The role of the PMA and barriers to the successful implementation of restorative clinical supervision

Abstract

Recognition of systematic and structural areas of concern has led to significant changes to midwifery supervision to meet the needs of midwives and the service as a whole. The A-EQUIP (Advocating for Education and QUality ImProvement) model was created to enhance the emotional and physical wellbeing of those providing care and in turn the quality of care provided to women and their families. It is deployed by professional midwifery advocates (PMAs), who have undergone training to deliver restorative clinical supervision. This article aims to critically review the implementation of restorative clinical supervision in practice, examining the potential challenges to the successful implementation of the A-EQUIP model.

Keywords

Professional midwifery advocate | Clinical restorative supervision | A-EQUIP | Midwives | Professional development

As a profession, there have been recent changes to improve the quality and effectiveness of care and learn from significant incidents. The need for change and improved support became apparent following significant failings in midwifery and the health profession as a whole. Reports including the Francis Report (2013), examining failings in care at Mid-Staffordshire NHS Foundation Trust, and the Kirkup Report (2015), investigating Morecambe Bay NHS Foundation Trust, emphasised the need for re-evaluation of midwifery services. Systematic problems and a collective and individual organisational failure to exercise an effective supervisory or regulatory function were identified (Kirkup, 2015). Both reports have given valuable insight into the health service, with the Francis Report concluding that:

> ***'All NHS Trusts and Foundation Trusts responsible for the provision of hospital services should review their standards, governance and performances in view of the report.' (Francis, 2013:15)***

Systems of regulation and staff support were described as no longer meeting professional and public requirements. A need to explore existing processes and Trust requirements was identified, and a more robust method of internal examination and quality improvement was sought. In 2013, the Parliamentary Health Service Ombudsman (PHSO) found that there was a structural flaw in the way midwifery regulation was organised, as it combined investigation and support for midwives (PHSO, 2013). As a result, it was recognised that:

> ***'As a specialty we must embrace the changes that are needed to ensure high standards, personal responsibility, strong leadership and outstanding patient safety.' (Simpson and Morris, 2014:188)***

The model of midwifery statutory supervision was determined no longer suitable to meet the needs of services, although the supportive and reflective aspects revealed through supervisory episodes were recognised to offer positive outcomes for staff and organisations alike. There was therefore a need to retain these aspects in a new model of care, as they offered significant benefits that needed to be preserved.

The need for supervision

Midwifery is an ever-evolving and challenging profession. Developments in theoretical knowledge, advancement in practice and the changing needs of society have led to a consistently fluctuating work environment with increased pressure and expectations. Budgetary restraints, increased public demand for services and the changing population demographic has meant that those working in the caring professions have a heightened vulnerability to stressors (Wallbank, 2016). This creates an interesting

Samantha Rouse
Senior Midwife Community,
University Hospitals of Derby and Burton
samantha.rouse@nhs.net

Box 1. Proctor's model of clinical supervision

- Restorative: focusing on health and wellbeing, supporting professionals working with stress and distress
- Normative managerial: focusing on ongoing monitoring and evaluation, exploring quality control aspects of professional practice
- Formative/educative: focusing on the development of knowledge and skills

Source: Proctor (1986)

and exciting work environment, but places a physical and emotional burden on midwifery staff to keep apprised of developments in practice, meet the expectations of women and their families in sometimes complex and difficult circumstances, and also meet the needs of their own family and loved ones at home.

It is important to understand aspects of midwifery practice that may hold adverse implications for midwives' psychological health, and which may subsequently affect their capacity to provide sensitive maternity care (Sheena et al, 2015). Attempts by midwives to meet the requirements of their employer, clients and loved ones, can lead to midwives being placed under considerable pressure to achieve all expectations. As the Royal College of Midwives (RCM) has concluded:

> ***'The role of the midwife is emotionally and physically challenging; birth rates are increasing, there are staff shortages and increasingly more complex cases for which to co-ordinate care.' (RCM, 2015)***

Banovcinova and Baskova (2014) suggested that midwives are subjected to a more general stress, as a result of physical, psychological and social aspects of the working environment. These high stress levels often result in burnout and a change of attitudes to work, which could negatively influence a health professional's care for patients.

