National Independent Audit of Local Supervising Authorities (England)

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We extend our thanks to the Local Supervising Authority Midwifery Officers (LSAMOs), Local Supervising Authority (LSA) midwives and LSA administrative staff for their work in making the records available for the audit and for being so welcoming and accommodating.

Finally, we would like to thank the NHS England Midlands and East region LSA team, who undertook the pilot audit, for their help in shaping the audit methodology.

Tracey Sparkes and Deirdre Dwyer - Independent Auditors

Points of note

Plans to change statutory supervision were taking place during the audit period. The planned changes include the removal of the additional tier of regulation relating specifically to midwives, by removing provisions on the statutory supervision of midwives. This change will be made via a Section 60 order which is a legislative vehicle used to amend legislation relating to regulated health professions. The statutory supervision model will be replaced by an employer led model of supervision and will not include a requirement to undertake supervisory investigations. Legislative change is expected to have taken place by April 2017. Until this time statutory supervision must remain.

In light of the pending legislative change, the recommendations of this report that relate to the current statutory model of supervision have a limited shelf life. They do however support the provision of consistent high quality supervisory investigations until such time when the legislation changes. The recommendations also propose helpful guidance for the new non statutory employer led model of supervision.

Throughout this report the findings of the audit of supervisory investigations are compared with the recent report of the Care Quality Commission (CQC) on learning from serious incidents in NHS acute hospitals.[1] These comparisons highlight that the need to improve incident investigations is not limited to supervisory investigations, but improvement is required across the wider health and social care sector.

[1] CQC 2016 Learning from serious incidents in NHS acute hospitals A review of the quality of investigation reports

1. Executive summary

1.1. Introduction

This report presents the findings of the Local Supervising Authority (LSA) independent national audit of supervisory investigations, undertaken across the four regions of NHS England (NHSE). The audit period extended from April to September 2016 and involved the audit of midwifery supervisory investigations carried out between 1 January 2014 and 31 December 2015. The first LSA Single Operating Model was published by NHS England in March 2016 (NHS England 2016). This model provides a robust platform for consistent deployment of LSA responsibilities and aims to reduce unwarranted variation. The supervisory investigations subject to audit took place prior to the publication of the LSA Single Operating Model.

The audit was commissioned by NHSE as a result of a response to a complaint report submitted to NHS England LSA.[2] The complaint related to the quality and comprehensiveness of a supervisory Investigation that was found to be flawed and not 'fit for purpose'. One of the recommendations outlined in the report was that an audit should be undertaken to provide assurance to LSA England that the weaknesses found in the LSA Investigatory Processes in 2009 are no longer inherent in the current process.

The audit used as its reference point, the Local Supervising Authority Midwifery Officer (LSAMO) Forum (UK) policy and guidance 2013 (hereinafter called '*the guidance*').[3] The purpose of this policy is to ensure that there is a single, clear and transparent process to investigate allegations of poor or impaired fitness to practice against a midwife. The policy is supported by a comprehensive set of appendices that guide midwives on how to work with families, other professionals and how to conduct the investigation interview.

The Nursing and Midwifery Order 2001 (The Order), supplemented by the midwives rules and standards (2012), sets the legislative context for the quality assurance (QA) of the LSA and form the basis of the QA of LSAs. Mott MacDonald delivers quality assurance activity on behalf of the NMC which involves quality reviews of the Local Supervising Authorities. These involve, quality assurance reviews and the issue and update of documentation.

For the purpose of this report and where there is relevance to the audit findings, reference is made to the NMC annual report that examines the key themes and risks that have emerged from the QA[4] activity of LSAs in the 2015–16 reporting year.

The 2013 guidance document sets out the processes by which all LSAs in the UK comply with Nursing & Midwifery Council (NMC) requirements. This is supplemented, on the LSAMO Forum website, by more detailed guidance about each stage, including additional template documents.

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[2] Graham, D; 2015 An External Review of a Supervisory Investigation in 2009

[3] LSA Forum: Local Supervising Authority Review and Investigation Processes (2013)

[4] NMC 2016 QA of Education and LSAs: Annual report 2014–2015

In keeping with the recommendation outlined in the Graham report (Graham 2016)[5], the audit was designed to assess compliance with each stage of the investigation process only and is not a critical review of each supervisory investigation.
Miss Davies, Mr and Stanton were given an opportunity to discuss the scope and methodology of the audit and their views were shared with the independent auditors.

The findings of the audit present opportunities for wider learning and continued improvement to processes that could potentially inform the new employer model of supervision. Therefore, in addition to capturing evidence about compliance with the current process, this report also aims to be forward-looking in its recommendations. There is particular synergy between the good practice identified through this process and the proposed new model of supervision, which involves personal action for quality improvement.

1.2. Audit Methodology

[5] Graham, D; An External Review of a Supervisory Investigation in 2009 (2015)

A random sample of midwifery supervisory investigations carried out between 1 January 2014 and 31 December 2015 were subject to audit against the standards outlined in the Local Supervising Authority Review and Investigation Processes (LSA 2013) that was published on 20 November 2013. This timeframe allowed for a brief transition period for the new guidance to be implemented and embedded (November 2013 through to 1 January 2014). In keeping with the duty of candour, any incidental findings identified during the audit process were to be reported through the appropriate escalation and governance processes.

The audit was carried out in the four regions of NHS England across the seven LSAs:

- North
- South
- London
- Midlands and East

A random sample of supervisory investigations was identified and the sample size was calculated, using a 95 per cent confidence rate and a =/- five per cent margin of error (Table 1) to ensure that a representative sample of investigations were subject to audit.

Nationally, the number of incidents with completed investigation reports between 1st January 2014 and 31st December 2015 was 1191. The sample size is presented in table 1.

Table 1 Sample size calculation

No. of incidents with completed investigation reports 1st Jan 2014 – 31st Dec 2015	Sample size (95 per cent confidence +/- 0.5 per cent)	Percentage of records
1191	291	24.43 per cent

The percentage of investigation records was rounded up to 25 per cent and this was applied on a regional basis outlined in Table 2.

Table 2 Sample size per LSA region

	Total no. of incidents with completed investigation reports 1st Jan 2014 – 31st Dec 2015	per cent of national total (1191)	No. to sample per region
North	342	25 per cent	86
South	353	25 per cent	88
London	162	25 per cent	40
Midlands and East	334	25 per cent	82

1.3. Data collection

The auditors undertook three methods of data collection:

1. An on-site assessment of 296 investigation reports and the associated records against a specifically designed standard checklist (Appendix 2), covering the steps in the 2013 guidance. The assessment included a focus on the experience of parents in terms of how their views were considered in the investigatory process.

2. Individual meetings with the seven LSAMOs and their LSA midwives, to identify any specific local arrangements for conducting investigations and also to feedback and discuss findings on a local basis.

3. A survey of Supervisors of Midwives (SoMs) across England. All 2,173 SoMs were invited to complete the on line survey. Although the main element of the audit was to assess whether the process for undertaking investigations was based on the steps in the 2013 guidance, the audit also included a qualitative aspect. The purpose of this was to add to the richness of the data.

1.4. Audit Findings

Throughout this report male and female midwives are referred to in the female form.

There were no incidental findings identified during the audit, that required escalation through the governance process.

A summary of findings are:

- The audit showed varying levels of compliance with the guidance. Low levels of compliance were most common in investigations that took place earlier in the sample timeframe, nearer to the time of publication of the guidance (January 2014). Audit of investigations undertaken towards the end of 2014 showed that compliance in these areas was improving.

- Gaps in data available for audit across all of the LSAs were evident. Three examples of these were: the use of the decision tool to trigger an investigation; involving the parents; and involving other staff. In these cases, the data were

absent from the case notes that were reviewed as a part of the audit process and therefore could not be attributed to a lack of compliance with the guidance. The latter statement is further supported by information reviewed such as letters and emails that showed that the evidence required to measure compliance was kept at the Trust, on a computer or was verbal communication by telephone, rather the information being included in the investigating file.

- The audit also highlighted that, despite the guidance and the templates developed by the national LSAMO Forum, there were differences in LSA approaches to the investigation process. For example, one LSA digitally recorded interviews with midwives and therefore did not have a record of signed transcripts. Another LSAMO sent an email to the SoM at the end of the investigation to sign off the investigation, which meant that there was no LSAMO signature on file. It was clear that each LSA was keen to support their SoMs by providing these support tools. However, the audit also showed that despite the availability of nationally available tools such as template letters and checklists, developed by the national LSAMO forum, each LSA had also produced and used its own version, which potentially caused a duplication of time and effort. Although this did not affect compliance with the guidance, the audit found that there was a tendency to duplicate effort by producing different local tools to support their SoMs, which were not shared as good practice with the other LSA regions.

Detailed findings were:

Preparation for an investigation

The audit found variable compliance in terms of preparing for the investigation across the seven LSAs. There was no consistency about which aspects of the process were more easily evidenced than others, with LSAs complying with different steps of the guidance in full, while meeting partial compliance on others and little consistency between them. For example, use of a decision tool used to determine whether an investigation was required, ranged from 22 per cent to 93 per cent (Table 5 page 20).

Undertaking an investigation

The audit found that the majority of SoMs complied with the guidance in terms of producing reports that fully described the chronology of events, the analysis of what happened and why. It was also evident that the majority of SoMs were compliant in following the investigation process in terms of briefing the midwife involved in the investigation and keeping her informed.

Involving the woman and family was less well evidenced and the survey results show that a reluctance to do this may have been affected by a lack of confidence of the investigator. Obtaining an account from the woman/ parents is likely to improve with the introduction of the duty of candour.[6] However, it will be important to ensure that SoMs feel adequately skilled to do this so that the experience is a comfortable one for the woman, her family and the midwife involved.

[6] NMC: Guidance on the professional duty of candour: 2015

Nearly 87 per cent of those responding to the survey had been involved in an investigation that exceeded 45 days and approximately half said that completing the report in 45 days was often unachievable. However, nearly a third felt it was achievable in most cases. The main reasons for delays were:

- No protected time (cited by 235 SoMs);
- Midwife or SoM sickness (cited by 217 SoMs); and
- Midwife or SoM annual leave (cited by 176 SoMs).

Completing the investigation

Nationally, the audit results showed that reports were rarely (87 per cent) delivered within the timescale set out in the guidance. It was acknowledged by the LSAs that these timescales were ambitious. However, between a third and half of all reports audited were also delayed past 60 days[7], so there is scope to improve the timeliness of reporting. Delayed reports can have a negative impact on the family if they are involved and the midwife who is being investigated. However, it is also important that reports are carefully written and of good quality.

QA activity of LSAs in the 2015–16 reporting year found that mitigating factors for the delay in completing investigations included: sickness of midwives under investigation, lack of protected time for statutory supervision activity, and increasing involvement of families with the process. With the exception of the latter reason, these findings are consistent with the findings of this audit regarding delayed completion of investigations (Table 16, page 30).

Overall, there is a varying degree of compliance across the seven LSA regions of evidence on file to demonstrate that the midwife, the family and the employing trust had been informed of the outcome of the investigation. Keeping such documentation on file or sharing learning with the employing organisation would improve governance about how the process had been followed and also demonstrate how wider issues, that were not the responsibility of the midwife, had been taken into account as part of the investigation.

Longer term outcomes of investigations

Being able to see evidence of outcomes and learning is a critical part of any investigation. This audit highlighted a lack of consistency of evidence about how longer term outcomes of supervisory investigations had been measured and monitored. This is because there was very little follow up once the investigation had been completed and based on the information provided, it was difficult to see any measure of impact as a result of the investigation. To make the investigation process truly useful, the next step should be a greater emphasis on following through the recommendations and assessing impact.

[7] 60 days is the designated time to complete serious incident investigations in trusts

Survey findings from SoMs about the supervisory investigation process

A total of 601 SoMs completed the survey, which is a response rate of 30.5 per cent. The survey findings form part of the overall audit conclusions.The key themes from the survey, included:

- The importance of the role of the LSA in support and training;
- The need to involve mothers and parents more closely than currently happens;
- The desire to produce timely reports;

The need for training for SoMs in:

- Involving families
- Root cause analysis
- Investigation (SI) processes
- Ways of managing investigations where non midwifery colleagues such as medical or ambulance staff are involved
- Report writing.

1.5. Recommendations

The audit has identified recommendations to inform the current supervisory investigatory process prior to the law change and recommendations for the new employer led model of supervision

- Ensure that SoMs and other staff involved in undertaking investigations complete SI investigation training. This should include root cause analysis training and receive continuing professional development to support them in strengthening their skills in this area;

- Develop a training package for managing the involvement of the woman and the family in investigations. This should include:
    - managing difficult conversations
    - taking accurate accounts of events
    - listening skills
    - the importance of documenting evidence
    - ensuring closure at the end of the investigation by informing families of the outcomes and documenting that this has happened;

- Ensure that appropriate time is allocated for the completion of investigations (within 60 days). This would be in line with trusts' serious incident investigation processes;

- Provide support to the LSA sub-regions to work with employing trusts to provide protected time for SoMs undertaking current investigations;

- Ensure the LSA sub-regions provide training for SoMs on the importance of maintaining an evidence base for every investigation, even after the investigation has been closed. Keeping all documentary evidence on file in one place will strengthen the overall governance of the investigation and provide better evidence for audit purposes;

- Work with NHS Improvement to encourage employing trusts to develop a system of learning audits regarding what has changed as a result of findings from complaint and incident investigations. These outcomes would provide more granular evidence of trusts learning from their mistakes.

The audit has identified the following recommendations to take forward into the new model:

- Assess regularly the content of the preparation course for the new midwifery supervisor, to ensure that the skills and competencies required to deploy the new model of supervision remain contemporary and fit for purpose;
- Work with Health Education England and Higher Education Institutions to ensure ongoing professional development is considered by the employing organisation when the new model is implemented. This should be in addition to the initial preparation programme.

1.6. Additional recommendations

On receipt of this report, NHS England consulted with Miss Davies and Mr. Stanton, seeking their views on the recommendations of this report. They suggested additional recommendations which NHS England accepted and they can be found at Appendix 1 of this report.

Detailed report

1.7. Introduction

This independent report presents the findings of the Local Supervising Authority (LSA) national audit of supervisory investigations, undertaken across the four regions of NHS England (NHSE).

The audit was commissioned by NHSE as a result of a response to a complaint report submitted to NHS England LSA.[8] One of the recommendations outlined in the report was that an audit should be undertaken to provide assurance to LSA England that the weaknesses found in the LSA Investigatory Processes in 2009 are no longer inherent in the current process.

A Midlands and East regional pilot audit, reported in March 2016, informed the methodology of the national audit.[9] The experience of the Midlands and East team meant that they were able to provide advice on the practicalities of auditing a larger sample and share lessons learned to help shape the audit tool.

It was agreed that the audit findings would be presented to Miss Davies and Mr Stanton, parents whose complaint led to the recommendation for the independent national audit, so that they could be appraised of the process and outcomes from the audit, and comment on how in their view, the findings of the audit should be used to inform learning.

