Supervision for midwives: moving from a statutory to an employer led model for Scotland

Final Report of the Transitioning Supervision of Midwives Taskforce

26 January 2017
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1. **Purpose of this paper**

This paper outlines a new employer led model of supervision for midwives and advice for NHS Boards, who are the Local Supervising Authority (LSA) in Scotland, on the changes required of them by 31st March 2017 (subject to legislative change).

1.1 **Background**

The Nursing and Midwifery Council (NMC) and the United Kingdom (UK) Government response to the Morecambe Bay Inquiry has been to propose the separation of midwifery supervision from regulation. Regulation is a matter reserved to the UK Parliament and the Department of Health (DH) in England will take forward the legislation required to underpin this change; which is anticipated by 31st March 2017.

Legislative change will mean that the LSA; alongside the statutory roles and functions associated with its responsibility for governing the standard of midwifery practice on behalf of the NMC will cease to exist.

Ministers in all four countries have agreed with the NMC decision and to the development of a professional, employer led model of supervision for midwives which preserves the supportive, rather than regulatory aspects of supervision in practice.

2. **Regulation and four country working**

There is a Ministerial commitment to four country working to regulate healthcare professionals. This ensures clarity and common standards for patients, straightforward staff mobility across the UK and the recognition of continuing professional development for healthcare practitioners. Four country working ensures a more robust regulatory system which applies consistently across the UK, while being sensitive to each country’s needs.

The NMC is the independent regulator for nurses and midwives in Scotland, England, Wales and Northern Ireland and was established by the UK Parliament under the Nursing and Midwifery Order 2001 (the Order). Governing legislation for the NMC (the Order) is reserved to the UK Parliament; however the regulation of new groups of healthcare professionals and those regulated since the Scotland Act 1998 is devolved to the Scottish Parliament. Further to proposed legislative change which will separate supervision and regulation, it becomes the responsibility of each of the four devolved administrations to develop and implement an employer led model of supervision for their country.

3. **Statutory supervision of midwives – the current model**

3.1 **Purpose**

The purpose of statutory supervision is to protect the public from substandard midwifery practice, through a regulatory supervision model which assures the standard of supervision and practice on behalf of the NMC.
3.2 Governance
Accountability for the statutory supervision of midwives is delegated to the Local Supervising Authority (LSA) in law through the Nurses and Midwives Act 1902. The Nursing and Midwifery Order (2001) gives the NMC power to establish standards for midwifery supervision and to monitor that LSAs are meeting those standards. Specific requirements for supervision and LSAs are outlined in the NMC Midwives Rules and Standards.1

3.3 The Local Supervising Authority (LSA) and functions
Individual health boards in Scotland are designated in law as the LSA, with delegated accountability for governing the standard of midwifery supervision and practice of all midwives within their geographical area. The Accountable Officer is the NHS Board Chief Executive. This supervision applies to midwives intending to practice regardless of employment arrangements; so those working in NHS Boards, higher education or other organisations, and the independent sector.

The LSA functions and infrastructure are independent from and additional to NHS Board employer responsibilities for public protection, including staff and clinical governance. Specific LSA responsibilities currently include:

- appointing an LSA Midwifery Officer (LSAMO) to exercise the LSA functions
- appointing Supervisors of Midwives (SOMs) to enact those functions in practice
- performance management of the LSAMO or SOMs, with de-selection as required
- providing midwives with 24 hour access to a SOM to ensure their practice is consistent with the regulatory framework
- ensuring supervisors and midwives meet annually to review practice and development needs of the midwife
- investigating and if required, referring a midwife to the NMC whose fitness to practise is called into question
- ensuring that intention to practise (ITP) notifications are sent to the NMC by the annual submission date specified by the Council
- further to audit, submitting an annual report on the standard of supervision and practice in line with NMC requirements.

3.4 LSA infrastructure
As individual LSAs, the 14 territorial NHS Boards have established a consortium arrangement to facilitate delivery of the LSA functions for Scotland. The consortium is hosted by NHS Fife, with national roles appointed on behalf of all LSAs; an LSA Midwifery Officer (LSAMO) and two LSA Midwives (total 2.6WTE); alongside administrative support 0.47WTE. The LSAMO has responsibility for ensuring that the standards of supervision and practice in each LSA meet those required by the NMC.

Each LSA (Board) is responsible for training and appointing an adequate number of Supervisors of Midwives (SOMs) to enable supervision of all midwives in its geographical area; there are approximately 225 SOMs in Scotland (source LSA database). The role of a SOM is separate from and additional to an individual's

substantive role. SOMs provide 24 hour support and advice for midwives and women, through on call rotas or other local arrangements. The NMC outlines that a SOM:

- is a practising midwife with at least 3 years experience
- has successfully completed an approved programme of education for the preparation of SOMs
- meets with each midwife for whom they are a named SOM at least once a year
- has a maximum of 15 midwives for whom they are the named SOM.

3.5 Education and training
The NMC sets the standard for the preparation of SOMs. In Scotland, this is a Scottish Credit Qualification Framework (SCQF) Level 11 Post Graduate Education programme, delivered through a higher education institution. The programme lasts approximately 30 weeks, over two academic semesters.

LSAs have responsibility for ensuring that all SOMs in their area have six hours of Continuous Professional Development (CPD) per annum.

3.6 Resources
LSAs (Boards) have financial responsibility for the infrastructure and functions associated with the statutory supervision of midwives. This has been managed within existing NHS Board allocations.

Resources include an initial investment in the training of SOMs, as well as the annual recurring costs associated with the activities undertaken by SOMs. The annual recurring costs for individual LSAs includes:

- a payment to each SOM of £500 (plus on costs)
- on call payments for 24 hour access to SOM support
- CPD for SOMs
- training for new SOMs due to turnover
- the time required for SOMs to undertake their specific duties, which includes annual practice reviews, clinical incident reviews and investigations.

Annual costs also include a proportion of the salary and running costs for the national roles of LSAMO, LSA Midwives and administrative support.

The total annual recurring costs, across all Boards, are estimated at £1.14 million per annum. Non-recurring costs associated with initial investment in the preparation of Scotland’s SOMs are estimated at just over £1 million.

4. NMC changes to the statutory supervision of midwives

4.1 Background
As a consequence of investigations into complaints about maternity services at Morecambe Bay NHS Foundation Trust, the Parliamentary and Health Services

Ombudsman published *Midwifery supervision and regulation: recommendations for change.* The Ombudsman identified two key principles which formed the basis of proposals to change the system of midwifery regulation:

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

The NMC subsequently commissioned the King’s Fund Review of Midwifery Regulation in the UK, and following publication of that Review, the NMC Council agreed to remove the additional layer of regulation currently in place for midwives. This brings midwives into line with other regulated healthcare professionals by putting the regulator, the NMC, in direct control of regulatory activity.

### 4.2 Four country work led by the Department of Health in England (DH)

The King’s Fund Review highlighted positive benefits associated with supervision, in supporting the midwifery profession and supporting outcomes for women and families. Further to the NMC decision, the DH led work with the four UK Chief Nursing Officers (CNO), the NMC and key stakeholders which concluded that separating supervision from regulation should not mean an end to supervision; rather to its statutory components. UK wide principles were agreed to underpin a new employer led supervision model which would preserve the supportive aspects of supervision in practice (Annex A).

The DH submitted a proposal to the Secretary of State for Health in England which sought agreement to undertake the necessary work to transition from a regulatory to an employer led model of supervision for midwives in each country. Ministers in all four countries subsequently agreed this proposal and the UK Government began processes to take forward the necessary legislation to make the change.

The Cabinet Secretary for Health and Sport approved the establishment of a Taskforce, to take forward the necessary work to transition from a regulatory to an employer led supervision model for midwives in Scotland.

### 4.3 Legislation - amendments to the Nursing and Midwifery Order 2001

In advance of legislative change, the DH was required to consult on proposals to amend the Nursing and Midwifery Order 2001, which will be made via a Section 60 Order (the Order) under the Health Act 1999. Public consultation ran from 21 April until 17 June 2016 and there were over 1,400 responses from individuals and organisations.

The Order’s objectives are to:

- remove the statutory supervision of midwives provisions, a recommendation of the Morecambe Bay Inquiry
- abolish the NMC statutory Midwifery Committee
- enable the NMC to make some improvements and efficiencies to their general fitness to practise processes.

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4.4 What legislative change means in practice

Once the Section 60 Order is in force, the LSA; alongside the statutory roles and functions of the LSA, LSAMO and SOM will cease to exist.

Removal of this additional layer of regulation brings midwives in line with other professions and means that governance for the standard of midwifery practice will rest exclusively with employers. This includes investigation of alleged misconduct or impaired fitness to practise and referral to the NMC where required; and is consistent with current processes and requirements for nurse registrants.

