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Final Evaluation Report: Pilot for New Model of Midwifery Supervision

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Glossary

EQUIP: Education and Quality Improvement (prior to change to A-EQUIP)

A-EQUIP: Advocating for Education and Quality Improvement (current name for the new model of midwifery supervision)

CS: Clinical Supervision

CNO: Chief Nursing Officer

HOMs: Head of Midwives

IS: Implementation Science

LSAs: Local Supervising Authorities

PMAs: Professional Midwifery Advocates

POSOM: Preparation of Supervisors of Midwives

QI: Quality Improvement

RCS: Restorative Clinical Supervision

RS: Restorative Supervision

SOMs: Supervisors of Midwives

SWFT: South Warwickshire NHS Foundation Trust

Declaration of conflict of interests

At the time of writing Rachel Jokhi was a practising supervisor of midwives and has previously delivered training for other supervisors through the Preparation of Supervisors of Midwives (PoSoM) course at the University of Sheffield. None of the other authors have any conflicts of interest to declare.

Executive Summary

The focus of the evaluation was a bridging programme to prepare existing supervisors of midwives (SOMs) to become professional midwifery advocates (PMAs) in order to deliver a new model of supervision (A-EQUIP). It set out to assess the bridging programme and the A-EQUIP model.

This report documents the following stages of the evaluation:
1. Establish baseline data, prior to the adoption of the A-EQUIP pilot
   a. Development and completion of a site pro-forma to provide contextual organisational data
2. Evaluation of the preparation of the A-EQUIP practitioner and assessment of the A-EQUIP model through the following mechanisms:
   a. Documentary analysis
   b. Supervisor/PMA survey
   c. Supervisee survey
   d. Supervisor/PMA interviews

1a. Key findings from the Site Pro-forma

The following review of baseline data should be taken into account as establishing the initial context of the pilot evaluation.

The majority of the Supervisors of Midwives (SoMs) who are part of the A-EQUIP pilot have completed their SoM training within the last 10 years. This pre-existing skill set may not be applicable to all future (i.e. non-pilot) A-EQUIP practitioners. Findings from this evaluation, therefore, may not be universally transferable. Each Trust chose a specific clinical area as the pilot site. Any feedback, therefore, will relate specifically to that specific type of service area and the potential for generalisation will be limited.

All the service providers stated that the SoMs form part of existing Trust escalation policies / processes and; not all out of hours contacts are concerned solely with statutory supervisory matters. Out of hours access was stipulated as part of the principles for changing midwifery supervision in the DoH Policy Proposal (22nd Jan. 2016): "midwifery supervision should be at least an annual event and also be proactively accessed at times when support and advice are needed on a 24 hour, 365 days of the year basis". However, there is no reference evident within the A-EQUIP model and associated documentation, that an on call rota / 24 hour access will form part of this approach. Indeed, feedback from the national taskforce indicated that as a provider-led model, 24 hour access to supervision could not be guaranteed.

2a. Key findings from the Documentary Analysis

The analysis focused on five main themes:
1. Adult learning theories and methodologies
2. A-EQUIP as clinical supervision for midwives
3. Quality improvement approaches
4. Implementation science frameworks
5. Practical elements of implementation within current midwifery practice

This summary includes some key findings from the Strengths, Weaknesses, Opportunities and Threats (SWOT) analyses of documentary evidence from the programme, and 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.

Adult Learning

STRENGTHS
- Provides opportunities for peer, experiential and self-directed learning

WEAKNESSES
- Learning aims, intended learning outcomes and competencies do not appear to be made available or explicitly linked to content

OPPORTUNITIES
- Content pertaining to the operationalisation of theoretical components could be incorporated

THREATS
- Uncertainty regarding the details of implementation at individual sites makes it difficult to assess the extent to which PMAs are prepared for these changes

RECOMMENDATIONS

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

STRENGTHS
- Focus on worker wellbeing/ restoration

WEAKNESSES

    Absence of delineation between Clinical Supervision and other professional support mechanisms (mentoring, managerial supervision)

OPPORTUNITIES
- Longer-term evaluation of training effectiveness and possible development of training into all functions of CS

THREATS
- Partitioning of the original model (RCS is one function of the Proctor and Inskipp model of CS) Exclusion of normative and developmental functions of CS. Potential for confusion of CS functions and CS models

RECOMMENDATIONS

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 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 (restoration is likely to be required more often than annually).

Quality Improvement

STRENGTHS

- Clear example for producing SMART(ER) aim statements and good introduction to basic theory of 'Plan, Do, Study, Act' (PDSA) cycles

WEAKNESSES

- Lack of clarity around how to integrate and implement all of the various concepts that are introduced

OPPORTUNITIES

- Could be linked to programme-wide expectations about how the system change will create supportive environments for QI projects to work in and potential for stronger focus on measurement and interpreting outcomes

THREATS

- Supervision alone is unlikely to produce sustained change in QI skills or behaviour

RECOMMENDATIONS

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

STRENGTHS

- Prescriptive approach to programme implementation covers a range of competency drivers

WEAKNESSES

- At a programme level, Organisational and Leadership (specifically adaptive leadership) drivers are not clearly defined

OPPORTUNITIES

- There is an opportunity to include implementation at policy, organisational and individual levels

THREATS

- Do organisational members feel confident that they can bring about change, and what ongoing coaching/support is required?

RECOMMENDATIONS

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

STRENGTHS

- The model aims to enhance personal and professional resilience of the midwives; assumed to improve care and service provision

WEAKNESSES

- Having an employer–led model with no recommended process for selection of PMAs, or how the supervisees can 'choose' the PMA they engage with could lead to role conflict/conflation between the PMA role and appraisal / management processes

OPPORTUNITIES:

- Opportunity for individual accountability and responsibility for service provision and quality to be developed and strengthened through adopting a QI methodology

THREATS

- There is a risk of variability in its operationalisation; a particular threat of such potential variability is that employers may choose not to utilise this approach. There is no evidence within the model of any recommendation for protected time for this role. There is much research describing the impact of time pressures and constraints on clinical staff

RECOMMENDATIONS

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 without a contract with an NHS Trusts can access supervisory provision.

2b. Key findings from the PMA supervisor survey

We received 33 completed surveys from a potential 40 supervisors who had very recently completed the PMA training (82.5%).

In answer to the question whether, as a result of the course, PMAs understood how to prepare midwives for their professional appraisal and revalidation using the A-EQUIP model feedback was largely positive. There is some concern, however, that although most

respondents agreed completely (53.1%); seven responded 'sufficiently' (22%), three (9%) responded 'a little', and a further three (9%) responded 'not at all'.

The least positive and most mixed responses were in answer to the question 'How much has this course improved and/or expanded your understanding of practicing as a midwifery supervisor?' Five replied 'not at all' (16%), twelve replied 'a little' (38%), seven replied 'sufficiently' (22%) and six 'completely' (19%). Two respondents (6%) were unsure. Therefore, 54% thought that the course had not, or had only marginally, expanded their understanding of practising as a supervisor. We recognise, however, that there could be a significant limitation to this finding: the phrasing of this question might have been unclear in its reference to the PMA role, rather than SoM role, and, thus, shaped participants' responses.

Mean scores (0-4)

As a result of this course, I know how to function effectively as an A-EQUIP supervisor (n=33)	3.03
As a result of this course, I know how to deliver effective restorative supervision using the A-EQUIP model (n=33)	3.18
As a result of this course, I understand how to prepare midwives for their professional appraisal and revalidation using the A-EQUIP model (n=32)	3.00
As a result of this course, I know how to foster continuous quality improvement in midwifery practice using the A-EQUIP model (n=33)	2.60
How much has this course improved and/ or expanded your understanding of practicing as a midwifery supervisor? (n=32)	1.91

These responses reinforce the view that the majority of participants for this pilot already had high self-confidence in their efficacy to act as supervisors. They also indicate variation in the learning needs of potential supervisors.

2c: Key findings from the midwife supervisee survey

We received 39 completed surveys. The response rate is not known, as this was cascaded to an unknown number of midwives from PMAs.

When asked about experiencing facilitation of restoration and resilience, five responded 'a little' (13%), fifteen responded 'sufficiently' (39%), and the most responses (seventeen) were 'completely' (44%). This question received the highest mean score (3.08).

When asked 'To what extent do you feel that your A-EQUIP supervision has enabled you to identify your continuing professional development needs?', the result was very mixed. The majority responded either 'sufficiently' (fourteen, 36%), or 'completely' (ten, 27%). However, five responded 'a little' (13%) and another five responded 'not at all' (13%). This was also the question with the lowest mean score.

Mean scores (0-4)

To what extent has your experience of A-EQUIP supervision been different to your prior experiences of supervision?	2.69
One of the aims of the A-EQUIP course is to train supervisors to facilitate restoration and resilience in the midwife (this means that your supervisor will help you to manage the emotional effects of the work on you so that you can continue to provide a high quality service). Have you experienced this during A-EQUIP supervision?	3.08
To what extent do you feel prepared for professional appraisal and revalidation as a result of A-EQUIP supervision?	2.56
To what extent do you feel that your A-EQUIP supervision has enabled you to identify your continuing professional development needs?	2.49

These findings resonate with the interview findings from the PMAs. The element of the model that is being best received and understood is associated with RCS. However, other elements of the model, such as embedding within appraisal and revalidation processes and incorporating development needs, do not appear to be implemented as effectively.

2d: Key findings from the PMA interviews

There were various perceptions about current practice, particularly regarding the extent to which RCS was already being undertaken. Despite this, the restorative element of the A-EQUIP model was very welcome and this element of the training was appreciated. Although, consistent with the findings from the supervisees' survey, many supervisors already had well-developed relational skills, it is possible that the course reinforced these. This could explain the finding that supervisees experienced little difference from previous supervision except in the restorative aspect. However, the training programme was reported to result in little additional understanding, or ability to implement, other elements of the A-EQUIP model.

Peer learning was considered an important part of the training and it was suggested that such learning could possibly be expanded and extended within the programme. It was felt that establishing such networks in training could partially compensate for the loss of information and sharing best practice that is currently happening through the Local Supervisory Authorities (LSAs), but which is not a feature of the Trust-led, A-EQUIP model. Some PMAs considered that other important elements of the current model could be considered for incorporation. They also recognised that future training for non-supervisors would need to be significantly reconsidered to compensate for lack of experience and prior knowledge when entering the PMA training programme.

There was lack of clarity regarding documentation of supervisory sessions; ranging from no documentation (in order to maintain confidentiality) to the benefits of documentation for aspects of quality improvement, or training and development. This represents a major change from previous supervision arrangements and it is important that it be given consideration and resolution.

The role of measurement, monitoring and benefit realisation was considered crucial for the sustainability of the model, in particular to maintain buy-in and investment in the model by managers and senior executives. Access to supervision, in terms of protected time for PMAs and midwives, was considered critical to enabling the success of the model. The possibility of lack of engagement from 'hard to reach' midwives was also recognised. There was also concern that such lack of engagement would become a punitive tool if practice issues were raised and, thus, create a fear of reprisal for midwives who did not attend for PMA sessions.

The implementation of supervisory sessions to ensure mutual understanding and expectations were seen to be important elements of delivering the model; to establish the "ground rules" and to ensure that a "supervisory contract" was in place. The relationship between PMAs under the A-EQUIP model and management within Trusts has not been tested. There were a number of significant concerns about potential management issues that might arise. Potential role conflict and conflation between management and supervisory contexts were repeatedly highlighted as problematic.

Introduction

The development of a new model of midwifery supervision in the UK was recommended following the publication of 'Midwifery supervision and regulation: recommendations for change' (PHSO, 2013) and 'Midwifery regulation in the United Kingdom' (The King's Fund, 2015). The Nursing and Midwifery (Amendment) Order 2017 has since been passed in Parliament to facilitate this change.

The policy paper 'Proposals for changing the system of midwifery supervision in the UK' (Department of Health, 2016), a framing document developed in collaboration with the UK Chief Nursing Officers and professional midwifery officers, was published on 22 January 2016 and outlined the requirement to devise an overarching system of midwifery supervision that would be put in place following legislative changes removing statutory supervision in March 2017.

Each UK country convened a taskforce led by the Chief Nursing Officers (CNO) of each country to examine and embed the principles for midwifery supervision outlined in the Department of Health's policy paper.

In England, a time limited task force was convened to develop a new model of supervision and to oversee the transition from a statutory model of supervision to an employer-led, professional model (DH, 2016). This has resulted in the development of the 'A-EQUIP' model of midwifery supervision, incorporating three key components:

1. Restorative clinical supervision
2. Quality improvement
3. Education and development

'The deployment of the model supports a continuous improvement process that builds personal and professional resilience, enhances quality of care and supports preparedness for appraisal and professional revalidation. The ultimate aim of using the A-EQUIP model is that through staff empowerment and development, action to improve quality of care becomes an intrinsic part of everyone's job, every day in all parts of the system.'
(Operational Guidance for Implementing the PMA Role, p11)

The England Supervision Taskforce was formed by NHS England and the England CNO in January 2016 and is responsible for developing the new model of midwifery supervision for England. Expressions of interest were sought to work with a small number of maternity providers who would test the new approach alongside the current statutory model of supervision. It was recognised as important that the new approach was tested in a variety of maternity settings. Bids to participate were, therefore, sought from large and small, urban, rural and independent providers who had the capacity to support the pilot whilst, simultaneously, maintaining their current supervision arrangements.

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. Following review of these expressions of interest, seven sites in England were chosen to pilot the new model with plans to train a total of 41 PMAs (in actuality, 40 undertook the training). These were:

- Airedale NHS Foundation Trust
- Calderdale & Huddersfield NHS Foundation Trust
- One to One Midwives (Wirral)
- University Hospitals Coventry and Warwickshire NHS Trust (UHCW)
- Taunton and Somerset NHS Foundation Trust
- Whittington Health NHS Trust
- Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT)

Prospective PMAs were selected from midwives who were currently supervisors, some of whom had undertaken the Preparation of Supervisors of Midwives (POSOM) course. The preparation of PMAs began in November 2016 and involved a taught programme (PMA bridging programme). This programme was designed to develop supervisors of midwives to become PMAs and was taught by a senior lecturer and a restorative clinical supervision expert.

The following stages were included in this evaluation work:

1. Establishment of baseline data prior to the adoption of the A-EQUIP pilot
2. Evaluation of the preparation of PMAs
3. Identification of perceived deficits in the A-EQUIP bridging programme
4. Evaluation of the A-EQUIP model
5. Assessment of the usefulness of using one or all elements of the model and the perceived impact and outcomes
6. Restorative clinical supervision - In addition to this commissioned work, the restorative clinical supervision (training) team also evaluated this element of the model

Scale and Scope

The evaluation was set in the context of the pilot implementation of a bridging programme to prepare existing supervisors of midwives (SOMs) to become professional midwifery advocates (PMAs) in order to deliver a new model of supervision (A-EQUIP).

The evaluation had two key areas of focus:
- Firstly, evaluation of the ability of the bridging programme to adequately prepare PMAs to deliver supervision in line with the new (A-EQUIP) model.
- Secondly, assessment of the A-EQUIP model in terms of its primary objectives and anticipated wider implementation.

Within the context of the implementation of the pilot, these two areas of focus (bridging programme and A-EQUIP model) have complex interrelationships and interdependencies, which are at times difficult or counterproductive to separate. Primarily, this is due to the only experience of the A-EQUIP model being through the delivery of the bridging programme.

This report has therefore explored the potential future training needs of trainees that might have little or no previous supervisory experience. It also anticipates the impact of the

removal of statutory provision, as this is the imminent context within which the A-EQUIP model and the newly trained PMAs will work.

The following are the evaluation aims and objectives taken from the original specification:

- *Establish baseline data, prior to the adoption of the Equip pilot for example, full time SOM, SOM on calls, frequency of using SoMs (the annual report will provide useful data, so this may be a desk top exercise). It may also be helpful to use the information outlined in the expression of interest, which outlines the reasons why the service should become an Equip pilot site.*

- *Evaluate the preparation of the Equip practitioner to establish if the practitioner is appropriately prepared to deploy the Equip model of midwifery supervision*

- *Identify perceived deficits in the Equip bridging programme*

- *Evaluate the Equip model in relation to: preparing midwives to build: personal and professional resilience, asses their understanding and use of quality improvement, review their preparedness for appraisal and revalidation and their commitment to be an advocate for the woman and child in their care.*

- *To assess the usefulness of using one or all elements of the model and the perceived impact and outcome- on the Equip Midwife and their respective supervisee. Outcome measures will be difficult to establish given the timeframe of deploying the Equip model to a small number of midwives within the time constraints of the pilot.*

The evaluation proposal included the following activities to address these aims and objectives:
1. Documentary analysis and service pro forma to establish baseline data
2. Documentary analysis of training and implementation materials
3. Survey for PMAs
4. Interviews with trained PMAs
5. Survey for midwife supervisees

The evaluation began in November 2016, an interim report was returned in February 2017 and the draft final report circulated for feedback in March 2017. This final report has incorporated feedback in agreement with the commissioner of this work.

The following 'methods' section described in more detail how these activities were implemented and how they addressed the aims of the original specification.

Methods

1. Establishment of baseline data prior to the adoption of the A-EQUIP pilot

Aim: This work-package aimed to describe important elements of the current services at pilot sites.

Methods: A pro-forma was created and initially populated using content from the expressions of interest from sites. Missing data were requested individually from each site. Requested baseline evidence included: numbers of staff and their experience, full time numbers of SOMs, number of SOM on calls, ratio of SOMs to midwives, and frequency of SOM use. Readiness for change, current or recent quality improvement work, communication practices, staff support and supervision, and descriptions of organisational structures also provided important contextual information.

2. Evaluation of the preparation of the A-EQUIP practitioner

This work-package had three main aims:

1. **Aim:** Gain a theoretical understanding of the development and implementation of the bridging programme **(Documentary Analysis)**

   Methods: An assessment of the learning materials and sessions for training A-EQUIP practitioners was carried out using the following themes:
   - Adult learning theories and methodologies
   - Current evidence for effective clinical supervision
   - Quality Improvement (QI) approaches
   - Implementation Science frameworks
   - Practical elements of application within current context

2. **Aim:** Establish whether the recently trained A-EQUIP practitioners consider themselves appropriately prepared to deploy the new model of midwifery supervision **(Supervisor Survey)**

   Methods: A short survey tool was developed and distributed to all (40) recently trained PMAs to identify their readiness to deliver the new model. The survey combined multiple choice and open questions in order to begin to explore experiences and perceptions of newly trained PMAs. Surveys were circulated to potential participants on the 10th of February and were closed to responses on the 6th of March.

   The questions on these surveys are informed by the outlines of A-EQUIP model and training programme made available to the evaluation team. The surveys were reviewed by the Ethics review process of the University of Sheffield (School of Nursing and Midwifery) and amended in accordance with the reviewer's feedback (some phrasing was made clearer and some demographic questions were removed to reduce the probability of participant identification). Copies of the surveys are appended (Appendix 1 & 2).

3. **Aim:** To explore newly trained PMAs' experiences of the training programme, gauging their understanding of the A-EQUIP model and highlighting issues and recommendations associated with successful implementation **(Supervisor Interviews).**

Methods: Between the first and the seventh of March 2017, eight telephone interviews were conducted with recently trained PMAs. An experience-mapping approach to the interviews was used to explore PMAs' experiences of the A-EQUIP training, their impressions of the model, and to gather early experiences about applying the model in practice. The short number of days between the completion of the PMA training and the requirement for the final evaluation report meant that transcription and analysis of verbatim audio recordings was not possible. The interviews were therefore recorded using hand-written notes on partially pre-themed paper sheets, and later typed up. An interview prompt list consisted of three superordinate themes: 'Experience of training', 'Perceptions of the new model', and 'Putting the model into practice'. Beneath these themes were lower level themes, developed into prompting questions (see appendix 4).

Interview records were entered into NVIVO (qualitative data analysis software). An initial coding theme was constructed inductively following the interview prompts. The records were analysed line-by-line, drawing out data excerpts into descriptive codes. Codes were iteratively constructed as analysis progressed, resulting in the development of new codes and merging of codes as required. Content within these high-level categories was then exported, and synthesised into finer themes.

3. Evaluation of the initial impact of the A-EQUIP model on midwives

Aim: Explore some of the key early outcomes of the programme, focusing on the effect of new supervision practices on midwives (**Supervisee Interviews**)

Methods: A short survey tool was developed and distributed to recently trained PMAs to cascade to midwives that had recently received supervision according to the A-EQUIP model. The survey combined multiple choice and open questions which were developed in light of emerging themes from the evaluation. The survey tool was reviewed by University of Sheffield ethics procedures and amended accordingly, as described above for the PMA survey.

The first survey was completed on the 8th of February (2017). To give as many midwives as possible (who had experienced supervision by a PMA using the new model) the opportunity to feed-back, the date for completing the supervisee survey was extended to the 10th of March in response to the later dates that some A-EQUIP training was completed (28th February). Midwives' experiences of A-EQUIP supervision were generally very limited due to the extremely short time lapse between PMAs completing training and then offering A-EQUIP supervision.

The original evaluation plan had included interviews with midwives (supervisees). Unfortunately, owing to time constraints between completion of the first supervisory sessions and the delivery of the final report, this was not possible.

Findings

1. Establish baseline data prior to the adoption of the A-EQUIP pilot

The following section describes and compares key features of Trust services, prior to piloting the A-EQUIP model. The aim of this work-package was to describe important elements of the current services at pilot sites and was largely a desk-based project. A pro-forma was created and populated initially using content from the expression of interest from sites. Missing data were requested individually from each site.

The baseline evidence included numbers of staff and their experience levels, numbers of full time SOMs, SOM on calls, ratio of SOMs to midwives, and frequency of SoM use. The readiness for change, current or recent quality improvement work, communication practices, staff support and supervision, and descriptions of organisational structures also provided important contextual information as has been outlined in the previous section.

Site descriptions of the pilot sites and commitment to the scheme

NORTH

Airedale NHS Foundation Trust – *Airedale NHS Foundation Trust is an award-winning NHS hospital and community services trust providing high quality, personalised, acute, elective, specialist and community care for a population of over 200,000 people from a widespread area covering 700 square miles within Yorkshire and Lancashire. The maternity services care for around 2,500 women and their families every year from a large urban and rural population. The Trust fully supports the time required by the Designated Midwifery Lead for the pilot within our organisation of 2 hours per week for 3-4 months, she will be released from clinical duties to enable her to do this. They supported 5 midwives to undertake PMA training and deliver the new approach.*

Calderdale and Huddersfield NHS Foundation Trust *Employ around 6,000 staff who deliver compassionate care from our two main hospitals. Maternity services are provided at Huddersfield Royal Infirmary and Calderdale Royal Hospital and in the communities of Calderdale and Kirklees. They propose to pilot the Equip approach in our free standing and alongside Birth Centres (n=22 midwives) and the Specialist Midwives Team (n=13 midwives). The rationale for deployment of the pilot in these areas is that midwives work in these areas autonomously and need to acquire, and sustain, high levels of personal and professional resilience. In order to support the pilot, the following resources would be provided:*

- ➢ *Designated Midwifery Lead: 2 hours per week for 3-4 months*
- ➢ *Designated Administrative Support: 2 hours per week for 3-4 months (to assist with organisation of meetings and data collection)*
- ➢ *5-10 PMAs: 3 days per midwife training plus time (to be agreed with pilot programme manager) to deploy the A-EQUIP approach with an identified cohort of midwives for the duration of the pilot*
- ➢ *Protected time to enable identified cohort of midwives to participate in the Equip approach (to be agreed with pilot programme manager)*
- ➢ *Local programme board members 1 hour per month for 3-4 months (membership to be confirmed)*

MIDLANDS and EAST

University Hospitals Coventry and Warwickshire NHS Trust. *This is one of the UK's largest teaching Trusts responsible for managing two major hospitals in Coventry and Rugby, which between them serve a population of over a million people. Staff at University Hospital delivers more than 6,000 babies a year and 229 midwives are currently employed by the Trust. This application represents collaboration between University Hospitals Coventry and Warwickshire NHS Trust (UHCW), George Eliot Hospital (GEH NHS Trust Foundation Trust (SWFT) and Coventry University. There is a history of shared working and an established and productive partnership between these organisations. The three NHS Trusts birth approx. 11,000 babies per year, and support 438 midwives across a diverse geographical region representing a mix of inner and health inequalities.*

> *Our specific proposal for the pilot phase is that 'A-EQUIP' will be delivered across the three NHS Trusts to support a cohort of newly qualified midwives who are due to join the register in November 2016 (approximately 25 midwives). As this pilot would be across 3 sites we will have one named midwifery lead (2 hrs a week 3-4 months; universal point of contact for LSA England supervision taskforce) and 1 named individual from each of the other NHS Trusts who will directly liaise with the lead.*

> *In addition to the midwifery leads we propose a steering and working group for the pilot phase. This steering and working group will consist of the HoMs from the 3 sites, maternity risk managers from 3 sites, current SoMs from education including Coventry University Lead Midwife for Education, safeguarding and clinical practice.*

SOUTH

Taunton and Somerset NHS Foundation Trust *- The maternity services of Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust maternity unit provides care for over 3,200 deliveries per year. Both Heads of Midwifery and their respective Directors of Nursing fully support the bid to become a joint pilot site for implementation and to providing the additional resources required in terms of protected time for those involved. A project group will be established with members from both sites and will be chaired by the contact SoM at Taunton. The pilot coincides with the appointment of a new cohort of newly qualified midwives so the intention is to trial the new system with a combination of newly qualified and experienced midwives; a total of 45 midwives. Nine Supervisors of Midwives from Yeovil and Taunton will undertake the 3 day training course prior to implementation of the pilot. In order to support the pilot, the following resources would include:*

> ➢ *9 x Current Supervisors of Midwives will be allocated to the 3 day A-EQUIP training.*
> ➢ *Each new PMA will receive 2 days per month to spend on direct A-EQUIP contact with their cohort of midwives.*
> ➢ *Each PMA will receive up to a further 2 days per month for admin / audit / meetings.*
> ➢ *2 x Heads of Midwifery will commit to the equivalent of 1 day per month for the duration of the pilot to work with the project group and liaise with the NHS England Supervision taskforce.*
> ➢ *IT / Audit department support from both Trusts*

LONDON

Barking, Havering and Redbridge University Hospitals NHS Trust - Barking, Havering and Redbridge University Hospitals Trust (BHRUT) Maternity Services is the largest single site provider of maternity services in East London and comprises of both midwifery and obstetric elements. Inpatient maternity services are delivered at the Queen's Hospital at Romford and provide maternity care to around 9,000 women each year, making it one of the largest maternity services in the country. The trust services a population that is hugely diverse in relation to ethnicity. A large proportion of women have medical problems with high rates of diabetes and obesity and within the local population there are high levels of deprivation.

> *There are two post-natal wards at Queen's and high risk postnatal ward, a low risk postnatal ward as well as a co-located birth centre. This means that we are ideally placed to pilot the postnatal A-EQUIP model in a variety of settings with differing cohorts of women and assess the areas of most impact and improved outcomes to inform future models for Supervision.*

> *The A-EQUIP Pilot team would comprise of the full time SoM plus 5 of the supervisors currently appointed by the LSA. This number is chosen in relation to the size of the current team and number of births in the trust.*

Whittington Health - We provide hospital and community care services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney. Every day about a dozen Whittington Health babies are born to women with a wide range of ethnic, cultural and religious backgrounds. The State of Maternity Services in England report (2016) highlights postnatal care as an area which requires improvement. This is mirrored by the feedback in our own Family and Friends test and from a user feedback project called Footprints of Birth. Women are generally satisfied with postnatal care but feel the environment, consistency and, continuity of care and information given could be improved while staffs working in the postnatal area report the work challenging and stressful in terms of demand and complexity. While there is a group of core staff in the postnatal area, the turnover of staff and use of temporary staff (bank/agency) leads to fragmented care, low morale and poor experience. The areas we specifically wish to address are improving care continuity and development of core midwives on the postnatal ward. Our Clinical Director, Head of Midwifery, Director of Operations and Director of Nursing are fully supportive of this bid.
We will do the following if successful with the bid:

> ➢ *Identify a pilot lead to oversee the project, maintain links with NHS England Supervision taskforce and keep the project on track ensuring timeframe is achieved.*
> ➢ *Engage with other pilot sites via electronic communication (emails, teleconferencing), face to face meetings, potential visits to sites, share expertise where required locally and nationally and attend meetings.*
> ➢ *Agree data collation, pilot and evaluation strategies and outcomes which will be shared across pilot sites including lessons learnt.*
> ➢ *Seek guidance and support from NHS England to ensure we are fulfilling the terms of the pilot.*

- Submit progress reports as required to NHS England and Trust board meetings ensuring key people are fully informed.
- Share information via our weekly unit maternity newsletter, the MSLC and other user groups, senior meetings, staff meetings, professional development team and clinical governance meetings.
- Produce a learning passport which can be used throughout the maternity services as evidence of learning, development and revalidation.

