Report on the Nursing and Midwifery Council's extraordinary visit to the maternity services at Northwest London Hospitals NHS Trust

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The Nursing and Midwifery Council

The Nursing and Midwifery Council (NMC) is the statutory body for Nursing, Midwifery and Specialist Community Public Health Nursing. The main function of the NMC is to protect the public by setting standards of education, training, conduct and performance for Nurses and Midwives and to ensure the maintenance of those standards in the interests of public protection.

In discharging these duties, the NMC quality assurance framework sets and monitors standards for the delivery of programmes in both education and practice, which lead to an entry on the professional register.

In addition, the NMC has responsibility for setting and monitoring the standards of Statutory Supervision of Midwives. As part of this, any concerns that may impact upon public protection or upon the suitability of any clinical environment as a safe and supportive place for the provision of care or as an appropriate learning environment should be made known to the NMC as part of the annual reporting mechanism.

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

This report sets out the circumstances under which an extraordinary visit was made by a review team of the Nursing and Midwifery Council. The intention of the review was to investigate the suitability of education and clinical placements in the maternity services of Northwick Park Hospital (NWPH), which is part of the North West London Hospitals NHS Trust (the Trust). This visit was as a result of the concerns and conclusions of the Health Care Commission (HCC) investigation into the maternity services at the Trust and the instigation of special measures at the Trust by the Secretary of State for Health.

The main focus of the visit was to gather information and evidence in relation to the current management and provision of pre-registration midwifery education and training within the maternity services of the Trust. The NMC had no pre-determined

[1] SI 2002 N0 253 The Nursing and Midwifery Order 2001

position on this before the visit took place. The visit took account of the validated curriculum, the education programmes available within the unit, the numbers of student midwives and student nurses within the maternity services as well as the levels and standards of mentorship and student support. The review team considered the systems within the Trust rather than the practice of individuals or individual cases that triggered the HCC investigation.

The impact of the current clinical environment and the circumstances identified in the Healthcare Commission's (HCC) report were also key factors in ascertaining the continued use of the maternity services at NWPH as a suitable environment to support high quality pre-registration midwifery and nursing education.

Introduction

The NMC was first alerted to concerns in relation to public protection within the maternity services provided by the Trust, on the 21st April 2005. This was as a result of a HCC press release regarding the decision by the Secretary of State for Health to put special measures in place at NWPH maternity services. A HCC investigation into maternal deaths within the unit had commenced in July 2004. A subsequent unannounced visit by the HCC on the 11th April 2005 revealed that there continued to be serious problems in the maternity services and that only some of the recommendations for remedial action had been carried out by the Trust.

The instigation of special measures raised concern at the NMC about the suitability of the learning environment in the Trust's maternity services for student midwives and student nurses. Correspondence took place between the NMC, the Trust and the education provider, Thames Valley University (TVU). TVU is the approved institution for the provision of pre-registration midwifery and nursing education programmes within the Trust. Discussions with the Chief Executive and the Director of Nursing and Midwifery of the Trust and the Lead Midwife for Education and the Dean of the Nursing and Midwifery school of TVU were hosted by the NMC on the 5th of May 2005. During this meeting, an invitation for the NMC to visit the maternity services was extended by Ms Mary Wells, the CEO of the Trust.

From the information provided by the Trust, TVU and the HCC[2] it was concluded that there was a need for an extraordinary visit by Council members. The purpose of the extraordinary visit was for the NMC review team to assure Council that the maternity services at NWPH remained a suitable learning environment for pre registration students.

A range of possible visit dates was given to the Trust who subsequently indicated that the 15th of July was their preferred date for an NMC extraordinary visit.

[2] Commission for Healthcare Audit and Inspection 2005. Review of maternity services provided by North West London Hospitals NHS Trust

Background

The Trust provides clinical practice placements for pre registration education programmes leading to registration as a nurse or midwife. The approved education institution managing these education programmes is TVU. In addition the maternity unit provides clinical placements for medical students.

TVU manage two types of pre registration midwifery education programmes. A 3-year programme with students qualifying at both advanced diploma and degree level and an 18-month programme leading to a degree for students who are already registered as a nurse (adult) in the UK. Both programmes are full time and both programmes have two entries per year. Further detail is available in appendix 4.

In addition, TVU provides pre registration nursing programmes and at the time of the special measures being instigated, 5 student nurses were placed within the maternity services at Northwick Park at any one time. The EU requirement is for student nurses to have exposure to 150 hours learning in the field of maternal and child health. One method of achieving this is for these students to be placed in a maternity setting, although this is becoming less common in the UK.

The Trust provides care to residents of Brent and Harrow. Although the two boroughs are different in terms of poverty and employment levels, both have large populations from a black and minority ethnic background. Brent has high rates of teenage pregnancy and above average fertility rates whilst Harrow has higher than average NHS abortion rates. The number of low birth weight births is above average in both boroughs. All of these factors have an impact on the maternity services provided by the Trust and the experience available to student midwives placed at the Trust.

Since April 2002 there have been 10 maternal deaths at the Trust. There have been a number of independent external and internal reviews of these maternal deaths prior to the first HCC investigation, which was requested by the Trust. Professor Arulkumeran from the Maternity Support Services Team has also reviewed these maternal deaths for the Trust since the introduction of special measures.

Birth rates at the Trust have increased year on year since 2003 and were at 5,028 by March 2005. This appears not to have been matched by increased midwifery establishments or recruitment. The maternity service is divided between two sites, NWPH and the Central Middlesex Hospital (CMH). CMH is run as a midwife-led birthing centre for women expected to have a normal, low risk pregnancy. There is some rotation of midwives between the two sites and a small number of student midwives gain experience at CMH. The birth centre opened in October 2004 and needs time to establish itself; birth numbers remain relatively low at this centre.