Legislative change will require any organisations employing practising midwives to ensure that existing staff and clinical governance systems and processes pay due regard to midwifery.

The recent introduction of NMC revalidation for all nurses and midwives intends to provide assurance for employers and the public that registrants are fit to remain on the NMC register. Revalidation requires nurses and midwives to undertake continuous professional development related to their scope of practice, alongside demonstrating ongoing reflection and feedback from others related to this practice.

There will be no requirement for midwives to notify annual intention to practise to the NMC; or for LSAs to provide midwives with 24 hour access to a SOM; undertake annual audit; or submit a report to the NMC on the standard of supervision and practice.

It is anticipated that legislative change will be in place by 31st March 2017; therefore LSAs (Boards) should take action to prepare for disaggregation of the statutory supervision infrastructure and to ensure corporate governance with regard to midwifery practice.

4.5 Action required of LSAs (Boards) by 31st March 2017 (subject to legislative change)

In line with NHSScotland Partnership Information Network (PIN) Policies, all LSAs, in partnership, should take forward the necessary work to disaggregate the national roles of LSAMO, LSA Midwives, and administrative support. Individual LSAs should take forward work to disaggregate the existing SOM role. The current payment for SOMs is subject to National Agreement and national consideration in relation to terms and conditions. Advice will be provided following assessment and appropriate partnership discussions.

In partnership with the LSAMO, LSAs should agree a policy for the transfer and ongoing management of all electronic and paper information and data associated with the functions of statutory supervision. This will include for example: case data related to investigations into a midwife’s practice; supervisory programmes; the LSA database; information associated with LSA systems and processes; and women’s clinical records returned from independent midwives. This work should include a policy for future handling of the clinical records of independent midwives.

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4 http://www.staffgovernance.scot.nhs.uk/partnership/partnership-information-network/pin-policies/
4.6 **Actions required of NHS Boards and other employing organisations by 31\(^{st}\) March 2017 (subject to legislative change)**

NHS Boards and other organisations employing practising midwives should ensure that existing staff and clinical governance systems and processes take account of midwifery practice.

National PIN Policies provide a minimum standard of practice in employment. To comply with PIN policies, organisations should ensure that current local systems and processes also include provisions for investigating any alleged misconduct or impaired fitness to practise by a midwife, alongside processes for referral to the regulator as required (the NMC).

To ensure fair and consistent management of staff in line with current legislation and best employment practice, NHS Boards should follow the procedures for managing employee conduct or capability outlined in the National PIN Policies.

Other employers should manage midwifery practice and conduct in line with the appropriate organisational policies.

NHS Boards should ensure that women and midwives have 24 hour access to support and advice within routine organisational governance provision.

5. **Developing a professional employer led model of supervision**

5.1 **Transitioning Supervision of Midwives Taskforce**

In line with the UK principles and further to approval by the Cabinet Secretary, a Transitioning Supervision of Midwives Taskforce was established in October 2015 to oversee the development, implementation and evaluation of a new model of supervision for midwives in Scotland. The Taskforce was led by the Scottish Government Chief Midwifery Advisor on behalf of the Chief Nursing Officer (CNO), with membership including a range of stakeholder interests (Annex B). The Taskforce aimed to:

- implement recommendations from the UK wide work within the Scottish context, to ensure that Scotland has an employer led model of midwifery supervision that is fit for purpose
- mitigate any non-statutory risks created by removing the LSAMO function
- support NHS Boards to oversee the transition.

Five working groups were established, with co-chairs appointed:

- Model – led by a NHS Board Executive Nurse Director and the LSAMO
- Resources – led by a NHS Board Director of Finance and Head of Midwifery
- Standards and governance – led by a NHS Board Associate Director of HR and Deputy Director of Quality Assurance at Healthcare Improvement Scotland
- Education – led by a Programme Director at NHS Education Scotland (NES) and a Lead Midwife for Education at a Higher Education Institute (HEI)
- Evaluation – led by a Professor of Maternal Health and Associate Professor.
Whilst working within the principles agreed at UK level, the Taskforce assumptions were that any new model would align with Scottish Government policy; be co-produced with midwives and other key stakeholders; be proportionate; cost neutral or cost less; and offer transferrable learning.

5.2 The evidence base and key messages
To underpin development of a non-regulatory model, the Chief Scientist Office Nursing, Midwifery and Allied Health Profession Research Unit (NMAHPRU) was commissioned to deliver an efficient review of the international literature related to clinical supervision. Three syntheses were undertaken:

- the practical implementation of clinical supervision
- evidence for the effectiveness of clinical supervision
- barriers and facilitators to the implementation of clinical supervision.

Clinical supervision is widely considered to be an integral part of good professional practice for healthcare practitioners. While there is no universally accepted definition of the term clinical supervision, there is broad agreement over its purpose and objectives. Clinical supervision is considered to be the facilitation of support and learning for healthcare practitioners enabling safe, competent practice; and the provision of support to individual professionals who may be working in stressful situations.

Although there is a lack of empirical evidence, several key benefits were highlighted that clinical supervision offers within the clinical environment:

- improved worker retention and increased job satisfaction
- maintenance of clinical skills and quality practice
- support for supervisees in a regular and formal arrangement to discuss clinical practice
- improved communication among healthcare workers.

There is little evidence to recommend the frequency, duration or structure of supervision in practice and there is significant variation. Most studies have required voluntary participation in clinical supervision, but have strongly recommended setting engagement and ground rules.

The model which is used most frequently is Proctor’s, which consists of normative, formative and restorative functions. The restorative element has particular relevance within the context of Scottish workforce policy outlined in Everyone Matters; in that it is designed to address the emotional needs of staff; helping them build resilience levels, reduce stress and thereby improving their health and wellbeing. It is of particular benefit for professionals working constantly with stress and distress and can support staff in how they respond emotionally to the stresses of working in a caring environment. Using a restorative model in a group context gives an opportunity for reflective practice and confidence building, as well as ongoing personal and professional development.

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5 http://www.crd.york.ac.uk/PROSPERO/display_record.asp?ID=CRD42015026647
5.3 Engagement and key messages

Staff engagement

Ensuring a co-production approach, four regional events were held, providing an opportunity to directly engage with the midwifery profession and managers to test out thinking around a new model of employer led supervision (Annex C). Over 90 staff attended, including practising midwives, SOMs, heads of midwifery and managers. The events took the format of a ‘World Café’ to facilitate open discussion; after an overview of the policy context and systematic review were shared. Appreciative Inquiry was used to support the development of a new model and midwives were encouraged to envision midwifery supervision differently and positively, as well as to challenge the status quo to co-create a future model.

Thematic analysis of the output was conducted by the Model working group, which included academic representation. To provide a level of external validation, independent thematic analysis was undertaken by Scottish Government policy officials within the CNO Directorate, who were removed from the existing statutory supervision model.

Emergent philosophy and themes align with existing policies such as Everyone Matters and National PIN Policy, namely:

- supporting advocacy for women
- supporting midwives through mentoring and coaching and
- effective education and training
- supporting consistent national standards.

Underpinning a potential framework for future supervision was the belief that midwives in the best supported environments can experience relationships through a process of clinical supervision; which in turn can impact on their relationships with women and families.

Third sector, women and families

In partnership with the Scottish Government’s Ingage Team, a session was held with women’s and families’ representatives to explore ‘What matters to me’; their experience of midwifery advocacy and how midwives might better support them with decision making throughout pregnancy. Whilst supervision is aimed at professionals rather than service users, advocacy is a key feature of supporting person and family centred care and services. Eight third sector organisations (Annex E) participated in a creative session which explored the citizen experience of advocacy, where this worked well, areas for improvement and what “good” would look like.

Key messages align with existing NHS Scotland policies, such as Compassionate Connections, and include:

- Continuity of care and relationship based compassionate care
- Listening to understand

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- Understanding the wider family and social context, recognising the critical role of dads, partners and others
- Understanding the family’s right to make decisions, regardless of the outcome
- Support to equip the midwife to have difficult conversations.

**Broader stakeholders**
Members of the Taskforce had responsibility for ensuring that their constituent groups were updated as work progressed. However, the following groups were directly engaged on the emergent model so that their input could be considered: Heads of Midwifery; Lead Midwives Scotland; Scottish Executive Nurse Directors; NHS Board Human Resources and Finance Directors; The Scottish Partnership Forum; Council of Deans Scotland; and NHS Chief Executive Officers.

6. **Employer led supervision for midwives – proposed model**

6.1 **Purpose**
The purpose of clinical supervision is to contribute to improved services, safer care and better outcomes for women and families, by supporting midwives to advocate for women’s needs and to reflect on clinical midwifery practice in line with professional accountability and regulation.

6.2 **The new model**
A restorative model of group based clinical supervision is proposed, primarily aimed at midwives who work in clinical practice roles providing direct clinical care for women and families.

