Re-framing midwifery supervision: a discussion paper

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This paper has been prepared for Royal College of Midwives and sets out key issues for discussion and further exploration following the recommendations to the Nursing and Midwifery Council from ‘Midwifery supervision and regulation: recommendations for change’ (Parliamentary and Health Service Ombudsman 2013) and ‘Midwifery regulation in the United Kingdom’ (The King’s Fund 2015) and the decision by the NMC to remove the supervision of midwives from regulation (Council papers January 2015).

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Contents

Part 1

1. Introduction 3
2. Summary 3
3. Recommendations 4

Part 2

4. Background 6
5. Supporting and developing people 7
6. Leadership of the midwifery profession 7
7. Strategic oversight of midwifery services 8

Part 3

8. Reframing midwifery supervision – the rationale for clinical midwifery supervision 8
9. Benefits for the individual 9
10. Benefits for the person using services 11
11. Benefits for service providers 11
12. A model and framework for clinical midwifery supervision 13
13. Integration within organisations 15
14. Consistent application of clinical midwifery supervision 16

Appendix 1
Health Visiting Service Specification 2015-16 20

Appendix 2
Suggested draft framework for the provision of clinical midwifery supervision 21
Part 1

1.0 Introduction

1.1 Following the publication of ‘Midwifery supervision and regulation: recommendations for change’ (Parliamentary and Health Service Ombudsman (PHSO) 2013) and ‘Midwifery regulation in the United Kingdom’ (The King’s Fund 2015), a consideration of the future model of midwifery supervision in the UK is required.

1.2 The Nursing and Midwifery Council (NMC 2015a) have accepted the two principles identified in the reports that:

- Midwifery supervision and regulation should be separated
- The NMC should be in direct control of regulatory activity

1.3 The conclusions of the PHSO report (PHSO 2013 p.21) also state that midwifery supervision may have real merits in the support it provides for midwives across the country on a daily basis, therefore there are no recommendations to remove the non-regulatory aspects of midwifery supervision. For the purposes of considering the way forward to continue the provision of midwifery supervision, a review of the non-regulatory aspects of supervision has been undertaken and considered in the context of recent government policy and strategy documents, guidance from the healthcare regulator, professional body and other relevant literature.

1.4 This paper presents a model and framework of midwifery supervision for discussion should the recommended legislative changes to remove the regulatory aspect be enacted.

2.0 Summary

2.1 The benefits of maintaining and enhancing the non-regulatory aspects of midwifery supervision are demonstrable. The King’s Fund report states that all of the current functions of statutory midwifery supervision are important and useful (The King’s Fund 2015). The future model of midwifery supervision should utilise the positive aspects of the foundations that have been established during the past century. The concept of a supervisory element integral to professional practice is already:

- embedded in midwifery practice beginning with pre-registration midwifery education
- custom and practice, now seen as the expected cultural norm for midwives and increasingly for women using maternity services
- ideally placed to contribute to the revalidation, appraisal and governance agendas

2.2 Given the recent identification of failures in the provision of safe and compassionate care within the health service and the self-regulation of the professions, it is timely to consider a complete reframing of supervision for all healthcare professionals. For midwifery, however the likelihood is that the regulatory and statutory aspect integral to midwifery supervision will cease to exist in the future. The current climate makes it an ideal time to seize the opportunity to shape a new model and framework for effective clinical midwifery supervision. The provision of clinical midwifery supervision has real potential to positively
influence the care that women receive and the opportunity to modernise the system, with
the consideration of extending such a system to all NMC registrants.

2.3 The reframing of midwifery supervision should consider the elements of best practice in
the supportive, restorative, educative aspects of clinical supervision as described by Proctor
(1987) integrated into established systems and processes, future proofed against the
continued shifting landscape of healthcare provision. The framework for the provision of
clinical supervision needs to be anchored to the organisations least likely to be re-organised
or restructured in the foreseeable future. This paper identifies a number of key
recommendations to be considered and the extensive work in future proofing supervision
recently undertaken in Wales could provide valuable information as to how a model of
clinical midwifery supervision could be delivered across the UK.

2.4 The term ‘supervision’ is widely used yet frequently misunderstood, with definitions and
understanding of the term varying widely between and within professions. Is ‘supervision’ a
meaningful term for women and midwives, employers and regulators? There is the
opportunity to call midwifery supervision something else, to shift understanding away from
previous concepts of what it entailed and the possible perception of surveillance.
Consideration should be given to the use of an alternative term that could be adopted to
indicate an integrated model of supportive supervision and clinical leadership in the future.

2.5 There will need to be further consultation and the risk analysis currently being
undertaken by the NMC considered before decisions as to the future framework for the
provision of clinical midwifery supervision can be developed in detail. Ratification by the
NMC Council will also be needed prior to any legislative change to the Nursing and
Midwifery Order.

3.0 Recommendations

Recommendation 1 (paragraph 5.3): A model of midwifery supervision and a framework
for provision needs to be developed with the following principles:

- Midwifery supervision is viewed as a vital aspect of contemporary midwifery
  practice.

- The non-regulatory aspects of midwifery supervision are retained, enhanced and
  integrated within proposed systems to support revalidation (NMC 2015) and
  should continue to be incorporated into pre-registration education programmes.

- The requirements of non-statutory midwifery supervision should be monitored to
  ensure consistency across all maternity care provision.