The NWPH site is undergoing significant refurbishment that adds to the difficulties that staff and students face in providing care to women. It was evident to the review team from what they saw and were told, that the refurbishment programme is impacting adversely on the environment of care for women. In spite of the impoverished working environment resulting from the refurbishment, midwives and managers maintain a high level of commitment to the Unit and demonstrated enthusiasm and confidence in being able to support student midwives to remain in practice.

The HCC report found a number of areas of concerns that are detailed in appendix 2.

The most significant of these in relation to the learning environment for student midwives and nurses are

- Insufficient capacity with too many women giving birth at the Trust with too few beds and too few staff.
- Culture of bullying and harassment and lack of cultural awareness amongst staff, which affected the quality of care.
- Record keeping was inconsistent and documentation of care planning was unsatisfactory.
- Compliance with national guidance and clinical guidelines was poor and inadequately monitored.
- The midwifery establishment was chronically understaffed with significant difficulties with recruitment and retention.
- Poor relationships between staff and an absence of effective team working.
- Attendance at mandatory training was unsatisfactory.

- The privacy and dignity of women was infringed by constraints caused by the environment of building and refurbishment work.
- Midwives did not always demonstrate that the needs of women were a priority.

Following the HCC reports the Secretary of State put special measures in place at the Northwick park site maternity services.

The Visit

The Director of Nursing and Midwifery, Sir Graham Morgan welcomed the review team to the Trust. Members of the review team are detailed in appendix 1.

Following a presentation by Dr Gail Thomas, the review team split into small groups with some members staying to interview staff and student groups whilst others took the opportunity to visit the unit itself. The visit timetable is detailed in appendix 5.

The review team would like to acknowledge and thank those members of NWPH and TVU staff who participated in and supported the visit. In particular the team would like to commend the open and helpful approach provided by the midwifery management team and in particular, Gillian Lee, Senior Midwife and acting Head of Midwifery in the absence of Collette Mannion the Director of Midwifery. The review team welcomed and appreciated the additional insights and information from Pat Wooster and Julia Savage from the special measures team, and by the whole of the supervisors of midwives team. The views and experiences of student midwives and midwife mentors were both valuable and informative and the review team fully appreciated the time and commitment of all those they met as part of this NMC review. We would also like to express our appreciation and thanks for the facilities and hospitality provided during the visit.

The review team recognised that lots of work had been done to improve the situation at NWPH since the HCC investigation and that staff and students were providing a united and positive front in very difficult circumstances.

With the exception of the antenatal ward the review team did not speak directly to women to gain their feedback although they did speak to a lay member of the maternity services liaison committee. As a result of annual leave the team were also unable to speak directly with the Director of Midwifery, the Lead Midwife for Education and the Local Supervising Authority Midwifery Officer. They were however well and ably represented by their respective deputies.

The environment of care and learning

It was evident that women, staff and students had to contend with a significant amount of upheaval due to the refurbishment of the unit, which had taken two years to date and was anticipated would be completed in April 2006. The review team were informed that this refurbishment was only a temporary measure in itself as a new building was being planned and that a dedicated project manager had recently been appointed to manage the remainder of the refurbishment project.

Although the review team found a committed workforce in whom midwives, managers, students and supervisors of midwives portrayed a positive attitude, they also identified that some parts of the building created difficulties in providing high quality care. Students and staff were very positive about the need for the building changes but said that the current clinical environment was less than ideal for care of pregnant women and their families.

Antenatal Inpatient Care

The 12 bed antenatal ward was found to provide little privacy for women and no comfortable relaxation space for them. This was the only area where review team members were able to speak directly to women. On the whole women on the ward were unresponsive although some commented that the staff were kind.

Midwife-led clinics are held in the antenatal ward. Review members observed women being assessed in a small space with an open door that staff acknowledged was a cupboard and provided no privacy. This is an inappropriate way or place to conduct antenatal assessment.

Student midwives attend the Antenatal Day Assessment Unit (ADAU) as part of their antenatal ward experience. The 2-couch unit was located outside of the antenatal ward and no women were present in the unit during the visit. Midwives manage this unit currently as the lead Consultant Obstetrician for the Unit had recently left the Trust. The Consultant's departure was reported as having a significant negative impact on interest in the unit and the effectiveness and running of the unit. A student midwife and a health care assistant were present when the team visited. Both were being taught by midwives to use the K2 package for Cardiotoco Graph (CTG)

interpretation at the time of the visit. Although the use of free time to teach students was commendable it is questionable as to why this skill would be appropriate for a health care assistant to learn as it would not be appropriate for use of CTGs to be delegated to non-clinical staff. In this instance however, the HCA was a medical student undertaking paid employment within the Trust.

The file of unit policies and practice guidelines available on the antenatal ward was out of date. The review team was advised not to look at them as the evidence-based guidelines were available on the labour ward.

The review team concluded that the antenatal inpatient areas in particular were unacceptable as a practice-learning environment because the environment was not conducive to students learning the importance of confidentiality.

Birth areas

The delivery suite has an integrated low and high-risk environment and midwives were reported to take the lead role in the High Dependency Unit (HDU) and recovery suite. Registered nurses (RN) are being recruited to work in the HDU and recovery areas and RNs are employed as scrub nurses in theatre for the elective lists. The working relationships between nurses and midwives were being kept under review as there have been past difficulties in interprofessional working.

A file of updated policies and guidelines were seen in one of the rooms albeit in some disarray. Whilst these guidelines represented best practice, it became evident that the policies and guidelines are not always implemented in practice. For example, when asked about the use of evidence based practice one final year student midwife responded affirmatively then gave the conflicting example that admission CTG's were routinely done on 'low-risk' women by a majority of midwives. This was confirmed by other sources during the visit but was not seen as a universal approach with only some of the midwives being resistant to a change in practice.

Staff reported that they felt that student midwives who had been placed at NWPH would be able to work anywhere because of their experience with a particularly diverse and high-risk community. It was difficult for the review team to ascertain any

reasonable balance between normality and the management of high-risk care within the birth areas.

It appeared to the review team that the focus in Northwick Park was on identifying and dealing with obstetric emergency, and this had at times obscured the normality of pregnancy and birth for the majority of women. This may be an understandable result of staff reaction to the HCC investigation and report. However, this shift in focus reduces the students' opportunities to learn the core midwifery skill of facilitating and supporting normal birth. The review team are concerned that this may impact adversely upon the 'fitness for practice' of student midwives at the point of qualification.

An example of this focus was the coloured posters on the walls of the birthing rooms that referred to emergency drill procedures in cases of shoulder dystocia and haemorrhage. These were eye catching and prominent and would be useful for staff and students involved in such events. Nevertheless, the review team felt they could cause significant anxiety for women and their partners to see them in this context. Consequently, this manner of imparting knowledge or a process of emergency care to staff may impact adversely on a woman's labour and is inappropriate. It was of concern to the review team when a member of teaching staff indicated her opinion that such posters provided positive learning and may be reassuring to women. The team were concerned if students were to regard their display in this environment as being acceptable.

In a similar vein, the team found a very strong emphasis on anti-violence with strongly worded posters requesting staff to be left alone to get on with their jobs displayed throughout the delivery suite. The prominence of this message conveyed a 'them and us' dynamic between service users and staff. While recognising the issues of violence facing NHS staff, the review team felt that the prominence of this message was inappropriate for labouring women.

There was concern that it may make labouring women feel less able to form positive relationships with their midwives. There was concern that it may also inhibit women from being active partners in their own care, for fear of being perceived as interfering in the midwife's job or being perceived as difficult. It also raised concern that relatives and the public might be perceived as problematic and a distraction to care rather than a resource for support of women and vital to their care.

Midwifery staff and managers came across as a very close-knit team and reported they felt the approach on the unit was very good. The reviewers however gained the impression based on the above that the organisation, while seeking to address staff needs, was at times less than woman-centred and might exclude families from full involvement in care.

The review team were concerned that what they heard and witnessed within the unit during their brief visit, was the result of the heightened awareness arising from the HCC report and perhaps has contributed to a swing that focuses education towards a 'what if this goes wrong' approach. The understanding of the potential impact of such an approach to women appears to have been forgotten. The review team saw no evidence of counterbalancing information being given to women or staff in relation to the promotion of normality such as mobility in labour or support for breastfeeding etc. Student midwives need to be exposed to normal low risk labour and birth and the team did not see evidence of this happening at NWPH at this time.

Facilities are limited for students to learn away from the clinical area, but this is planned to be addressed in the new build. Student notice boards and learning equipment were evident around the wards including:

- K2 Package for CTG interpretation
- Dolls and pelves

Postnatal inpatient care

Care in the postnatal inpatient areas is led by midwives and supported by health care assistants. Students have the opportunity to experience holistic care of the mother and baby.

The health care assistants provide support to the midwife in areas such as baby bathing and breastfeeding support and have the opportunity to undertake NVQ level 3 training. Some have progressed to midwifery training at TVU.

The representative of the maternity services liaison committee who was a non-executive member of the Trust board met with the panel. She informed the team

about the support the committee had given in developing the improvements to Northwick Park facilities and the progression of midwifery led care provision.

She also reported that women voice concerns about the lack of breast-feeding support for them although she linked this to their six-hour discharge home.

Supervision of Midwives

The review team acknowledge and thank the supervisors of midwives (SoM) for their frank discussions. The SoMs were open about trying to change the culture and practice at NWPH and their recognition that they had in part, failed in this regard in the past.

SoMs informed the review team that supervision of midwives is now central to the practice of midwives working at NWPH and that it was no longer marginalised as it had been in the past. They felt that their role and value was now recognised at all levels of the Trust and many of the SoMs were now members of a number of management and review groups which were established after the introduction of special measures. These include
:

- Maternity Services – Risk Management Group
- Maternity Services – Women's Partnership Group
- Labour Ward Forum and Guidelines group
- Maternity Governance Board

There is also a Midwifery Supervision Group that includes all Brent and Harrow Supervisors of Midwives.

SoMs were unclear about the mechanism for inputting to any agreement relating to increases in student numbers and this is an area that should be addressed as a matter of urgency by the Trust and the Strategic Health Authority.

SoMs need to recognise that inappropriate student / staff ratios may well have an adverse impact upon the time and quality of care given to women. In such circumstances, they should have a voice to support or reject any increase in student midwife numbers or any educational placements that may diminish the quality of clinical provision and care to mothers and babies. The SoM's role is pivotal in ensuring that midwifery practice and student education is safe and in accordance with the NMC standards.

SoMs were highly appreciative of the efforts made by TVU to increase support for students in the clinical area but were concerned about the sustainability of this

support in the long term; a very real concern that is shared by the review team. The Trust and TVU have a joint responsibility to ensure sustainable long-term support for student midwives and nurses.

The SoM ratio to midwives is approximately 1:15. This meets the standards required by the *Midwives rules and standards* [3](NMC 2004). Preparations of Supervisors of Midwives programmes are undertaken at Thames Valley University, Kings College London and the University of Hertfordshire.

SoMs informed the review team that group supervision for students was being implemented. The Trust had recently introduced opportunities for student midwives to hold caseloads and it was reported that the Local Supervising Authority Midwifery Officer (LSAMO) wants SoMs to get more involved with this approach to care management.

Although there are no midwife teachers appointed by the Local Supervising Authority (LSA) as supervisors, one SoM is also the Clinical Practice Facilitator whose role it is to identify mentors for students.

The NMC has not been informed through the statutory supervision process about any serious practice issues or that the Healthcare Commission was investigating the Trust. It was reported to the review team that LSA investigations had taken place after the first three maternal deaths had occurred and processes had been put in place. It was also reported that the LSAMO had not known about the HCC involvement until called to a meeting at the Strategic Health Authority.

It is of concern that communication of the problems and concerns at NWPH was not relayed to the NMC through the supervision process as this was directly relevant to public protection and preparation of future registrants.

SoMs reported they had been involved in supporting staff and students in relation to the maternal deaths that had occurred and they recognised the adverse impact of such events on morale, confidence and the decision making of practising Midwives.

[3] Midwives rules and standards. SI 2004/1764 Nursing and Midwifery Council (Midwives) Rules 2004

Statutory Supervision of Midwives at NWPH and within the wider Trust appears to have recognised and responded to the concerns raised by the HCC's report. Staff and students commented favourably on the supervisory process and the review team was impressed by the commitment from the SoMs to ensure that any potential for future failings that might impact adversely on women and staff, would be dealt with swiftly.

SoMs recognised their role in supporting evidence-based and woman-centred care at the Trust to ensure appropriate learning opportunities for students. However, it was stated that only some SoM are proactive in challenging practice that falls outside these criteria. The review team believes that supervision will be key to increasing student's experience of woman-centred, evidence-based practice and that all SoMs need to be active in making this more evident within midwifery practice at NWPH.

Student Midwives

In total, 24 midwifery students from all stages of both the 18 month and 3 year programmes contributed to the visit. All student midwives on the programmes had been approached to contribute and those who attended did so voluntarily. No student nurses were present during the review team's visit as they had been relocated by TVU from working within the maternity service at NWPH following the instigation of special measures.

Student midwives who met with the review team recognised that the Trust was under great pressure because of the HCC's report and they believed that the support for them in the clinical area had improved as a result. They were aware that jobs were available to them in the Trust at the point of registration. The very clear message was that they wished to continue their practice experience at Northwick Park Hospital and that the majority of them intended to seek employment at the Trust once qualified.

Student midwives reported that support from TVU staff had improved and the numbers of midwife teachers and practising midwife mentors in the unit had increased over the past year. They expressed satisfaction with these measures.

Student midwives reported that arrangements for practice learning were well organised by TVU and they were informed of the location of placements well in

advance. Students felt that some mentors were confused about the use of the assessment documentation. However input by link teachers had led to a better understanding and clarified the uncertainty.

Students reported their mentors were often only identified to them at the commencement of a placement. This contradicts the reports from mentors that they know well in advance of a placement who their student will be. This indicates that communication is not good in relation to this and needs to be addressed by TVU and the Trust.

Student midwives identified that they were not always exposed to evidence based practice whilst on placement. They agreed that they were taught evidence based theory and practice in the classroom but it had not always been visible within the clinical area. Examples given by the students to support this were use of admission cardiotocographs, no experience of physiological management of the third stage of labour (no student had witnessed one), no initial breast feed in the delivery suite and lack of skin-to-skin contact between mother and baby at birth.

Some felt that only one or two of the SoMs would raise concerns with mentors who were teaching students non evidence-based practice by challenging any inappropriate use of admission CTGs.

Views were expressed that midwives were conducting care to 'cover their backs' which was to say protocol driven rather than meeting women's' needs. Several commented on the high-risk nature of much of the care they observed in the unit yet only 3 – 4 weeks were allocated to normal labour and birth in the birth centre placement.

Concerns were raised with the review team about many of the night staff being long term agency staff and that there was a lack of rotation between days and nights for permanent staff. This resulted in limits to the experience available to the student midwives as it was reported that agency staff cannot mentor pre-registration students.

Group evaluations of their practice experience were undertaken so student's anonymity was not secured. This may impact on their ability to be open and honest without fear of recrimination.

Student nurses

Student nurses have a 3-day allocation to the Maternity Unit at NWPH comprising one-day postnatal care, one day in the community and one day on the delivery suite.

Some midwives and managers commented on the presence of student nurses within the maternity unit and the additional and at times unnecessary strain this created on the unit. Their removal had been welcomed and it is questionable whether any such provision is in the interests of the service, students of midwifery and mentors. In addition it is unclear what educational benefit there is for the student nurse if they were to continue in the maternity services.

As a result of the special measures being introduced TVU made arrangements for student nurses to receive their education in maternal and child health outside of the maternity services at NWPH. However student nurses continue to be placed at the birth centre at CMH and it remains questionable as to the value of this for the students aside from adding to the workload of already stretched midwifery staff.

Thames Valley University

Dr Gail Thomas gave an overview of the support provided by TVU staff to student midwives and student nurses placed at Northwick Park Hospital. Dr Thomas informed the team that a QAA Major Review had been undertaken in May 2005 and the report was made available to the review group.

It is of note that there was no specific mention of ongoing difficulties with mentor support or practice at NWPH in TVU's self evaluation documents or in the relevant QAA reviews reports. Indeed in subsequent discussion it was identified these had been long standing problems at NWPH.

The NMC recognises these can be difficult areas nationally, however we would expect such issues to be brought to our and others attention, and they should be reflected in any self-evaluation documents.

There is one lecture-practitioner (joint appointment) who spends three days per week at the maternity unit and there are five link lecturers (3.8) Whole Time Equivalent (WTE), each of whom spend 20% of their time in the Trust. Each are in practice once per week. There is one practice educator based in the Trust and funded by the SHA. In addition support is provided to students through

- teaching in practice,
- a monthly student forum where more general issues can be discussed
- production of newsletters,
- provision of a resource area
- inter-professional forums to discuss cases
- provision of a student notice board
- use of SMS texting.

These measures were in place prior to special measures being introduced at the Trust.

The University and Trust took prompt action to withdraw student nurses from the unit when special measures were implemented. In addition TVU redeployed a new set of

student midwives due to commence at NWPH to other Trusts as an interim measure. The ability of the other Trusts to cope with increased numbers of student midwives was not explored as part of this visit. It is an issue that must be considered by TVU however, as it is essential that other Trusts are not pushed inadvertently into a similar position by overload of students.

It was clear there was a lack of judgement by past Trust management in seeking to increase student midwife numbers in an environment with falling numbers of qualified staff to support them. TVU should have resisted this pressure in the interests of their students and the quality of their programmes.

Arrangements to confirm Student competence

Mentors reported that there is improved information sharing since the HCC's report. The review team were informed that the majority of the mentors present during the visit had been prepared through the ENB 997 or SLICE (Supporting Learning in Clinical Environments) programmes.

It should be noted that the 997 was called 'Teaching and Assessing in Clinical Practice Course for Midwives. This would be considered an appropriate preparation for mentors providing there has been updating of the mentor since to the current NMC standards. (Appendix 4)

There was some discrepancy in the mentors' understanding of what constitutes appropriate updating and a mentor preparation programme. For example some mentioned the emergency drills and skills sessions that take place, which are multi disciplinary.

Mentors reported that mentor updating was part of the Trust's mandatory training and that they had received recent updating. However the mandatory training is Trust led and does not identify continuous professional development for individual midwives.

Approaches to updating included ad. hoc. meetings with the link tutor, formal workshops and the mandatory group training. They felt that accessing mentor updating has been difficult but is better with the new Head of Midwifery and practice educator now in post.

Mentors reported that the student allocation is organised by the link tutor to coincide with the staff off-duty however the students have the responsibility to organise their own off-duty. Mentors stated they knew about student allocation in advance of them arriving with those mentors in the community having prior knowledge of when students would arrive up to six weeks in advance. As mentioned before this is not the perception reported by the students. Students are allocated to the neo-natal intensive care unit for periods of between 3 to 6 weeks.

If the mentor has a student but takes annual leave during the allocation, then the mentor would arrange for cover and handover to a 'covering mentor'. Handover includes informing the 'covering mentor' about the level of knowledge and skills the student has achieved so they can continue where they 'left off' rather than revisiting prior experience unnecessarily. Such an approach may impact adversely on continuity for a student and is symptomatic of the need to improve communication about allocation of mentors.

There is a system of group mentoring in place at the Trust, where a student is allocated a group of mentors, one of who takes the lead for a particular student. The mentor who has worked with a student the most signs off the student's competence, in liaison with the other mentors as appropriate.

Students have a proficiency booklet in which initial, middle and final meetings with their mentor are recorded. During the initial meeting the student's needs are identified and the mentor explains what would be expected of them. It was noted that some mentors do not understand how to use the booklet when they have students on placement, but the student would explain this to the mentor.

On the day of the visit no 'working document' on student mentoring was available for the review team to examine. This was regrettable, as such documentation would have helped the team understand and consider its use in more detail.

NMC standards require that midwives who are consolidating their own knowledge and confidence in their first year of practice may not act as mentors. It was reported that agency midwives may support a student and be involved in feedback to a student but are never used as signatory to sign off an individual's competence. As stated elsewhere in this report, at NWPH agency midwives are most frequently used

on night shifts, which reduce the number of students who are able to gain experience at night.

When asked what they would do if they knew an agency midwife has ‘signed off’ a student’s competencies, mentors responded by saying they would challenge the midwife concerned.

There appears to be a clear perception that only members of NHS Trusts can be mentors. This view is not supported by the NMC mentor standards. Providing a midwife has consolidated her knowledge and skills for a minimum of one year after registration and she has met the NMC standards for preparation of mentors she can act as a mentor.

It is important that there is continuity between a mentor and a student so the student can gain most from the experience. However, the Trust may wish to support an agency midwife who works with them on a long-term basis to be prepared to become a mentor and this would help increase support and available experience for students.

It was reported that students take on “confidence cases” towards the end of their training and that student’s work with the co-ordinator to develop an understanding of multi-professional working, both of which are examples of good practice. If students are faced with a difficult case then the issues are talked about at the end of shift and if necessary the Mentor will liaise with the university or link tutor.

The Practice Educator provides support for newly qualified Midwives.

Conclusions

Staff and students within the Trust are still coping despite the long time taken to make progress at this unit. The NMC recognises and commends that a lot of work has been done and that staff and existing students were positive about the HCC investigation and resulting special measures.

The present culture at NWPH has been informed by the maternal deaths and the HCC investigation and report. The NMC recognises that this is very important. However, not all women should be looked at and cared for as though they are high risk. This is not providing a woman centred approach to care or a balanced approach to the preparation of future midwives.

This should not jeopardise pre-registration training in the short term but there are concerns for the long term in relation to the extended programme of refurbishment and the ability of existing staff to cope with the changes that need to take place in the unit.

Students and staff alike recognised that the environment was not a good place to care for women. All were keen that existing students were left in the unit to complete their training but shared their concerns about its suitability if the refurbishment programme was to go on for much longer.

The NMC review team consider that there is a need for some passage of time to take place in order to enable a comprehensive rethink as to how student midwives, mentors and mothers are supported in the practice environment. It is only with the passage of time and the lessons that can be learnt from the tragic events at NWPH that anyone can be more confident about it being a suitable learning environment for student midwives.

Those people already in the system understand why things are as they are at NWPH at this time and that it is not a usual approach to care. It would not be appropriate to place new students who would not have this prior knowledge and lived experience in this environment. In addition, further intakes of new students may well place unnecessary pressures on mentors and further risk the learning environment for current students of midwifery.

It would appear that the changes that resulted in all acute maternity care moving to the NWPH site were implemented without a commensurate increase in the numbers of midwifery staff to enable 1:1 care of all women in labour. This, we believe, has had a negative impact on the provision of care and the ability of staff to ensure they are well able to supervise students on the site.

The current diminished numbers of students in the unit is a result of student nurses being redeployed and new intakes of student midwives being placed elsewhere. The review team were informed by staff that this had helped them cope with a very difficult situation.

Staff in the unit need breathing space to solve the communication issues in the unit. There is danger in the number of women vs the number of midwives available to care for them safely and appropriately. This does not need to be compounded at this time by the addition of new students.

There is little rationale for continuing placement of student nurses within any part of the maternity services. This applies equally to the provision of maternity care at the Central Middlesex Birth Centre. The requirements for 150 hours exposure to maternal and child health can be met innovatively and more purposefully for the student concerned without placement in a maternity unit. This also removes an additional burden on overstretched midwifery staff and enables them to concentrate on supporting and teaching student midwives in the unit.

The decision to increase student midwife commissions in this unit over the past five years was unfortunate. It would have been better to increase available staff numbers by improving recruitment and retention of staff or by increasing agency staff and providing appropriate support and training to regular agency midwives. Smaller numbers of students who are therefore better supported and supervised by existing staff are more likely to remain in the profession and indeed in the unit.

Supervisors of midwives must be consulted purposefully in relation to any discussions about increased student numbers as they are well placed to advise on the impact of such increase to the care of mothers and the safety of the unit.

We recognise that TVU had intended to recruit to a March and April 2006 intake provided the review concluded that student midwives should be allowed to continue at the Trust.

Under the circumstances, the NMC will have to conduct a further visit before it can assure Council that the learning environment at the Trust is appropriate for more student midwives. This visit will be planned to take place several months after the complete withdrawal of the special measures team, as this will enable the NMC to assess whether the improvements have been sustained.

Recommendations to NMC Council

As a result of the data and information provided to the NMC along with the findings of the review panel who visited the Trust, the following recommendations have been approved by the Council of the NMC.

1. Support retention of existing student midwives at the Trust, including Northwick Park Hospital and the birth centre at Central Middlesex.

2. There should be no further intake of student midwives until subsequent review by the NMC satisfies Council that the improvements developed and implemented by the special measures team at Northwick Park are sufficient and sustainable by the Trust.

3. Student nurses should be removed from the maternity clinical environment in both Northwick Park Hospital and Central Middlesex Hospital.

4. Thames Valley University should confirm that alternative arrangements have been made to enable student nurses to meet the EU requirements for maternal and child health experience.

5. The Trust and Thames Valley University should further strengthen mentor preparation and support in the Trust

6. Thames Valley University in collaboration with the Trust must review the balance of normal/abnormal pregnancy and birth that student midwives experience in this environment.

7. Northwest London Hospitals NHS Trust must support midwives to use best practice in their clinical work.

8. Northwest London Hospitals NHS Trust needs to identify sustainable long-term support for students.

9. The NMC will conduct a further visit in May 2006 to assure Council that sustainable improvements are in place at North London Hospitals NHS Trust before approving further intakes of student midwives to be recruited for placement at the Trust.

Appendix 1

The review team

Mrs Jill Crawford
NMC Council member
Vice Chair of the Statutory Midwifery Committee

Professor Diane Fraser
NMC Visitor
Nottingham University

Ms Pauline Hudson
NMC Visitor

Professor Paul Lewis
Lead NMC Council member for the review
Bournemouth University

The following NMC staff supported the review team

Ms Lynn Smith
Midwifery Advisor
NMC

Ms Susan Way
Midwifery Advisor
NMC

The report was collated by

Mrs Christina McKenzie
Head of Midwifery
NMC

Mr Roger Thompson
Professional Advisor - Quality Assurance
NMC

Trust and Thames Valley university staff involved in the visit

Chief Executive
Director of Nursing and Midwifery
Non-executive director and member of the maternity services liaison committee
Senior midwife managers
Supervisors of midwives
Midwives
Student midwives
Dean of the midwifery and nursing school
Midwife lecturers
Local supervising authority representative
Special measure team members
Women using antenatal inpatient services

Appendix 2

Summary of Health Care Commission findings on maternity services provided by North West London Hospitals NHS Trust

Findings on the outcome of care and treatment of women and their babies

1. The number of maternal deaths at the trust in the past three years was significantly higher than the national average.
2. The rate of perinatal deaths was within the average range when compared to other trusts with similar populations.

Findings about management and leadership

1. The trust board and the management team failed to take effective action to ease operational pressures in maternity services.
2. The severe issues of capacity were worsened by the trust's failure to assess and manage effectively the impact of the refurbishment project at Northwick Park Hospital.
3. The trust and the managerial team failed to bring together the different cultures and working practices in maternity services at Northwick Park Hospital and Central Middlesex Hospital.
4. There was a culture of bullying and a lack of cultural awareness among staff.
5. The previous leadership and managerial team for maternity services did not deliver sustained changes in the way in which maternity services operated.
6. There was a lack of clinical leadership on the labour ward.
7. The trust was experiencing severe financial challenges, which affected the operation of maternity services.

Findings on partnership working with others

1. PCTs had good public health information about the diverse needs of the local population and were using this information to plan maternity services.
2. Poor sharing of information between the trust and the PCTs was worsened by the poor quality of data collected by the trust.
3. The strategic health authority was working to address the significant pressures on maternity services across northwest London.
4. The trust failed routinely to inform PCTs of serious untoward incidents.

Findings on the management of risk

1. Links between systems for managing risks in maternity services and the trustwide systems were weak.
2. Staff received inadequate feedback about incidents that had been reported and investigated.
3. Most serious incidents in the maternity services were reported and investigated, but staff received little feedback.
4. Management of risk in maternity services was not active and there was little evidence that the trust learnt from incidents, implemented changes to its work practices, or implemented action plans to address risks.
5. There was poor attendance by staff from maternity services at important meetings, including those relating to the management of risk.

Findings on the use of information

1. There were acknowledged inadequacies with the coding of the ethnicity of women who used maternity services.
2. The quality of information collected by the trust's maternity IT system was poor.
3. Staff did not have sufficient time to have access to computers for information and training.
4. Maternity clinical information was incomplete, which was acknowledged by the trust.
5. Record keeping was inconsistent and documentation of care planning was unsatisfactory.

Findings on the use of clinical guidelines and recommended best practice

1. The process for developing and using clinical guidelines was unsatisfactory.
2. Compliance with national guidance and clinical guidelines was poor and inadequately monitored.
3. There was no evidence of specialist services for women in the high-risk maternity unit.
4. Audit was weak, and findings from audits were not adequately implemented to bring about changes in the way in which the trust operates.

Findings on staff in maternity services

1. The midwifery establishment was chronically understaffed.
2. There were significant difficulties with the recruitment and retention of doctors and midwives.
3. There was inadequate cover by consultants of the labour ward.
4. The trust failed effectively to manage poor performance in maternity services, particularly in relation to the behavior of some consultants and the management of some staff.
5. There were poor relationships between staff and an absence of effective working in teams.
6. The trust failed to manage conflict between midwives and recovery nurses in maternity services.
7. There was a culture of bullying and harassment.
8. There was a lack of cultural awareness, which affected relationships between staff.
9. The system for referring women to maternity services did not ensure accountability.
10. The rate of appraisals of performance carried out in a six-month period was low, particularly among midwives.
11. Attendance at mandatory training was unsatisfactory.
12. The system for recording attendance at training was inadequate.

Findings on the experience of women

1. The privacy and dignity of women was temporarily undermined by the constraints imposed on the environment by building and refurbishment work.
2. The system for ensuring that equipment was appropriately maintained was ineffective and there was no up to date equipment inventory.
3. Many women experienced limited support when breastfeeding.
4. The provision of bereavement support for women and their families was limited.
5. The provision of translation services for women was inadequate.

6. The quality of care provided by maternity services was affected by the lack of cultural awareness among staff.
7. The management of complaints was poor.
8. Midwives did not always demonstrate that the needs of the women were a priority.
9. The views of women were not influential in the development of maternity services.
10. Mechanisms established to provide a voice to women in maternity services were weak.

Appendix 3

Pre registration education programmes at North London Hospitals NHS Trust

Thames Valley University
Faculty of Health and Human Sciences

Students at Northwest London Hospitals (NWL) NHS Trust

At any given time, there are three year and eighteen month pre registration midwifery students and student nurses from Thames Valley University in practice at NWL. The breakdown of the current cohorts is as follows:

3-year midwifery programme

October 2002 intake	5
April 2003 intake	2
October 2003 intake	10
April 2004 intake	7
October 2004 intake	9
Total	**33**

18-month midwifery programme

March 2004 intake	3
September 2004 intake	6
March 2005 intake	6
Total	**15**

The average number of student midwives in practice at anyone time is 19.

Student nurses
4 to 6 per week (three days experience in total)

Medical students
January 2004- July 2005 45 per year

There are five rotations in the maternity service with 9 students on each

The number of students in practice at any one time could average 34

The total numbers of midwives on duty in the unit in one shift is normally 33 with a maximum of 40.

The areas in which student midwives gain experience within the Trust and the number of qualified midwives on duty per shift include:

Antenatal clinic	3
Day assessment unit	2
Antenatal ward	2
Delivery suite	10
Postnatal ward	4
Community	Harrow 6 - 9; Brent 4 – 8
Birth centre	2

In addition, students go to the Neonatal Unit on a rotation basis.

May 2005

Appendix 4

NMC Requirements for Mentor Standards

Nurses and midwives who take on the role of mentor must have current registration with the NMC. This includes second level registered nurses. They will have completed at least twelve months full time post-qualifying experience (or equivalent part-time). They should receive support from qualified nurse and midwife teachers and experienced practitioners in carrying out their mentor role.