In order to achieve this, the following resources will be required:
- In addition to the 15 hours a month for SoMs an extra 45hrs is available from a full time SOM allocation
- Total Supervision hours available per month is 240hr
- 8 of the Supervisors (inclusive of the lead) will undergo training 3 days over 3 weeks
- Lead for pilot will be released for 2 hrs per week over a period of 4 months = 32 hrs
- Releasing time for A-EQUIP pilot work to be done with core staff an estimate of 7hrs a week
- Supervisors required to work with 15 core postnatal ward staff
- Each PMA will caseload 3-4 core midwives to work with during the pilot
- Evaluation data will be agreed and collated by the lead
- Admin support is already in place for our Supervision Team
- Weekly half hour briefing with HOM to ensure pilot is progressing

INDEPENDENT MIDWIFERY SUPERVISION PROVIDER

One to One Midwives is a private maternity service company who specialise in the case-loading model; Working within the Caseloading model, midwives work in small self-managed teams, encouraging professional accountability, autonomy and empowerment. Each team has a Lead Midwife to oversee the day-to-day management and outcomes of care, and provide midwifery leadership supported by the Clinical/Operations/Supervision/Governance departments. For the purposes of the A-EQUIP pilot, One to One could focus on a team/ locality (e.g. Wirral/Liverpool/Warrington) or the northwest region in totality. One to One are currently running two models of caseloading – team based caseloading, and traditional caseloading. The A-EQUIP model could be piloted within one or both of these models of care. As a preference One to One would like to embed the model across the organisation from the beginning .We are commissioned by the NHS in the North West region and are insured and regulated in the same way as other NHS providers.

> One to One midwives have always found the current model of supervision to be supportive approachable and know that a supervisor of midwives is accessible 24/7. Because of the nature of case-loading it is imperative that our midwives continue to have the level of support they have received so far once supervision is no longer in statute. Therefore throughout the organisation, from Board to midwife we are keen to continue with the model of integrated governance ensuring that midwives are supported in their growth and development.

> We believe that the A-EQUIP pilot would be an opportunity for One to One to enhance its model of support for midwives, promote professional resilience and ensure that additional pastoral support is available for staff – particularly when

dealing with the stresses of work, and maintaining a work-life balance. This in turn will also help staff retention and morale across the board. Midwives are keen to participate in the model and in a recent survey, expressed a desire for group clinical reflective sessions as a supportive and educational tool.

Themes identified

Experience of SoMs undertaking A-EQUIP bridging programme

From the data that was available at the time of writing the report, it was evident that Supervisors of Midwives (SoMs) who had been approached to undertake the AEQUIP training had a range of length of experience as SoMs. This ranged from those SoMs who qualified in 1996 (2) to those who qualified in 2015 (1). Most of the SoMs in the pilot had undertaken their education and preparation as a SoM between 2000 and 2010 (n=12) and 2010 -2015 (n=11). Related to the range of experiences, the academic levels attained by SoMs during their training was also varied; 7 undertook the programme at level 6 (degree) but the majority of SoMs undertook the programme at level 7 (Masters) level. This is reflective of the change of provision of the Preparation of Supervisors of Midwives programme to being provided primarily at Level 7 throughout the country during this period of time.

Ratios and Supervisory on- call

All of the Trusts demonstrated that they maintained their ratios of SoMs to midwife either within the NMC recommended ratio of 1:15 or just slightly above this; but all maintained a ratio of less than 1:20. All Trusts stated that the SoM provided a 24 hour on call system, a responsibility shared by all members of the supervisory team.

Rule 9(1)(d) of the Nursing and Midwifery Council [Midwives] Rules (NMC, 2012a) required all midwives within the Local Supervising Authority (LSA) to have 24 hour access to a supervisor of midwives. Under this provision, A SoM could be contacted at any time by midwives, members of the public, managers or other health professionals. Such contact may be for a number of reasons, however, they should relate to issues concerning the statutory supervision of midwives.

The responsibility of the "available supervisor" was to give advice for issues relating to supervision and professional standards and therefore any questions relating to the management of service or midwives should have been directed to the appropriate manager. Midwives were required to have access to a supervisor of midwives at all times to:

- offer advice and guidance on the statutory supervision of midwives and the NMC professional standards,
- offer advice and support to midwives,
- provide professional leadership,
- offer guidance and support to women accessing maternity services and ensure that these services respond to the needs of vulnerable women who may find accessing care more challenging,
- offer guidance and support to women who are experiencing difficulty in achieving their care choices (NMC, 2012a) and

- be informed of any practice or service issue which may affect a midwife's ability to care for women and their babies or could directly impact on the safety and protection of the public (NMC 2012b).

The information from the Trusts identified that, at the time of the data collection, SoMs were contacted for the following reasons.

- Discussions with women regarding care that is outside current provider guidelines and formulating birth plans
- Discussion of choice of place of birth with women
- Advocating for women with care choices and planning – women who "do not fit" birth centre criteria
- Supporting staff with unexpected events – intrapartum stillbirth , maternal deaths
- Review of clinical practice (not clinical **outcome**) and application of LSA toolkit to benchmark against NMC Rules and Standards
- Safeguarding issues
- Supporting staff with decisions regarding staffing shortages/ acuity issues 'out of hours'
- Bed occupancy / capacity issues
- Support for staff when the maternity unit is in escalation (addressing staffing pressures)

All of the Trusts involved in the pilot stated that their SOMs were included in the local escalation policy when concerns regarding staffing / acuity are identified out of hours. Many Trusts stated that their SOMs acted as the first point of contact for clinical staff when the maternity unit is in escalation. They would then escalate to the Head of Midwifery (HoM) or appropriate manager, as required.

All of the Trusts identified that, within the framework of statutory supervision, SoMs had protected time to undertake supervisory activities. Protected time was anticipated to be maintained by most Trusts as part of the A-EQUIP pilot.

Preparedness for the pilot
All of the service providers involved in the pilot had expressed institutional support for the bridging programme, as can be evidenced from the previous section. Each provider had given thought as to how they would support the pilot that would also run alongside statutory supervision.

Clinical areas where A-EQUIP was to be piloted in the Trusts
Each Trust had identified a specific area where the A-EQUIP model was to be applied – and this was based on the service provider's perception and identification of the area of greatest need for emotional resilience and support for the midwives. This included the postnatal wards, intrapartum care / birth centre and support for newly qualified staff.

Implications for the pilot implementation and evaluation
Following review of this baseline data, the following factors should be taken into account as part of the evaluation of the pilot.

The majority of the SoMs who are part of the A-EQUIP pilot have completed their SoM training within the last 10 years and have done so at either degree or, more commonly in recent years, Masters level study. This level of study, therefore, provides them with critical analysis and evaluation skills which they can apply to their role as SoM. This skill set may not be available to all future (i.e. non-pilot) PMAs. Findings from this evaluation are only directly applicable to this particular cohort of midwives and may not be universally transferable to future PMA trainees.

All the service providers stated that their SoMs form part of the escalation policy/ process at the time of data collection and, from the detail regarding why SoMs are contacted out of hours, it can be noted that not all the issues are concerned solely with statutory supervisory matters. Given that there is no evident on call rota or 24 access stipulated within the A-EQUIP information provided to the evaluation team, the impact of potentially removing this support system was explored; as this is an important element of the changing context that newly trained PMAs will be expected to work within.

Each Trust chose a specific clinical area in which to implement A-EQUIP and, therefore, any feedback that is received from the SoMs who have undergone the bridging programme can only be applied specifically to that area. Themes which emerge from the analysis of the datasets collected from PMAs and supervisees will be similarly context specific.

The site description data received from each pilot site is detailed in Table 1 for comparison.

Table 1	Number of births Per year	Number of Supervisors	SoM: Midwife Ratio	Is a full time / substantive SoM employed?	How many times a month does each SoM provide on call cover?	Numbers of SoMs undertaking A-EQUIP training	Year that SoM education was undertaken	Academic level of study of the PSoM programme (if appropriate)	Area where A-EQUIP pilot is to take place
Airedale NHST	2,500 per year	10	1:11	No	3	5	Not available	2 at level 7	Postnatal wards
Calderdale and Huddersfield NHST	Approx 5,000	16	1: 20	No	3	4	2005 2009 2010 2015	All at level 7	Birth Centre
University Hospitals Coventry and Warwickshire NHST / South Warwickshire NHSFT	Over 11,000 births per year over 3 sites	9 (South Warwickshire) 18 (UHCW)	1: 18 (SW) 1:15 (UHCW)	No No	4 2-3	3 4	1998 2001 2006 2005 2013 x4	Diploma Level 6 Level 7 Level 6 Level 6	Support for newly qualified midwives
Taunton and Somerset NHSFT	Over 3,200 births	6	1:19	No	1-2	3	Not available at the time of writing	2 at level 6 1 at level 7	Newly qualified
Barking Redbridge and Havering NHST	9,000 births	14	1:18	Yes	2-3	5	1996 x2 2000 2002 2013	Not accredited Level 6 Level 7 Level 7	Postnatal wards
Whittington Health	Not available at the time of writing	15	1:14	Yes	3	5	2003 2008 2011 2011 2013	Level 7 Level 7 Level 6 Level 7 Level 7	Postnatal care
One to One Midwives (Wirral)	Not available at the time of writing	5	1:14	No	7	1	2012	Level 7	Caseholding model

2.0. Documentary analysis of programme materials

The following are findings from the documentary analysis undertaken to assess the development and implementation (actual and planned) of the bridging programme. This was conducted within a SWOT (Strengths, Weaknesses, Opportunities and Strengths) analysis framework. The following documents were analysed:

- 1611_E_Quip_ModelPresentation TM.ppt
- Amended Version -A-A-EQUIP FINAL Quality Improvement.ppt
- Amended Version A-EQUIP - Who wants to be led by you – Leadership.ppt
- 1611_TMpartA_A-EQUIPBridgingProgrammeTrainingInformation_Final.doc
- 1611_TMPartB_A-EQUIPModelPresentation_FINAL.pdf
- 1611_TMpartC_A-EQUIPPilotEducationSpec_Final.doc
- RCS FAQ_Delegates on Midwifery RCS Training Programme – 2016.doc
- Midwifery-RCS Introduction Day Final Version Oct 2016.pdf
- MidwiferyPilot - Restorative Clinical Supervision Manual 2017.pdf
- RCS Midwifery Sign Off Document- 2016.pdf
- RCS FAQ-Delegates on Midwifery RCS Training Programme - 2016.doc
- Contract for midwifery supervision.doc
- Action Plan for raising an issue.doc

Overview of the structure and content of the taught programme for A-EQUIP practitioners

The bridging programme for the pilot implementation of the A-EQUIP model consisted of the following elements and provisions:

- Delegate information pack
- 3 x face to face teaching days with advance preparatory work and information
    - Day one: Education, development and leadership
    - Day two: Restorative clinical supervision
    - Day three: Personal action for quality improvement
- Operationalising the model information pack
- 4 one to one episodes of Restorative Clinical Supervision (RCS)
- 1 group RCS
- Assessment of participants against competencies which they must demonstrate 'proficiency' in, in order to be signed off
- Ongoing support available from training providers throughout duration of evaluation
- Teaching ran between Nov 2016 – Feb 2017

Five key themes

Findings from the documentary analysis have been synthesised into five key themes:
1. Adult learning theories and methodologies
2. A-EQUIP as clinical supervision for midwives
3. Quality improvement approaches
4. Implementation science frameworks
5. Practical elements of implementation within current context

These themes have been identified with reference to 'Theories of Change' (TOC) methodologies, which highlight the importance of theorising potential causal links and necessary preconditions within an implementation chain. The rationale for these key themes is summarised below.

- **Adult Learning:** The success of the model depends on effective teaching, and enabling PMAs to understand the rationale for change, and providing PMAs with appropriate knowledge and skills to implement the new A-EQUIP model.

- **Clinical Supervision:** The model of clinical supervision being proposed must be fit for purpose and logical assumptions should exist between the underpinning theory of the model, its practical application, and expected outcomes.

- **Quality Improvement:** The new model incorporates a Quality Improvement element, which should be designed so as to most effectively support service improvement. There should be logical assumptions relating the implementation of QI methods to outcomes through plausible change mechanisms.

- **Implementation Science:** The new model is a complex intervention; the success of the programme will rely on a deep, yet clearly focused, appreciation of the implementation. Implementation science methodologies provide theories and frameworks which can help to understand, evaluate and guide the various levels of the implementation process.

- **Practical Application:** Complex interventions require intimate knowledge of the context in order to successfully interpret and predict barriers and facilitators to embedding change. It is similarly necessary to understand what works, for whom, in what circumstances, and why. A consideration of practical elements of the implementation of the new A-EQUIP model within current midwifery contexts will help to determine the core, required elements of the programme and, in addition, the more flexible, peripheral elements that can be tailored to the specific needs of individual settings.

Adult learning theories and methodologies

Background

The teaching materials have been assessed in relation to two premises: andragogy and constructive alignment. These premises are relevant, respectively, to adult learners and how elements of teaching curricula might be coherently drawn together. A contextual overview of these analytical tools is as follows.

Andragogy

Asserts that adult education has largely derived from an understanding of how children learn, whilst contending that there are a specific set of assumptions which apply to adult learners; constituted by both their learning needs and preferences (Hartree, 1984). It is not that there is a dichotomy between adult and child learners, but that children progress towards adult learning over the course of their childhoods (Knowles, 1978). A criticism of andragogy is that it is neither a theory of learning nor a theory of teaching practice, but a somewhat muddled approach to both (Hartree, 1984). The principles of andragogy have, nevertheless, become an intrinsic part of the language and practices of adult, managerial (Hagen and Park, 2016) and midwifery/nurse education (Milligan, 1999; Moss et al, 2010; Sharples and Moseley, 2009; Embo et al, 2014).

In healthcare education, andragogic principles are often reflected in problem, or inquiry based learning approaches (Milligan, 1999). The assumptive tenets of an andragogic approach are that; first, adult learners should have their existing knowledge and experience acknowledged and, second, that the learner (rather than the instructor) is central to the process of learning. These tenets underpin the six (though others have distilled this to four - Hagen and Park, 2016) principles of andragogy which include the 'role of experience', 'self-directedness', 'need to know', 'readiness to learn', 'orientation to learning,' and 'intrinsic motivation' (Conaway and Zorn-Arnold, 2015; 2016). Each principle is discussed individually and a series of contentions are posed in relation to each principle which, subsequently inform the SWOT analysis.

Role of experience

The existing experiences of learners are drawn together as a foundation for growth. The instructor recognises the pools of knowledge that learners bring and integrates these with new concepts to direct learning. The facilitator is key for the role in encouraging reflection and critical analysis in order that learners are enabled to interpret their experiences in new and meaningful ways, which they can apply in their future experiences.

- There is a need to ensure that the existing knowledge of learners is established in order to ascertain how to build on this.
- There is a need to recognise disparity between learners in existing knowledge and experiences and how this might impact the learning experience (Moll, 2014).
- There is a need to share experiences between learners to enable peer

learning and a sense of the 'bigger picture'. Related to this, White and Winstanley (2009) found that educators drawing on andragogic principles needed to ensure a positive group dynamic to ensure successful learning. Facilitators need to be conscious of variable learning needs and preferences of learners (White and Winstanley, 2009). Further, White and Winstanley (2009) have asserted that time for group socialisation was paramount in ensuring group cohesion and effective sharing of experiences and support of learning between peers.

- Higher order thinking and learning can only be achieved through a reflective and critical approach to integrating experiences with taught content.

Self-directedness

Adults have the ability to make independent choices and decisions, and to accept responsibility for the outcomes of such decisions. Didactic teaching is, therefore, not felt to be conducive to effective adult learning. Rather adult learners want to have their autonomous decision making and ability recognised, as well as having opportunity to exercise this in their learning experiences.

- Self-directedness may be limited in its capacity to be implemented where there is a large volume of new information to be imparted to learners and/or limited timescales to do so. Similarly, learners may be less confident in directing their learning in this context and require the support of 'teachers'. A balance between ensuring that sufficient and adequate learning is accomplished and enabling learners to self-direct their learning, therefore, needs to be struck.
- Forrest and Peterson (2006) have asserted imperatives to use such techniques as role-play, group discussion, service learning and problem-based learning as tools to provide relevance to learning experiences.
- The notion of the 'self-directed adult learner' aligns readily both with the scope of midwifery responsibility and with what Supervisors of Midwives (SoMs) currently support midwives to achieve in their practice. As PMAs need to impart and nurture self-directedness in midwives (as well as needing to learn in this way themselves), a focus on the practicalities of how to encourage confident self-directedness in others would seem to be indicated. Similarly, Hagen and Park (2016) have argued the need to impart the principles of andragogy when 'training the trainers'.
  N.B this may be a skill already well developed in existing SoMs and, therefore, not necessary to impart to this cohort.

Need to know

Adult learners realise that they need to accrue further skills and knowledge in pursuit of their goals. They may not know exactly what is to be learned, but can establish a void in knowledge between what is known and what is aimed for. To be successful, learning needs to fill that void.

- A taught programme should identify with learners what it is they feel they are aiming for and what it is they feel is lacking in their current knowledge.
- Learning outcomes should be guided by self-directed learning aims.
- Individual learners will variably perceive the void between where they are and what they are aiming for. Teaching activities need to be flexible enough to accommodate this.

Readiness to learn

Adult learners undertake learning in response to a known development task. Learners are prepared to do what it takes to learn because it has an impact on their professional role/responsibilities.

- Learners benefit from explicit explanation of what is to be learned and the process of learning in order to ensure their preparedness to learn effectively and to ensure that they understand what is to be done to fulfil the developmental task (assessment) (Nicol and Macfarlane-Dick, 2006; Biggs and Tang, 2011).

Orientation to learning

Orientation is learner (rather than teacher) centred as well as being problem centred. That is, students as self-directed learners utilise 'problems' to identify what it is they need to know. This is to allow learners to deepen their current understandings, to identify future learning needs, and to readily apply their learning to their everyday lives. Problem based learning, as an approach to meeting andragogic needs, has been asserted to draw together cognitive (thinking), affective (emotional) and behavioural learning processes (Brownell and Jameson, 2004) and, through this, to encourage 'deep' learning.

- Learning activities should involve reflection and critique of the 'problems' provided by the content in relation to the experiences and insights of the learners.
- Effective learning can be measured in how readily learning can be effectively applied and the extent to which the application of knowledge is reflexively informed (Anderson et al, 2014).
- The role of the facilitator is key to drawing together experiences with taught content. The facilitator achieves this through encouraging and enabling reflection and critique. Milligan (1999) has argued, however, that the implicit power relationship between teacher and learner is difficult to redress and, consequently, does not foster the support of critical reflection amongst learners, but rather a tendency toward conformity with what learners perceive the facilitator wants of them. It has been postulated that learners may 'reduce' their experiences/issues to 'fit' with the perceived learning outcomes. As such, what is 'learned' may not be readily applicable in practice.
- The fulfilment of identified learning needs for the future should be supported in practice.

Intrinsic motivation

Adults learn because they want to, not because of the expectation of external reward or punishment. Formative assessment and feedback of adult students has been asserted to empower students as self-regulating learners (Nicol and MacFarlane-Dick, 2006)

- Taught content should emphasise what is to be learned and how this will be achieved and measured, not what is to be gained externally.
- Students may want to have access to the learning aims, intended learning outcomes, the assessment, and the assessment criteria.
- Feedback between teacher and learners should be ongoing and reciprocal.

Constructive alignment

'Constructive alignment' reflects, syntactically, its two constituent elements. 'Constructive' implies, like andragogy, that learners create meaning for themselves; knowledge is not simply transferred from teacher to student. 'Alignment' refers to the notion that teaching activities and assessment of students should support and reflect the intended learning outcomes (Biggs et al, 2011).

Declarative and functioning (applied) knowledge can be reflected in intended learning outcomes. Students may be able to understand and describe what they learned (declarative), but where they are also able to apply this – this makes such knowledge *functional*. Functional knowledge represents a higher level of understanding and learning. The language used in the intended learning outcomes should reflect the aspirations for the intended level of learning. Teaching/learning activities should be designed in ways which elicit the level of understanding aspired to in the intended learning outcomes. Teachers should reflect on the limitations of 'chalk and talk' lecture formats in achieving higher level learning.

Students may fixate on the assessment (Ramsden, 1992) – seeing learning as necessary and relevant only to their successful completion of assessment. Indeed, Ramsden (1992) has argued that, for students, the assessment *is* the curriculum. To this end, students may learn what they think they will be assessed on and no more. Consequently, it is paramount that all the *intended* learning outcomes are reflected in the assessment as well as the teaching activities structured to meet the learning outcomes. In this way, it is difficult for students to select the learning they wish to engage with, or to complete the course without meeting the learning outcomes.

Nevertheless, it has also been argued that ongoing formative feedback can support learners' intrinsic motivation to learn (Nicol and Macfarlane Dick, 2006); written feedback, in particular, helping students to identify their strengths and weaknesses as they progress through a taught course (Murtagh and Baker, 2009). In this way, formative feedback may detract from the predominance of summative assessment in students' minds. It may also serve to inform teachers in their understanding of student responses to the taught content, so that they may respond appropriately.

STRENGTHS	WEAKNESSES
- The taught content blends didactic teaching with andragogic principles and, therefore, may better meet the varied learning needs and preferences of learners than if it did not take this blended approach. - There are opportunities for learners to self-direct their learning by drawing on existing skills and experiences as leaders/supervisors. - The existing experiences of SoMs are established in the 'deploying the model' presentation, as are their motivations to learn and existing understandings of the A-EQUIP model; thus identifying the void in knowledge to be filled. - Leadership presentation (Day One) draws on and encourages the development of existing skills. - Content appears well aligned to the intended learning outcomes. Assessment is derived from the learning outcomes. - There are opportunities for ongoing formative feedback throughout the course in ways which support student learning.	- No criteria for assessment of competencies and, therefore, a lack of clarity as to what constitutes 'proficiency' vs. a lack of it. - The timing of the discussion around motivations to learn (Day 3, deploying the model presentation) seems late in the programme, particularly given that adults are thought to be motivated to learn by the process of learning, rather than external and subsequent reward. - Leadership presentation (Day One) does not appear to attribute any time to group socialisation; an element felt to be integral to effective adult learning. - Learning aims, intended learning outcomes and competencies do not appear to be made available to students from course content provided. - Taught content only sporadically makes reference to the learning outcomes it is linked to (Day One course material, but not Day Three). - Competence 4a and LO4 encourage practitioners to acquiesce to the notion that A-EQUIP adds value without encouraging critical reflection on and evaluation of this. Not well aligned with the notion that higher order thinking/ learning can only be attained through critique. - Not clear how students will receive feedback on their assessed competence
OPPORTUNITIES	**THREATS**
- Reviewing feedback forms for the programme may allow for insight into the extent to which facilitators were considered effective in their role. - Evaluation of the taught content by	- Facilitators need to have consistently strong teaching skills in order to ensure effective adult learning. Multiple sites/methods of delivering future training may influence this.

learners at various intervals in the course may allow for a greater sense of ongoing and reciprocal feedback between teacher/learners. - Facilitators should be clear that a critical approach is essential to learning and fostering functional knowledge. - Ensure learning aims, outcomes, assessment criteria and how these relate to one another and the taught content are well defined and communicated to students. - Ensure there is a clear set of criteria against which competencies are assessed. - Create space for socialisation of the group. - The duration and content of future programmes needs to reflect the existing knowledge/skills of learners and their need to self-direct learning as adults. - Accessing tutors after face to face study days may give insight into how readily learning can be applied and the effectiveness of the taught content.	- Future iterations of the programme will be delivered to individuals who may not bring existing skills as SoMs. As such, the existing programme may not adequately meet their learning needs, nor can it be evidenced to do so until their learning needs are known. - Each cohort of students will be different. Any findings from the evaluation of this programme may only be partly transferable to future cohorts. - There is limited time to develop programmes. - There is, as yet, an unknown level of resource to develop programmes.

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A-EQUIP as Clinical Supervision of Midwives

This section is organized into three areas of discussion:

1. Conceptual considerations about clinical supervision
2. Training in clinical supervision
3. Effect of conceptualisation and training on implementing clinical supervision

Conceptual considerations about clinical supervision

Clinical supervision (CS) is a process aimed at improving clinical accountability, developing clinician's professional knowledge, skills and competences; especially the ability to reflect on and learn from practice, and managing the psychological impact of work, both the "wear and tear" and critical points of their professional role. CS is related to the concept of the "use of self". Clinicians' selfhood is understood to be involved in the practice of helping professions. It is linked to key emotional factors involved in the delivery of high quality services. Such emotional factors include empathy, compassion, and the general awareness, use, management and regulation of the professional helper's emotions. Compassion fatigue, emotional exhaustion, burnout and related concepts have been proposed in attempting to understand how delivering care can impact on the individuals and teams involved. Experiencing these has been associated with negative developments in the physical and psychological health of staff (Mollart et al, 2013; Walsh and Walsh, 2001), poorer performance, absenteeism, and lower levels of satisfaction with work.

As the literature demonstrates, although originally developed within the professions of social work and psychological therapies, CS has been adapted and adopted in various disciplines and appears to be interpreted and practised accordingly. In some contexts, CS has become part of "policing" and disciplining clinicians. This has eroded the nature of the supervisory relationship, particularly its restorative function. CS is experiential learning, a phronetic activity (relying on practical wisdom or common sense interpretation) that develops professional expertise (Benner, 2004) through learning from applying skills and knowledge to practice (doing), reflecting on and adjusting practice case-by-case with emphasis on the ethical and professional dimensions of work.

CS is used differently depending on the supervisee's needs; including level of competence, confidence, and expertise. For example, in CS of trainees or newly qualified clinicians, learning "how to" routinely (the technical aspects of routine clinical work) may be prioritised, while the supervision of experienced clinicians may focus on professional autonomy, particularities or dilemmas requiring sophisticated cognitive and emotional processing (Stoltenberg and Delworth, 1987) about clinical work and contextual issues such as the supervisee's role in developments and dynamics in the service where they work and the wider organization (e.g. NHS Trust). CS is founded on a professional relationship the nature of which facilitates such discussion between supervisee and supervisor.

CS is distinguished from managerial supervision (Yegditch, 1999), appraisal, mentoring, leadership, and more generic peer support by the nature of this professional relationship which is preferably independent of managerial structures

as the latter may be discussed and reflected upon as one of the problems encountered (and among possible solutions). A balanced discussion on dual/ multiple roles as managerial and clinical supervisor exists in Scaife (2009:206-220). In summary, because of the differences inherent in the role remits and the authority they carry (including budgetary, assessing performance, supporting, and disciplining) the professional supervisory relationship may be undermined in the process of exercising all roles simultaneously with one supervisee.

The professional relationship in CS is usually long-term, confidential, supportive and challenging, based on respect and honesty, evolving through regular and frequent (approx. monthly) prearranged times for discussion, each meeting usually lasting about 60-90 minutes. Power discrepancies due to participants' grades and length of experience do not manifest in the ways they might within managerial relationships. Rather, poor practices are discussed and supportively confronted and dealt with (for example, reporting of significant clinical errors), facilitating optimal conditions for maximum possible learning from mistakes (Casement, 2004) and reducing clinical risk.

Increasingly, there are expectations for research-based evidence regarding the efficacy and effectiveness of each model of CS (good discussion of the evidence in Milne, 2009). The various models become fit for purpose by taking account of supervisee characteristics (length of experience, type, quality and duration of training, etc.), job role characteristics and their demands on the clinician, supervisor's and supervisee's preferred ways of learning, contextual factors and any contractual obligations to supervisee's employer. All CS models rely on a professional relationship of sufficient clarity and on explicit understandings of ethics in clinical practice, the latter often being the focus of supervisory discussions. This elucidates the fundamental importance of the supervisory relationship which is usually bound by a formal, explicit contract or a verbal agreement.

