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EVALUATION OF THE NEW EMPLOYER-LED MODEL OF CLINICAL SUPERVISION FOR MIDWIVES IN SCOTLAND

September 2022

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Executive summary

A review of maternity care into the deaths of babies and a mother in Morecambe Bay NHS Foundation Trust raised concerns about the effectiveness of Statutory Supervision of midwives in protecting the public. Following this, the NMC commissioned a review of Statutory Supervision of midwifery which recommended that the dual roles of supervision and regulation should be separated.

A new Nursing and Midwifery (Amendment) Order 2017 came into force on 31 March 2017 which removed the provision of Statutory Supervision and devolved responsibility to develop a new Clinical Supervision (CS) model to each of the Chief Nursing Officers in all four UK countries. In Scotland, a decision was made to adopt a restorative, resilience-based CS model, designed to be delivered in group settings of up to ten with a facilitator, based on the concepts of reflect, restore and respond. The University of Dundee was awarded a Chief Scientist Office (CSO) PhD studentship to undertake the evaluation of the implementation of the new model. This report is an abridged version of the full PhD thesis which sets out a description of the study and the findings.

To inform the study, a literature review was undertaken. It found that there had been limited empirical work of CS in relation to midwifery. The review reflected the tensions found in the reports by Kirkup (2015) and the King's Fund (Baird et al., 2015) in relation to the conflicting responsibilities of support and regulation. This was evidenced in the desire of midwives to have a trusting relationship with an assurance of confidentiality in supervision, with the need for Statutory Supervisors of midwives to investigate practice. There was limited evidence of effectiveness in care delivery and there was a lack of understanding on the part of midwives about the role of Statutory Supervision in protection of the public.

None of the studies explored the content of midwifery Supervisory meetings. The concept of trust was raised in several studies showing that good Supervisory relationships with trust can be motivational and empowering but in in poor relationships, lack of trust can result in lack of openness which may impact upon standards of practice and safety. Further research is needed in this area. There was a lack of literature in relation to the model adopted by Scotland, demonstrating the need for the study.

The aim of the research was to evaluate the implementation of the new model of employer-led Clinical Supervision for midwives in Scotland. The following two research questions were developed for the PhD project:

1. How is the new model of CS of midwives being implemented across Scotland?
2. What are the views and experiences of those participating in the new model of CS?

Qualitative methodology was selected as the most appropriate to explore in-depth the implementation and participants' experiences of CS for midwives. A case-study approach was adopted to help understand how the new model of CS was implemented both at an

organisational level (meso) and an individual level (micro). The design of the study was a single case i.e., implementation of CS for midwives in Scotland, with three nested sub-cases: Heads of Midwifery (HoMs) and two Health Boards. The first sub-case comprised HoMs across Scotland and provided an opportunity to explore implementation at a managerial or operational level (meso-level) and to compare approaches to implementation between Health Boards. The other sub-cases were two Health Boards (referred to in this report as site X and site Y) to understand the experiences of midwives participating in CS (micro-level). The criteria for selection of the two Health Boards were variation in: population size and diversity; the urban/rural context and the number of births per annum.

Ethics approval was obtained from the University of Dundee (UoD\SNHS\RPG\2019012) and Research and Development permissions were granted by all 14 Health Boards. Data collection took place from August to November 2019.

In total, 10 HoMs were interviewed, seven by telephone and three face-to-face. Data collection in the micro-level sub-cases comprised face-to face interviews with midwives and non-participant observations. In total 18 midwives participated (nine from each sub-case site) and four episodes of non-participant observation were conducted, two in site x and two in site Y. All the interviews were audio-recorded and then transcribed verbatim. The data were analysed using the Framework Method (Gale et al., 2013).

The findings are presented by sub-cases and under six overlapping themes: Preparing to implement CS; Uptake; Delivery; Function and processes; Resources; and Context.

Recruitment of Clinical Supervisors of Midwives (CSoM) was successful initially, but recruitment and retention became more challenging over time and no further training for CSoMs was provided. Various strategies were used to promote CS to midwives and to encourage them to undertake the preparatory module. The uptake of midwives participating in a session of CS annually in the first year of implementation ranged across Health Boards from 50% - 100%. The intention of the new model was that all midwives in clinical practice would engage in clinical supervision. The HoMs reported uncertainty regarding whether CS attendance was mandatory and whether there should be consequences for midwives for non-attendance. Some HoMs preferred to encourage midwives to attend and were optimistic that implementation would be seen as a positive cultural change.

Delivery of CS varied between Health Boards although predominantly it was delivered in groups. Uptake of one-to-one session was variable and due to administrative challenges, there was a lack of reliable data on uptake of individual CS. Other variations in delivery included ad hoc sessions and planned sessions, sessions with pre-determined topics for discussion and those where the agenda was set by participants. Session of CS were often planned as part of mandatory training days for midwives. In some areas, supervision sessions specifically for newly-qualified midwives took place.

Being able to formalise reflective practice in the workplace was identified as a positive aspect of implementing CS and supporting managers. The HoMs thought that CS could support their workforce to improve and sustain high quality midwifery care. However, HoMs also recognised that opportunities to attend CS and participate in reflection could be affected by workload pressures. All HoMs felt optimistic about implementing CS to build resilience within their workforce including benefits to both midwives and the organisation. A culture of blame and fear of mistakes were felt to be challenges to reflection.

The HoMs described lack of resource as having an impact on the feasibility of implementing CS such as the limited time provided to CSoMs to prepare for sessions and complete associated administrative tasks, as well as the challenges in facilitating midwives to attend sessions because of a high workload, operational pressures and lack of resources to allow midwives time to attend when they were on duty. The change in funding arrangements meant that the administrative and educational support available to Statutory Supervisors was no longer in place and HoMs struggled to manage expectations of CSoMs and midwives with the limited resources available to them.