As women's needs increase and the population being cared for grows in size and complexity, many midwives have found the expectation too great, leaving the profession or retiring early. This has compounded the pressure for those remaining in the profession. As Bloxome et al (2019:398) found:

> ***'Midwives are needed now more than ever, and the various threats to their recruitment and retention is now a serious issue that if left unresolved will impact on women's and babies' maternity care outcomes.'***

Figures from the Nursing and Midwifery Council (NMC) suggested that the numbers of UK-trained midwives appears to be stabilising after a period of decline and those joining the register for the first time is at its highest level for 4 years (NMC, 2018). Until these increases translate to more midwives in the NHS, governments must do all they can to support and retain NHS maternity staff (RCM, 2018).

The benefits of clinical supervision have long been recognised. Hawkins and Shohet (2012) acknowledged the opportunity that supervision could offer in allowing the chance to step back, reflect, avoid blaming others, engage in the search for new options and learn from difficult situations. Organisational strategies have been shown to support midwives experiencing traumatic events and displaying significant symptoms (Sheena et al, 2015).

A-EQUIP, the PMA and restorative clinical supervision

The A-EQUIP (advocating for education and quality improvement) model (NHS England, 2017) was launched on the 28 April 2017, replacing statutory supervision of midwifery, which ceased on the 31 March 2017. The professional midwifery advocate (PMA) role was developed to provide leadership in deploying the model. Inspired by Proctor's three function model of clinical supervision (Proctor, 1986) (*Box 1*) the A-EQUIP model aims to:

> ***'Facilitate a continuous improvement process that values midwives, builds their personal and professional resilience, and contribute to the provision of high-quality care.' (Dunkley-Bent, 2017: 278)***

The A-EQUIP model was developed to continue the supportive and developmental aspects of supervision, and proactively improve and enhance the quality of care provided to women and their families.

The role of the PMA covers a wide range of skills including advocacy, leadership, active listening, and offering care and support to midwives, multidisciplinary teams, women and families. Although each PMA and NHS Trust will develop their own approach, key aspects will remain paramount to the process and all will retain the aim of the PMA role, which will be to:

> ***'Support staff through a continuous improvement process that aims the build personal and professional resilience, enhance quality of care and support preparedness for revalidation.' (NHS England, 2017:11)***

Leadership forms an essential part of the role of the PMA, who is required to project integrity, know their personal values and principles, and build and maintain

relationships with midwives through active listening, building trust and effective advocacy. By providing professional care, compassion and support both personally and professionally, PMAs encourage a climate of ongoing service improvement by engaging midwives in the process of improvement and innovation.

The A-EQUIP model (NHS England, 2017) adopts four key areas of focus:

- Monitoring, evaluation and quality control (normative): supporting individuals to develop their ability and effectiveness in their clinical role by validating clinical actions or discussing consequences of clinical errors
- Clinical supervision (restorative): addressing the emotional needs of staff and supporting the development of resilience
- Education and development (formative): focusing on the development of skills through education
- Personal action for quality improvement: encouraging staff at all levels to contribute to systems of quality improvement and quality assurance, and embedding lessons from incidents.

Specifically trained PMAs use the most suitable function of the model to meet the precise needs of individual midwives, therefore encouraging a continuous process of improvement and support. The model emphasises the importance of the support and wellbeing of care providers in enabling them to build resilience, reflect consistently, seek learning opportunities and develop their practice in the interest of patient safety and improved quality of care (Clarke et al, 2018).

Restorative clinical supervision

A key feature of the A-EQUIP model is restorative clinical supervision. This focuses on the emotional needs of staff and the development of resilience by providing midwives with a space (physically and metaphorically) to think. By supporting professionals to slow down and consider experiences of care through reflective discussion, supportive challenges and open and honest feedback, restorative clinical supervision provides an opportunity to consider new perspectives and supports decision-making (NHS England, 2017).