Clinical supervisors are required to be able to form, maintain and restore their professional relationship with the supervisee where supervisor's power, seniority, authority, and influence are not of administrative but of relational and expert nature. Although supervisors have a responsibility and duty to highlight poor practice and even report it when necessary (and this is made explicit through the written or verbal CS contract between supervisor and supervisee), they are not in the role of disciplining the supervisee. In addition, where the supervisee is a qualified professional, they are not in the role of appraising formally the supervisee's performance (the clinical supervision of trainee clinicians may entail formal appraisal).

There are various models for CS (see, Scaife: 2009, for detailed descriptions) focussing on different elements or processes of CS (for example, the differing supervisory needs of beginner and expert practitioners). The A-EQUIP and SWFT programme have selected Proctor and Inskipp's model that consists of at least three functions of CS: normative, formative and restorative. It is unclear why this specific model has been chosen for A-EQUIP and why it is not chosen in its entirety. Whilst the SWFT training is called Restorative Clinical Supervision as a "model", it actually

refers to only one of the functions of CS (restorative) in the selected model (ie. Proctor and Inskipp).

The normative function of CS does not appear to be part of A-EQUIP or SWFT, when in fact it facilitates restoration through validation of supervisees' clinical actions or through discussion of any consequences resulting from clinical errors. Where poor practice is brought to CS, managing the disclosure requires a complex set of skills that clinical supervisors develop through training. Such skills include awareness/ knowledge that what is discussed is poor practice, sensitivity in receiving the information and feeding back the observation that practice has not met standards; and communication skills that enable dealing with poor practice in ways that stop it (including reporting it) while preserving the dignity of the supervisee and the professional relationship. Learning the skills to deliver the normative function is therefore very important for the entirety of CS process.

Additionally, in A-EQUIP, the developmental function has been split into "Education & Development" and "Personal action for quality improvement". The purpose of these modifications and the reason for focusing supervisor training on the restorative function would benefit from further consideration in relation to expected outcomes of the programme.

Usually, in CS, the professional development needs of the supervisee emerge through the process of accounting for and reflecting on practice, and often such development needs are identified by the supervisee, who may choose to present them to their manager at any time, and certainly during formal appraisal, as part of planning for the development of staff and service. Professional development is a requirement for continuing professional registration and CS is considered part of professional development.

Psychological restoration of staff may result from both of the other functions. For example, through the alleviation of fear and anxiety regarding performed or future practice, anticipation of further professional development and improved practice as well as career prospects. In addition, the restorative function of CS operates through a variety of psychological mechanisms which may not always be entirely conscious or even predictable. Such mechanisms may include relief due to emergence of new meanings after narrating one's story within a confidential trusting relationship, improved reappraisal of performance, normalisation and working through difficult emotions such as guilt and anxiety, and restoration of supervisee's confidence in themselves as a good professional and/or "good person".

Training in CS
Training is central in implementation and should be delivered by appropriately qualified and experienced professionals. Training content should include conceptualisation, evidence/ research related findings, and experiential components. Formal assessment of learning and skills with clear criteria/ requirements to demonstrate attainment should form part of course completion, especially for the training of new clinical supervisors. Detailed discussion on aspects of training and quality improvement are presented in the chapters on adult learning and quality improvement of the present document.

Although A-EQUIP pertains to the training of midwifery supervisors, leading authors on CS highlight the importance of training supervisees about what CS is and how to use it best (Carroll & Gilbert, 2011). As a new programme, implementation of A-EQUIP would benefit from facilitating understanding of its nature and processes for both supervisors *and* supervisees. Both are given consideration here. It is also helpful to plan awareness raising activities for service managers as it will be part of their role to implement the operation of CS (though, preferably, not provide it to their staff).

Training of supervisors

The duration of clinical supervisors' training varies depending on their prior training and experience. Foundational training usually lasts from a few days to year-long certification programmes. It includes updates / continuing professional development and on-going *supervision of supervisors* (every 3-6 months). It is important to clarify the professional nature of the supervisory process throughout; that it is not a chat but a purposeful and powerful conversation. Again, this highlights the importance of training supervisors to be competent in managing the supervisory relationship across all functions of CS.

To facilitate understanding and ultimately implementation, training content is influenced by considerations about the profession/ discipline for which CS will be used (it is important that "ownership" is felt by prospective supervisees and supervisors). A-EQUIP is commended for its emphasis on the restorative function of CS. However, this emphasis appears at the exclusion of other functions of CS contained in the Proctor and Inskipp model. This exclusion needs to be accounted for in relation to midwifery practices.

The absence of the normative function prevents learners from the opportunity to discuss issues and dilemmas related to dual-role responsibilities (colleague, managerial supervisor and clinical supervisor). Additionally, it is not known what effect may be created by the introduction of the concept of "advocacy", as this is not an idea met in CS. The term Professional Midwifery Advocate does not convey that this role entails clinical supervision and invites the question "advocate for whom?" and "about what?". A further deviation from the established model is the fragmentation of CS into its functions (normative, formative, restorative) and presenting them as different models (as in the SWFT course material).

To develop interest in the topic and autonomy in learning, learners are encouraged to read outside the course. Reading resources are an essential foundational element of training and support learners' independence, facilitated by the provision of reading lists referencing good quality essential and desirable reading including articles, book chapters, online videos and other educational material. The current list of such resources (SWFT) would benefit from more recent references and stronger focus on relevance specifically to supervision. Current trainees should receive such materials and encouragement as they continue to be in contact with course staff after completion.

As regards self-leadership, the description presupposes a level of power, authority and influence within the systems midwives operate that may not reflect the midwife's reality and may, therefore, lead to frustration, disillusionment and stress, instead of restoration (Timmins, 2016). Assertions about the behaviours / actions encouraged need to be pragmatic. Supervision is not a panacea; therefore learners' expectations of CS and of the training programme should be managed so as to be realistic and avoid disappointment and consequent loss of motivation.

The beneficial effects of the set of CS functions are likely to be experienced in the domains of burnout due to supervisee's style of managing work-related emotions (emotional labour, Hochschild, 1983). Beneficial effects of CS may also be experienced in relational dynamics, including with service users, colleagues, or with other services (Deery, 1998 & 1999). A clinical supervisor does not ordinarily have administrative power over the supervisee's work. Consequently, CS may be only marginally beneficial to stress-related reactions due to low staffing levels/ work overload or other management or budgetary issues beyond the supervisor's power to change, that may trigger stress responses in supervisees (Chana et al, 2015).

The SWFT course feedback from trainees indicates that supervisors approach the new course with enthusiasm and positive energy. The learning available through the course appears new to them and they seem keen to put it in practise. These are all promising indicators for implementation. It is, therefore, important to help them sustain their enthusiasm and impetus.

Training for supervisees

Apart from their hopes, expectations and anticipation, supervisees, especially those new to CS, generally have little preparation for their responsibilities in the supervisory relationship (Carroll & Gilbert, 2011; Vespia et al, 2002). Such responsibilities include preparing for CS, using time effectively/ respecting professional and time boundaries, being open and honest in their accounts of their work, reflecting on their work, being aware of issues of diversity in their work and enabling an appropriate professional and ethical environment for their work.

In some disciplines, training about CS is provided as part of the general professional training (for example, at undergraduate level). There may also be opportunities to develop one's capabilities as a supervisee through continuing professional development (CPD). As A-EQUIP is a new programme, CPD opportunities can be created for current and prospective midwives to understand what CS is about and the use of CS for their personal benefit and for providing best service.

Effect of conceptualisation and training on implementing CS

It is clear that the systematic implementation of CS needs to be underpinned by a thorough understanding of its nature and process by PMAs and supervisees as well as service managers/ directors (Love et al, 2016). By eliminating misconceptions and managing expectations to match CS outcomes, the experience and meaning of CS will result in better satisfaction with one's own performance through accounting for it, validating it, identifying professional development needs, and feeling restored.

It is important that managers understand CS. This is because, as research suggests, among the reasons clinicians do not use CS are time and legitimisation or perception of CS: that staff do not make time for CS for practical and emotional reasons (eg. loyalty) due to perceptions of abandoning duty and colleagues in order to engage in CS (Cruz et al, 2012; Dinshaw, 2006; Love et al, 2016). Therefore, managers' role is not only to ensure that such time is available but also that CS is seen as a legitimate and necessary professional activity that enhances good practice and is distinct from disciplinary supervisory procedures. Availability of time should include supervision for supervisors and CPD time.

CS has an important function in change management and in establishing new learning (Haggstrom & Bruhn, 2009; Hansebo & Kihlgren, 2004; Milne, 2009). In this transition from statutory to clinical supervision, the new learning to be established has various facets: for the supervisors to understand their new roles and responsibilities, the change is likely to be established if they are provided with regular support (their own supervision) to discuss any problems either with the supervisory relationship and/ or process, or with implementation in their service. For supervisees, training in using CS efficiently, combined with regularity of CS, will establish the experiential learning cycle of applying learning and skills in practice, discussing practice, reflecting on it, amending practice as per case needs, and fine-tuning skills further through opportunities for reflection and education.

Acknowledging the significance of this change for midwifery and to ensure continuous quality improvement, mechanisms such as audit and evaluation are likely to reinforce initial and sustained implementation. Such mechanisms can include:

- Regular audits of how CS is delivered in practice;
- Evaluations of the experience of supervision from the supervisee's perspective
- Evaluation of the supervisory process according to the new model from the supervisors' perspective.
- More innovative evaluations may include the views of the clients traced to the services they used.

The results of these would be included in the further development of the A-EQUIP training programmes that will also be continuously evaluated, creating a circle of learning and development beneficial for the profession and its service-users (Macfarlane et al, 2013). This will require commitment not only from those participating in audit and evaluation but also the organisations they work for and their commissioners, and commitment to all stakeholders' voices being heard.

Summary
A-EQUIP represents a major change in midwifery supervision. As such, it requires a comprehensive approach to its implementation, both currently and in terms of its sustainability in the longer term. A comprehensive approach will take account of conceptual factors (how CS is understood by each party associated with it), training quality, and on-going audit and evaluation that will support, challenge and develop this innovation in the profession.

The SWFT programme must be seen as a top-up rather than comprehensive training in CS for the preparation of midwifery supervisors. Future midwifery supervisors, who (unlike the cohort currently in A-EQUIP training) might not have benefitted from the training afforded towards qualifying as statutory supervisors, will require a more comprehensive training. Training should be available to both supervisors and supervisees (how to make good use of CS). Service managers/ directors would also benefit from training to improve their awareness of the importance of supervision and their role in implementing it.

The quality and amount of additional training to facilitate understanding of the nature and processes of CS for supervisees and service managers/ directors is important as it impacts on planning, implementation and longer-term sustainability of this innovation. The new training needs to be understood as an evolving process that will grow through various loops of feedback mechanisms, as will the new model of midwifery supervision.

SWOT Analysis

STRENGTHS	WEAKNESSES
The fact that supervisors undergo training is a strength in itself.	Implicit rationale for choice of particular CS model.
Clarity that this is a different model of midwifery supervision (although currently applied in a context of existing knowledge and skills).	Potential confusion between models of CS and functions of CS
Provision of (4 hours) personal experience of RCS to supervisors as supervisees themselves.	Absence of normative function of CS.
	Restoration is conceptualised as addressing "challenges" rather than "wear & tear" of routine practice.
Focus on worker wellbeing/ restoration (therefore, potentially better awareness and acknowledgement of work-related threats to wellbeing).	Potential "deficit" experienced in skills and knowledge from cessation of statutory supervision training in future.
Potential for stress management and workforce retention.	Model of CS used requires long-term professional alliance based on regular meetings, confidentiality, and trust, while A-EQUIP is currently proposed to be annual (fitness for purpose issue).
OPPORTUNITIES	THREATS
Develop training in restorative supervisory alliance as part of a more complete CS model.	Intervention (RCS) is only a part of the Proctor and Inskipp model and conflated with existing training and expertise of supervisors, therefore impossible to assess as distinct variable.
Monitor and report on supervisee wellbeing.	
Assessing quality of training.	
Develop mechanisms of assessing effectiveness of training (implementation).	Potential confusion of conceptualisations at training level may translate into poor implementation practices or non-adherence.

Evaluation and research.	Future new supervisors may experience the lack of statutory supervision training as a deficit.
Research the impact of A-EQUIP on clinical outcomes.	
Training could be linked to the rationale for change in midwifery supervision policy and practice.	How to demonstrate improved clinical outcomes.
There is an opportunity to further develop the training materials and list of reading resources.	Transferred from other clinical areas, thus potential issues of "ownership" within midwifery.

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Quality Improvement (QI) and Implementation Science frameworks

This section is informed by the available documentation for the NMOMS pilot/bridging programme, and is specifically focused on the course materials for the training day on Quality Improvement. These documents were appraised in terms of the relationship of content and structure to current evidence for Quality Improvement (QI) and Implementation Science methodologies.

Whilst there is some overlap between QI and Implementation Science, there are also some significant differences. One of the key differences is that Implementation Science has a background in EBP (evidence-based practice), involving the development of theoretically based approaches for integrating substantiated evidence or research findings into practice (Bauer, Damschroder et al. 2015). On the other hand, QI methodology tends to take a more 'bottom up' approach; being reliant on practitioner knowledge and developing and testing hunches and assumptions about how to incrementally improve services in a specific local context (Jones and Woodhead 2015).

Within the context of the NMOMS pilot programme, QI approaches are being taught to supervisors (Professional Midwifery Advocates-PMAs). The intended outcome is for these PMAs to be able to teach and support QI activities undertaken by their supervisees. We will, therefore, be assessing the content and process of QI training for PMAs and considering the potential for this learning to be cascaded to supervisees.

The consideration of Implementation Science methods and theories will assist the evaluation by providing a framework within which to assess the linkage between the evidence for elements of the A-EQUIP model and the implementation of the model.

Quality Improvement

The following is an appraisal of the QI training day materials. The appraisal is organised in accordance with the themes presented on the PowerPoint slides used for A-EQUIP training.

Introduction

Learning outcomes:

- *Develop an understanding of what is needed for change to be successful*
- *Develop an understanding of what quality improvement is and how it can help you to make improvements*
- *Know how you could get started with improvement*
- *Apply this to being a Professional Midwifery Advocate*

These learning outcomes align well with the course content; firstly, being concerned with factors for successful change, then, introducing some QI methodology. Some guidance on starting a QI project is given, and finally, there is a session on how to approach application within a supervisory role.

These could be considered very general aims, particularly considering that this is an introduction to a large and complex area. Within the time constraints, more specific

knowledge and skills development might be appropriate to ensure that participants have experience of activities that they can take away and begin to use. This is, however, a difficult balance to achieve and the development of a contextually appropriate method may be an iterative process. Further evaluation work will explore this theme.

At certain points, effort is directed at trying to persuade PMAs that their expected assumptions or experiences are incorrect e.g.
- You can only improve things from a position of power (true or false).
- Targets are punitive (true or false).
- Use of data/information for improvement, NOT for judgement
- Change coming from the bottom up supported by managers

However, it is not clear how this wider organisational culture change is expected to come about. For instance, organisational power is an important element in creating service improvements; managerial support is clearly a key enabler to facilitate bottom-up change. However, it is likely that PMAs and supervisees could find themselves in a position of powerlessness. Supportive conditions in the wider environment are therefore required.

This element of implementation requires some thought about how management and organisational structures will support the new model, and how this can be ensured. The implementation framework for the entire programme, therefore, should be focused on how the proposed changes will be affected by, and in turn will affect the whole system. If these issues of broader organisational culture and context are to be retained, they should be linked to programme-wide expectations about how the system change will transform the environments that QI projects will be working in.

The QI Model
This section also focuses some effort on dispelling assumptions and challenging previous experiences. It is assumed that PMAs have had experience of large-scale and ineffective change programmes.

Small steps compared to the 'usual approach':
- *Lots of things at once - different directions*
- *Direction/purpose not always clear*
- *Intimidating for many*
- *Wait long time before measuring*
- *.. then hard to piece together the findings*
- *Often don't involve those most involved in the process or those affected by it*

In the 'Plan, Do, Study, Act' (PDSA) cycles, three fundamental questions (what are we trying to accomplish? How will we know that change is an improvement? What change can we make that will result in improvement?) are introduced. SMART and SMARTER aims (Specific, Measurable, Achievable, Realistic, Time-bound, Engaging, Recorded) are also introduced to be used as tools to develop aim statements.

The introduction of the GROW framework (Goal, Reality, Obstacles & options, Way forward) and associated fifteen questions could be an area where the course moves into rather complex peripheral concepts with lots of questions to consider. The inclusion of this section could be reconsidered, in order to provide more time to focus on core QI elements. The example of a partially formed aim, which is then developed into a SMART(ER) aim statement, is a clear practically based example.

Understanding and implementing measurements that are fit for purpose are key elements of a successful QI project. There are two slides on why we need to measure and one on types of measures (Outcome, process, balancing, financial).

There is a simple chart with two data points. It is likely that participants will need to interpret more complex data; for instance, run chart trends. This element could be stronger to demonstrate the need for caution and provide practice on how to interpret outcomes.

Engagement

There is some crossover of topics when considering challenges around stakeholder engagement in the course materials when compared to Dixon-Woods, McNicol et al. (2012) study of 14 QI evaluations. However, it might be worth considering some topics from this study, particularly those framed in an active, problem-solving fashion (e.g. "Convincing people that there is a problem").

The following "Challenges to change" are drawn from the course materials:
- *No interest*
- *Too 'set in their ways / long in the tooth' to change*
- *Suspicious of motives*
- *Personal responsibility/focus on the individual – not whole system view*
- *Little time for improvement*
- *Temporarily change / then return to the old ways*
- *Tribalism*

In a study of 14 quality improvement programme evaluations (Dixon-Woods, McNicol et al. 2012), 10 key challenges were consistently identified. These were:

    1. convincing people that there is a problem
    2. convincing people that the solution chosen is the right one
    3. getting data collection and monitoring systems right
    4. excess ambitions and 'projectness'
    5. the organisational context, culture and capacities
    6. tribalism and lack of staff engagement
    7. leadership
    8. balancing carrots and sticks – harnessing commitment through incentives and potential sanctions
    9. securing sustainability
    10. considering the side effects of change.

The evaluations also showed that time taken to get an intervention's theory of change, measurement and stakeholder engagement right, resulted in enthusiasm, momentum and profound results.

Thinking differently

This section of the course consists of an optical illusion, a creativity test and a slide describing De Bono's hats. It is common to find optical illusions in these sections of QI courses to encourage creative thinking. The creativity test performs a similar function, although it is not clear how this might be translated to thinking creatively, or encouraging creative thinking in practice.

The slide covering De Bono's six thinking hats, whilst potentially relevant could be adding unnecessary complicated elements to this section. The De Bono group (http://www.debonogroup.com/) currently offer basic public training on this method through a one-day course with an online programme. It is therefore not clear what level of proficiency or understanding can be achieved within this course. Teaching QI in one day is a very challenging proposition, the 'six thinking hats' framework might therefore be considered peripheral and risk limiting the time available to learn core elements of QI well.

Sticky, Spread and Sustain

Adoption, sustainability and spread of innovation are key elements of quality improvement. The content in this section tends towards abstract, academic themes, which might be difficult for participants to apply. However, within the notes there are some questions and exercises that help to adopt principles in practice; these practical elements might benefit from expansion. Regarding the complexity of including additional concepts and questions, recognised earlier, the 'Sternin's 8' checklist could be considered overly complicated, and another framework for participants to incorporate. The key concepts of identifying positive deviance, ownership of change and learning by doing could be introduced and incorporated into the general approach.

Tipping points and adopter categorisation are useful themes to consider. It is not clear from the materials how participants might apply these theories in the workplace.

The summary slide includes 'Key Elements of Successful Improvement Work Planning':

- *Scoping the work – provide some background*
- *Clear aims & objectives*
- *Defining resources and roles*
- *Defining measures*
- *Identifying risk*
- *Patient contribution*
- *Implementing the plan*
- *Preparing to Sustain*
- *Evaluation*

If the focus of the training is to prepare participants to carry out PDSA cycles, it is important that these key elements are framed within a PDSA model; otherwise they might appear as additional.

A final exercise, 'Applying QI to the A-EQUIP model', gives participants an opportunity to apply their learning to a supervisory session. This seems like a rather large leap from the general principles to application. There is no guidance within the session about how to integrate QI methods into supervision, so it is not clear how the session has prepared them for this.

- *Prepare of a meeting with your 'supervisee'.*
- *She is not a positive person!*
- *One example per group*
  - *Midwife who is burnt out and clearly demotivated*
  - *Lecturer who is not interested in what the student feedback says*
  - *Independent midwife who is advocating care which is concerning the LW co-ordinators*
  - *Newly qualified midwife who is struggling to adjust to being qualified and questions whether this career is for her*

Summary

The Institute of Medicine's generally accepted six dimensions of quality are covered (safe, effective, patient-centred, timely, efficient & equitable). Practical issues of prioritisation and conflict between these dimensions might be considered further.

There is some evidence that change is more likely to happen and be sustained as a result of a model involving service users and staff in developing, designing and implementing changes (Health Foundation, 2012). As service users experience the whole pathway, it might be worthwhile considering how their role in QI might be emphasised. The respective roles of PMAs, midwives, commissioners, provider organisations, etc., within the new model could help to contextualise QI work within a wider network of stakeholders.

The content pertaining to introducing the theory of PDSA cycles is relevant. However, in addition there are a lot of other theories, and lists of questions, which could become confusing (e.g. GROW, Sternin's 8, De Bono's Hats etc). It is unclear as to how all of these elements should be integrated and incorporated within a QI project using PDSA cycles. It might be useful to consider what would be required to initiate a PDSA cycle, and whether the other elements are necessary or potentially distracting and somewhat disconnected.

A stronger focus on the basic elements of PDSA cycles might allow greater balance between the elements of PDSA cycles. In particular, the session might benefit from more content relating to measurement, particularly the interpretation of run charts and caution regarding their limitations. Challenges to change could be reframed; offering ways to overcome challenges (Dixon-Woods, McNicol et al. 2012).

An evidence scan by the Health Foundation (2012) identified a number of different approaches to QI training:

- One-to-one
- Distance learning
- Practical projects
- Collaboratives
- Ad hoc training during projects
- Train the trainer approaches
- Feedback for improvement

"Continuing professional development for quality improvement can be divided into three main areas:

- Structured group training sessions
- More informal group training
- Practical initiatives, and individualised training.

Many studies combine some of these approaches" (Health Foundation 2012, p.18). When considering the effectiveness of various approaches for implementing QI methods to improve health care:

- "Didactic sessions alone are unlikely to improve care processes or patient outcomes.
- Learning methods that encourage active participation may be more effective than classroom-based learning alone.
- Online courses and other distance learning approaches may be useful and popular, especially when 'blended learning' approaches are used which also incorporate face-to-face tuition.
- Mentorship, supervision and audit and feedback cycles may be useful as components of training, but used alone are unlikely to produce sustained changes in quality improvement skills or behaviour." (Health Foundation 2012, p.32)

These findings indicate that active participation should be encouraged, and blended learning approaches considered for PMAs. The ambition of the programme, to cascade QI approaches to supervisees is not supported by the evidence, which recommends supplementing mentorship and supervision with other training components.

Considering the extent of the materials, models and theories that could be of some use for PMAs as they develop; ongoing access to resources and guidance should be recommended (possibly online resources, guided learning and/or forums). This would have the dual benefit of allowing the training day to focus more on learning and practice of core elements of implementing PDSA cycles, whilst simply signposting to other useful areas to explore.

If midwives are intended to use QI methods in practice, reliance on cascading knowledge down through PMAs is unlikely to adequately prepare them for this challenge; particularly if supervisory sessions are infrequent. Further resources and support should be considered.

SWOT Analysis

STRENGTHS	WEAKNESSES
-Learning outcomes align well with the course content -Clear example for producing SMART(ER) aim statements -Good introduction to basic theory of PDSA cycles	-Limited focus on practical application of the model: how to integrate QI methods into supervision -A lot of potentially peripheral and confusing concepts are introduced -No consideration of various stakeholders' roles in the new model -Supervision alone is unlikely to produce sustained change in quality improvement skills or behaviour
OPPORTUNITIES	THREATS
-Potential for additional resources, materials and ongoing support -Could be linked to programme-wide expectations about how the system change will create supportive environments for QI projects to work in -Potential for stronger focus on measuring and interpreting outcomes -Possibility of including active, problem-solving approaches to stakeholder engagement -Consider expanding practical considerations of adoption, sustainability and spread.	-A large and complex area to cover in a limited time -Very little focus on implementation: creating a supportive environment for change -No consideration of the role of service users in QI -Lack of clarity around how to integrate all of the various concepts that are introduced -Infrequent midwife supervision sessions

Implementation Science

There are elements of the QI training that are closely related to issues of implementation, whether this is implementation of QI methods themselves or wider organisational conditions required to create a supportive environment for the new model.

Implementation Science is grounded in the belief that generalizing through consistent use of theory (or models or frameworks) may be more efficient than learning afresh in different settings (Foy, Ovretveit et al. 2011), and theories can be employed to bring about changes to individuals' behaviours (French, Green et al. 2012).

Implementation science approaches generally encapsulate: Frameworks, Theories, and Models. Frameworks are broad sets of propositions with elements that either require investigation and understanding (diagnostic), such as the implementation context; or describe the implementation plans, such as learning events for supervisors (prescriptive).

Guiding theories can be established/grand theories or mid-range (e.g. stakeholder knowledge, working assumptions and hypotheses). These theories enable the explanation of processes and prediction of outcomes. Importantly for this project, another dimension of theories is the level at which they are expected to operate. They may be targeted at individual level change (e.g. Theory of Planned Behaviour), at the collective or organizational level (Klein, Conn et al. 2001), or at a systems or policy level (Rogers 2002). The NMOMS programme can be broadly considered to be targeted at affecting change at all three of these levels.

1. Policy: Implementation of the bridging programme & planned post-pilot A-EQUIP model
2. Organisational: Implementation of training and support by PMAs to midwives
3. Individual: Implementation of the model by midwives (including QI aspects)

Models are context specific, simplified representations of complex realities, which often represent important elements of the implementation, combining implementation plans with theories, assumptions and relationships between various elements.

A useful overall model for the implementation could include a systems/policy level (prescriptive) framework, combined with an individual and organisational level (diagnostic) framework. These two elements would benefit from conceptually different implementation approaches. Two approaches that fulfil these criteria are outlined below.

System-Level Framework
For instance, Fixsen, Naoom et al. (2005) reviewed the literature to create an approach which has been widely adopted by the USA National Implementation Research Network (NIRN) and the Idea Data Centre (Davis 2015). This approach is a collection of various implementation science principles brought together to provide

a theoretical framework for policy implementation. Similar to the A-EQUIP programme, this approach is focused on selection, training and coaching of implementers and operates at a programme implementation level suitable for systems-wide change. This approach is modelled around a known and planned implementation process (prescriptive). Within this approach there are three types of Implementation drivers (competency, organisation and leadership):

1. **Competency Drivers**
   - Selection of initial implementers
   Improve likelihood that training, coaching and supervision will result in implementation
   - Training for initial implementers
   Basic skills & buy-in
   - Coaching for initial implementers
   Ensure fidelity, provide feedback, & ensure implementation
   - Performance assessment
   Develop skills, interpret outcome data, build on strengths
2. **Organisation Drivers**
   - Systems Intervention
   Aligning of external variables, policies, systems, and structures to support the implementation; creating a hospitable environment
   - Facilitative Administration
   Aligning of internal processes policies, regulations, and structures to support implementation; leading & allocating resources
   - Decision Support Data System
   Identifying, collecting, and analysing data for assessment and development
3. **Leadership Drivers**
   - Technical Leadership
   Using a traditional management approach to problem solving, managing, and monitoring implementation: technical knowledge and practical skills
   - Adaptive Leadership
   Adapting management approaches to issues (e.g. managing change, culture, emotional responses, and emergent issues) related to implementation that requires differing:

   o   Leadership types
   o   Leadership levels
   o   Leadership strategies

Organisational Readiness for Change

On the other hand, the wider implementation involves PMAs and midwives applying the A-EQUIP model within their individual, complex organisational contexts. The model of this implementation process needs to operate at an individual or supra-individual level and be able to incorporate emergent and complex combinations of factors (diagnostic). For instance, the **organisational readiness for change** approach (Weiner 2009), which focuses on "collective behavior change in the form of systems redesign-that is, multiple, simultaneous changes in staffing, work flow, decision making, communication, and reward systems" (p.2).

