



A-EQUIP

a model of clinical
midwifery supervision

A-EQUIP: an acronym for Advocating for
Education and Quality ImProvement

Equalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

Contents

| | |
|--|----------|
| Foreword | iii |
| Executive Summary | iv |
| Context and background | iv |
| A new model of midwifery supervision | iv |
| Transition from a statutory model to an employer led model | v |
| Conclusion | vi |
| Introduction | vii |
| Part 1 The case for change | 1 |
| Background and context | 2 |
| Part 2 A-EQUIP a new model of supervision | 3 |
| Developing A-EQUIP | 4 |
| New Model principles | 4 |
| Co-production with stakeholders | 4 |
| You said we did | 5 |
| The four functions of A-EQUIP | 6 |
| Clinical Supervision (restorative) | 7 |
| Monitoring, evaluation and Quality Control (normative) | 8 |
| Personal action for quality improvement | 9 |
| Education and development (formative) | 10 |
| The role of the Professional Midwifery Advocate (PMA) | 11 |
| The PMA as a leader | 12 |
| Regional support for PMAs | 12 |
| PMA to Staff ratio | 12 |
| Frequency of meetings with a PMA | 13 |
| Selection of a PMA | 14 |
| General Principles for a PMA | 15 |
| Joint responsibilities of the PMA and Midwife | 16 |
| Beginning a clinical supervision session | 16 |
| Concluding the meeting | 16 |
| Do you have a question? | 16 |

| | |
|---|-----------|
| How A-EQUIP and the PMA role works for women | 17 |
| Advocating for women | 17 |
| Providing direct support for women within a restorative approach | 19 |
| Undertaking personal action for quality improvement in collaboration with women | 19 |
| Part 3 Case Studies | 21 |
| Using the A-EQUIP model | 21 |
| Part 4 Guidance for Implementation | 29 |
| Introduction | 30 |
| Section 1: Guidance for providers | 31 |
| Section 2: Guidance for commissioners | 33 |
| Clinical Commissioning Group Maternity Specification | 34 |
| Section 3: Guidance for Higher Education Institutions | 35 |
| Education Programmes preparing PMAs | 36 |
| UK Education principles | 36 |
| The PMA Preparation Programmes | 37 |
| Conclusion | 39 |
| References | 40 |
| Appendices | 43 |
| Appendix 1: Reviews and recommendations | 44 |
| Appendix 2: Membership of the Supervision Task Force and Work Streams | 46 |
| Appendix 3: Key reports and published works | 50 |
| Appendix 4: Professional Midwifery Advocate Job Profile | 52 |
| Appendix 5: Professional Midwifery Advocate Education Programme | 61 |
| Appendix 6: Frequently Asked Questions | 78 |
| Appendix 7: Professional Midwifery Advocate Competency Framework | 81 |
| Appendix 8: Evaluation of the Pilot Sites | 89 |

Foreword

Professor Jane Cummings, Chief Nursing Officer for England

As Chief Nursing Officer for England I am immensely proud of our Midwifery profession and the way midwives continue to strive to improve the maternity experiences and outcomes for women and their families.

Professional development and support similar to clinical supervision has been available to midwives since 1902 through statutory supervision.

Over recent years, the identification of failures in the provision of safe and compassionate care within maternity services (Parliamentary and Health Service Ombudsman [PHSO] 2013, Francis 2013, National Advisory Group on the Safety of Patients In England 2013, Kirkup 2015, The King's Fund 2015) has led to a fundamental change in the way midwives are regulated. This has provided an ideal opportunity for the midwifery profession to develop a new model for midwifery clinical supervision (Department of Health [DH] 2016a).

As Chief Nursing Officer for England and on behalf of other senior professional leaders in England, I am launching a new model of clinical supervision for midwives that aims to facilitate a continuous improvement process that values midwives, builds their personal and professional resilience and contributes to the provision of high quality care. These aims are aligned with the ambitions of

the National Maternity review: *Better Births* (DH 2016b), the *NHS Five Year Forward View* (National Health Service England [NHSE] (2014), and *Leading Change Adding Value; a framework for nursing, midwifery and care staff* (NHSE 2016).

I would like to thank the Local Supervising Authority (LSA) national Task Force for steering the production of the new supervision model and I commend them for working in partnership with women who use maternity services, midwives, leaders and educators, to develop a model that will add value to outcomes for women and their families and the profession. I also thank the pilot sites for the contribution that they have made to testing the new model and assisting with the evaluation. The outcome of this work has had far reaching consequences for the implementation of a model of midwifery clinical supervision that invests in midwives and supports them in the provision of safe high quality care for women, babies and their families.

Jane Cummings

Professor Jane Cummings, Chief Nursing Officer for England

Date 7 April 2017

Executive Summary

This document describes the new model of midwifery supervision, A-EQUIP, an acronym for advocating and educating for quality improvement and provides guidance for implementation. It is of particular relevance to:

All midwives, student midwives, members of the multi professional team, providers of maternity services, Clinical Commissioning Groups (CCGs), Higher Education Institutes (HEIs), The Care Quality Commission (CQC), Maternity Service Liaison Committees (MSLC), Maternity Voices Partnership and Patient Advisory Groups.

The document describes the impact of the legislative change on midwifery regulation and the changes to midwifery supervision. It describes the A-EQUIP model and its benefit to midwives and service users. Case studies have been developed to show how the model can be deployed to support staff working in clinical and non-clinical roles. Key actions for midwives, maternity providers, CCGs and HEIs have been described to aid implementation.

Context and background

Professional development and support similar to clinical supervision has been available to midwives since 1902 through statutory supervision. As a result of legislative change, the function of Local Supervising Authorities (LSA) and statutory supervision of midwifery have now been removed. This was prompted by the brave efforts of three families, who raised complaints that related to local midwifery supervision and regulation. "In all three cases, the

midwifery supervision and regulatory arrangements at the local level failed to identify poor midwifery practice" (Parliamentary and Health Service Ombudsman [PHSO] 2013, page 2)

The PHSO report and the Department of Health (DH) investigation led by Dr Bill Kirkup¹ were critical of the additional tier of midwifery regulation provided by Statutory Supervision of Midwives. The Nursing and Midwifery Council (NMC) therefore commissioned the King's Fund to undertake an independent review of midwifery regulation.

The findings of the Kings Fund review (January 2015) was broadly aligned with the findings of the PHSO report and, subsequently, the Kirkup Report (March 2015) making the recommendation that the supervision and regulation of midwives should be separated and the NMC as the regulator should be in direct control of all regulatory activity.

The governing legislation (the Nursing and Midwifery Order 2001) has been subject to a Section 60 order and the function of Local Supervising Authorities (LSA) and statutory supervision of midwifery have been removed.

A new model of midwifery supervision

With the sponsorship of the Chief Nursing Officer for England, a time limited Task Force² developed a new model of midwifery clinical supervision and set out plans for the transition from a statutory model of supervision, to an employer led professional model (DH 2016a) called A-EQUIP.

1 The relevant sections of these reports can be found at Appendix 1.

2 <https://www.england.nhs.uk/ourwork/futurenhs/mat-transformation/midwifery-task-force/>

The development of A-EQUIP and the associated role of the Professional Midwifery Advocate (PMA)³ have been co-produced with women who use maternity services, midwives, academics, midwifery and nurse leaders and managers, commissioners, the Royal College of Midwives (RCM) and Birthrights.

In developing the new model, the Task Force agreed that Proctor's three function model of clinical supervision (Proctor 1986) and Hawkins and Shoheit's (2012) adaptation of the model, closely described the functions identified by stakeholders as being important for inclusion in the A-EQUIP model. In addition to the functions of Proctor's (1986) model (formative, normative and restorative,) the A-EQUIP model includes a fourth function described as 'personal action for quality improvement', which indicates the importance of continuous improvement.

The A-EQUIP model supports a continuous improvement process that aims to build personal and professional resilience of midwives, enhance quality of care for women and babies and support preparedness for appraisal and professional revalidation. The restorative function has been shown to: have a positive impact on the immediate wellbeing of staff, helps staff to feel 'valued' by their employers for investing in them and their wellbeing, influence a significant reduction in stress and burnout, the job satisfaction of staff, improve the retention of staff, reduce stress levels whilst maintaining compassion, improve working relationships and team dynamics, help staff to manage work/life balance more effectively and increase enjoyment and satisfaction related to work (Pettit and Stephen 2015).

The A-EQUIP model works for women in three ways:

- Supporting midwives to advocate for women
- Providing direct support for women within a restorative approach and
- Undertaking quality improvement in collaboration with women.

Transition from a statutory model to an employer led model

The transition from the statutory model of midwifery supervision to the employer led model requires support from maternity providers, commissioners and HEIs.

Until Professional Midwifery Advocates (PMAs) are prepared through a programme of education, maternity providers are required to support the non-statutory functions of the supervisor of midwives role, that should be provided within the context of the organisations management and governance processes.

To support commissioners and providers to understand the commissioning requirements of the A-EQUIP model, a commissioning specification has been developed and can be found at part four of this guidance. The NHS Standard Contract 2017/18-2018/19 is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care. In accordance with this contract, the provider must ensure that arrangements are in place for all midwives to receive the new national model of midwifery supervision.

The preparation of PMAs is crucial to the success of the PMA role. The four UK countries have collectively agreed the principles that should underpin programmes of the education designed to prepare the new supervisors (Northern

3 The PMA is the practitioner who will deploy the A-EQUIP model and the associated leadership role, see Appendix 4 for the job profile

Ireland, Scotland and Wales) and PMAs (England).

The PMA bridging module/shortened programme and long PMA programme have been developed for the purpose of preparing those midwives who intend to seek appointment as a PMA. Midwives who have completed the preparation of supervisors of midwives course (PoSoM), which was a requirement of the old statutory model of supervision, are required to undertake the PMA bridging module/shortened programme. Midwives who have not completed the PoSoM course will be required to undertake the long PMA programme. Entry onto either programme will require the midwife to undergo an approved selection process, and complete a 30 minute [A-EQUIP e-learning module](#). Recognition as a PMA will be dependent on successful completion of the PMA bridging module/shortened programme or the long PMA programme.

Conclusion

Developing a new model of midwifery supervision for England has been an ambitious and worthwhile process, with far reaching consequences for the midwifery profession and maternity services. The A-EQUIP model was developed in response to changes in legislation and shaped by the contribution of users of maternity services, midwives, educators, managers and nurses. The lessons learned from the pilot sites have also had a significant impact on the final design of the model. We believe that the A-EQUIP model harnesses the strengths of the statutory model, avoids the problems of the past and embraces the opportunities of the future.

The NHS England Supervision Task Force would like to thank service users, midwives, leaders, educators and the pilot sites who have worked with us to co-produce this model. The next phase of implementation is absolutely crucial to its success and will be dependent on maternity providers preparing for implementation of the new model, HEIs developing preparation programmes and NHS England supporting roll out and implementation locally, whilst monitoring process and impact.

Introduction

Since 1902, statutory supervision of midwives has been an integral part of midwifery regulation. The function of the Local Supervising Authority (LSA), has been to uphold the NMC Midwives Rules and Standards (NMC 2014). This function has been quality assured by the NMC annually. However, prompted by complaints raised by three families⁴ (PHSO 2013), statutory supervision of midwifery has been removed.

The DH acknowledged that there were a number of non-regulatory elements of statutory supervision that were highly valued by midwives and women and in January 2016 the DH published a set of principles that were to underpin the development of new models of clinical midwifery supervision (DH 2016a).⁵

This document describes the new model of midwifery supervision, A-EQUIP, an acronym for advocating and educating for quality improvement and provides guidance for implementation. It is of particular relevance to:

- All midwives and student midwives
- Members of the multi professional team
- Providers of maternity services
- Clinical Commissioning Groups (CCGs)
- Higher Education Institutes (HEIs)
- The Care Quality Commission (CQC)
- Maternity Service Liaison Committees (MSLC)/Maternity Voices Partnership
- Patient Advisory Groups.

This document is organised in four parts:

- **Part one** describes the impact of the legislative change on midwifery regulation and the changes to midwifery supervision
- **Part two** describes the A-EQUIP model and its benefit to midwives and users of maternity services
- **Part three** has a clinical focus. Case studies show how the model can be deployed to support staff working in clinical and non-clinical roles and the benefits of the model to the multidisciplinary team
- **Part four** provides guidance for:
 - Midwives and providers of maternity services and describes key actions for maternity providers
 - CCGs
 - HEIs

4 Complaints raised by three families related to the failure of local midwifery supervision and regulation to identify poor midwifery practice” (The Parliamentary and Health Service Ombudsman (PHSO) 2013, pg 2),

5 DH (2016) ‘Proposals for changing the system of Midwifery Supervision in the UK’ January



Part 1

The case for change

Background and context

The Parliamentary and Health Service Ombudsman (PHSO) and a DH investigation led by Dr Bill Kirkup produced reports⁶ following the Morecambe Bay Investigation (MBI) which highlighted weaknesses in the current system of midwifery regulation that failed to identify inadequate care. Following this investigation, the NMC commissioned the King's Fund to undertake an independent review of midwifery regulation.

The findings of the Kings Fund review (2015) was broadly aligned with the findings of the PHSO report and, subsequently, the Kirkup Report (2015) making the recommendation that the supervision and regulation of midwives should be separated and the NMC as the regulator should be in direct control of all regulatory activity. The main conclusion of the Kings Fund (2015) was that the peer investigation model, a key function of the statutory framework, was not impartial, and led to confusion about processes of clinical governance. This additional investigatory process was not present in other health professions. The NMC agreed with the Kings Fund recommendation in January 2015 and commenced proceedings to secure legislative change.

The DH consulted on proposed changes to the legislative framework governing the NMC, the Nursing and Midwifery Order 2001 (NMO), from 21 April to 17 June 2016 (DH 2017).

The proposed changes to the Order would:

- remove the additional tier of regulation relating specifically to midwives by removing provisions on the statutory supervision of midwives
- remove the Midwifery Committee as a statutory committee of the NMC
- make a number of changes to improve the efficiency and effectiveness of the NMC's fitness to practise processes.

The DH received 1,424 responses to the consultation and after consideration of the responses received, the DH made a decision to move forward with the proposals and lay the Order in Parliament for debate. The changes to the NMO were made via a Section 60 Order which is a legislative vehicle used to amend legislation relating to regulated health professions. The Section 60 Order was approved by Privy Council on the 8 February 2017 and the Order came into force on the 31 March 2017.

⁶ The relevant sections of these reports can be found at Appendix 1.



Part 2

A-EQUIP - a new model of supervision

Developing A-EQUIP

The DH recommended that each UK country establish a Task Force to develop a new non-regulatory model midwifery clinical supervision for midwives.

With sponsorship of the Chief Nursing Officer for England, a time limited Task Force was established in England to develop a new model of midwifery supervision and support the transition from a statutory model of supervision, to an employer led professional model (DH 2016a). Information about the Task Force, its members and working groups can be found at: <https://www.england.nhs.uk/ourwork/futurenhs/mat-transformation/midwifery-task-force/> and [Appendix 2](#).

“The legislative changes do not mean an end to supervision, only to its statutory components. The developmental and supportive nature of supervision is important to the midwifery profession and for outcomes to women and babies. This culture of developmental and supportive supervision should be preserved”

When developing the A-EQUIP model, the Task Force considered input from stakeholders, the findings of the evaluation⁷, key reports and published evidence at [Appendix 3](#), to confidently develop the A-EQUIP model and the “Professional Midwifery Advocate” (PMA) role. The PMA replaces the statutory supervisor of midwives.

New Model principles

The Task Force agreed that the new model should be:

- **Consistent** – standards developed nationally, delivered locally with education and training
- **Strategic** response to national initiatives and strategies such as the quality and safety aspects of Five Year Forward View (NHSE 2014), the DH Mandate (DH 2015)/recommendations from Better Births the National Maternity Review (DH 2016b), registrant revalidation requirements (NMC 2015a) and Leading Change Adding Value (NHSE 2016) with a focus on reducing unwarranted variation.
- **Integrated** – employer led model incorporated into local governance arrangements.

(Gillman and Lloyd 2015)

Co-production with stakeholders

Midwives, nurses and users of maternity services have worked in partnership to co-produce the new model of midwifery supervision.

We have listened to staff and women who use maternity services who have told us what the new model of supervision should include what it should be called, the name of the new supervisor and how they should be prepared for their role. Engagement has involved more than ten months of engagement with over 2,400 people, across the healthcare system including:

- 1,400 survey responses
- An online platform used by 280 people
- Contributions from over 400 delegates at the 2016 RCM conference

⁷ The evaluation of the A-EQUIP pilot sites was undertaken by Sheffield University’s School of Health and Related Research and the School of Nursing and Midwifery

- Contributions from over 800 delegates at various midwifery conferences
- 'Think Tank' made up of key stakeholders including expert service users who have worked within the statutory supervision framework as LSA lay auditors.

You said we did

Following the analysis of engagement and feedback data, it was agreed that the new model of clinical supervision should:

- Have a supportive function
- Build professional resilience
- Support all midwives to provide high quality care and seek to improve it
- Support the advocacy role of the midwife
- Include strategies that value, develop and invest in midwives
- Allow flexibility for local organisational application
- Not create additional financial pressures on providers.

In developing the new model the Task Force considered the findings of the Health Education England '*Mind the Gap*' report (Jones et al 2015) that highlights the need for employers and educators to 'consider models of supervision,

mentorship preceptorship and coaching within the context of meeting the needs of generation Y⁸. This generation make up the majority of the midwifery workforce and require regular support and feedback to develop progress and strengthen their capabilities (Jones et al 2015).