The benefits of restorative clinical supervision in the healthcare system as a whole have been acknowledged. During her exploration into the role of restorative clinical supervision in the support of health visitors (who were recognised to be at risk of increased stress and burnout due to the emotional demands of their role), Wallbank (2010) concluded that regular restorative clinical supervision sessions offered significant benefits to health professionals. Staff who had attended restorative clinical supervision sessions were found to have maintained, or slightly increased, levels of compassion satisfaction (the pleasure derived from performing work duties), which is a protective factor against individual stress and burnout. Reciprocal relationships between teams of health professionals resulted in enhanced teamwork and reduced burnout, producing a calmer workforce that was able to process the needs of the work environment more clearly. The aim of those providing restorative clinical supervision is to support staff to build their own resilience levels and to reduce personal stress and burnout. As part of restorative clinical supervision, emphasis is placed on strengthening the professional's resilience, improving their own health and wellbeing, and supporting their ability to make appropriate clinical decisions in often complex situations. The work of Wallbank (2010) in addressing the emotional needs of health visitors has provided considerable insight into the health benefits of restorative clinical supervision.

However, White (2017) concluded that the inclusion of the term 'clinical supervision' in public policy statements and health service governance reports had caused confusion regarding the role of restorative clinical supervision. White (2017) argued that evidence-based guidelines about delivery and evaluation remained insufficient, and that implementation had likely been evaluated by staff attendance at restorative clinical supervision activities and whether key performance indicator targets had been achieved, rather than the quality of restorative clinical supervision and staff perception of the experience.

Barriers to implementation

Although evidence supports restorative clinical supervision, implementation in practice can offer challenges. Brunero and Lamont (2012) identified four main potential barriers to the success of restorative clinical supervision: clinicians' time away from clinical demands, availability of supervisors, physical space to have the sessions and potential ongoing training costs.

Time and space for supervision

Love (2017) found while implementing restorative clinical supervision sessions that midwives often felt unable to attend sessions during working hours due to busy work environments and time constraints, with some supervisees suggesting that they felt indulgent if they took time out to reflect on practice and examine their actions and interactions.

The location and timing of a restorative clinical supervision session appears to hold great importance in its overall success, especially if those attending cannot fully engage with the process due to interruptions, or if the environment is not conducive to the needs of attendees by not offering privacy or confidentiality, for example. This will impact the benefit achieved by attending the

> Other studies have suggested that midwives struggled with the concept of taking time out for themselves, as they were accustomed to dealing with adverse outcomes or stressful situations and being expected to absorb their emotions

session. However, sessions can take place in many forms and locations. Taylor (2013) suggested that group sessions should be located in a quiet, comfortable and non-clinical environment, and therefore a good location for sessions should offer easy accessibility, close to the main area of work, but a neutral and comfortable environment, protected from interruption and disturbance.

Protected time for restorative clinical supervision may also present difficulties in areas with compromised staffing levels. As midwives need time to reflect and explore their practice, opportunities to participate in such activities are often difficult to achieve, for the fear of compromising women and colleagues. Services may also be challenged in ensuring that organisational permission is given to professionals to enable them to take time for restorative clinical supervision sessions (Wallbank, 2013). During a study into the benefits of restorative clinical supervision for health visitors, Wallbank (2012) found that perceived availability of time to attend sessions was the main suggested reason for the low uptake. Other studies (Love, 2017) have suggested that midwives struggled with the concept of taking time out for themselves, as they were accustomed to dealing with adverse outcomes or stressful situations and being expected to absorb their emotions.

Availability and suitability of supervisors

The limited availability of trained PMAs presents a further issue to developing the model further. Although PMAs are increasing in numbers, the availability of PMAs to midwives who may need support remains limited. In many cases, PMAs are also confined to the duties of their substantive role, which again has the potential to create challenges in creating opportunities for protected time. As A-EQUIP is a new model of supervision, the emerging perception is that low knowledge among midwifery staff regarding A-EQUIP and the role of the PMA is affecting its incorporation into practice (NHS England, 2017). A lack of understanding of the aim of restorative clinical supervision also appears to be affecting attendance at sessions. This is supported by Ariss et al (2017), who, in their final evaluation of piloted A-EQUIP sites, noted a lack of awareness and understanding of the A-EQUIP model among midwives, and a reliance on newly qualified PMAs and management to spread information about A-EQUIP.