While the audit was commissioned specifically to meet the recommendation, it also presents opportunities for wider learning and continued improvement to processes that could potentially inform the new employer led model of supervision. Therefore, in addition to capturing evidence about compliance with the current process, this report also aims to be forward-looking in its recommendations. There is particular synergy between the good practice identified through this process and the proposed new model of supervision, which involves personal action for quality improvement.

1.8. Background and context

Between 2000 – 2012, complaints about the way maternity services were run in various parts of the country highlighted a variation in the quality of supervisory investigations. In response, in 2013, the Local Supervising Authority Midwifery Officer (LSAMO) Forum (UK) updated its policy to guide colleagues when undertaking investigations locally.[10]

This LSA policy for investigations has now been in place for over two years. In the meantime, however, an external investigation was undertaken in 2015 as a result of

[8] Graham, D; An External Review of a Supervisory Investigation in 2009 (2015)

[9] The Midlands and East pilot developed an audit tool to measure compliance of five per cent of local supervisory investigations against the standards outlined in the LSA Review and Investigation Processes Policy (2013)

[10] LSA Forum: Local Supervising Authority Review and Investigation Processes (2013)

a serious incident at Shrewsbury and Telford Hospitals NHS Trust (SaTH) in 2009.[11] The investigation found that the initial supervisory investigation was not 'fit for purpose' and one of the report's recommendations called for a national audit to provide assurance to LSA England that the weaknesses in the LSA Investigatory Processes in 2009 identified in the investigation into the complaint report, were no longer inherent in the current process.

While the audit was commissioned specifically to deliver this recommendation, it was recognised that the findings may have the potential to contribute to wider learning and in particular inform the development of the new model of midwifery supervision.

Currently, the four NHSE regions are covered by seven LSA offices (Table 1)

Table 1 NHS England and LSA regions

London	London
Midlands and East	Midlands and East of England Midlands and East (West)
North	North of England, Cumbria and Yorkshire and Humber North West of England
South	South of England, South East and Wessex South of England, South West and South Central

Each LSA office has an appointed LSA Midwifery Officer (LSAMO), supported by LSA midwives.

Supervisory investigations are carried out by Supervisors of Midwives (SoMs). These are experienced, practicing midwives who are nominated by their peers and have been successful at an interview with their local LSA to undertake a practice and theory based course, which has been accredited by the NMC.[12] SoMs are appointed to the Local Supervising Authorities and are independent of the Trusts in which they are employed and where they work. In June 2016, there were 2173 SoMs working in England.

The LSA has a responsibility to ensure that investigations are properly resourced. The LSAMO Forum website holds the necessary templates and additional guidance to support SoMs with the investigation process.

[11] Graham, D; An External Review of a Supervisory Investigation in 2009 (2015)

[12] NMC 2014; Standards for the preparation of supervisors of midwives

1.9. Audit scope and methodology

A national independent audit of LSA supervisory investigations was undertaken within the four regions of NHS England, measuring compliance of supervisory investigations with the standard outlined in the Local Supervising Authority Review and Investigation Processes (LSA 2013).

Terms of reference for the audit sets out the scope and process[13] (See Appendix 2).

Miss Davies and Mr. Stanton were given an opportunity to discuss the scope and methodology of the audit and their views were shared with the independent auditors.

In keeping with the duty of candour any incidental findings identified during the audit process were to be reported through the appropriate escalation and governance processes.

The audit referred to the Local Supervising Authority Midwifery Officer (LSAMO) Forum (UK) guidance (hereinafter referred to as 'the guidance') to address each stage of the investigation process in detail as follows:

Prior to starting the investigation

- Was a decision making tool used to help frame the need for an investigation?
- Was conflict of interest considered?
- Was the midwife informed in writing?
- Was the employing Trust informed?

Undertaking the investigation

- Is there a time line of the key clinical events and critical factors that may have impacted on the outcome, with immediate and root causes identified?
- Have accounts from the woman and family have been considered?
- Have accounts from other staff taken into account, where appropriate?
- Has the midwife been informed of the interview procedure and have seen a copy of the transcript of the interview?

Completing the investigation

- Was a concluding report written according to guidance?
- Was the midwife involved been informed of the outcome and recommendations?
- Were learning objectives/outcomes agreed?

1.9.1. Scope

[13] NHS England: Terms of reference - Local Supervising Authorities (England) National Audit (2015)

The audit covered the four regions of NHS England:

- North
- South
- London
- Midlands and East

The audit considered a random sample of Midwifery Supervisory Investigations carried out between 1 January 2014 and 31 December 2015. This timeframe allowed for a brief transition period for the 2013 guidance to have been implemented and embedded. A recent reconfiguration of LSA office boundaries meant that the records audited did not always follow local procedures, as they had been part of a different sub-region during the timescale for the review.

1.9.2. Sample

Investigations were identified at random and the sample size calculated[14] to ensure that a representative sample of investigations were subject to audit.

Nationally, the number of incidents with completed investigation reports between 1 January 2014 and 31 December 2015 was 1191. Table 2 shows the sample size:

Table 2 Calculation of sample size

No. of incidents with completed investigation reports 1st Jan 2014 – 31st Dec 2015	Sample size (95% confidence +/- 0.5%)	% of records
1191	291	24.43%

[14] Using a 95 per cent confidence rate and a +/- five per cent margin of error

The percentage of records was rounded up to 25 per cent and this was applied on a regional basis as outlined at Table 3.

Table 3 Sample number by LSA region

	Total no. of incidents with completed investigation reports 1st Jan 2014 – 31st Dec 2015	% of national total (1191)	No. to sample per region
North	342	25%	86
South	353	25%	88
London	162	25%	40
Midlands and East	334	25%	82
Total number of records to audit			**296**

1.9.3. Methodology

To measure compliance of supervisory investigations with the standard outlined in the Local Supervising Authority Review and Investigation Processes (LSA 2013), there were three main strands to the audit:

1. An on-site assessment of the sampled investigation records against a specifically designed standard checklist, covering the steps in the 2013 guidance. This included a focus on the experience of parents and families in terms of how their views were considered in the investigatory process. The checklist is at Appendix 3.

2. Meetings with each of the seven individual LSAMOs and their LSA midwives, to identify any specific local arrangements for conducting investigations and also to feedback and discuss findings on a local basis; and

3. A survey of SoMs across England. All SoMs were invited by email to complete the on line survey (Appendix 4). Although the main element of the audit was to assess whether the process for undertaking investigations was based on the steps in the 2013 guidance, the audit also included a qualitative aspect, the purpose of which was to add to the richness of the data.

1.10. Audit findings

The findings are presented both by region and LSA (where appropriate). It is acknowledged that three of the four regions cover two LSA regions, but London is a stand-alone region. Of note, there were no incidental findings identified during the audit process, that were escalation through the governance process.

Throughout the report there are examples of regional variations. However, this highlighted differences in LSA approaches to the investigation process, rather than a lack of compliance with the audit criteria. For example, a large number of documents were shared as part of the audit, which have been developed by the LSAs to support

SoMs in the investigation process. Many of the documents were different representations of the same items, for example process flowcharts and model report templates. This highlighted that, despite national guidance and templates, there were differences in LSA approaches to the investigation process. Although this did not affect compliance with the guidance, the audit found a tendency to duplicate effort by producing different local tools to support their SoMs, which were not shared as good practice with the other LSA regions.

The audit process used the LSAMO Forum (UK) guidance to address each stage of the investigation process. Therefore, the findings are presented under the three main headings of the guidance, complemented by the views of the SoMs gained through the qualitative survey:

1. Preparing for the investigation;
2. Undertaking the investigation;
3. Concluding the investigation;
4. Views of SoMs.

1.10.1. Preparing for the investigation

Nationally, the audit found varying degrees of completeness of the evidence on file to demonstrate SoMs had completed the paperwork in accordance with the guidance. The main themes and findings are outlined in Table 4.

Table 4 Preparing for an investigation – a summary of guidance and findings

LSAMO Forum guidance and theme	Summary of the guidance	Summary of findings
The decision making tool **(paras 3.8 – 3.10)**	The SoM should undertake an initial review of care or evidence supplied to decide whether or not to investigate.	Nationally, findings from the audit indicate that SoMs consistently used the decision-making tool for those investigations that were initiated later in the audit timeframe (supervisory investigations carried out from March 2015). However, qualitative discussions with LSA staff suggest that this may be because the tool was filed separate to the main investigation documentation in previous years. Similarly, letters informing the employing trust were often filed separately. Recording that a conflict of interest had been considered was also variable, but on discussion with the LSA staff it became clear that there was variation in
	The SoM must demonstrate robust decision making processes that are able to stand up to external scrutiny by using the LSA decision tool to demonstrate their decision making in whether to investigate or not.	
	The completed decision tool must be returned to the LSA	
Conflict of interest **(paras 4.10 –**	The investigating SoM should not be the named SoM for the midwife involved in an incident as this could pose a perceived conflict of interest for service uses and their family.	

4.11)	When allocating an investigating SoM, the LSA should consider the potential for conflict of interest.	how this was recorded and evidence of emails and phone calls was not always kept on file, thus affecting the audit findings.
	The SoM also has responsibility to let the LSA know of any potential or actual conflict of interest and decline to undertake the review.	
	The midwife and named SoM must be informed in writing of the issues/concerns that are being investigated.	
Informing the employer **(table 1 step 3)**	The employing Trust needs to be informed of the need to initiate a LSA investigation. The aim of the latter is to discuss any practice concerns with the employer who, after discussion with the SoM, must consider whether continuance at work is appropriate	

More detailed findings from each of these key stages are addressed below:

Use of a decision tool

It is clear that consistent use of the decision tool can lead to efficiency, as its use means that smaller issues that do not require a full investigation can be exposed at an early stage and addressed. The construct of the LSA decision tool, which encourages the SoM to assess whether or not the midwife followed professional standards of practice, also meant that it was easy to identify the reason for the decision to investigate. Further, it allowed for sharing learning even in cases where no action was required.

Tables 5, shows that a decision tool was used in the majority of cases in three regions during the period reviewed. Of the investigations audited in the North and Midlands and East region, there was 93 per cent compliance with this standard. However, there was evidence of a decision tool having been used in 22 per cent of audited records in the London region. Discussions with the London LSA staff indicate that there had never been any concern about SoMs not using the decision tool, but that until 2015, SoMs were often filing the completed tool at the trust. These were therefore not available for the purposes of auditor. This is reflected in the London region's results as the older cases audited did not contain this document.

Table 5 Use of the decision tool based on evidence available for audit

Region	Use of decision tool
London (n = 41)	22%
Midlands and East (n = 81)	93%
North (n = 76)	93%
South (n = 88)	73%

Some LSA offices had produced a sample decision tool to help guide the SoMs. The following case study describes how this part of the process is encouraged and supported by the Midlands and East (East) LSA:

Good practice case study – Use of the Decision Tool

The Decision Tool (DT) was developed to support Supervisors of Midwives (SoMs) to determine whether a full supervisory investigation should be undertaken. The DT enables the SoM to work through the incident, using the Midwives Rules and Standards (Nursing and Midwifery Council 2012) and The Code (Nursing and Midwifery Council 2015) to help identify areas of potential poor midwifery practice. The DT has evolved over time based on the comments of the SoMs using the tool and the need for the LSA to continue to improve the rigour of the investigation process.

In the Midlands and East LSA all new DTs are requested by a SoM from the LSA office by email. Each DT is allocated a unique identifying number, which is also used throughout any further communication with the LSA, which allows the LSA to track the progress of the DT and any subsequent investigation.

The SoM is encouraged to complete the DT as fully as possible in order to ensure that there is enough information on which to base the decision for further investigation or not. A recent addition to the DT information is that the SoM clearly identifies and documents the rational for why no further investigation is required. This helps the LSA to be able to support (or question) the recommendation made by the SoM.

The completed DTs are returned to the LSA and filed under the relevant investigation number to ensure a clear governance process is evidenced. All the DTs are reviewed by the LSA Midwife or the LSAMO to ensure that they are appropriately completed and that the LSA agrees with the recommendation made by the SoM in relation to further investigation or not. The LSA may request further information from the SoM if the information shared is not in enough depth or there is a lack of clarity around the incident. There needs to be enough information on the DT so that an informed decision can be made by the LSA with regards to closing the case or continuing with a full investigation.

Following review by the LSA midwife the decision is then documented on the DT by the LSA to confirm that there is agreement with the SoM to proceed with further investigation or close the case

The use of the DT has helped to provide clarity in identifying potential midwifery practice issues and a clear rationale for no further investigation. While the number of requests for DTs has risen in the last two years, the number of full investigations has remained consistent. This would seem to indicate that SoMs are reviewing more incidents using the DT (potentially signalling a more robust interface with clinical risk) but correctly identifying those incidents which require further investigation.

Considering conflict of interest

It was not always possible to see evidence that conflict of interest had been considered, which does not mean that it had not been considered and mitigated. However, in the absence of documentary evidence it is difficult to draw conclusions. Of the investigation cases audited, it was easy to see in the majority, that the investigating SoM was a different person to the named SoM through the correspondence on file.

Potential conflicts of interest can be further minimised if the SoM is not employed by the provider organisation in which the practice allegations arose. North East, Yorkshire and Humber LSA office demonstrated that they always tried to use SoMs from other trusts where they could. Of its benefits, they said:

Good practice case study - Externally led investigations

Anecdotal LSA feedback and evidence indicates the additional benefits of externally led supervisory investigation are:

- No confusion for the midwives or Trusts involved that this is a LSA and not a management process
- Complete objectivity
- A “fresh eyes” approach to practice issues that might previously have been accepted as “custom and practice”
- Sharing of good midwifery and supervisory practice and of lessons learned.

The use of external SOMs assists in the recognition and impact of the ‘local culture’ which may not encourage contemporary, evidence based midwifery care and successful multi professional working.

Table 6, shows that there was evidence that conflict of interest had been considered in the majority of cases. In each region, there were direct examples, including those in which LSA midwives themselves undertook the investigations when senior or well-known midwives were being investigated and also some in which SoMs requested to be taken off investigations where they felt there was a conflict. Qualitative feedback from the LSA staff indicated that conflict of interest was always considered when selecting SoMs to undertake supervisory investigations. However, table 6 shows that in the cases audited, this was not always documented. Findings from the North East LSA demonstrate this point well, as although the LSA encourages the use of SoMs external to the trust, this was not always recorded on the file.

Table 6 Consideration of conflict of interest based on evidence available for audit

Region	Evidence of consideration of conflict of interest
London (n = 41)	100%
Midlands and East (n = 81)	81%
North (n = 76)	64%
South (n = 88)	99%

Informing the midwife of the investigation

It is recognised that being investigated is a stressful and worrying event for midwives. Therefore, it is important that they are provided with clear information about the process and the expectations on them to participate. The 2013 guidance includes a suite of template letters that should be used by SoMs at different stages in the investigation process, including one to inform midwives of the need for an investigation, what will happen and what she is required to do.