The Task Force agreed that Proctor's (1986) three function model of clinical supervision and Hawkins and Shoheit's (2012) adaptation of the model, closely describes the functions identified by stakeholders for inclusion in the new model of clinical supervision.

Proctor's model (Proctor 1986) is described as having three broad functions:

- '*Formative*', which involves increasing knowledge and skills development
- '*Normative*⁹', which has a managerial focus on monitoring, evaluation and the quality control aspects of professional practice (Cutcliffe and Proctor 1998)
- '*Restorative*', which is concerned with the provision of support required to enhance health and well-being.

This model has been adapted by the inclusion of a fourth function described as '*personal action for quality improvement*' which indicates the importance of continuous improvement (Figure 1).

8 Baby Boomers, Y generation , born 1980 to 1994

9 This function has been added to the A-EQUIP model as a result of the evaluation findings.

The four functions of A-EQUIP

The A-EQUIP model as shown in Figure 1 is made up of four distinct functions: clinical supervision, personal action for quality improvement, education and development and monitoring and evaluation. The model aims to support the midwife through a process of restorative clinical supervision, personal action for quality improvement and preparedness for professional revalidation through a process of reflection. The deployment of the model supports a continuous improvement process that aims to build personal and professional resilience, enhance quality

of care and support preparedness for appraisal and professional revalidation. The model incorporates the important function of on-going monitoring and evaluation to accommodate audit and review.

The new model of clinical supervision is employer led and non-regulatory; it does not involve investigating practice concerns; imposing interim orders; specifying and monitoring local programmes or any regulatory matters relating to the NMC.

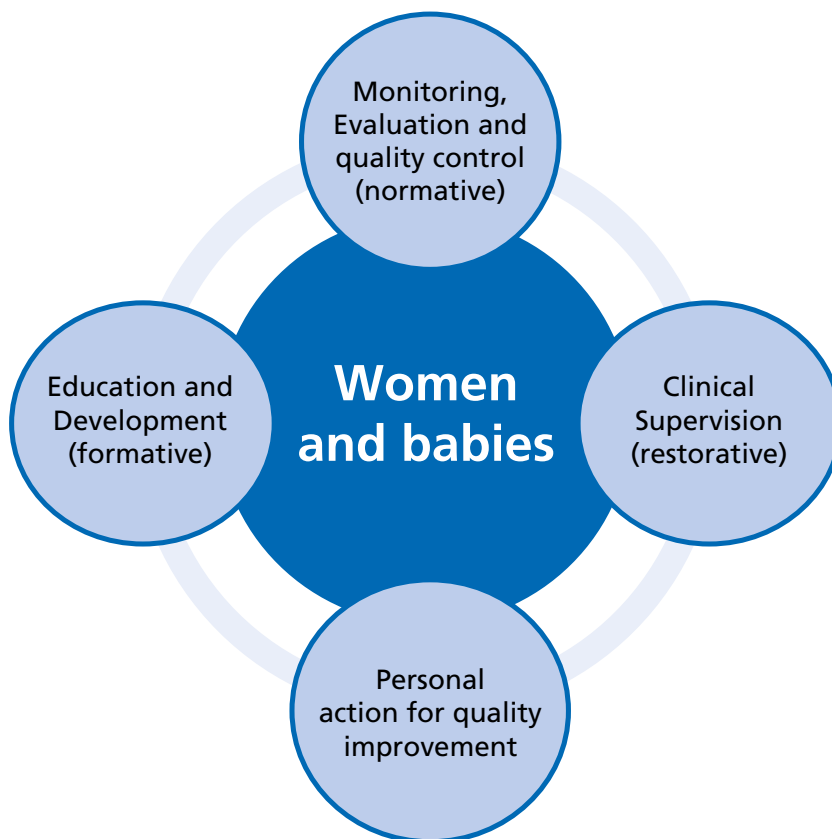


Figure 1: The A-EQUIP model

Clinical Supervision (restorative)

This function is concerned with addressing the emotional needs of staff and supporting the development of resilience. Restorative Clinical Supervision (RCS) involves the creation of thinking space, supporting the practitioner to physically and mentally 'slow down', through a process of discussion, reflective conversation, supportive challenge and open and honest feed-back. RCS restores 'thinking' capacity, enabling the professional to 'understand' and process thoughts which 'free' them to contemplate different perspectives, and inform their decision making (Pettit and Stephen 2015).

This approach has been found to reduce stress and has had a positive impact on physical and emotional well-being, job satisfaction and relationships with colleagues as shown in Box 1 (Pettit and Stephen 2015). During supervision sessions the difficult emotions that professionals are exposed to, are processed through a supportive (Kadushin 1976), confidential relationship rooted in the concepts of Containment and Reciprocity¹⁰ (Solihull Approach 2001) so that the worker feels restored (Proctor 1986).

Box 1: The benefits of RCS

This element of the model has been shown to:

- Have a positive impact on the immediate wellbeing of staff
- Help staff feel 'valued' by their employers for investing in them and their wellbeing
- Influence a significant reduction in stress
- Influence a significant reduction in burnout
- Improve the compassion and job satisfaction of staff
- Improve the retention of staff
- Reduce stress levels whilst maintaining compassion
- Improve working relationships and team dynamics
- Help staff to manage work/life balance more effectively
- Increase enjoyment and satisfaction related to work.

(Pettit and Stephen 2015)

10 Containment is a process which restores individual's capacity to think and the ability to process their emotions and Reciprocity forms the basis of all interactions within relationships and involves initiation, regulation and closure of the interaction. <https://www.learningtrust.co.uk/TPG/PFS/.../Solihull%20Approach%20Workshop.pdf>

Monitoring, evaluation and Quality Control (normative)

The normative function is concerned with evaluation and quality control aspects of professional practice, referred to as the accountability or normative function (Proctor 1986). This element focuses on supporting individuals to develop their ability and effectiveness in their clinical role, whilst facilitating restoration through validation of the midwife's clinical actions or through discussion of any consequences resulting from clinical errors. The benefits of the normative function include:

- Promotion of personal and professional accountability
- Awareness of self-development
- Involvement in service improvement
- Support to the delivery of a high standard of ethical, safe and effective care
- Enhancements to performance.

Personal action for quality improvement

Recognising the increasing complexity of healthcare, the personal action for quality improvement function of the A-EQUIP model requires professionals to be familiar with and contribute to quality improvement. A midwife's personal action(s) to improve the quality of care for women and babies (Box 2), involves ensuring that the right thing takes place, within the right context at the right time to improve quality of care.

Contributing to systems of quality assurance and quality improvement is a fundamental part of the midwife's role as shown in Box 2. Promoting the safety of those who use maternity services is of particular importance. Personal action for quality improvement is a function that aims to ensure that through staff development, action to improve quality of care becomes an intrinsic part of everyone's job, every day, in all parts of the system.

Box 2: A midwife's personal action for quality improvement

A midwife's personal contribution to quality improvement may include:

- Opportunities where they have reflected, learned and taught others about their personal action for quality improvement
- Participation in audit and research and contribution to implementation of findings where appropriate
- Embedding learning from incidents in practice
- Contributing to service improvements made as a result of user feedback and staff feedback
- Addressing public health concerns that require feedback and reassurance to the public
- Facilitating the implementation of research findings,
N.B. active contribution to a quality improvement activity does not need to be in a clinical setting.

Education and development (formative)

This function of the model aims to focus on the development of knowledge and skills through education and can inform appraisal, revalidation and leadership development.

This process can be facilitated by guided reflection (Proctor 1986). Self-leadership can be explored, examining how the midwife interacts with others, influences change and improves care. This will also increase self-awareness and self-confidence.

One of the outputs of the restorative and personal action for quality improvement functions of the A-EQUIP model may be to explore opportunities for personal and professional development, whilst assisting the midwife to recognise and build on links between appraisal and revalidation. The case studies in part 3 of this guidance show how the A-EQUIP model can be applied in difference situations.

The role of the Professional Midwifery Advocate (PMA)

The PMA is a new and fundamental leadership and advocacy role designed to deploy the A-EQUIP model. The role supports staff through a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for professional revalidation (Figure 2). The PMA role descriptor can be found at [Appendix 4](#) and the PMA competency framework at [Appendix 7](#) involves:

- Deployment of the A-EQUIP model
- Supporting and developing the advocacy role of midwives
- Supporting and guiding midwives through actions that will be of benefit to women and their families

- Providing support and feedback to develop, progress and strengthen the capabilities of the midwifery workforce

To undertake the role, a midwife must successfully complete a PMA preparation programme (bridging module/shortened or long programme). Further information regarding this programme and the competency framework can be found at [Appendix 5](#). A PMA can be employed full time, or the role can be undertaken on a sessional basis, in addition to a midwife’s substantively employed position. The employer should choose the approach that meets the needs of the maternity service.

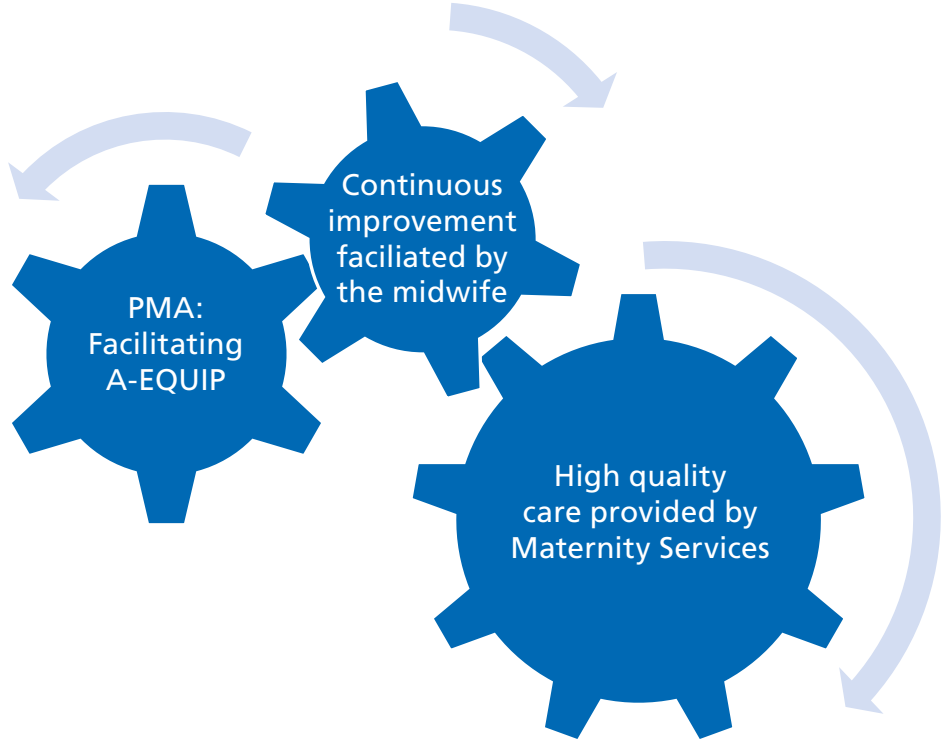


Figure 2: the PMA supporting continuous improvement

The PMA as a leader

- Leadership is an essential part of the PMA role and the practical elements of leadership are described in the job profile at [Appendix 4](#). Leadership skills are a key component of the PMA preparation programmes
- PMAs show leadership by being self-aware, knowing their own values principles and assumptions and being able to learn from experiences
- They are able to manage and organise themselves whilst taking account of the needs and priorities of others
- PMAs act with integrity behaving in an open, honest and ethical manner and uphold the NMC Code (NMC 2015b) in all they do
- They build and maintain relationships with midwives by actively listening, gaining trust and by being an effective advocate. PMAs create a climate of continuous service improvement by encouraging improvement and innovation. (NHS Leadership Academy 2011)
- PMAs provide care and support (personally and professionally) to midwives and multi-disciplinary teams.

Regional support for PMAs

The changes to statutory supervision of midwifery have created an opportunity to develop a new midwifery leadership structure at regional level. The roles of: Regional Maternity Lead and Deputy Regional Maternity Lead have been established in each of the four NHS England regions¹¹.

These roles will provide midwifery leadership and professional guidance to ensure that the NHS ambitions are realised and deployed through the commissioning of high quality, safe maternity services.

The Regional Maternity Leads and their deputies will support maternity providers to embed A-EQUIP, the PMA roles and support the development of process and outcome measures.

PMA to Staff numbers

- The A-EQUIP model is flexible and can be implemented in response to organisational requirements. Each organisation has the opportunity to review their workforce requirements and implement a ratio of PMAs to midwives.
- The number of PMAs are dependent on tasks, standards and responsibilities of the PMA and the midwife. Effective supervision ratios are dependent on tasks, standards and responsibilities (Cleveland 2012). The number of midwives to PMAs considered to be appropriate for deploying effective supervision can range from 5-1 or 20-1.
- Some healthcare organisations have already decided how they will implement the A-EQUIP model, some are considering sessional PMAs and others are considering a combination of one full time PMA and a small number of sessional PMAs. The example at Box 3 describes the approach of one maternity service.

11 There is one Regional Maternity Lead and a Deputy Regional Maternity in each of NHS England's four regions (North of England, Midlands and East, London and the South)

Box 3: One provider's approach to deploying the PMA role

The Royal Free Experience

Context

The Royal Free London NHS Foundation Trust provides maternity services on multiple sites (Barnet Hospital, Chase Farm Hospital, Edgware and the Royal Free Hospital (RFL). They have approximately 9,000 births per year and a midwife to birth ratio of 1:29. To implement the A-EQUIP model they are proposing to introduce 2 full-time PMAs to cover all hospital sites.

PMA role

The full time PMA roles will join the existing cross site maternity education team which includes two practice development midwives, two clinical practice facilitators and a part-time clinical teacher role. This team is led by the consultant midwife who leads on education and practice development. It is proposed that the education team will undertake the PMA preparation programme. This will ensure that the PMA role can contribute to quality improvement strategy.

The RFL has developed its own job description based on the national PMA job profile and personal specification at Appendix 4. This will be submitted for job matching locally.

(Mai Buckley, Director of Midwifery).

- PMAs appointed on a sessional basis can be responsible for deploying the A-EQUIP model to midwives, medical and support staff ¹²working in a specific clinical area such as the; antenatal clinic, labour ward, birth centre, postnatal ward or the community
- Independent providers of midwifery services can commission places on the PMA bridging module/shortened or long programme to be able to implement the A-EQUIP model locally. This includes Midwifery Employment Agencies and Independent Midwifery practices.
- Midwives should consider with the PMA, the time required for supervision
- Health care providers should be committed to releasing midwives to access clinical midwifery supervision through the A-EQUIP model
- Whilst some midwives may require frequent meetings with a PMA; providers must ensure that all midwives have an opportunity to meet with the PMA at least once a year (DH 2016a) if required. The NHS England Task Force has produced an annual review tool for this purpose which links directly to revalidation¹³. The PMA must be available to meet with the midwife as the need arises. For some midwives this may mean meeting with the PMA once a year, for others, a more frequent meeting with the PMA may be required

Frequency of meetings with a PMA

This guidance does not specify how many hours of clinical supervision midwives should have because different midwives will have different needs, however:

12 The inclusion of medical and support staff in group supervision sessions may be beneficial when there are items relating to 'team' that fall within the remit of the PMA role. See section 3 clinical scenarios.

13 <https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2016/12/nhs-supervisor-midwives-annual-rev.pdf>

(Turner and Hill 2011) for example student and preceptorship midwives.

Selection of a PMA

The job profile for full time PMAs can be found at [Appendix 4](#). This should also be used as a role descriptor for sessional PMAs and can be adapted by the employer in line with local requirements and in preparation for Agenda for Change [AFC] (NHS Employers 2014) matching where appropriate.

- The Head/Director of Midwifery is responsible for the selection of PMAs. Peer nomination should be considered as part of this process (DH 2016a);
- Midwives who have previously successfully completed the PoSoM course or equivalent, are eligible to be selected to undertake the bridging module/shortened programme, if they meet the criteria stipulated by the HEI and they satisfy the employers internal processes for attending a programme of education

General Principles for a PMA

- A-EQUIP sessions must be confidential between the PMA and the midwife, with the exception of when prior permission is given by the midwife or, for example:
 - There is disclosure regarding child protection and vulnerable adult legislation or
 - The midwife discloses something that the PMA considers to be unsafe or negligent.
- Sufficient time must be allocated for supervision to occur at planned intervals
- Each session must have strict boundaries in terms of the length of the session and may take, for example, one hour. This must be established at the beginning of the session
- The PMA and midwife need to ensure ground rules are set for supervision sessions, and that these are documented and stored by the midwife receiving clinical supervision.

In these situations, the PMA must support the midwife to follow the appropriate process to address the issues and ensure that action is taken within time frame agreed. If appropriate processes are not followed, the PMA must inform the midwife's line manager and inform the midwife that the manager has been contacted.

Responsibilities of the PMA and Midwife

- The PMA must ensure that the midwife knows how to access their services
- The PMA should utilise a safe, space for the midwife to reflect on issues for discussion. A private and confidential space for one to one sessions should be identified
- The midwife must take responsibility for arranging to meet with a PMA as the need arises. The PMA should ensure that their availability and contact details are clearly displayed
- The midwife should identify issues for discussion and negotiate the session agenda with the PMA.

Box 4 gives examples of opening questions the PMA may wish to consider.

Box 4

Beginning a clinical supervision session

Following preliminary introductions, the PMA *may* choose one/all of the following to start the meeting after general introductions have been made:

1. What would you like to accomplish from supervision?
2. What would you like to share/discuss to ensure that this session is worthwhile?