Consideration should also be given to how the substantive position of the PMA may affect a supervisee's desire to request support. Many PMAs will hold a senior or experienced positions within the same area of care provision, which has the potential to create a barrier for midwives to approach them in their PMA capacity. During the implementation of the A-EQUIP model at a pilot site, McCalmont (2018) concluded that midwives found benefits to having a PMA who was not their line manager, which removed the possibility of a conflict of interest and gave midwives the opportunity to focus on their learning and development. Felton et al (2012) stated that the relationship between supervisor and supervisee is essential to creating the right environment for skills development; therefore the individual PMA will need to clearly define roles to ensure the confidence for open dialogue and reflection. Tension or apprehension could be created by changing previously established roles through the process of supervision; however, Wallbank (2012) argued that restorative clinical supervision enables staff to re-engage with their organisation, observing that the development of reciprocal relationships with the use of supportive challenging techniques, both for professionals and management teams, allowed relationships to become more constructive and barriers to be removed by means of productive discussions. This also has the potential to affect individual PMAs themselves: those in need of support may be plainly visible to the PMA, but support cannot be personally offered due to their substantive role and a conflict of interest, which may affect the PMA's own personal compassion satisfaction.

The leadership style of the PMA also has a large role to play in the success of restorative clinical supervision sessions. Wallbank (2013) suggested that enabling those in leadership roles to empower, rather than rescue, is essential to learning and development. Skilfully supporting others to critically reflect and consider the opinions of themselves and others leads to essential learning and development. Leadership can follow many styles and approaches and it is important to recognise that one style does not fit all supervisees. Butterworth (1992) states that clinical supervision is a personal and professional experience that allows for a variety of approaches. However, where leaders have adopted a reciprocal-productive style, drawing on the ideas of both those leading and those contributing with mutual cooperation of all involved (as opposed to an adversarial leadership style, which takes a more combative style to discussions with an expectation of a winning and losing argument), relationships have developed.

Participants' attitudes to supervision

Although midwives have historically, through the process of supervision, sought to reflectively examine their care

to improve outcomes for women and families, examining experiences for the benefit of their own wellbeing has yet to be embraced. Bush (2005) found that the overall perceived benefit of restorative clinical supervision was widely misunderstood among health professionals in general, and that a lack of understanding and underlying mistrust by health professionals could hinder those attempting to offer reflective support. Restorative clinical supervision may, in some cases, only be adopted when adverse patient outcomes force exploration of individual midwives wellbeing or personal needs. Despite more recent exploration that has emphasised how restorative clinical supervision sessions can benefit the general wellbeing of staff, the overall work environment and patient care (Wallbank, 2013), staff remain dubious of the benefits and continue to place their own needs as a low priority (Taylor, 2013). As restorative clinical supervision sessions are implemented into practice, challenges are to be expected as midwives become accustomed. Taylor (2013) studied participants of group restorative clinical supervision sessions and recognised this stage of development as 'settling in: the suspicious newcomer', a reference to some attendees' cautiousness when attending a session for the first time. Attendees described early experiences of group sessions as 'scary' and 'unsettling' due to its format, which was more intense and open than supervision they had previously experienced.

> ***'The novelty of the process prompted supervisees to question its purpose, express doubt over its benefit and also feel concerned that this might not be an appropriate style of supervision for them.' (Taylor, 2013: 862)***

Taylor concluded that supervisees' feelings of uncertainly and insecurity about their role in the session led to their reluctance to contribute to a discussion, meaning that instead they chose to sit self-consciously in silence.