A triangulated approach informed the new model, taking account of Scottish Government policy; evidence from the literature review; and information from the stakeholder engagement. Working within the principles agreed at UK level, the proposed model reflects a proportionate and risk based approach, which seeks to maximise best value through prudent use of public funds. Annex E illustrates in detail the difference between statutory supervision and the proposed clinical supervision model.

6.3 **Rationale**
The introduction of NMC revalidation for all nurses and midwives intends to provide assurance for employers and the public that registrants are fit to remain on the NMC register. Revalidation requires nurses and midwives to undertake continuous professional development related to their scope of practice, alongside demonstrating ongoing reflection and feedback from others related to this practice. It is considered that revalidation is sufficient for those midwives whose scope of practice does not include the provision of direct clinical care for women and families.

Effective supervision has been highlighted in many critical incidents, including the Mid Staffordshire NHS Foundation Trust Public Enquiry. The Quality Standards for

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7 [www.midstaffspublicinquiry.com](http://www.midstaffspublicinquiry.com)
Health and Social Care recommend that an effective system for supervision can enable organisations to meet clinical and social care governance standards.

“We know from evidence that staff who are valued and treated well improve patient care and overall performance” (Everyone Matters)

Everyone Matters: the 2020 Workforce Vision sets out a commitment to valuing the workforce and treating people well. The Staff Governance Standard provides the framework to support and enable staff to play their full part in achieving that Vision; also providing the minimum standards to be achieved to ensure the fair and consistent treatment of all staff. Clinical supervision will contribute to the delivery of Everyone Matters and the Staff Governance Standard by ensuring an appropriately engaged and motivated midwifery workforce; enhancing capacity to support development of multiprofessional working and transformational roles. This will be of particular relevance in light of the recent National Review of Maternity and Neonatal Services.

Facilitating reflective practice will also underpin the Programme for Government ambition of Protecting and Reforming Our Public Service, by supporting midwives to provide person centred, safe and effective care. Supervision will enhance the midwifery contribution to the NHS values of care and compassion; dignity and respect; openness, honesty and responsibility; quality improvement and teamwork. Many of these values were identified as key issues within the Morecambe Bay Inquiry. It will have a direct role in supporting midwives in clinical practice to reflect in line with NMC requirements for revalidation.

6.4 Governance
NHS Boards will have accountability for the provision of clinical supervision for midwives within their Board area.

This will include midwives employed by the Board, alongside those from organisations such as Higher Education Institutions who undertake contractual clinical sessions in the Board. Midwives who practice independently will be encouraged to participate in supervision within the Board nearest to their home address. Although NHS Boards will have no accountability for the practice or supervision of independent midwives, women can be transferred into NHS care; therefore it is in the interest of women for independent midwives and NHS Boards to maintain open, two way dialogue.

It is proposed that Executive Nurse Directors have overall responsibility at Board level for clinical supervision of midwives, and liaison with the Chief Nursing Officer (CNO) as required.

Outwith the NHS, it will be for employing organisations to consider whether to introduce clinical supervision for staff who are practising midwives whose scope of practice does not include the provision of direct clinical care for women and families.

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10 [www.staffgovernance.scot.nhs.uk/](http://www.staffgovernance.scot.nhs.uk/)
Organisations may wish to consider partnerships with the NHS should that be considered beneficial.

6.5 Clinical supervision functions
The fundamental aim of clinical supervision is to promote best clinical practice through a process of reflection, discussion and review of all aspects of clinical care; including the relationship between midwives, women and families. This will support a culture of continuous quality improvement in practice.

Restorative supervision is designed to address the emotional needs of staff and help them build resilience levels by reducing their own stress and burnout levels; thereby improving health and wellbeing. It creates a relationship that nurtures and cares for the person being supervised as well as facilitating reflection and self-awareness through critical analysis, exploration of events and feelings.

It is proposed that Scotland’s clinical supervision for midwives is based on:

- group supervision for cohorts of a maximum of 10 midwives, with sessions taking participants through a restorative process
- midwives attending a minimum of 1 group session per annum
- one to one supervision for individual midwives as required
- confidentiality and contracting for all sessions
- appropriate record keeping.

An example toolkit for clinical supervision including guidance and templates is provided at Annex F. To minimise variation in practice, it is proposed that this toolkit be further developed in partnership with key stakeholders during the implementation phase.

6.6 Infrastructure
There will be no requirement for national roles. There is no empirical evidence for a ratio of supervisor to midwives; therefore NHS Boards will be responsible for training and appointing an adequate number of supervisors to meet local midwifery workforce needs.

Heads of Midwifery will have responsibility for implementing the systems and processes for the selection and appointment of supervisors in line with organisational Human Resource (HR) processes. The role of clinical supervisor will be separate from and additional to an individual’s substantive role. Performance management of supervisors will be through normal organisational staff governance processes. To be appointed, a supervisor should:

- demonstrate the leadership capacity and capability to undertake the role
- be subject to a process of peer/self nomination
- have successfully completed a nationally agreed programme of education.

It will be for NHS Boards to establish local networks which support consistency of clinical supervision. NHS Boards should work collaboratively to establish an approach to annual national networking; aiming to share best practice in clinical supervision, minimise unwarranted variation and facilitate ongoing CPD for supervisors.
Independent midwives should seek to access supervision through the Head of Midwifery in the NHS Board closest to their home address.

Outwith the NHS, it will be for employing organisations to establish systems and processes which meet their needs, should they opt to implement clinical supervision.

6.7 Education and training
To prepare supervisors for their role, NHS Education for Scotland will work collaboratively with NHS Boards and Scottish Higher Education Institutions in the development of national educational resources that can be delivered locally. A blended learning educational approach will be taken, including e-learning resources and face-to-face workshop delivery. The content of the education will involve an exploration of appropriate subject areas such as: leadership skills; advocacy for women and their families; mentoring and coaching approaches; group facilitation skills; and promoting reflection.

SOMs from the previous statutory model will not automatically transfer to clinical supervision; however it is recognised that many may have the skills and desire to do so. To accommodate this transition, a two tier education model will be developed comprising:

- A one day workshop for existing SOMs (accompanied by appropriate e-learning resources)
- A three day workshop for new clinical supervisors (accompanied by an e-learning package).

Some Higher Education Institutions in Scotland may continue to offer an SCQF level 11 module for new supervisors who wish to undertake this learning as part of a wider Masters programme (previous completion of the e-learning resource and workshops will provide evidence of Recognition of Prior Learning). This will not be a requirement to be appointed in the new model.

NHS Boards should expect clinical supervisors to maintain their supervision skills in line with their NMC requirements for revalidation related to their scope of practice. To support this in practice, a refresher education session will be developed for completion at least annually or as required by supervisors.

6.8 Resources
NHS Boards will retain financial responsibility for the new employer led supervision model, within existing NHS Board allocations.

Under the proposed model, there will be no provision of 24 hour on call access to supervision. The national LSA roles shared between the 14 territorial Boards will not continue, however there will be costs associated with disaggregating these roles. The current annual allowance for SOMs is subject to National Agreement and advice will be provided further to partnership consideration.

Based on assumptions of the activities to be undertaken by the professional supervisors (section 6.5), as well as CPD and ongoing training, the recurring annual
costs nationally across all NHS Boards associated with the employer led model is estimated at £242k per annum.

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<tr>
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<th>Existing Model</th>
<th>Future Model</th>
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<tbody>
<tr>
<td>Annual SOM Payment</td>
<td>£144k</td>
<td>£0k</td>
</tr>
<tr>
<td>SOM on call payments</td>
<td>£137k</td>
<td>£0k</td>
</tr>
<tr>
<td>LSA Infrastructure</td>
<td>£273k</td>
<td>£0k</td>
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<tr>
<td>SOM Activities</td>
<td>£342k</td>
<td>£56k</td>
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<tr>
<td>Training/CPD/Conferences</td>
<td>£222k</td>
<td>£168k</td>
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<tr>
<td>Formal training (new SOMs)</td>
<td>£23k</td>
<td>£18k</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£1,141k</strong></td>
<td><strong>£242k</strong></td>
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It should be noted that some resource associated with the statutory SOM activities may need to be reinvested locally to support additional workload which may transfer to existing line management and clinical governance structures. For example, whilst Boards have an existing responsibility to undertake clinical incident reviews and investigations; separate SOM reviews have focussed on midwifery practice in line with NMC codes and standards and have contributed to Board processes. Future local resources may also need to include a provision for pay protection of the current annual SOM payment; and for costs associated with disaggregating the national roles. In total, these resources would need to be in excess of £899k before the new model was no longer cost neutral.

There will be a one-off implementation cost of approximately £116k associated with moving to the new model. This includes the development of the educational resources required to support the new clinical supervisor role, as well as the initial training of any new clinical supervisors. This is significantly reduced compared with preparation of SOMs in the statutory model, which is estimated at just over £1 million.