Weiner's model of organisational readiness for change has two key facets: change-commitment and change-efficacy. Change-efficacy refers to a shared belief in collective capabilities to change, whilst change-commitment is based on the observation that complex organisational change relies on collective action, and that problems occur when there is variable commitment to change.

Herscovitch and Meyer (2002) "observe that organizational members can commit to implementing an organizational change because they want to (they value the change), because they have to (they have little choice), or because they ought to (they feel obliged). Commitment based on 'want to' motives reflects the highest level of commitment to implement organizational change" (p.2). However, whilst efficacy and commitment are related, confidence in ability to bring about change does not guarantee commitment to change, and neither does commitment guarantee confidence in ability. There are three key principles of this theoretical framework:

1. Individual change-efficacy judgements take into account the organisation's structural assets and deficits (e.g. organisational support).
2. A receptive context (e.g. good managerial- clinical relationships) is a necessary, but not sufficient condition for readiness.
3. "Organizational readiness is likely to be highest when organizational members not only want to implement an organizational change but also feel confident that they can do so" (p.3).
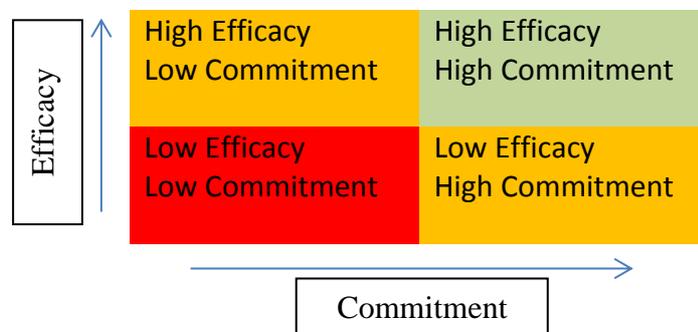
The key question related to **commitment** is: "regardless of their individual reasons, do organizational members collectively value the change enough to commit to its implementation"? "For example, do they think that it is needed, important, beneficial, or worthwhile" (p.4)?

In terms of **efficacy** there are three key questions: "do we know what it will take to implement this change effectively; do we have the resources to implement this change effectively; and can we implement this change effectively given the situation we currently face?

It is also important to recognise the influence of organisational culture, which can amplify or dampen readiness for change depending on whether the change fits or

conflicts with existing cultural values. Past experiences of change efforts can also positively or negatively affect readiness.

Summary

Using the Fixsen, Naoom et al. (2005) framework to explore the programme implementation, it is clear that there is a strong focus on competency drivers for PMAs in terms of selection and training. There is some limited short-term coaching available through the training programme. However, the extent to which longer-term coaching would be beneficial is as yet unknown. It is not clear whether plans will be put in place for ongoing fidelity assessment.

As discussed in other areas of this report, organisational drivers are not necessarily aligned with the programme. The complexity of the programme indicates that it will have adaptive, emergent and unanticipated features. Leadership drivers, specifically the need for adaptive leadership related to managing complex changes to service provision, are not currently well formulated within the programme.

Importantly, there are considerable overlaps between the programme-level (Davis, 2015; Fixsen, Naoom et al. 2005) and organisational/individual-level (Weiner, 2009) implementation frameworks described above. Organisational readiness for change depends, to a large extent, on the success of implementing competency, organisational, and leadership drivers. These will help to provide the required environment to promote change-efficacy and change-commitment, which are in turn required to complete the implementation chain.

In considering the QI training content within an Implementation Science framework, elements of the programme that might benefit from closer consideration were recognised at all three levels of the programme.

1. Implementation of the bridging programme & planned post-pilot A-EQUIP model

Use of data for improvement not judgement:

The materials indicate a change in organisational culture from using data for judgement, to the use of data for improvement. How will use of data for improvement not judgement be brought about? What behavioural change mechanisms are expected to be enacted? For instance, will this be enforced or monitored? Will robust processes be put in place to facilitate this change? How plausible will midwives consider this proposal to be? If this change is considered broadly beneficial, then there might be strong commitment to change, but is there also belief that this can be implemented in the current situation, and considering past experiences?

Non-punitive targets:

The trainees are asked, true or false: Targets are punitive. This seems to be trying to encourage culture change or to disprove previous experiences of targets being used

punitively. The current implementation chain is strongly reliant on bottom-up change which will require the creation of a receptive context and enhanced structural assets (e.g. support by managers). It is currently not clear how this will be brought about.

2. Implementation of training and support by PMAs to midwives

Readiness for change of PMAs:

The training session is predominantly focused on teaching theoretical elements of QI. However, it is not clear how human change is intended to come about, as there is not a strong focus on practical application. It is likely that some elements of the practical application of methods are being considered in the follow-up one-to-one/group sessions. This is a critical link in the implementation chain, which requires closer investigation.

Whilst commitment to involvement in the programme appeared high, judging from the expressions of interest, it would be useful to gauge ongoing commitment and to explore perceived change-efficacy.

3. Implementation of the model by midwives (including QI aspects)

Culture change:

A conflicting culture can dampen readiness for change; collectively, do organisational members value the change enough to commit to its implementation? How does the model propose to "Develop a culture of positive inquiry, embrace Improvement/ Transformation as the way we do things"? If this is the current cultural environment, are there stakeholders that might be resistant to this change, and do they have power? This could negatively affect the perceived change-efficacy of midwives.

Power to change:

A key element of change readiness is the perception of change efficacy, which is closely linked to assuming that you have the power to change. The trainees are asked: "True or False: You can only improve things from a position of power". We assume that this question is designed to suggest that power is not needed to effect change. However, there are various types of power required to bring about improvement, and this is key to answering the question 'can we implement this change effectively given the situation we currently face?' It is difficult to effect change if you feel powerless; therefore, it would be a useful exercise to explore areas where introducing empowerment mechanisms would assist in perceptions of change-efficacy.

SWOT Analysis

STRENGTHS	WEAKNESSES
-Prescriptive approach to programme implementation covers a range of competency drivers	-At a programme level, Organisational and Leadership (specifically adaptive leadership) drivers are not clearly defined

OPPORTUNITIES	THREATS

-There is an opportunity to include implementation at policy, organisational and individual levels
-Could consider organisational-level and individual-level change within an organisational readiness for change framework (commitment and efficacy).
-Supervisors and supervisees could benefit from formal involvement in, and understanding of the implementation process.
	-Do key stakeholders value the change enough to want it?
	-Are organisational structural assets supportive?
	-Is the context receptive?
	-Do organisational members feel confident that they can bring about change?
	-What ongoing coaching/support is required?
	-Specific threats were identified around the following themes:
	    - Use of data for improvement not judgement
	    - Non-punitive targets
	    - Readiness for change of PMAs
	    - Culture change

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Practical elements of clinical application within current context

The A-EQUIP model has three distinct elements (education and development, personal action for quality improvement and restorative clinical supervision) which interrelate. Each can be accessed separately, but it is anticipated that the A-EQUIP PMAs will move between these elements throughout their practice as they interact with midwives.

The A-EQUIP model

The development of the new model of midwifery supervision was inspired by Proctor's three function model of clinical supervision (Proctor 1986) and Hawkins & Shohet's adaptation of the model. This model (Proctor 1986) is described as having three broad functions: 'formative', which involves increasing knowledge and skills development, 'normative'; which has a managerial focus on monitoring, evaluation and the quality control aspects of professional practice (Cutcliffe and Proctor 1998) and 'restorative', which is concerned with the provision of support required to enhance supervisee's health and well-being. Within the A-EQUIP model, both the formative function (knowledge and skills development) and the restorative function have been adopted to inform the new model of midwifery supervision. The third function of the Proctor model, which is concerned with evaluation and quality control aspects of professional practice, has been omitted from the model of midwifery supervision because it already exists within employers' governance structures.

AEQUIP presents a new model 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. These are aims that are aligned with the ambitions of Better Births, the report of the National Maternity review (NHS England, 2016), Leading change, adding value- A framework for nursing, midwifery and care staff (NHS England, 2016) and the NHS five year forward view (NHS England, 2015). This also echoes the recommendations of the Berwick report (2013), which argued that more emphasis should be placed on reforming the NHS 'from within' by appealing to the intrinsic motivation of staff and providing them with the skills, knowledge and support to offer high-quality and to continually improve care provision. Necessarily, this includes acting on evidence of high levels of stress in the health care workforce and improving the working lives of staff. The well-established relationship between staff experience and patient experience underlines the need to give greater priority to these issues as a matter of urgency

Supporting the model in clinical practice

A significant limitation of this evaluation is the introduction of the bridging programme alongside statutory provision. We have therefore considered how the A-EQUIP model might work once statutory provision has been removed. This has implications for the preparedness of the current PMAs for working in this new context as well as considerations for how further training might be developed.

Provider-led model: time and resource implications

Reviewing the literature concerning clinical supervision and the literature received from the Taskforce, it is apparent that the implementation of the A-EQUIP model in its current form poses a number of risks that may impact upon the consistency of adoption and, therefore, equity of service and care provision.

There is a risk that an employer-led model may increase inconsistencies in approach, as it is variably taken up and enacted within individual Trusts. This is particularly pertinent given that maternity services across England are faced with increasing challenges of staffing shortages and resignations. The impact of the shortages has been demonstrated by Heads of Service who report routinely reducing services, temporarily closing services and reducing midwives' access to training and development opportunities in response to staff shortages. The Royal College of Midwives have evidenced this in the State of Maternity Services Report (2015). The impact is also shown in the amount of unpaid additional hours midwives routinely work, their failure to take required breaks and the stress they experience.

Whilst these factors would support the rationale for the restorative aspect of the model, they may, simultaneously, compromise the success of the A-EQUIP model. The programme documentation states that the *"PMA must be available to meet with the midwife as the need arises, but a minimum of once per year for one hour is advisable. However, supervision may need to be provided more frequently, for example every six weeks (Turner and Hill (2011)) for one hour for new staff and those who are new to a role"* (Operational Guidance for Implementing the PMA Role, p.19)

The Healthcare Commission (2008) stated that 86% of Trusts allocated 1-2 days a month per midwifery supervisor to undertake supervisory activities. Yet Mead and Kirkby (2006) found that, in reality, twice this amount of time was required for effective supervision. Further, the Henshaw et al (2012) review findings suggest supervision was undervalued and under resourced by many NHS Trusts; findings supported by McDaid and Stewart Moore (2006) and Smith and Dixon (2008). There is no clear assurance that such an eventuality will be averted, nor is there an explicit plan to minimise the risk of such an eventuality within the documents reviewed regarding the operationalisation of A-EQUIP.

Time is, however, one of many resources which will need to be assured. Robust arrangements will need to be in place for the Health Boards and Trusts to provide supportive clinical supervision for midwives and adequate funding for the training of new PMAs. The evaluation team would recommend that this be identified as part of the documentation that underpins the model. The risk otherwise is that the model is perceived as being materially supported, but not accommodated within clinical working arrangements and, therefore, becomes an 'extra' activity to be accommodated outside contractual hours.

The documents state that there will be a Clinical Commissioning Group with maternity commissioning specification. There is a risk that this will be freely and variably interpreted by individual employers in terms of service provision. It is

encouraging that there is consideration of the ratio of midwives to PMA as this will add to the quality of service provision and support by, and for, the PMA. There is, however, literature to suggest that midwives are sympathetic towards their SOMs and recognise the workload associated with their supervisory roles. They would, therefore, choose not to approach them for support if they perceived them to be 'busy' (Kirkham and Morgan 2006).

Lack of knowledge and understanding about (statutory) supervision and the role of supervisors of midwives was a theme identified by Henshaw et al (2012) but it was unclear whether this contributed to a lack of engagement with supervision, or whether it reflected a lack of engagement because of the perceived lack of value of supervision. In the absence of a statutory obligation to undertake a task, identifying ratios will encourage Trusts to support the PMA role and in turn help to strengthen and embed this new role into midwifery culture and practice. This is essential if A-EQUIP and the role of the PMA are to be fully understood at a conceptual level and that superficial delivery of the model is prevented. A lack of full engagement with the operationalisation of A-EQUIP by Trusts may lead to ineffectual delivery and potential detrimental impacts for the supervisee and service user.

Access to a Professional Midwifery Advocate
Within the documents reviewed by the evaluation team, the A-EQUIP model is consistently referred to as an employer–led model with decisions about who will be a PMA being made within the Trusts (p.15 of E-QUIP Bridging Programme information). Within the Frequently Asked Questions section there is a comment regarding those midwives who currently do not work within Trusts, yet require (statutory) midwifery supervision (namely educationalists and Independent Midwives), which states that all midwives are entitled to supervision. At the time of writing this final report, the future of how and whether independent midwifery will be supported is unclear. Clear guidance and information regarding the model are needed to address access to PMA by midwives who work outside NHS providers.

There is a risk that midwives, such as educationalists, may not be able to access a PMA as a number of Trusts do not offer honorary contracts to educationalists and, therefore, they will not be employees of a Trust. Within statutory midwifery supervision, all midwives had to have an allocated SOM and access supervision via the annual review. If the model is employer led and the midwives do not work for a Trust, there is nothing evident within the model and operationalisation documentation to suggest that Trusts have an obligation to support these staff. If the A-EQUIP model is seen to support the revalidation process that all midwives have to participate in, there is a risk that midwives who work outside Trusts will be disadvantaged if they cannot access a PMA for this support. Therefore, consideration must be given as how to support such midwives in accessing this service.

The A-EQUIP model serves to support guided reflection on practice in order to facilitate quality improvement of services. The normative function of the Proctor model, on which A-EQUIP is based, involved monitoring, evaluation and the quality

control aspects of professional practice. This function has been removed from the A-EQUIP model as superfluous because there are such processes within the local internal governance system. The statement is made in p14 of E-QUIP Bridging Programme information that, if a midwife does not engage with the process and there are concerns about midwifery practice, this should be escalated via the organisational governance processes. The evaluation team could not ascertain how the training programme would support the PMA in establishing and maintaining a system that allowed for the transfer of appropriate concerns to the local clinical governance agenda, or what such concerns might be. Similarly, there is little guidance as to how this would transfer to non-Trust based midwives.

Senior personnel involvement

QI literature places much emphasis upon the involvement of senior management and executive teams within new models in order to lead and support initiatives and 'buy in' from those affected by the change. Within the documents reviewed by the evaluation team, there is no reference to how this could or should be achieved during the implementation process of A-EQUIP. This is surprising given the findings of the review of midwifery regulation, that a significant number of Heads of Service and Directors of Nursing were not aware of the role or purpose of the supervisor of midwives in supporting safety for women and their families and safe and effective practice (King's Fund, 2015).

Whilst this information could be escalated through local internal governance structures, the model could be strengthened by offering guidance as to how senior management teams should be informed about and involved with A-EQUIP in order to promote a positive and supportive managerial culture. This would reflect the good practice identified in Sparks and Dwyer (2017) *National Independent Audit of Local Supervising Authorities (England)*.

This audit noted that when the Contact Supervisor of Midwives met the Director of Nursing regularly, this increased Directors' of Nursing knowledge and understanding about the role of the supervisor and statutory supervision and resulted in SOMs gaining a greater appreciation of issues from a strategic perspective and an ability to articulate issues with senior team members more clearly. Mutual value was, therefore, demonstrated in the briefing and meeting between the Director of Nursing and Contact Supervisor. This should form part of the operationalisation guidance in order to provide support for both senior management teams and PMAs when implementing the model.

Summary

It is very positive that consideration has been given to the development of a bridging programme of support for midwives to address the removal of statutory supervision, and that this model will have familiar aspects. However, consideration should also be given to how this is promoted and discussed with midwives; describing it as the 'new model of midwifery supervision' could be misleading and confusing.

A key tenet of A-EQUIP is the move from an independent statutory model to an employer led one. This poses a number of risks for effective clinical operationalisation in A-EQUIP's currently proposed form. Greater attention is required to how this will be effectively supported and resourced within the Trusts to ensure: a consistent approach, the success of the PMA role, and establishment of the professional mind-set that this model is an integrated part of midwifery and not an additional and optional activity.

Consideration should also be given to how midwives outside NHS Trusts can access this process in the absence of an NHS contract. It should also be recognised that whilst restorative supervision and quality improvement methodology may help midwives to achieve the best level of care, it cannot compensate for systemic influences upon practice. It is unlikely that this model or the PMA will have an impact upon such variables as workload/ staffing issues, high acuity and demanding clinical workloads.

SWOT Analysis

STRENGTHS	WEAKNESSES
- Consideration has been given to maintaining aspects of the strengths of statutory midwifery supervision and developing a model which will have familiar aspects. - Several opportunities for peer learning and reflective discussion which draw on the service based experiences and problems which practitioners have. - The prior experience of SoMs is established - The model aims to enhance personal and professional resilience of the midwives which is closely tied to care and service provision.	- Referring to this model as the 'new model of midwifery *supervision*' could be misleading and confusing. Many midwives may view A-EQUIP as an extension of statutory supervision rather than a completely separate model, and their expectations may be similar. - Whilst this is referred to as a 'model' throughout, there is no reference to any framework within which A-EQUIP is supported or can be operationalised. - There is a lack of detail about how PMAs should enact this model and how outcomes/ success will be measured/ benchmarked. - The absence of a recommended ratio of PMAs to midwives presents the potential for under resourcing which will reduce opportunities for midwives to access and seek the restorative function, seen as an important aspect of this model. - Having an employer–led model with no recommended process for selection of PMAs or how supervisees can 'choose' the PMA they engage with could lead to this being linked to internal appraisal / management processes. This could lead to conflict of interest within such a model – i.e. the PMA also being the immediate line manager or Head of Service. - Unclear how, within an employer-led model, PMAs could support midwives to advocate for women if their choice of care is not supported by Trust guidelines/ polices/ commissioning.

OPPORTUNITIES	THREATS
- Evaluating the existing skills of SoMs and with reference to their assessed competence at the end of the programme/their evaluations of the programme may focus the design of future A-EQUIP programmes to ensure that they meet the needs of learners without such existing skills. - Opportunity for individual accountability and responsibility to be developed and strengthened regarding service provision and quality through adopting a QI methodology. - Opportunity to support the revalidation process for midwives.	- In future, prospective PMAs may lack the skill set and experience that current AEQUIP trainees have. - There remains uncertainty as to who/ how many A-EQUIP practitioners will be trained and who will fund/ resource the training - Although this is to be undertaken as part of PMAs' substantive post, there is no recommendation within the model for protected time to enable them to undertake this role. There is much evidence and research that shows time pressures and constraints on clinical staff, which may impact PMAs' ability to facilitate sessions and midwives' attendance. - Consideration should be given to whether non-Trust employed clinicians (educators) could be part of A-EQUIP and how this would be supported in an employer-led model - As this is employer led professional model, and not statutory or mandated, there is a risk of variance in operationalisation of this model, employers may choose not to utilise this approach but focus on existing clinical governance and clinical education practices.

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2.1. Supervisor and supervisee surveys

As part of the evaluation of the pilot, online surveys were sent to site contacts for cascading: one to A-EQUIP trained supervisors and one to midwives who have received CS from A-EQUIP trained supervisors.

We received 33 completed surveys from a potential 40 supervisors that had very recently completed the training (82.5%). There were 39 supervisee responses. Two respondents indicated that they had undertaken the A-EQUIP training (but were responding as supervisees). Several respondents accompanied their ticked option with comments which were clustered into themes.

Supervisor Survey: quantitative results

As a result of this course, I know how to function effectively as an A-EQUIP supervisor (n=33)

Answer Options	Response Percent	Response Count
Not at all	0.0%	0
A little	9.1%	3
Sufficiently	69.7%	23
Completely	21.2%	7
Unsure	0.0%	0
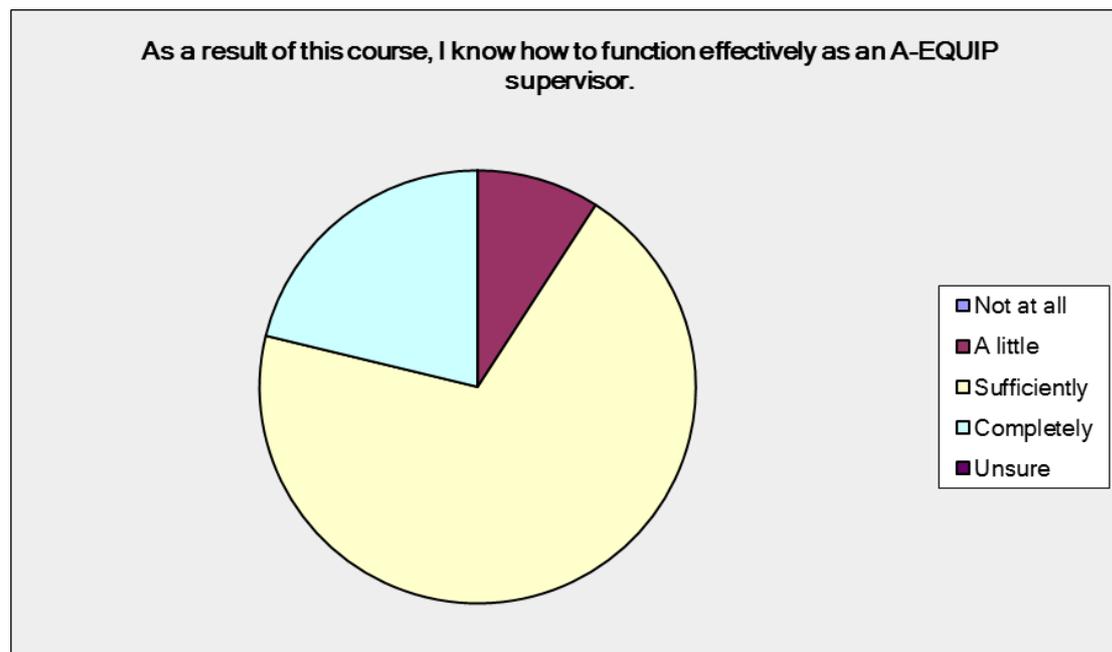
As a result of this course, I know how to deliver effective restorative supervision using the A-EQUIP model (n=33)

Answer Options	Response Percent	Response Count
Not at all	0.0%	0
A little	12.1%	4
Sufficiently	45.5%	15
Completely	42.4%	14
Unsure	0.0%	0
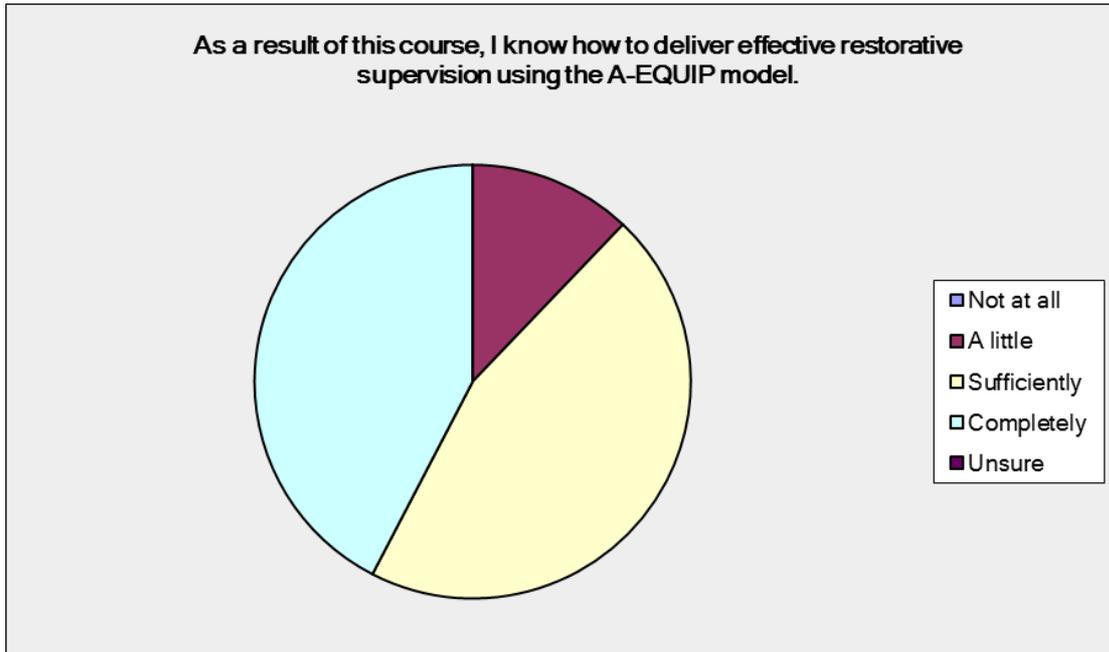
As a result of this course, I understand how to prepare midwives for their professional appraisal and revalidation using the A-EQUIP model (n=32)

Answer Options	Response Percent	Response Count
Not at all	9.4%	3
A little	9.4%	3
Sufficiently	21.9%	7
Completely	53.1%	17
Unsure	6.3%	2

As a result of this course, I understand how to prepare midwives for their professional appraisal and revalidation using the A-EQUIP model.
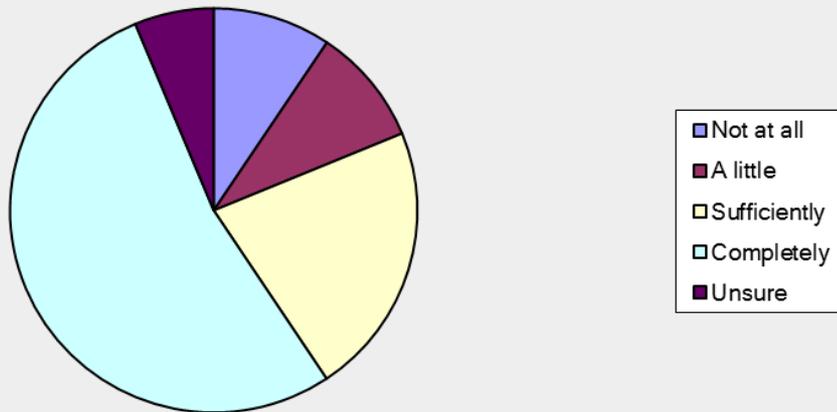
As a result of this course, I know how to foster continuous quality improvement in midwifery practice using the A-EQUIP model (n=33)		
Answer Options	Response Percent	Response Count
Not at all	6.1%	2
A little	27.3%	9
Sufficiently	33.3%	11
Completely	33.3%	11
Unsure	0.0%	0

As a result of this course, I know how to foster continuous quality improvement in midwifery practice using the A-EQUIP model.
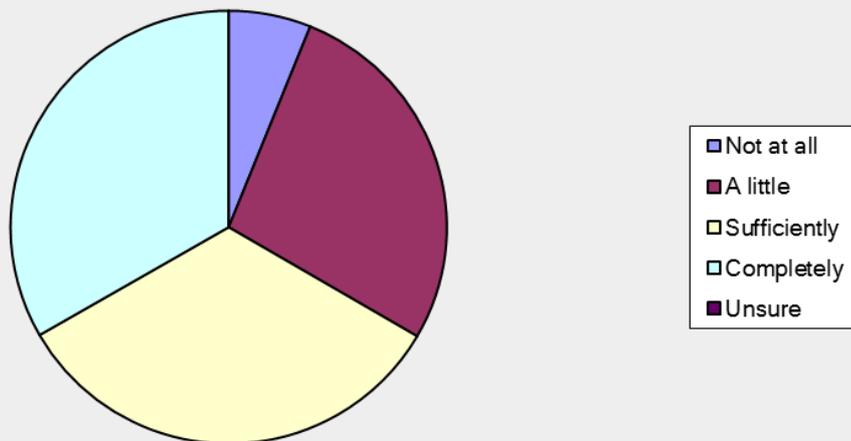
How much has this course improved and/ or expanded your understanding of practicing as a midwifery supervisor? (n=32)

Answer Options	Response Percent	Response Count
Not at all	15.6%	5
A little	37.5%	12
Sufficiently	21.9%	7
Completely	18.8%	6
Unsure	6.3%	2

How much has this course improved and/ or expanded your understanding of practicing as a midwifery supervisor?