Conclusion

The need for organisational change following critical review of significant events led to the emergence of a new model of support, quality assessment and improvement in midwifery practice. A-EQUIP was introduced to meet the demands of service users by providing support to health professionals, with the hope of enhancing the quality of care for women and professionals alike. By exploring new methods of quality assurance, but retaining positive aspects of the now-ceased statutory supervision of midwifery, the A-EQUIP model aims to maintain and strengthen the midwifery profession and reduce the risk of repeating past errors. Successful implementation of A-EQUIP and the role of PMAs requires input and support from all levels, through midwives' engagement with the process, organisational support in the allocation of protected time, and the selection of ambassadors to deliver the model. The success of the model is heavily reliant on the individual investment of all involved, due to its voluntary, non-statutory nature, and on the potential long term benefits to the profession as a whole being appreciated.

Midwifery is constantly changing and adjusting to meet the needs of service users and workplace challenges. This can create increasingly stressful and demanding situations, requiring high levels of personal resilience. The role of the PMA in the support of staff experiencing high levels of stress or burnout, or in using appreciative enquiry and reflective models to encourage internal exploration of experiences or perceptions, gives the opportunity to significantly enhance compassion satisfaction. This in turn reduces the stress and burnout experienced by midwives and increases the quality of care received by service users.

As with any new change, time and patience are required to fully integrate new methods of practice and thinking. Challenges to the implementation of the A-EQUIP model are inevitable and integral to the development and evolution of the model. In exploring these barriers, attempts can be made to address and overcome these obstacles. This article has considered how the substantive role and leadership style of the PMA may affect their perceived approachability by supervisees, and the cultural opinion of midwives to suppress the emotional impact that the role can have.

Key points

- Attempts by midwives to meet the requirements of their employer, clients and loved ones can lead to them being placed under considerable pressure to meet expectations
- Enhancing and retaining the positive aspects of supervision and reflective practice, the A-EQUIP model has been developed to continue the supportive and developmental aspects of supervision and proactively improve and enhance the quality of care provided to women and their families
- Although evidence supports the use of restorative clinical supervision, implementation in practice can offer challenges
- Staff remain dubious of the benefits and continue to place their own needs as a low priority
- Successful implementation of A-EQUIP and the role of the professional midwifery advocate (PMA) requires input and support from all levels, through midwives embracement and engagement with the process, organisational support in the allocation of protected time, and the selection of ambassadors to deliver the model
- The relatively recent adoption of the A-EQUIP model and the role of PMAs appears to be the main hurdle to the implementation of the model and the uptake of group restorative clinical supervision sessions by midwives

CPD reflective questions

- Are you aware how to access professional midwifery advocate (PMA) support at your Trust?
- Can you consider how restorative clinical supervision would allow you to reflectively share experiences? How could this affect quality assurance in your work area?
- What qualities do you feel would be beneficial for a PMA?
- What would affect your ability or desire to attend a restorative clinical supervision session?

Overall, the relatively recent adoption of A-EQUIP and the role of PMA appears to be the main hurdle to the integration of the model and midwives' uptake of group restorative clinical supervision sessions. Many Trusts are developing adapted versions of the A-EQUIP model to suit the specific needs of individual services, although the primary aim of the model, to enhance the quality of care through the support and development of midwives, remains paramount to the process. A-EQUIP is an opportunity to enhance the quality of care and experience of service users through the investment in the emotional and physical wellbeing of those providing the care. BJM

***Declaration of interests**: The authors have no conflicts of interest to declare.*

***Review**: This article was subject to double-blind peer review and accepted for publication on 20 March 2019.*

Ariss SM, Earley V, Jokhi R, Merodoulaki M. Final Evaluation Report: Pilot for New Model of Midwifery Supervision. London: NHS England; 2017

Banovcinova L, Baskova M. Sources of work-related stress and their effect on burnout in midwifery. Procedia Soc Behav Sci. 2014;132(15):248–254. https://doi.org/10.1016/j.sbspro.2014.04.306

Bloxsome D, Ireson D, Doleman G, Bayes S. Factors associated with midwives' job satisfaction and intention to stay in the profession: an integrative review. J Clin Nurs. 2019;28(3-4):386–399. https://doi.org/10.1111/jocn.14651