7. **Implementation**

To mitigate any potential impact on public protection, the Taskforce agreed that the statutory and employer led models should not operate simultaneously. It was recognised that this would be both confusing for the midwifery profession and add an unwelcome layer of complexity for NHS Boards in particular.

Subject to approval by the Cabinet Secretary, NHS Board systems and processes for the selection and appointment of clinical supervisors should commence from 1st April 2017; in preparation for implementation of the new model from 8th January 2018.

This will ensure a clear distinction for staff and organisations between the statutory supervision model and the new employer led model. From 31st March 2017 (subject to legislative change), responsibility for the governance of midwifery practice will rest exclusively with employers.

The Scottish Government will expect NHS Boards to have an implementation plan in place for delivery of an employer led model of clinical supervision from 8th January 2018 at the latest.
7.1 **Action for the Scottish Government by 31st December 2016**
The Scottish Government will commission NHS Education for Scotland to undertake the work required to develop nationally consistent education to prepare supervisors for their role, alongside a refresher package to facilitate annual CPD.

7.2 **Action for NHS Education for Scotland by 31st March 2017**
NHS Education for Scotland will work collaboratively with NHS Boards and Scottish Higher Education Institutions in the development of national educational resources that can be delivered locally.

7.3 **Actions required of NHS Boards from 1st April 2017**
In line with National PIN Policy and current recruitment processes, NHS Boards should have systems and processes in place for the selection, recruitment and appointment of clinical supervisors.

Prospective supervisors should be released to complete the nationally agreed education and training, dependant on individual need.

7.4 **Actions required of other employing organisations and independent midwives from 1st April 2017**
Employing organisations, such as Higher Education Institutions and others, should identify employees who have contractual arrangements with NHS Boards for clinical practice that includes the provision of direct clinical care for women and families.

Where such contractual arrangements exist, organisations and their employees should work in partnership with the relevant NHS Board to ensure access to and provision of clinical supervision.

Midwives who practice independently should make contact with the Head of Midwifery in the NHS Board nearest their home address to seek access to clinical supervision.

Non NHS organisations should consider whether to introduce clinical supervision for employees who are practising midwives whose scope of practice does not include the provision of direct clinical care for women and families. Organisations may wish to consider partnerships with the NHS should that be considered beneficial.

8. **Evaluation**
The Taskforce considers evaluation critical in assessing the impact of Scotland’s new model in practice and ensuring best use of future public funds going forward. Funding has been agreed within CNOD to undertake this evaluation over 3 years. Evaluation will measure the impact in practice of the new employer led supervision model; outline learning from and changes required further to initial implementation; and describe opportunities for transferring learning to other professions under the CNOs leadership.
9. Next steps

Further to internal Scottish Government governance requirements, the CNO will seek approval from the Cabinet Secretary to proceed to the implementation phase for the employer led supervision model. The Scottish Government will advise NHS Boards and other employers of their responsibilities regarding disaggregation of the statutory supervision model and implementation of the employer led model.

The CNO will convene a group by February 2017, in partnership with the Scottish Executive Nurse Directors and key stakeholders (including third sector), to support NHS Boards with the transition to and implementation of the employer led supervision model for midwives.
Supervision for Midwives: a four country approach

The principles of supervision for midwives outlined here underpin a single model used by the four UK countries. They are that:

- it maintains and improves quality and thereby protects the public
- it applies to all registered midwives regardless of their scope of practice or mode of employment
- a system of midwifery supervision is a vital aspect of contemporary midwifery practice and needs supervisors of sufficient expertise and experience to support registered midwives
- midwifery supervision should be at least an annual event
- midwifery supervision is a proactive, developmental and supportive partnership between a midwife and the supervisor and links to effective clinical governance
- supervisors are in professional leadership roles and may or may not be in managerial roles or the supervisee’s line manager
- supervisors need to be registered midwives themselves
- supervisors are adequately prepared and experienced enough to be both critical and supportive
- supervisors are selected by heads of midwifery and peer feedback should be used to inform the selection process
- supervisors are selected for a fixed time period and consideration will be given to a system of refreshing their skills and rotating them in and out of supervisory roles periodically
- alignment with the NMC Code (2015) is essential
- alignment with the NMC revalidation process is essential and will be the same process for all its registrants
- the NMC should hold only information about practising midwives which contributes to protection of the public
- it is for employers to ensure that all their registered midwives are subject to supervision
- it is for all registered midwives to seek supervision even if they are self-employed or do not work regularly for one employer consistently
- any new system must not be more costly than the present system
- for the majority of midwives who are employed, there should be clarity about the legitimacy and distinctiveness of supervision as a facet of professional good practice and appraisal as a responsibility of the employer.
# Annex B

## Transitioning Supervision of Midwives Taskforce membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Ann Holmes (Chair)</td>
<td>Chief Midwifery Advisor &amp; Associate CNO</td>
<td>Scottish Government</td>
<td>CNO Directorate (CNOD)</td>
</tr>
<tr>
<td>Elaine Cockburn</td>
<td>Professional Advisor, Midwifery Care, Maternal &amp; Infant Health</td>
<td>Scottish Government</td>
<td>Children &amp; Families Directorate</td>
</tr>
<tr>
<td>Margaret Syme</td>
<td>Senior Policy Manager</td>
<td>Scottish Government</td>
<td>Regulatory Unit, CNOD</td>
</tr>
<tr>
<td>Donna O’Boyle</td>
<td>Professional Regulatory Advisor</td>
<td>Scottish Government</td>
<td>Regulatory Unit, CNOD</td>
</tr>
<tr>
<td>Kerry Chalmers</td>
<td>Senior Policy Manager</td>
<td>Scottish Government</td>
<td>Health Workforce Directorate</td>
</tr>
<tr>
<td>David Clarke (secretariat)</td>
<td>Policy Officer</td>
<td>Scottish Government</td>
<td>Regulatory Unit, CNOD</td>
</tr>
<tr>
<td>Yvonne Bronsky</td>
<td>LSA Midwifery Officer (LSAMO)</td>
<td>NHS Scotland</td>
<td>Local Managing Authority</td>
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<tr>
<td>Helen Paterson</td>
<td>NHS Board Executive Nurse Director</td>
<td>NHS Fife</td>
<td>Scottish Executive Nurse Directors</td>
</tr>
<tr>
<td>Ruth Deery</td>
<td>Professor of Maternal Health</td>
<td>University of the West of Scotland</td>
<td>CSO NMAHP literature review (midwifery) / HEIs</td>
</tr>
<tr>
<td>Mick Fleming</td>
<td>Associate Professor</td>
<td>Napier University</td>
<td>CSO NMAHP literature review (nursing) / HEIs</td>
</tr>
<tr>
<td>Helen Bryers</td>
<td>Professor of Maternal &amp; Child Health</td>
<td>NHS Highland</td>
<td>Heads of Midwifery</td>
</tr>
<tr>
<td>Audrey McColl</td>
<td>Director of Finance</td>
<td>NHS Education Scotland</td>
<td>NHS Scotland Directors of Finance</td>
</tr>
<tr>
<td>Loraine Penman</td>
<td>Interim Senior Information Analyst</td>
<td>NHS Education Scotland</td>
<td>NHS Scotland Directors of Finance</td>
</tr>
<tr>
<td>Susan Key</td>
<td>Programme Director</td>
<td>NHS Education Scotland</td>
<td>NHS Education Scotland</td>
</tr>
<tr>
<td>Hilary Patrick</td>
<td>Senior Lecturer / Lead Midwife for Education</td>
<td>University of the West of Scotland</td>
<td>Lead Midwives for Education / HEIs</td>
</tr>
<tr>
<td>Jacqueline Macrae</td>
<td>Deputy Director of Quality Assurance</td>
<td>Healthcare Improvement Scotland</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Carmel Lloyd</td>
<td>Head of Education &amp; Learning</td>
<td>Royal College of Midwives UK</td>
<td>Royal College of Midwives UK</td>
</tr>
<tr>
<td>Frances Dow</td>
<td>Honorary Fellow</td>
<td>University of Edinburgh</td>
<td>Public Interest Partner</td>
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<tr>
<td>Gillian Smith</td>
<td>Director</td>
<td>Royal College of Midwives Scotland</td>
<td>Royal College of Midwives Scotland</td>
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<tr>
<td>Alana Harrower</td>
<td>Midwife</td>
<td>NHS Forth Valley</td>
<td>Midwife Supervisee</td>
</tr>
<tr>
<td>Avril Marshall</td>
<td>Midwife</td>
<td>NHS Greater Glasgow &amp; Clyde</td>
<td>Supervisors of Midwives</td>
</tr>
<tr>
<td>Amanda Gotch</td>
<td>Lecturer, School of Nursing &amp; Midwifery</td>
<td>NHS Grampian</td>
<td>Midwife Supervisee</td>
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<tr>
<td>Mary Burnside</td>
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<td>NHS Highland</td>
<td>Supervisors of Midwives</td>
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<tr>
<td>Joyce Jones</td>
<td>LSA Midwife</td>
<td>NHS Scotland</td>
<td>Local Supervising Authority</td>
</tr>
<tr>
<td>Alison Richmond-Ferns</td>
<td>Associate Director of HR</td>
<td>NHS Forth Valley</td>
<td>NHS Scotland HR Directors</td>
</tr>
<tr>
<td>Carrie McIntosh</td>
<td>Independent Midwife</td>
<td>NHS Forth Valley</td>
<td>Independent Midwife</td>
</tr>
<tr>
<td>Cassie McNamara</td>
<td>Independent Midwife</td>
<td>NHS Forth Valley</td>
<td>Independent Midwife</td>
</tr>
<tr>
<td>Bob McGlashan</td>
<td>Senior Officer</td>
<td>Royal College of Nursing</td>
<td>Scottish Partnership Forum</td>
</tr>
</tbody>
</table>