- Not at all
- A little
- Sufficiently
- Completely
- Unsure

Mean scores (0-4)

As a result of this course, I know how to function effectively as an A-EQUIP supervisor (n=33)	3.03
As a result of this course, I know how to deliver effective restorative supervision using the A-EQUIP model (n=33)	3.18
As a result of this course, I understand how to prepare midwives for their professional appraisal and revalidation using the A-EQUIP model (n=32)	3.00
As a result of this course, I know how to foster continuous quality improvement in midwifery practice using the A-EQUIP model (n=33)	2.60
How much has this course improved and/ or expanded your understanding of practicing as a midwifery supervisor? (n=32)	1.91

Supervisor Survey: quantitative interpretation

The respondents reported that they are mostly well prepared to function effectively as an A-EQUIP supervisor. Most reported they were 'sufficiently' prepared (70%), some 'completely' (21%), and three respondents reported that they were only 'a little' prepared.

Responses to the question *'As a result of this course, I know how to deliver effective restorative supervision using the A-EQUIP model'* were almost evenly split between sufficiently (46%) and completely (42%), with four 'a little' responses.

There is some concern that although most respondents reported that, as a result of the course, they 'completely' understood how to prepare midwives for their professional appraisal and revalidation using the A-EQUIP model (64.3%); seven responded 'sufficiently' (22%), three responded 'a little' (9%) but a further three responded 'not at all' (9%).

Perceived efficacy for fostering continuous quality improvement in midwifery practice using the A-EQUIP model was another area where respondents were considerably divided in their opinions. Results were evenly split (33% each) between 'sufficiently' and 'completely'. However, nine responded 'a little' (27%) and two 'not at all'.

The lowest and most mixed responses were to the question *'How much has this course improved and/or expanded your understanding of practicing as a midwifery supervisor?'* Five replied 'not at all' (16%), twelve replied 'a little' (38%), seven replied 'sufficiently' (22%) and six 'completely' (19%). Two respondents (6%) were unsure. However, it is possible that this question could have been either interpreted as relating to the SOM or PMA role, and therefore would benefit from further investigation.

These responses reinforce the view that the majority of participants for this pilot already had confidence in their efficacy to act as supervisors. They also indicate that there is extensive variation in the learning needs of potential supervisors.

Supervisor Survey: qualitative themes
Of the 40 participants in the pilot, 33 completed the survey. Under each question of the survey, there was space for comment. Most participants used these spaces to clarify their response. Their comments have been clustered into themes and superordinate themes.

Hopes and Expectations

A wide range of hopes and expectations from the training were shared in the surveys. For some, there was clear enthusiasm for being part of an innovation, and their expectations were a general wish to learn about the new model. Others reported no hopes or expectations, attributable to lack of clarity about the terms of engagement, about to how to do it (structure/ procedure) and about the relation between this training and statutory supervision training.

Early adopter enthusiasm
Several comments expressed respondents' enthusiasm for being part of a new professional development, and energy to find out about it and participate in implementation.

I hoped that all staff will see this as an opportunity to enhance their working environment, having time and space to think. Hope that staff will engage with the model. Hope that it will improve staff morale and stimulate create thinking and different ways of doing things. Exciting new times

As a pilot team we were determined to be pro-active in commencement of the restorative sessions for staff

We are so proud to be part of the pilot

Really pleased I have had the opportunity to learn about A-EQUIP

To empower all the midwives I work with and help them have a more positive approach to midwifery

Excited to be part of something new.

It was greater than I expected

That I would receive training in this exciting new model that could provide an alternative to statutory supervision

To embrace a new way of looking at supporting Midwives to provide excellent clinical and look at their own coping strategies in the current climate of health care.

Lack of clarity
Respondents expressed their lack of knowledge about what the programme would entail and the consequences on their roles and their profession.

I am not sure I had any expectations as we knew nothing about the programme before we started

I was unsure as to how the programme and the role of the PMA would differ from that of a SOM. I hoped the programme would clarify the differences and give me an idea of how I can ensure changes in practice whilst continuing to support midwives in my trust

We knew nothing about the programme before we started just that we had a desire to be involved in the infancy of a new way of working

I honestly did not know what to expect

Understanding the structure and implementation of the new model
Respondents expressed the wish to find out the "how to" about the new supervision model and this included improved support for midwives and organisational aspects, such as commitment to the model.

Having an understanding of the new model of clinical supervision

I expected more information on improvement techniques

That we would be told what to do and how to do it!

I hoped that we would have a clear picture of exactly what the new model would be, whether trusts were absolutely committed to this new model and what it would mean for midwives and women

to be able to continue to support midwifery colleagues.

To have a clear outline of what is expected on the new model

To be confident in delivering the A Equip model and ensuring staff get the restorative supervision that they require. To be part of process in implementing a new model of quality support for midwives to enhance their practice and outcomes for families

To be prepared for the future as a PMA

how to go through a change process

Identified areas of improvement

Three themes were identified as related to improvement: Improvement of the training; improvement of the pilot; the restoration of the supervisors themselves.

Improvement of the training

There seemed to be some confusion as to what the training was about (this could be related to themes about feeling that the training had been rushed therefore, some areas required further clarification and depth).

I haven't had the A-EQUIP training just the restorative supervision

But this course did not specifically prepare me for this [appraisal and revalidation]

More RCS

More time to learn the methods of restorative supervision

Good training just needed more time on the pilot

the final group session would have been more beneficial earlier in the programme as it focused on the practical side of delivering

Training needs to be longer - about 6 months and possibly more structured - with a focus on all three elements more and to fully understand how the model can be used effectively in clinical practice

Balance the theory/ information with more time to actually practice

More training on improvement methodologies and staff development

It will improve with time the more it runs. This is the first of its kind with our specialty and hence repeating it will only enhance the outcomes as tweaks will no doubt happen as it is evaluated.

The program felt rushed and should be further extended to enable PMAs to develop the role

More joint training with other units would be beneficial

I think we should have had an extra 2 group restorative clinical supervision sessions to embed the knowledge and skills we have learnt

Improvement of the pilot
Several participants commented on the time scale in which the pilot was completed, describing feeling unclear about what they were engaging with, rushed, and that there had been insufficient time to implement and observe the effects of training in practice.

I have not had time to fully use the training I received. The time interval between completion of training and a Review has been too short for this to be possible

I felt that the pressures of time and not knowing, if it was appropriate to start

I believe it is a good model, but feel that training has been rushed and I would appreciated a longer time scale to pilot the model- to really identify what elements work well.

Needs to be longer and more detailed, with a timescale that allows for proper evaluation

We would need a bit more meat to the bones academically and perhaps be allowed to see it in action elsewhere perhaps in Warwick where it had been used before.

I think it should have been thought about much sooner, it feels like the PILOT I have been involved in has been rushed through as we have only just finished our training on restorative supervision

Restoration of supervisors
Restoration was a valued aspect of the training, but some participants felt they did not experience restoration from the RCS available to them during the training, while others did not understand the importance of the experiential element of RCS.

More practical info - I didn't see the value of undergoing restorative supervision myself as part of the training. What I needed to know was how to deliver it

effectively to others.

If the main element is to be restorative supervision, I would like to feel restored. Although my assessment documentation is completed, I still feel that unless I missed something, I never actually received restorative supervision myself.

Introduce group supervision earlier

A second group supervision

A final joint meeting with the other London team

Use the session to restore the trainers.

Reflections about moving to the A-EQUIP model

Participants offered various comments about the sense they made between A-EQUIP and statutory supervision training, several emphasising their prior experience/ existing skills developed through statutory training and practice, particularly with regard to preparing midwives for appraisal and revalidation, and fostering continuous quality improvement. The majority viewed A-EQUIP, and RCS in particular, as valuable additional training but not as the totality of midwifery supervision training due to insufficient amount and depth given to issues broader than RCS (specifically: preparation for appraisal, revalidation, and quality improvement). Some suggested that training of longer duration and covering all aspects in more detail would be desirable.

There were mixed feelings about the benefits of comparing the old and new models. Whatever the approach, it is clear that making a distinction between the two models is considered important.

Comparing the new model to the old way of working is not beneficial as it is completely different.

It has given me a greater understanding of the differences between statutory supervision and the role of a PMA.

Previous experience

Participants highlighted that they already had knowledge and skills in midwifery supervision through training they had attended and practising as supervisors.

I believe that my skills as a supervisor already include many of those taught in this training. I myself have experienced poor supervision and excellent supervision - I have had 3 supervisors throughout my career. I also know from talking to peers that supervision varies from supervisor to supervisor but I am always mindful about what a midwife is bringing with her to our meetings - personally and professionally, I feel the two are intrinsically linked.

I am and always have been passionate about supervision and the benefits for

midwives and women. I have become disenchanted with what I feel to be a large proportion of our meetings been dedicated to more corporate and managerial matters as I feel there are enough managers meetings to discuss these.

POSOM: A more detailed programme

Respondents highlighted that their previous training offered more extensive preparation for the role of supervisor, especially in more practical aspects such as governance, appraisal, development, and revalidation.

This training was quite different as the POSoM training prepared me for many things as opposed to A-EQUIP concentrating on restorative clinical supervision and does not touch on things like Governance, Education, Safety of Women etc.

The SOM course was a detailed module. This is a separate course and the restorative supervision sessions with XX were by far the most useful.

The non-restorative elements did not bring any new learning personally and was based on leadership models. This would be useful for others though.

Well as I will no longer be a supervisor in the old sense this is a very new role which I continue to consolidate my knowledge and skills in. My POSOM course was more rounded as there was more time to take on the information and there was an academic component.

I was already trained fully in revalidation process prior to the course because I lead in my trust in Revalidation for midwives. The course did not cover this [appraisal and revalidation]

The POSOM training although very informative and inspiring, I felt that oftentimes the focus was more towards the negatives in practice such as involvement in investigation processes etc.

RCS seen as the whole course

Although A-EQUIP consists of more than the restorative supervision element, some respondents' comments indicate that the focus on restorative supervision meant that this was the entire course and the entirety of their function as supervisors.

However, despite the model including an element of education and training, I believe that we were told that A-Equip midwives would be providing restorative supervision only.

The training was to develop Supervisor of Midwives to become Professional Midwifery Advocates. The training included improving on leadership skills and new knowledge and understanding of Restorative Clinical Supervision. Once the course was complete I was confident to delivery restorative clinical supervision session to individual midwives or groups of midwives as a PMA.

My knowledge of restorative supervision has increased. I understand the importance

of making midwives to feel valued. I understand about making the midwife feel comfortable and that I need to be well prepared for our meetings

self-reflection ready for change listening skills, able to provide restorative supervision

Part way - in relation to the restorative supervision

Need for more clarity
However, despite the model including an element of education and training, I believe that we were told that A-Equip midwives would be providing restorative supervision only. The main principles of this are there is no agenda, the midwife will set the themes for the meeting, only attendance will be recorded, unless any serious concerns the details of the meeting will never be disclosed to a third party and re-validation and appraisals will remain firmly with managers.

I feel supervision had an element of quality and education before as well.

It was completely different and like stepping into the unknown.

This is not the same as midwifery supervision and thus hard to compare as the A-EQUIP model has the midwife at the centre whereas supervision had the woman at the heart of all we did.

Positive comments about the course
Positive comments about the course include satisfaction with (improved) knowledge of restorative supervision and enjoyment of the RCS element of the course, satisfaction with training facilitators, and enthusiasm about the potential for RCS to empower midwives and women in their care.

The added value of RCS/A-EQUIP
Respondents welcomed the additional element of restoration in their practice as supervisors, some seeing it as long needed in supervisory practice and looked forward to making it available to midwives.

I do hope the A-EQUIP is adopted as midwives do need to learn to have a calm space to be allowed to think and reflect so they could be free to be creative and innovative with the care they give.

I have loved the course and the opportunity to discuss differences in the way supervision is delivered in different Trusts. I didn't think there would be anything to replace statutory supervision I thought it was to cease as it provided a layer of governance not provided within nursing.

The RCS component has enhanced my practice

The addition of RCS is good

Improved knowledge of RCS

Respondents welcomed the additional knowledge and skills they gained in restorative supervision and the benefits they envisaged.

Highlighted some areas where previously we have not been empowering our supervises as well as we should have

I find it to be brilliant. Being listened to and having a quiet time to talk during the restorative session is quite amazing. It also make you feel valued and enable you to think clearly and improve your leadership style

It has been hugely interesting especially the RCS component

The A-EQUIP programme has provided me with a fresh outlook and enthusiasm for supervision that can only benefit all in the profession

Satisfaction with facilitators
Respondents expressed satisfaction with their facilitators of training.

very supportive programme leads

the restorative supervision sessions with Helen Lake were by far the most useful.

The facilitator was excellent and was able to clarify lots of issues.

Empowering the midwives
Some respondents envisaged that the encouragement to listen more and prioritise the agenda and needs of their supervisee was powerful and empowering for the supervisees.

I am more able to facilitate change behavior and to help the midwife to make changes herself and be able to discuss issues. My listening skills have improved

Do less talking and more listening Able to effectively run group supervision

Giving the space to think and reflect - no rushing no agenda

Given the power and control back to the individual

Listening to my supervisee more. Knowing is about them finding solutions to any issues without having to find an answers for them

The key development for me was awareness of the need to facilitate staff learning and quality improvement by giving them space to reflect about themselves and their care in a very unstructured but supportive environment. This role is not to offer solutions but to offer space for staff to identify solutions.

Listening and empowering midwives to come up with their own solutions to problems/issues facing there working environment.

Negative comments about the course
Criticisms of the course include lack of clarity about the programme, the time constraints that participants associate with poor opportunity to practise and test their new knowledge and skills, including reflection on how the course fulfilled the restorative function for the supervisors.

due to the time constraints has felt a little rushed and as no one yet knows the outcome there is a lot of uncertainty which impacts on us all

I don't feel there was enough practical information on how to implement the new model - I didn't feel the information was sufficiently clear on what was expected of us as PMA's

well. Interesting if not short.

it has been more ideas that the pilot has been set to explore but i don't feel there has been sufficient time

If the main element is to be restorative supervision, I would like to feel restored. Although my assessment documentation is completed, I still feel that unless I have missed something, I never actually received restorative supervision myself.

Positive comments about RCS
Participants enjoyed the training in restorative clinical supervision (RCS) and predicted a positive impact of it on their supervisory practice and on the practice of their supervisees.

I think the A-Equip model, and particularly the RCS component could make a real difference to the morale in the midwifery workforce

The RCS component has enhanced my practice

To become a PMA, the training helped with adding to my leadership skills and trained me in 'restorative clinical supervision'

I honestly did not know what to expect but the training has been so inspiring with the promotion of openness, honesty and empowerment of midwives

The restorative sessions with Helen Lake were very useful. The other learning events were interesting but would not change the way I practice.

Concerns
Several participants expressed concerns, fears and anxieties about the clarity and efficacy of their preparation. Having felt a lack of clarity from the start of the pilot there were concerns about the value that their organisations and managers would attach to supervision in the absence of a legal obligation to provide this.

Concerns were also expressed about the usefulness of evaluation in the face of decisions already made regarding the abolition of statutory supervision and confusion as to the overlap period between abolition of statutory supervision and having enough fully trained A-EQUIP supervisors. These concerns are essentially about the various stages of implementation.

Clarity and concerns about implementation
Respondents were concerned about the rushed nature of the pilot and their training, which had left them with uncertainties and with questions about what to convey to the midwives they supervised.

if it was appropriate to start these sessions before the team had completed their training could have been made clearer

I don't feel there was enough time to prepare midwives for the dissolution of statutory supervision - it all felt a bit cloak and dagger....e.g. we didn't know whether ITPs would be sent to midwives until we received the same email at the same time that midwives were informed.

Trust management and A-EQUIP
Respondents expressed some pessimism about the commitment that their managers and organisations would make to A-EQUIP, particularly the financial aspect of the commitment, and therefore concerns about its implementation.

in the current financial climate I am not sure how Trusts will be able to resource this

PMA role is not in statute and with the financial pressure we are all facing, I am not confident it will be fully supported or be sustainable because of the same.

My fear is that the A equip model will not be valued by management

main considerations are lack of statutory role and lack of formalising discussions within written documentation

That our organisation will allow the midwives time off the ward to access this support and to develop an ethos of allowing them time to think and reflect as this will not be statutory.

am aware that it will be dependent on the chief nurse, director of midwives and management

I feel this new model will be completely separate from management and although most of my supervisory colleagues are both and can distinguish between the two, many of their supervisees cannot.

Percieved gaps
Respondents highlighted gaps that needed more and earlier consideration, such as what supervision would/ should be in place in Trusts that were not part of the pilot,

how the new model would be resourced and delivered, and how midwives on night shifts would be enabled to access supervision.

Concerned that this is being implemented at too short notice and nothing in place for many maternity units at end of March 2017 to support midwives. This pilot continues until end of March 17 so where is the period for evaluation and consideration if it is the most appropriate model to take forward supporting midwives? What happens if the evaluation does not indicate that this is a useful model?

the model is clear, however how this will be delivered in terms of resources (time and funding) is unclear.

Difficult to catch up with colleagues who work night shifts.

Concerns about the adequacy of (A-EQUIP) preparation
Some respondents were unsure about their confidence in delivering the model in terms of how well prepared they would be and looked forward to finding out in practice. They were also concerned about the useful elements of their previous training not featuring in the new model. These concerns appear reinforced by the lack of clarity and information about implementation as well as by their supervisees' apprehension about it.

I hope that the best areas from midwifery supervision which is now being taken out of statute will be included in the model

I have not fully completed my training as an A-equip supervisor, so not yet using skills fully. I hope to be signed off at end of Feb

It has met my expectations but I will only know how effective I am once I practice as a PMA and have fed back from midwives and my manager (appraisal)

With only one group meeting left, I feel uncertain about what A-Equip midwives will provide, whether this will be the same from Trust to Trust, how the A-EQUIP midwives will be selected etc.

It is difficult to give a true evaluation as we have only just begun this journey

Staff are very uneasy as to the discontinuation of statutory supervision and I have been limited into the information I have been able to provide my supervisees with.

Summary
The response rate of A-EQUIP trainees to the survey was excellent, with 33 of the 40 trainees having completed the survey and given extensive comments to supplement tick-box responses. Themes in their comments include:
Hopes and expectations: Respondents expressed enthusiasm, pride and positive energy to be part of an innovation to their profession and benefit their supervisees and midwifery practice. They also highlighted lack of clarity about the purpose and content of the course that inhibited the development of more specific hopes and

expectations. On the whole, they wished to understand the model and how it could be structured and implemented.

Improvements: to the pilot mainly pertaining to its rushed nature, the lack of information or clarity, and the lack of time to test it in practice. Improvements to the training, especially about advance clarity of its purpose, increased training time to incorporate more in-depth understanding of restorative supervision as well as the other components of A-EQUIP. Improvement to their own feeling of restoration.

Comparison of supervision models: Respondents were already knowledgeable, skilled and experienced in midwifery supervision, having trained in the previous model, POSOM. They appreciated the addition of restorative supervision, enjoyed the course, but also found it less detailed and extensive than POSOM, especially with regard to A-EQUIP components other than restorative supervision. Reported lack of clarity manifests in some respondents' interpretation of the focus on restorative supervision as their new role, believing that the other A-EQUIP components will be the role of managers.

Positive comments about the course: Participants expressed appreciation for the additional knowledge and the added value of restorative supervision to their supervisory practice. Some respondents also expressed satisfaction with the performance of course facilitators.

Positive comments about restorative supervision: Respondents spoke of embracing learning about restorative supervision, envisaging that it would have a beneficial effect on their supervisory practice and on the psychological wellbeing of midwives/ supervisees.

Concerns: Respondents expressed concerns, fears and anxieties about the clarity and efficacy of their preparation (associated with lack of clarity at the start of the pilot). They also expressed concern and some pessimism about their managers' and organisation's response and commitment to the new model, highlighting lack of clarity regarding implementation, lack of value for the midwifery supervision in the face of financial constraints, but also concerns about the lack of their knowledge about plans for supervision in sites that had not been part of the pilot and for colleagues working night shifts.

Supervisee survey

Supervisee Survey: quantitative results

To what extent has your experience of A-EQUIP supervision been different to your prior experiences of supervision? (n=39)

Answer Options	Response Percent	Response Count
Not at all	2.6%	1
A little	25.6%	10
Sufficiently	28.2%	11
Completely	35.9%	14
I'm unsure	7.7%	3
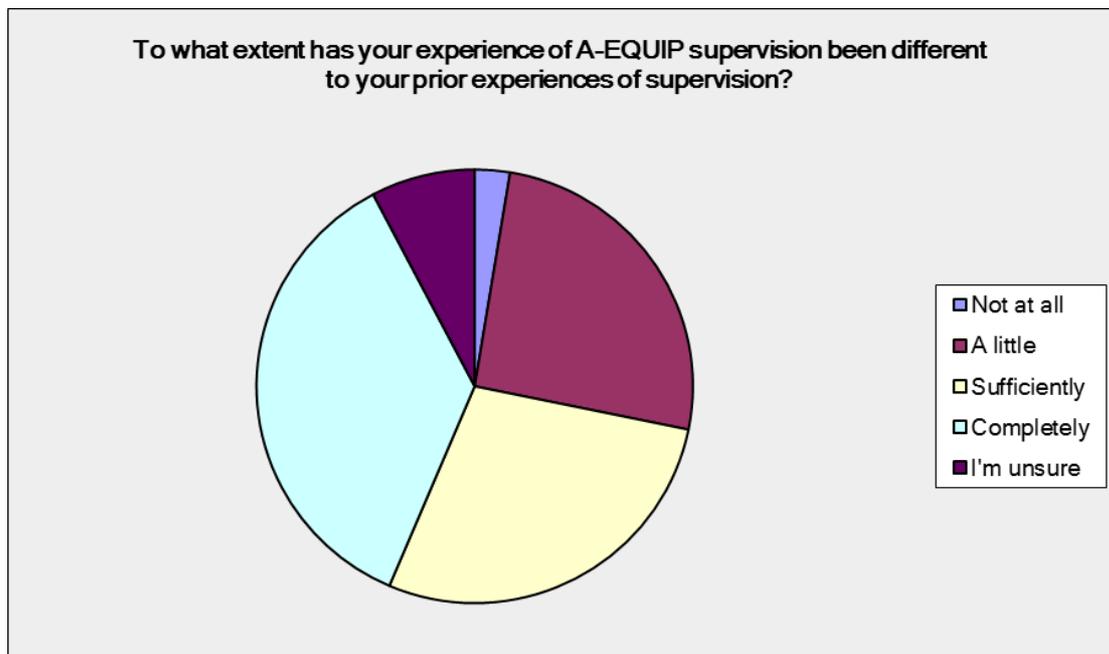
One of the aims of the A-EQUIP course is to train supervisors to facilitate restoration and resilience in the midwife (this means that your supervisor will help you to manage the emotional effects of the work on you so that you can continue to provide a high quality service). Have you experienced this during A-EQUIP supervision? (n=39)

Answer Options	Response Percent	Response Count
Not at all	2.6%	1
A little	12.8%	5
Sufficiently	38.5%	15
Completely	43.6%	17
Unsure	2.6%	1

Have you experienced facilitation of restoration and resiliance
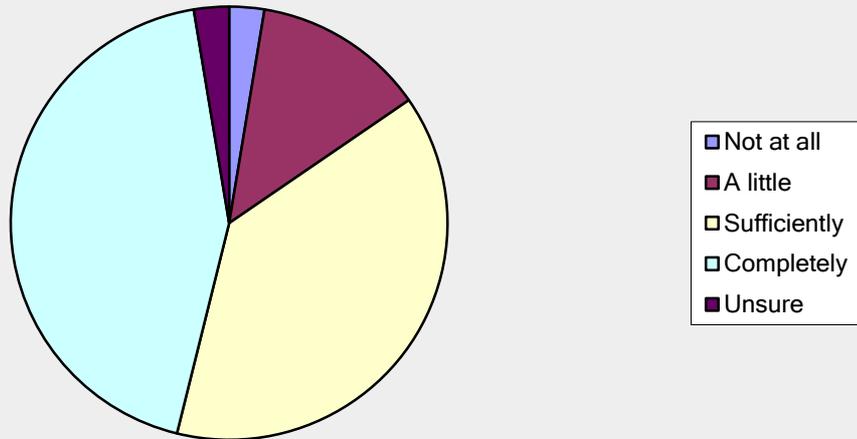
To what extent do you feel prepared for professional appraisal and revalidation as a result of A-EQUIP supervision? (n=39)

Answer Options	Response Percent	Response Count
Not at all	5.1%	2
A little	20.5%	8
Sufficiently	46.2%	18
Completely	20.5%	8
Unsure	7.7%	3

To what extent do you feel prepared for professional appraisal and revalidation as a result of A-EQUIP supervision?
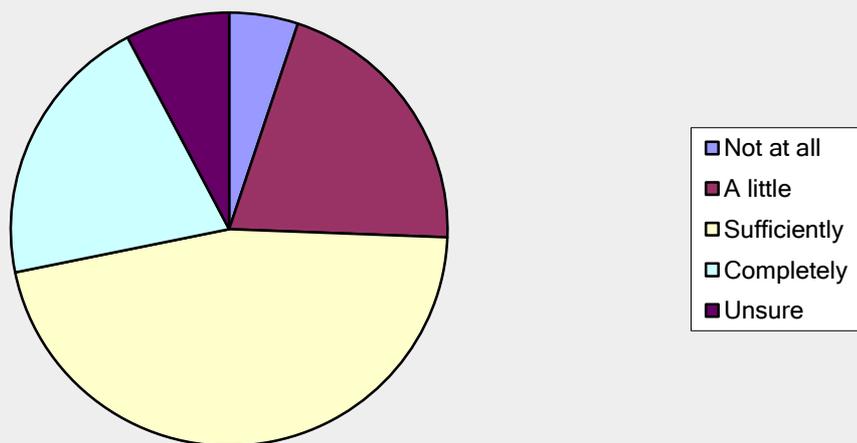
To what extent do you feel that your A-EQUIP supervision has enabled you to identify your continuing professional development needs? (n=39)

Answer Options	Response Percent	Response Count
Not at all	12.8%	5
A little	12.8%	5
Sufficiently	35.9%	14
Completely	25.6%	10
Unsure	12.8%	5

To what extent do you feel that your A-EQUIP supervision has enabled you to identify your continuing professional development needs?

- Not at all
- A little
- Sufficiently
- Completely
- Unsure

Mean scores (0-4)

|	
To what extent has your experience of A-EQUIP supervision been different to your prior experiences of supervision?	2.69
One of the aims of the A-EQUIP course is to train supervisors to facilitate restoration and resilience in the midwife (this means that your supervisor will help you to manage the emotional effects of the work on you so that you can continue to provide a high quality service). Have you experienced this during A-EQUIP supervision?	3.08
To what extent do you feel prepared for professional appraisal and revalidation as a result of A-EQUIP supervision?	2.56
To what extent do you feel that your A-EQUIP supervision has enabled you to identify your continuing professional development needs?	2.49

Supervisee Survey: quantitative interpretation

Fourteen respondents (36%) considered their experience of supervision to be 'completely' different. More than a quarter of respondents considered it only 'a little' different (ten, 26%), and eleven 'sufficiently' different (28%).

When asked about experiencing facilitation of restoration and resilience, five responded 'a little' (13%), fifteen responded 'sufficiently' (39%). The majority of

responses (seventeen) were 'completely' (44%). This question received the highest mean score.