Table 7, shows that, in most cases, there was evidence of the template or similar letter on file to demonstrate that midwives had been informed of the investigation. Again, qualitative feedback from LSA staff shows that midwives were informed in writing in the majority of cases, but sometimes the letter could be filed at the trust and therefore the evidence was not on file at the time of the audit.

Table 7 Informing the midwife of the need for an investigation based on evidence available for audit

Region	Evidence that the midwife had been informed of the investigation
London (n = 41)	90%
Midlands and East (n = 81)	79%
North (n = 76)	93%
South (n = 88)	89%

Informing the employing Trust of the investigation

It was not always easy to evidence that the employing trust had been informed of the need for an investigation. Table 8, provides the breakdown by region. In discussion with LSAMOs and LSA midwives, it was apparent that this was sometimes undertaken in a face-to-face meeting and not documented. Therefore, this evidence was not available for audit purposes.

Table 8 Informing the employing Trust of the investigation based on evidence available for audit

Region	Evidence that the employing trust had been informed of the investigation
London (n = 41)	51%
Midlands and East (n = 81)	65%
North (n = 76)	73%
South (n = 88)	85%

1.10.2. Undertaking the investigation

The main themes and findings around undertaking the investigation are summarised in Table 9.

Table 9 Undertaking the investigation – a summary of guidance and findings

LSAMO Forum guidance and theme	Summary of the guidance	Summary of findings
Data collection (step 5)	The SoM should establish the facts through various means of data collection, starting with the medical records.	Nationally, the audit found that SoMs were compliant with the guidance in terms of producing reports that fully described the chronology of events and analysis of what happened and why. It was also evident that SoMs followed the process in terms of briefing the midwife and keeping her informed. Considering an account from the woman and family was less well evidenced and the survey results show that a reluctance to do this may have been affected by lack of confidence. Consideration of obtaining an account is likely to improve as part of the introduction of duty of candour. However, it will be important to ensure that SoMs feel adequately skilled to do this.
Chronology of events (step 6)	The SoM should then compile a time line of the key clinical events and establish from the time line, which critical factors may have impacted on the outcome (care delivery problems or service delivery problems). For each of the critical factors, they need to establish immediate and root causes.	
Informing the midwife involved (step 7)	The midwife must be informed of the interview procedure in writing.	
Involving the family (step 8)	Ensure accounts from the woman and family have been considered.	
Involving other professionals (step 9)	Ensure accounts from other staff have been taken into account, where appropriate	

Providing transcripts of interviews (step 13)	In addition, the midwife should have seen a copy of the transcript of the interview.	

More detailed findings from each of these key stages are addressed below:

Chronology of events and root causes

Being able to describe exactly what happened and why is an essential part of any investigation and Table 10, shows that there was evidence that this was done in the majority of the investigations reviewed. As with other aspects of this audit, discussions with LSA staff highlighted that on occasions, SoMs did not always submit this evidence to the LSA. This does not mean that they had not completed this step of the guidance, but does affect the audit findings as the evidence was not available. The findings of the national CQC serious investigations review (CQC 2016) found that very few reports in their sample of 74 reports reviewed included clearly documented evidence of a well structured methodology and analysis leading to identification of key causal factors.

Root cause analysis (RCA) is a comprehensive method of assessing all the contributory factors that can impact on an adverse event and in most cases the SoMs had undertaken a form of root cause analysis. However, across the board, very few had explicitly considered the full range of factors. Whilst feedback from LSA staff indicated that RCA training had been provided for SoMs, there possibly is potential for this to be revisited. This is supported by the findings from the SoM survey, where a number of SoMs requested training in RCA. Training would improve SoMs confidence in this skill and enable consistency with Trust risk management processes.

Table 10 Establishing a timeline based on evidence available for audit

Region	Chronology of events	Detailed timeline with root causes
London (n = 41)	95%	88%
Midlands and East (n = 81)	97%	99%
North (n = 76)	93%	91%
South (n = 88)	93%	90%

Considering an account from the woman and/or family

The guidance includes a procedure for obtaining an account from the woman and her family about their experience and is clear that the LSAMO must be contacted before contacting the family. Discussions with LSAMOs and LSA midwives provided evidence that this was followed when families were contacted.

It is clear that it is not always appropriate to obtain a woman's account, especially in the case of incidents that were not relevant to the mother or baby's health. Examples include record keeping and information governance incidents. In these cases the family may not have been aware there had been an issue and to involve them could then cause unnecessary anxiety. In these cases, some SoMs made it clear in the notes that this was not applicable so the auditors accepted this as having been considered.

In some of the cases audited, the investigation had been triggered by concerns raised by a woman and/or her family about a midwife's fitness to practice.

Table 11, shows that between 44 per cent and 58 per cent of the records audited contained evidence that obtaining an account from the woman or her family had been considered. This ranged from 26 per cent to 66 per cent by LSA. In discussion with LSAMOs, it is clear that this is changing and that the recent introduction of the professional duty of candour[15] means that there are now clearer expectations on involving women and families in investigations. This would suggest that more recent investigations would now include this where appropriate.

These findings are not exclusive to supervisory investigations only and appear to be widespread across the NHS, according to the findings of the national CQC review of investigations. This review found that only nine (12 per cent) of the 74 reports reviewed included clear evidence that the patient or their family had been involved in the investigation and only 27 of the 74 reports (36 per cent) included any evidence that the patient or their family had been offered a chance to discuss the report (CQC 2016).

Table 11 Involving the woman and/ or the family based on evidence available for audit

Region	Evidence that an account from the woman and/or family has been considered
London (n = 41)	44%
Midlands and East (n = 81)	47%
North (n = 76)	58%
South (n = 88)	55%

[15] NMC: Guidance on the professional duty of candour: 2015

The quality assurance[16] activity of LSAs in the 2015–16 reporting year stated that LSAMOs have reported that midwives are "becoming more accustomed" to informing the woman and her family of errors and incidents following the release of the duty of candour guidance.

The following description shows how this is done in the North West LSA region, where involving the family has become a regular part of the investigation process.

Good practice case study - Involving Families

In the North West, the Supervisors of Midwives write to the families informing them of a supervisory investigation. (NB. If there is a good rationale for not doing so, this will be documented on the LSA decision making toolkit at the outset). All letters and summary reports to the family are sent to the LSA before being sent to the family.

Involving the family is not just about ensuring a duty of candour is met, but it also ensures we keep the woman as the focus of the work we undertake and reminds us that the safety of the woman and the baby is our principal concern.

Moving forward, the survey results highlight that this has not been a routine part of the investigation process for SoMs; only 16 per cent said they had involved the mother/parents in almost all of their investigations and 31 per cent had never done this. The survey comments suggest that many SoMs do not feel confident about this aspect of their role and feel they need more training and support to do this.
One comment illustrates this:

> *"The involvement of the family was quite stressful and I was not confident with this. I found it difficult to communicate my findings as they disagreed with them and I could see their understandable anger but it was not easy and I have had no training for this"(SoMs)."*

Factual accounts from other staff

The guidance suggests that a factual account of events may be requested from any health care workers if it is identified that they were involved in the incident. This should not be a repetition of what is in the notes and should include any additional information of what the midwife saw, heard or did, that is not contained within the medical record. If there is nothing else to add then no account is needed.

Table 12, shows a varied level of evidence nationally that factual accounts from other staff had been considered where appropriate. The survey results show that this is not always required but also may not always be easy to establish for various reasons. Lack of access to the other disciplines such as doctors and ambulance staff; difficulty in contacting bank and agency staff or others who may have left the trust; or a general lack of understanding of the role of the SoM were reasons given in the

[16] NMC 2016 QA of Education and LSAs: Annual report 2014–2015

comments provided by the SoMs in the survey. Regardless of these reasons, it is interesting to note that these results are similar to the findings of the CQC review of SI investigation and staff involvement (CQC 2016). This review found that only 29 (39 per cent) of the 74 reports that were reviewed included evidence of interviews with members of staff who were involved in, or who had a perspective on the incident

Table 12 Involving other staff based on evidence available for audit

Region	Evidence of factual accounts from other staff
London (n = 41)	46%
Midlands and East (n = 81)	51%
North (n = 76)	70%
South (n = 88)	95%

Keeping midwives informed

The 2013 guidance provides a list of skills the SoM should have if undertaking an investigation interview with the midwife involved. It also clearly sets out the purpose of the interview.

Some LSA offices have produced an interview checklist, which the SoM had included in the notes as evidence. Most records showed that the midwife had been informed of the purpose of the interview through the letter inviting him/her for interview. In others, the purpose of the interview and checking that the midwife understood this was part of the interview transcript.

Providing a copy of the interview transcripts contributes to an open, transparent fair and timely process that stands up to external scrutiny. One LSA office recorded the interviews and sent recordings on compact disks instead of written transcripts to the midwife.

Table 13, shows that most investigation cases in three of the regions contained evidence that the midwife had been informed of the purpose of the interview (81 to 88 per cent). In the Midlands and East, the lower number (67 per cent) is due to the fact that the letters informing the midwife of the interview were not always kept on file.

Table 13 Informing the midwife based on evidence available for audit

Region	Midwife informed of the purpose of the interview	Midwife sent transcripts of the interview
London (n = 41)	85%	83%
Midlands and East (n = 81)	67%	61%
North (n = 76)	88%	66%
South (n = 88)	81%	73%

Across the LSAs, there was little evidence that midwives had seen the transcript of their interview. LSA staff indicated that this was often because midwives responded directly to the investigating SoM on email and this was not always kept on file.

Comparisons can be drawn with the findings of the national CQC review of a sample of serious incident investigation reports, where only 29 (39 per cent) of the 74 reports reviewed included evidence of interviews with members of staff who were involved in, or who had a perspective on the incident. These data suggest that this issue is not limited to supervisory investigations.

1.10.3. Concluding the investigation

The main themes and findings around concluding the investigation are summarised in Table 14.

Table 14 Concluding the investigation – a summary of guidance and findings

LSAMO Forum guidance and theme	Summary of the guidance	Summary of findings
Producing the report (step 17)	The production of a report and letter to the midwife informing them of the outcome of the investigation and the process for appeals	Nationally, the audit results showed that reports were rarely completed within the timescale set out in the guidance but it is acknowledged by LSA staff and the SoMs themselves that these timescales are ambitious. This is often because of staff sickness, annual leave and finding time to meet. In addition, investigating SoMs were often undertaking an investigation in addition to a full time midwifery role. It is likely that LSA investigation
Concluding a draft report (step 15)	The guidance states that the first concluding report should be done within 30 days and sent to the LSAMO for comment. The final report should be signed off by the LSAMO within 45 days.	
Informing the family (step 18)	The mother and family should be informed of the outcome if they have been involved.	

Informing the employing Trust (step 20)	The employing Trust should be informed of the outcome, highlighting any systems issues that the Trust needs to consider.	timelines will move in line with trust serious incident investigation timelines of 60 days turnaround. However, this audit showed that between a third and half of all reports audited were also delayed past 60 days Overall, there is a varied level of evidence on file to show that the midwife, the family and the employing trust had been informed of the outcome of the investigation. Keeping such documentation on file would improve governance about how the process had been followed and also demonstrate how wider issues, that were not the responsibility of the midwife, had been taken into account.
Professional development plans and meeting the midwife (step 21)	The SoM should make clear recommendations, with timescales for the commencement of any professional development or training plans and a meeting between the investigating SoM, named SoM and midwife.	

Findings from each step are discussed in more detail below.

Investigation reports

The guidance states that every investigation report should be signed off by the LSAMO. This shows that the quality of the report has been reviewed. LSAs have different ways of evidencing this, including electronic signatures on each report and email confirmation to the investigating SoM of the conclusion of the report. The audit fieldwork provided many examples of reports being reviewed by the LSAMOs and returned to the SoM for the report to be improved. Table 15, shows that there was evidence of reports being signed off by LSAMOs in most of the cases audited.

Table 15 Report sign off by LSAMO based on evidence available for audit

Region	Evidence that reports are signed off by the LSAMO
London (n = 41)	93%
Midlands and East (n = 81)	84%
North (n = 76)	99%
South (n = 88)	89%

The 2013 guidance states that the aim is to complete the investigation within 45 days and that this means that the first concluding reports should be sent to the LSA within 30 days. For the audit, report timescales were counted from commencement of investigation (as written on the decision tool) to sending the first draft to the LSA.

Table 16, presents the range of days by region and what percentage of first draft reports were delayed over 30 days. This shows that most first concluding reports took SoMs longer than 30 days to produce. The guidance also states that LSAs should be informed of delays to reports past 30 days. Table 16, also shows that this this was adhered to approximately half of cases. However, discussions with LSAMOs made highlighted that custom and practice meant that LSAs did not count the report as being delayed if it was going to be completed within 45 days.

Table 16 Concluding the report based on evidence available for audit

Region	Range of days from commencement of investigation to first concluding report	Percentage of reports delayed past 30 days	LSA informed of delay
London (n = 41)	21 - 202	93%	42%
Midlands and East (n = 81)	9 - 115	79%	56%
North (n = 76)	1 - 180	78%	58%
South (n = 88)	12 - 340	84%	45%

It is acknowledged by LSA staff and the SoMs who responded to the survey that there can be delays in producing investigation reports, which mean it is difficult for the SoMs to comply with the guidance. Reasons include sick leave and annual leave, which can cause delays in setting up the interviews.

Nearly 87 per cent of those responding to the survey had been involved in an investigation that exceeded 45 days and approximately half said that completing the report in 45 days was often unachievable. However, nearly a third felt it was achievable in most cases. The main reasons for delays were:

- No protected time (cited by 235 SoMs);
- Midwife or SoM sickness (cited by 217 SoMs); and
- Midwife or SoM annual leave (cited by 176 SoMs).

Sometimes, reports were delayed because of LSA workload. This was mentioned by 55 SoMs.

In April 2016, a new 60 day timeframe was agreed by the LSAMO Forum UK with members monitoring the output of this change. This timeframe is now in line with trust risk management processes. Table 17 presents the percentage of reports that were produced within 60 days and findings suggest that a proportion of investigations continue to fall outside the new timeframe.

Table 17 Percentage of reports produced within 60 days

Region	Percentage of reports produced within 60 days
London (n = 41)	52%
Midlands and East (n = 81)	62%
North (n = 76)	69%
South (n = 88)	50%

Report turnaround time is also affected by whether SoMs have protected time for investigations. The guidance states that the LSA has a duty to ensure that investigations are properly resourced and that the SoM should negotiate protected time and should inform the LSAMO if resources are an issue. The survey results show that this varies but that 30 per cent did have protected time from their employer to undertake an investigation and 44 per cent sometimes had protected time.

One LSA (North East, Yorkshire and Humber) has negotiated protected time for all its SoMs, which can be seen to have impacted on its report turnaround times (75 per cent of reports are produced within 60 days).