## Observers

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<th>Name</th>
<th>Title</th>
<th>Organisation</th>
<th>Representing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Sloane</td>
<td>Head of Midwifery</td>
<td>Isle of Man</td>
<td>Isle of Man</td>
</tr>
<tr>
<td>Lisa Stephens</td>
<td>Head of Midwifery</td>
<td>Guernsey</td>
<td>Guernsey</td>
</tr>
<tr>
<td>Julie Mycock</td>
<td>Head of Midwifery</td>
<td>Jersey</td>
<td>Jersey</td>
</tr>
</tbody>
</table>
Report on Taskforce Regional Engagement Events to inform the development of a different model of ‘supervision’ in Scotland: an appreciative inquiry approach

Professor Ruth Deery, University of the West of Scotland
Helen Paterson, Director of Nursing, NHS Fife (Chair of Model Group)
Yvonne Bronsky, LSAMO, NHS Scotland
Joyce Jones, LSA Midwife, NHS Scotland
Associate Professor Mick Fleming, Edinburgh Napier University
Avril Marshall, Supervisor of Midwives, NHS Greater Glasgow & Clyde

August 2016

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Introduction

In the UK, government midwifery officers, Chief Nursing Officers (CNOs), Local Supervising Authority Midwifery Officers (LSAMOs), the Royal College of Midwives (RCM) and midwives are contributing to shaping the future direction of midwifery supervision. In Scotland, the Chief Midwifery Advisor & Associate Chief Nursing Officer has met with lead midwives and nurses, service users, researchers and educationalists to begin exploring the future design of supervision and a Taskforce with five work streams has been established to explore various options:
1. Model of supervision;
2. Education;
3. Resources;
4. Standards and Governance;
5. Evaluation.

This report documents the process and findings from the first work stream – the model of supervision. The aim was to contribute to the development of an evidence based model of supervision to provide professional support for midwives.

**Background: Possibilities and current focus**

The current regulatory position in the UK is that statutory supervision of midwives contributes to patient safety and quality of care for women, babies and the profession (NMC, 2015; Parliamentary and Health Service Ombudsman, 2013). This contribution is recognised in the policy and practice literature (Henshaw et al., 2013, RCM, 2015a; Stapleton et al., 1998). In 2015, Kirkup reported serious failures of clinical care at a maternity unit in the north of England. The inquiry uncovered avoidable harm to mothers and babies, including unnecessary deaths and a series of missed opportunities to intervene at almost every level of the NHS. A culture of deeply entrenched patterns of ‘defensiveness, denial and blame shifting’ (p.17) were highlighted. Following the investigation two key principles were formed:

(a) that midwifery supervision and regulation should be separated to avoid ‘muddling’ of investigation and support, and
(b) the Nursing & Midwifery Council (NMC) should be in direct control of regulatory activity.

This will result in the end of the current statutory requirement for supervision. A King’s Report (Baird et al., 2015) suggests that this could lead to failure to identify poor midwifery practice leading to avoidable harm and deaths. This situation is concerning given that other major reports into non-maternity NHS failures (Francis, 2013; Grey & Kennedy, 2016) have focused on the importance of support and practice development training for staff. There is strong empirical evidence that high quality, safe and effective maternity services lead to better outcomes for women and babies (Renfrew et al., 2014; Sandall, 2012). Also, reducing avoidable healthcare injury or harm provides the strategic impetus for on-going Scottish Government-led health initiatives and programmes (Scottish Government, 2010, 2013). The Royal College of Midwives has reported concerns that one-fifth - 21.9% in 2014 and 20.3% in 2015 - of Heads of Midwifery have had to reduce training for their midwives at a time when there is a need for transformational development in healthcare (RCM, 2015b). Training and continuing professional development are critical to support midwives to deliver safe care.

**Systematic review**

Our systematic review (Pollock et al., 2016) was commissioned by Scottish Government and concluded that whilst there is positive appraisal of clinical supervision there is insufficient empirical evidence currently to support its effectiveness. Whilst highlighting the lack of high quality evidence the review highlighted aspects of a clinical supervision model which could be used to inform the development and implementation of a different model in midwifery. Three different syntheses were undertaken in the systematic review. This report is concerned with the third synthesis.

1. The practical implementation of clinical supervision;
2. Evidence for the effectiveness of clinical supervision;
3. **Barriers and facilitators to the implementation of clinical supervision**
The most commonly reported barriers and facilitators in the literature affecting the facilitation of clinical supervision were seen as:

- Putting effective administration in place to support the planning and organisation of clinical supervision;
- Ensuring there was clarity around the requirements for documentation;
- Ensuring there was an accessible venue;
- Making time available to staff and clinical supervisors;
- Ensuring there was clarity around the roles and responsibilities of supervisors and supervisees e.g. making a contract and boundary setting;
- Guidance around whether supervisees can choose a supervisor, and how to facilitate this process effectively;
- Ensuring there is clear consensus on session content and structure;
- The knowledge and skills of the supervisor are perceived as important;
- Confidentiality and trust were important;
- Terminology was seen as important e.g. the term ‘clinical supervision’ is a barrier in itself (Pollock et al. 2016).

Despite the absence of empirical evidence clinical supervision is widely facilitated in the NHS and there are a considerable number of peer-reviewed papers and books in which there are examples of the successful facilitation of clinical supervision for nurses, midwives and allied health professionals (Bond & Holland, 1998, Deery, 2005, Calvert, 2014, Proctor, 2008, Sloan, 2005, White & Winstanley, 2010). The majority of these papers highlight the above factors as important features to its successful facilitation. Clinical supervision also offers structured staff support that can help to ensure service users receive high quality, safe care at all times from midwives who are able to manage the personal and emotional impact of their practice (Deery, 2005, White & Winstanley 2010). Members of the model group work stream have drawn on best available evidence and data collected at the regional engagement events to inform the development of a different model of supervision in midwifery.

**The way forward**

Scottish midwives now find themselves in a unique position to be able to develop, implement and evaluate an evidence-based model of clinical/professional supervision that meets the needs of all midwives and promotes best practice and excellence in midwifery care at a time when the UK Government has stated its intention to abolish statutory supervision in its current form (DoH, 2016). At the same time, and importantly, the health departments (through the four UK Chief Nursing Officers) have reiterated their commitment to the supportive elements embedded within statutory supervision and have suggested clinical supervision (or its equivalent) as a model to this end.

Given that the model will not have a regulatory function there is the opportunity to focus on bringing, and reflecting on, issues from work in a safe and supportive, but challenging context that also fits with current policy (Scottish Government, 2013). In a work environment where midwives are supported feelings of safety, trust and reciprocity are likely to become evident (Deery et al., 2010, Deery & Fisher, 2016, Hatem et al., 2009, Hunter, 2005, Hughes et al., 2002, McCourt & Stevens, 2009, Walsh, 2011). An ‘enriched environment’ is also key to Nolan et al’s relationship centred care - a place where a different model of supervision has the potential to transform the organisation of midwifery. This is predicated on midwives taking care of themselves so that the inevitable stresses that have become part of midwifery work are not transferred to women and babies.
Reciprocity is also an important aspect of relationship (Deery & Kirkham, 2006, Hunter, 2004). In several studies where midwives have reported that their relationships with women have been beneficial, rather than a one-way process, a sense of mutual trust has developed (Deery and Fisher, 2010, Hunter, 2005, Hunter & Warren, 2013). When relationships are reciprocal midwives feel valued and able to be the midwives they want to be (Hunter, 2004). Women are also more likely to experience a relationship with a midwife where they feel confident, supported and fully informed (McCourt & Stevens, 2009). The same principles are applicable to relationships with work colleagues. Clinical/professional supervision has the potential to develop these principles and the skills necessary for relationship based care.