When asked *'To what extent do you feel prepared for professional appraisal and revalidation as a result of A-EQUIP supervision'* there was a mixed respo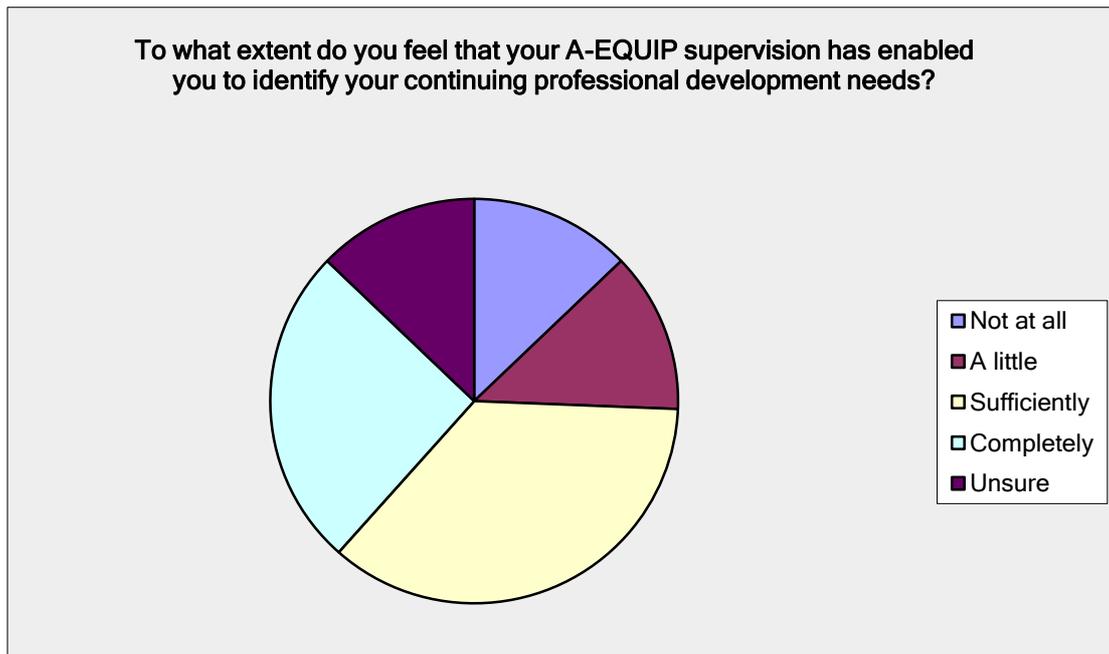nse. Whilst 46% (eighteen) felt sufficiently prepared, an equal number (eight) were 'a little' and 'completely' prepared (21%). Two respondents reported that they felt 'not at all' prepared.

When asked *'To what extent do you feel that your A-EQUIP supervision has enabled you to identify your continuing professional development needs?'*, the result was very mixed. The majority responded either 'sufficiently' (fourteen, 36%), or 'completely' (ten, 27%). However, five responded 'a little' (13%) and another five responded 'not at all' (13%). This was also the question with the lowest mean score.

Supervisee Survey: qualitative themes

Prior hopes and expectations

Twenty-three (59%) respondents commented that they had no specific hopes or expectations as they knew very little about the model and what could be expected. Others commented on hopes that various aspects they had already experienced as useful in previous supervision could be retained.

I did not know anything about it

I came to the process with no knowledge of it, and therefore with an open mind.

I hoped she would give me some advice re revalidation which she did

Hoped it would still be supportive of building a good relationship with the advocate - not just the person that is watching you, ready to tell you off.

I hoped to receive feedback about my practice and I expected to feel supported.

update training

I was able to use it to feel valued as a member of the team and reflect on both positive and negative experiences.

I feel that this will be invaluable to midwives. Having protected time to do it is great providing the unit isn't crazy busy and you can't be released.

it is focused more on the individual than the profession which is positive

I started off a bit cynical-old dog, new tricks and didn't feel that I would learn a lot

a brilliant supportive addition to Midwifery practice.

I hoped that it would continue to be supportive as the previous supervision model was.

I was hoping it would give the opportunity to discuss emotional effects and it did.

to get continuing support

That it continues and is adopted nationally.

What's the difference?

Most participants indicated that they experienced A-EQUIP supervision as different from that available previously. Some participants reported no change, while others who chose the option "a little" explained that this was because they experienced their supervisor as very supportive regardless of supervision model. The main difference was a new focus on them as persons, not just workers, and on their psychological wellbeing. A few participants commented that they wished to retain the best elements of the previous model of supervision.

No difference

unsure if that is due to the type of supervision, or due to my supervisor being an amazing person.

My experiences are the same. My supervisor and I have been having supervision meeting like this since I qualified

I feel it was just time to chat or moan

To date I have always had areas I've identified for CPD and that hasn't changed because of the model

The character of difference

Boundaries: more meaning than formality

Previously I have found annual supervisory reviews to be driven by the contents of a pre-defined printed form containing set fields for discussion, with little time remaining for free discussion after completing the form. My experience of A-Equip has been entirely different, centred around uninterrupted time with my PMA to focus on my own agenda. I have found it immensely valuable to have protected time to talk about (and reflect on) issues of relevance to me personally, rather than box-ticking against a checklist of priorities nominated by person/persons unknown.

Less formal and no duplication between supervision and PDR

More focused on a discussion rather than a 'tick-box' exercise. Much more enjoyable and felt more was taken out of it as able to discuss what I felt I wanted to and the conversation was led by that.

It was fine, I liked not having to tick boxes on a form, or prepare notes for review. Felt much simpler

I felt there was more time given to me as an individual and it was not a "tick-box"

exercise

There was a very long, onerous form which I needed to complete last time so I am please and relieved that this was not required now

A-Equip is not a tick box exercise - it focuses on me as an individual

less formal

more informal and relaxed and more of a chat than a practice review

The session felt more reflective rather than answering a series of questions. She has arranged a follow up meeting to discuss further an incident.

Less formal, group session held which not previously done, good to discuss things with colleagues that I had not spoken to on this level before

More relaxed and non-judgemental

You can discuss anything and not feel like you are being continually monitored and judged

The session was primarily led by one supervisor with others observing. It was safe non-judgemental and relax open forum where my concerns was acknowledged and discussed.

self-reflection is a feature of revalidation

I thought the structure of the meeting was beneficial, and the reiteration of boundaries was helpful.

Supportively midwife-centred

A more holistic approach

Previous supervision involved focus on women and families. This model appears to concentrate on empowering midwives to investigate their concerns, interests and be pro-active in managing their working practices to improve.

Very much given time to talk about ANY issues of concern to me at the current time. No focus on my pdp much more personal. Very much felt a listening ear and not lots of ideas given to me but opportunity to discuss things in confidence without feeling judged

an increased counselling role

I have only met my PMA once as part of a pilot study, but already it seems a very different type of 'supervision' it seems strange to have no targets/ objectives. I think it will be useful to be able to meet up and discuss issues 'safely'

I feel that this new model focussed more on me as a person, where the previous

model focussed on me as a midwife. This gives the flexibility to discuss professional issues if I want to, but feels more supportive in a personal sense.

I feel reassured that I can discuss any concerning issues in complete confidentiality with my supervisor.

A more relaxed meeting covering any topic pertinent to how im feeling rather than focusing on practice related skills, documentation etc.

Promotes an environment which is confidential and friendly. I felt I could talk about personal and work related issues easily.

This was a group supervision rather than one to one. I appreciated the different opinions expressed by my colleagues

supervisor listen more to midwife and do not focus only on patients

group rather than individuals allows for exchange of ideas peer support safe environment

I think supporting in this way can only be a positive thing and it could prove more beneficial than Supervision.

I'm not familiar with the term POSOM but if it is the supervision we have had in the past: I think this recent session was definately more helpful as I needed to talk at length at this time

Psychological self-care

A new focus on strengthening the midwife's emotional/ psychological self-care was consistently reported. This appeared to be the main difference between A-EQUIP and past supervisory arrangements. It was provided through a professional relationship bearing the hallmarks of psychological therapy (non-judgemental, supportive of exploration, reflection and psychological restoration). Respondents commented on their appreciation of this and of the prospect of emotional support in their work if the need arose.

Support re emotional needs to reduce stress and anxiety and therefore enabling me to provide high quality care.

The conversation was focussed around me and my emotional, psychological needs rather than where I saw my career progressing. Inevitably e conversation related back to my career plans but that wasn't the focus.

We discussed how I provided self-care for myself and I offered examples of how I reflect and access emotional support of and when it's required.

Being able to talk openly and freely with my supervisor whilst no notes were taken was refreshing and meant that the emotional aspects of the job were easily approached

Refreshed, updated, structured for group supervision. Felt restored myself

It helped me to feel listened to and supported. Being able to talk about areas causing anxiety will undoubtedly help me develop resilience

In the past we've had a short chat about how I was feeling about work and significant events I might have wanted to discuss; this time as there has been so much happening in my work and role we mainly talked about how I was coping with that. There was so much to cover about events in the last 6 months and agreed changes to the role that most of the session was used to off-load. This was wonderful for me to share with someone else as I work in a small team and I have a specialist role. It isn't appropriate for me to discuss everything with colleagues I work with.

In the past we have mostly discussed my updating and ways to progress knowledge and skills. She was a very good listener which was what I needed in this session. I was able to see how the changes have affected me and am able to look to the future more positively. As I said above it was good to be able to off-load to someone in a completely confidential capacity. Also I don't work with my supervisor so I know this helped me to be very open. This was last week.

I felt that it was all about me and how I was feeling in general and how this impacted on my attitude to work.

A-EQUIP gave me the opportunity to discuss situations or cases that has caused me anxiety or worry.

The A-EQUIP reassured me that if I should have an emotional situation, there is somebody to listen on a regular basis. I feel yearly supervision didn't provide this. I felt when I had emotional situations I didn't want to bother my supervisor in between.

I attended a one to one meeting which enabled me to discuss work/home and highlight areas that were positive and where I felt support was needed. Very useful.

Allows us to freely discuss and offer new ideas to cope

Knowing protected time was given and that nothing was written down and everything was completely confidential was very helpful. At the time of the meeting there wasn't a huge amount of emotional support I felt I needed, but I can see that something stressful was happening at work or at home having someone you can talk to is hugely important.

Ask about positives and challenges of new role I am in currently. I felt my emotional wellness was considered and would have been further explored if required.

It has been less structured, informal & more supportive

It's only been a short period of time, but I feel that with POM support resilience will improve, unsure how it will affect knowledge & skills.

Reassuring to know that it's ok to experience emotional 'wobbles' in the work place and be able to talk them through.

The group support has helped me feel more resilient.

I was pleasantly surprised at the outcome and found it rewarding because I felt listened to

I have always felt that I can discuss any concerns with my supervisor which I feel is very important especially considering how emotionally, physically and mentally challenging our job can be. Having someone you feel comfortable with that, and not worrying about being judged is very valuable in sustaining fit and healthy midwives.

More clarity in roles: manager/supervisor
Respondents appear to start distinguishing between the role of managerial supervision and A-EQUIP supervision, although this requires further and formal clarification.

A yearly supervision in the past has been similar to yearly appraisals. Supervision discussed whether I was up to date with training, career progression etc.

I feel appraisals with team leaders will discuss professional continuing professional development. I'm hoping A-EQUIP will support emotional needs.

I am attending a follow up group session next week which I think will cover more detail about revalidation; I am unsure as yet. I have my appraisal with my manager, someone else who is also trained in A- Equip. This will be separate from the supervision group work.

Line managers could use this model to meet with staff and give them time to be heard and foster positive relations

No preparation required. No formal note taking. No duplication of issues normally covered in PDR. For example training requirements etc.

Staff will feel valued by the A-Equip supervisor but I doubt this will enhance a feeling of value from management. Many of my colleagues have taken early retirement because of the increased demands and limitations of the service.

I don't feel I have used the process to identity professional development needs - there are other systems in place to focus on this aspect of my job.

I'm not clear yet as to whether PMAs will be involved in carrying out investigations into adverse events in the way that SoMs were; and if so, what effect that might have on the relationship with a PMA

Empowering and enabling
There are early indications that the combination of acknowledging and working supportively with the whole of the person of the midwife and focusing on their agenda results in a sense of greater control and power, and enables the supervisee

to arrive at their own plans, solutions, and decisions about managing work-related issues, especially regarding their professional development.

The supervisory discussion was very supportive and enabling and strategies to manage negative issues were discussed.

I am aware of my professional development needs and it is more empowering to come up with those for myself rather than be told what is needed.

The process has enabled me to focus on elements which I had not previously considered to be relevant to revalidation.

Feel encouraged to take a more managerial role in day to day workings of ward and unit as a whole to help it run better. Encouraged to attend audits and case study sessions on unit.

It is a model I like-I like to be in control and have the chance to self-reflect with an experienced colleague who can give valuable feedback if needed- or ask the right questions.

Less formal meeting. But informative in its content. I like the fact that I can dictate the subjects/ topics covered

This was my first session and revalidation was not discussed but I am empowered to such an extent that I feel my suggestions and ideas for professional development will be supported

Suggestions for improvement

The timing of this survey was very early in the application of A-EQUIP to midwifery supervision so, some of the respondents commented they did not know how provision of A-EQUIP supervision could be improved. Nevertheless, several suggestions have been offered, including the carrying over of some of the most useful features of previous supervision model:

To keep supervision as it was

As long as we continue to be supported I feel the model will work well

I think the education and QI aspects could be addressed via appraisal

That paid time must be given to be away from the unit to have the meeting. An endeavour to protect meal breaks and support finishing shifts on time

It is allowing staff to take time out for an hour for themselves-

annually could be too infrequent possibly

24 hour access in case of emergency situations.

Potentially to contact an A-EQUIP supervisor at any point should I have a particularly stressful or emotional case. Not waiting for the next routine meeting where appointment slots may be full.

Mandatory roll out.

I wonder if it should be a regular feature i.e. every 6-12 months. I wonder if people will request it as that suggests you need it and need to come up with something significant.

A sample of revalidation paperwork and examples of what the content needs to be. Group revalidation paperwork help.

Teaching from someone about relaxation and meditation and doing them

given more time not enough time, more time needed

Loss of complex care planning by the PMA role and to come back to Midwives. Yet support in this remains which is reassuring.

My concern is that there little that demonstrates advocacy for women and this should be strengthened

I needed more notice to prepare and would benefit from another session now that I understand it more

I feel that this will be invaluable to midwives. Having protected time to do it is great providing the unit isn't crazy busy and you can't be released.

the groups that were picked were all of similar professional backgrounds and grades. I wonder if having different skill mixes in the groups will encourage more open discussion that may benefit the unit. although I'm aware that this is not necessarily the right forum for this kind of discussion.

On call POM… Concerned about 24/7 support

Really liked that in the older model quite a lot of the shift coordinators were also SOMs - so you were never far from one on shifts. Would be good to know in the new model who the advocates are and that the supportive and positive presence is still going to felt on shifts.

I regret the loss of the more experienced practitioner who was able to view issues from a professional perspective and not one of the employer.

Help could be given with the practical steps required to fulfil training needs

I think the group sessions are very good, the individual sessions may need some form of record keeping as many issues can be covered that may require further action and evaluation.

I am a very grounded person. I feel, however, I can see that many would value and use this role. I do think that this undertaking is a very big responsibility for the supervisor. I feel that an hour would be insufficient.

it would be beneficial to be allowed work time to have the review. This would give an indication that the employer valued the supervisory role and purpose

[A-EQUIP can be improved] With use and further input from national bodies.

I found that meeting with the PMA in a small group situation with colleagues from my team allowed us to bond and promoted a closer sense of team identity. But due to the practicalities of the job, it's very difficult to get us in the same place at the same time. Building this protected time into future working rotas would be invaluable, both on a personal and professional level in that the team (which is newly-established) would become more coherent with a shared sense of worth and purpose.

I appreciated the opportunity to take protected time for the process. As so many things th ese days seem to be squeezed in without notice in a random (and inevitably fleeting) free few minutes, it made me feel valued by my PMA that she organised our meetings to fit my timetable.

Encouraging to know the new role of PMA exists and hold the key elements that Supervision did

Summary

Despite time limits, 39 responses were received from supervisees who had experienced A-EQUIP supervision with freshly trained PMAs who had also been experienced SoMs. The responses contained several comments which were clustered into themes:

Prior hopes and expectations: 59% reported that they knew very little about the new model of midwifery supervision and entered A-EQUIP with an open mind and some with curiosity. Comments about hopes and expectations were about their continuing support at professional and emotional level, that supervision would continue in some format, and that useful features of the previous supervision model would be retained.

What's the difference? This was a superordinate theme containing the subthemes:

"No difference" mainly based on experiencing supervisors as excellent regardless of model of supervision, and on the availability of factors such as appraisal and continuing professional development matters through the previous supervision arrangements.

"The character of difference" contained elements about the management of the supervisory relationship and professional boundaries in ways that were effective, efficient and meaningful without being so formal and directive as to be experienced as distancing and onerous. The emphasis of A-EQUIP on the whole of the midwife's person (not exclusively practice), wellbeing, and support complemented the lower level of formality well and facilitated a sense of being listened to, valued and emotionally supported.

Psychological self-care: As one participant commented, the new model of

supervision contained more elements of counselling. The emphasis is on a different, more supportive and less evaluative professional relationship and supervisory process facilitated openness to sharing heavy emotions ("offloading"). Some respondents reported relief, restoration and increased motivation to seek supervision again, not just for clinical problems but for its broader benefits.

Emerging clarity in roles: manager/ supervisor: The change towards a more supportive supervisory relationship seems associated with participants drawing distinctions between the role of a clinical supervisor vs a manager, the former offering support with clinical practice and its impact on the midwife, the latter taking care of appraisals and arrangements for continuing professional development. Some participants suggested that the relational element of A-EQUIP could be useful to managers in approaching staff management and facilitating a sense of staff being valued.

Empowering and enabling: Participants reported feeling empowered by the supervisory process to identify their own work-related ideas, solutions, plans and coping mechanisms. They evidenced this with comments that they were able to identify their own professional and career development aims rather than being told them, and one wrote that s/he had already enrolled for training following A-EQUIP supervision. Others commented on feeling encouraged to participate in other professional development and quality improvement activities such as audit and case discussions.

Suggestions for improvement: Considering how limited participants' experiences of A-EQUIP supervision was, they were forthcoming with suggestions for improvement. These included safeguarding work time to engage in supervision more frequently than once annually, having 24-hour access to supervision, strengthening the appraisal and continuous improvement processes, more advocacy for the women, the possibility for managers to also train in A-EQUIP and use it to help staff feel better valued (rather than as clinical supervision) in general and in carrying out appraisals. For some participants, more or less explicitly, there also appears to be a need to manage the impact of the loss of the previous model and salvage the best of what it provided or substitute it appropriately in A-EQUIP to minimize the sense of loss. The addition of teaching relaxation techniques as part of wellbeing promotion was also suggested.

2.2 Interviews with recently trained PMAs

Findings

Limitations and interpretation

There are some significant limitations of this part of the evaluation: the model has not had chance to become fully developed or embedded in practice, the research methods were designed to be implemented in a short amount of time, the number of respondents was small, and respondents were mostly from one geographical region. These findings should, therefore, be interpreted with caution and treated as representative of and contributing to a range of emergent views and hypotheses about how the model might be more generally received and implemented.

Experience of training

Motivations for involvement

Supervisors had various motivations and reasons for attending the A-EQUIP training. Some of these were related to their current supervisory roles; having seen the benefits of previous supervision for both women and midwives, and enjoying their current supervisory role.

Respondents indicated that not taking part in the training could be viewed as a threat to continued involvement in supervision. They were keen to continue to use training and expertise and maintain positive working relationships; to 'hang on to supervision'. One respondent stated that, although being reluctant to lose the previous model, they did not want to 'get left behind'.

There was an element of wanting to help the new model work, and viewing being involved in the pilot as a good opportunity (for the Trust and the individual) to help shape the future of supervision through their mutual 'leading from the front'. There was a common desire to promote the benefits of A-EQUIP for midwives: to prevent services being run by managers and numbers, rather than understanding the strains that midwives are under. Others were attracted by the restorative element of the new model; wanting to ensure that A-EQUIP would provide the best for midwives. One respondent stated that they were put forward by their Trust.

Anticipations

It was broadly anticipated that the proposed A-EQUIP model would meet midwives' needs. Respondents that considered themselves to be well informed about the bridging programme and the proposed new model of supervision (A-EQUIP) were generally enthusiastic about seeing how restoration would form part of the new system, and hoped to ensure that the remuneration and perceived value of supervisors would be retained under the A-EQUIP model.

Respondents also highlighted that they had very few expectations, as a result of very little information being provided about the model and the bridging programme in

advance. They were interested to see what elements of previous model were to be retained.

Some hopes for the training included: the anticipation of detailed frameworks for how individual Trusts would make use of the A-EQUIP model, the PMA role and the A-EQUIP model. Midwives were also equally interested in 'how' to embed such elements in practice. One respondent anticipated that it would be a lot of work to undertake the pilot.

Regarding the details of the model some hopes included: that it would encompass all things that midwives themselves value about supervision (the 'real principles' upon which supervision was initially founded). These aspirational facets comprised: support and nurture rather than investigation of 'issues', and scope for positive impact from restorative supervision.

Duration and content

Respondents particularly enjoyed and valued the elements which were orientated toward restoration. This seems to have been to the detriment of other aspects of the training: other elements of the A-EQUIP model (personal action for quality improvement and education and development) "may have been covered, but that didn't come out to me" because "we were all talking about restoration."

It was felt that there was a strong focus on restorative clinical supervision, but the other elements of the A-EQUIP model felt more like works in progress and there were "no real answers" to the questions that were asked about them. One trainee stated that she was not convinced that she had learned anything new from the QI and Education and Development days of the course. Restoration was the primary focus of the programme and, related to this; greater time on the other elements of the model would have been beneficial. In contrast, one trainee noted that restorative supervision was emphasised and stipulated that this was, in actuality, necessary: she perceived that personal action for QI and education and development would emerge from effective restoration. This was echoed in how others articulated their perceptions regarding the combination of the three individual elements of the A-EQUIP model within an instance of supervision.

Some respondents considered that the course focused on what supervisors were already doing (i.e. restorative supervision), rather than explicating how PMAs would fulfil the QI and Education and Development aspects of the PMA role. As discussed later, however, other respondents found the restorative supervision new and exciting.

One respondent reported learning how to undertake a one to one interview within the PMA training programme, a component which was noted to be absent even from the PoSoM course.

There was some criticism about how the current supervisory role was portrayed: refuting the importance of highly valued existing elements of current supervision. One respondent stated that the overarching message from this first day was that "there was nothing special about supervisors," despite having given "so much of

ourselves" as supervisors, this was now inconsequential and to simply be swept aside.

The pre-course information pack and the booklet were identified by a trainee as useful learning resources offered reassurance that she was "doing it right."

There was concern about the speed of the implementation and the evaluation; PMAs felt that there needed to be time given to embed learning and to undertake "all the background" work that would allow the model to be rolled out successfully in Trusts. Respondents also felt that their ability to provide meaningful feedback for the evaluation was compromised by the lack of time to try the model in practice.

The course was largely considered informative. Although one trainee thought it would have been better if explication of the model and its background were longer, another thought explanation of forthcoming legal changes was unnecessary.

Strengths

Peer learning and information sharing were underscored as vital components of learning. Respondents commonly highlighted the positive experience of having been paired with another Trust for training and the value of being able to share experiences and ideas ('core strength of the training'; fostering collaborative working and information sharing). Larger groups were seen to be more beneficial.

The restorative element of the course was described as 'brilliant' particularly the experiential element; the group restoration sessions were described as being 'highly successful'.

One trainee noted that, while it was initially a shock that the focus was not on the 'how', this was, ultimately, beneficial given that all units work so differently and each unit would, therefore, need to tailor the model in order that it best work for them. Another stated that as they progressed as PMAs to undertaking their own restorative sessions (in individual and group sessions) then the real value of this approach became apparent.

Areas of possible improvement

For one respondent communication with all of the pilot Trusts would have been beneficial and was notable for its absence.

It would also have been beneficial to link the model much more closely to its role in appraisal and revalidation as this would, undoubtedly, support PMAs in "advertising" it to midwives. The lack of awareness and understanding of midwives about the A-EQUIP model and the responsibility felt by PMAs to address this issue has clear resource implications for PMAs.

Again, the speed of implementation was seen as a problem regarding short time period between finishing the training, going out and undertaking PMA sessions and then being expected to feed-back on how this had 'gone'. Additional restorative

group sessions would have been beneficial in order that they might have embedded their learning before putting it into practice.

One respondent noted that the training concentrated on what they were already doing, rather than providing particular direction in explicating how PMA's would fulfil the quality improvement and education and development aspects of the PMA role. Another respondent stated that more time afforded to the other elements of the A-EQUIP model (beyond restoration) would be necessary in future iterations of the course. One trainee would have liked greater clarification as to the role and the expectations of the PMA, including where the PMA 'fitted' in the midwifery world. One respondent pointed out that there might also be other elements of the PoSoM training, which could be usefully and successfully integrated into the A-EQUIP course.

Adaptations for new supervisors

The following comments were offered by respondents to describe how the bridging programme might be adapted for new supervisors that have not undergone prior training.

Given that SoM training gives the midwife opportunity to observe and develop relationships within all strata of local midwifery practice, future courses need to give thought to how this will be achieved for PMAs who are trained without existing experience as SoMs.

Those who might attend a PMA course without existing skills as supervisors would need the full restorative element which those in the bridging programme had received. The leadership programme would need to be longer in duration than the time currently attributed to quality improvement and education and development in the bridging programme.

The course was informative and with an appropriate duration and content for those with existing leadership skills. Existing knowledge of and skills in navigating internal clinical governance structures and processes meant that the relatively little time given to covering "leadership" (QI and education and development) on the course was not detrimental, but someone who was not already a supervisor, could not undertake the same course and be an effective practitioner.

While initially believing that the A-EQUIP model was totally different to the existing model of supervision, one respondent mentioned that it will require many existing skills as a supervisor in order to enact the role of the PMA effectively. It was important for PMAs to have existing supervisory knowledge. Knowledge of clinical governance, referral pathways, and educational opportunities is integral to supporting midwives' practice and development under the current and the A-EQUIP models of supervision.

While the supervisory team, who are now PMAs, would be a useful information sharing resource for a PMA who had not had prior supervisory training, there would be a significant knowledge gap if large numbers of PMAs without existing knowledge and skills were integrated into the team. The respondent questioned whether such a gap would be sustainable.

Outcomes of training

One respondent was impressed with the restorative element of the training, explaining the iterative way in which the tutor was able to develop and embed their learning. She did feel, however, that (as with any learning) it would be further developed once put into practice.

A trainee reported lots of personal support and development; highlighting in particular, tools to help her manage her work-life balance which she was not expecting. Another positive outcome for this trainee was improved perceived competence and confidence to manage difficult situations.

Whilst some respondents considered the restorative element to be what they were already doing, the restorative element was entirely new for at least one respondent. Another said that the key thing which came out of the training was the restorative element of clinical supervision. They found that the training had changed their everyday interactions with people.

Thoughts about the model

Weaknesses and limitations

One observation was that the model was being interpreted in different ways at different sites which gave rise to concerns that they had the "wrong understanding". Some considered that the training disregarded valued elements of existing model. For instance it was reported that it is "too easy" to be isolationist and think that "our way is the only way." Within the existing supervisory model, the LSA network also provided an important source of information sourcing and sharing; there was doubt as to whether such networks could feasibly be coordinated, resourced or maintained once the LSA was dissolved.

One of the trainees noted that there were large portions of existing supervisory practice which were not covered under statute, and there would be an ongoing need for such elements of supervision, which they would strive to continue to deliver. For example, the provision of mandatory training to midwives. She saw such responsibilities as part of the PMA role. There was also a reported lack of clarity as to whether women would be able to contact a PMA directly if a resolution could not be reached with the midwife responsible for their care.

There was some lack of clarity about how the A-EQUIP model might fit into other structures and processes. One respondent felt that the personal action for quality improvement and the education and development elements fell much more clearly

under the jurisdiction of appraisal and revalidation than they aligned with restorative clinical supervision.

Because PMAs have no authority and no budget, they can only empower the individual midwife to go to appraisal having considered and identified their learning needs. Fulfilling these needs falls outside of the remit of restorative clinical supervision. Appraisal was considered the place for education and development. Given that there is no funding attached to A-EQUIP, it may be that the individual midwife will need to advocate to management to resource her ideas or training needs as this would fall outside of the remit of the PMA. One Supervisor participant stated that:

> *The restorative supervision part of the model is something I wholeheartedly embrace …The other two elements 'sit' better within a managers role and are already part of the annual appraisal. Consideration should be given to the PMA role providing restorative clinical supervision only'*

As discussed below, not having a written record of supervisions, would make it difficult to evidence the efficacy of restorative supervision.