Additional prompt questions that may be helpful during the meeting:

1. Think of something you would like to move forward – describe it in one sentence
2. What do you want to achieve? What long-term result would you get and by when?
3. When you get to the desired result, what would be the benefit to you; to the women you care for or to students and colleagues?
4. What have you done about it before and what caused that to not be fully successful?
5. What is really at the heart of the issue or situation today?

Concluding the meeting

1. Do you know if this session has been worthwhile? How do you know?
2. Which idea are you going to take forward?
3. What is the first thing you are going to do?
4. What support do you need?

Do you have a question?

For further information regarding the PMA role and the A-EQUIP model, please see the frequently asked questions at [Appendix 6](#).

How A-EQUIP and the PMA role works for women

This section of the guidance has been designed to facilitate understanding of how the A-EQUIP model and how the PMA role can benefit women and babies.

The A-EQUIP model works for women in three ways:

- Advocating for women
- Providing direct support for women within a restorative approach
- Undertaking quality improvement in collaboration with women.

The model has been designed to provide all midwives via PMAs with the skills and knowledge to be able to advocate confidently for women. It also provides the flexibility for PMAs to continue to offer direct support to women if the maternity provider chooses this approach. PMAs can also use the specialist knowledge gleaned from their PMA role to contribute to making service improvements through their local Maternity Voices Partnership.

Advocating for women

Advocacy calls for midwives to apply their knowledge and skills flexibly and use their privileged position to empower women to:

- Have their voices heard on issues that are important to them
- Safeguard their rights, flowing from the European Court of Human Rights (ECHR) and the Human Rights Act 1998, to be treated with dignity, respect and as autonomous individuals from whom informed consent is required for any intervention undertaken

- Have their decisions respected about their care and that of their unborn or new-born baby
- All midwives will be supported by the PMA to advocate for women, including those planning more complex care that may fall outside traditional pathways, recognising that women have a legal right to be informed about the benefits and risks of all available options and to weigh these up for themselves, supported by their midwife and obstetrician where required.
- The PMA will help colleagues to recognise that a woman's view of benefit and risk is subjective and may differ from that of the healthcare professional, but nonetheless needs to be respected and advocated for, as long as the woman has been given all the information required to make an informed choice
- The Montgomery and Lanarkshire judgement (2015) marked a significant change in approach away from "treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome)" to an approach which "treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices." Part of the PMA's role is to support midwives to support women whose care choices they do not necessarily agree with and may find distressing.

- The human rights framework¹⁴ and specifically the 2011 judgement made by the ECHR (see box 5) also provide a legal context for advocating for women's right to choice of place of birth. Lipsky (1980) however points out that advocacy must seek out the best outcome in the context of constraints of a service.

However it needs to be recognised that women cannot be compelled to attend hospital in labour and the NMC Code (NMC 2015b) as well as human rights law compels midwives to attend a woman in labour. A woman-centred approach will require in depth discussions with a woman in advance, about her views and wishes. If a woman wants to birth at home, even if a service is stretched or her pregnancy is complex, the provider needs to put in place the appropriate support for this.

- The PMA has a role to play in supporting all midwives to be effective advocates for women throughout their pregnancy, birth and in the postnatal period. This should be a central element of their work with all midwives
- Advocacy should be strongly embedded in research and evidence based practice, but needs to recognise the legal right of a woman to make any decision relating to her care, as long as she has mental capacity. This holds EVEN if a woman makes a decision which seems irrational to her care team.

- The PMA should support midwives to advocate for women who choose birth options that are outside the maternity provider's policies and guidelines. The advocacy approach should be based on: research and evidence based practice and case specific risk assessment relating to a woman's past and current experience, or her specific feelings/wishes/decisions about her care
- Maternity providers must assure themselves that women, particularly vulnerable women, have access to the range of evidence based information and advice presented in a fair and transparent way. This can be via PMAs support for midwives or other means
- The PMAs role is to help midwives to develop the skills to be able to plan safe personalised care for every woman, including women with complex care requirements and to mediate with other professionals, and the women and her family when appropriate
- PMAs should seek to establish themselves as safe trusted voices on the basis of their evidence based and impartial judgements of what best serves a women's interests.

Box 5

In 2011, the European Court of Human Rights considered an application brought by a woman who wished to give birth at home with the assistance of a midwife. The Court found that the right to respect for the private life under Article 8 included the right about where to give birth. This meant that the state had to provide 'a legal and institutional environment' that enabled midwives to support women's choice of place of birth'.

(The British Institute of Human Rights 2016)

14 <https://www.rcm.org.uk/news-views-and-analysis/news/new-human-rights-guideline-for-midwives>

Providing direct support for women within a restorative approach

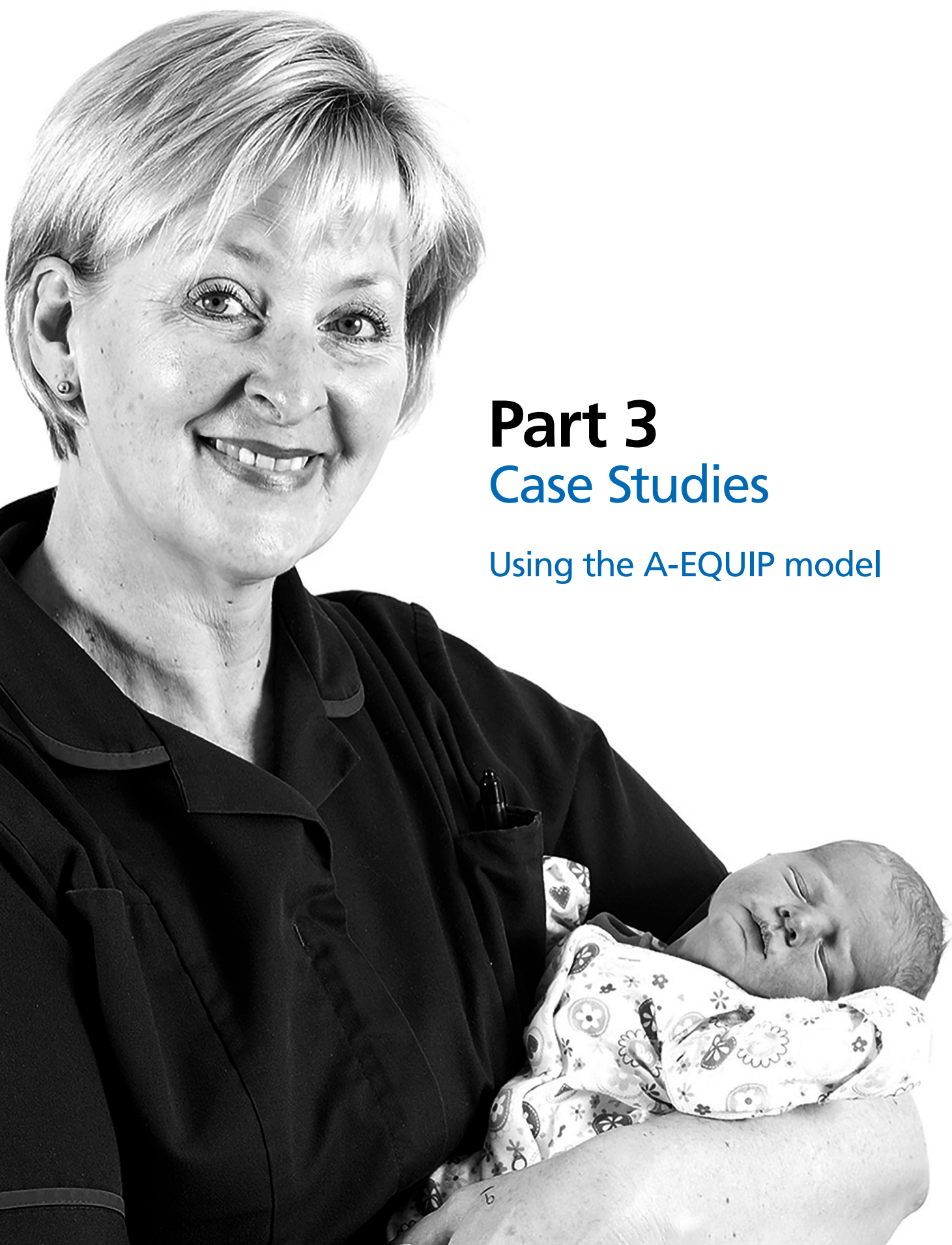
The Midwives rules and standards (NMC 2012) provided scope for supervisors of midwives to develop ways of responding to issues raised by women about their care that had not been addressed by other channels.

Listening clinics designed to receive feedback from women about their birth experience and to enable discussion on birth planning were widely established by supervisors of midwives (a non-statutory function of the statutory supervisor of midwives role) in response to this. There is scope within the PMA role to continue this work and introduce learning from the restorative function of the A-EQUIP model.

- Maternity providers should give consideration to establishing or continuing listening services and clinics through which PMAs directly support midwives to undertake this role with women, or should identify how this function can be delivered elsewhere within the maternity service
- PMAs should support midwives to seek to integrate their learning and understanding of the restorative approach into their direct work with women.

Undertaking personal action for quality improvement in collaboration with women

- Listening clinics and similar services will provide feedback from women which can be aggregated and fed back to the local Maternity Voices Partnership
- This can allow individual midwives to reflect and make changes to their practice that lead to improvement in the quality of the care they provide, and at service level can lead to operational changes that impact on how the service is delivered
- PMAs should consult with women when they are initiating service improvement initiatives and women from a diverse range of communities should be involved in the co-design co-production of those initiatives through their Maternity Voices Partnership.



Part 3

Case Studies

Using the A-EQUIP model

The A-EQUIP model can be applied in different ways and can be of benefit to clinical and non-clinical midwives regardless of where they are employed. This is illustrated by the following case studies.

Case Study 1

Tammy works as a midwife in the antenatal clinic and is preparing for her annual supervision meeting with her PMA. She re-reads the letter sent to her by her PMA and accesses the 'Annual Review form for Midwives supporting revalidation'¹⁵. Tammy identifies two examples of practice related feedback and two reflective accounts that she wishes to discuss with her PMA. She then completes the Annual Review tool, as far as she is able to, prior to meeting with her PMA.

Meeting with the PMA

Following the usual preliminary introductions, the PMA explains the aim and objectives of the meeting and asks Tammy what she would like to share to ensure that the session is worthwhile. Tammy shares her reflective account which describes her frustration and stress about using limited antenatal appointment time running around trying to find supplementary educational information for women, and the sonicaid that is shared between two rooms. She shares her frustration regarding her inability to complete bookings and follow up appointments on time and she feels that this affects the quality of the time she spends with women.

PMA uses the A-EQUIP model

Following acknowledgement of Tammy's account, the PMA decides to start the restorative clinical supervision process. The PMA utilises a containing, reciprocal approach in both the physical and emotional environment provided for Tammy, enhancing her experience to one that is conducive to clearer, calmer thinking and emotional restoration. (South Warwickshire NHS Foundation Trust [SWFT] 2016).

The PMA goes on to discuss quality improvement and Tammy's personal action based on the experiences that she has shared. The solutions that Tammy shares include: developing a process to ensure that pre-prepared information packs are always available. She also discusses with her line manager the rationale for purchasing additional sonicaids for the antenatal clinic.

Tammy completes her action plan with the Annual Review tool and it is signed by both Tammy and her PMA. Tammy saves her reflective accounts and evidence of practice related feedback in her personal revalidation portfolio.

15 <https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2016/12/nhs-supervisor-midwives-annual-rev.pdf>

Case Study 2

Group scenario

Following a multidisciplinary incident review meeting, the PMA is asked to facilitate a group supervision session for members of the team. The PMA books a suitable venue and ensures that invitations are distributed to everyone who may benefit from the session.

Meeting the PMA

The PMA welcomes the multidisciplinary team to the session. The PMA explains that the aim of the meeting is to support the group to have the time and 'thinking space' to revisit the clinical incident identified at the incident review meeting and in doing so promote healthy, reflective conversation that supports, challenges and encourages open and honest feedback (Pettit and Stephen 2015).

PMA uses the A-EQUIP Model

The PMA encourages the group to revisit their experience, initially using a restorative approach. This approach has been found to reduce stress and have a positive impact on physical and emotional well-being, job satisfaction and relationships with colleagues (Pettit and Stephen (2015)). The PMA encourages the group to reflect on the shared incident, including the sequence of events and the factors that influenced decision making. This process enables staff to contemplate each-others perspectives as advocated by Pettit and Stephen (2015).

Once all attendees have had the opportunity to contribute, the PMA focuses on the education and development function. The PMA encourages the multidisciplinary team to recognise the key issues that emerged from the discussions and encourages the attendee's to reflect on what they have personally gained from the opportunity of viewing the incident from a shared perspective. The PMA promotes the value of reflection and encourages written reflection, highlighting how they can support both revalidation and appraisal.

One midwife recognises an individual learning need as a result of the discussions at the meeting, and speaks to the PMA about an identified area of practice improvement she wants to pursue. The PMA encourages her self-evaluation and supports her recognition of personal actions that she feels will contribute to quality improvement.

Case Study 3

Hannah is a new midwifery lecturer at a local University. Hannah has contacted her PMA and requested an urgent meeting, as she has received student feedback from a recent module evaluation which has caused her concern in her new role. Hannah briefly shares her concerns with her PMA and explains that the urgency is due to the fact that she has her annual appraisal in a few days' time and that the next run of this module starts in four weeks.

Meeting with her PMA

Recognising Hannah's anxiety and the need for a timely discussion, the PMA organises a meeting with Hannah for the following morning. At the meeting the PMA explains her role and asks Hannah to talk more about her concerns. Hannah explains that in the feedback the students had queried the relevance of some of the subject matter and the way in which Hannah had structured and delivered the lessons.

Hannah is concerned about her ability as a new lecturer to support students to see the relevance and application of theory and research to practice. Hannah worries that she lacks confidence in developing quality learning experiences and that she is not competent in her role.

PMA uses the A EQUIP model

The PMA explores with Hannah what the focus of the module is, how she structures the sessions and why she feels that she lacks competence. The PMA assists Hannah to review the feedback given by students more objectively. The PMA and Hannah discuss the general difficulties in bridging the theory-practice gap, including types of learning activities that might help to address this. The discussion explores general student anxiety about the need to be fit for purpose in a busy maternity unit and how this can manifest into dissatisfaction with theoretical learning environments which do not always have a direct practical or clinical skill focus.

The PMA empowers Hannah to use a PDSA (Plan, Do, Study, Act) model to assess her current performance and identify what her development needs are. Hannah reflects on this model and identifies that she needs to discuss her development as a midwifery educator at her appraisal and also with other colleagues. Whilst reflecting, Hannah also identifies the parallels of receiving service user feedback from her time working in a clinical midwifery role. Appreciating the importance of feedback as a tool for her own development as a midwifery educator, Hannah makes a plan to work with students and colleagues to assist her to develop sessions that promote the relevance, and application, of theory to contemporary midwifery practice.

The PMA encouraged Hannah to document the discussion and her reflection to add to her revalidation portfolio.

The PMA supported Hannah to reflect and have protected time to reach her own solution to what she perceived as a problem by using a restorative function and an exploration of her personal action for quality improvement.

Case Study 4

Felippe is a newly qualified midwife who observed a serious clinical incident which has resulted in a poor outcome for the baby. He has contacted his PMA as he feels very anxious and is not sure what to do.

Meeting with his PMA

The PMA organises a meeting as soon as possible recognising how anxious and distressed Felippe is. The PMA explains her role and encourages Felippe to talk through what happened. He is very upset and requests a meeting with the PMA.

PMA uses the A-EQUIP model

As Felippe recalls and reflects on what had happened it becomes apparent that he recognised a few risks that caused him concern. He correctly escalated his concerns to a senior midwife and a doctor who expedited the delivery. The PMA facilitated a reflective discussion and focused on the restorative function of the A-EQUIP model. She supported Felippe to identify that his anxiety was due to never experiencing that situation since qualifying as a midwife. The PMA identified that Felippe would benefit from further sessions of restorative clinical supervision and arrangements were made to meet the following week. Felippe was relieved following this supportive intervention by his PMA and also felt empowered to approach his line manager to ask for additional support on his next shift on the labour ward. Following his reflection Felippe met again with his PMA and requested a skill and drills update to provide him with further reassurance. This was arranged and Felippe's confidence improved as a result.

The important part of the reflective session with the PMA was that Felippe was able to be supported in his good practice and to personally identify areas for his own learning and professional development.

Case Study 5

Morgan is an independent midwife working within a practice which has access to a PMA. This is Morgan's first meeting with the PMA and Morgan is aware that whilst the PMA works in a NHS organisation he is experienced in working with Independent Midwives. Morgan wants to discuss her revalidation requirements as she has to submit her evidence in 10 months' time. The PMA has recommended that Morgan uses the Annual Review form for Midwives supporting revalidation and Morgan brings all the relevant paperwork to her meeting. Morgan also accesses the NMC website and prints off the Revalidation Handbook.

Meeting with the PMA

Following the usual preliminary introductions, the PMA explains the aim and objectives of the meeting and asks Morgan what she would like to share to ensure that the session is worthwhile. Morgan explains that she is anxious as she has to compile her evidence in order to successfully revalidate with the NMC and that she is overwhelmed by all the information she has to provide and what happens if the detail is inappropriate and she is unable to revalidate.