There is also strong evidence that stress is created by the need for midwives to juggle competing organisational demands (Hunter, 2004, 2005, O’Connell & Downe, 2009). This has been characterised as ‘conflicting ideologies’ (Hunter, 2004). Although midwives aim to work in a ‘with woman’ way, which meets their ideals of ‘good practice’ by providing individualised care for women, this is frequently unachievable (Deery & Fisher, 2016, O’Connell & Downe, 2009.). Midwifery work is often dominated by a ‘with institution’ approach, focused on meeting institutional demands (Hunter, 2004, 2005, O’Connell & Downe, 2009). Relationship centred care, facilitated through an effective clinical supervision process, has the potential to focus on the creation of ‘enriched’ and balanced working environments (Nolan et al. 2006).

**Recruitment to the regional engagement events**

Prior to the Taskforce regional engagement events midwives were informed of the purpose of the events and provided with an information leaflet (appendix 1). They were aware that their views would be used to inform future work and were assured that their views would be treated anonymously and that information could not be traced back to them. Ethical approval to undertake the work was granted by the University of West of Scotland. Lead midwives in each NHS Board were asked to cascade information about the events via email.

**Methodology**

Appreciative inquiry is an approach used to explore and bring about change in social systems (Cooperrider & Whitney, 2005), in this case midwifery and maternity services. Over time appreciative inquiry has been adapted from the business sector to a rapidly changing healthcare context and as an aide to support action research. As an approach, appreciative inquiry works from the premise that organisations can only transform if different knowledges (clinical supervision in this case) and human relations (relationship centred care) are taken into account (Cooperrider & Whitney, 2005). For contemporary midwifery practice relationship centred care or skilled interpersonal relationships are fundamental to, and key to the delivery of, high quality care (Deery & Hunter, 2010, Moloney & Gair, 2015). They are also key priorities for policy, practice and research globally. It was important therefore that that the chosen methodology reflected midwifery work and actively engaged midwives in the process of co-creation to help shape a future model of supervision.

The five principles of appreciative inquiry were used to support the development of a different model when exploring the data. We accounted for different knowledges, communication and dialogue with others as well as organisational destiny in midwifery and maternity services (the constructionist principle). We used the 4D cycle (Figure 1) as inquiry, remembering that change begins with the first question asked (the simultaneity principle), we encouraged midwives to think differently and challenge the status quo of the organisation (the poetic principle), and we focused on and promoted positivity in
midwifery (the anticipatory principle) emphasising the effects of positive emotion and how that can support flexibility, creativity and high expectations (Bushe, 2011).

Methods

Four regional engagement events were undertaken during the month of May 2016; Inverness (n=20), Glasgow (n=36), Tayside (n=26) and Forth Valley (n=18). Some of the midwives participated via teleconference.

The events were introduced by the Chief Midwifery Advisor and Associate Chief Nursing Officer, Scottish Government who gave an overview of the policy context. An overview of the systematic review (Pollock et al., 2016) and the nature of clinical supervision were then given. The LSAMO gave an overview of the process of the engagement events and provided overall facilitation. The group work was facilitated by members of the model group work stream. Facilitator briefing notes were provided (appendix 2).

At each event the midwives were split into groups with one facilitator at each table. The 4D cycle associated with appreciative inquiry was used as the intervention (Bushe & Kassam, 2005). This consists of four phases: Discovery, Dream, Design and Destiny. In the discovery phase we encouraged the midwives to talk to each other to discover the times when supervision had worked well. We encouraged stories around the positive aspects of current midwifery supervision and the identification of the specific elements that contributed to that success. The dream phase encouraged the midwives to imagine and co-create the future. They were encouraged to envision midwifery supervision differently and positively. ‘What would things be like if...?’ They were encouraged to elaborate their visions as much as possible. The design phase focused on possibilities and the dream for supervision as well as key relationships which have an impact on the dream, and key organisational elements in maternity services that would be required to fulfil the dream.

The destiny phase is future facing genuinely embracing the principles of co-creation and participation. This phase was undertaken by the model group members and will be further developed by the other work streams e.g. education.

Each group had 10 minutes for discussion before the main facilitator (LSAMO) asked them to move through to the next phase (Discovery, Dream, Design). Different coloured ‘post its’ were used for each phase. The midwives were encouraged to write their own post its and to write comments on flip chart paper available at each table. At the end of each phase the ‘post its’ were collected; Inverness n=234, Glasgow n=253, Tayside n=289 and Forth Valley n=211).
Data analysis

Following the four regional engagement events the data collected were taken back to the model group for analysis. Through a process of thematic analysis and drawing on the Compassionate Connections framework key themes were identified from the comments received at each phase of the cycle and mapped against the themes of ‘Compassionate Caring’ (as shown below). From a midwifery perspective, this framework is underpinned by the belief that midwives, in the best supported environments, can experience relationship based care which in turn can impact positively on their relationships with women and their families.
The table below has recorded the frequency of comments made by midwives in response to questions posed by the facilitators at each regional event.

**Table 1: Frequency of the comments recorded for the key themes at each phase of the appreciative inquiry cycle**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Discover</th>
<th>Dream</th>
<th>Design</th>
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<tr>
<td>Role definition/title</td>
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<td>32</td>
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<tr>
<td>Accessibility</td>
<td>27</td>
<td>7</td>
<td>5</td>
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<tr>
<td>Advocacy</td>
<td>16</td>
<td>9</td>
<td>4</td>
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<tr>
<td>Non-hierarchical/non-managerial</td>
<td>10</td>
<td>9</td>
<td>3</td>
</tr>
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<td>Protected time</td>
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<td>Supportive role</td>
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<td>26</td>
<td>16</td>
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<td>Education</td>
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<td>13</td>
<td>42</td>
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<tr>
<td>Underpinning philosophy</td>
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<tr>
<td>Leadership/networking</td>
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<td>Clinical governance link</td>
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<td>Regular meetings</td>
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<td>National standards/scrutiny</td>
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**Total**: 325 322 331
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<tr>
<th>Caring Conversations</th>
<th>‘opportunity to debrief/distress, confidentiality, with respected colleague’</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>‘facilitate reflection of practice in protected time’</td>
</tr>
<tr>
<td></td>
<td>‘support mechanism for midwives to enable delivery of excellent care’</td>
</tr>
<tr>
<td></td>
<td>‘inspiring and motivational’</td>
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<td>Flexible person centred risk taking</td>
<td>‘must be able to demonstrate added value. Through audit and evaluation depending on agreed framework’</td>
</tr>
<tr>
<td></td>
<td>‘protect our profession’</td>
</tr>
<tr>
<td></td>
<td>‘ensure safe and effective midwifery practice’</td>
</tr>
<tr>
<td>Knowing You, Knowing Me</td>
<td>‘new Supervisors must be proactive leaders, approachable and assertive’</td>
</tr>
<tr>
<td></td>
<td>‘Support staff and women stories for care assurance – team as well as individual midwives’</td>
</tr>
<tr>
<td>Involving, Valuing and Transparency</td>
<td>‘support individual midwife development and identify support needs, confidence and education’</td>
</tr>
<tr>
<td></td>
<td>‘reflect managerial and professional expectations’</td>
</tr>
<tr>
<td>Feedback</td>
<td>‘audit able standards of compliance with implementation of model reportable to SGHD’</td>
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<td></td>
<td>‘standardisation of implementation and evaluation across Scotland’</td>
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<td></td>
<td>‘need to provide a system of sharing good practice within model across Scotland’</td>
</tr>
<tr>
<td>Creating spaces that work</td>
<td>‘national lead required as if no clear steer this process may become ineffective, disjointed ore impractical’</td>
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<td>‘midwives will feel more able to approach supervisors without threat of regulation’</td>
</tr>
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<td></td>
<td>‘focus on culture change being dynamic. Think about 5-10yrs time and midwives of the future’</td>
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<td></td>
<td>‘provide leadership role for midwives enable increased confidence’</td>
</tr>
</tbody>
</table>
Based on the data collected the model below was devised.

**Figure 2: Model of Supervision for Midwives**

The process by which the model of supervision would be facilitated in Scotland was then developed and is described in the form of a flow chart (see Figure 2 below). A different work stream – *education* – is now working towards the content and some of the process issues within the new model.
**Figure 3: Process of supervision flowchart**
Conclusion

Midwifery supervision and regulation are to be separated to avoid ‘muddling’ of investigation and support and the Nursing & Midwifery Council (NMC) will be in direct control of regulatory activity. This will result in the end of the current statutory requirement for supervision. Recent investigations into NHS failures have emphasised the importance of support and practice development training for staff and there is strong empirical evidence that high quality, safe and effective maternity services lead to better outcomes for women and babies. Our recent systematic review (Pollock et al., 2016) showed that whilst there is positive appraisal of clinical supervision in the literature there is insufficient empirical evidence currently to support its effectiveness. Given that clinical supervision continues to be delivered across the NHS there remains much to learn from current practice and the literature regarding its development and facilitation.