One respondent identified time pressure as a limitation, she felt that two instances of A-EQUIP supervision per year was ideal, rationalising that, in practice, midwives might receive one per year. Another pointed out the limitations of the restorative approach within interactions "Restoration is not counselling and that is where things get difficult. If you aren't getting anywhere with restoration, then it becomes a signposting service."

Midwives are currently required to undertake a mandatory annual review. However, within the new model, it would be necessary to accept that not all midwives would see a PMA. Most midwives would come "when they needed it," but also asked "how do you get to those ones that don't even know that they need it?"

It is vital that midwives were properly informed about the changes to supervision, noting that the vast majority of midwives still do not know what is proposed, or how things will change. This issue is clearly linked to ensuring that PMAs and managers have a clear understanding of the A-EQUIP model.

Record keeping and communication through the LSA
There is a robust system for the documentation of supervisory practice within the existing model and such records are stored in an LSA repository which covers multiple Trusts. It is believed that this will be archived on the 31st March 2017 and no longer accessible. This provided an important source of and repository for information; informing what practice issues to refer on and to where. It is also an important tool for looking up information on, for example, agency midwives, or new

midwives taking up employment and any practice issues that there may have been in the past.

PMAs are not encouraged to retain documentation of their efforts and encounters in pursuit of the restoration of midwives. This is, in part, to promote confidentiality. However, there was also a perceived need to ensure that a robust referral system and instruments that would facilitate this were in place in order to fulfil all three elements of the A-EQUIP model. One respondent had some reservations about the lack of record keeping which were about remembering events at supervision, therefore to be able to "jot things down" might provide an important reference point, not just for her in future meetings with a midwife, but also if another PMA took up the supervision of the same midwife at a later date.

There was a keenness to maintain links with PMAs in other Trusts as the LSA network was felt to have provided an invaluable source of information and best practice sharing within the statutory supervisory model. Without such communication with the wider LSA network of supervisors the potential to share best practice will also be impeded. Respondents were hopeful that, in the future, networks of PMAs would develop between Trusts in order to share best practice and to consider potential improvements.

Measurement, monitoring and benefit realisation

For some, it was very clear that there would be a need to evidence the benefits of restorative supervision, or the programme would be ripe for cost cutting measures and simply "cease to exist."

If midwives attended for appraisal and revalidation better prepared as a result of restorative supervision, then this would be a measurable outcome. However, as it is not compulsory for midwives to attend a PMA session prior to revalidation and this only happens every three years, the benefits of A-EQUIP may not be measurable in this way.

Reduced sickness and absence rates had been one mechanism through which health visiting had shown the benefits of restorative supervision, but a trainee felt that, within her Trust, sickness rates were already low.

A key issue for one PMA, on which she noted that the A-EQUIP model would "stand and fall," was confidentiality. For example, if a manager had noted an issue with a particular midwife and asked the PMA to meet with her, she would then likely expect feedback as to "what had been put in place" as a result of the restorative experience. If managers do not perceive that their concerns are acted on and alleviated, then they will not see the benefit or continue to invest in the programme of restoration.

As discussed earlier, the timing of the bridging programme relative to the evaluation was considered inappropriate. A respondent asserted the impossibility of evaluating a programme that has not really been experienced: You simply would not know if A-EQUIP were a success until it had been embedded for a few years.

The short duration of the bridging programme and its evaluation highlighted a need to continue to audit and evaluate the model to ensure its effectiveness. Another respondent perceived that management would also see this as necessary. However, the present pilot and evaluation needed much more time to be effective.

Strengths

Having time out to talk and someone to listen was a rare opportunity for midwives to feel heard and very much what midwives need and want. A trainee was delighted that restoration is central to the new model as this is, in her understanding, a central part of what she has always done as a supervisor. It was welcome to be giving midwives the "tools to be more mindful in their practice" and the skills to "prioritise" their work and be more "care focussed." It was considered that the A-EQUIP model fostered a meaningful approach to collaborative working.

There was some confidence that the A-EQUIP model would elicit positive change. It was perceived that the model was proven to increase staff satisfaction, improve communication and reduce staff sickness and that such benefits were required in midwifery contexts. It was understood that midwives would feel supported to identify the gaps in their own practice and feel empowered to be the "best midwives they could be" as a result of restoration, in particular. It was felt to be enormously beneficial for midwives to have someone to talk to who understood what they were going through, but in a confidential environment. It was asserted that some midwives had come to see the statutory model of supervision as punitive because they felt that supervisors were looking for gaps in their practice, rather than to support them.

Midwifery is both stressful and demanding and, consequently, having the time and space to sit and talk with someone professionally provided a sense for midwives that they were valued, in addition to having potential practice benefits. Having the opportunity to think about stressors in practice or personal life, fostered the ability to identify and change the root cause of such stressors.

Under the statutory model of supervision, one PMA asserted that only "certain" women were reached, and often those who were not most in need of care. With a focus on the midwife taking personal responsibility in advocating for all women, it was felt that there was potential for midwives to reach and to improve care for all women. Using restorative supervision also permitted 'seeing' below the surface level of the individual midwife and exploring what was 'really going on' from their perspective. It was understood that midwives would be given permission to "care

about themselves" as well as the women and families under their care. Not completing a written record of the supervision (unless an escalation is made) was considered an important element in allowing midwives to talk freely. However, this should be understood in the context of other concerns about the lack of documentation for other purposes (such as evidencing whether the model is working as intended or expected)

Difference to current model

Within the A-EQUIP model the focus was very much on midwives and, within this model, there would be an emphasis on PMAs and supervisees "learning together" rather than being "supervised" *per se*; a reorientation of supervision from the dual foci of women and midwives, to midwives alone. Under the statutory supervisory framework, mothers and women contact supervisors, but under the A-EQUIP model, only midwives will. Should a woman require care outside of guidelines, the onus would then be on the individual midwife to advocate and orchestrate such care needs and preferences. Individual midwives were asserted to have the same scope to deliver care outside of guidelines as supervisors by one respondent.

The emphasis in the existing model was on "protecting the public" and "advocating for women", whereas, in actuality, "all midwives should do this" not just SoMs. This represents a reorientation of supervision from a more 'top-down' approach to something more 'bottom-up', within which the primary focus is the midwife herself. However, concerns were expressed that women seemed absent from the model, which demonstrates a contradictory understanding to respondents that saw the model as being able to reach more women.

One respondent had doubts about the public protection element of the new model, stating that in many ways, the A-EQUIP model was similar to the existing model of midwifery supervision. The primary distinction between the two models was identified as follows:

> "supervision is more about protecting the public, restorative supervision will do some of those things, but midwives will have to choose to engage with it."

Implementation

Topics discussed in this section relate to Experiences of implementation during the pilot and perceived implications for national roll out and continued delivery of the A-EQUP model after statutory supervision ceases.

Access to supervision

One respondent recognised that it was trickier than they initially anticipated finding time to meet with midwives and this presented the issue of who would cover the work of midwives while they attended PMA sessions. Finding time had been challenging even with protected time and a very small caseload of midwives during the pilot. Given that the A-EQUIP model is not coming with additional funding, there

will need to be consideration of how to 'backfill' work, if PMA sessions are delivered within working time. They did not anticipate that protected time was likely to continue after the pilot.

The problem would be compounded if PMAs were to lose their protected time and have to find cover for their own clinical work, in addition to the midwives that they were seeing. One respondent stated that it was planned that there would be regular protected time (one day each month) for PMAs to undertake A-EQUIP supervisions and that PMAs would (for that first year) continue to receive their financial honorarium. They hoped that such a minimum would be maintained under the A-EQUIP framework, but that the need for supervision would be determined based on the midwife's individual need, in the first instance. There was a great deal of concern that midwives would have to attend clinical supervision in their own time as midwives cannot just "down tools" in the middle of a shift, especially if they are caring for a woman in labour.

Given the unpredictability of the demands on the service, one suggestion to achieve 'protected time' would be through advance planning of off duty and ensuring that 'sessional PMAs' would be able to cover the clinical work of midwives and provide PMA supervisions as appropriate to the needs of the midwives/Trust around their substantive roles. If management do not protect the time for PMA supervisions, then it was felt that the programme would "fall flat on its face." At one Trust a proposal for a single, full-time, remunerated PMA was being developed. A full time PMA could run a "drop in surgery" which would allow them to, simultaneously, undertake administrative work and be there to respond to the supervisory needs of midwives as required. However, it was identified as a possibility that such a resource would also need to be protected from 'abuse' by midwives.

Many harboured significant reservations about how adequate resources, time in particular, would be found to facilitate the model. It was strenuously and repeatedly highlighted that time should be protected so that midwives did not have to attend PMA sessions in their own time and that midwives should have opportunity to self-refer. There was some divergence reported between those trained as PMAs and "senior management" as to how many PMAs might be required. One Trust was in a process of surveying existing supervisors to gauge interest in becoming PMAs; this could determine the number of PMAs. It was recognised that there would be a need for additional PMAs if A-EQUIP was to be rolled out to other clinical areas. It was also noted that there could be a lack of incentive to volunteer as a PMA if additional remuneration is removed.

One issue that was highlighted was that providing access was not necessarily adequate to ensure supervisory contact; "hard to reach midwives", which might need restoration the most, would not necessarily access A-EQUIP. Most midwives

would come "when they needed it," but it was also asked "how do you get to those ones that don't even know that they need it?"

Requirements/facilitators, and barriers/risks

Requirements/facilitators:

It is considered highly necessary for existing PMAs to maintain the momentum behind A-EQUIP, to retain their own enthusiasm as well as to inspire it in others.

Midwives training as PMAs would need to feel that the role was worthwhile and there would need to be some sense that PMAs were taking responsibility for and contributing toward improvements in midwives' experiences and in care.

The pilot had focussed on a single clinical area and will, from the 1st of April, need to respond to the needs of midwives in all areas.

In some Trusts PMAs considered that they were lucky to have the support of senior management, but if there are sites that are more resource focussed and, potentially see A-EQUIP as a cost saving measure then the success of the programme might be in jeopardy.

Barriers/risks:

There was some anxiety at the lack of established training programme and the uncertainty as to when HEI's would be able to deliver this.

It had been recognised that there were a number of practical issues (group sizes for supervision, possible caseloads, regularity of contact, models of contact) in relation to operationalising, which were still uncertain. PMAs had taken responsibility for disseminating information about the changes to midwives as they felt there were varied levels of understanding.

As an employer led model, unsupported by a statutory framework, it was perceived by several respondents that there were very real risks that the A-EQUIP model would not be taken forward if there was no 'buy in' from Chief Executives, or an understanding of where the money would come from, for example to train PMAs or to support ongoing evaluation of the model. The lack of remuneration for PMA's was also described as potentially problematic. Several respondents explained that removing the honorarium which SoMs receive could be considered as devaluing the work they do. However, this view was also contested, as another respondent stated that financial remuneration was a relatively new addition to supervision, and that there would be engaged and enthusiastic midwives who would want to develop and further their clinical role regardless of whether they were remunerated or not.

Currently there is no fixed plan for the operationalisation of A-EQUIP from the 1st of April and this is, in part, intentional; in order that Trusts can implement A-EQUIP in

accordance with localised needs and preferences. Midwives (as opposed to PMAs) were not seen to be well versed in the new model and there was much concern amongst midwives about "who they would call," what would happen without the 24 hour on call, who they would refer women to and a general feeling that they just "did not get it." It would be the dual responsibility of the Trust and the existing PMAs to ensure that midwives were well briefed as the changes approached. One respondent felt that they had been doing this and awareness was increasing, but she was not sure how PMAs would continue to resource this if they no longer had protected time for supervision after the 31st of March.

Others were concerned about the lack of knowledge amongst midwives with respect to the new model and understood that the onus would be on the PMAs to publicise, promote and sell the need for restoration to the midwives. For one PMA, this "selling" of A-EQUIP felt somewhat at odds with the midwife led approach advocated by a restorative framework. Variable levels of knowledge which midwives had about the proposed changes to midwifery supervision could potentially lead to varying levels of uptake of the PMA service.

Having been involved in a pilot site, respondents were concerned for areas which had not had such an opportunity as they were somewhat "in the dark." It would take time to embed the model once it was fully rolled out. Despite still not being 100% clear on all of the details, pilot sites were in a privileged position compared to other Trusts that were "in a void." In the event of a gap in the provision of supervision, 'starting again' would be so much more difficult, especially given resource constraints within Trusts.

While there may be good intentions to make time for A-EQUIP, a busy shift might constrain the enactment of such good intentions. Question marks were seen to hang over whether midwives should self-refer or whether PMA time should be planned into off-duty.

The speed of the change to the new model was discussed. One PMA perceived the change to be happening at such a pace that it constrained her ability to really understand what its benefits and limitations might be because she simply had not had the time to "get into the role."

How will supervision work
Some respondents recognised that time would be required to embed new practices. It would only be through continuing to deliver and evaluate the A-EQUIP model that they would be able to arrive at a more concrete understanding of how A-EQUIP would look and work in their particular Trust.

Ensuring mutual understanding and managing expectations were seen to be critical elements of delivering the model; to establish the "ground rules" and to ensure that

a "supervisory contract" was in place was felt to be the foundation of effective supervision. Expectation-setting regarding the level of support the PMA can offer is an integral part of the "contract setting" at the initiation of the PMA supervision.

Another critical element of the model is to allow the midwife to speak "openly and honestly". One PMA found it challenging to let midwives take the lead in restorative clinical supervision as she was not accustomed to doing so within her existing supervisory practice. She also found it a challenge to "sit on her hands" and not write anything down. Problems were foreseen in not having a written record of supervisions, notably that it would be tremendously difficult to evidence the efficacy of restorative supervision. There is, therefore, a balance to be struck in how much and what paperwork needs to be developed and completed to support the A-EQUIP model.

There was some concern about losing the information resource of the LSA network. There were doubts as to whether such networks could feasibly be coordinated, resourced or maintained once the LSA was dissolved. Participants were keen to maintain links with PMAs in other Trusts after the change to the A-EQUIP model as the LSA network had proved an invaluable source of information and best practice sharing within the existing supervisory model. There were hopes that, in the future, networks of PMAs would develop between Trusts in order to share best practice and to consider potential improvements.

Management issues

As previously discussed; management buy-in, provision of adequate finance, resources for training and development, and the need to demonstrate value of the model are significant areas to consider for relationships of management with the model.

Whilst some protected time was maintained for the pilot, this might change in forthcoming years. In order to mitigate such a risk it was thought necessary for PMAs to maintain an audit trail of the ways in which A-EQUIP improves outcomes (reducing sickness, improved outcomes from education interventions, etc.).

It was felt that, for the PMA role to work, it would need Trust 'buy in' and time to "build up" their learning from 'doing' the PMA role. The emphasis is on the idea that individual Trusts would make use of and operationalise the model in different ways. One respondent expected that those "at the top" had a clear and detailed plan for A-EQUIP, but she now knows this not to be the case and, in many ways, feels that she has been left with more questions than answers from the bridging programme.

One Trust, however, was reported as being 'really enthusiastic' about implementing the model and ensuring its success; management were particularly interested in the potential of the model to also be rolled out to nursing. However it is initially

received, ongoing negotiation within the Trust regarding the practical details of the PMA system would be required, including numbers of PMAs and how they would work with specific clinical areas (e.g. rotating or a fixed allocation).

One PMA highlighted that stress experienced by midwives could be caused through interactions with management. PMAs should, therefore, not be the line manager of the midwives they support. It was stated that managers can forget the emotional strains of the work that midwives do, due to their focus on the numbers. It would empower midwives to take responsibility for their own conduct and it may avoid managers having to "go down the HR route".

One respondent reported that they would find it difficult to move to the new PMA role. She felt it necessary to maintain "close contacts with clinical governance" and she did not want to put her practice support role "to one side." She was conscious that, as a supervisory team, they had implemented many education and quality improvement initiatives within the Trusts, which had benefitted midwives and improved care. Related to the years of hard work and positive outcome you cannot "just say it will all be gone as of March 31st"

How to link elements of the new model

Restoration was considered to be at the "heart of the model", and the other elements of the A-EQUIP model were felt to emerge from the discussions which might take place in a PMA session. That is, the QI and education and development of the model emerge from 'doing' restorative supervision. In particular, the QI element was felt to "not be about big dynamic changes," but the "ground level." In this way, it was felt that restoration was a means of helping midwives to see their personal role in QI by identifying things that they could "do there and then." All three elements were linked, in 'doing' restoration. Personal action for quality improvement and education and development were described as emerging from restoration, as a form of counselling, if "done right."

Importantly, it was felt that it might not be appropriate for some midwives to consider quality improvement or education and development needs if they had a significant emotional burden from practice. When midwives were sufficiently 'restored' then the PMA would be able to draw out their ideas about QI and their associated learning and development needs. Thus, PMA sessions (both in frequency, content and mode of delivery – individual or group) could and would work best when tailored to the needs and preferences of the individual midwife.

It was highlighted that the midwife was enabled to identify ideas for service improvement which, in turn, would lead to the identification of education and development needs which might support her in achieving her improvement ideas. In order to ensure that midwives could fulfil the 'quality improvement' and 'education and development' elements of the A-EQUIP model, it was key that the PMA had

strong signposting skills and knowledge of where midwives might be signposted. It is notable that signposting does not form an explicit part of the current A-EQUIP model.

For some, there was a more active role proposed for PMAs; there was an understanding that the QI and education and development elements of the A-EQUIP model should be "taken forward" by the PMA as after being highlighted in an A-EQUIP supervision.

Alternatively, as discussed above, there was some confusion as to whether QI and professional development should be included with restorative supervision or would more appropriately be located within appraisal and revalidation processes. There is also conflict, or areas of refinement to be worked out, regarding documentation, as there are issues of confidentiality to be considered as well as clinical governance, quality improvement and professional development. It is not clear what role education and development has in appraisal rather than supervision, or how this role might be managed within these separate processes.

Managing critical incidents (emotional and practice)
In terms of managing critical incidents highlighted in supervisory sessions, there might be a need to escalate an issue and such a referral would be assisted by existing knowledge of referral pathways as a supervisor. The PMA would need to make decisions about referral routes and processes. If practice issues were revealed in a PMA supervision, this would need consideration as to whether the midwife needed referral for educational training, or if this was a clinical practice referral within the internal governance structure.

One respondent considered the potential problems that would be encountered if midwives did not access supervision; they acknowledged the difficulties in engaging people, but noted that "if people don't access the PMA and are involved in an incident, then this would form part of the conversation." As mentioned above, one respondent felt it necessary to maintain "close contacts with clinical governance" and she did not want to put her practice support role "to one side."

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** for whom being the lead PMA was their substantive role, rather than in addition to it. 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'**

Areas where the pilot has been trialled

Most pilots were carried out in specific clinical areas. There would be a need for additional PMAs if A-EQUIP is to be rolled out to all clinical areas beyond that which were the focus of the pilot. One Trust focused their use of the model on the postnatal area due to it being particularly pressured and a source of significant complaints regarding the communication and attitude of midwives. In another pilot, the clinical area selected was "notorious" for being a high pressure area, and midwives working in this area regularly experience stress. As such, their supervisory

team felt that there was good potential for seeing improvements in care as a result of the use of A-EQUIP in this clinical area.

However, in one Trust, the PMAs had focused on specific groups of midwives to support, rather than clinical areas. Interestingly, it was noted from experiences of training that mixing midwives from different clinical areas had been seen as particularly valuable in group sessions, encouraging information sharing and a broadening of awareness amongst midwives.

Summary and discussion

A number of motivations for attending the training were associated with trainee's current roles as supervisors. Therefore, it is not clear how new PMAs would be recruited.

Most participants particularly valued the restorative clinical supervision element of the programme. However, some thought that this was what they were currently doing. The quality improvement and learning and development aspects of the training were largely described as lacking in terms of learning achieved and guidance for implementation. Learning about how the PMA role fits in to the wider working environment could also be an area of welcome development.

Peer learning and information sharing were considered vital components of the learning process. Indeed, a wider learning collaborative might have been beneficial.

The PMAs brought a large amount of experience of supervision and knowledge of all strata of midwifery practice to the training, which would need to be allowed for in the training of prospective completely new supervisors. Knowledge of clinical governance, referral pathways and educational opportunities is integral to supporting midwives' practice and development under the current and the A-EQUIP models of supervision. There could be a significant knowledge gap if large numbers of PMAs without prior experience were integrated into the team.

Whilst some respondents thought that flexible implementation was necessary to fit with the local needs and context, the lack of consistency was seen as leading to confusion and uncertainty. The model was seen as being too dismissive of important elements of the existing supervision; for instance provision of training and communication, networking and information provision through the LSAs. There was also lack of clarity regarding how the new model fits into existing structures and processes, such as revalidation and appraisal.

There are significant concerns about the role of documentation of supervisory sessions. Different functions of the model require different approaches to documentation, and this was currently being worked out at a local level. Restorative supervision promotes not making notes about the session to maintain confidentiality and encourage openness. However, quality improvement and learning and

development requires record-keeping. Concerns about practice that will, under the new model, require referral to management might also be an area that would benefit from records of the session.

There was a concern that important functions of the LSAs would be lost and require replacement. No suggestions were provided for how the information repository function might be replaced. Indeed it is unlikely that this will be required under the A-EQUIP model. However, the sharing of information and best practice could be replaced through collaborative networks between Trusts.

The role of measurement, monitoring and benefit realisation was considered crucial for the sustainability of the model, in particular to maintain buy-in and investment in the model by managers and senior executives. For instance, if managers do not perceive that their concerns are acted on and alleviated, they will not see the benefit or continue to invest in the programme of restoration.

In terms of strengths of the model, the focus on restoration of the midwife was considered to be a much needed development. It could be beneficial for midwives to have someone to talk to, in a confidential environment. It was considered that whilst currently only some women are reached by supervision; under the A-EQUIP model, the focus on the midwife could ensure that the benefits of supervision reach all service users. However, there were also, somewhat contradictory, concerns raised that women seemed absent from the model.

Access to supervision was a key concern of the PMAs; time would need to be protected for PMAs and for midwives. There were significant doubts that A-EQUIP supervisions could otherwise be achieved within allotted work time. The numbers of available PMAs was also a concern, particularly considering that potential PMAs have not yet been identified and training beyond the bridging pilot programme was not yet in place. Yet another access issue concerned the non-mandatory nature of supervision under the A-EQUIP model; there could be 'hard to reach' midwives that do not attend supervision. In such circumstances, their non-participation could become a punitive mechanism should a practice issue come to light. A fear of reprisal for non-attendance would, undoubtedly, shape the perception and experience of the supervisory relationship.

Respondents noted a lack of awareness or understanding of the proposed changes by midwives. It was recognised that it is currently the recently trained PMAs and their managers that are being relied upon to spread information about A-EQUIP. It was a concern that non-pilot sites were still largely unaware of the proposed changes.

Mutual understanding and expectations between PMAs and midwives were seen to be important aspects of delivering the model. Knowledgeable PMAs were also felt to

be vital, in order that they might be able to effectively signpost midwives as required. There was some lack of clarity about how the elements of the model were to operate together in practice. For instance, some PMAs considered quality improvement and education and development to fall under appraisal and revalidation rather than restorative clinical supervision.

The model would need to be supported, both operationally and financially by management within Trusts. This will need to be negotiated on a case-by-case and, to some extent, on an ongoing basis. Empowering midwives to take responsibility for their own conduct will create new relationship dynamics with management, and it is useful to note that relationships with management can currently be seen as a significant source of stress for midwives. Some PMAs saw the new model as promoting a more active role for supervisors, whilst others saw it as reducing their involvement in organisational matters.

Limitations of the evaluation

The evaluation has several significant limitations, which should be taken into account when interpreting the findings. Notably, the timing of the intervention and deadlines for evaluation outputs where particularly compressed; meaning that there was limited opportunity to put the training into practice and for respondents to feel that their contributions were as fully considered as they would like.

There were a large number of relevant stakeholders including provider organisations, service-users and contributors to the design and implementation of the bridging programme that it was not feasible to fully engage with due to the available timescale.

The trainee PMAs were from services that were selected regarding their enthusiasm and preparedness to implement the bridging programme, and therefore the representativeness of these services could be in question. In addition, the selected services implemented the new model in specific sites within their services; again limiting the potential representativeness of findings.

The PMAs experience of implementing the A-EQUIP model was running in parallel with the pre-existing statutory model. Therefore, it is not yet possible to evaluate how well the training has prepared them for the transition to the provider-led model. The pilot implementation that occurred during the evaluation was also supported with protected time for PMAs that would not necessarily be available over the longer-term or in relation to scaling-up.

There were rapid changes being made to the bridging programme, training materials and A-EQUIP model of midwife supervision up to and including the time of writing this report; indeed the evaluation was designed to inform this rapid development.

Therefore, various elements of this report might represent situations that have since changed. Importantly, however, the topics and themes raised within this report will have currency regarding ongoing evaluation, for instance to determine the extent to which specific concerns have been addressed.

Conclusions

The skill set of Supervisors of Midwives (SoMs) who are part of the AEQUIP pilot may not be applicable to all future (i.e. non-pilot) A-EQUIP practitioners. Participants commented that they will require many of the existing skills they have developed as a supervisor of midwives in order to enact the role of the PMA effectively.

It was considered important by many of the participants for PMAs to have existing supervisory knowledge, adding that knowledge of clinical governance, referral pathways and educational opportunities is integral to supporting midwives' practice and development under the current and the A-EQUIP models of supervision.

Perceived deficits in the A-EQUIP bridging programme

Some respondents requested training of longer duration and covering all aspects in more detail. Specific reference was made to teaching QI in one day being very challenging. It is important in future iterations of the course, for more time to be afforded to the other elements of the A-EQUIP model (beyond restoration) so that the focus on 'restorative' sessions is not at the expense of, or to the detriment of, the other aspects of the model. The evaluation team understands that the recommendation for future A-EQUIP bridging programme training is for an additional contact day and that the face to face contact will be supported by an e-learning package (currently under development with Health Education England). This may go some way to addressing the concerns regarding successfully delivering the content within the timeframe.

The element of the model that was best received and understood is restorative clinical supervision (RCS). Most participants (both supervisor and supervisee) particularly valued and enjoyed the RCS element of the programme. However, other elements such as embedding within appraisal and revalidation processes and incorporating development needs were not as effective, with little or no application identified within the model. Integration with the wider working environment and relationships with management were identified as areas where development would be welcome.

There was a perception that little or no attention was given to how quality improvement and learning and development elements would work alongside, or relate to, the restorative element of the A-EQUIP model.

Perceived impact and outcome on the A-EQUIP Midwife and their supervisee
Restorative clinical supervision sessions

The change in emphasis to a different, more supportive and less monitoring-focused professional relationship and supervisory process facilitated openness to sharing emotions. For some participants, this resulted in relief, restoration and increased motivation to seek supervision.

There was some lack of clarity amongst both supervisors and supervisees about how the A-EQUIP model fits into other structures and processes such as internal clinical governance and revalidation.

Midwifery is both stressful and demanding and, therefore, having the time and space to sit and talk with someone professionally, provided midwives with a sense that they were valued in addition to having potential practice benefits. Having the opportunity to think about stressors in practice or personal life fostered the ability to identify and change the root cause of such stressors.

Awareness of A-EQUIP and comparison with statutory supervision

One theme that emerged from the surveys and interviews, particularly from the supervisees, was the comparison of the A-EQUIP model with statutory supervision. Concerns were raised that there are significant and 'vital aspects' of statutory supervision and of existing supervisory practice which are not covered within the A-EQUIP model. These specifically included potential loss of access to a 24 hour support service (for both women and midwives) '*in case of emergency situations*' *(Supervisee participant).*

As discussed above, there was concentr regarding the loss of the information resource provided by the LSAs. Doubt about the public protection element of the new model and the loss of responsibility for complex care planning with the PMA role was also highlighted as a concern.

Concern of sustainability

Concern was expressed regarding the sustainability of the A-EQUIP model, given the pressures and clinical demands that are currently a feature of maternity services. Some participants identified that finding time to meet with midwives was more challenging than initially anticipated. This raised the issue of covering the work of midwives while they attended PMA sessions.