Recommendation 2 (paragraph 6.3): Strong midwifery leadership and the ability to
advocate and stand up for the maternity service is critical for the delivery of high quality
and safe maternity care. The current positioning of midwifery leaders both locally and
nationally needs to be re-evaluated and the lack of development and career progression
needs to be addressed. These issues should form a key criteria in the review of maternity
services in England and Scotland.

Recommendation 3 (paragraph 7.3): The current links between supervisors, maternity
service providers and regional and national policy makers should be strengthened in the
absence of the LSA, to ensure that a strategic view of maternity provision is maintained
and the appropriate services commissioned. This should form a key criteria in the review of maternity services in England and Scotland.

Recommendation 4 (paragraph 9.8) A framework of clinical supervision should be developed to support midwives to maintain and promote standards of care in accordance with the NMC Code including revalidation, lifelong learning and professional development and enable them to provide high quality safe care to women in a continuing changing service environment.

Recommendation 5 (paragraph 10.3): All women should continue to have access to an experienced midwife 24 hours a day, this has traditionally been undertaken by the supervisor of midwives in the absence of other experienced and available midwives. Careful consideration should be given to the need to have in each Trust/Health Board a Consultant Midwife (or equivalent) who undertakes this function and ensures that all women have access to individualised, equitable and dignified care. This should be the responsibility of service delivery and should therefore be a key criteria in the review of the maternity services in England and Scotland.

Recommendation 6 (paragraph 11.8): The NMC should consider retaining the current system of notification of Intention to Practise for midwives and for the current LSA database to be retained by the NHS and used as the electronic system whereby revalidation requirements can be evidenced.

Recommendation 7 (paragraph 12.8): The overall benefit of supervision as recognized in the literature and by the PHSO and Kings Fund reports, is sufficient to merit continued investment in clinical supervision for midwives. The investment currently dedicated to the statutory supervision of midwives should be maintained although clinical supervision is likely to require less resource than currently.

Recommendation 8 (paragraph 12.9): The current cohort of SoMs and student SoMs are in a position to be able to continue to provide the identified elements of clinical midwifery supervision. Preparation of supervisors is crucial to the success of clinical supervision. Relevant practice experience is important as well as the development of the necessary skills, qualities and characteristics. These include but are not limited to active listening, facilitating constructive reflection, mentoring, coaching and enabling practitioners to be outcome focused.

Recommendation 9 (paragraph 12.10): Programmes for the Preparation of Supervisors of Midwives (PoSoM) should be adapted to provide the required knowledge and skills for the changed role of the supervisors. If the NMC decide that it will no longer be responsible for setting the standards for education provision, validation and monitoring of programmes, consideration will need to be given as to where this responsibility will lie.

Recommendation 10 (paragraph 13.4): The proactive element of clinical supervision may identify areas in which integrated work with clinical governance and risk management systems need to occur. Clear protocols should be developed to identify how concerns from midwives or women that are raised about access to services or respect for choice in childbirth can be escalated through the established governance processes in order to inform service development and enhancement.

Recommendation 11 (paragraph 14.10): A system for clinical midwifery supervision should be determined nationally, included in the NMC professional standards, the NHS education commissioning bodies standards and health systems regulators standards for the provision of health services. Consideration should be given as to how compliance could be
monitored such as through the framework put in place by the health systems regulator, for example, the CQC in England.

Part 2

4.0 Background

4.1 The stated purpose of midwifery supervision is to protect women and babies by actively promoting a safe standard of midwifery practice (NHS England 2015, Parliamentary and Health Service Ombudsman 2013).

4.2 Midwifery supervision currently provides a mechanism of support and guidance for every midwife, and every woman and her family accessing maternity services in the UK. Supervisors of midwives (SoMs) are experienced, practising midwives who have undergone education and training in the knowledge and skills needed to supervise midwives. They monitor the safety of midwives’ practice and encourage midwives to develop their knowledge and skills. SoMs also have an important role in relation to supporting women in their maternity care choices or if they have problems accessing care (NMC 2012, NMC 2014a, NHS England 2015). The elements of the supervisory model, utilised in midwifery, have been commended by The Health Committee as an effective model and a ‘tried and tested means of assuring the quality of midwifery practice’ (House of Commons 2011 p.11).

4.3 The PHSO (2013) report states that there is a lack of evidence to support the continuance of the current dual regulatory and supervisory role of SoMs. The report subsequently commissioned by the NMC (The King’s Fund 2015) whilst supporting this position, also acknowledges that the qualitative data gathered in the process of the review was often contradictory. This has been attributed to confusion over the regulatory and supervisory elements of the role of the SoM, and the perceived conflicts of interest that can arise when supervisors combine their supportive supervisory role with that of a manager or investigator. There has been a recent systematic review of the literature on the supervision of midwives (Henshaw et al 2013) however, it is important to note that the majority of the studies included in this review were undertaken prior to the publication of the Midwives rules and standards (NMC 2004 & 2012). Additionally a lack of evidence does not necessarily equal a lack of efficacy, it can equally amount to a lack of funding to test the efficacy.