NMC Guidance for preparing mentors

The NMC advises a flexible approach toward preparation of mentors that involves learning in both practice and academic environments in order to meet the required outcomes. Programme providers, HEIs and their service partners, should agree an approach that is designed to meet both local needs and NMC requirements.

The NMC does not require a specific academic level for mentorship preparation. Council requires that pre-registration programmes must be a minimum of Diploma of Higher Education and that Specialist Practice Qualifications be at no less than degree level. Therefore the expectation would be that mentorship programmes would be set at an appropriate academic level.

It would be a matter for HEIs and their service partners to justify the mode and level of mentor preparation at approval events for programmes leading to registration or recordable qualifications.

Programme providers should consider how accreditation of prior (experiential) learning (AP(E)L) might be used to bring all mentors to an equitable level of preparation in meeting the NMC requirements. This would allow those who have undertaken short preparation programmes, alternative programmes such as for assessing NVQ/SVQ, or developed their competence through experience to reach a comparable standard to those undertaking a contemporary preparation programme.

Guidance for updating mentors

Programme providers should develop a process for updating mentors on a regular basis. The NMC requires regular updating of mentors.

Visit schedule – Northwick Park Hospital Maternity Service **Appendix 5**

Time	Event	Key personnel	Concurrent sessions key personnel	Location
8.30am	NMC arrives at NWPH	Sir G. Morgan, DON Gillian Lee, Senior midwife Dr Gail Thomas, Dean of school of nursing and midwifery NMC Council members and visitors		Main hospital entrance NWPH
8.45	Overview of student support at NWPH	Dr G. Thomas, Gillian Lee NMC Council members and visitors Midwife teachers		Parent education room 7th floor, NWPH
9.15	In camera session for NMC	NMC		Parent education room NWPH
9.30	Tour of unit for NMC	Gillian Lee, senior midwife ½ of NMC Council members and visitors	Meet with student midwives ½ of NMC Council members and visitors	Maternity unit
10.30	Refreshments Meet with mentors/assessors	NMC Council members and visitors Group / individual meets	Individual visits to unit by NMC	Parent education room NWPH & Maternity unit
11.30	Meet with SoMs and LSAMO	½ of NMC Council members and visitors Group / individual meets	Meet with student midwives ½ of NMC Council members and visitors	Parent education room NWPH & Maternity unit
12.30	Lunch as in camera session for NMC	NMC Council members and visitors		Parent education room NWPH
1.00pm	Meet with midwifery managers	NMC Council members and visitors Group / individual meets	Individual visits to unit by NMC	Parent education room NWPH & Maternity unit
2.15	Overview of maternity services and service improvement measures	Mary Wells, Chief executive Sir Graham Morgan Gillian Lee, Senior Midwife Onsy Louca , Clinical Director Pat Wooster, Maternity Services Support Team NMC Council members and visitors	Individual visits to unit by NMC	Parent education room NWPH & Maternity unit

Time	Event	Key personnel	Concurrent sessions key personnel	Location
3.00	Meet with MSLC lay members	Sir Graham Morgan Sally Kirkwood, non executive of the trust NMC Council members and visitors	Individual visits to unit by NMC	Parent education room NWPH & Maternity unit
3.30	Wash up session with NWPH staff re final information NB there will be no feedback from NMC on day of visit.	NMC Council members and visitors Mary Wells Sir Graham Morgan Gillian Lee Supervisor of midwives Dr Gail Thomas A Midwife teacher		Parent education room NWPH & Maternity unit
4.30	Visit ends → in camera session for NMC	NMC Council members and visitors		Meeting Room NWPH & Maternity unit
7.00	Depart NWPH site			

- *2nd meeting room confirmed available from 8.30am – 7.00pm*
- *Laptop with power point facilities and an overhead projector available if required.*
- *Comprehensive list of training provided to midwives by TVU and the Trust (included training on cultural awareness undertaken by NWPH Health and Race department)will also be available.*

NMC Council members and visitors

Professor Paul Lewis, Midwifery Committee (leading the visit)
Susan Way, Professional Adviser
Lynn Smith, Professional Adviser
Jill Crawford, Midwifery Committee
Professor Diane Fraser, NMC Visitor
Pauline Hudson, NMC Visitor
Roger Thompson, Education Advisor (arriving at 4.30pm)
Christina McKenzie, Head of Midwifery (arriving at 4.30pm)

Key personnel the NMC would like access to as part of the visit.
Whilst some of these meetings will be as a group as per the programme, the NMC will wish to see some members on an individual basis.

Mary Well, Chief Executive
Sir Graham Morgan, Director of Nursing
Members of NWP maternity services medical staff
Lauren Griffiths

Collette Mannion, Director of Midwifery
Midwifery managers
Dr Gail Thomas, Dean of school of nursing and midwifery TVU
Ms Carmel Bagness, Lead midwife for education
Midwife teachers involved with NWP students
Practice placement facilitators
Members of the special measures support team

Goretti Dowdican-McAndrew
Supervisors of Midwives
Lay members of the maternity services liaison committee of NWP
Student Midwives (in separate groups and as individuals re year 1, year 2, year 3 and 18 month programme students)
Medical students in the maternity services if present in unit

Areas to be visited

All clinical areas where midwifery is practiced and midwifery students are placed including the off-site midwifery led unit.

Information requested from NWP to assist in the conduct of the visit

Copies of midwifery and medical rosters for the 15th July 2005 including those for midwife students or any other students in the maternity unit on the day