Brunero S, Lamont S. The process, logistics and challenges of implementing clinical supervision in a generalist tertiary referral hospital. Scand J Caring Sci. 2012;26(1):186–193. https://doi.org/10.1111/j.1471-6712.2011.00913.x

Bush T. Overcoming the barriers to effective clinical supervision. Nurs Times. 2005;101(2):38–41

Butterworth T. Clinical Supervision and mentorship in nursing. London: Chapman and Hall; 1992

Clarke L, Garrett D, Lees S, Ward L, Waterfall M, Bailey E. A-Equip: pilot to practice through partnership and power. The Practising Midwife. 2018;21(6):20–24

Dunkley-Bent J. A-EQUIP: The new model of midwifery supervision. Br J Midwifery. 2017;25(5):278-279. https://doi.org/10.12968/bjom.2017.25.5.278

Felton A, Sheppard F, Stacey G. Exposing the tensions of implementing supervision in pre-registration nurse education. Nurse Educ Pract. 2012;12(1):36–40. https://doi.org/10.1016/j.nepr.2011.05.004

Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office; 2013

Hawkins P, Shohet R. Supervision in the helping professions. 4th edn. Maidenhead: Open University Press; 2012

Kirkup B. The Report of the Morecambe Bay Investigation. London: The Stationery Office; 2015

Love B, Sidebotham M, Fenwick J, Harvey S, Fairbrother G. "Unscrambling what's in your head": A mixed method evaluation of clinical supervision for midwives. Women Birth. 2017;30(4):271–281. https://doi.org/10.1016/j.wombi.2016.11.002

McCalmont C. Practice the latest practical guide…Implement A-Equip. RCM Midwives. 2018;Summer:36-37

Nurisng and Midwifery Council. The NMC Register 2018. London: NMC; 2018

NHS England. A-EQUIP: A Model of Clinical Midwifery Supervision. London: NHS England; 2017

Proctor B. Supervision: A Co-operative exercise in accountability. In: Marken M. Payne M (eds). Enabling and Ensuring. Leicester: Leicester National Youth Bureau and Council for Education and Training in Youth and Community Work; 1986

Parliamentary and Health Service Ombudsman. Midwifery supervision and regulation: recommendations for change. London: The Stationery Office; 2013

Royal College of Midwives. State of Maternity Services Report 2015. London: RCM; 2015

Royal College of Midwives. Rise in EU midwives leaving the UK. Midwives. 2018;9

Sheena K, Spilby H, Sladea P. Exposure to traumatic perinatal experiences and posttraumatic stress symptoms in midwives: prevalence and association with burnout. Int J Nurs Stud. 2015;52(2):578–587. https://doi.org/10.1016/j.ijnurstu.2014.11.006

Simpson PD, Morris EP. The implications of the Francis report. Obstetrics, Gynaecol Reprod Med. 2014;24(6):186–188. https://doi.org/10.1016/j.ogrm.2014.04.008

Taylor C. Receiving group clinical supervision: a phenomenological study. Br J Nurs. 2013;22(15):861–866. https://doi.org/10.12968/bjon.2013.22.15.861

Wallbank S. Restorative Clinical Supervision Manual. NHS West Midlands Restorative Clinical Supervision Programme; 2010

Wallbank S. Health visitors' needs--national perspectives from the Restorative Clinical Supervision Programme. Community Pract. 2012;85(4):29–32

Wallbank S. Reflecting on leadership in health visiting and the restorative model of supervision. J Health Visiting. 2013;1(3):173–176. https://doi.org/10.12968/johv.2013.1.3.97598

Wallbank S. The Restorative Resilience Model of Supervision. Shoreham-by-Sea: Pavilion Publishing and Media Lt; 2016

White E. Clinical Supervision: invisibility on the contemporary nursing and midwifery policy agenda. J Adv Nurs. 2017;73(6):1251–1254. https://doi.org/10.1111/jan.12970