Informing the midwife of the outcomes of the investigation

The 2013 guidance states that the investigating SoM should agree with the midwife the process by which she wishes to receive feedback and recommendations from the investigation. The midwife also needs to be informed in writing of any recommendations and the process for any appeals.

Table 18, shows that this was evidenced in most of the records audited. The process for appeals was communicated either by the letter informing the midwife of the outcome, or in the report, or both. Discussions with LSAMOs indicated that where this could not be evidenced, this did not mean that it was not done but that the letters were not kept on file.

Table 18 Informing midwives of outcomes and appeals

Region	Midwife informed of outcome and process for appeals
London (n = 41)	73%
Midlands and East (n = 81)	46%
North (n = 76)	99%
South (n = 88)	86%

Informing the family of the outcomes

In concluding the investigation, the 2013 guidance states that, if involved, the SoM must inform the family of the recommendations made on conclusion of the investigation.

Table 19, shows that three LSAs presented evidence in under half of the cases audited to show that the families that had been involved were then informed of the outcome. Discussion with the LSAMOs highlighted that, in those cases where a trust investigation is being undertaken alongside the midwifery investigation, the trust would take responsibility for feeding back to the family. However, for governance purposes and to ensure transparency of process, this should also be documented in the midwifery investigation records.

Table 19 Informing the families of the outcome based on evidence available for audit

Region	Families informed of outcome where they have been involved
London (n = 9)	44%
Midlands and East (n = 34)	44%
North (n = 19)	68%
South (n = 26)	46%

The following case studies from the North West LSA describe how outcomes have been shared with families:

Good practice case studies - Examples of good involvement with the family

Case study 1
Following a serious incident, an external investigation was undertaken supported by the LSA Midwife. By linking with the Trust family liaison officer, we informed the family of the supervisory investigation. The investigating supervisors took into account the concerns raised by the family when undertaking the investigation, and included their questions as part of the investigation process.

When the investigation was completed a summary report was sent to the parents, and the investigating supervisors linked with the family liaison officer and met with the family to answer the questions. As requested by the family, the full reports (redacted) were then sent to the family.

The LSA midwife was involved in the practice programmes for two midwives, and ensured the local action plans were completed in a timely manner. When these were all completed, the family were also informed of their successful completion, to provide assurance to them that any learning needs identified were met.

Case study 2
A complaint was made directly to the LSA regarding a meeting of parents with a Supervisor of Midwives. The LSA midwife decided to look into this matter as it involved a supervisor of Midwives. The first meeting was between the LSA midwife and the parents in their own home. The parents shared their story and the LSA midwife summarised their concerns and sent them a copy of the meeting. These concerns instigated the start of a supervisory investigation which was undertaken by the LSA midwife. Once completed, the parents were sent a summary report followed by a further meeting with the LSA midwife to discuss the report. The parents were happy that the matter had been addressed and no further action was needed.

Case study 3
Following an intrapartum death, an investigation was undertaken externally. The investigating Supervisor of Midwives contacted the family and planned to meet with them. After re- scheduling the meeting at the mother's request, the meeting was cancelled again by the mother as she did not feel she could deal with a meeting. The LSA were informed throughout and provided support to the investigating Supervisor and offered to accompany her when meeting with the family if required.

The investigation proceeded with the mother, keeping her informed of the progress, and once completed; the parents were contacted and asked if they wanted a copy of the summary report. The parents requested one and the investigating midwife sent a summary report to the parents (following approval from the LSAMO). An offer was made to the parents to meet to discuss this further if they wished, but this was declined.

Informing the Trust about the outcome

This part of the process provides an opportunity for the SoM to highlight any organisational factors that contributed to the incident. The 2013 guidance provides a process for reporting to the midwife's employer and other healthcare regulators as appropriate, in circumstances where the investigation identifies issues with systems or governance, or issues that concern other professions that may have contributed to the unsafe practice. The letter/report must include: the service and organisational contributing factors and any changes that the investigating SoM perceives should be implemented and action plans should be developed. Good/notable practice should be identified within the outcome summary letter. The LSA must inform the Head of Midwifery (HoM) and/or Director of Nursing (DoN) if other health care regulators are going to be informed of concerns identified.

Table 20, shows a wide regional variation of evidence of such a letter to the employing trust. Again, this does not mean that this was not completed or undertaken but that the evidence was not on file for audit purposes.

Table 20 Informing the employing trust of the outcome based on evidence available for audit

Region	Outcome summary to HoM on file
London (n = 41)	22%
Midlands and East (n = 81)	49%
North (n = 76)	72%
South (n = 88)	68%

It was evident from the discussions with the South, South East and Wessex LSAMO that SoMs are encouraged to always highlight the trust organisational issues in its concluding letter. This is described in the following good practice case study.

Good practice case study - Informing trusts of external causal factors

The context and environment which midwives work within contributes to their ability to practice competently, safely and effectively. With this in mind it is essential that mitigation is explored closely for each midwife subject to investigation. In the South East & Wessex area during an investigation Supervisors of Midwives consider any external causal factors that may have affected the midwives ability to practice within the Code (NMC 2015) and the Midwives rules and standards (NMC 2012). The areas that are categorized are: human factors, service delivery and governance problems. Midwives may bring forward issues they have identified as mitigating circumstances but SOMs also critically analyse these using root cause analysis methodology. Once these are identified recommendations are made to the service leads to ensure that service or governance shortcomings are addressed by the organisation. These recommendations and actions are tracked by SOMs through their meetings with the HOM at their SOM meetings and the DON at their quarterly briefing meeting. Where there is an inability to progress this is fed back to the LSAMO for involvement of the LSAMO at Trust level or escalation to Clinical Care Groups for action at commissioner level. These also inform the report the LSA makes to the CQC prior to an inspection.

In one case the following was identified and recommended:

Identified system or team failure	***Recommendation***
Failure to identify tachysystole and hyper-stimulation	CTG teaching sessions to include emphasis on the importance of recognition of abnormal uterine action and incorporating this into analysis of CTGs
Band 6 midwives taking charge of Delivery Suite without adequate training or support	Decision regarding who should 'act up' in case of Band 7 sickness to be taken at senior level with appropriate consideration for skill mix and experience of available staff Trust to develop a program to enable Band 6 midwives to take charge of Delivery suite safely.

Since this investigation the service has completed a review of their midwifery practice and is introducing a buddy learning system for junior midwives where each midwife has a senior midwife 'sponsor' who is responsible for the development and nurturing of their midwifery skills in day to day practice. Although these recommendations where not the initial catalyst they helped to create a compelling argument for action in this area. The practice development team have also reviewed and updated their training plan regarding CTG interpretation.

The South West and Central LSA has introduced a regular briefing (a template and a meeting with the LSAMO) for each Director of Nursing. This has raised the profile of the SoMs and LSA and has been well received by the Trusts:

Good practice case study - Briefing employing Trusts

Purpose
To provide an overview of the activities of supervisors of midwives on a quarterly basis to the Director of Nursing.

Process
The Contact Supervisor of Midwives meets the Director of Nursing once a quarter, providing a briefing paper prior to the meeting.

The briefing paper should be discussed with the Head of Midwifery prior to submission to the Director of Nursing. The meeting may or may not include the Head of Midwifery, this is agreed locally.

Monitoring
The LSA formally monitor the effectiveness of the briefing at the LSA annual review.

Outcome
The LSA are assured that Directors of Nursing are fully informed about supervisory activities and any concerns or challenges. The briefing and meeting has increased knowledge and understanding by Directors of Nursing about the role of the supervisor and statutory supervision.

The LSA has been informed by Directors of Nursing and the Contact Supervisor that the meetings are worthwhile and effective, providing an opportunity to discuss a range of issues both directly and indirectly related to supervision.

Contact Supervisors describe how they value the relationship with the Director of Nursing, describing how this has resulted in a greater appreciation of issues from a strategic perspective and ability to clearly articulate issues with senior team members.

There is therefore mutual value in the briefing and meeting between the Director of Nursing and Contact Supervisor.

Outcomes and action

The aim of the investigation was to assess a midwife's continuing fitness to practice. Very few resulted in a referral to the Nursing & Midwifery Council (NMC) but most of those audited, highlighted improvements in practice that could be met through a local action plan or a more formal LSA Practice Programme; a training programme developed in conjunction with the local University.

The critical part of any investigation is that it should result in learning. The final part of the 2013 guidance states that: recommendations should form part of the investigation report, with an agreed plan and a meeting agreed between the midwife, investigating SoM and named SoM to agree the learning objectives. This would not be expected in cases where the outcome was referral to the NMC, so these have been disregarded and are not included in the audit findings.

Table 21, shows wide regional variation in the evidence in files audited of 'plan clearly identified' and 'meeting to agree learning objectives'. Discussions with LSAMOs highlighted that this is possibly because records may not always contain such evidence.

Table 21 Planning and meeting to discuss learning based on evidence available for audit

Region	Plan clearly identified	Meeting to agree learning objectives (where appropriate)
London (n = 41)	61%	56%
Midlands and East (n = 81)	66%	57%
North (n = 76)	39%	87%
South (n = 88)	95%	90%

The following case study describes the West Midlands approach to working with its local universities:

Good practice case study - LSA Practice Programmes

The West Midlands LSA has always had a very good relationship with the local universities and LMEs across the region. As good practice, all but one had a midwifery lecturer, as an appointed Supervisor of Midwives, who contributed effectively to both the clinical link team and the Trusts supervisors of midwives group, all holding a supervisory caseload. This was reciprocally advantageous in that there was direct contact with the Academic Education Institution (AEI) and trust staff, engagement with local resolution and action, developments within the trust could be easily facilitated and an objective view from outside the trust provided. LSA Practice programmes (Supervisory practice programmes) were effectively planned and managed to ensure that there was a reliable assessment process following NMC Standards for assessment and that sign-off mentors were prepared and supported. The Programme leader for the Preparation of Supervisors of Midwives programme and LME (AK) was appointed as a Link Supervisor of Midwives, with others, to offer support to the LSAMO and assist in a broad range of LSA activities forging strong links with the Heads of Midwifery and supervisors across the region. Since the re-configuration of the LSA and the planned removal of statutory midwifery supervision this has subsequently become an adapted model.

The LSA employed a LSA Midwife in 2009 and this post existed until 2012. The current LSA Project Midwife (AK) took up post in December 2013. She has developed the published LSAMO Forum 'Domains', which were adapted from the NMC (2009) Standards for Pre-registration Midwifery Education to assisting in the formulation of LSA Practice programmes and Local Action planning. In addition to supporting supervisors of midwives undertaking LSA investigations, an important

emphasis is placed on ensuring that crucially the learning from incidents has taken place. LSA Practice programmes are planned or monitored by AK and she endeavours to meet all midwives undertaking them to ensure support is provided. Additionally, completion of Local action is closely monitored as part of this role and workshops and events are planned and delivered to facilitate timely completion and updating.

1.11. Survey of Supervisors of Midwives – key results

A survey was carried out as part of the national audit of compliance with supervisory investigations process in England. As part of the audit, we were keen to understand the views of SoMs about what happens currently; what they thought worked well and where there were gaps. The survey questions are at Appendix 3.

The on-line survey was sent, via the LSAs, to all current SoMs in England (2,173). A total of 601 SoMs completed the survey, which is a response rate of 30 per cent. The

national results are presented in this report. Each LSA has also been sent a copy of their own results.

The survey findings form part of the overall audit conclusions:

- The importance of the role of the LSA in support and training;
- The need to involve mothers and parents more than now;
- Producing timely reports;
- The need for protected time to carry out an investigation thoroughly and in a timely manner; and
- The need for training for SoMs in:
  - Involving families;
  - Root cause analysis
  - Investigation (SI) processes
  - Dealing with non-midwifery staff
  - Report writing.

1.11.1. Survey results

Nationally, 30 per cent of SoMs responded to the survey. Charts 1 and 2 show that on a regional and LSA basis, this ranged from 16 per cent of all SoMs in Midlands and West to 44 per cent of all SoMs in Midlands and East.

Chart 1 NHSE Region

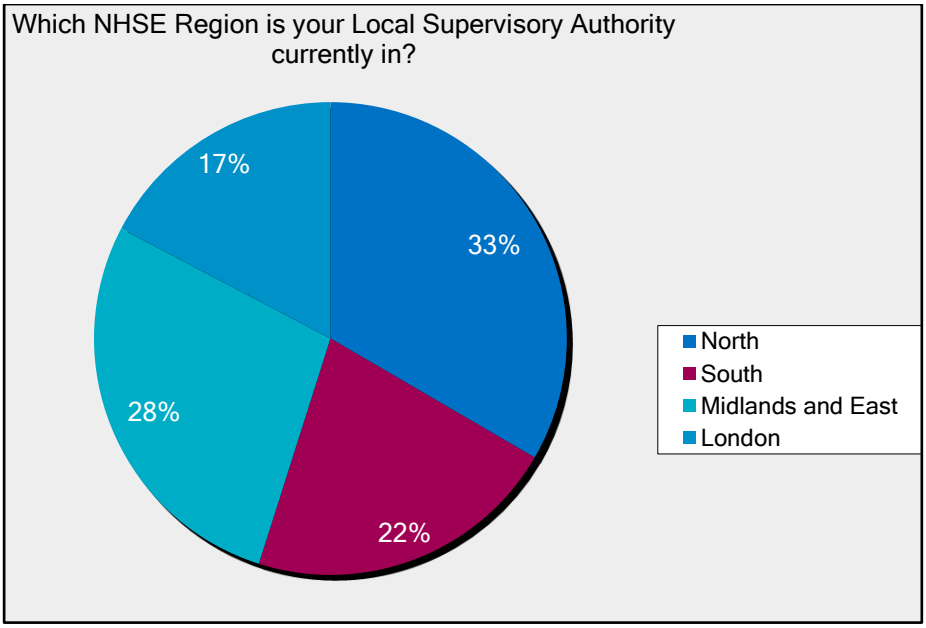
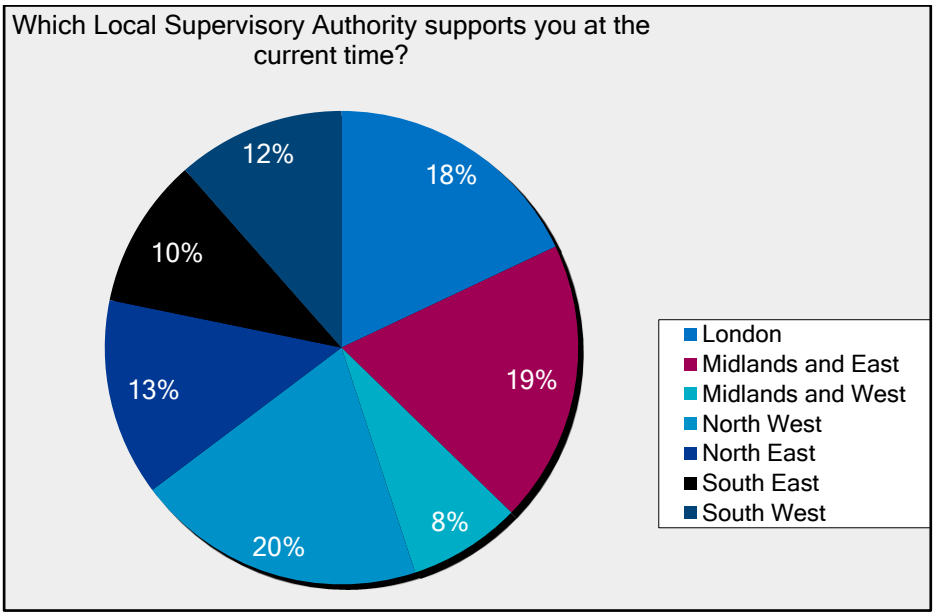
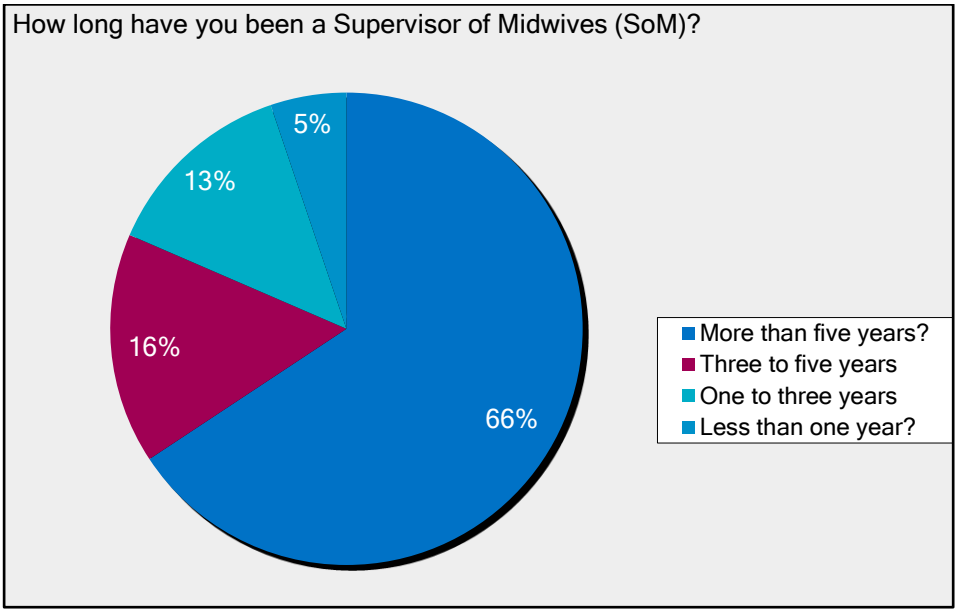