Clinical supervision is about continuous learning and development for all concerned who will need to be committed to self-assessing their skills and competencies through reflection and review of their performance (Bond & Holland, 1998; Proctor, 2008; Sloan, 2005). Some supervisors of midwives will not want to be clinical supervisors. In the new model of supervision there will need to be training and knowledge development of the new supervision process, to include interpersonal skill training and commitment to establishing a contract between supervisor and supervisee. The work of the model group and their deliberations in terms of developing a model and the process of supervision linked to compassionate connections are presented in this report. Clinical supervision is a complex intervention that will require collaboration and participation across NHS Boards. Against this backdrop we now need to take these proposals forward in an effective and valuable way in Scotland.

References


Appendix 1: Participant Briefing

Participant Briefing
Transitioning Supervision of Midwives:
Regional Engagement Events May 2016

Context
Following investigations into complaints about maternity services at Morecambe Bay NHS Foundation Trust, the Parliamentary and Health Services Ombudsman published Midwifery supervision and regulation: recommendations for change (PHSO, 2013).

Further to this, the Nursing and Midwifery Council (NMC) commissioned the Kings Fund review of Midwifery Regulation in the UK; and following publication of their report, the NMC agreed to remove the additional layer of regulation currently in place for midwives. This requires a change in the current legislation, which is expected to be in place from April 2017.

The Department of Health in England leads this work and the four UK countries have been working together to agree principles that will underpin a future model of midwifery supervision across the UK. In Scotland, a Transitioning Supervision of Midwives Taskforce has been established to develop and implement a new professional and employer-led model of supervision for Scotland’s midwives.

Purpose of the Regional events
Input from midwives is vital in ensuring that we develop a model that will support contemporary midwifery practice. Events will therefore facilitate engagement with midwives in NHS Boards, who will be amongst those most affected by the change. Sessions will take a world café approach, ensuring that midwives have the opportunity to influence and shape the Taskforce’s work going forward.

World Café
A ‘World Café’ creates a hospitable environment to facilitate open discussion and encourages everyone to contribute. Participants will work at tables in small groups and discuss predetermined questions. Each question will have an allocated time and participants will also have an opportunity to write down their own comments which will feed into the collective views of the cafe.

Useful information

http://www.kingsfund.org.uk/projects/midwifery-regulation-united-kingdom


Sharing your views
If you would like to contact the Scottish Government directly, please email RegulationUnit@gov.scot
Appendix 2: Facilitator Briefing Notes

Facilitators’ Briefing Note
Transitioning Supervision of Midwives:
Regional Engagement Events May 2016

Context
The Regional Events are based on the principles and methodology of a ‘World Café’ and Appreciative Inquiry. Input from midwives is vital in ensuring that we develop a model that will support contemporary midwifery practice. These events will facilitate engagement with midwives in NHS Boards, who will be amongst those most affected by the change, and will ensure that midwives have the opportunity to influence and shape the Taskforce’s work going forward.

World Café
A ‘World Café’ creates a hospitable environment to facilitate open discussion, and encourages everyone to contribute. Participants will work at tables in small groups and discuss predetermined questions. Each question will have an allocated time and participants will also have an opportunity to write down their own comments, which will feed into the collective views of the cafe.

World Café events are designed and hosted according to the following principles:
- Clarify the context
- Create a hospitable environment
- Explore questions that matter
- Encourage everyone’s contribution
- Connect diverse perspectives
- Listen together for insights and deeper questions
- Gather and share collective discoveries

4Ds Appreciative inquiry
Through predetermined questions, Appreciative Inquiry is about:
- valuing the ‘best of what is’
- envisioning what might be
- engaging in dialogue about what should be
- innovating what will be

A common model of Appreciative Inquiry uses a cycle four processes, which focus on what it calls – discover, dream, design and destiny (or deploy). For the purposes of this event, three predetermined questions will be asked to generate ideas about what a future professional employer led model of supervision might look like. This will need to be within some boundaries linked to the need for legislative change. Outputs from the events will contribute to wider thinking within The Transitioning Supervision of Midwives Model Workstream (destiny).

The predetermined questions are:
1. **DISCOVER**: what strengths might we take from supervision to date; what strengths/assets do midwives have to bring to a new model going forward
2. **DREAM**: what would a good model do, what would it look like, what would it feel like
3. **DESIGN**: how would we make that a reality in practice
Appendix 2: Facilitator Briefing Notes

How the sessions will work in practice
- After 10 minutes discussion there will be an announcement informing delegates that there is 5 minutes left. Each group member will be asked to write on a post-it their priorities in relation to the element being discussed. Individual post-its will be used for each “priority”. These will then be placed on to a flip-chart.
- The groups will move on to the next table for the process to be repeated a further twice, until all 3 groups have visited all 3 tables.
- Further to the event, the Models Workstream will arrange the post-its under “themes” which will represent midwives thinking on a future model (i.e. Destiny).

Facilitators
Facilitators must make sure that each participant has equal airtime and the opportunity to have their say. Conversations shouldn’t be dominated by one or two individuals.
Appendix 2: Facilitator Briefing Notes

Proposed legislative change (early 2017) and boundaries

1. What’s preserved?
   • Protected title ‘midwife’
   • Protected function ‘attendance on woman in childbirth’

2. What are the changes?
   • LSAs disestablished
   • Statutory roles/functions LSAMO/SOMs cease
   • Midwifery Rules and Standards revoked
   • NMC Midwifery Committee ceases
   • New model will be cost neutral

Suggested prompts, if needed

1. **DISCOVER:** what strengths might we take from supervision to date; what strengths/assets do midwives have to bring to a new model going forward

   **Consider:**
   • what does the evidence tell us (e.g. about supervision)
   • conversations shouldn’t get bogged down in one topic (e.g. ‘supervision’)
   • steer conversations away from traditional statutory roles and functions and the things that are changing
   • encourage to think about a new model with different focus and purpose, alternative suggestions could be brought in under dream or destiny

2. **DREAM:** what would a good model do; what would it look like; what would it feel like

   **Consider:**
   • what would be most helpful in supporting midwives in practice
   • how would that link to/support midwives to revalidate
   • what would be important for the model to work e.g. contracting, supportive, no blame etc etc
   • how could supervision work in practice i.e. one to one, group, how often etc
   • what is practical and achievable – must cost the same or less than the existing model
   • what would help midwives see it as different from the ‘statutory’ model
   • what could SOMs be called
   • what could supervision be called
   • what opportunities does this change present
   • what would a transferrable model look like (across nursing)
Annex D

Third sector, women and families event (11 October, Edinburgh)

Workshop aims:
- To find out from 3rd sector organisations about personal and wider service users experiences of midwives supporting them with decision making throughout pregnancy.

Workshop outcomes:
- To understand how midwives can best advocate for women, dads, partners and families.

Participants were asked:
- How can midwives support you and your family with decision making throughout your pregnancy
- How did your midwife work with you and your family to help support you to make decisions throughout your pregnancy?
- What, in your experience worked well?
- Were there any specific decisions you made that you wanted more help with?

Organisations represented:
- AIMS
- SiMBA
- Sands
- Pregnancy and Parents Centre, Edinburgh
- Best Beginnings
- Mellow Parenting
- Families Need Fathers, Scotland
### Statutory model and employer led model comparisons