PMA uses the A-EQUIP model

Following acknowledgement of Morgan's concerns, the PMA starts the restorative clinical supervision process beginning with the Annual Review tool which is directly linked to revalidation. He discusses the paperwork that Morgan has brought to the meeting (examples of reflective pieces and practice based feedback) and encourages Morgan to reflect on the suitability of the evidence. This discussion and honest feedback reduced Morgan's feelings of stress and helped her to gain a deeper insight of self. Through a process restorative supervision, she felt able to manage the process of revalidation preparation without feeling overwhelmed and stressed.

At the end of the meeting Morgan discusses her action plan with her PMA and he recommends that Morgan uses the NMC revalidation reflection template to write a reflective piece about her meeting with her PMA and submit it as part of her evidence for Revalidation.

Morgan concluded that she found the experience to be positive and useful.

Case Study 6

Florence has been qualified for two years and has recently rotated into the community where she carries her own caseload. Florence books Mo onto her caseload and she chooses to have a home birth. The risks associated with Mo's pregnancy however, indicate that she does not meet the Trust eligibility criteria for a home birth. It is Florence's responsibility to explain the Trust eligibility criteria and ensure that Mo is fully aware of the risks associated with her decision. Despite Florence's explanation, Mo insists that she will have a home birth regardless of the Trust guidance. Florence decides to discuss Mo's request with a PMA


Meeting with the PMA

Following the preliminary introductions, the Florence shares her concerns and is anxious about advocating for Mo knowing that she does not meet trust eligibility criteria for a home birth. She asks the PMA for support. Florence also shares her concerns about being on call for home births.

PMA uses the A-EQUIP model

Having listened to Florence's concerns the PMA encourages Florence to talk about advocacy and what it means to her. Together they explore Florence's experience of being an advocate for women. Florence expresses her hope to observe a 'Birth Choices conversation' with the Consultant Midwife and the PMA supports this request to be fulfilled. Florence's confidence is enhanced by this experience and she asks the PMA to accompany her when she meets with Mo and her family. The PMA guides Florence through the process of accessing all necessary evidence as demonstrated by the Consultant Midwife and together they explore how to conduct the meeting with the woman and the importance of communicating the outcome of the meeting in the woman's health care records and with the team leader.

Following the care planning meeting Florence engages the PMA to reflect on her experience and provide feedback. Together they discuss the complexities of balancing women's choice of place of birth with the clinical risk. This experience increases Florence's confidence in advocating for women and being on call and she uses it to create an induction plan for new community midwives which she shares with her team leader. The PMA suggests that Florence's reflection on this experience should be added to her revalidation portfolio.



Part 4
Guidance for
Implementation

Introduction

The process for developing the role of the PMA and implementation of the A-EQUIP model requires consistent guidance for midwives, maternity providers, CCGs, and HEIs. Women who use maternity services also need guidance regarding the transition from the statutory model to the employer led A-EQUIP model. The following sections have been designed to provide this guidance. Further information can be found at [Appendix 6](#), 'frequently asked questions':

- **Section one** provides guidance for midwives and providers of maternity services and describes key actions for midwives, maternity providers and in particular leaders and managers
- **Section two** has been designed to support the commissioning of the A-EQUIP model and has been designed for CCGs
- **Section three** describes the education preparation programmes and provides guidance for HEIs.

Section 1: Guidance for providers

The transition from the statutory model of midwifery supervision to the employer led A-EQUIP model requires an understanding of the model, how it is used (see part 2 and 3) and transformational leadership to support implementation.

The legislative change has brought about an end to the LSA, LSAMO and SoM function. From 1 April 2017, maternity providers are required to support the implementation of A-EQUIP and the PMA role. It is estimated that the preparation of sufficient numbers of PMAs to deploy the A-EQUIP model and the associated functions of the role will take approximately two years.

During this transition period, providers should consider supporting the non statutory function of the supervisor of midwives role and are encouraged to:

- Review the number of PMAs required by the service to implement A-EQUIP
- Review and risk assess the scope of the non-statutory roles undertaken by supervisors of midwives¹⁶ and based on the outcome of the risk assessment choose to:
 1. Support the non-statutory components of that role incorporating the management and governance responsibilities into the existing provider framework
 2. Cease all non-statutory activity, supported by actions that reduce the risk and give consideration to

how these functions can be delivered elsewhere within the maternity service.

- Consider how and what type of support will be provided to midwives in the absence of 24-hour access to a statutory SoM, that enabled midwives to seek immediate support, proactive planning, risk mitigation, and an opportunity for the woman's birth experience and choices to be discussed
- Ensure that communication regarding the legislation change is shared with women who use maternity services. This may involve: adding information to the provider's website and sharing the information with the Maternity Voices Partnership (also referred to as the MSLC [Maternity Services Liaison Committees]) and Patient Advice and Liaison Services (PALs) or the equivalent associated patient advice and liaison services
- Where there are large maternity providers or where a provider has maternity services on more than one site, consideration could be given to amalgamating PMA resource across the local maternity system¹⁷ (LMS) within the sustainability and transformation plan (STP) footprint.

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

17 The purpose of a Local Maternity System (LMS) is to provide strategic cross organisational leadership to enable local maternity services to become safer, more personalised, kinder, more professional and family friendly (DH 2016b)

- Inclusion of the MSLC and the Maternity Voices Partnership¹⁸ is key when implementing the A-EQUIP model. Providers should ensure that they are consulted and involved, particularly in relation to the plans to support women who request atypical care
- Develop plans to commission the PMA preparation programme¹⁹
- Ensure that time is allocated for PMAs to deploy their role
- Ensure that midwives are released to meet with the PMA as required
- The responsibility for providing access to the A-EQUIP model rests with the management team within an organisation. The responsibility for getting the most out of clinical supervision rests with the individuals taking part 'Complex organisational change relies on collective action, and problems occur when there is variable commitment to change' (Helen and Douglas House 2014, p46).

18 Maternity Voices Partnerships are independent formal multidisciplinary committees which come together to influence and share in the decision-making of the Local Maternity System and its constituent parts

19 The preparation of PMA shortened programme will be made available by HEIs no later than September 2017. There are 15 HEIs that have expressed an interest in providing this programme of education. Further information can be found at <https://batchgeo.com/map/4e75337751a4a672cd7871ee72e912d7>

Section 2: Guidance for commissioners

The NHS Standard Contract (NHS England 2017/18) is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care.

The 2017/18 contract has been adjusted to include supervision for midwives (Box 6), and the requirement to follow guidance issued by NHS England regarding its implementation.

Box 6 – NHS Standard Contract (NHS England 2017/18), clinical supervision of midwifery

The Provider must have in place systems for seeking and recording specialist professional advice and must ensure that every member of Staff involved in the provision of the Services receives:

5.4.1 proper and sufficient induction, continuous professional and personal development, clinical supervision, training and instruction;

5.4.2 full and detailed appraisal (in terms of performance and on-going education and training) using where applicable the Knowledge and Skills Framework or a similar equivalent framework; and

5.4.3 professional leadership appropriate to the Services,

each in accordance with Good Practice and the standards of their relevant professional body, if any, and, in relation to clinical supervision for midwives, any Guidance issued by the Department of Health or NHS England.

General Condition 5.4, can be found here (on the NHS Standard Contract webpage, <https://www.england.nhs.uk/nhs-standard-contract/17-18/>)

Clinical Commissioning Group Maternity Specification

This section will assist commissioners and providers to understand the commissioning requirements for the PMA role and the deployment of the A-EQUIP model. It has been developed by the commissioning work stream²⁰ and can be incorporated into an existing maternity commissioning specification at regional and sub regional level.

The provider must ensure that arrangements are in place for all midwives to receive the new national model of midwifery supervision” (Standard NHS Contract 2017/18).

The specification for this model must be outlined in each CCGs Maternity Specification:

- The provider must ensure that arrangements are in place for all midwives to receive the new national model of clinical midwifery supervision” (Standard NHS Contract 2017/18)
- In accordance with DH guidance (DH 2016a) the provider must nominate the staff members who will become PMAs replacing supervisors of midwives
- The number of PMAs required to deploy the A-EQUIP model should be determined by the provider in accordance with this guidance
- Providers must ensure that practitioners have the appropriate qualifications, experience, skills and competencies to perform the duties required of them (NHS Standard Contract 2017/18)
- The provider must ensure that the nominated PMA attends a preparation course, as specified in this guidance (Appendix 5)
- In certain circumstances, some providers may access a locally integrated approach to deploying the A-EQUIP model and the role of the PMA across a local maternity system. This should be locally agreed and include a service level agreement and financial arrangements. Such a service will operate in a highly collaborative way and ensure adherence to and integration with locally agreed pathways, policies and protocols
- The co-ordinating commissioner and the maternity provider must participate in the development of any local quality indicators and/or plans regarding the PMA role and the deployment of the A-EQUIP model.

20 Members: Kate Brintworth, Head of Maternity Commissioning, North East London NHS WALTHAM FOREST CCG, Caroline Brunt, Chief Nurse Dudley Clinical Commissioning GROUP DUDLEY CCG, Sue Collis, former maternity commissioner, Diane Jones, Director Integrated Governance, NHS GREENWICH CCG, Judith Ward, Deputy Chief Nurse Ashford CCG and Canterbury CCG NHS CANTERBURY AND COASTAL CCG, Chair – Jacqueline Dunkley-Bent, Head of Maternity, Children and Young People

Section 3: Guidance for Higher Education Institutions

The preparation of PMAs is crucial to the success of the PMA role. This section has been designed for use by HEIs in preparation for the development of the education specification for the PMA bridging module/shortened and long programme.

The education work stream of the supervision Task Force have developed a PMA shortened and long PMA programme that have been informed by the findings of the evaluation of the A-EQUIP pilot sites (see [Appendix 7](#)).

Education Programmes - preparing PMAs

UK Education principles

The four UK countries have collectively agreed the principles that should underpin programmes of the education designed to prepare the new supervisors (Northern Ireland, Scotland and Wales) and PMAs (England).

These principles include learning relating to:

- The role of the supervisor/PMA within the context of national and local governance policies
- The role supervision plays in supporting midwives to consider their practice in relation to the Code (NMC 2015b) and the requirements for revalidation (NMC 2015a)
- The educational principles which facilitate effective supervision
- Supervision frameworks and models²¹ which can be used for understanding and managing the supervisory relationship
- Skills which underpin the setting up and development of a successful supervisory relationship, including setting ground rules, negotiating and working in partnership
- A range of supervisory approaches and methods including facilitation, coaching, motivational interviewing, reflection, debriefing and managing challenging conversations
- Approaches to evidence based practice and quality improvement to ensure women and their families experience safe, person-centred care including the concept of advocacy
- Ethical issues in clinical supervision which may affect the supervisory process for example, conflict of interest and maintaining professional boundaries
- Techniques and processes to evaluate the clinical supervision process, including eliciting and utilising feedback
- The need for on-going development of supervisory skills and for further reflection and updating of knowledge.

Supervisors/PMAs should demonstrate the following attributes/values.

S/he should:

- Be perceptive to the needs of others and able to develop supportive relationships
- Possess good communication skills including the ability to listen
- Promote a culture of collaborative working
- Be self-aware and able to acknowledge own limitations
- Inspire through leadership and role-modelling
- Have integrity and insight.

Principles for delivery of the programme:

- Programmes should be subject to a quality assurance mechanism which ensures that it adheres to the principles of the education programme and is delivered consistently on a national basis

21 These may include supervision models such as Proctor's (1986) Model of Supervision

- The learning outcomes of the programme should be mapped to these principles to ensure supervisors/ PMAs have transferable skills
- Supervisors/PMAs should keep and be prepared to provide a portfolio of evidence demonstrating that the principles of the education programme set out here have been achieved.

In response to the findings of the evaluation of the pilot sites, the following should be considered by HEIs when preparing the content of the shortened and full education programmes:

- Ensure that the existing knowledge of learners is established in order to ascertain how to build on this during the education programme
- Ensure that the disparity between learners in existing knowledge and experiences is recognised and how this might impact the learning experience. This could include development of self-guided learning outcomes
- Programmes which include sharing participant experiences and drawing on andragogic principles between learners facilitates a positive group dynamic and can lead to successful learning
- Facilitators need to be conscious of variable learning needs and preferences of learners
- Ensure that programmes allow group socialisation ensuring group cohesion and effective sharing of experiences and support of learning between peers
- Inclusion of reflective and critical approach to integrating experiences with taught content is recommended.

The PMA Preparation Programmes

1. The PMA bridging module/shortened programme and the long PMA

programme have been developed for the purpose of preparing those midwives who intend to seek appointment as a PMA. Midwives who have completed the preparation of supervisors of midwives course, (known as PoSoM) will be required to undertake the PMA shortened programme. Midwives who have not completed the PoSoM course will be required to undertake the long PMA programme. Entry onto either programme will require the midwife to undergo an approved selection process and complete a 30 minute [A-EQUIP e-learning module](#). A certificate is available on completion as evidence for re-validation and educational development. Recognition as a PMA will be dependent on successful completion of the programme.

2. The PMA programme for midwives is envisaged to be a credited module at level 7. The rationale for this being that it is not cost effective to be individual days, nor to be at level 6; level 7 attracts higher education funding and has the value added benefit of contributing to a masters degree. It also provides the assurances of adherence to the Qualifications Higher Education Framework (QAA 2008) alongside the quality assurance processes of the institution.
3. Whilst undertaking the preparation programme, midwives must demonstrate proficiency in all competencies through successful completion of theoretical and practical assessments. There should be a clear competence proficiency document which forms part of the evidence portfolio of the education programme participant.
4. Following completion of the programme employers will hold a local record of PMAs.

5. PMAs must maintain and evidence their competence in this role.
6. The PMA framework and accompanying competencies are set as a national standard. However, it is acknowledged that the implementation of activities within this framework is undertaken in country and region specific contexts and that support from employers to assist PMAs to undertake their duties effectively should be made available.

Reference to the NHS Standard contract 2017/18 and local CCG maternity specification and adherence will support implementation.

The PMA bridging module/shortened education programme specification and the proposed competency framework for the preparation of professional midwifery advocates can be seen at [Appendix 5](#).



The midwives at the Whittington Hospital who undertook the PMA bridging module/shortened programme as one of the pilot sites are proudly displaying their certificates for successfully completing the assessment for the restorative function of the A-EQUIP model. Course delivered by Helen Lake (centre), RCS Programme Lead, South Warwickshire NHS Foundation Trust.

Conclusion

Developing a new model of midwifery supervision for England has been both an ambitious but worthwhile process with far reaching consequences for the midwifery profession and maternity services. The development of the A-EQUIP model has been completed as a response to changes in legislation and shaped by the contributions of women, midwives, educators and managers. The lessons learned from the pilot sites have also had a significant impact on the final design of the model. The A-EQUIP model harnesses the strengths of the statutory model, whilst avoiding the problems of the past and embracing the opportunities of the future.

The ambition of the NHS England supervision Task Force was to develop a model of midwifery supervision that built on the strengths of the statutory model and embraced the opportunities to ensure that Midwives are supported, valued and enabled to provide safe and compassionate care to women and their families. The Task Force believes that this ambition has been achieved.

The NHS England Supervision Task Force would like to thank all women, midwives, leaders, educators and the pilot sites who have worked with us to co-produce the A-EQUIP model and the associated role of the PMA role. The next phase of implementation is absolutely crucial to its success and will be dependent on maternity providers preparing for implementation of the new model, HEIs developing preparation programmes and NHS England supporting roll out and implementation locally, whilst monitoring process and impact.

References

- Cleveland, B. (2016) Staff to supervisor ratio available at: ICMI <https://www.icmi.com>
- Cutcliffe, J. and Proctor, B. (1998) An alternative training approach to clinical supervision, *British Journal of Nursing*. 7 (5) 280-285.
- Department of Health (2017) *The Nursing and Midwifery Council amendments to modernise midwifery regulation and improve the effectiveness and efficiency of fitness to practise processes: Consultation Report*. Leeds, The Stationery Office.
- Department of Health (2016a) *Proposals for changing the system of midwifery supervision in the UK*. London, DH.
- Department of Health (2016b) *National Maternity Review. Better Births. Improving outcomes of maternity services in England. A five year forward review for maternity care*. (Chair: Cumberlege, J.), London, DH. Available at: <http://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>
- Department of Health (2015) *The Government's Mandate to NHS England for 2016-17*. London, DH.
- European Court of Human Rights (2011)
- Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, London, The Stationery Office. Available at: <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>
- Gillman, L., and Lloyd, C., (2015) *Reframing midwifery supervision: a discussion paper*, London, RCM.
- Hawkins, P., and Shoheit, R., (2012) *Supervision in the Helping Professions (4th ed)* Maidenhead, Berkshire, Open University Press.
- Helen and Douglas House (2014) *Clinical Supervision Toolkit* available at: http://www.helenanddouglas.org.uk/get_information/useful-resources
- Jones, K., Warren, A., Davies, A., (2015) *Mind the gap: Exploring the needs of early career nurses and midwives in the workplace*, Birmingham and Solihull Local Education Training Council (NHS HEE).
- Kadushin, A. (1976). *Supervision in Social Work*. Clinical Supervisor. New York, Columbia University Press.
- Kirkup, B. (2015) The Report of the Morecambe Bay Investigation, Preston, Lancashire, The Stationery Office. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf
- Lipsky (1980) *Street - level Bureaucracy: Dilemmas of the individual in Public Services*, 30th Anniversary expanded edition. ISBN: 978-0-87154-544-2
- National Advisory Group on the Safety of Patients in England (Chair: Berwick D) (2013) *A promise to learn – a commitment to act: improving the Safety of Patients in England*, London, Department of Health. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf
- National Health Service Employers (2014) *How Agenda for Change works*. Available at: <http://www.nhsemployers.org/your-workforce/pay-and-reward/pay-agenda-for-change-pay/how-agenda-for-change-works>

- National Health Service England [NHSE] (2016), *Leading Change Adding Value; a framework for nursing, midwifery and care staff*, London, The Stationery Office.
- National Health Service [NHS] England (2014) *The NHS Five Year Forward View (FYFV)*, London, The Stationery Office. Available at: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
- NHS Leadership Academy (2011) *Leadership Framework*, Coventry: NHS Institute for Innovation and Improvement. London, The Royal College of Midwives Trust.
- Nursing and Midwifery Council (2015a) *Revalidation: How to revalidate with the NMC – requirements for renewing your registration*. London, NMC.
- Nursing and Midwifery Council (2015b) *The Code: Professional standards of practice and behaviour for nurses and midwives*, London, NMC.
- Nursing and Midwifery Council (2012) *Midwives rules and standards*, London, NMC.
- Nursing and Midwifery Order (2001) Statutory Instrument 2002 No 253 [The Order]. London, The Stationery Office.
- Parliamentary Health Service Ombudsman (2013) *Midwifery supervision: recommendations for change*. London, The Stationary Office. Available at: https://www.ombudsman.org.uk/sites/default/files/Midwifery%20supervision%20and%20regulation_%20recommendations%20for%20change.pdf
- Pettit, A., and Stephen, R., (2015) *Supporting Health Visitors and Fostering Resilience Supporting Health Visitors and Fostering Resilience*. London, Institute of Health Visiting.
- Proctor, B., (1986) *Supervision: A Co-operative Exercise in Accountability in: Marken, M., Payne, M. (eds.) Enabling and Ensuring – supervision in practice* National Youth Bureau, Council for Education and Training in Youth and Community Work. Leicester, UK.
- The British Institute of Human Rights (2016)
- The Kings Fund (Baird, B., Murray, R., Seale, B., Foot, C., and Perry, C.) (2015) *Midwifery Regulation in the United Kingdom: report commissioned by the Nursing and Midwifery Council*, London, The Kings Fund. Available at: <https://www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/council-2015/kings-fund-review.pdf>
- Turner, J., and Hill. A., (2011) *Implementing clinical supervision (part 2), using Proctor's model to structure the implementation of clinical practice in a ward setting*, *Mental Health Nursing*, 31 (4) 14-19.