4.4 The conclusion of The King’s Fund report highlights some key risks of the proposed legislative changes. The significant risk in relation to the current model of midwifery supervision is that once the key functions of support and development, leadership of the profession and strategic clinical leadership cease to be addressed through statutory supervision, no one else will accept responsibility. Therefore the recommendations of the report also include a statement to the Departments of Health to consider how best to ensure access to ongoing supervision and support for midwives and other healthcare professionals (The King’s Fund 2015). Consideration of how supervision will be coordinated and provided, and which body will be responsible for standard setting and monitoring, needs careful thought in the current climate of constant healthcare reconfigurations.

4.5 Any future framework for the provision and monitoring of non-regulatory midwifery supervision must mitigate the risks identified above. Therefore the responsibility for ensuring that midwifery supervision occurs must be held by organisations with the authority to enforce it. The challenge in the current climate of constant re-organisation and reconfiguration of healthcare services is in identifying a framework of responsibility that is sustainable.
4.6 Within the King’s Fund report, the conceptual framework illustrating the current functions of midwifery regulation and supervision, clearly identifies three key areas of non-regulatory activity (The King’s Fund 2015 p.11):

- supporting and developing people (which includes: clinical supervision, ongoing development, 24 hour availability)
- leading the profession (which includes developing best practice and supporting women)
- strategic oversight of midwifery services

5.0 Supporting and developing people

5.1 The current model of statutory midwifery supervision incorporates a significant element of clinical supervision and, by providing immediate advice and guidance through 24-hour availability of a Supervisor of Midwives (SoM), student midwives and midwives are able to access independent support when they require it. This facilitates an immediate safe, confidential environment for midwives to discuss difficult or complex clinical decisions with someone other than a midwifery manager, who may be balancing issues of service delivery and other competing demands. The relationship with the on-call SoM also provides the opportunity to reflect on practice after an event, and enables midwives to identify areas for personal and professional development. ‘Midwifery 2020 Delivering expectations’ (Midwifery 2020 Programme 2010 p.24) acknowledges and supports the pivotal role that supervision plays to support and develop midwives in the provision of safe, quality care for women.

5.2 The revised NMC Code requires nurses and midwives to ‘provide honest, accurate and constructive feedback to colleagues’ and ‘gather and reflect on feedback from a variety of sources, using it to improve your practice and performance’ (NMC 2015b p.8). The current model of midwifery supervision provides an ideal framework in which to facilitate this requirement. It is significant that in the recent NHS staff survey, only 58% of the respondents felt that they received feedback from their manager about their practice (NHS Staff Surveys 2015).

5.3 Recommendation 1: A model of midwifery supervision and a framework for provision needs to be developed with the following principles:

- Midwifery supervision is viewed as a vital aspect of contemporary midwifery practice.
- The non-regulatory aspects of midwifery supervision are retained, enhanced and integrated within proposed systems to support revalidation (NMC 2015) and should continue to be incorporated in to pre-registration education programmes.
- The requirements of non-statutory midwifery supervision are monitored to ensure consistency across all maternity care provision.

6.0 Leadership of the midwifery profession

6.1 The annual reports of the LSA to the NMC have identified that SoMs have been in a key position to lead and change midwifery practice within a maternity service. As experienced clinicians they have been ideally placed to provide collective leadership, which has been
Reframing midwifery supervision: a discussion paper – not for circulation

identified by a recent King’s Fund report as the key to unlocking cultural change throughout the NHS.

6.2 Collective leadership is identified as distributed leadership in which skilled clinicians work alongside managers. ‘Reforming the NHS from within’ (The King’s Fund 2014) identifies that the responsibility for developing a collective leadership strategy rests with NHS organisations, with the Care Quality Commission (CQC 2014) also echoing this in their new framework for well-led organisations. Following the Francis report (Mid Staffordshire NHS Foundation Trust 2013) the response from the Department of Health, ‘Hard Truths: The Journey to Putting Patients First’ also emphasized the need to strengthen professional clinical leadership within organisations (DH 2014). More recently the conclusions of the Morecambe Bay Investigation also reiterated that clinical leadership at all levels within an organisation are key to ensuring good governance and clinical quality (DH 2015).

6.3 Recommendation 2: Strong midwifery leadership and the ability to advocate and stand up for the maternity service is critical for the delivery of high quality and safe maternity care. The current positioning of midwifery leaders both locally and nationally needs to be re-evaluated and the lack of development and career progression needs to be addressed. Leadership and management of the maternity services should form a key criteria in the review of maternity services in England and Scotland.

7.0 Strategic oversight of midwifery services

7.1 Under the current statutory duty of the LSA, every maternity service is subject to an annual audit of standards of statutory supervision. The LSA audits are seen as a quality assurance tool and provide valuable information regarding the safety and quality of maternity care within a service, with reports shared with other regulators. This is currently the only system in place to provide a review of maternity services on an annual basis (Read and Wallace 2014). The LSA annual quality assurance monitoring by the NMC is a further mechanism in which a strategic oversight of midwifery can be obtained, trends identified and examples of good practice shared.

7.2 Future plans for the mechanisms to provide non-regulatory midwifery supervision will need to consider the process of strategic input to meet the recommendation of The King’s Fund report that ‘NHS England, the Welsh Assembly, Scottish Government and Northern Ireland Assembly should assure themselves that they have adequate facility for accessing strategic input from the midwifery profession into the development of maternity services’ (The King’s Fund 2015 p.28).

7.3 Recommendation 3: The current links between supervisors, maternity service providers and regional and national policy makers should be strengthened in the absence of the LSA, to ensure that a strategic view of maternity provision is maintained and the appropriate services commissioned. This should form a key criteria in the review of maternity services in England and Scotland.

Part 3

8.0 Re-framing midwifery supervision – the rationale for clinical midwifery supervision

8.1 The areas of non-regulatory activity are explored in the context of contemporary policy and strategy reports and broadly fit the five key aspects found within most definitions of clinical supervision. These key aspects are:
• Reflection
• Support from a skilled facilitator
• Focus on clinical practice
• Professional development
• Improving patient treatment and care.

8.2 The additional elements within the current model of midwifery supervision include:

• 24 hour availability for midwives ensuring that supervision is proactive and reflexive as well as reflective.
• Support and advocacy for women if they wish to discuss any aspect of their midwifery care that they do not feel has been addressed through other channels or are experiencing difficult accessing the care they require.

8.3 The concept of supervision is one that has been interpreted in different ways within the professions and the understanding of what it consists of is widely variable (Davys and Beddoe 2010). The King’s Fund report (2015) echoes this stating that there was significant confusion around terminology, with the term ‘statutory supervision’ being used in different ways and referring to a wide range of functions.

8.4 Clinical supervision was first described as a systematic tool for improving healthcare from a nursing perspective more than twenty years ago (DH 1993) and in response to recommendations from the Winterbourne View Serious Case Review the CQC published information and guidance for supporting effective clinical supervision. This document describes the key differences between appraisal and supervision and uses the definition of supervision from Skills for Care (2007), as ‘an accountable process which supports, assures and develops the knowledge, skills and values of an individual, group or team’ (CQC 2013 p.4).

8.5 Clinical supervision is not a managerial control system. It is not therefore:

• the exercise of managerial responsibility or managerial supervision although links between clinical supervision and management are important
• a system of formal individual performance review or
• hierarchical in nature.

8.6 Although there are different approaches to supervision and the way in which it is provided varies, it is widely accepted that supervision within healthcare has benefits for the individual engaging in supervision, people who use services, and for the organisations providing healthcare services (CQC 2013).

9.0 Benefits for the individual

9.1 One of the key functions of clinical supervision as identified by Proctor (1998 cited by Helen & Douglas House 2014 p.24) is that of support. Support is also referred to as the ‘restorative’ function of supervision, concerned with how supervisees respond emotionally to their work. This function fosters resilience and can help individuals to manage the personal and professional demands of working in healthcare environments, providing an environment where personal and emotional reactions can be explored (CQC 2013). Hunter & Warren (2013) and Byrom & Downe (2015) identify the development of resilience in midwives as an important factor in the delivery of compassionate midwifery care.

9.2 The NHS Constitution for England (DH 2013) pledges to provide support and opportunities for staff to maintain their health, wellbeing and safety in order to ensure the
provision of high quality compassionate care. It has been argued that effective clinical supervision can be protective against work-related stress and ‘burnout’ and plays an important role in maintaining the health and wellbeing of practitioners (Hawkins & Shohet 2000). Evidence also supports the correlation between staff experience and the quality of care (Maben et al 2012), which is recognised in the Compassion in Practice strategy that states: ‘Our shared purpose will only be achieved if staff are supported to do their job well. This involves providing supervision and support within a culture of care, compassion and a recognition of the emotional labour of nursing, midwifery and care giving’ (DH & NHS Commissioning Board 2012 p.24).

9.3 Whilst the regulatory framework has always been clear that a midwife is an autonomous practitioner, the context of maternity care provision is changing (Midwifery 2020). More midwives are likely to be working in smaller teams in community settings providing care in midwifery-led units and home birth services (NICE 2014). The Five Year Forward View also supports groups of midwives setting up their own NHS funded midwifery services (NHS England 2014).

9.4 The Compassion in Practice Vision and Strategy: An Approach in Midwifery Care (NHS England 2012) identifies some of the current challenges in maternity care, which affect the work environment for midwives:

- increasing complexity and intensity of physical, psychological or social needs of women
- associated increasing acuity and activity levels
- meeting increasing expectations of women, their families and health care partners
- a rising birth rate
- making every contact count to improve public health

9.5 As well as the challenges identified above and midwives promoting better births for these women, it is has also been documented that midwives are often required to provide care for high-risk women outside of an obstetric unit due to maternal choice (Carr 2008, NMC 2014a).

9.6 The expectation that midwives will work across community (midwifery-led services) and acute hospital (obstetric-led) settings and provide all women with midwifery care will continue to have a direct impact on the way that midwives work and has the potential to increase work-related stress. Effective supervision has been shown to be particularly important in supporting practitioners who work in varied and complex clinical situations where they practice autonomously, work in flattened hierarchical structures and may need to make difficult ethical decisions. It is also considered to enhance the provision of safe services (Hawkins & Shohet 2000, Kirkham & Stapleton 2000).

9.7 Both the context in which midwives work and the unique role they play in forming meaningful and empathetic relationships with the women they care for, may place them at risk of experiencing secondary traumatic stress (Lienwebe & Rowe 2008). Effective supervision provides an opportunity for midwives to reflect on their interpersonal relationships both with their colleagues and the women they care for. The development of interpersonal skills and ways of managing emotions at work are essential to help midwives cope with the often-stressful nature of their work (Deery 2005).

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1 Since the publication of the strategy in 2012 the birth rate has stabilised but remains high
9.8 Recommendation 4: A framework of clinical supervision should be developed to support midwives to maintain and promote standards of care in accordance with the NMC Code including revalidation, lifelong learning and professional development and enable them to provide high quality safe care to women in a continuing changing service environment.

10.0 Benefits for the person using services

10.1 High quality care is likely to be delivered by staff who can access support when they require it, and are therefore able to manage the personal and emotional impact of their practice (CQC 2013 p.5). This supports the current provision of 24-hour access for advice, guidance and support in addition to regular supervisory contact. The 24-hour availability of a SoM has also ensured access to an independent expert if advice is required outside of the usual healthcare provision. This is a mechanism that enhances high quality woman centred care, which respects choice and aims to keep women and their babies safe. There is evidence of the effectiveness of SoMs in providing support in order for women to access care that meets their needs and ensures that their human rights are protected (Amesu 2011, Carr 2008, Jessiman and Stuttaford 2012, Read 2014, Fletcher personal communication 2015).

10.2 The NMC quality assurance reports of the local supervisory authorities (LSAs) highlights that SoMs have been called upon to offer support to women and midwives, highlighting the complexity of decision-making as an increasing trend. The reports also note that women are increasingly wishing to give birth at home, and that through the supervisory framework, LSAs work collaboratively with SoMs, education providers and employers to ensure that all midwives and women continue to have the necessary skills to deliver safe and effective care (NMC 2014a). The 24-hour access to a SoM currently enables midwives to be able to seek support immediately and enables proactive planning, risk mitigation, and enhances the woman’s birth experience as her choices can be discussed and respected. The potential loss of this support for women is of a particular concern to organisations which support women’s rights in childbirth (Prochaska, Birthrights & Duff, nct, personal communication 2015) and the Kings Fund state that organisations providing maternity care will need to consider how they will continue to provide access to such a resource.

10.3 Recommendation 5: All women should continue to have access to an experienced midwife 24 hours a day, this has traditionally been undertaken by the supervisor of midwives in the absence of other experienced and available midwives. Careful consideration should be given to the need to have in each Trust/Health Board a Consultant Midwife (or equivalent) who undertakes this function and ensures that all women have access to individualised, equitable and dignified care. This should be the responsibility of service delivery and should therefore be a key criteria in the review of the maternity services in England and Scotland.

11.0 Benefits for service providers

11.1 The culture of an organisation sets the tone, values and behaviours expected of staff, with practitioners more likely to provide excellent care when the organisations they work in are well led, and driven by commitment (The King’s Fund 2013).

11.2 In making recommendations for creating lasting improvements in patient safety and quality, the Berwick report concluded that these are best achieved through the creation of a supportive organisation, that of a ‘learning NHS’. Two of the four main principles stated in
order to achieve this, could be achieved through a supportive model of midwifery supervision:

- Engaging, empowering, and hearing patients and carers throughout the entire system, and at all times
- Fostering wholeheartedly the growth and development of all staff, their ability and support to improve the processes in which they work

(National Advisory Group on the Safety of Patients in England 2013 p.36)

11.3 In a recent study exploring the relationship between the patient’s experience of care and the influence of staff wellbeing, it was found that high levels of social support from supervisors, in addition to that of co-workers and the organisation, had a positive effect on wellbeing. This type of support helps to reduce exhaustion, and enhances satisfaction and relative positive affect at work (Maben et al 2012).

11.4 Higher levels of job satisfaction lead to improved staff retention and effectiveness, reducing the risk and financial costs of recruitment and of employing agency staff. Effective supervision may increase employee’s perceptions of organisational support indicating a well-led organisation. The Boorman report into staff well-being in the NHS states that: ‘organisations that prioritised staff health and well-being performed better, with improved patient satisfaction, stronger quality scores, better outcomes, higher levels of staff retention and lower rates of sickness absence’ (DH 2009 p.2).

11.5 A recent review by the Healthcare Professions Council (HCPC 2015): ‘Preventing small problems from becoming big problems in health and care’ was commissioned with the aim of bringing new thinking and empirical data to the field of professional regulation, and explored the issues of regulation competence and professionalism in the healthcare professions. The review identified the important factor of staff engagement and concluded that where staff were engaged, patient and service user outcomes were better and quality improved. The review explored the causes of staff disengagement and ways to address the causes of disengagement. Supervision, integrated into a governance system was seen as a key component to catching small problems and being able to address them in an appropriate manner, preventing them from escalating into major issues.

11.6 Supervision can be complementary to other governance aspects such as risk management, practice development, appraisal and revalidation. The proposed model for revalidation (NMC 2014b) will require third party verification of continued fitness to practice. Supervisors are ideally placed to be able to offer this in addition to facilitating gaining service-user feedback, and ensuring a prospective rather than retrospective approach to the education and development needs of midwives, complementing and enhancing the process of management appraisal.

11.7 Currently the LSA maintains the electronic database of all midwives practising in their locality. The database holds information regarding the midwife’s practice and educational requirements identified, dates of supervisory reviews and submission of a midwife’s notification of Intention to Practise (ItP). Submission of the ItP links to the NMC database ensuring that only midwives who meet the standards for practice have live midwifery status on the NMC register. With the NMC plans for nursing and midwifery revalidation to be fully implemented at the end of 2015, it seems counter-intuitive to discontinue the current system.
11.8 Recommendation 6: The NMC to consider retaining the current system of notification of Intention to Practise for midwives and for the current LSA database to be retained by the NHS and used and the electronic system whereby revalidation requirements can be evidenced.

12.0 A model and framework for clinical midwifery supervision

12.1 Professional development and support similar to clinical supervision has been available to midwives since 1902 through statutory supervision. A model of clinical midwifery supervision has been developed, which incorporates a framework for provision and monitoring. The elements within the model illustrate a supportive approach to supervision that is integrated, strategic and is monitored for consistency (Figure 1). There are a number of models of clinical supervision, no single model of clinical supervision is preferred although Proctor’s model perhaps describe must closely the basis of the proposed new model. Clinical supervision can be delivered in a variety of ways, one to one, group and peer are all thought to be effective.

Figure 1: A model for clinical midwifery supervision
12.2 Supportive Supervision: Midwifery supervision needs to be supportive to both midwives and women accessing maternity services. The current 24-hour access to a SoM ensures that immediate support is provided when it is needed most, in situations when midwives and women may be the most vulnerable, enabling a proactive approach to supervisory support. This central element of the model consists of three aspects of supportive supervision: proactive, educative and restorative (Figure 2) adapted from Proctor’s model of supervision (Proctor 1987).

Figure 2. The supportive elements of clinical midwifery supervision

12.3 Proactive: The proactive aspect is that which Proctor calls the accountability or normative component, and focuses on supporting individuals to develop their ability and effectiveness in their clinical role. This aspect supports delivery of a high standard of ethical, safe and effective care and supports difficult or complex clinical decision making. Within midwifery supervision this aspect represents the 24-hour availability of a SoM to midwives and women. Proactive support enables early intervention and risk mitigation to occur, particularly in situations where women may be seen to be making decisions that could be perceived by the establishment as being unwise (Carr 2008, Stone 2014).

12.4 Educative: Proctor considers the learning or educative aspect of clinical supervision as that which enhances professional skills through the development of knowledge, attitude and understanding by insightful, guided reflection. Reflecting on clinical cases and situations with guidance from a SoM supports personal and professional development, encourages lifelong learning and identifies education or training needs that can inform appraisal and revalidation. Educative supervisory support can be effectively delivered in either one-to-one or group situations.
12.5 The educative element of clinical supervision may be fulfilled within the annual supervisory review. Integration of the key themes identified from this into the appraisal and revalidation processes of employer organisations will also ensure a coherent and multi-dimensional approach to supporting staff and influence the practice development agenda.

12.6 Restorative: The restorative component of supervision is concerned with how midwives respond emotionally to providing care for women and their babies. Providing restorative support fosters resilience through the nurturing of supportive relationships that can be protective against work-related stress and 'burnout', and can play an important role in maintaining the health and wellbeing of practitioners (Hawkins and Shohet 2000, Maben et al 2012). Restorative support is particularly important following serious untoward incidents or traumatic events.

12.7 Restorative support is also a vital component in the provision of compassionate care for women and their families. Women may seek advice regarding a situation where birth choices have not been respected or any situation in which debriefing may be necessary. Support from a named supervisor for women and their families following a serious untoward incident throughout the investigation and beyond, has been shown to be a positive supervisory intervention (Read 2014).

12.8 Recommendation 7: The overall benefit of supervision as recognised by the PHSO and Kings Fund reports is sufficient to merit continued investment in clinical supervision for midwives. The investment currently dedicated to the statutory supervision of midwives should be maintained although clinical supervision will require less resource than currently.

12.9 Recommendation 8: The current cohort of SoMs and student SoMs are in a position to be able to continue to provide the identified elements of clinical midwifery supervision. Preparation of supervisors is crucial to the success of clinical supervision. Relevant practice experience is important as well as the development of the necessary skills, qualities and characteristics. These include but are not limited to active listening, facilitating constructive reflection, mentoring, coaching and enabling practitioners to be outcome focused.

12.10 Recommendation 9: Programmes for the Preparation of Supervisors of Midwives (PoSoM) will need to be adapted to provide the required knowledge and skills for the changed role of the supervisors. If the NMC decide that it will no longer be responsible for setting the standards for education provision, validation and monitoring of programmes, consideration will need to be given as to where this responsibility will lie.

13.0 Integration into organisations

13.1 The report of a review into the provision of clinical supervision in Northern Ireland for nurses and midwives concluded that it is crucial that supervision is considered: ‘integral to, and embedded within an organisational learning culture that recognises the complementary nature of supervision, alongside learning and development, performance management and through influencing a care system governed by patient safety and continually improving practice’ (NIPEC 2008).

13.2 There are many references to ‘missed opportunities’ in the Report of the Morecambe Bay Investigation (DH 2015) and indeed other reviews where systematic failures have been identified due to a lack of integrated systems. The opportunity to integrate systems with clear accountability and responsibility defined should not be missed. Findings from the Report of the Morecambe Bay Investigation (DH 2015 p.182) stated that ‘major problems
highlighted by our findings lay not so much in the failings of individual organisations as in the lack of clarity over roles and relationships and the poor communication between organisations’, and led to the recommendation to NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the service quality and patient safety systems suggesting that the Care Quality Commission, take prime responsibility. The Berwick report (National Advisory Group on the Safety of Patients in England 2013) also recommended a high level of coherence between and within organisations, with all systems fully aligned to ensure optimum patient safety.

13.3 Ensuring an integrated approach to supervision contributes to an effective risk management strategy. In high-pressure situations sensitivity to human factors is heightened, in particular those that are most likely to affect perception and cognitive functions (Patient Safety First 2010). This was also considered to be a factor in the incidents where there were concerns about the fitness to practise of the doctors involved in the cases at Morecombe Bay (DH 2015). The provision of 24-hour access to a supervisor (proactive support) enables the midwife to temporarily step outside of a stressful situation to reassess the issues with an experienced colleague, independent of the situation, in order to pre-empt risks and plan the safest course of action through reflexive clinical decision making.

13.4 Recommendation 10: The proactive element of clinical supervision may identify areas in which integrated work with clinical governance and risk management systems need to occur. Clear protocols should be developed to identify how concerns from midwives or women that are raised about access to services or respect for choice in childbirth can be escalated through the established governance processes in order to inform service developments and enhancements.

14.0 Consistent application of clinical midwifery supervision

14.1 Currently there is a designated LSA for each of the four countries of the United Kingdom. The LSA for England is NHS England whilst in Scotland; the Health Boards carry out the LSA function. The Healthcare Inspectorate Wales on behalf of the Welsh Government act as the LSA in Wales, and in Northern Ireland the Public Health Agency undertakes the function. The NMC validates and monitors the provision of education programmes to prepare SoMs for their role, and sets the standards for supervision identified in Midwives rules and standards (NMC 2012) and monitors this through the LSA quality assurance reports.

14.2 If the proposed legislative changes take place, the responsibility for consistency will no longer lie with the NMC or LSA. This will pose a risk in terms of ensuring that the provision of clinical midwifery supervision is both consistent and equitable across the four countries of the UK. Although there will be some variation in the devolved nations in terms of management, regulation and commissioning structures, a framework for clinical midwifery supervision that ensures consistency of approach, with options for local flexibility, is recommended.

14.3 The NMC, as the professional regulatory body and only UK wide organisation would be in the strongest position to take responsibility for ensuring the provision of clinical midwifery supervision through creating an additional condition of registration. Other professions such as psychotherapists, cognitive behavioural therapists, social workers, probation officers and most allied health professionals are required to declare that they receive regular supervision as a condition of registration. Implementing this requirement for midwives, and potentially all registrants, and for this to be verified by the supervisor, would be a timely addition to the revalidation requirements.
14.4 The recommendations from the Francis Report (Mid Staffordshire NHS Foundation Trust 2013) suggest close liaison between the CQC and the professional regulatory bodies, to monitor the effectiveness of appraisal and support. ‘Essential standards of quality and safety’ (CQC 2010a p.134) state that the staff working in healthcare environments should receive appropriate professional development, supervision and appraisal. Using this as an indicator integrated into maternity service inspections could be a solution to monitoring the consistency of clinical midwifery supervision provision.

14.5 The ‘Summary of regulations, outcomes and judgement framework’ (CQC 2010b) state the requirement for service providers to ensure that there are mechanisms in place so that ‘people employed for the purposes of carrying out regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people who use services safely and to an appropriate standard by: receiving appropriate training, professional development, supervision and appraisal’

14.6 The NHS education commissioning bodies monitor the consistency of education programmes through contract monitoring and this would continue to be the case for the provision of PoSoM courses from higher education institutions. Electronic templates to enable supervisors to use the model of supportive supervision, record supervisory activity and annual review could be provided through web access via the NHS education bodies to promote consistency of approach.

14.7 Consideration should be given to the further development of electronic learning resources and systems for recording such activities to link into the NHS electronic portfolio in the nations where this is not yet established, learning from those with established systems such as that provided by The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) & NHS Education for Scotland (NES).

14.8 Immediately following the publication of the Morecambe Bay Investigation report, NHS England announced a major review of the commissioning of NHS maternity services. The terms of reference for the review, released state that it will:

- review the UK and international evidence and make recommendations on safe and efficient models of maternity services, including midwife-led units;
- ensure that the NHS supports and enables women to make safe and appropriate choices of maternity care for them and their babies; and
- support NHS staff including midwives to provide responsive care.

14.9 The recently updated service specification for health visiting: Health Visiting Service Specification 2015-16 (NHS England) sets out the standards required for service providers in terms of supervision standards (Appendix 1). It seems timely to suggest that a similar model is considered in the revised maternity service specification for maternity service providers.

14.10 Recommendation 11: A system for clinical midwifery supervision should be determined nationally, included in the NMC standards, the NHS education commissioning bodies standards and health systems regulators standards for the provision of health services. Consideration should be given as to how compliance could be monitored such as through the framework put in place by the health systems regulator, for example, the CQC in England.
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Appendix 1

Health Visiting Service Specification 2015-16 (December 2014)
[last accessed 06.03.15]

5.11 Supervision

5.11.1 The provider will work with NHS England, HEE and Local Education Training Boards (LETBs) to ensure effective support for trainees and newly qualified HVs. This will be delivered by ensuring the provision of: sufficient practice teachers; support through mentoring and supervision for students and newly qualified staff; and, placement capacity and high quality placements in line with NMC and HEI requirements.

5.11.2 The provider will develop and maintain a supervision policy and ensure that all health visiting staff access supervision in line with the framework below:

5.11.2.1 Clinical supervision
Health visitors will have clinical supervision according to their needs using emotionally restorative supervision techniques on a regular planned basis.

5.11.2.2 Safeguarding supervision
Health visitors will receive a minimum of 3 monthly safeguarding supervisions of their work with their most vulnerable babies and children. These are likely to include children on a child protection plan, those who are ‘looked after’ at home and others for whom the health visitor has a high level of concern. Safeguarding supervision should be provided by colleagues with expert knowledge of child protection to minimise risk. For example, supervision must maintain a focus on the child and consider the impact of fear, sadness and anger on the quality of work with the family.

5.11.2.3 Management supervision
HVs with a requirement to line manage in their roles will have access to a HV manager or professional lead to provide one-to-one professional management supervision of their work, case load, personal & professional learning and development issues. https://www.gov.uk/government/publications/health-visitor-vision18

5.11.2.4 Practice Teacher Supervision HV Practice Teachers must have access to high quality supervision according to the requirements of their role.

5.12 All the above forms of supervision will have an emotionally restorative function and will be provided by individuals with the ability to:

5.12.1 Create a learning environment within which HVs can develop clinical knowledge, skills and strategies to support vulnerable families. This will include experiential and active learning methods.

5.12.2 Use strengths-based, solution-focused strategies and motivational interviewing skills to enable HVs to work in a consistently safe way utilising the full scope of their authority.

5.12.3 Provide constructive feedback and challenge to HVs using advanced communication skills to facilitate reflective supervision.
## Appendix 2

Suggested draft framework for the provision of clinical midwifery supervision

<table>
<thead>
<tr>
<th>Suggested activity</th>
<th>Suggested responsibility/ accountability</th>
<th>Suggested enforcement/monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring that each practising midwife has a named supervisor of midwives</td>
<td>Maternity service provider</td>
<td>NMC Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Systems regulator</td>
</tr>
<tr>
<td>At least annually, a supervisor of midwives meets each midwife for whom she is</td>
<td>Individual midwife</td>
<td>Supervisor</td>
</tr>
<tr>
<td>the named supervisor of midwives to review the midwife’s practice and to identify</td>
<td>Supervisor</td>
<td>NMC revalidation</td>
</tr>
<tr>
<td>her education needs</td>
<td>Maternity service provider</td>
<td>Employer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Governance framework</td>
</tr>
<tr>
<td></td>
<td>Supervisor NHS education bodies</td>
<td>Systems regulator</td>
</tr>
<tr>
<td>All supervisors of midwives within its area maintain records of their supervisory</td>
<td>Supervisor NHS education bodies</td>
<td>Supervisor</td>
</tr>
<tr>
<td>activities, including any meeting with a midwife;</td>
<td></td>
<td>Governance framework</td>
</tr>
<tr>
<td></td>
<td>Maternity service provider</td>
<td>Systems regulator</td>
</tr>
<tr>
<td>All practising midwives have 24-hour access to a supervisor of midwives.</td>
<td>Maternity service provider</td>
<td>Governance framework</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Systems regulator</td>
</tr>
<tr>
<td>A framework exists to provide equitable, effective supervision for all midwives.</td>
<td>NHS education bodies (NES, NIPEC, WEDS,</td>
<td>Governance framework</td>
</tr>
<tr>
<td></td>
<td>HEE)</td>
<td>Systems regulator</td>
</tr>
<tr>
<td>Support for student midwives to enable them to have access to a supervisor of</td>
<td>NHS education bodies AEI Clinical</td>
<td>Governance framework</td>
</tr>
<tr>
<td>midwives.</td>
<td>placement provider</td>
<td>Education contract monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AEI quality review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NMC education quality monitoring</td>
</tr>
<tr>
<td>The ratio of supervisor of midwives to midwives reflects local need and</td>
<td>Maternity service provider</td>
<td>Governance framework</td>
</tr>
<tr>
<td>circumstances</td>
<td></td>
<td>Systems regulator</td>
</tr>
<tr>
<td>A strategy to enable effective communication between all supervisors of midwives.</td>
<td>Maternity service provider</td>
<td>Governance framework</td>
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<td></td>
<td></td>
<td>Systems regulator</td>
</tr>
<tr>
<td>Monitor and ensure that adequate resources are provided to enable supervisors of</td>
<td>Maternity service provider</td>
<td>Governance framework</td>
</tr>
<tr>
<td>midwives to fulfill their role.</td>
<td></td>
<td>Systems regulator</td>
</tr>
<tr>
<td>Publish guidelines to ensure consistency in the approach taken by supervisors of</td>
<td>NHS education bodies to agree a consistent</td>
<td>Governance framework</td>
</tr>
<tr>
<td>midwives in their area to the annual review of a midwife’s practice.</td>
<td>approach and provide the tools via the</td>
<td>Systems regulator</td>
</tr>
<tr>
<td>These must include that the supervisor undertakes an assessment of the midwife’s</td>
<td>e-platforms</td>
<td></td>
</tr>
<tr>
<td>compliance with the requirements to maintain midwifery registration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure the availability of local systems to enable supervisors of midwives to</td>
<td>NHS education bodies Maternity service</td>
<td>Governance framework</td>
</tr>
<tr>
<td>maintain and securely store records of all their supervisory activities.</td>
<td>provider</td>
<td>Systems regulator</td>
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</tbody>
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