Given that the A-EQUIP model is to be a cost-neutral intervention, there will need to be consideration of how to 'backfill' work, if PMA sessions are delivered within working time. During the pilot, most (if not all) PMAs had received protected time in accordance with what they would normally have as SoMs. However, they did not anticipate that this was likely to continue after the pilot.

Given the unpredictability of the demands on the service, suggestions to address this issue included employing full-time PMAs and holding drop-in surgeries. Consideration should also be given to how midwives who are employed outside of

maternity service providers (such as midwives who work within Higher Education Institutions) can access this process if they do not have an NHS contract.

Attention should be given to how A-EQUIP will be supported and resourced within the Trusts to ensure a consistent approach and establish the model as an integrated part of midwifery.

Time scales of the pilot and evaluation period

A consistent theme from both supervisor and supervisee participants in the evaluation process was the time frame in which participants were expected to undertake the A-EQUIP training and implement this before being asked to participate in the evaluation process. Many participants felt that they were unable to comment about the actual impact and effectiveness because of this. This was compounded by the fact that some pilot sites had not completed their programme of training until the 28th February 2017 and had therefore very limited opportunity to try to implement this.

This is also a limitation of the evaluation. It is therefore recommended that further evaluation takes place once the PMA training has been rolled out and begun to be implemented across England, in order to give a truer sense of the impact and effectiveness of this approach.

Considerations for future implementation of the A-EQUIP model

Early feedback from pilot sites and participants suggests that the restorative supervision aspect of the A-EQUIP model is appreciated by both supervisors and supervisees. Supervisees recognised this was also a feature of statutory supervision experiences and not unique to A-EQUIP, and attributed it to the supervisor's relational capabilities rather than to any supervision model.

Considering the limited experiences of A-EQUIP supervision, participants were forthcoming with suggestions for improvement. These included:
- safeguarding work time to engage in supervision more frequently than once annually
- having 24-hour access to supervision
- strengthening the appraisal and continuous improvement processes
- more advocacy for the women
- the possibility for managers to also train in A-EQUIP and use it to help staff feel better valued in general and in carrying out appraisals (rather than just as clinical supervision).

Respondents also suggested the need to manage the impact of the loss of the previous model.

The findings of the evaluation of the pilot suggest that there are mixed views about the A-EQUIP model, but generally these are supportive of a bridging programme to replace the support that was provided by Supervisors of Midwives through the framework of statutory midwifery supervision. As such, the pilot findings, limited as they are by the time constraints, would suggest that this model may go some way to achieving the aim of *providing a continuous improvement process that builds: personal and professional resilience, enhance quality of care and supports preparedness for appraisal and professional revalidation.*

How this wider organisational culture change is to be achieved requires further clarity and evaluation. As stated earlier in the report, organisational power is an important element in creating service improvements; managerial support is a key enabler to help facilitate bottom-up change. It is likely that PMAs and supervisees could find themselves in a position of powerlessness, or have their QI efforts undermined by managers. The new model of supervision, therefore, requires supportive conditions in the wider environment.

Suggestions for implementing A-EQUIP

At this early stage in the programme implementation, the following suggestions (provided by participants) should be viewed as initial hypotheses that have yet to be tested or refined. However they could form part of any considerations for the future development of the PMA role.

- *Give yourself time*
- *Be organised and plan ahead*
- *Be responsive to the unit / area*
- *Ensure that midwives know what A-EQUIP is about*
- *Encourage those individuals who are enthusiastic about the new role to undertake this*
- *Time should be provided and protected by the Trusts for 'doing' and training in the PMA role*
- *Consideration of a lead PMA*
- *PMAs should not be the line manager of the midwives they support*
- *Midwives should be able to choose their PMA*
- *Consideration should be given to caseloads / ratios*

Appendix 1: Supervisor Survey

1. A-EQUIP Midwifery Supervision Survey to Supervisors

Thank you for completing this survey. It is part of a greater evaluation plan commissioned by NHS England to obtain information about your experience, views and opinions as a midwifery supervisor who has attended the A-EQUIP course.

Your participation is voluntary. You can opt out before you submit your replies by closing the browser. However, once you have submitted the survey, it is not possible to withdraw as submissions cannot be linked to respondents in order to protect anonymity. The information you provide in this survey will be presented in aggregated form, for example, as frequencies, to NHS England to inform decision making about clinical supervision training in future. It may also be presented at site level for cross-site comparisons.

The questions are about A-EQUIP training. Some provide multiple choices with space for text comments while others ask for text.Please click on one of the options provided to indicate your preferred answers. Please also use the space after the questions to provide more details. At the end of the survey, there are demographic questions that will help us understand the context of your replies.

If you have any questions about this survey, please contact Manya Merodoulaki, supervision consultant: G.Merodoulaki@sheffield.ac.uk, or the midwifery lead, Rachel Jokhi: Rachel.Jokhi@sheffield.ac.uk

If you are happy to continue, please click the button at the bottom of this screen.

1. As a result of this course, I know how to function effectively as an A-EQUIP supervisor.

○ Not at all

○ A little

○ Sufficiently

○ Completely

○ Unsure

Please tell us how the training is influencing the supervision you provide?

2. As a result of this course, I know how to deliver effective restorative supervision using the A-EQUIP model.

○ Not at all

○ A little

○ Sufficiently

○ Completely

○ Unsure

Please give more details

3. As a result of this course, I understand how to prepare midwives for their professional appraisal and revalidation using the A-EQUIP model.

○ Not at all

○ A little

○ Sufficiently

○ Completely

○ Unsure

Please explain how you will do this:

4. As a result of this course, I know how to foster continuous quality improvement in midwifery practice using the A-EQUIP model.

◯ Not at all

◯ A little

◯ Sufficiently

◯ Completely

◯ Unsure

Please give more details:

[ ]

5. How much has this course improved and/ or expanded your understanding of practicing as a midwifery supervisor?

◯ Not at all

◯ A little

◯ Sufficiently

◯ Completely

◯ Unsure

Please give more details

[ ]

6. Considering your training as POSOM supervisor, please describe how your A-EQUIP training has shaped your knowledge and practice as a midwifery supervisor.

[ ]

7. What were your hopes and expectations at the start of A-EQUIP?

[ ]

8. To what extent has the A-EQUIP programme met your hopes and expectations?

9. How could the A-EQUIP training programme be improved

10. In what year did you complete your training to be a statutory midwifery supervisor?

11. What is your pay band?

12. Please use this space for any other comments you wish to make

To help us understand your experience of A-EQUIP better, we will also carry out interviews. We invite you to take part in these. If you would like the opportunity to expand further on your answers and to contribute to clinical supervision in your profession, please contact Victoria Earley who is conducting the interviews and can provide more information about the interviews: nra05vse@sheffield.ac.uk

You have now completed this survey. Thank you!

Appendix 2: Supervisee Survey

NHS England Survey for Clinical Supervision in Midwifery

A-EQUIP Midwifery Supervision Survey to Supervisees

Thank you for completing this survey. It is part of a greater evaluation plan commissioned by NHS England to obtain information about your experience, views and opinions as a midwife supervised by an A-EQUIP trained supervisor. As you may know, NHS England is planning changes to the statutory supervision of midwives and A-EQUIP is the new model of supervision. One of the aims of the A-EQUIP course is to train supervisors to facilitate restoration and resilience in the midwife. This means that supervisors will help to manage the emotional effects of the work on the midwife to continue to provide a high quality service. Your supervisor has attended this course, and we are contacting you to find out about your latest experience of supervision.

Your participation is voluntary. You can opt out before you submit your replies by closing the browser. However, once you have submitted the survey, it is not possible to withdraw as submissions cannot be linked to respondents in order to protect anonymity. The information you provide in this survey will be presented in aggregated form, for example, as frequencies of reply, to NHS England to inform decision making about supervision training in future and for cross-site comparisons.

The questions are about A-EQUIP supervision. They are multiple choice with space for text comments. Please click on one of the options provided to indicate your preferred answers. Please also use the space after the questions to provide more details. Demographic questions at the end of the survey will help us understand the context of your replies.

If you have any questions about this survey, please contact Manya Merodoulaki, supervision consultant: G.Merodoulaki@sheffield.ac.uk, or the midwifery lead, Rachel Jokhi: Rachel.Jokhi@sheffield.ac.uk

1. To what extent has your experience of A-EQUIP supervision been different to your prior experiences of supervision?

- ○ Not at all
- ○ A little
- ○ Sufficiently
- ○ Completely
- ○ I'm unsure

Please give more information about your observations of the difference/s and how you feel about them.

2. One of the aims of the A-EQUIP course is to train supervisors to facilitate restoration and resilience in the midwife (this means that your supervisor will help you to manage the emotional effects of the work on you so that you can continue to provide a high quality service). Have you experienced this during A-EQUIP supervision?

◯ Not at all

◯ A little

◯ Sufficiently

◯ Completely

◯ Unsure

Please give details of how your supervisor performs the restorative function of supervision.

[   ]

3. To what extent do you feel prepared for professional appraisal and revalidation as a result of A-EQUIP supervision?

◯ Not at all

◯ A little

◯ Sufficiently

◯ Completely

◯ Unsure

Please explain how supervision is helping you to work towards appraisal and revalidation

[   ]

4. To what extent do you feel that your A-EQUIP supervision has enabled you to identify your continuing professional development needs?

○ Not at all

○ A little

○ Sufficiently

○ Completely

○ Unsure

Please give example/s of what personal action you will take towards continuous professional development

[ ]

5. Considering your POSOM supervision, has A-EQUIP helped you develop additional knowledge, skills and resilience as midwife? Please give details:

[ ]

6. Did you hold any hopes or expectations about the new (A-EQUIP) supervision? Please give details:

[ ]

7. To what extent have such hopes and expectations been met?

[ ]

8. How might A-EQUIP supervision be improved?

[ ]

9. What other observations have you made of A-EQUIP supervision in relation to your experiences of the existing model of supervision?

[ ]

10. How long have you been practising midwifery?

11. Please use this space for any other comments you wish to make:

To help us better understand your experience of A-EQUIP supervision, we will also carry out interviews. We invite you to take part in these. If you would like the opportunity to expand further on your answers and to contribute to supervision in your profession, please contact Victoria Earley, who is conducting the interviews, for more information about the interviews:

mra05vse@sheffield.ac.uk

You have now completed the NHS England Midwifery supervision survey.

Thank you for your participation.

Appendix 3: Quality Improvement Resources

PH556X: Practical Improvement Science in Health Care: A Roadmap for Getting Results
https://www.edx.org/course/ph556x-practical-improvement-science-harvardx-ph556x-0#!

Free online course

Lesson 1: What is the Science of Improvement?

Lesson 2: Applying the Model for Improvement

Lesson 3: Introduction to Measurement for Improvement

Lesson 4: Practical Tools that Support Improvement (including a seven-piece toolkit)

Lesson 5: Using Systems Principles to Spread Improvement

Lesson 6: Working within Interprofessional Teams

Lesson 7: Implementing Sustainable Improvement Work

The Point of Care Foundation: Patient Centred QI
https://www.pointofcarefoundation.org.uk/our-work/quality-improvement/what-we-offer/

Our QI work draws on two well-established methodologies, Experience-Based Co-Design (EBCD) and Patient and Family-Centred Care (PFCC). Both methods have been evaluated and published in peer-reviewed journals and have been proven across a range of care settings

We offer four core one-day QI modules. Taken together these create a complete patient-centred service design programme which can be delivered over a 6-month period.

We can also offer these modules and follow-up tailored coaching support in bespoke combinations depending on your needs

Module 1 – Discovery

Understanding your patients' and families experience and creating urgency for change

This module equips you with a range of options to truly understand patients' and families' lived experience of care, which is the starting point for creating urgency for change and identifying goals for improvement. Our approach is practical and supportive, recognising that different techniques are suited to different circumstances. These include:

- Interviewing, filming and editing patient interviews for use in co-design

- Patient shadowing and its use in quality improvement

- Structured observations of care and their use in improvement

- Process mapping the care experience and emotional mapping

Module 2 – Definition

Setting out your goals in improving patients' and families' experiences

The second step in the improvement journey is to translate what you have learned about patients' and families' experiences into tangible goals for improvement. In this module we cover

- Scoping your improvement project

- Interpreting patient experience data

- Creating goals for improvement – what are you trying to achieve, what can you change that might be an improvement, how will you know a change is an improvement

- Carrying out small tests of change

- Designing, collecting and interpreting measures for improvement

Module 3 – Delivery

Getting your patient centred quality improvement project off the ground and keeping it on track

Understanding the current care experience and the improvements you want to make is only half the battle. Many health and care staff tell us that they struggle to translate this insight into tangible improvements. Within this module we help you to:

- Create functional and resilient improvement teams, ensuring that the key people are engaged in your project.

- Understand who are the key influencers in your organisation who can help or hinder your improvement project

- Create a strategy for managing your stakeholders, that will maximise your impact and influence and the ultimate success of your project

- Establish a simple, time-efficient, low bureaucracy system for getting and keeping your project on track

Module 4 – Design

Working inclusively with your team and service users to create ideas for improvement, prototype and test them

The final step in the QI process is to translate your understanding of the current care experience into tangible improvement ideas and tests of change. This module equips you with a range of skills to do this:

- Generating ideas for improvement

- Prototyping improvement ideas

- Running and refining small tests of change

- Setting up, running, and facilitating co-design groups with staff and service users

Quality Improvement in Healthcare: the Case for Change
https://www.futurelearn.com/courses/quality-improvement

Free online course

Why is quality improvement in health and social care systems so difficult? Why is it so challenging to bring in new and better ways of organising health and social care services?

Many reasons have been put forward: lack of money; lack of appropriate or complete knowledge; excessive and perhaps unnecessary regulations; and entrenched professional opinions and interests.

This free online course suggests that the main reason is complexity. Health and social care systems are inherently complex, with many interconnected activities and processes, and thus difficult to measure, analyse, change and improve.

Understand how to overcome complexity and lead quality improvement in healthcare

Over six weeks, this course will help you to understand some of this complexity, showcase some simple methods that can help you improve the quality of care services and point towards resources that can be used to further your knowledge and understanding.

By the end of the course, you will:

- learn about what quality and process improvement entails, especially in a health and social care setting;

- understand how quality improvement can lead to better outcomes for staff and organisations, including customers and/or patients;

- gain confidence to start and lead a quality improvement project within your organisation;

- learn how to access additional support and get others to join in;

- understand how quality improvement can help you deal with the complexity in organisational systems, using health and social care systems as a case study, and how to improve in key areas while not worsening others;

- and understand how systems modelling and analytics techniques support quality improvement initiatives.

Institute for Healthcare Improvement. Open School Online Courses:

- **Individual professional subscription** for a single professional user

- **Professional group subscription** for organizations interested in bringing the courses to staff and monitoring their learning

- **Academic group subscription** for learning institutions interested in tracking student or resident course usage

Costs:
http://www.ihi.org/education/IHIOpenSchool/Courses/Pages/SubscriptionInformation.aspx

Improvement Capability: Curriculum Overview

http://www.ihi.org/education/IHIOpenSchool/Courses/Documents/Course%20Catalog.pdf

QI 101: Introduction to Health Care Improvement (1 hr, 15)

Lesson 1: Health and Health Care Today

Lesson 2: The Institute of Medicine's Aims for Improvement

Lesson 3: Changing Systems with the Science of Improvement Course Objectives

After completing this course, you will be able to:

1. Describe common challenges for health care systems around the world.

2. List the six dimensions of health care, and the aims for each, outlined by the Institute of Medicine in 2001.

3. Explain the value of improvement science in health care.

QI 102: How to Improve with the Model for Improvement (1 hr, 30)

Lesson 1: An Overview of the Model for Improvement

Lesson 2: Setting an Aim

Lesson 3: Choosing Measures

Lesson 4: Developing Changes

Lesson 5: Testing Changes

Course Objectives

After completing this course, you will be able to:

1. List the three questions you must ask to apply the Model for Improvement.

2. Identify the key elements of an effective aim statement.

3. Identify three kinds of measures: process measures, outcome measures, and balancing measures.

4. Use change concepts and critical thinking tools to come up with good ideas for changes to test.

5. Test changes on a small scale using the Plan-Do-Study-Act (PDSA) cycle.

QI 103: Testing and Measuring Changes with PDSA Cycles (1hr, 15)

Lesson 1:

How to Define Measures and Collect Data

Lesson 2: How to Use Data for Improvement

Lesson 3: How to Build Your Degree of Belief over Time

Course Objectives

After completing this course, you will be able to:

1. Describe how to establish and track measures of improvement during the "plan" and "do" phase of PDSA.

2. Explain how to learn from data during the "study" phase of PDSA.

3. Explain how to increase the size and scope of subsequent test cycles based on what you're learning during the "act" phase of PDSA

QI 104: Interpreting Data: Run Charts, Control Charts, and other Measurement Tools (1hr, 30)

Lesson 1: How to Display Data on a Run Chart

Lesson 2: How to Learn from Run Charts and Control Charts

Lesson 3: Histograms, Pareto Charts, and Scatter Plots

Course Objectives

After completing this course, you will be able to:

1. Draw a run chart that includes a baseline median, a goal line, and annotations.

2. Describe the difference between common and special cause variation.

3. Explain the purpose of a Shewhart (or control) chart.

4. Apply four rules to identify non-random patterns on a run chart.

5. Explain when and how to use the following tools for understanding variation in data: histograms, Pareto charts, and scatter plots.

QI 105: Leading Quality Improvement (1 hr, 15)

Lesson 1: The Four Phases of a Quality Improvement Project

Lesson 2: Change Psychology and the Human Side of Quality Improvement

Lesson 3: Working with Interdisciplinary Team Members

Course Objectives

After completing this course, you will be able to:

1. Describe how to lead an improvement project through four key phases.

2. Identify and describe the components of IHI's Framework for Spread.

3. Apply strategies to assess and overcome resistance to change.

4. Apply strategies to work effectively with interprofessional colleagues.

QI 201: Planning for Spread: From Local Improvements to System-Wide Change (1 hr, 15)

Lesson 1: How Change Spreads

Lesson 2: Tactics for Spreading Change

Lesson 3: Case Study in Spreading Innovations: Transforming Care at the Bedside

Course Objectives

After completing this course, you will be able to:

1. Describe how change spreads according to Kurt Lewin and Everett Rogers.

2. Assess the likelihood that a new idea will spread.

3. Apply IHI's Framework for Spread to spread an innovation across an organization

QI 202: Achieving Breakthrough Quality, Access, and Affordability (1 hr, 45)

Lesson 1: Two Mustangs

Lesson 2: How to Make Complex Systems Fail

Lesson 3: Solving Problems in Complex Systems

Course Objectives

After completing this course, you will be able to:

1. Explain why system complexity requires us to take a methodical approach to system design, operation, and improvement.

2. Explain how the absence of this methodical approach will cause complex systems to fail predictably.

3. Propose specific applications of this methodical approach to the design, operation, and improvement of health care

QI 301: Guide to the IHI Open School Quality Improvement Practicum (1 hr, 15 + project time)

Lesson 1: Putting Quality Improvement into Practice

Lesson 2: Starting Your Project

Lesson 3: Looking for Changes? Try Cause and Effect Diagrams

Lesson 4: Spell Improvement with P-D-S-A

Lesson 5: Data: Collect and Display

Lesson 6: Summarizing Your Project

Course Objectives

After completing this course, you will be able to:

1. Use the Model for Improvement to plan and carry out a quality improvement project in your local health care setting.

2. Develop a charter to guide you through a clinical quality improvement project.

4. Develop a cause and effect diagram to help you understand your theories for accomplishing your aim.

5. Use multiple Plan-Do-Study-Act (PDSA) cycles to test changes in a health care setting.

6. Construct a run chart that tracks measures over time for your improvement project.

7. Create a summary report that summarizes the learning from your project.

NHS Scotland Quality Improvement Hub
http://www.qihub.scot.nhs.uk/education-and-learning/qi-e-learning.aspx

Quality Improvement Modules (mostly 1 hr each)
In this section you will find e-learning resources to support you on your Quality Improvement learning journey. These resources have been designed for staff working across NHS Scotland.

- o Introduction to Healthcare Systems

- o Introduction to Quality Improvement Methods

- o Introduction to Measurement for Improvement

- o Lean in Healthcare

- o Knowledge into Practice in Healthcare

- o Building a Quality Culture (45 min)

- o Leading Quality Improvement

- o Creativity and Innovation in Healthcare

- o Introduction to Data Analysis

- o Measurement for Improvement - Presenting Data (45 min)

- o Evaluating Quality Improvement (30 min)

- o Introduction to Our Purpose and Values

- o Introduction to Statistical Process Control (30 min)

- o Introduction to Quality and Quality Improvement

- o Skills for Improvement: Measurement Module A – Planning (90 mins)

- o Skills for Improvement: Measurement Module B – Analysing data

Improvement Academy: Yorkshire and Humber AHSN
http://www.improvementacademy.org/training-and-events/bronze-quality-improvement-training.html

Gold

Train the Trainer: Gold Level 'Train the Trainer' is designed to provide trainees with the knowledge and materials to deliver the AHSN IA's one-day Silver Level Training for individuals. This competency-based 2-day programme provides training in the following:

how to deliver the AHSN IA's one-day Silver QIT;

how to mentor and support staff who have chosen to undertake the optional silver project.

After completing the 2-day training and subject to assessment, Gold Level 'Train the Trainer' trainees are registered as an AHSN IA-approved Silver Level trainer and are expected to deliver the 1-day silver training to colleagues in their organisations. They are also expected to either:

mentor and support any of their silver trainees who choose to undertake the optional silver project,

OR

train colleague(s) in their trust to carry out the mentoring/support role to trainees who complete a project.

Silver
Silver Level for Individuals: this training offers an introduction to Quality Improvement and provides examples of methods, tools and techniques that engage multidisciplinary teams in quality improvement initiatives. Attendance is contingent on completion of the Bronze Level on-line training and all trainees receive a certificate of attendance. Attendees are encouraged to carry out an optional follow-up improvement project with the support of their organization.

Silver Level for Teams: this new training course has been designed for teams that are ready and keen to work together to improve aspects of their services, but who lack the skills and confidence to get started. The training takes a practical focus and throughout the day teams will be supported to develop their own project. Attendance is contingent on completion of the Bronze Level on-line training and all trainees receive a certificate of attendance. Teams are encouraged to carry out an optional follow-up improvement project with the support of their colleagues.

Additional Silver training

A number of non-core face-to-face courses are currently available to help individuals and organisations to develop their capacity to support improvement activities, including 'Understanding and Reducing Variation in Healthcare', 'Achieving Behaviour Change for Patient Safety', and 'The Science of Improvement' .

Bronze (free online)
This Bronze training can be used on a 'stand-alone' basis, or as entry to more advanced training. For example, in Yorkshire and Humber the Improvement Academy offers 'silver training for individuals' and 'silver training for teams'. You can find out more about Silver training in Yorkshire and Humber by clicking here. (*Trainees from outside the Yorkshire and Humber should consult your local training or improvement team to see what opportunities are available in your area*).

The content and materials for the Bronze on-line modules are based around material originally produced for the '1000 Lives Plus Campaign' by NHS Wales.

Content of the Bronze Training

A key objective of the training is to help participants understand how and why everyone has a role to play and can contribute to Quality Improvement in their work area.

Module 1: Introduction to Quality Improvement Training (5 mins)
Module 2: Quality Improvement in Yorkshire and Humber (30 mins)
Module 3: How can I improve patient care? (30 mins)
Module 4: Your Model for Improvement (30 mins)

BMJ Learning: Quality and safety in healthcare (10 hours)
https://learning.bmj.com/learning/course-intro/quality-safety-healthcare.html?locale=en_GB&courseId=10035821

Free online

About this course

Within this course you will find a series of learning modules which will provide you with a good foundation in some of the theory behind patient safety as well as structured information about how to carry out a successful quality improvement project. Whilst the information is centred around doctors, it is equally applicable to all healthcare professions.

Learning outcomes

After completing this course you should know:

- The importance of patient safety in healthcare

- How systems can compromise patient care and are the key to making it better

- The impact of Human Factors on quality and safety

- The importance of leadership in improving care

- How to design an intervention to a problem

- How to engage others in your interventions

- How to undertake measurement within quality improvement

- What the model for improvement it and how it is used in quality improvement.

Modules in this course

Quality and safety in healthcare - introduction to patient safety

> Understand what patient safety is and how it is defined

> Appreciate what error is and its impact

Appreciate the extent of error and harm

Understand what is meant by quality and its relationship to safety

Be able to learn from other industries.

Quality and safety in healthcare - systems

Be able to understand what a system is and how it relates to health care

Be able to appreciate that the majority of errors that occur in health care are related to systems and not workers

Be able to understand what makes a system reliable and safe

Know how to understand a clinical case from a systems perspective

Be able to understand what latent conditions are.

Quality and safety in healthcare - human factors

Understand what is meant by human factors

Understand what factors affect error

Appreciate what affects human performance

Demonstrate examples of the influence of human factors

Employ strategies to reduce error.

Quality and safety in healthcare - clinical leadership

Understand the importance of clinical leadership within the healthcare system

Be able to recognise good leadership skills and good leaders

Know where to begin with developing your clinical leadership skills

Understand team working and how to apply clinical leadership skills within your team

Understand how to apply clinical leadership skills in order to improve clinical services and patient care.

Quality and safety in healthcare - measurement

Be able to understand the key components of quality that can be measured

Understand the different steps involved in measurement

Define the term statistical process control

Know how to create and understand run charts.

[Quality and safety in healthcare - intervention design](#)

Understand the importance of intervention

Be able to describe the criteria important to developing an intervention

Be able to design an appropriate intervention to a problem.

[Quality and safety in healthcare - stakeholder relations](#)

Appreciate what stakeholders are

Understand why stakeholder relations are important

Understand the psychology of individuals

Engage the relevant stakeholders.

[Quality and safety in healthcare - improving the quality of clinical care using the Model for Improvement](#)

Understand and apply the principles of healthcare quality to clinical care

Appreciate the relationship between audit and quality improvement

Be able to write an effective aim statement for your improvement project

Feel confident to apply the Model for Improvement to clinical dilemmas

Know how to construct your own Plan-Do-Study-Act (PDSA) cycles in practice

[Quality improvement activity for appraisal and revalidation in the United Kingdom](#)

Describe what quality improvement activity is

Describe what the requirements are for revalidation in this area

Identify the key principles of any quality improvement activity

Recognise that quality improvement activity is about making changes to improve the quality of health care.

[Teamworking: a user's guide](#)

Different theories of teamwork and how teams develop and work together

The different roles required in an effective team

How to get the best out of your team, both as a team member and as a leader.

Alison
https://alison.com/learn/quality-management

Six-Sigma

TQM

Statistical Process Control

Appendix 4: Supervisor Interview Prompts

Training

- Why did you put yourself forward for the training?
- What did you anticipate of the training?
- How did you experience the programme?
  - Weighting of elements within the programme
  - Duration and content of programme
    - Practical application/training the trainers noted as absent in the surveys – what do you make of this?
  - How has your knowledge expanded as a result of the course?
    - Extent such expansion might be shaped by existing supervisory experiences.
    - How has the course changed knowledge of each of the elements of the A-EQUIP model? (restorative clinical supervision, personal action for quality improvement, and education and development).
  - How might the programme be improved?
  - Where there any key strengths of the programme?
- How do you think the programme might need to be adapted to train midwives who may not have undertaking POSM/have supervisory experience?
- What do you now understand of the role of the PMA?

Perceptions of the new model

- How is A-EQUIP different from the current model of midwifery supervision? What value is it adding?
- What is the purpose of the model?
- Are there particular strengths or shortcomings of the model in your opinion?
- What do you understand by restoration?
- What is your understanding of the rest of the model incl: how the elements are weighted?

Putting the model into practice

- How do you envisage an A-EQUIP supervision playing out?
  - What shapes your priorities as to the focus of the session?
  - How will you link the elements (personal and professional development) of the model together?
  - How would you manage a critical incident within a session?
    - An emotional crisis?
    - Revelation of a practice issue?
- What practical elements will you need to consider in ensuring you can fulfil your role as a PMA?
  - Are there any perceived barriers/facilitators to implementation? How will you manage this?
    - Ratios?
    - Being an advocate for A-EQUIP
    - Trust resources (making time, training and financing the role)
- Proposed regularity of contact is once per annum, for one hour: what do you make of this?