to equality, the greater Please see template regard that should be paid. Where it is concluded that the policy is not relevant for an EQIA, this should be recorded here with the reasons and*	Due regard given to process in relation to characteristics. Extensive engagement with patients and groups disproportionately affected. Contribution from services and stakeholders Please see template

• Religion or belief • Pregnancy and maternity • Sexual orientation • Deprivation	*evidence.*	
Proposal/ policy/function/service aims	*Consider:* • *Why is the proposal/policy/function/service needed?* • *What does NCL hope to achieve by it?* • *How will NCL ensure that it works as intended?* • *Who benefits?* • *Who doesn't benefit and why not?* • *Who should be expected to benefit and why don't they?*	This proposed service model will strengthen the provision of core services with the opportunity to expand, innovate and develop services further within a more cost effective, efficient and patient focused model
Evidence gaps	*Identify what evidence is available and set it out here. This includes evidence from involvement and consultation. Identify where there are gaps in the evidence and set out how these will be filled.*	Important that complex patients are not disproportionately affected by service change and further work on service model is reducing this risk
Involvement & consultation	*What involvement and consultation has been done in relation to this (or a similar) policy or function, and what are the results?* *What involvement and consultation will be needed and how will it be undertaken? Report any results.*	Patient questionnaires were distributed in each of the clinics across the cluster and further patient engagement included interviews and patient focus groups. This work has shown that location, good transport links and being seen quickly are the most important issues for TB patients and TB patient contacts.
Addressing the impact	***Outcome 1: No major change****: the EQIA demonstrates the policy /change is robust and there is no potential for discrimination or adverse*	Outcome 1

	impact. All opportunities to promote equality have been taken. ***Outcome 2: Adjust the policy****: the EQIA identifies potential problems or missed opportunities. Adjust the policy to remove barriers or better promote equality.* ***Outcome 3: Continue the policy****: the EQIA identifies the potential for adverse impact or missed opportunities to promote equality. Clearly set out the justifications for continuing with it. The justification should be included in the EQIA and must be in line with the duty to have due regard. For the most important relevant policies, compelling reasons will be needed.* ***Outcome 4: Stop and remove the policy****: the policy shows actual or potential unlawful discrimination.*	

Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London Sector

16 January 2012

Future Work Plan

1. Introduction

1.1 This report outlines the work plan for future meetings of the JHOSC.

Monday 27 February – Islington

1.2 Items for this meeting are currently as follows:

- QIPP update
- Transition
- Contract management of acute trusts
- Primary healthcare strategy
- Barnet Enfield and Haringey Clinical Strategy - update

Future Meetings:

1.3 Further meetings of the Committee will take place as follows:

- 16th April (Haringey)
- 28th May (Enfield)
- 16th July (Barnet)

1.4 Agenda items for these meetings will be agreed in due course.

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