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Statutory Model</th>
<th>Employer led Model</th>
<th>Action Required</th>
<th>Responsibility</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>Public protection by exercising supervision in line with the NMC Nurses, Midwives &amp; Health Visitors Act and NMC Rules and Standards.</td>
<td>To contribute to improved services, safer care and better outcomes for women and families, by supporting midwives to advocate for women’s needs and to reflect on midwifery practice in line with NMC revalidation.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Who For</td>
<td>All midwives regardless of setting / employment.</td>
<td>All midwives in clinical practice or who have a clinical component to their role.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Structure</td>
<td>LSA Accountable for governance of standard of midwifery practice (CEO's NHS Board) x 14 LSAMO - Consortia arrangement - LSAMO x 1, LSA Midwife x 1 SOMs - Appointed by LSA x 224 Ratio = 1 SOM to 15 midwives, currently 1:18</td>
<td>NHS Board accountable for governance of standard of midwifery practice. Executive Nurse Directors have responsibility at Board level for supervision and liaison with the Chief Nursing Officer as required. Supervisor number dependant on local workforce requirements.</td>
<td>Disestablish national and local statutory supervision structure.</td>
<td>LSAs</td>
<td>31/03/17</td>
</tr>
<tr>
<td>Activities</td>
<td>LSA (NHS Board) &amp; LSAMO Appoints and manages LSA Midwifery Officer Implements and monitors NMC Standards for Supervision Manages ITP, submits to NMC annually Sets standards for supervision in LSA Arranges transfer of records from Independent Midwives Maintains supervision records Maintains list of SOMs Provides 22.5 hours CPD for SOMs in 3 year period Submits annual report to NMC in line with NMC requirements Selects, appoints and deselects SOMs.</td>
<td>LSA activities no longer required due to legislative changes.</td>
<td>Selection and recruitment of supervisors, facilitate education, allocate supervisors to midwives</td>
<td>NHS Boards</td>
<td>From 1/04/17</td>
</tr>
<tr>
<td>Investigation of alleged impaired fitness to practise, suspension of midwife from practice and referral to NMC</td>
<td>NHS Boards and other employers responsible for governance of midwifery practice, including fitness for purpose/practice, investigation of alleged impairment and referral to NMC in line with existing policies and governance processes.</td>
<td>Ensure existing staff and clinical governance takes account of midwifery practice</td>
<td>NHS Boards Employing organisations</td>
<td>In place by 1/04/17</td>
<td></td>
</tr>
<tr>
<td>SOMs</td>
<td>Meet named midwives at least annually  Enables 24/7 access to SOM for advice  Maintains records on supervisory activities  Undertakes annual reviews if practice, clinical incident reviews, investigations and audits  Role additional to and separate to substantive role</td>
<td>Facilitates / coaches group supervision sessions (maximum 10 people per session)  1:1 sessions with midwives if required (estimate approx 10% midwives = 358)  No requirement for 24/7 access  Role additional to and separate from substantive role  Midwives utilise e-portfolio to record reflections to meet revalidation requirements.</td>
<td>Supervisors establish systems and process for group supervision.</td>
<td>NHS Boards</td>
<td>In place by 9/01/18</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Midwives</td>
<td>Meet SOM at least annually to discuss practice and ad hoc as required if midwife needs advice/ support.</td>
<td>Attend a minimum of 1 group supervision sessions  Seek 1:1 supervision as required - (estimate 10% of midwives - around 358 midwives). Midwives utilise e-portfolio to record reflections to meet revalidation requirements</td>
<td>HOMs monitor attendance</td>
<td>Midwives HOMs</td>
<td>9/01/18</td>
</tr>
<tr>
<td>Education</td>
<td>SOMs</td>
<td>PSOM course - HEI led and delivered (PSOM)  2 modules for each SOM at Masters level</td>
<td>CPD x 1 Day for existing SOMs who may wish to transfer to new role if skill set matches.  CPD x 3 Day for new supervisors - blended option of some e-learning and some face-to-face time.</td>
<td>NES to develop education  HOMs to release supervisors to attend.</td>
<td>NES NHS Boards</td>
</tr>
<tr>
<td>Total costs (estimated, indicative costs)</td>
<td>Total start up costs</td>
<td>Estimated – SOM course initial training requirement for over 224 SOMs (will have been much more accrued over the years)  (180 hours and 2 Masters modules for 224 SOMs)</td>
<td>£1,043,213</td>
<td>Estimated – Developing education (incl development costs) and initial training (154 supervisors, some with previous SOM experience, therefore lesser training requirement)</td>
<td>£115,545</td>
</tr>
<tr>
<td></td>
<td>Total annual running costs</td>
<td>Estimated (LSAMO costs/admin/Masters/annual payment/on-call, SOM education and activities)</td>
<td>£1,140,939</td>
<td>Estimated – Supervisor education and activities</td>
<td>£242,004</td>
</tr>
</tbody>
</table>
Annex F

EXAMPLE ‘TOOLKIT’ FOR CLINICAL SUPERVISION POST 31/03/17

QUALITIES OF A CLINICAL SUPERVISOR
Feedback from regional events and other stakeholders suggests that clinical supervisors must be supportive and approachable, facilitative yet challenging, inspiring and motivational as well as having coaching skills to support midwives to advocate better for women. Confidentiality and mutual respect are fundamental. Supervisors will be key in supporting midwives to build confidence to practise safely whilst delivering relationship based care in an enriched working environment. This will have a positive impact on professional relationships with colleagues.

SELECTION OF CLINICAL SUPERVISORS
Each NHS Board (or other employing organisation) will be responsible for the selection and internal recruitment of supervisors through a process of peer nomination. Heads of Midwifery (HoM) may agree a process to ensure consistency across Scotland. The activities of a supervisor are additional to and separate from a substantive role. Not all current supervisors of midwives will want to become clinical supervisors or have the required skill-set to support the new model. The HoM (or equivalent) will be responsible for the recruitment and performance management of supervisors in line with HR processes. Once appointed, each supervisor will require to be released for education and training that is appropriate to their scope of practice.

EDUCATIONAL REQUIREMENTS
The new model will require training to develop the restorative elements which will enable midwives to be supported, resilient and strong advocates for women. Education will include interpersonal skill training, coaching, facilitating, mentoring, supporting advocacy and encouraging caring and courageous conversations.

NHS Education for Scotland will deliver a blended learning educational approach, including e-learning resources and face-to-face workshop delivery. A one day workshop will be available for existing SOMs (supported by appropriate e-learning resources). A three day workshop for new supervisors will be available (supported by an e-learning resource). A refresher package will be available to support annual CPD.

EXPECTATIONS
Midwives will be expected to attend at least 1 group session per year (in protected time) with additional 1:1 meetings where required. Sessions should be pre-arranged for planning purposes but have flexibility for ‘drop in’ to provide support at short notice if required. Ground rules as well as confidentiality and contracting must be agreed for all sessions and accompanied by appropriate documentation.

GROUP SESSION ACTIVITIES
It is proposed a group supervision session will be provided for a maximum of 10 midwives to ensure a restorative model of supervision can be delivered that enhances midwifery care and ultimately benefits women, their partners and families.

Reflection is a key component of clinical supervision and affords an opportunity to initiate caring and courageous conversations whilst learning from events. Scenario based or specific case discussions could be used to review what went well and what could have been done differently. Midwives may wish support to share good practice or challenge poor practice to improve women’s experiences and outcomes.
**1:1 SESSIONS**
Midwives may seek support on an individual basis for a variety of reasons, such as discussing a challenging case in order to reflect on practice and outcomes, to gain support in dealing with difficulties in the workplace or seek advice about coping with stressors. The need for coaching and strategies to support individual needs may be more apparent than in group sessions to ensure midwives feel safe, valued and empowered.
Example toolkit templates

**Supervision record**

Supervisee:
Supervisor:
Date:

<table>
<thead>
<tr>
<th>Topic / discussion</th>
<th>Action</th>
<th>When by</th>
<th>Who by</th>
<th>Done</th>
</tr>
</thead>
</table>
Supervision contract

Supervisee:
Supervisor:
Date:
Review date:

Purpose and type of supervision
Include model, method and means of communication

Frequency
Please specify frequency

Environment
The supervisor and supervisee should work to ensure a safe environment.

Emergency contact
The supervisor or supervisee can request an ‘urgent’ supervision session where necessary. Each will, where possible be accessible and available.

Content
The supervisee is responsible for bringing material from his/her work and any issues that arise from it to supervision. The supervisor will work to assist the supervisee to attain and maintain the professional, ethical and safety standards that are set by the profession. Personal Development Plans may also be part of supervision sessions.

Supervision records
A record of material brought to supervision and an action or review plan is to be kept. This record remains the property of the supervisee and supervisor. Should this record be used for revalidation purposes it will be anonymised.

Review of progress
There will be ongoing review of predetermined supervisory outcomes. After 3 months, there will be an informal evaluation of the supervision relationship by both parties, and thereafter an annual review.
Responsibility and accountability
The supervisor is responsible for the advice and information they give in supervision but not for the response taken by the supervisee to the advice/information. The supervisee is responsible for their own practice.

Confidentiality
Supervision is a confidential process with the following exceptions:
- When both parties agree that an issue can be shared outside of supervision
- If an issue requires attention out with the supervision relationship, then this will be discussed within the session between supervisee and supervisor e.g. this relates to child protection and vulnerable adult legislation.
- The supervisee reveals any practice that the supervisor considers to be unsafe or negligent, and the supervisee is unwilling to go through the appropriate organisational procedures to deal with it.

In the event of the circumstances outlined above, the supervisor will:
- Attempt to support the supervisee to deal with the issue themselves through the agreed appropriate channels. Follow up with individual to ensure appropriate action is taken within an agreed time scale.
- If the supervisee is unwilling to deal with the issue him/herself, the supervisor will advise the supervisee of their professional duty to reveal the information to the appropriate individual or authority prior to taking action themselves.

Signatures
Supervisee:
Supervisor:
Date: