The Professional Midwifery Advocate (PMA) Deploying a new model of midwifery supervision for England called A-EQUIP (Advocating & Educating for Quality Improvement)

England Supervision Taskforce

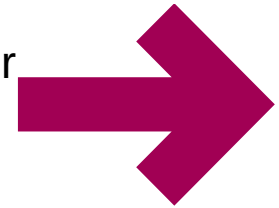
Responsibility of the Chief Nursing Officer to:

- Convene a task force to develop a new model of supervision
- Oversee the transition from a statutory model of supervision to an employer led model
- Taskforce supported by work streams: models, education, commissioning, editorial and HR

Stakeholder engagement

We have listened to staff and women who use maternity services who have told us:

- What the new model of supervision should include
- What it should be called
- The name of the new supervisor and how they should be prepared for their role.



Engagement

More than ten months of engagement with over 2,400 people, across the healthcare system including:

- Survey responses -1,400
- Online platform used by 280 people to comment on the replacement model
- Contributions from over 400 delegates at the 2016 RCM conference where we tested the evolving A-EQUIP model
- Contributions from over 800 delegates at various conferences
- ‘Think Tank’ event of stakeholders

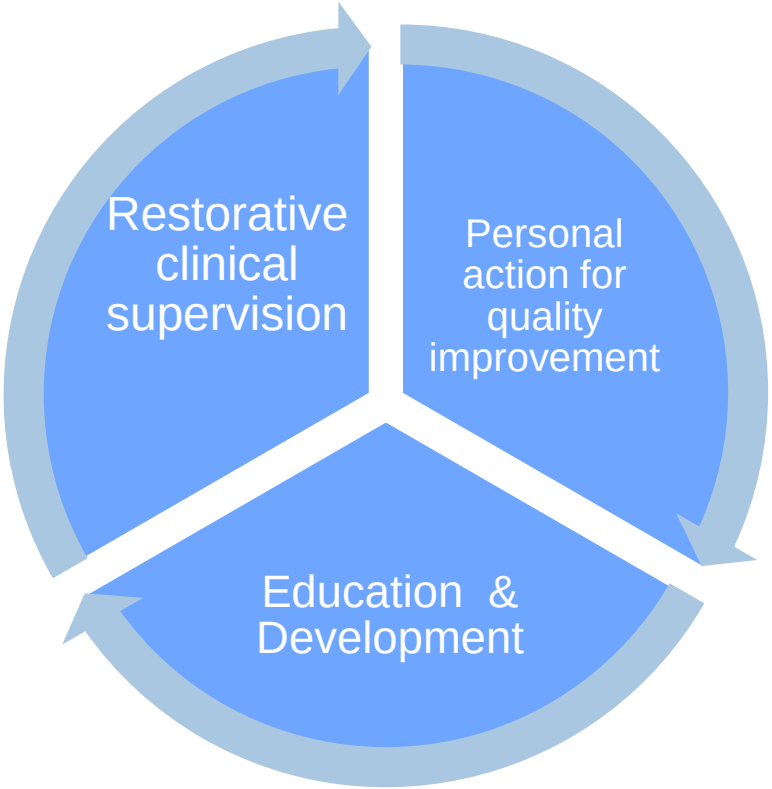
What did midwives say…

- Supervision will become punitive and not restorative”
- “Midwives will be referred to the NMC at the drop of a hat”
- “Without the law supervision will be difficult to enforce”
- “Midwives need to feel valued, to do a good job”
- “Cheaper health care roles will replace midwives”
- “Women will lose support”
- “Supervision does nothing”
- “Invest in staff, the current model pays lip service to this”
- “With good leaders no supervisors needed”
- “Introduce a model that builds staff”
- “Who will support self-employed and agency midwives?”
- “How will we benchmark if there are no audits? “
- “Who’s going to provide professional midwifery advice across England?” Select wisely don’t set midwives up to fail”
- “Expertise for providing advocacy for women will go, include it in new model” “stop midwives from leaving by providing something better”

What did women say?

- “Not sure what supervision is”
- “Who will we contact for support?”
- “Who will have fresh eyes?”
- “I am concerned about being medicalised”
- “Supervisors advocate for women, midwives don’t”
- “Who will I speak to about my choices?

You said and we listened -The A-EQUIP Model



- The A-EQUIP model is made up of three distinct functions: restorative, personal action for quality improvement and education and development.
- The model aims to support the midwife through a process of restorative clinical supervision, personal action for quality improvement and preparedness for professional revalidation.
- The deployment of the model supports a continuous improvement process that builds personal and professional resilience, enhances quality of care and supports preparedness for appraisal and professional revalidation.
- The ultimate aim of using the A-EQUIP model is that through staff empowerment and development, action to improve quality of care becomes an intrinsic part of everyone's job, every day in all parts of the system.

Restorative clinical supervision (RCS) function

- Concerned with addressing the emotional needs of staff & supports the development of resilience
- It involves the creation of thinking space supporting the practitioner to physically and mentally ‘slow down, through a process of discussion, reflective conversation, supportive challenge and open and honest feed-back.
- It restores ‘thinking’ capacity, enabling the professional to ‘understand’ and process thoughts which ‘frees’ them to contemplate different perspectives, and inform their decision making (Pettit & Stephen 2015)

RCS has been shown to:

- Have a positive impact on the immediate wellbeing of staff
- Staff feeling ‘valued’ by their employers for investing in them and their wellbeing
- A significant reduction in stress
- A significant reduction in burnout
- Staff receiving RCS demonstrated an improvement in their compassion satisfaction- the pleasure one derives from doing their job.
- Improve the retention of staff in the group receiving RCS
- Over half the staff surveyed felt they functioned better as a result of receiving RCS
- Reduce stress levels whilst maintaining compassion
- Improve working relationships and team dynamics
- Help staff to manage work/life balance more effectively
- Increase enjoyment and satisfaction related to work

(Petit & Stephen 2015)

Personal action for quality improvement

- Requires all professionals to be familiar with and contribute to quality improvement
- aims to ensure that action to improve quality of care becomes an intrinsic part of everyone's job, every day, in all parts of the system
- aims to equip professionals to be familiar with and contribute to quality improvement that places women and babies at the centre of care. Advocacy and personalisation is central this function
- contributing to systems of quality assurance and quality improvement is a fundamental part of the midwives role

A midwife's personal contribution to quality improvement

May include:

- participation in audit
- embedding learning from incidents in practice
- improvements made as a result of user complaints/ staff complaints
- using evidence based guidance to inform practice
- facilitating the implementation of research findings
- any active contribution to a quality improvement activity (this does not need to be in a clinical setting).

Education and development

- aims to focus on the development of knowledge and skills through education, to inform appraisal, revalidation and leadership development.

- This process can be facilitated by guided reflection (Proctor 1988). Self-leadership can be explored, examining how the midwife interacts with others, influences change and improves care.

- The depth and breadth of this function can be influenced by the output of the restorative and quality improvement functions of the A-EQUIP model, whilst assisting the midwife to recognise and build on the links between appraisal and revalidation.

- *The new model of clinical supervision is employer led and not statutory*
- *It does not involve regulatory matters: investigating concerns; imposing interim orders; specifying and monitoring local programmes or making referrals to the NMC.*

The Professional Midwifery Advocate (PMA)

- New role that replaces the supervisor of midwives
- A midwife must successfully complete a PMA preparation programme provided by the HEI
- Shortened PMA programme (no more than 4 days, may be taught in-house by your HEI) – designed to prepare midwives who have completed the PoSoM course to become PMAs
- Long PMA programme (length to be confirmed and will be outlined in the operational guidance) – designed to prepare midwives who have never completed the PoSoM or associated programme
- A-EQUIP e learning module – 30 minute module that will compliment and replace aspects of the short and long PMA programme
- Selection of PMAs is the responsibility of the Head/Director of midwifery
- Selection process and job profile - see operational guidance, publication date end March 2017

Using the A-EQUIP Model

- Each element of the A-EQUIP model can be accessed in isolation of other elements according to the needs of the midwife, alternatively progression through all elements may be required.
- The A-EQUIP model can be deployed in a group or one to one.
- Midwives are expected to meet with the PMA as required (office hours), but for most, this may mean a minimum of one interaction per year
- Effective ratios are dependent on tasks, standards and responsibilities of the PMA and the midwife.
- Guidance regarding ratios will be outlined in the A-EQUIP operational guidance that is being prepared for: midwives, providers, HEI's commissioners and the wider NHS system. Publication date: end of March 2017

Transitioning from the statutory model to the employer led A-EQUIP model

Maternity providers to:

- Review the number of deselected SoMs and prepare plans for selecting them for PMA preparation
- Review and risk assess the scope of the non statutory roles undertaken by supervisors of midwives and based on the outcome of the risk assessment choose to:
    1. Support the non statutory components of that role incorporating the management and governance responsibilities into the existing provider framework, until PMAs are prepared
    2. Cease all non-statutory activity, supported by actions that reduce the impact of risk, if risk has been identified
- Ensure that communication is shared with women –briefing? on the provider's website?
- Inform the Maternity Voices Partnership/MSLC/ PALs

A-EQUIP model will be flexible enough to…

Midwife

Woman

Organisation

Assess Impact at 3 Levels

Consider 3 types of impact where the intervention…

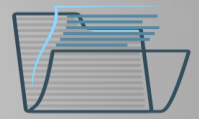
Address a particular deficit

Start to cause a developmental change

Causes a <u>real shift</u> in culture, behaviour or performance

Account for…

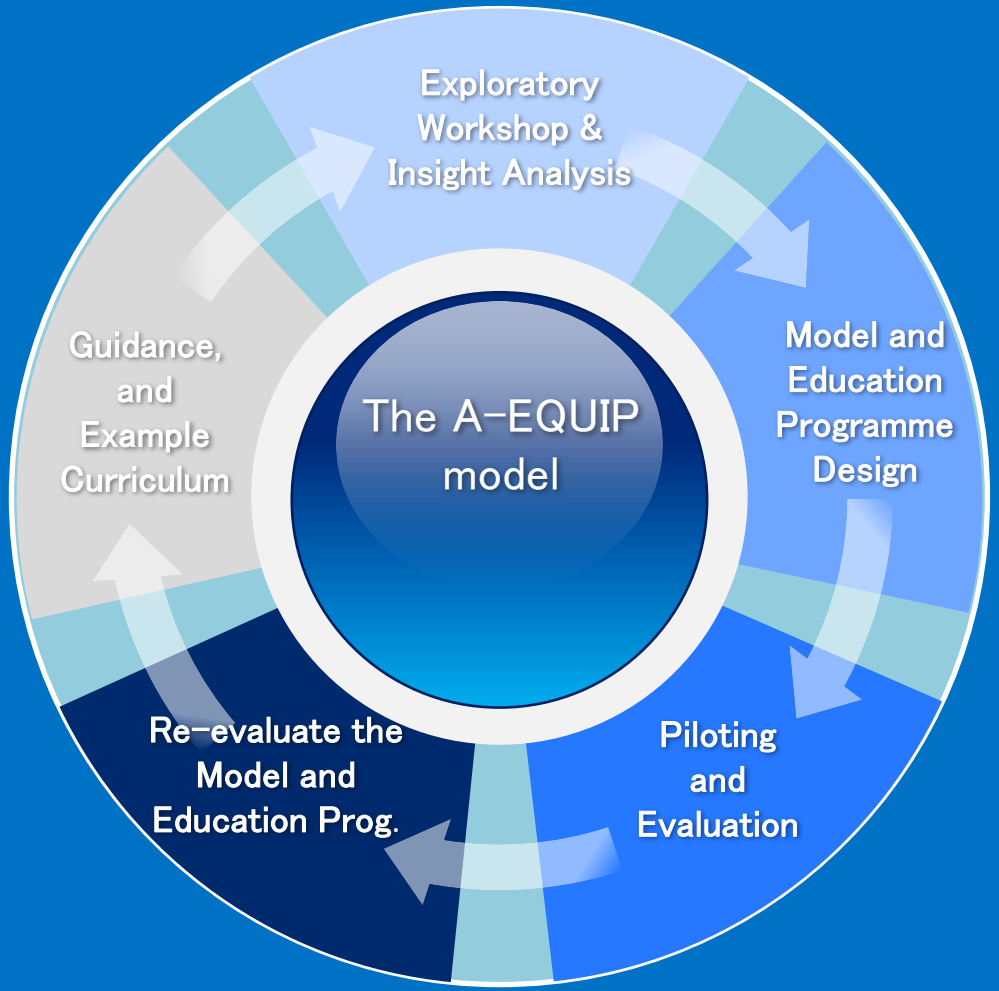
Evidence Base



Opinion Base

Testing the new model

- 49 expressions of interest – plus 12
- Selection of midwives to become PMA's – existing PoSoM education programme, support from HoM/DoM – nomination process in future
- Bridging/conversion programme – 3 days in house -leadership
- Programme specification for the 'PMA bridging programme
- Competencies align with the CQC Key Lines of Enquiry that address the key priorities of every service, determine quality and identify risks
- Plans by some HEI's to modifying an existing module
- PMA trained and new approach deployed
- Focus of evaluation – process, impact and outcome
- A-EQUIP model adjusted to reflect the outcomes of the evaluation



The evaluation of the pilot sites will include:

- Establishing baseline data
- Evaluation of the preparation of the PMA
- Evaluation of the A-EQUIP model
- Assessment of the usefulness of using one or all elements of the model and the perceived impact and outcome-

Our Pilot Sites

41 SoMs trained to be PMAs
- Now delivering the new model to 205 Midwives

Publication of new model guidance

- NHS England will publish guidance once the evaluation of pilot sites is complete. This publication will include the findings of the evaluation and provide implementation guidance

Indicative content

- Guidance for midwives and providers of maternity services
- Guidance for commissioners
- Guidance for HEI's
- Generic guidance
- Case studies – how to use the model as a clinical and non clinical midwife
- Frequently asked questions

Levers and incentives

- Why implement the new model?

Based on available evidence

It's in the contract!

- The NHS Standard Contract (NHS England 2017/18), is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care
- Clinical Commissioning Group Maternity Specification
- CNO request for implementation
- Considered to be best practice
- Cost neutral – cost saving?

Getting ready for implementation

- Communications strategy includes: Monthly update to CNO bulletin
- Briefings/updates on the NHS England website
- Publication of operational guidance for implementing the new model – guidance for: providers, commissioners, HEI's, women
- SoMs de-selected, LSAs dissolve – NMC guidance
- Interim arrangements whilst Higher Education Institutions train PMAs?
- None statutory element of the role continues until such time that PMAs are prepared ?
- Longer term – HEI's to develop 'Long PMA preparation programme'
- 28 March 2017 – Manchester!