On 28 April 2017, the Advocating for Education and Quality ImProvement (A-EQUIP) model of midwifery supervision was introduced in England (Dunkley-Bent, 2017) in response to the removal of statutory supervision from the Nursing and Midwifery Order 2001. In the UK, there had been a version of midwifery supervision in place since the Midwives Act in 1902 and, over the years, the model of supervision had undergone many revisions. The most recent version of midwifery supervision was described in Statutory Instrument 2002 No. 253, of the Nursing and Midwifery Order 2001. The Nursing and Midwifery Council (NMC) set out the rules that governed the practice of supervision of midwives in the former Midwives’ Rules and Standards (NMC, 2012). After the publication of reports by the Parliamentary and Health Service Ombudsman (PHSO) in 2013 and the King’s Fund (nd), the NMC accepted the recommendations that midwifery supervision and regulation should be separated, with the NMC solely being in control of the regulation of midwives (Purdy and Read, 2019). On 31 March 2017, the statutory supervision of midwives was removed from statute as well as the Midwives Rules and Standards.

In 2016, the Department of Health tasked all four countries in the UK with establishing a time-limited taskforce to ensure processes of good clinical governance and support for professional practice were put in place for the midwifery profession. In England, the taskforce consisted of stakeholders including women who used maternity services, midwives, academics, midwifery and nurse leaders and managers, commissioners, the Royal College of Midwives and Birthrights. A new model of employer-led midwifery supervision – A-EQUIP (Fig 1) – emerged from the consultation (NHS England, 2017). It provides a framework that...
A-EQUIP model

Fig 1. A-EQUIP model

Clinical Practice

Discussion

Box 1. Role of the professional midwifery advocate

- Use the Advocating for Education and Quality ImProvement model to support the supervision of midwives
- Act as a role model, promoting safe and effective evidence-based care for women, babies and their families
- Support midwives to identify how personal actions can improve the quality of care provided to women and families
- Use a process known as restorative clinical supervision to support midwives to focus and develop professional and career aspirations
- Support midwives in emotionally difficult and challenging situations
- Provide visible leadership in the workplace

More details on suggested activities that can be undertaken by professional midwifery advocates, along with case studies, are available from regional maternity leads.

Source: NHS England (2018b)

Box 2. Professional midwifery advocate model: benefits

- Having a positive impact on the immediate wellbeing of staff
- Helping staff to feel valued by their employers for investing in them and their wellbeing
- Influencing a significant reduction in stress and burnout
- Improving compassion, enjoyment and job satisfaction
- Improving the retention of staff
- Improving working relationships and team dynamics
- Helping staff to manage work/life balance more effectively

Source: NHS England (2018b)

supports a culture of improvement, with the aim of building personal and professional resilience, thereby enhancing care quality and supporting preparedness for appraisal and revalidation. The evidence base derives from Proctor’s (1987) three-function model of clinical supervision, and Hawkins and Shohe’s (2012) adaptation of that model. The model also has a fourth function – personal action for quality improvement – and highlights the importance of continuous improvement.

A professional midwifery advocate (PMA) is a practitioner who uses the A-EQUIP model and takes on the associated leadership required. The model and PMA role are employer led, so it is the responsibility of the NHS provider to decide how these are implemented. The need to use the model is contained in the NHS Standard Contract as a means of supporting the midwifery workforce (NHS England, 2018a).

PMAs are qualified midwives who have undertaken further recognised training provided by a higher education institute (NHS England, 2017). Once trained, PMAs can take on a range of duties as part of their substantive midwifery role (Box 1), set out in the A-EQUIP operational guidance.

The evidence base for restorative clinical supervision

Restorative clinical supervision (RCS) is one part of the A-EQUIP model, which is also associated with wellbeing benefits, team working and staff retention (Box 2). RCS offers midwives a safe space to reflect on the experiences they wish to discuss so they can source their own solutions, individually or in groups (Macdonald, 2019).

The RCS model in A-EQUIP promotes and uses the principles of the Solihull Approach (Douglas and Ginty, 2001), which involves concepts of reciprocity, containment and behaviour management to allow professionals to process emotions, focusing on their interactions with others and maintaining professional boundaries. The sessions can be formal and rostered or done on an ad-hoc basis and tailored to the needs of the practitioners. The benefits of RCS can be embraced by health professionals at any level, including students (Tyler and Lachanudis, 2020; Power and Thomas, 2018).

The supportive culture that RCS facilitates is designed to promote a positive staff culture, the impact of which will be demonstrated through high-quality, safe midwifery care (Whatley et al., 2021). Research has suggested that the benefits of this positively affect emotional wellbeing, reducing levels of stress and anxiety (Wallbank and Woods, 2012).

How RCS is taught

Anecdotal evidence suggests that RCS is a new skill for most midwives and seems to cause most concern during PMA training programmes. There is a lack of understanding of what RCS is and how it can be used to support staff. The principles seem straightforward, but it is often not clear how they work until practitioners experience RCS for themselves.

Initially, student PMAs were learning RCS face to face but, due to the Covid-19 pandemic, academic institutions moved to the use of virtual platforms. Teaching RCS is based on the A-EQUIP model, which includes practical experience as well as building wider relationships with peers outside of their workplace. PMA students may be asked to develop ‘powerful questions’ to have in their PMA toolkit should the session be slow to start, but they should not be afraid of silence.

The importance of confidentiality and a safe space – not breaching safeguarding or the NMC’s (2018) Code – is reiterated, alongside feedback and evaluation. Skills
Box 3. How PMAs learn clinical supervision skills in training

PMAs are introduced to the theoretical principles and techniques to ensure that a safe space is maintained without distraction and taught how to facilitate and lead conversations using:

- Theoretical models
- Reciprocity through meaningful interactions and communication skills
- Behaviour management by way of the mutual creation of a contract with both the attendees and facilitator.

This contract could include being in a confidential space (except for safeguarding and legal reasons), keeping to time (generally recommended to be no longer than one hour), not taking notes and respectful communication.

Through role playing, students get to experience issues that can cause a distraction in a restorative clinical supervision (RCS) session, such as overtalking and difficult conversations. They are also encouraged to develop active listening skills and practise other theoretical techniques they can use in practice. Students experience an RCS session over five days during the course. They are placed in small groups of around eight people, with a member of the academic team for support, so they can try being a session participant as well as leader. It is vital to provide a safe environment for student PMAs to learn about RCS, gain confidence and develop a support network.

PMA = professional midwifery advocate.

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