Chart 2 LSA



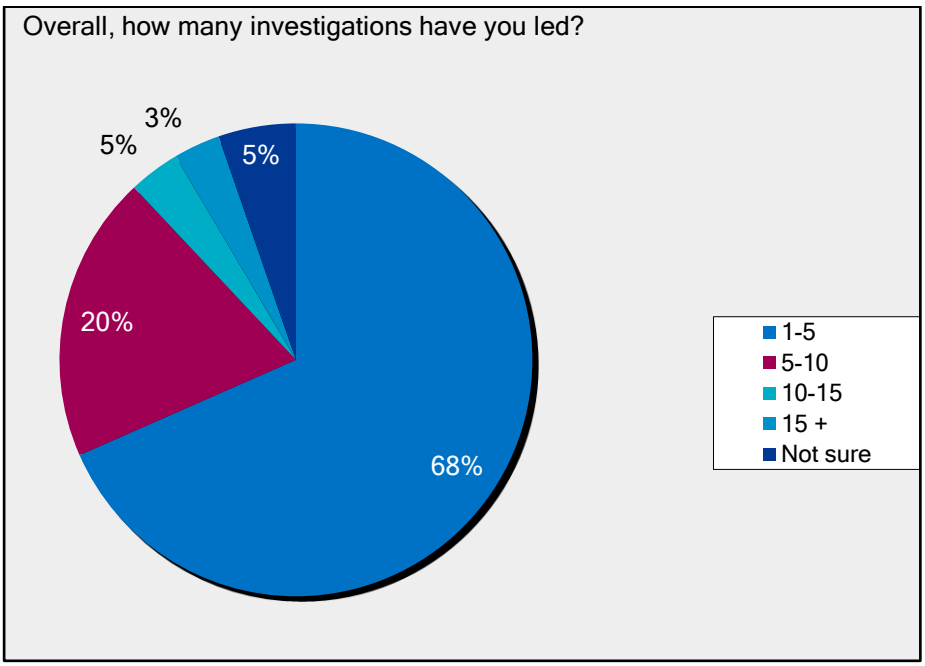
Most SoMs had been in the role for more than five years; indicating that they are an experienced workforce (see Chart 3).

Chart 3 Length of time as a SoM



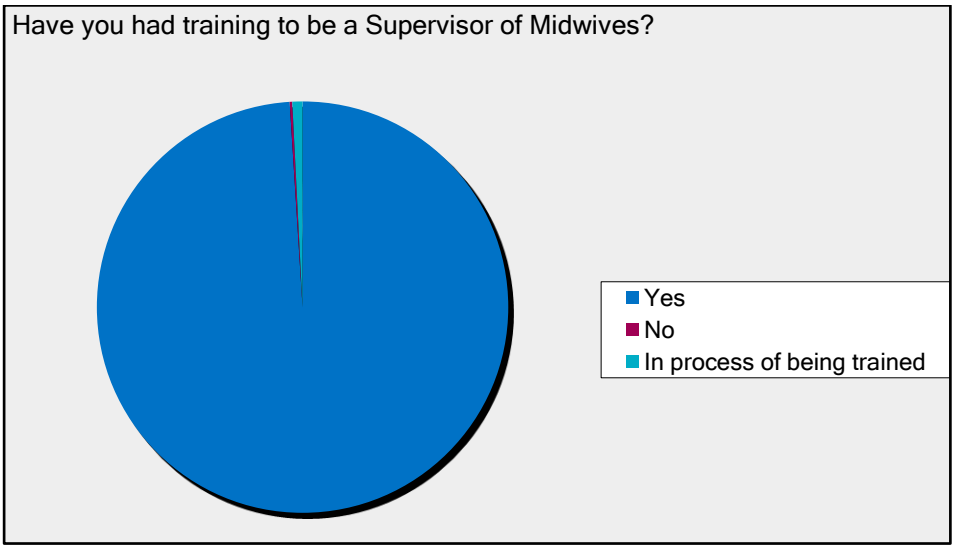
However, despite having done the role for a number of years, most had done fewer than five investigations. This is likely to be due to the ratio of SoMs to investigations and the investigations are only part of their role. It suggests that few SoMs do sufficient investigations to enable them to become expert at them. This may have an impact on speed and efficiency.

Chart 4 Number of investigations led



595 (99 per cent) of the 601 SoMs who completed the survey had received training for their role. Five were in the process of being trained and one said they had not received training (see chart 5).

Chart 5 SoM training



Charts 6 and 7 highlight the support LSAs provide for their SoMs in the form of training. More than half of SoMs had been offered Continuing Professional Development (CPD) training by their LSA in the previous three months. Over two-thirds gave high scores for the training in terms of meeting their needs. Only 5 per cent provided low scores for this question.

Meetings with LSAMOs during the audit supported this finding through the evidence the LSAs provided to show the range and frequency of CPD training for SoMs to support them in their role.

Chart 6 CPD training

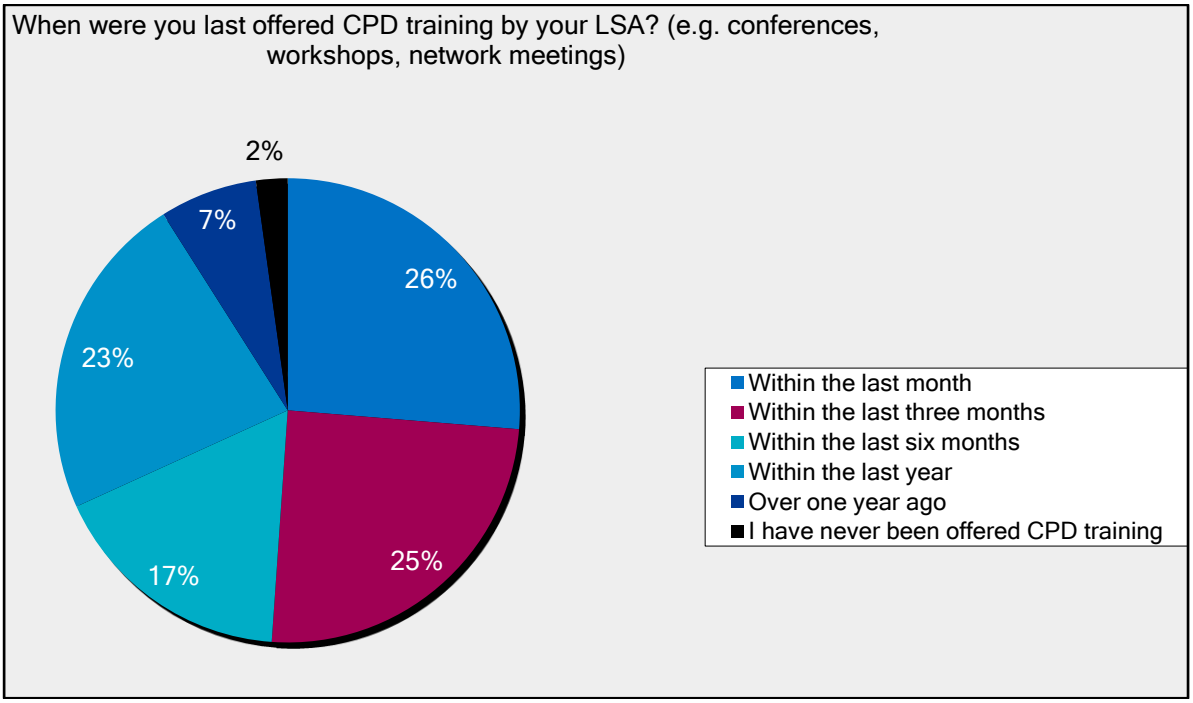
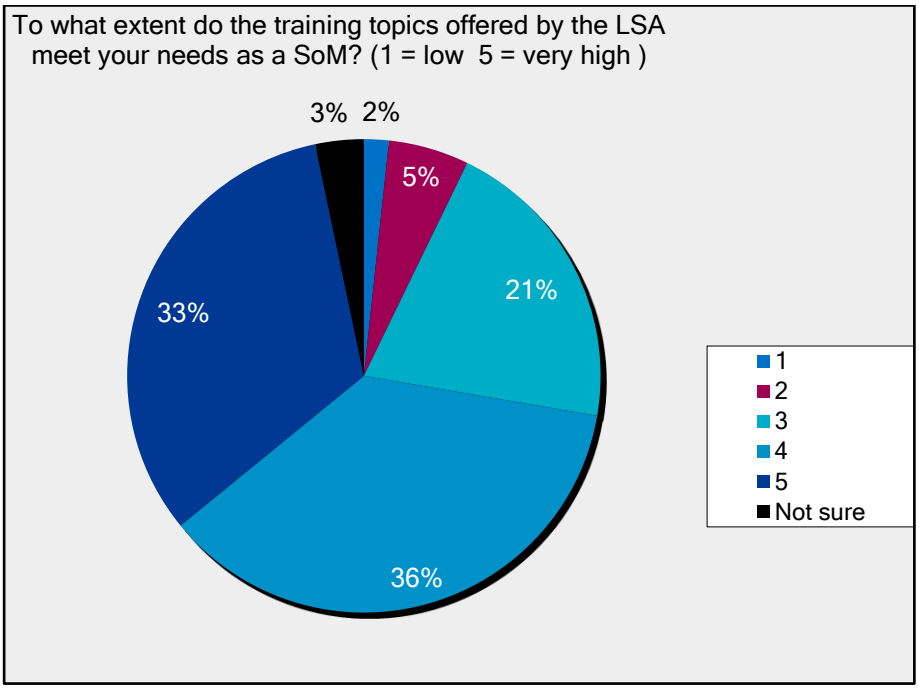
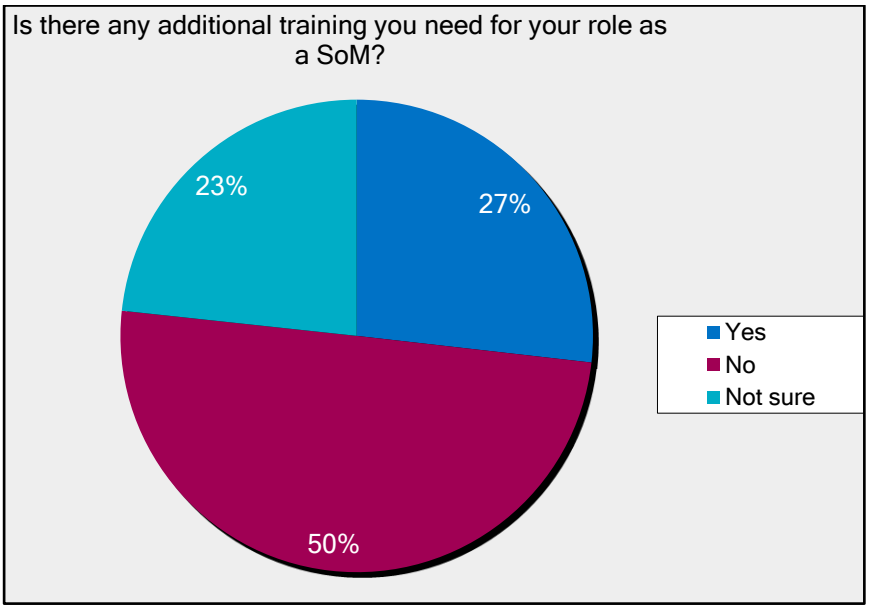


Chart 7 Training topics offered



However, 50 per cent of those who responded to the survey felt that they did or may need additional training.

Chart 8 Additional training needed

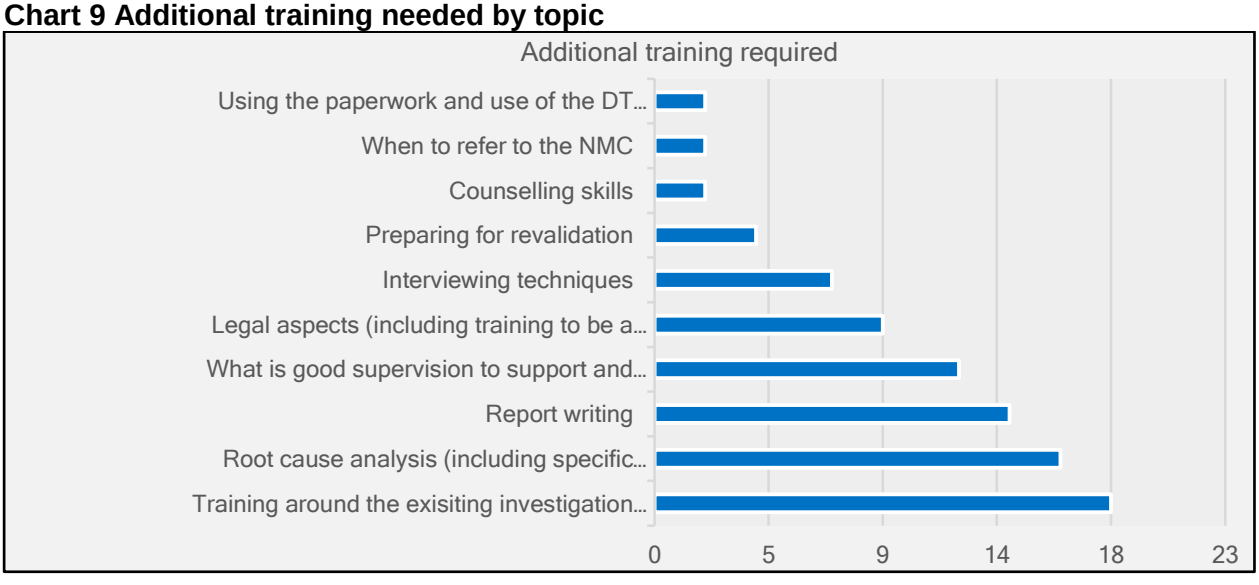


When prompted what additional training they felt they needed, 191 SoMs responded. The top ten responses can be seen in chart 9. The topic with the highest number of responses was for training around the existing investigation process and three SoMs commented that they had not received investigation training before they did their first investigation.

Sixteen SoMs said they needed training in root cause analysis. This was identified through the case file review part of the audit and is one of the report recommendations.

Fourteen SoMs felt they needed report writing training. This is also highlighted by the comments provided by the SoMs in later parts of the survey.

Chart 9 Additional training needed by topic

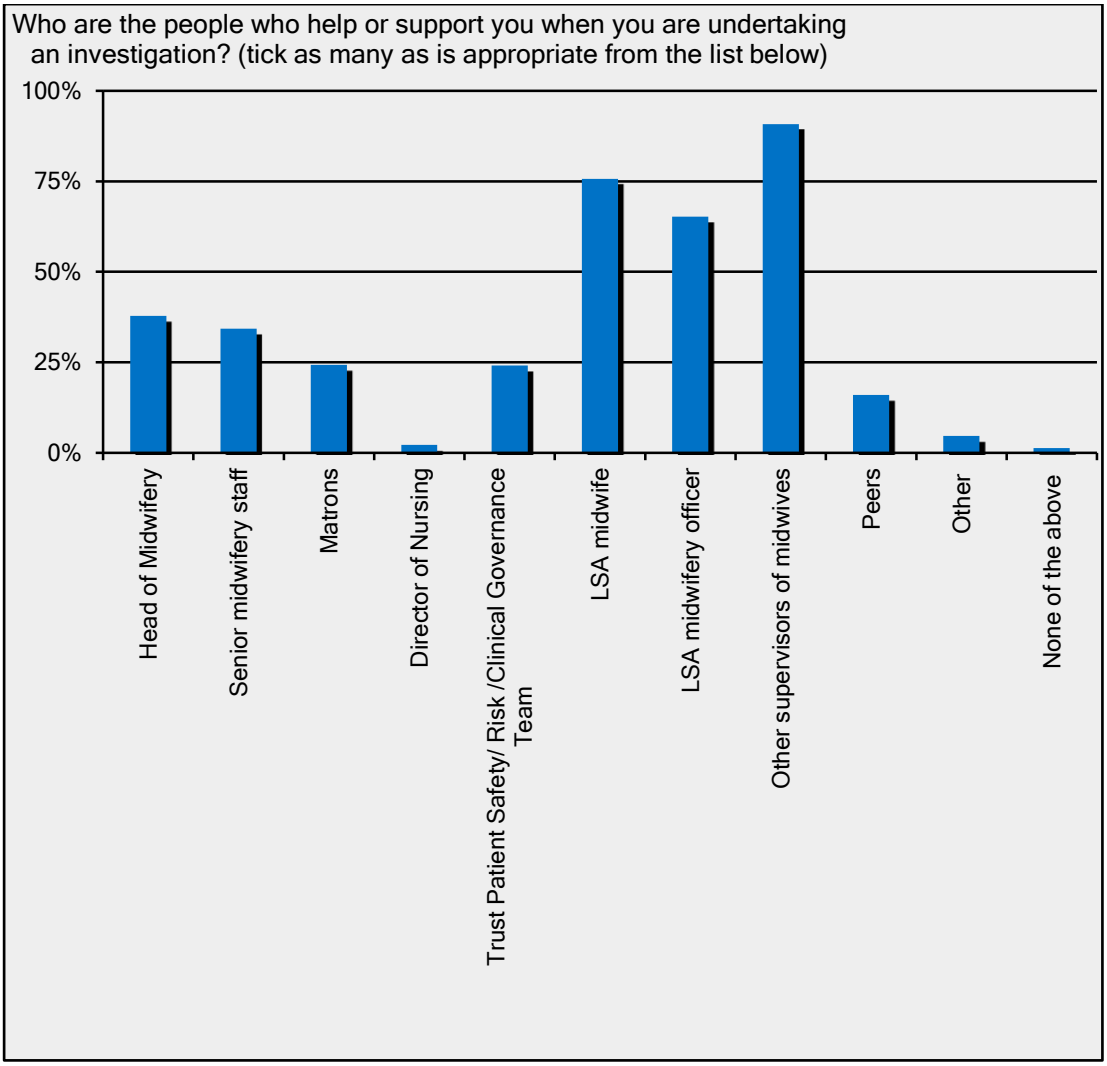


When asked who were the people who supported them when they were undertaking an investigation (and they could tick as many as they wanted from a drop down list), 546 (91 per cent) of SoMs ticked “other SoMs.”

However, it is also clear that the support they receive from the LSA is also important; over 75 per cent ticked that the LSA midwife supported them and over 65 per cent ticked that the LSAMO supported them. When asked for comments in this section of the survey, 153 (15 per cent) of SoMs specifically mentioned LSA team support and a further 15 per cent mentioned the templates and paperwork (supplied by the LSAs).

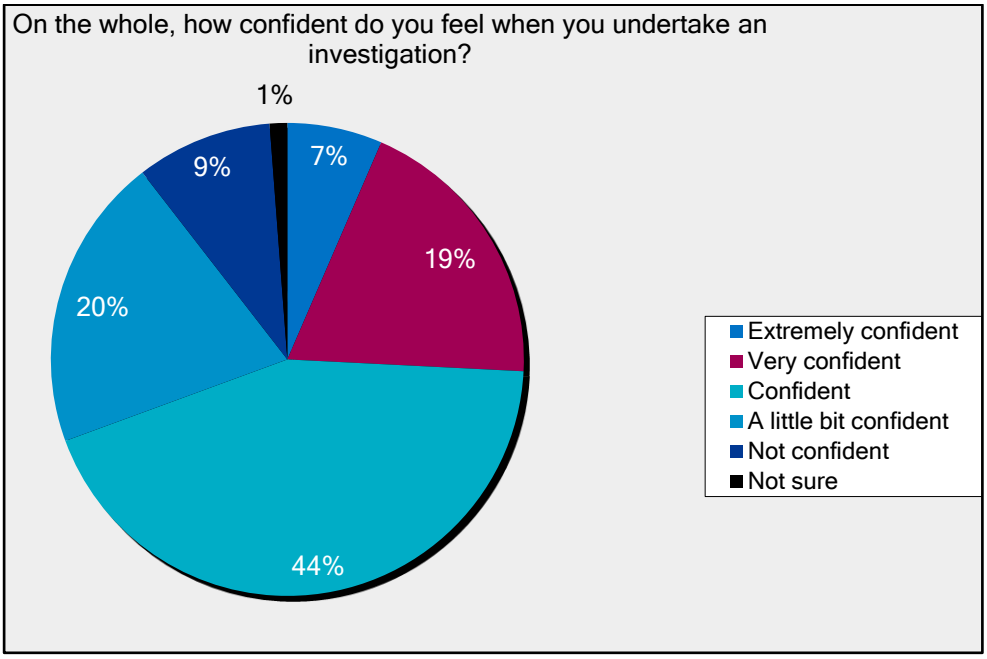
This supports the audit findings from the fieldwork element of the audit; that the importance of the role of the LSA in supporting SoMs is highly regarded.

Chart 10 Support for SoMs when undertaking investigations



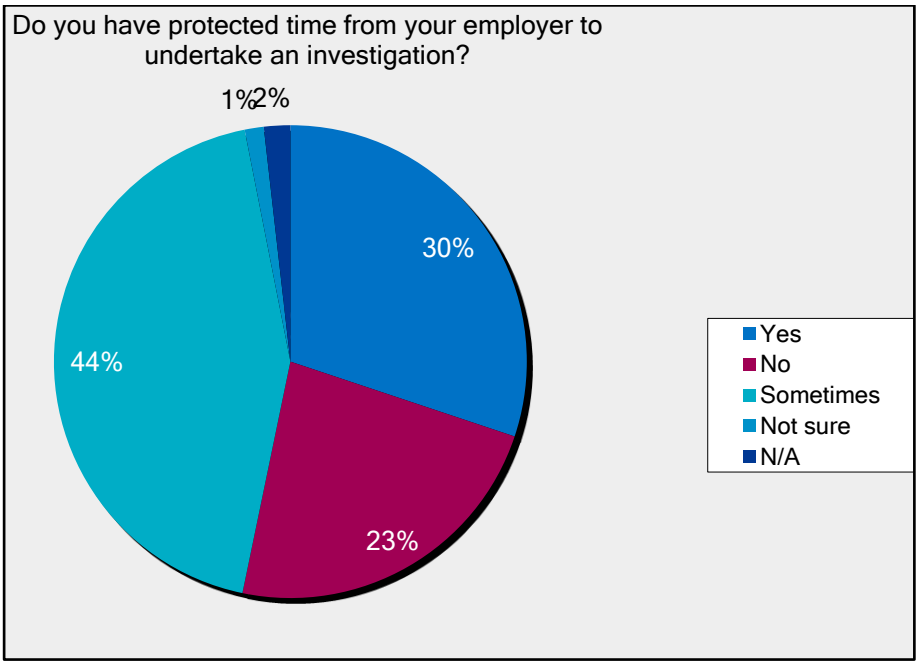
Seventy percent of SoMs said they were confident when undertaking an investigation. The percentage of those that felt less confident varies slightly between LSA and this will be fed back to the LSAs in their own individualised survey reports.

Chart 11 Confidence in undertaking investigations



The survey results presented a mixed picture in terms of whether the SoMs had protected time from the trusts to undertake investigations.

Chart 12 Protected time for investigations



Charts 13 and 14, consider whether SoMs have been required to interview or take statements from non-midwifery staff as part of the investigations they have undertaken and, if so, whether this is a straightforward process. This question was included as discussions from LSAMOs suggested that this could be difficult as the

SoMs had no jurisdiction to insist on involvement from doctors for example, which could impact on the investigation.

The charts show that fewer than half of the SoMs who responded to the survey had been required to do this but that over half of those who had experienced difficulties in doing so.
When asked why this was difficult, the top four responses were:

- Difficulties co-ordinating shifts/ leave/ sickness (15 SoMs)
- Medical staff can be obstructive and close ranks (14 SoMs)
- Lack of access to other professionals for various reasons (rotation, agency staff, ambulance crew, left trust, university student (13 SoMs)
- People do not understand the role of the SoM or the investigation and therefore do not respond quickly (10 SoMs)

Chart 13 Interviewing non-midwifery staff

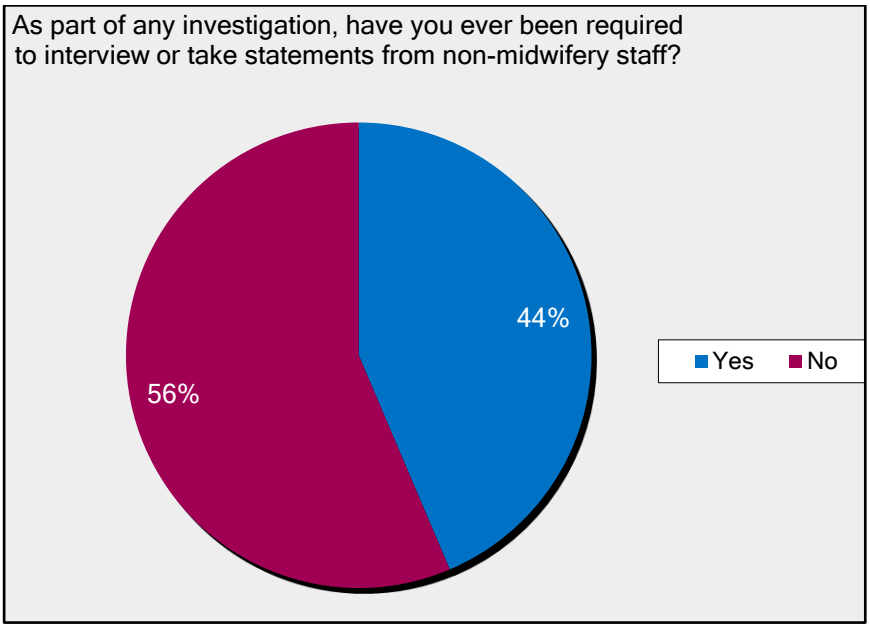
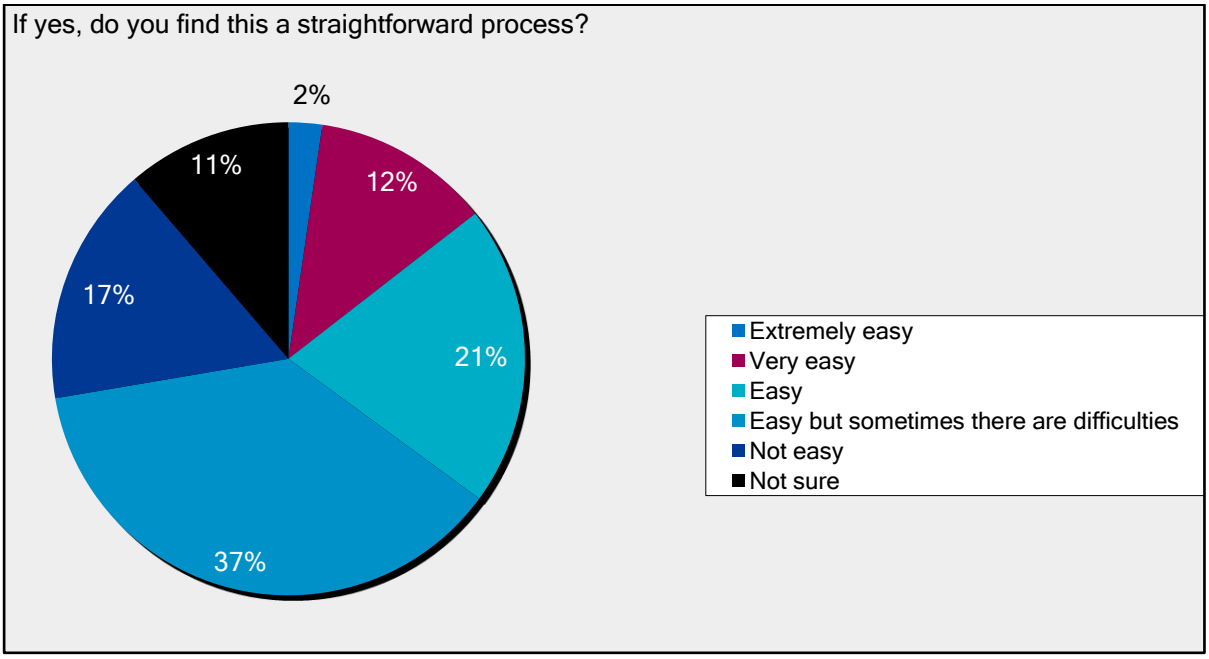
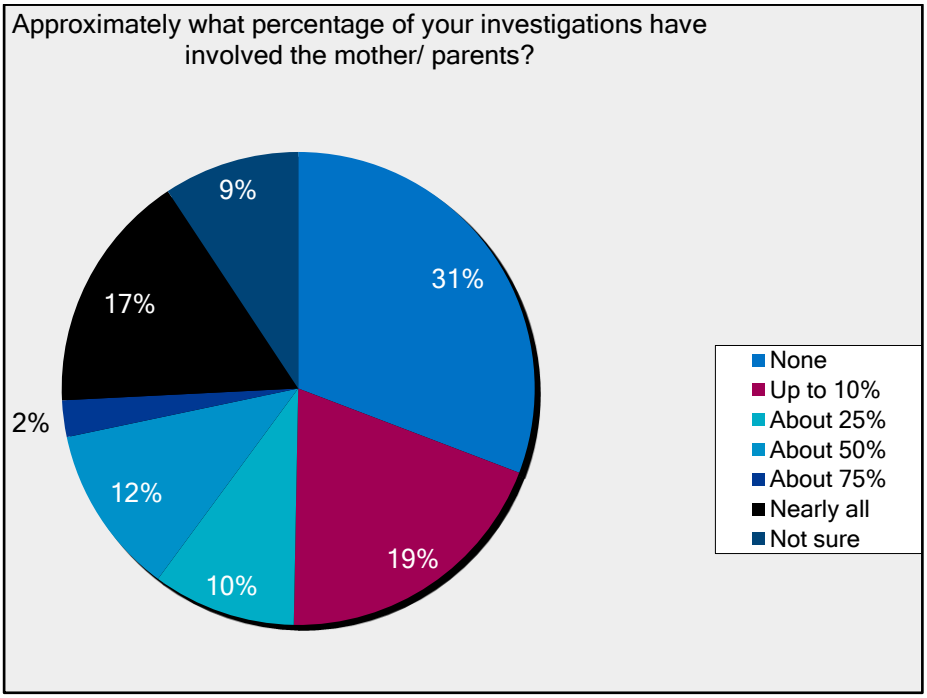


Chart 14 Ease of interviewing non-midwifery staff



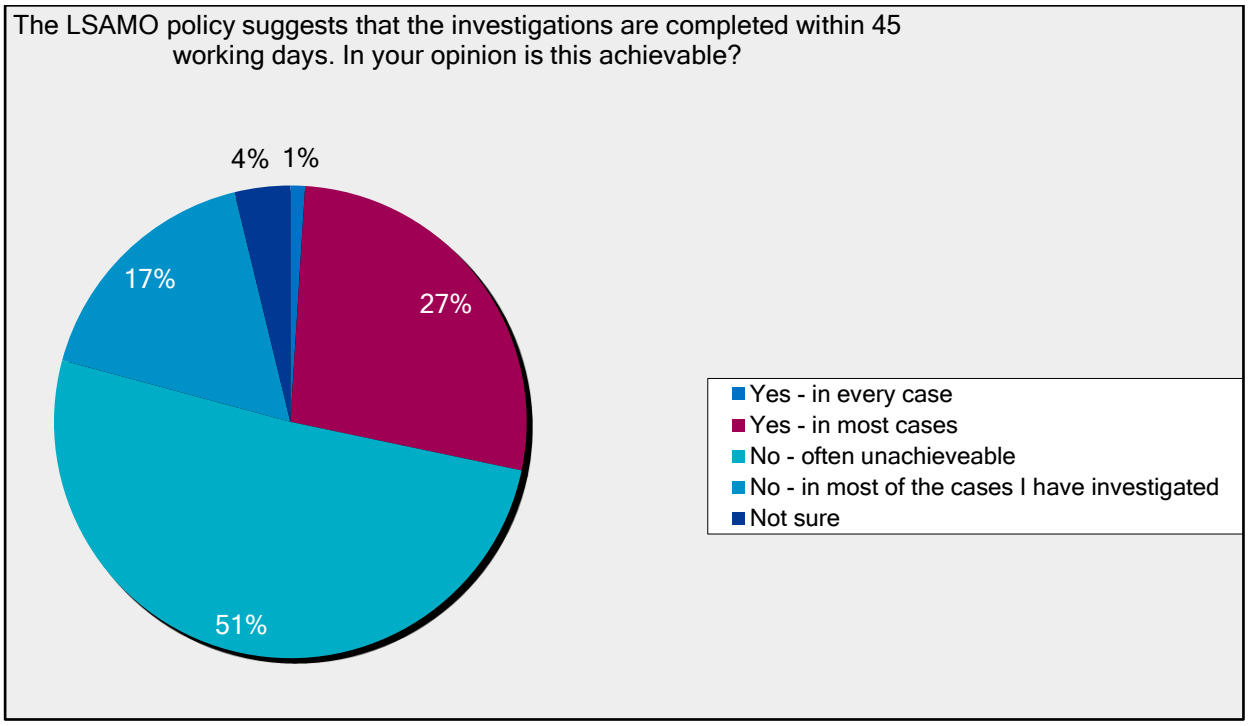
Around a third of SoMs said that none of their investigations had involved the mother or parents (see chart 15). Some of these may have been non-applicable so this does not necessarily mean that this was overlooked. However, only 17 per cent said that nearly all of their investigations had involved the mother or parents. These figures support the findings of the case file audit. When commenting on a different survey question, it was noted that 13 SoMs said it was stressful interviewing families.

Chart 15 Involving mothers/parents



Charts 16 and 17 consider the length of time it takes SoMs to produce an investigation report. The guidance suggests that each report is completed within 45 days. The field work part of the audit already highlighted that this was difficult. These charts support that finding. Only 27 per cent felt this was achievable and 68 per cent felt it was unachievable.

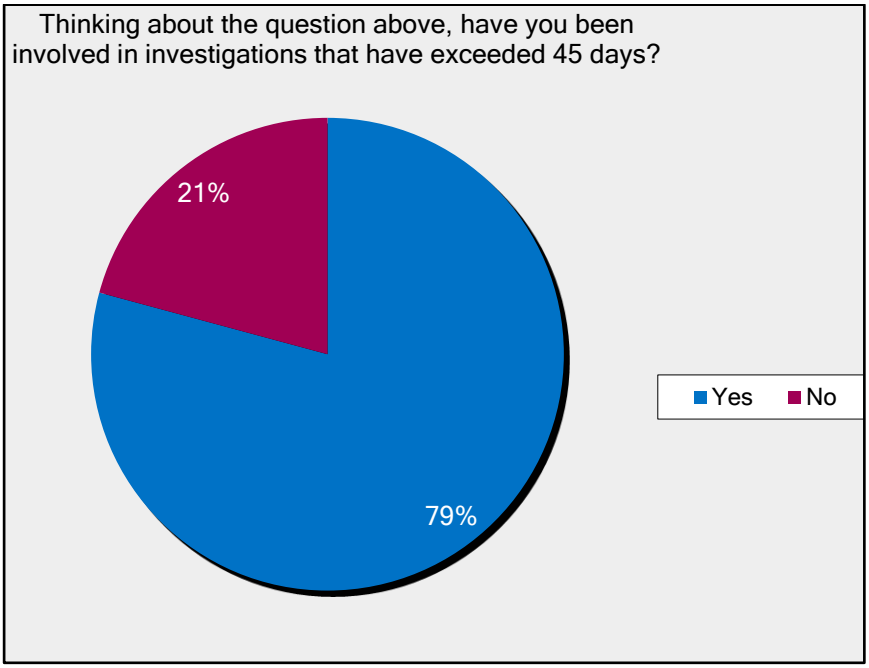
Chart 16 Achievability of completing investigation reports in 45 days



Seventy-nine percent of SoMs had been involved in investigations that exceeded 45 days. When prompted for reasons for delays, the top three were:

- No protected time (cited by 235 SoMs);
- Midwife or SoM sickness (cited by 217 SoMs); and
- Midwife or SoM annual leave (cited by 176 SoMs).

Chart 17 Number of investigation reports exceeding 45 days



Finally, the SoMs were asked for their views on the following:

Is there anything that would make undertaking midwifery investigations a smoother process?

All 601 SoMs responded and the top three suggestions were:

- More time/protected time to do the investigations (cited by 110 SoMs);
- More timely turnaround/less perceived pedantry from the LSA (cited by 30 SoMs);
- More or some administrative support (cited by 29 SoMs).

Other suggestions made by more than 1 SoM were:

- Do external investigations (12 SoMs)
- Better support for SoMs doing first few investigations/ have a buddy (10 SoMs). *NB some LSAs already do this.*
- Have a dedicated investigating SoM or team of SoMs (8 SoMs)
- Do joint investigations with the trust SI investigation where possible (7 SoMs)
- LSA investigations should be stopped – they add no value (7 SoMs)
- Dedicated room or venue to carry out interviews (4 SoMs)
- Change the decision tool (2 SoMs).

Please suggest up to three things that work well in the current investigation process (or put 'nothing')

There were 990 suggestions in response to this question. Two were mentioned by more than others:

- LSA team support (cited by 153 SoMs); and
- Templates and paperwork (cited by 147 SoMs).

Other suggestions made by more than three SoMs were:

- The Decision Making Tool (45 SoMs)
- Guidance (43 SoMs)
- Support from other SoMs (37 SoMs)
- Having a buddy (25 SoMs)
- Having a clear process (11 SoMs)
- Support from other midwives (10 SoMs)
- External investigations (6 SoMs)
- Workshops and LSA training (5 SoMs)
- Flow chart (5 SoMs)
- The chronology in the report template (5 SoMs)
- Support from the HoM (4 SoMs)
- Close working with the trust patient safety/ governance teams (4 SoMs)

Please suggest up to three things that could be put in place to improve any future investigation process (or put 'nothing')

There were 795 suggestions in response to this question. The top three were:

- Give protected time (cited by 99 SoMs)
- Increase the 45-day limit (cited by 59 SoMs)
- Reduce/ simplify paperwork (cited by 46 SoMs)

Other frequently mentioned suggestions were:

- External investigations (29 SoMs)
- More admin support (29 SoMs)
- Timely turnaround from LSA (21 SoMs)
- Work more closely with the Trust staff (17 SoMs)
- More training (15 SoMs)
- Work in SoM pairs (14 SoMs)
- More support from the LSA (13 SoMs)
- Have dedicated investigator SoMs (8 SoMs)
- More support from HoM/ Dept/ Trust (8 SoMs)
- Better IT (6 SoMs)
- Reduce travel time in external investigations (4 SoMs)
- Involve the families more (3 SoMs)
- Maintain the LSA database (2 SoMs)

- Access to midwives when off sick (2 SoMs)
- Keep the 45-day deadline (2 SoMs)

Do you have any other comments, questions, or concerns?

Most respondents left this blank or wrote “no.” However, there were 160 responses. The top four were:

- Concerned that future investigations will be about blame and not support (cited by 21 SoMs)
- Concerned about what will come next (cited by 16 SoMs)
- I don't like doing investigations (cited by 11 SoMs)
- Investigations should stop (cited by 11 SoMs)

These show a mixed picture about how SoMs are anticipating the future. Some are concerned and others welcome the change. This was echoed by the other more frequently mentioned comments:

- Not enough time to complete investigations properly (8 SoMs)
- Positive comments about the support from the LSA and three who specifically mentioned the North West LSA midwife (7 SoMs)
- Negative comments about the LSA (micro-management, time delays to turn reports around) (5 SoMs)
- Investigations are a duplication of the Trust processes (5 SoMs)
- New system could increase NMC referrals (4 SoMs)
- SoM role not valued by the Trust (2 SoMs)
- Receives good support from the Trust (2 SoMs).

2. Recommendations and next steps

2.1. Recommendations

The recommendations are in two sections:

1. First, for the current process; and
2. Second, for the new model of supervision.

The audit has identified the following recommendations to inform the current supervisory model prior to the law change:

- Ensure that SoMs and other staff involved in undertaking investigations complete SI investigation training. This should include root cause analysis training and receive continuing professional development to support them in strengthening their skills in this area;

- Develop a training package for managing the involvement of the woman and the family in investigations. This should include:
  - managing difficult conversations
  - taking accurate accounts of events
  - listening skills
  - the importance of documenting evidence
  - ensuring closure at the end of the investigation by informing families of the outcomes and documenting that this has happened;

- Ensure that appropriate time is allocated for the completion of investigations (within 60 days). This would be in line with trusts' serious incident investigation processes;

- Provide support to the LSA sub-regions to work with employing trusts to provide protected time for SoMs undertaking current investigations;

- Ensure the LSA sub-regions provide training for SoMs on the importance of maintaining an evidence base for every investigation, even after the investigation has been closed. Keeping all documentary evidence on file in one place will strengthen the overall governance of the investigation and provide better evidence for audit purposes;

- Work with NHS Improvement to encourage employing trusts to develop a system of learning audits regarding what has changed as a result of findings from complaint and incident investigations. These outcomes would provide more granular evidence of trusts learning from their mistakes.

The audit has identified the following recommendations to take forward into the new model:

- Assess regularly the content of the preparation course for the new midwifery supervisor, to ensure that the skills and competencies required to deploy the new model of supervision remain contemporary and fit for purpose;
- Work with Health Education England and Higher Education Institutions to ensure ongoing professional development is considered by the employing organisation when the new model is implemented. This should be in addition to the initial preparation programme.

2.2. Next steps

Although this is an audit of a process that is due to end, this report is aimed to be forward looking and to enable reflection about the current process into action for the future.

Therefore, it is envisaged that the findings and recommendations of this audit report can influence the development of the new model of supervision. It is expected that this report is shared with the National Supervision Taskforce for discussion of the recommendations.

The report will be published on the NHSE website.

3. Appendices

3.1. Appendix 1 – Additional recommendations following discussion with Miss Davies and Mr. Stanton

Recommendations

NHS England

- An independent case note review should be undertaken of supervisory investigations identified from a sample of cases that were subject to the audit

LSA

- Local Supervising Midwifery Officers must demonstrate that there is no conflict of interest prior to the designated SoM undertaking the supervisory investigation

The LSA and NHS Providers

- Providers must ensure that where appropriate, there must be evidence that changes have been made as a result of learning from incidents and this should be shared with the affected family
- In the absence of statutory supervision maternity providers must demonstrate that there is no conflict of interest when staff are selected to lead incident investigations
- Supervisors of midwives and in the absence of statutory supervision, maternity providers should ensure that affected families are involved in the investigation process. This should be evidenced in the investigation report
- When undertaking an investigation, SoMs and in the absence of supervision, maternity providers should ensure that documentary evidence of actions, conversations and all items that relate to investigations are recorded
- SoMs and in the absence of supervision, maternity providers should ensure that investigation findings are recorded and integral to the organisations incident governance processes

Recommendation for the NMC, NHS Improvement, CQC and NHSLA

- Organisations with regulatory responsibilities must ensure that learning from incidents should be shared nationally where there is national applicability.

3.2. Appendix 2 – Terms of reference

Terms of reference

Local Supervising Authorities (England) National Audit

Document filename: Terms of reference			
Directorate / programme	Nursing	**Project**	LSA National Audit
Document reference			
Project manager	Charlotte Bourke	**Status**	Live
Owner	Jacqueline Dunkley-Bent	**Version**	1.0
Author	Charlotte Bourke	**Version issue date**	26/04/2016

Document management

Revision history

Version	Date	Summary of changes
0.1	14.03.2016	First draft for discussion
0.2	21.03.2016	Revisions to draft v0.1, circulated for comments
0.3	04.04.2016	Revisions to draft v0.2 accepted and circulated for wider comments
0.4	08.04.2016	Final revisions following feedback to finalise prior to wider circulation

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title/responsibility	Date	Version
Jacqueline Dunkley-Bent	Head of Maternity, NHS England	31.03.2016	0.2
Frances Healey	Head of Patient Safety Insight NHS Improvement	07.04.2016	0.3
Alaina MacDonald	Comms Team NHS England	07.04.2016	0.3

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Jacqueline Dunkley-Bent		Head of Maternity, NHS England	10. 04 .2016	0.3
Hilary Garratt		Deputy CNO & Director of Nursing, NHS England	11. 04. 2016	0.3

Related documents

Title	Owner	Location

Document control

The controlled copy of this document is maintained by NHS England. Any copies of this document held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

Introduction

This document sets out details of the Local Supervising Authority (England) independent national audit of supervisory investigations.

A national audit of LSA supervisory investigations will be deployed within the four regions of NHS England.

This is as a result of a response to a complaint submitted to NHS England LSA, which made the following recommendation:

that an audit should be undertaken to provide assurance to LSA England that:
the weaknesses in the LSA Investigatory Processes c2009 identified in the investigation into the complaint report (Graham 2015) are no longer inherent in the current process.

Whilst the audit has been commissioned specifically to deliver this recommendation, there are opportunities for wider learning and continued improvement to processes that will be maximised through this audit process.

Background

A pilot audit was undertaken in the Midlands and East Region (ME) that measured compliance of supervisory investigations against the standards outlined in the LSA Review and Investigation Processes Policy (2013). This pilot audit methodology and findings will inform the methodology of the national audit to include the pilot site (ME).

Audit Objective
Undertake a national audit of LSA supervisory investigations within the four regions of NHS England, measuring compliance of supervisory investigations with the standard outlined in the Local Supervising Authority Review and Investigation Processes (LSA 2013)
Complete and submit an audit report in keeping with the contract agreement

Scope

A random sample of Midwifery Supervisory Investigations carried out, from the 20th November 2013 – 31st December 2015 should be audited against the standards outlined in the Local Supervising Authority Review and Investigation Processes (LSA 2013) that was published on 20th November 2013.

The pilot audit instrument will be reviewed against the pilot audit findings and adapted to ensure that the objectives of the national audit can be achieved.
Access to LSA investigations and associated instruments will be facilitated by regional LSAMO's

Accountability

This project will be accountable to the Chief Nursing Officer, as the professional lead for Midwifery in England.

Roles and responsibilities

Project Sponsor

Professor Jacqueline Dunkley-Bent (Head of Maternity, NHS England) is the Project sponsor and is responsible for providing professional leadership and guidance for the project.
The project sponsor will approve the final audit report prior to submission to the National Maternity Programme Board.

Programme Management

Charlotte Bourke (Programme Manager, NHS England) is responsible for managing the PMO function, ensuring that project support and admin is delivered to the audit team.
In addition the Programme manager will ensure the audit team have access to the regional teams as required to obtain data and undertake the audit.
Secretariat support will be provided by the Programme Manager and the secretariat team.

Audit Team

The audit team will be responsible for undertaking the audit and meeting the objectives outlined at item 1.1 in line with the contract agreement.

Name	Organisation	Role
Tracey Sparkes	Independent Contractor	Auditor
Deidre Dwyer	Independent Contractor	Auditor

Working arrangements

The audit team will be peripatetic, utilising pre-arranged work spaces.
Telephone meetings will be held with the audit team, the Programme Manager and the Head of Maternity on a fortnightly basis, with more frequent contact as required.
Formal updates will be required on a monthly basis and will be submitted to NHS England to provide assurance around progress of the national audit.

Audit Process

The audit team will review and utilise learning from the Midlands and East (ME) regional pilot audit to help shape the methodology for the wider national audit of LSA supervisory investigations conducted since 2013.

In keeping with the duty of candour any incidental findings identified during the audit process will be reported through the appropriate escalation and governance processes.

Phase 1 – Design

Review ME pilot audit – methodology & findings
Consider qualitative contributions about the LSA supervisory investigations from supervisors/midwives/service users and how these will contribute to meeting the objectives of the audit
Design national audit methodology Socialise proposed methodology with SRO & key stakeholders
NHS England National Maternity Programme or equivalent Board to agree proposed methodology

Phase 2 – Undertaking the audit

Carry out the audit in the four regions of NHS England
North
South
London
Midlands and East
Support will be provided by the Project Sponsor and the Programme Manager to ensure regional teams are ready to support the national audit effectively and efficiently.

Phase 3 - Report

Produce draft report for comment
Production of final report based on feedback
Final report approved by project sponsor
Progress through NHS England internal governance process
Progress NHS England Gateway process to seek approval to publish report & findings.

Timetable for audit

Phase	Task		Complete by:
Phase One	Contracting process with audit team	Ongoing user engagement – at key intervals (to be agreed)	April 2016
	Review ME pilot audit – methodology and findings		April 2016
	Design of national audit – sample size, selection criteria, methodology		April/May 2016
Phase Two	Undertake national audit as agreed		May 2016
Phase Three	Draft report submitted for comments		June 2016
	Final report submitted for approval		July 2016
	Publication of final approved report		Sept 2016

3.3. Appendix 3 - The checklist template

Audit question: Do the Midwifery Supervisory Investigations that take place in England comply with the Local Supervising Authority Review and Investigation Processes Policy 2013?

	Question	Yes	No	Comment	Reference/ evidence source
Prior to the investigation – the decision tool					
1	Is there evidence that an agreed decision making tool was used or considered to assess whether the investigation was required?				
2	Does it clearly set out what action was taken?				
3	As part of the decision-making process, have standards of midwifery care been reviewed and benchmarked against current NMC standards?				
4	Is there evidence that this completed document was shared with the LSA?				
The investigation					
5	Is there evidence that a conflict of interest on the part of the investigating midwife has been considered?				
6	Is there evidence that the employing trust has been informed of the investigation?				
7	Is there evidence of a clear chronology of key events in the investigation notes, regardless of which aspect of care the complaint/incident relates to?				
8	Is it clear that critical factors and their root causes have been established with a detailed timeline?				

9	Is there evidence that the midwife involved has been informed in writing and has had an opportunity to participate in the investigation in line with guidance?				
10	Is it clear that the investigator has considered obtaining an account of the woman and her family's experience?				
11	Has the woman and her family's account been obtained in accordance with guidance? (ref: appendix 1)				
12	Have factual accounts from other staff been considered as part of the review? (ref: appendix 2)				
13	Is there evidence that interviewees have been made aware of the purpose of the interview and the process both during and after?				
14	Is there evidence that interviewees have seen the transcript of their interviews? (re: appendix 3)				
Concluding the investigation					
15	Is a concluding report written within 30 days of the start of the investigation?				
16	If not, is there evidence that the LSA has been informed of a delay and the reasons why?				
17	Has the report and associated recommendations been signed off and agreed by the LSAMO?				
18	Is there evidence that the midwife has been informed of the outcome and the process for appeals?				

19	Do the investigation records show that recommendations/outcomes are available, noting the commencement and conclusion of any supervisory plan?				
20	Do the investigation records show that a summary letter/report been sent to the HoM and DoN, which includes the service and organisational contributing factors and recommended changes?				
21	Where appropriate, is there evidence that the parent/ mother has been informed of the outcome?				
22	Is there evidence of a meeting between the investigating SoM, Midwife and Named SoM to agree the learning objectives/outcomes (Local action plan or LSA Practice Programme?				

3.4. Appendix 4 – SoM survey

Supervisors of Midwives Questionnaire June 2016

Introduction

This survey is part of the national audit of compliance with supervisory investigations process in England. As part of this audit, we are keen to understand the views of Supervisors of Midwives about what happens currently; what you think works well and where there are gaps. The survey findings will form part of the overall audit conclusions and contribute to a final report and recommendations, helping to shape the new investigatory model.

The survey is anonymous - with no identifying information other than your LSA region. It should take 5 - 10 minutes to complete and has to be completed in one sitting. There are no right or wrong answers - this is about your views. All of the questions are mandatory and the survey will not close until they have all been answered. Please note that once you have clicked 'Done' at the end of the survey you will not be able to return to it.

We would be grateful if you could complete the survey by 1st July 2016.

If you have any questions, or would like to speak to us in addition to completing the survey, please contact us in one of the following ways:

Deirdre Dwyer - ddwyer@nhs.net or 07710428945
Tracey Sparkes - tracey.sparkes1@nhs.net or 07932042703

* 1. Which Local Supervisory Authority supports you at the current time?

- ◯ London
- ◯ Midlands and East
- ◯ Midlands and West
- ◯ North West
- ◯ North East
- ◯ South East
- ◯ South West

* 2. Which NHSE Region is your Local Supervisory Authority currently in?

- ◯ North
- ◯ South
- ◯ Midlands and East
- ◯ London

* 3. How long have you been a Supervisor of Midwives (SoM)?

- ◯ More than five years?
- ◯ Three to five years
- ◯ One to three years
- ◯ Less than one year?

* 4. Overall, how many investigations have you led?

- ◯ 1-5
- ◯ 5-10
- ◯ 10-15
- ◯ 15 +
- ◯ Not sure

* 5. Overall, how many investigations have you been involved in, where you were not the lead but made a contribution (e.g. as named SoM, as witness)?

- ◯ 1-5
- ◯ 5-10
- ◯ 10-15
- ◯ 15+
- ◯ Not sure

* 6. Have you had training to be a Supervisor of Midwives?

◯ Yes ◯ No ◯ In process of being trained

* 7. When were you last offered CPD training by your LSA?
(e.g. conferences, workshops, network meetings)

- ◯ Within the last month
- ◯ Within the last three months
- ◯ Within the last six months
- ◯ Within the last year
- ◯ Over one year ago
- ◯ I have never been offered CPD training

* 8. To what extent do the training topics offered by the LSA meet your needs as a SoM?
(1 = low 5 = very high)

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ Not sure

* 9. Is there any additional training you need for your role as a SoM?

Yes No Not sure

If your answer is Yes please list the topics that would be useful in the comments box below.

* 10. Who are the people who help or support you when you are undertaking an investigation? (tick as many as is appropriate from the list below)

- Head of Midwifery
- Senior midwifery staff
- Matrons
- Director of Nursing
- Trust Patient Safety/ Risk /Clinical Governance Team
- LSA midwife
- LSA midwifery officer
- Other supervisors of midwives
- Peers
- Other (please expand on your answer below)
- None of the above (please expand on your answer below)

Other or None of the above (please specify)

* 11. On the whole, how confident do you feel when you undertake an investigation?

- Extremely confident
- Very confident
- Confident
- A little bit confident
- Not confident
- Not sure

* 12. Do you have protected time from your employer to undertake an investigation?

Yes No Sometimes Not sure N/A

* 13. As part of any investigation, have you ever been required to interview or take statements from non-midwifery staff?

Yes No

14. If yes, do you find this a straightforward process?

- ◯ Extremely easy
- ◯ Very easy
- ◯ Easy
- ◯ Easy but sometimes there are difficulties
- ◯ Not easy
- ◯ Not sure

If you have indicated it is difficult or not easy please explain your reasons below

* 15. In your opinion, is there anything that would make undertaking midwifery investigations a smoother process?

* 16. Approximately what percentage of your investigations have involved the mother/ parents ?

- ◯ None
- ◯ Up to 10%
- ◯ About 25%
- ◯ About 50%
- ◯ About 75%
- ◯ Nearly all
- ◯ Not sure

* 17. The LSAMO policy suggests that the investigations are completed within 45 working days. In your opinion is this achievable?

- ◯ Yes - in every case
- ◯ Yes - in most cases
- ◯ No - often unachievable
- ◯ No - in most of the cases I have investigated
- ◯ Not sure

* 18. Thinking about the question above, have you been involved in investigations that have exceeded 45 days?

- ◯ Yes
- ◯ No

19. If yes, what were the reasons for the delay?

1
2
3
4
5

* 20. Please suggest up to three things that work well in the current investigation process (or put 'nothing')

1
2
3

* 21. Please suggest up to three things that could be put in place to improve any future investigation process (or put 'nothing')

1
2
3

22. Do you have any other comments, questions, or concerns?

Thank you for time in completing this questionnaire.

If you have anything to add but it would take too long to write in the comments box above, please feel free to contact us on the numbers and email address detailed at the beginning of the questionnaire.

4. References

The following references and their location were correct at time of publication.

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4. Local Supervising Authority Midwifery Officer (LSAMO) Forum (UK) policy and guidance 2013 - http://www.lsamoforumuk.scot.nhs.uk/policies-guidelines.aspx
5. The Nursing and Midwifery Order (2001)- http://www.legislation.gov.uk/uksi/2002/253/contents/made
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10. NMC; 2014; Standards for the preparation of supervisors of midwives