Appendices

Appendix 1: Reviews and recommendations

There have been a number of reviews which have commented on the distinct model of midwifery regulation and have made a number of recommendations (Parliamentary and Health Service Ombudsman [PHSO] 2013, Kings Fund 2015, Kirkup 2015).

The PHSO (2013) Report states;²²

“Health and care professionals are subject to a number of mechanisms to ensure safe practice, from frameworks put in place by employers or service providers, to professional regulation. The case for an additional tier of regulation for midwives is not clear. Moreover, other health and care professions benefit from supervision without it being a statutory right, or an aspect of their professional regulation.”

It recommended that the following principles should inform the future model of midwifery regulation:

- That midwifery supervision and regulation should be separated;
- That the NMC should be in direct control of regulatory activity.

Kings Fund (2015) Report – Midwifery regulation in the UK:18

“The NMC as the health care professional regulator should have direct responsibility and accountability solely for the core functions of regulation. The legislation pertaining to the NMC should be revised to reflect this. This means that

the additional layer of regulation currently in place for midwives and the extended role for the NMC over statutory supervision should end.

The de facto implication of this recommendation is that for the NMC the system of regulation for midwives would be the same as for nurses, as we found no risk-based evidence to conclude that an alternative model is justified.

The NMC as the health care professional regulator should have direct responsibility and accountability for the core functions of regulation, that is:

- The registration and renewal of registration of professionals;
- Ensuring the quality of pre-registration and post-registration education and training;
- Setting standards for professional conduct and practice and ensuring ongoing practice standards (for example, through revalidation);
- The investigation and adjudication of fitness-to-practise cases.

The existence of the LSAs as separate structures does not meet the criteria of the regulator having clear oversight of regulatory decisions and we recommend that the LSA structure should be removed from statute as it pertains to the NMC”.

22 <http://www.ombudsman.org.uk/reports-and-consultations/reports/health/midwifery-supervision-and-regulation-recommendations-for-change>

Kirkup (2015) Report – Investigation into Morecambe Bay²³: Recommendation 32:

“The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally;

however, the nature of the failures and the recent King’s Fund review (Midwifery regulation in the United Kingdom) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King’s Fund findings, with effective reform of the system”.

23 <https://www.gov.uk/government/publications/morecambe-bay-investigation-report>

Appendix 2: Membership of the Supervision Task Force and Work Streams

| Name | Organisation | Role |
|-------------------------|---|--|
| Birte Harlev-Lam | NHS Improvement | Clinical Director - Maternity and Children |
| Carmel Lloyd | Royal College of Midwives | Head of Education and Learning |
| Charlotte Bourke | NHS England | Senior Programme Manager |
| Debra Bick | Kings College London | Professor of Evidence Based Practice |
| Elizabeth Duff | National Childbirth Trust | Senior Policy Advisor |
| Hilary Garratt | NHS England | Deputy CNO England and Chair of the Task Force |
| Jacqueline Dunkley-Bent | NHS England | Head of Maternity |
| Jane Clegg | NHS England | Interim Chief Nurse, London |
| Jason Westwood | NHS England | Senior Programme Manager |
| Jessica Read | NHS England | LSA Midwifery Officer, London Region & Chair of LSAMO Forum UK |
| Joan Douglas | Homerton University Hospital | Head of Midwifery |
| Katherine Hawes | NHS England | Supervisor of Midwives, Midlands and East Region |
| Lynne Wiggins | NHS England | Chief Nurse, Midlands and East Region |
| Margaret Kitching | NHS England | Chief Nurse, North Region |
| Neil Tomlin | NHS England | LSA Midwifery Officer, North Region |
| Nicky Clark | LME UK Executive Group | LME Rep (Chair of LME UK Exec Group) |
| Patricia Bartlett | NHS England | Supervisor of Midwives, South Region |
| Radhika Howarth | Hillingdon Clinical Commissioning Group | CCG Outreach Worker |
| Sarah Elliott | NHS England | Chief Nurse, South Region |
| Sascha Wells | Morecambe Bay NHS Trust | Deputy Director of Midwifery – Women’s and Children’s Services |
| Sue Doheny | NHS England | Chief Nurse, South Region |

| Name | Organisation | Role |
|---------------|--|---|
| Sue Hatton | Health Education England | Senior Nursing Policy Manager |
| Tracey Cooper | RCM National Consultant Midwives Forum | Consultant Midwife and Supervisor of Midwives |

Work Stream Members

| Name | Role | Organisation |
|--|--|--|
| Alison Talbot | Head of Midwifery | George Eliot Hospital NHS Trust |
| Carmel McCalmont | Director of Midwifery | University Hospital Coventry and Warwickshire NHS Trust |
| Carol Porteous | Midwife Lecturer/Supervisor of Midwives and Academic lead for clinical practice | The University of Manchester |
| Carolyn Tomlinson | Lead Midwife Quality, Risk and Safety and Supervisor of Midwives | Nottingham University Hospitals NHS Trust |
| Clare Capito | London LSA Support Midwife | NHS England – LSA London |
| Jacqueline Dunkley-Bent (JDB) Chair | Head of Children and Maternity Services | NHS England |
| Jane Herve | Head of Midwifery Maternity services | Oxford University Hospitals NHS Trust |
| Jane Suppiah | LSA Lay Auditor | |
| Jason Westwood | LSA National Supervision Task Force Project Manager | NHS England |
| Jayne E Marshall | Professor of Midwifery, Associate Dean (Practice Education and Workforce Development) and Lead Midwife for Education | Kingston University and St George's University of London |
| Jessica Read | LSA Midwifery Officer & Chair of the LSAMO Forum UK | NHS England – London Region LSA |
| Julia Austin | Consultant Midwife | University Hospitals of Leicester NHS Trust |
| Manya Merodoulaki | Chartered Psychologist (The British Psychological Society) and Counselling Psychologist | Sheffield University |

table continues

Work Stream Members *continued*

| Name | Role | Organisation |
|---------------------|--|---|
| Margaret Richardson | Independent Maternity Services Advisor / Expert Witness | |
| Maria Booker | Project Co-Ordinator | Birthrights |
| Mia Buckley | Director of Midwifery | Royal Free London NHS Foundation Trust |
| Neil Tomlin | LSA Midwifery Officer North of England – North Cumbria, North East of England and Yorkshire and the Humber sub-regions | NHS England – North Region LSA |
| Nicky Clark | Senior Lecturer/ Head of Department (Interim) Midwifery and Child Health and Chair of the LME-UK Executive Group | University of Hull |
| Sue Hatton | Senior Nursing Policy Manager | Health Education England |
| Teresa Shalofsky | Associate Head of Department Nursing and Midwifery | University of the West of England (Bristol) |
| Toni Martin | Lead Midwife for Education, Programme Leader – Midwifery & Academic Integrity Tutor | University of Worcester |
| Yana Richens | Consultant Midwife | University College London Hospital |

Education Workstream

| Name | Role | Organisation |
|-----------------------------|----------------------------|---|
| Nicky Clark Chair | Lead Midwife for Education | The University of Hull |
| Toni Martin Co Chair | Lead Midwife for Education | University of Worcester |
| Clare Capito | LSA Support Midwife London | NHS England |
| Carol Porteous | Midwifery Lecturer | University of Manchester |
| Sue Hatton | Programme Director | Health Education England |
| Professor Jayne E Marshall | Lead Midwife for Education | Kingston University and St Georges University of London |
| Jane Herve | Head of Midwifery | Oxford University Hospitals NHS Trust |

| Name | Role | Organisation |
|------------------|--|--|
| Julia Austin | Consultant Midwife | University Hospitals of Leicester NHS Trust |
| Teresa Shalofsky | Lead Midwife for Education | University of the West of England |
| Neil Tomlin | LSA Midwifery Officer North East, Yorkshire and the Humber | NHS England-North Region LSA |
| Trixie McAree | Head of Midwifery | Birmingham Women's and Children's NHS Foundation Trust |

New Model Workstream

| Name | Role | Organisation |
|------------------------------|---|--|
| Jessica Read Chair | LSA Midwifery Officer for London Chair of the LSAMO Forum UK | NHS England |
| Charlotte Bourke | Project Management Officer | NHS England |
| Georgina Sims | Associate Professor Midwifery and Lead for the PoSoM course | Kingston and St Georges University |
| Helen Pearce | LSA Midwifery Officer South West | NHS England |
| Jane Suppiah | Lay Member | |
| Maria Dore | Head of Midwifery | University Hospital Southampton NHS Foundation Trust |
| Becky Collins | LSA Support Midwife South East | NHS England |
| Tracey Cooper | Consultant Midwife | Worcestershire Acute Hospitals Trust |
| Julie Scarfe | Head of Nursing and Midwifery | Leeds Teaching Hospitals NHS Trust |
| Gemma McGeachie | Finance Officer | NHS England |
| Kate Hawes | LSA Support Midwife East of England | NHS England |

Appendix 3: Key reports and published works

The Gathering Storm (RCM 2017) identified several challenges in maternity care, that remain current today and have been found to affect the work environment for midwives: increasing complexity and intensity of physical, psychological or social needs of women associated with increasing acuity and activity levels, meeting increasing expectations of women, their families and health care partners, a rising birth rate and making every contact count to improve public health;

The Francis Report (2013) refers to creating a culture of compassion within the NHS. More recently, the vision for maternity services outlined in *Better Births: the report of the National Maternity Review* (DH 2016b), makes reference to supporting staff to provide the best care for women and their families and for all staff to be supported to deliver care which is women centred;

Midwifery supervision should include discussions of resilient approaches to adversity, positive mood changers and how to care for the self. This suggests the need to adopt a clinical supervision approach, which focuses on self-development (Hunter and Warren 2014):

Stress and high levels of burn-out have been experienced by midwives and other maternity workers due to feelings of being overworked and understaffed (Royal College of Midwives [RCM] 2016a);

The RCM's '*Caring for You Campaign*' (RCM 2016b) with its '*Caring for You Charter*' aims to improve midwives', student midwives' and maternity support workers'(MSW) health, safety and wellbeing at work, so they are able to provide high quality care for women and their families. Pledge five of this campaign specifically focuses on nurturing a compassionate and supportive workplace that cares for midwives and MSWs so that they are able to fully function in their role. This highlights the importance of developing a model of supervision that has a focus on the well-being of staff;

Better staff health and wellbeing is associated with improved outcomes and experience for those individuals and populations that we serve relating to Commitment six of *Leading Change, adding value, a framework for nursing, midwifery and care staff* (NHS England 2016);

The conclusions of the Berwick report when making recommendations for creating lasting improvements in patient safety and quality, concluded that these are best achieved through the creation of a supportive organisation, that of a 'learning NHS'. One of the four main principles to achieve this; "Fostering wholeheartedly the growth and development of all staff, their ability and support to improve the processes in which they work" could be partly achieved through midwifery supervision (National Advisory Group on the Safety of Patients in England 2013 p.36).

References

- Department of Health (2016b) *National Maternity Review. Better Births. Improving outcomes of maternity services in England. A five year forward review for maternity care.* (Chair: Cumberlege, J.), London, DH. Available at: <http://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>
- Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, London, The Stationery Office. Available at: <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>
- Hunter, B., and Warren, L., (2014) Midwives' experience of workplace resilience, *Midwifery*. 30 (8) 926-934.
- RCM (2017) *The gathering storm: England's midwifery workforce challenges.* Available at: <http://www.england.nhs.uk/wp-content/uploads/2012/12/6c-midwifery.pdf>
- National Advisory Group on the Safety of Patients in England (Chair Berwick D) (2013) *A promise to learn – a commitment to act: improving the Safety of Patients in England*, London, Department of Health. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf
- National Health Service England [NHSE] (2016), *Leading Change Adding Value; a framework for nursing, midwifery and care staff*, London, The Stationery Office.
- Royal College of Midwives (2016a) *Why Midwives Leave: Revisited.* London, RCM.
- Royal College of Midwives (2016b) *RCM campaign for healthy workplaces delivering high quality care.* London, RCM.

Appendix 4: Professional Midwifery Advocate Job Profile

Trust Logo

JOB PROFILE

Please note that sections 1 to 3 and the Person Specification have been developed to be used as a guide for developing the Job Description for each Trust when recruiting a substantive Professional Midwifery Advocate (PMA)

It should also be used for sessional PMAs (PMAs who undertake the role on a sessional basis without remuneration)

| | |
|--------------------------------|--|
| Job Title: | Professional Midwifery Advocate (PMA) |
| Band: | 8a (if this is a substantive appointment) |
| Working Hours: | TBC |
| Tenure: | TBC |
| Line responsibility to: | HoM/DoM and/or Midwifery Trust Lead for Education |
| Accountable to: | Director of Midwifery (DoM)/Head of Midwifery (HoM) |

Location:

The post holder will be employed by the Trust, based in the Trust and located within the Maternity Unit.

1. JOB SUMMARY

This is a new role that has been developed to replace the role of the supervisor of midwives that was deselected in April 2017 due to legislative change. The model that will support the deployment of this role is called "A-EQUIP" which provides a continuous improvement process that builds upon personal and professional resilience, enhances quality of care for women and supports preparedness for midwives in appraisal and professional revalidation.

The ultimate aim is that this continuous improvement process of the "A-EQUIP" model will become an intrinsic part of everyone's job, every day in all parts of the system. Thus the post holder will assist the Trust by implementing the elements of the A-EQUIP model utilising the guidance issued by NHS England in April 2017.

2. KEY RELATIONSHIPS

Internal:

- Director of Midwifery/Head of Midwifery at the Trust;
- Leads for Midwifery Education for commissioned education programmes at the Trust;
- Other PMA's appointed in the Trust;
- Chief Nurse;
- Clinical governance team;
- Consultant Midwives.

External:

- Regional Maternity Leads (NHS England);
- Deputy Regional Maternity Lead Midwives (NHS England);
- Service users;
- CCG;
- NMC;
- Other PMAs from other Trusts/organisation both within the Region and the Sector;
- Higher Educational Institutes (HEIs).

3. FUNCTIONAL RESPONSIBILITIES FOR THE PROFESSIONAL MIDWIFERY ADVOCATE ROLE

The post holder must be available to deploy the A-EQUIP model as required by the Trust. The post holder will ensure that midwives are invited to meet with the PMA a minimum of once per year.

(Based on the "Proposed competency framework for the A-Equip Model and the Professional Midwifery Advocate" NHS England Task Force: Education work stream, September 2016).

3.1 Involvement in safety and quality improvement

The post holder will:

- Support midwives to identify their own personal action for quality improvement;
- The post holder will use their understanding of personal and professional; resilience and support others to develop this attribute;
- Ensure that there is a strong interface between the PMA and clinical governance at the Trust;
- Use their expert knowledge in midwifery practice to support Heads of Midwifery and Consultant Midwives in implementing and monitoring midwifery practice ensuring that there are robust clinical governance assurance systems in place relating to midwifery practice;
- Provide support to midwives in sharing of good practice learnt through the maternity services' internal risk management processes with the aim of reducing the incidence of harm and obstetric litigation cases;

- Be involved in continuous monitoring and maintaining quality standards of clinical practice through a variety of ways for example audit, working clinically with midwives for those who require additional support and development;
- Act as a role model at all times and promote a high standard of safe and effective care which is based upon best evidence.

3.2 Be effective

The post holder will:

- Meet with midwives in their designated area and/or caseload on either an appointment or ad hoc basis;
- Use effective communication strategies and influencing skills to achieve desired outcomes and make appropriate referrals for advocacy, mediation or arbitration;
- Support midwives to work in partnership with women to develop plans of care which meet their individual needs, to listen to them and to advocate for them as required;
- To assist in implementing the Trust's *Better Births* (DH 2016b) and the NHS *Five Years Forward View* (NHSE 2014) strategy;
- Promote women centred care and autonomous midwifery practice in all clinical areas;
- Support midwives through "Restorative Clinical Supervision" (RCS) to examine their role in the maternity department;
- Assist midwives to develop their professional and career development choices
- Maintain a database of all midwives' revalidation dates for the Trust and ensure that they are prepared to revalidate effectively as per NMC guidance;
- Ensure that they maintain their own knowledge and clinical skills by all appropriate means.

3.3 Be caring and compassionate

The post holder will:

- Attend the bespoke training programme for PMAs to undertake Restorative Clinical Supervision (RCS) in order to become competent and confident in undertaking RCS sessions with midwives;
- Use appropriate strategies to support midwives to maximise their potential in practice, implementing the principles of RCS;
- Enable midwives to be responsible and accountable for their actions and behaviours by creating a safe space to think, feel, reflect utilising the principles of RCS;
- Utilise their skills, knowledge and experience of RCS to facilitate effective reflective discussions with midwives;
- Escalate responsibly and appropriately if a midwife makes disclosures regarding child protection and/or vulnerable adult legislation;
- Contribute to the education and development of student midwives to ensure that they understand the role of the PMA and provide space for them to experience group reflection on midwifery practice;

- Support the team of sessional PMAs to provide sessions to each midwife to assist in personal reflection related to clinical practice which adhere to the principles of RCS;
- Appropriately communicate sensitive information to women, families and midwives;
- Be able to deal with clients in emotionally difficult situations. Take appropriate action when confronted by aggressive clients/relatives;
- Demonstrate understanding on barriers to effective communication and modify behaviour in response;
- Manage complex situations sensitively and effectively where there may be conflicts and communicate effectively with the multi-professional team and the client and if there are any language barriers ensure that appropriate interpreting service has been engaged.

3.4 To act responsively

The post holder will:

- Demonstrate understanding of the role of the PMA within the context of national governance policies and procedures;
- Work with the maternity management team to assist in the implementation of any clinical guidelines or clinical practices as required to improve the quality and safety of the maternity services;
- Work alongside Clinical Governance to review midwifery practice and provide an expert opinion in the clinical care;
- Utilise agreed metrics to demonstrate ongoing added value of the role of PMA; and monitoring outcomes for staff and women e.g. whether there is a reduction in complaints by women, or improved satisfaction surveys or there is a reduction in sickness absence for midwives and improved retention of midwives;
- Identify, collate, analyse and interpret quantitative and qualitative data to inform the development of reports regarding the process, impact and outcome of the PMA role and the A-EQUIP model;
- Support midwives implementing improvement in practice and thus demonstrating both the post holder's and midwife's responsiveness to the needs of the healthcare environment, thus contributing to quality improvement;
- The post holder will work closely with management, the practice development and education team to devise learning objectives for midwives in need of remediation to improve their midwifery skills and competencies;
- Be innovative and creative when determining strategies to improve quality of care and embed evidence based practice
- Be able to maintain moderate physical effort the duration of the period of duty to the clinical area;
- Ability to work under pressure and maintain good clinical judgement at all times;
- Demonstrate responsibility in ensuring that key recommendations from risk incidents are effectively implemented.

3.5 Demonstrate effective leadership

The post holder will:

- Lead the team of PMAs who have been appointed on a sessional basis ensuring that they maintain a rota and develop a database to monitor all the activities that each of the PMAs undertake;
- Develop an effective communication strategy that ensures all PMAs are kept informed of current issues so that the A-EQUIP model is implemented;
- Inform the DoM/HoM if any of the team are experiencing challenges or concerns about carrying out the role of the PMA and decide on an appropriate plan of support to assist the PMA and monitor whether the plan has been effective;
- Act as a role model by applying best practice in motivating staff to drive improvements and provide visible leadership in the workplace;
- Act as a role model by applying continuous personal improvement by using positive learning approaches and encourage others to adopt this culture;
- Lead and participate in the development, implementation and evaluation of standards of care, including guideline development, audit and quality improvement initiatives;
- Contribute to service development using quality improvement methodology;
- Contribute to multi-professional meetings/team debriefs and advocate as required on behalf of midwives and women in order to ensure that high standards of clinical care are aspired to and thus maintained;
- Lead as required on any projects to improve the quality of care within the maternity service;
- Ability to work under pressure and maintain good clinical judgement at all times;
- Appropriate use of resources to minimise risk from potentially harmful substances and to minimise risk of hospital acquired infection;
- Use of infection control measures when carrying out exposure prone procedures. Updating own vaccinations as necessary;
- Inform the DoM/HoM of any emerging safety issues becoming evident in the maternity service;
- Provide emergency cover and at short notice for unexpected absence/sickness across the maternity service;
- Exercise leadership within the maternity unit to manage provision of effective care to mothers and babies to safeguard their well-being and interests and take appropriate action when safety of care cannot be provided;
- Be aware of the Trust's vision statement and how this relates to the maternity services;
- Ensure that the Trust's behaviour standards are maintained.

N.B. The Trust should use the trust standard template to complete the Professional Midwifery Advocate Job Description.

Person specification for professional midwifery advocate role

| Attribute | Essential | Desirable | How tested | |
|---|---|---|------------|---|
| | | | A | I |
| Knowledge, Training and Experience | <ul style="list-style-type: none"> ● Registered midwife. ● Demonstrable experience of broad knowledge of midwifery practice and supervision of midwives. ● Is willing to undertake the PMA Bridging programme. ● Educated to BSc level or equivalent. ● Is a qualified sign off mentor. ● Demonstrable well-developed leadership skills. ● Professional credibility with senior colleagues, and Midwives. ● European computer driving license (ECDL) or equivalent experience. ● Evidence of CPD. ● Proven track record of a leadership role. ● Management skills including chairing meetings, presentations, report writing, managing change, performance management. | <p>Criteria that can be acquired once in employment or a means to employ the most suitable candidates.</p> <p>Has been appointed as a Supervisor of Midwives.</p> <p>Educated to MSc level.</p> | | |

table continues

Person specification for professional midwifery advocate role *continued*

| Attribute | Essential | Desirable | How tested | |
|-----------------------------|--|---|------------|---|
| | | | A | I |
| | <ul style="list-style-type: none"> • A thorough understanding of the The Code (NMC 2015). • An appreciation of strategic issues affecting health and health care provision. • Knowledge of clinical governance and its implementation. | | | |
| Communication Skills | <ul style="list-style-type: none"> • Possession of well-developed negotiation, networking and communication skills. • Knowledge of issues of confidentiality and demonstrate appropriateness in dealing with sensitive personal, patient and corporate information. • Experience of working as part of a team and can demonstrate principles of effective team working. | Criteria that can be acquired once in employment or a means to employ the most suitable candidates. | | |
| Analytical | <ul style="list-style-type: none"> • Evidence of gathering, analysing, interpreting and disseminating in-depth information. | Criteria that can be acquired once in employment or a means to employ the most suitable candidates. | | |
| Planning Skills | <ul style="list-style-type: none"> • Evidence of working in a complex environment and coping with competing priorities. • Evidence of being able to manage her own diary via Microsoft Outlook, organise and manage meetings as a PMA. | Criteria that can be acquired once in employment or a means to employ the most suitable candidates. | | |

| Attribute | Essential | Desirable | How tested | |
|-------------------------------|---|---|------------|---|
| | | | A | I |
| Physical Skills | <ul style="list-style-type: none"> • Demonstrate IT skills in using applications e.g. Word, Powerpoint and Excel spreadsheets. • Evidence of excellent skills in report writing. | Criteria that can be acquired once in employment or a means to employ the most suitable candidates. | | |
| Autonomy | <ul style="list-style-type: none"> • Experience of working autonomously in planning and organising own diary. • Experience of working with a wide range of disparate individuals. | Criteria that can be acquired once in employment or a means to employ the most suitable candidates. | | |
| Equality and Diversity | <ul style="list-style-type: none"> • Able to consider the most effective way to promote equality of opportunity and good working relationships in employment and service delivery and has the ability to take actions which support and promote this agenda. | | | |

KEY

A = Application

I = Interview

The Professional Midwifery Advocate

Deploying a new model of midwifery supervision for England called A-EQUIP (advocating & educating for quality improvement)

PMA Bridging/Shortened Education Programme



Document Title – Professional Midwifery Advocate, deploying a new model of midwifery clinical supervision for England called A-EQUIP (advocating & educating for quality improvement)

Subtitle – PMA Shortened Education Programme Specification

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Prepared by: Toni Martin, University of Worcester (on behalf of NHS England)

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Contents

| | | |
|---|---|----|
| 1 | Introduction | 64 |
| 2 | The A-EQUIP model | 65 |
| | 2.1 Education and development | 65 |
| | 2.2 Personal action for Quality improvement | 65 |
| | 2.3 Restorative Clinical Supervision | 66 |
| | 2.4 Normative function | 66 |
| 3 | Implementation of PMA Bridging Module/Shortened Education Programme – the pilot | 67 |
| 4 | The PMA Bridging Module/Shortened Education Programme | 68 |
| 5 | The PMA Bridging Module/Shortened Education Programme Competency Framework | 69 |
| | 5.1 The Competencies | 69 |
| 6 | Achievement on the PMA Bridging Module/Shortened Education Programme | 71 |
| | 6.1 A-EQUIP and Leadership pre-reading | 71 |
| 7 | Example Outline Timetable | 73 |
| 8 | Learning Resources | 77 |
| 9 | References | 78 |

1 Introduction

The policy paper '*Proposals for the changing of midwifery supervision in the UK*' (Department of Health [DH] 2016), a framing document developed in collaboration with the UK Chief Nursing Officers (CNO) and professional Midwifery Officers, outlines the requirement to devise an overarching system of midwifery supervision that will be put in place subject to a change in legislation to remove statutory supervision of midwifery from April 2017.

In response to the DH (2016) paper, each UK country convened a supervision Task Force led by their CNO to examine and embed the principles of midwifery supervision. The England Supervision

Task Force was formed by NHS England and the England CNO in January 2016 and was made responsible for developing a new model of midwifery supervision for England. This new model will be implemented in April 2017, subject to a change in legislation.

The 'Models' work-stream, which arose from the England Task Force, developed the 'A-EQUIP' programme model to succeed the NMC (2014) Standards for the preparation of supervision of midwives. This programme specification details the content of the 'A-EQUIP' model and this should be bridging/shortened programme programme.

2 The A-EQUIP model

The A-EQUIP model has four distinct functions, which interrelate. Each can be accessed separately but it is anticipated that the Professional Midwifery Advocate (PMA) will move between these aspects throughout his/her practice as he/she interacts with midwives:

2.1 Education and development

This function of the model focuses on the development of knowledge and skills through education, to inform appraisal, revalidation and leadership development.

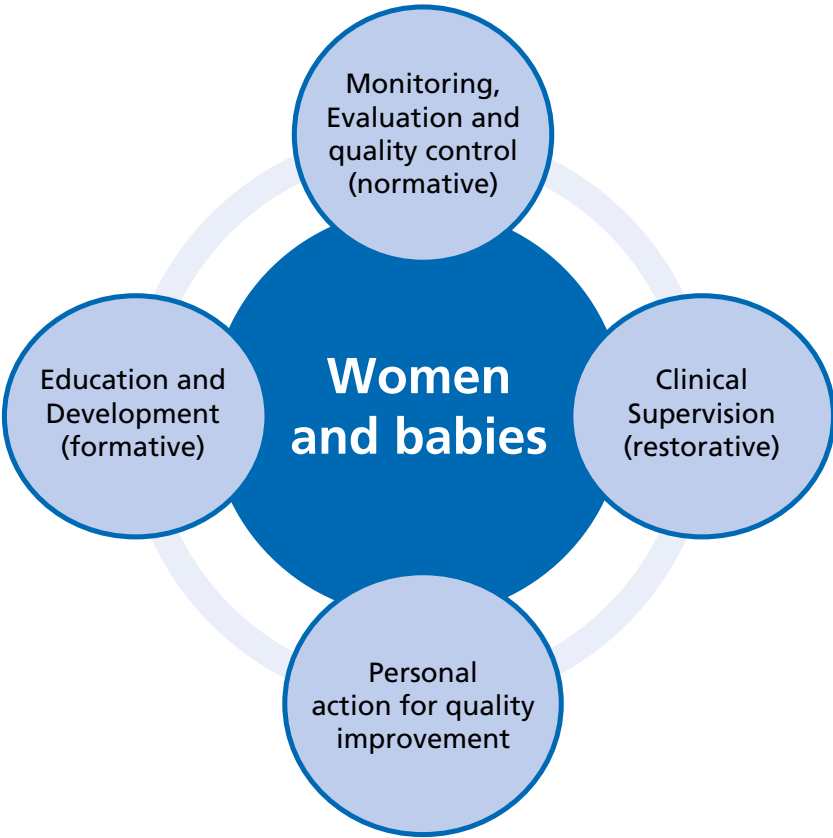
This process can be facilitated by guided reflection (Proctor 1986). Self-leadership will be explored, examining how the individual interacts with others and can influence change. This will enable the PMA to support midwives in challenging their own and others' practice in order to improve care. Women and their families

are central to the model and all midwives will be encouraged and supported to advocate for them.

2.2 Personal action for Quality improvement

Recognising the increasing complexity of healthcare systems and the reliability of healthcare provision, the A-EQUIP supervision approach aims to A-EQUIP professionals to be familiar with and contribute to quality improvement methodology, a concept that will become a core competence in practice for all doctors (Academy of Medical Royal Colleges 2016).

A-EQUIP will not create quality improvement experts but is designed to help midwives to become active participants in contributing a personal action to improving quality of care. The



midwife's role as the woman's advocate will be integral to this element of the model.

2.3 Restorative Clinical Supervision

This element of the model focuses on the 'Restorative/Supportive' function of supervision and aims to create space for thinking, feeling, reflecting and understanding. During supervision sessions the difficult emotions that professionals are exposed to are processed through a supportive (Kadushin 1976), confidential relationship rooted in the concepts of Containment and Reciprocity (Solihull Approach 2001) so that the worker feels restored (Proctor 1986).

This element of the model has been shown to:

- Have a positive impact on the immediate wellbeing of staff.
- Staff feeling 'valued' by their employers for investing in them and their wellbeing.
- A significant reduction in stress.
- A significant reduction in burnout.
- Staff receiving RCS demonstrated an improvement in their compassion satisfaction- the pleasure one derives from doing their job.
- Improve the retention of staff in the group receiving RCS.

- Over half the staff surveyed felt they functioned better as a result of receiving RCS.
- Reduce stress levels whilst maintaining compassion.
- Improve working relationships and team dynamics.
- Help staff to manage work/life balance more effectively.
- Increase enjoyment and satisfaction related to work.

(Pettit and Stephen 2015).

2.4 Normative function

This is concerned with evaluation and quality control aspects of professional practice, referred to as the accountability or normative component (Proctor 1986) and focuses on supporting individuals to develop their ability and effectiveness in their clinical role. Implementing this function facilitates restoration through validation of the midwife's clinical actions or through discussion of any consequences resulting from clinical errors. It is interlinked with the other functions of the framework and encourages midwives to focus on issues of accountability within their practice.

3 Implementation of PMA Bridging Module/Shortened Education Programme – the pilot

Seven pilot sites (NHS Trusts) were established to test the model for a period of four months, from December 2016 to March 2017 and were formally evaluated. The pilot evaluations and experiences of the pilot sites are instrumental in developing the final education programme for the future.

The 'Education' work-stream, a sub group of the LSA Supervision Task Force, whose membership comprised of educationalists, heads of service and LSA staff, developed the PMA shortened education programme to further prepare Supervisors of Midwives (SoMs) to deploy the model at the pilot sites. The purpose of the PMA shortened education programme is to prepare nominated SoMs to undertake the role of PMA.

It is acknowledged that the SoMs within the pilot sites have successfully gained the competencies and required training from approved academic institutions and are experienced SoMs.

The programme is designed to enhance and build on the existing skills and competencies, whilst concentrating on skills that:

- Focus the midwife to address the key priorities of the maternity service.
- Support the midwife to focus on creating space for thinking, feeling and understanding, through a process of **restorative clinical supervision**.
- Focus the midwife on quality and safety in clinical practice through a process of reflection, engagement and advocacy with women using **quality improvement**.
- Develop knowledge and skills in clinical practice through **education and training and utilising the normative function of the model** that informs appraisal and revalidation.

4 The PMA Bridging Module/ Shortened Education Programme

The programme is specifically designed to enhance the skills and knowledge of existing SoMs who have undertaken the Preparation of Supervisors of Midwives programme (NMC 2014) or equivalent training, and who are considered by the employing NHS Trusts to be eligible to become PMAs.

The programme will be provided in the specified HEI. The programme consists of three days of training over consecutive weeks with 4x hourly sessions for each attendee over the following weeks to complete the restorative element of the training. The programme delivery is designed to recognise the existing knowledge and experience of, and work with, the participants and will be one of blended learning – an approach which combines and aligns learning undertaken in face to face sessions with online learning opportunities. It is expected that the attendees will be prepared to actively participate in-group discussions and take responsibility to ask questions, give feedback and support their colleagues.

PMA Bridging Module/Shortened Programme Aims

The Professional Midwifery Advocate Bridging module/shortened education programme is designed to equip successful students to deliver the following outcomes:

- Demonstrate understanding of the role of the PMA, to include: providing support to enhance health and wellbeing; developing education and training to progress knowledge and

skills; and leading personal action for quality improvement practices to ensure that women and their families experience safe, enriching care.

The PMA Bridging module/shortened education programme is designed to ensure that the following learning outcomes are met:

1. In association with the employing organisation create an interdependent leadership culture that will lead to quality, compassionate care.
2. Work collaboratively with other PMAs within the existing governance and quality improvement frameworks actively contribute to assurance and quality improvement initiatives, creating an environment of cultural change and opportunities to develop transformative care for women.
3. Demonstrate understanding of the enablers of good health and wellbeing and actively support midwives to optimise this by recognising when they are anxious or in distress and respond appropriately to promote their wellbeing, personal safety and resolve conflict.
4. Contribute to the evidence base to demonstrate added value of the PMA and the A-EQUIP model to the service, organisation and profession.

5 The PMA Bridging Module/ Shortened Education Programme Competency Framework

The Competencies for the PMA bridging module/shortened education programme are aligned with the five Care Quality Commission (2013) Key Lines of Enquiry. These five areas address the key priorities of every service, determine quality and identify risks.

1. Safety and quality improvement;
2. Effective;
3. Caring;
4. Responsive;
5. Well-led;

5.1 The Competencies

1. Safety and quality improvement.

PMAs must demonstrate how they:

- a. articulate and apply the principles of quality improvement techniques, facilitating others to develop these skills;
- b. have an understanding of the use, interpretation and analysis of relevant data to promote personal action for quality improvement and influence strategy and service development;
- c. portray an understanding of personal and professional resilience and support others to develop this attribute.

2. Effective

PMAs must demonstrate how they:

- a. use effective communication strategies and influencing skills to achieve desired outcomes and make referrals for advocacy, mediation or arbitration; **(this should be evidenced from the PoSoM course);**

- b. Support other midwives to work in partnership with women to develop plans of care which meet their individual needs, to listen to them and to advocate for them when required;
- c. demonstrate a managerial focus on monitoring, evaluation and the quality control aspects of professional practice.

3. Caring

PMAs must demonstrate how they:

- a. contribute to the education and development of student midwives to ensure they understand the role of the PMA; **(this should be evidenced from the PoSoM course);**
- b. demonstrate the ability to think critically, apply knowledge and utilise evidence and experience to facilitate effective reflective discussions; **(this should be evidenced from PoSoM course);**
- c. Use appropriate strategies to support midwives to maximise their potential in practice, linked to the professional re-validation process, implement the principles of restorative clinical supervision;
- d. Demonstrate the ability to think critically, apply knowledge and utilise evidence and experience to facilitate effective reflective discussions.

4. Responsive

PMAAs must demonstrate how they:

- a. use understanding of the role of the PMA within the context of local governance policies and procedures; **(this should be evidenced from PoSoM course);**
- b. Use agreed metrics to demonstrate on-going value of the PMA role;
- c. In collaboration with the existing organisational processes support improvement in practice, demonstrating responsiveness to the needs of the healthcare environment, contributing to quality improvement.

5. Well-led

PMAAs must demonstrate how they act as a role model:

- a. demonstrating inspiration, motivation and visible leadership in the workplace; **(this should be evidenced from PoSoM course);**
- b. by applying continuous personal improvement by using positive learning approaches and encourage others to adopt this culture;
- c. working within existing healthcare systems, actively contribute to service development using quality improvement methodology.

6 Achievement on the PMA Bridging Module/Shortened Education Programme

The programme is based on developing the attendee's skills and expertise in the four areas of: clinical leadership; restorative clinical supervision, normative function and personal action for quality improvement. Its focus will be practical application of existing models to real scenarios, testing the individual's ability to adapt and use transferrable skills to problem solve with confidence.

Teaching will include lectures, discussion, reflection and group work. Participants must demonstrate proficiency in all competencies with the support of the programme providers. Competency proficiency should be provided using a portfolio of evidence submitted to the relevant HEI.

In order to support the PMA Bridging Module/Shortened Education Programme, pre-reading is required by all participants. The learning resources in Section 9 should be accessed.

6.1 A-EQUIP and Leadership pre-reading

You will be required to have an understanding of how the model was developed and implemented across England. Access the NHS England site on the new model of supervision and NHSE (2016) *Leading Change: Adding Value*.

Access the Healthcare Leadership Model in the NHS Leadership Academy and once you have explored the nine dimensions, undertake the free self-assessment tool. This will form part of the discussions on day 1 of the programme.

A-EQUIP e-learning module

Interim Operational Guidance 2017

View these TED Talks prior to the programme

https://www.ted.com/talks/drew_dudley_everyday_leadership

https://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action

6.2 Quality Improvement pre-reading

You will be required to have an awareness of the theoretical component on change models and quality improvement methodology. You will also be expected to access data tools and to become familiar with data interpretation linked to quality improvement.

View this TED Talk prior to the programme

https://www.ted.com/talks/derek_sivers_how_to_start_a_movement?language=en

<http://www.ihl.org/education/IHIOpenSchool/Courses/Documents/Course%20Catalog.pdf>

| <p>*PMA Bridging Module/ Shortened Education Programme Day 1: A-EQUIP model and education, development and leadership²⁴</p> | <p>PMA Bridging Module/ Shortened Education Programme Day 2: Training to be a Restorative Clinical Supervisor</p> | <p>PMA Bridging Module/ Shortened Education Programme Day 3: A-EQUIP model and personal action for quality improvement</p> |
|---|--|---|
| <ul style="list-style-type: none"> ● 7 hours of facilitated learning exploring the theory behind the model and its application to practice. Includes practical advice on leadership in practice. ● Named Education Lead throughout commission. ● On-going advice and support from Education Lead throughout the pilot. ● Supports NMC revalidation and CPD. ● Supporting information manual. | <ul style="list-style-type: none"> ● Introductory Day. ● 4 x 1 hour sessions of 1:1 supervision. ● 1 x Group supervision – 3hrs. ● Sign off assessment of readiness to supervise. ● Pre and Post supervision measures and reports. ● Named Programme Lead support throughout commission. ● Certificate of completion. ● Supports NMC revalidation and CPD. ● Supporting guidelines/ manual. | <ul style="list-style-type: none"> ● 7 hours of facilitated learning examining quality improvement as a PMA. Includes practical advice on quality improvement. ● Named Education lead throughout commission. ● On-going advice and support from Education Lead throughout the pilot. ● Supports NMC revalidation and CPD. ● Supporting information manual. |

24 This is an example programme only. HEI’s should develop the content for this programme ensuring that it aligns with the learning outcomes and competencies of the programme specification. Following feedback from the pilot sites, it is anticipated that this programme will extend to four days.

7 Example Outline Timetable

| Day 1: Content of the day will relate to learning outcomes 1(a), 2, 3(b) and 5(a) | | | | |
|---|---|-------------|----------|--|
| Date | Themes | Facilitator | Time | Learning/Teaching Activities |
| | <p>Aims and objectives.</p> <p>Exploration of the A-EQUIP model; policy drivers; its inception; rationale for development.</p> <p>Adult learning styles- how do you learn – self-directed learning outcomes.</p> <p>Reflection and critique of the ‘problems in relation to the experiences and insights of the learners.</p> <p>The role of the PMA.</p> <p>Leadership theories in practice.</p> <p>Who wants to be led by you-feedback from self-assessment questionnaire.</p> <p>Leadership challenges.</p> <p>Advocacy in practice.</p> | | 9am -5pm | <p>Group introductions.</p> <p>Reflection of experiences as SoMs.</p> <p>Group work, facilitated discussions.</p> <p>Case studies, scenarios.</p> <p>Film clips.</p> |
| | Challenges for the group. | | | <p>Group discussion</p> <p>Preparation for Day 3.</p> |

| Day 2: Content of the day will relate to learning outcomes 1(b) and 3 | | | | |
|---|---|-------------|--------------|--|
| Date | Themes | Facilitator | Time | Learning/Teaching Activities |
| | <ul style="list-style-type: none"> ● Welcome, introductions and data collection. ● Introduction to Restorative Clinical Supervision model. ● Contracting. ● Research findings, evidence and outcomes. | | 9am – 4.30pm | Power Point Presentation throughout. Group Discussion. Delegate Contributions. Questionnaire. |
| | <ul style="list-style-type: none"> ● Compassionate Resilience. ● Impact of stress on self and others. ● Mindfulness and reflection. ● Self Compassion. | | | Group work. Scenarios. Film Clips. Reflective discussions and listening. |
| 4 x 1 hour individual sessions over four consecutive weeks to explore the application of RCS. One 3 hour group session to complete the RCS training. | | | | |

| Day 3: Content of the day will relate to learning outcomes 1(b), 2, 3(b), 4 and 5 | | | | |
|--|---|--------------------|-------------|--|
| Date | Themes | Facilitator | Time | Learning/ Teaching Activities |
| | <p>PMA and personal action for quality improvement.</p> <p>What it is QI?.</p> <p>Rationale for use.</p> <p>Current skills and knowledge.</p> <p>Quality improvement tools and how to integrate QI methods into practice.</p> <p>Making it work in practice –implementation.</p> <p>Exploring system readiness for change.</p> <p>Making data work for you – focus on measuring and interpreting outcomes.</p> <p>How this could linked to programme-wide expectations.</p> <p>How the system change will create supportive environments for QI projects to work in.</p> <p>Active, problem solving approaches to stakeholder engagement.</p> | | 9am-5pm | <p>Group work, facilitated discussions.</p> <p>Presentation and discussions.</p> <p>Case Scenarios.</p> <p>Group work.</p> |
| | <p>What does A-EQUIP mean to you?</p> <p>Moving on to become an A-EQUIP practitioner.</p> <p>Scenario testing.</p> | | | Group discussion. |

8 Learning Resources

A-EQUIP and Leadership

<https://businessballs.com>

NHS England <https://www.england.nhs.uk/ourwork/futurenhs/mat-transformation/midwifery-task-force/>

The Department of Health (2016) www.dh.org.uk <https://www.gov.uk/government/publications/changes-to-midwife-supervision-in-the-uk/proposals-for-changing-the-system-of-midwifery-supervision-in-the-uk>

NHS Improving Quality <http://www.nhs.uk/capacity-capability/change-model.aspx>

<https://www.england.nhs.uk/ourwork/qual-clin-lead/nhsiq/>

Leadership: Better leadership for tomorrow NHS Leadership Review Lord Rose (2015) <https://www.gov.uk/government/publications/better-leadership-for-tomorrow-nhs-leadership-review>

<https://www.england.nhs.uk/ourwork/futurenhs/mat-transformation/midwifery-task-force/>

NHS Leadership Academy <https://www.leadershipacademy.nhs.uk/resources>

<https://leadershipacademy.nhs.uk/discover/leadership-framework/setting-direction/making-decisions/>

Quality Improvement

<https://www.england.nhs.uk/rightcare/>

<http://www.health.org.uk/publication/quality-improvement-made-simple>

National Institute of Health and Clinical Excellence

<https://www.nice.org.uk/>

<http://ccgtools.england.nhs.uk/cfv2016/maternity/atlas.html>

<https://www.england.nhs.uk/leadingchange/>

http://webarchive.nationalarchives.gov.uk/20100408015550/http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html

9 References

- Academy of Medical Royal Colleges (AMRC) (2016) *Quality Improvement – training for better outcomes*. London, AMRC.
- Batalden P, Davidoff F. (2007) What is 'quality improvement' and how can it transform healthcare? *Quality and safety in health care*, 16 (1) 2–3.
- Care Quality Commission (2013) *A new start: Consultation on changes to the way CQC regulates, inspects and monitors care*. Newcastle upon Tyne, CQC.
- Department of Health (2016) *Proposals for changing the system of midwifery supervision in the UK*. London, DH.
- Kadushin, A. (1976). *Supervision in Social Work*. Clinical Supervisor. New York, Columbia University Press.
- National Health Service England [NHSE] (2016) *Leading Change Adding Value: a framework for nursing, midwifery and care staff*, London, The Stationery Office.
- Nursing and Midwifery Council (2014) *Standards for the preparation of supervisors of Midwives*, London, NMC.
- Pettit, A., and Stephen, R., (2015) *Supporting Health Visitors and Fostering Resilience*, Institute of Health Visiting, England
- Proctor, B. (1986) *Supervision: A Co-operative Exercise in Accountability in: Marken, M., and Payne, M. (eds.) Enabling and Ensuring*. Leicester National Youth Bureau and the Council for Education and Training in Youth and Community Work.
- Solihull Approach
www.solihullapproachparenting.com

Appendix 6: Frequently Asked Questions

Q: What Is A-EQUIP?

A: Advocating and educating for quality improvement (A-EQUIP) is a new model and framework of midwifery supervision that aims to: facilitate a continuous improvement process that values midwives, enhances health and well-being, builds their personal and professional resilience and contributes to the provision of high quality of care and quality improvement.

Q: Who will deploy the A-EQUIP model?

A: A midwife who has undertaken the Professional Midwifery Advocate (PMA) education programme will deploy the A-EQUIP model.

Q: How long is the PMA education programme and can a supervisor of midwives (SoM) become a PMA?

A: A three day bridging programme has been designed to prepare midwives who have previously completed the preparation of supervisors of midwives (PoSoM) course to become PMAs. This programme is currently being evaluated. A longer PMA preparation programme is being developed for midwives who have never completed a PoSoM course or an equivalent programme of education.

Q: Who will undertake investigations and investigate concerns about midwives if there is no SoM?

A: Local Supervising Authorities are responsible for undertaking regulatory investigations of concerns relating to the performance of midwives. These are additional to any investigations employers undertake as part of their accountability for the safety and quality of their services. When the proposed

changes became law, concerns about midwives must be handled in the same manner as concerns about other health professionals. If a midwife is employed then her employer will undertake a preliminary investigation, and if the concern is upheld the employer will put measures in place to remediate it. If the concern is sufficient to meet the threshold for regulatory action it should be referred to the NMC.

Q: In the absence of the LSA who will oversee concerns about independent midwives?

A: Independent midwives can be referred to the NMC by a service user, a member of the public, or a member of the profession. There is no change to the threshold for midwifery referrals to the NMC.

Q: As a Self-employed midwife how do I access a PMA?

A: Employment agencies and Independent providers of Midwifery services have expressed an interest in accessing PMA training programmes to ensure the provision of A-EQUIP within their organisations. Training of PMAs will be an iterative process however it is anticipated that within two years there will be enough PMAs trained who can work in a variety of ways to provide access to all midwives.

Q: As a PMA will I be asked to investigate poor practice or clinical incidents?

A: If you have the skills to investigate an incident in your substantive role as a midwife, you may be asked by your employer to do so. The A-EQUIP model does not involve investigation of incidents. When the proposed changes

become law, incidents involving midwives will be handled in the same manner as incidents that involve other health professionals.

Q: What will replace the notification of intention to practise?

A: Whilst the NMC will no longer require midwives to notify the LSA or the NMC of their intention to practise in any given year, the NMC will collect information about midwives' scope of practice and other matters through the revalidation process. The latter will be every three years, not annually. The NMC has committed to sharing revalidation data widely with those in the sector who may find it helpful in their work to support high standards of maternity care.

Q: Does the PMA role involve being on call?

A: No, the PMA role does not involve being on call. However your employer may request that you do this in line with on call arrangements within your place of work.

Q: When deploying the PMA role how often should I meet midwives?

A: The outcome of the evaluation of the PMA role and the A-EQUIP model, will inform the frequency of meetings. At present there is a suggestion that an annual meeting should take place with midwives with further access to a PMA being available during daytime hours as the need arises.

Q: I don't have the expertise or the time so how can I as a midwife contribute to quality improvement?

A: The PMA preparation programme will prepare you for this. Quality improvement using a recognised method is simply looking at the care or service you provide and seeing if it can be improved. This might involve you thinking about how you can improve your skills, or it could involve changing

something in the environment or system in which care is provided or the area that you teach or advise. It is not always about big system change but small improvements that make a difference to the maternity experiences of women and their families as well as students and academic colleagues. By critically examining your practice and initiating evidence based changes, you are immediately involved in quality improvement. Quality improvement is everybody's business.

Q: As a PMA, will I continue to be involved in making individual care plans for women (especially women with complex needs)?

A: All midwives are responsible for giving women the information they need to make informed choices, and to support them in planning care which supports their individual needs. As a PMA, your role is to help midwives develop the skills to be able to plan personalised care for each woman.

Q: Was it a statutory requirement for women to approach a supervisor of midwives to support them with their birth options?

A: There was no statutory basis for the provision of women approaching a supervisor of midwives when accessing maternity services and providing support about birth options and how to pursue them. This became custom and practice and providers must now assure themselves that women, particularly vulnerable women, have access to informed, impartial advice on maternity options.

Q: In my Trust we have supervision clinics will these stop when the law changes?

A: Whilst statutory supervision will cease when the law changes, employers can choose to support these clinics to run in a non-statutory capacity. In addition however, the PMA will use the A-EQUIP

model to support midwives to strengthen their advocacy role.

Q: In my Trust SoMs wear a uniform/ badge/tabard to show they are SoMs and available that day. Do I still do this as a PMA?

A: When the LSA function ends SoM identification becomes redundant. Maternity providers can decide how they may want to identify the PMA.

Q: I deliver training as a SoM. Can I still do this as a PMA?

A: Yes, training and education is part of the PMA role.

Q: I am a re-validation confirmer as a SoM. Can I still do this as a PMA?

A: Yes, you can, the NMC states that 'It is for individual nurses and midwives to decide who their confirmer should be. However, we recommend that where possible, a line manager should act as the confirmer.'

Q: As a PMA, can midwives come to me to discuss a difficult experience?

A: Yes, you can use the A-EQUIP model for this purpose.

Q: Is remuneration compulsory?

A: No, your employer will make this decision.

Q: Has the A-EQUIP model been evaluated?

A: The model is being evaluated in seven pilot sites. The findings will be used to improve the model, its implementation and the education preparation programme.

Q: In the absence of the Local Supervising Authority Midwifery Officers, what will replace the regional midwifery leadership role?

A: A new structure of regional midwifery leaders has been developed. There will be a Regional Maternity Lead, and a Deputy Regional Maternity Lead in each NHS England region. These roles will provide midwifery leadership and professional guidance regionally, and across the health system, ensuring that the NHS ambitions are realised and deployed appropriately through commissioning of high quality, safe maternity services. These new roles will also support maternity providers to embed the PMA roles and support the development of process and outcome measures.

Q: Will PMAs provide 24hr on call?

A: No, statutory supervision of midwifery ensured that every midwife had 24 hour access to a Supervisor of Midwives. The NMC no longer requires this and therefore this is not a requirement of the PMA role unless it forms part of employment processes. Employers need to consider how 24 hour access to midwifery advice is provided. The organisation may provide this access through existing mechanisms such as a dedicated 24 hr advice line, 24hr case loading midwives on call and the maternity escalation process (senior midwifery manager on call).



Better outcomes Better experience Better use of resources

**Proposed competency framework for
the preparation of Professional
Midwifery Advocates**

NHS England Task Force: Education Workstream
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Contents

| | |
|--|----|
| Section one | 83 |
| Introduction | 83 |
| The A-EQUIP process aims to: | 83 |
| Context | 83 |
| Section two | 85 |
| The competency framework | 85 |
| Aims | 85 |
| The Competencies | 86 |
| Mapping of programme outcomes to competencies | 87 |
| Education standards for the preparation of Professional Midwifery Advocate | 87 |

The Professional Midwifery Advocates will *not* undertake investigations, unless this is requested by their employer. The Professional Midwifery Advocate role and the function that they deploy is completely separate to, but may be parallel to governance structures already in place.

Section one

Introduction

In January 2015, the Nursing and Midwifery Council (NMC) agreed to recommendations made in the Kings Fund review to remove statutory supervision from its legal framework. Following this, NHS England set up a Task Force to develop a new model of midwifery supervision and consequently set out a vision for the deployment of this model that aims to:

- improve outcomes;
- improve experience (midwives and users);
- improve system performance;
- enhance personal professional development;
- ensure that action to improve quality becomes an intrinsic part of everyone's job, every day, in all parts of the system.

The model adopted to achieve this vision is predicated on a continuous improvement process that builds personal and professional resilience, enhances quality of care and supports preparedness for appraisal and professional revalidation. The title of the model is A-EQUIP, advocating for education and quality improvement.

The A-EQUIP process aims to:

- Focus the midwife to address the key priorities of the maternity service.
- Support the midwife to focus on creating space for thinking, feeling and understanding, through a process of **restorative clinical supervision**.
- Focus the midwife on quality and safety in clinical practice through a process of reflection, engagement

and advocacy with women using personal action for quality improvement.

- Develop knowledge and skills in clinical practice through **education and training and utilising the normative function of the model** that informs appraisal and revalidation.

Professional Midwifery Advocates will deploy this model and, therefore, require an appropriate preparation programme to support their development in this role and enable them to achieve the underpinning competencies aligned to the role.

Context

1. The framework and accompanying competencies set out within this document are set by the NHS England Supervision Task Force and describe the responsibilities and scope of the Professional Midwifery Advocate.
2. This programme has been developed for the purpose of preparing those midwives who intend to seek appointment as a Professional Midwifery Advocate. Entry onto the programme will require the midwife to undergo an approved selection process, and recognition as a Professional Midwifery Advocate will be dependent upon successful completion of the programme.
3. Whilst undertaking the preparation programme, midwives must demonstrate proficiency in all competencies through successful completion of theoretical and practical assessments.
4. Employers will hold a local record of Professional Midwifery Advocates.

5. Professional Midwifery Advocates must maintain and evidence their on-going competence in this role.
6. The Professional Midwifery Advocate framework and accompanying competencies are set as a national standard. However, it is acknowledged that the implementation of activities within this framework is undertaken in region specific contexts and that specific support from employers to assist Professional Midwifery Advocates to undertake their duties effectively should be made available.
7. Also reference to: the NHS Standard contract 2016/17 and local CCG maternity specification and adherence to the guidance for implementing the new model of midwifery clinical supervision (NHS England 2017), will support implementation.
8. The requirements for education providers wishing to provide the Professional Midwifery Advocate preparation programme will be outlined in guidance for implementing the new model of midwifery clinical supervision (NHS England 2017)

Section two

The competency framework

The Competencies for the Professional Midwifery Advocate programme have been arranged to align with the Care Quality Commission (2013) Key Lines of Enquiry. These five areas address the key priorities of every service, determine quality and identify risks.

1. Safety and quality improvement;
2. Effective;
3. Caring;
4. Responsive;
5. Well-led.

Aims

The Professional Midwifery Advocate education programme aims to:

Prepare registered midwives to achieve the standards and competencies required to successfully undertake the role of the Professional Midwifery Advocate (PMA). This will include developing an understanding of the role of the Professional Midwifery Advocate and of the deployment of that role using the A-EQUIP model. PMA students will develop the knowledge and skills necessary to enable them to provide support to enhance health and wellbeing; develop education and training to progress knowledge and skills; and support quality improvement practices to ensure that women and their families experience safe, enriching care.

The Professional Midwifery Advocate education programme is designed to equip successful students to deliver the following outcomes:

1. In association with the employing organisation, create an interdependent leadership culture that will lead to quality, compassionate care for women and their families.
2. Working collaboratively within the existing governance and quality improvement frameworks actively contribute to assurance and quality improvement initiatives, creating an environment of cultural change and opportunities to develop transformative care for women.
3. Support and work collaboratively with Professional Midwifery Advocate colleagues and members of multidisciplinary and governance teams to improve standards of care and ensure a safe service to women and their families.
4. Enact strategies to raise awareness of the enablers of good health and wellbeing and of signs of anxiety or distress in the workplace.
5. Apply models of support to promote and optimise colleagues' wellbeing, personal safety and to resolve conflict.
6. Contribute to the evidence base to demonstrate added value of the Professional Midwifery Advocate and the A-EQUIP model to the service, organisation and profession.

The Competencies

6. Safety and quality improvement

Professional Midwifery Advocates must demonstrate how they:

- a. articulate and apply the principles of quality improvement techniques, facilitating others to develop these skills;
- b. have an understanding of the use, interpretation and analysis of relevant data to promote personal action for quality improvement and influence strategy and service development;
- c. portray an understanding of personal and professional resilience and support others to develop this attribute.

7. Effective

Professional Midwifery Advocates must demonstrate how they:

- a. use effective communication strategies and influencing skills to achieve desired outcomes and make referrals for advocacy, mediation or arbitration;
- b. support other midwives to work in partnership with women to develop plans of care which meet their individual needs, giving consideration to human rights principles, to listen to them and to advocate for them when required;
- c. demonstrate a managerial focus on monitoring, evaluation and the quality control aspects of professional practice

8. Caring

Professional Midwifery Advocates must demonstrate how they:

- a. contribute to the education and development of student midwives to ensure they understand the role of the Professional Midwifery Advocate;

- b. use appropriate strategies to support midwives to maximise their potential in practice, linked to the professional re-validation process, implement the principles of restorative clinical supervision;
- c. demonstrate the ability to think critically, apply knowledge and utilise evidence and experience to facilitate effective reflective discussions;
- d. enable others to be responsible and accountable for their actions and behaviours by creating a safe space to think, feel, reflect.

9. Responsive

Professional Midwifery Advocates must demonstrate how they:

- a. use understanding of the role of the Professional Midwifery Advocate within the context of local governance policies and procedures;
- b. use agreed metrics to demonstrate the on-going value of the Professional Midwifery Advocate role;
- c. In collaboration with the existing organisational processes support improvement in practice, demonstrating responsiveness to the needs of the healthcare environment, contributing to quality improvement.

10. Well-led

Professional Midwifery Advocates must demonstrate how they act as a role model:

- a. demonstrating inspiration, motivation and visible leadership in the workplace;
- b. by applying continuous personal improvement using positive learning approaches and encouraging others to adopt this culture;
- c. working within existing healthcare systems, actively contributing to service development using quality improvement methodology

Mapping of programme outcomes to competencies

| Competencies | PO 1 | PO2 | PO3 | PO4 | PO5 | PO6 |
|--------------|------|-----|-----|-----|-----|-----|
| 1a | X | X | X | | | |
| 1b | X | | X | X | X | |
| 1c | | | | X | X | |
| 2a | X | X | X | X | X | X |
| 2b | X | X | X | X | X | X |
| 2c | X | X | X | X | | |
| 3a | | | X | X | X | X |
| 3b | X | | X | X | X | |
| 3c | X | | X | X | X | |
| 3d | X | | X | X | X | |
| 4a | | X | X | | | X |
| 4b | X | X | X | X | X | X |
| 4c | X | X | X | | | X |
| 5a | X | | X | X | X | X |
| 5b | X | X | X | X | X | X |
| 5c | X | X | X | | | X |

Education standards for the preparation of Professional Midwifery Advocate

Standard 1: Programme providers must demonstrate robust quality assurance processes.

- 1.1 The preparation programme for the deployment of the A-EQUIP model will be at level 7 or its equivalent, with adherence to the Frameworks for Higher Education Qualifications (QAA 2008).
- 1.2 Programme providers must appoint a designated programme lead to oversee this provision, who holds an NMC recordable teaching

qualification and should have past or current experience as a Professional Midwifery Advocate. Where the programme leader is not a current Professional Midwifery Advocate, a Professional Midwifery Advocate must be a member of the programme's development, teaching and assessment teams.

- 1.3 Programme providers must ensure that the programme planning team must include representation from educationalists, users of the maternity service, currently appointed professional midwifery advocates and midwives.

- 1.4 Programme providers must ensure that the programme is no less than 10 days in duration, which may include on-line, e-learning and face-to-face tuition.
- 1.4.1 For existing Supervisors of midwives undertaking a bridging programme, this is to be no less than 4 days.
- 1.5 Programme providers must ensure that the assessment for both the bridging module/shortened and the full PMA programmes comprises of both practice and theoretical components and must evidence the achievement of the competencies of the professional midwifery advocate.
- 1.6 Programme providers must have a reliable and valid assessment strategy.

Standard 2: Programme providers must evidence robust recruitment and selection processes.

- 2.1 Programme providers must have an equality and diversity strategy that is reflective of current legislative requirements.
- 2.2 Programme providers must be open, accurate and fair in all selection, admission, progression and completion processes.
- 2.3 Entry onto the programme requires an equitable selection process to be employed.
- 2.4 Selection must adhere to the person specification of the professional midwifery advocate role.

Standard 3: Programme providers must provide the necessary resource to promote and sustain programme delivery

- 3.1 All student professional midwifery advocates must be allocated to a

mentor, which should be a current professional midwifery advocate.

- 3.2 Programme providers must ensure practice-based learning opportunities are safe and appropriate to the programme outcomes.
- 3.3 To achieve the practice-based elements of the programme and competencies in practice, students must have opportunity to observe and engage in a range of A-EQUIP related activities, for example:
- Attendance at Professional Midwifery Advocate meetings;
 - Attendance at strategic planning and/or policy meetings;
 - Attendance at clinical governance meetings and activities where quality improvement methodologies are employed;
 - Clinical, restorative sessions or coaching workshops;
 - Maternity services liaison committees and other service user groups.
- 3.4 The programme outcomes must ensure that the competencies within this document are met and that students are fit for practice and fit for award.
- 3.5 Upon completion of either the A-EQUIP education programme or the bridging module, Regional Midwifery Lead will make contact with the provider to establish the numbers of Professional Midwifery Advocate who have achieved all learning outcomes and competencies through practice and theory based assessments. This must be done as soon as possible and within 4 weeks from the date of completion of the programme.

Appendix 8: Evaluation of the Pilot Sites

Expressions of interest to become a pilot site to test the A-EQUIP model were received from 49 of the 136 maternity providers in England. The ten sites chosen to pilot the new model with plans to train a total of 41 PMAs were:

North

- Airedale NHS Foundation Trust.
- Calderdale and Huddersfield NHS Foundation Trust.

Midlands and East

- University Hospital Coventry and Warwickshire, South Warwickshire Foundation Trust, George Eliot Hospital Trust and Coventry University.
- One to One Independent Midwifery

South

- Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust.

London

- The Whittington Health
- Barking Havering and Redbridge University Hospitals NHS Trust.

Midwives who had undertaken the Preparation of Supervisors of Midwives Course were selected to undertake the PMA training. The preparation of PMAs began on 7th November 2016 and involved participants completing a PMA bridging module/shortened programme. For further information about the programme, please see [Appendix 5](#).

Evaluation Recommendations

The following is a summary of the evaluation report completed by Sheffield University in March 2017:

Recommendations

The documentary analysis has been successful in highlighting areas for further investigation. There are some clear strengths of the current approach, as well as some identified weaknesses which indicate areas for development. Importantly, there are opportunities and threats which may emerge as the A-EQUIP model and programme are iteratively developed.

The main recommendations are:

Adult Learning: There is a requirement for further development of assessment criteria for competencies and for explicit linking of the course content with the learning outcomes. The course would also benefit from encouragement of critical reflection by learners and the active use of feedback.

Future iterations of the course will be available to learners with varying levels of skills and experience and this will need to be reflected in the course design (e.g. content and duration). The course would benefit from elements focused on operationalisation of the theoretical components.

Clinical Supervision: It is unclear why normative and developmental elements of the model have been excluded and a sole focus on the restoration has been favoured. There is an absence of delineation between CS and other forms of support, which could affect clarity of application of the model. Other areas of

41 SoMs trained to be PMAs
 – Now delivering the new
 model to 205 midwives



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Our pilot sites

possible development include ongoing monitoring and evaluation of supervisee wellbeing, training quality and effectiveness.

The frequency of supervision should be addressed. If annual supervision only is expected, this has consequences for delivery of supervision and should be reflected in the course content.

Quality Improvement (QI): The focus should be on developing minimum core competencies and skills (e.g. PDSA cycles) with access to further learning resources and support. Time spent by PMAs with supervisees will be, potentially, very short, and, even with increased time, supervision alone is not an effective method for developing capacity for QI. To be effective in creating the required cultural change, this approach should be considered as a contribution within a wider programme of work.

Implementation Science: As PMAs will be expected to implement change in a wide variety of environments, an established framework could be useful for them to understand pre-requisites for implementation and to diagnose and address problems (e.g. organisational readiness for change). At a policy implementation level, the programme should endeavour to create a supportive environment for change (e.g. organisational support, promoting good management-clinical relationships).

Practical Application: It is very positive that there has been consideration given to the development of transitional model of support for midwives to address the removal of statutory supervision and that the A-EQUIP model will have familiar aspects. However, consideration should be given to how this is promoted and discussed with midwives as describing it

as the 'new model of midwifery supervision' may be misleading and confusing.

Greater attention could be given to how the A-EQUIP model will be effectively supported and resourced within Trusts to ensure a consistent approach. The success of the PMA role, relies on the embedding of the notion that this model is an integrated part of midwifery (and not a 'bolt on activity).

Consideration should be given to how the time for this new model will be protected for both the PMA and the midwife in order to prevent superficial delivery of the model; leading, in turn, to potential detrimental impact on supervisees and service users.

Consideration should also be given as to how midwives from outside NHS Trusts can access supervisory provision if they do not have an NHS contract.

Recommendations for putting into practice

Several respondents considered funding to ensure that time was protected for supervision as a key element of the sustainability of the model. In view of this, one respondent suggested redirecting the money saved from the payment of the SoM honorarium to support the payment of a coordinating PMA to lead other sessional PMAs. The following list of recommendations was offered by respondents. At this early stage in the programme implementation these should, for the most part, be viewed as initial hypotheses that have yet to be tested or refined.

- Give yourself time. This was all so rushed, you need to think about the logistics of training, planning, communicating with the wider PMA team and how time will be made for PMAs and midwives to meet for PMA sessions;
- Be organised and plan ahead. Planning should give consideration to the needs and working patterns of the teams you are supporting;
- Be responsive to the unit. A-EQUIP will only work where it is tailored to context;
- Communication: Information sharing between pilot sites would have been useful good communication and sharing of ideas (within and between Trusts) would be central to the success of A-EQUIP;
- Ensure that midwives know what A-EQUIP is about;
- Though they were advised that experienced SoMs should undertake the course, the enthusiasm and new ideas of newly qualified SoMs could offer real benefits. It could be important that PMAs have a diverse range of perspectives to offer to midwives and within the PMA team;
- Time should be provided for 'doing' and training in the PMA role;
- It would be important to have a lead PMA with the role being **substantive**, rather than it being an "addition", otherwise, the administrative burden for midwives doing the PMA role alongside their substantive clinical post could not be effectively managed;
- PMAs should not be the line manager of the midwives they support (as manager midwife interactions have been identified as a source of stress within the PMA sessions to date- role conflicts);
- Midwives should be able to choose their PMA;
- Time should be provided for PMAs to support one another;
- Support is required from the Trust/ employer.