Two key contextual issue impacting on implementation of CS were the concurrent implementation of the Best Start policy and comparisons made with the previous policy of Statutory Supervision for midwives.

In the two sub-case sites, there were varied views on the pre-requisite education module with some feeling well-prepared and others not able to recall the content. The CSoMs suggested there was initial resistance to CS. There was confusion in both sites regarding whether CS was mandatory and in one site, participants perceived punitive consequences of non-attendance. The premise underpinning CS is that it should be a source of support for midwives and there is an expectation that they will engage (SGHD, 2017b). However, the focus on attendance led to most participants describing CS as a 'tick box exercise'.

Participants had mostly experienced group CS and some were unaware that individual supervision was an option. A critical issue for midwives was that the groups did not have fixed membership which was a barrier to developing trust. The shift from a formal structure driven by the supervisor to a more spontaneous approach generated by the participants was difficult for some midwives to accept. There was dissatisfaction with the lack of structure of the sessions with some participants expressing that they did not benefit from attending as it lacked focus or was dominated by a few individuals. Despite this, midwives were positive about the benefits of reflection for their practice and there was enthusiasm about the opportunity to reflect together in a group. Some CSoMs were uncertain about whether they were delivering the model as intended and they wanted more time, training and support. Notably, none of the participants mentioned use of a reflective cycle to structure reflection. The opportunity to reflect and build resilience through CS was linked by participants to quality of care. Participants explained how CS was used to highlight good practice and share helpful and positive experiences. The key resource issue for midwives was lack of time to deliver and attend CS.

The challenges involved in delivering Best Start alongside implementing CS were highlighted frequently during interviews with HoMs. One of the sub-case sites was a pilot site for the Best Start policy and while CS was seen as a mechanism to support midwives through service delivery change, some midwives felt it dominated all discussions. Participants also highlighted valued features of Statutory Supervision that were not integrated into CS such as relational continuity with an allocated Supervisor of Midwives and the privacy of one-to-one conversations. For example, reflecting on practice errors can be a powerful learning experience but undertaking this in a group could be challenging for midwives, especially if they feel that they will be blamed about making mistakes, with some HoMs acknowledging that there was a culture of fear around acknowledging mistakes. A model which allowed midwives to explore mistakes in a one-to-one situation could facilitate learning. Some HoMs in the study continued the practice of allocating a named CSoM for midwives, although staff could approach any CSoM for support. Identifying a named CSoM was believed to enhance continuity and facilitate a trusting relationship between the midwife and the CSoM.

HoMs and CSoMs drew attention to the challenges of delivering the model as intended. While HoMs appreciated the support given by NES to implement the new model, some expressed uncertainty about midwives' understanding of the model, particularly midwives who had experienced the old model or who were unfamiliar with reflection. CSoMs found the training provided by NES helpful but were concerned about ongoing support in the delivery of supervision. Time to prepare and deliver were also cited as challenges for CSoMs. Although NES had developed a generic evaluation tool, it was not always possible to gain feedback, either because midwives left quickly at the end of the session or because of administration and IT system issues. This led to CSoMs feeling uncertain about the effectiveness of their delivery of the new model.

In conclusion, the findings of this evaluation highlight that HoMs invested substantial effort in implementing the new model of CS. Initially there was enthusiasm among midwives to be CSOMS and good participation from most midwives. The evaluation participants were mostly positive about the potential for CS to build resilience and improve midwifery practice. The challenges of implementation were mainly related to lack of time for providing and participating in CS. The lack of ongoing support for CSoMs to develop and maintain skills of facilitating group reflection was a significant barrier to its successful implementation. The emphasis by employers on midwives attending CS once a year resulted in it being perceived by most as a 'tick box' exercise. The predominant mode of delivering CS in open groups prevented midwives feeling safe to reflect openly on their practice. Midwives who had experienced Statutory Supervision expressed the view that having a named supervisor and the opportunity for one-to-one support made them feel valued and respected and this had been lost in the new model of supervision. The view frequently expressed by midwives in the study was that there was a lack of time for meaningful discussion and the offer of one group supervision session a year was a token gesture. Midwives were generally unaware that they could request a one-to-one session. Our evaluation found enthusiasm for the concept of restorative supervision from midwives. For the new model to

realise its potential and achieve the benefits, there should be sufficient investment to address these challenges. In particular, better support for CSoMs and protected time for CSOMS and midwives to engage meaningfully in regular supervision are needed as well as ongoing evaluation of the model.

Based on this evaluation the following recommendations are proposed:

1. Reinforce to midwives and employers, CS for midwives as facilitative, restorative and supportive;
2. Implement a programme of ongoing education and support for CSoMs to ensure they develop and maintain skills to facilitate reflection, using a reflective cycle, for groups and individuals and regularly evaluate the education and support;
3. Ensure that CSoMs have access to regular supervision;
4. Provide a national forum for CSoMs to share experiences, challenges and good practice;
5. Refresh the preparatory training module for midwives to participate in CS with increased emphasis on midwives' responsibility to set the agenda for supervision and participate in reflection;
6. Protect time for midwives and CSoMs to participate meaningfully in CS without disruption from workload pressures;
7. Raise awareness that CS can be provided individually or in groups according to the individual midwife's preference;
8. Develop systems and processes to ensure that midwives are able to develop a meaningful relationship with a CSoM and to have the opportunity for one-to-one sessions where privacy is required.
9. Where supervision occurs in groups, facilitate midwives to form fixed supervision groups to develop trust and encourage open reflection on practice issues;
10. Consider offering HoMs supervision either on a one-to-one basis or with a group of managers to ensure that they are able to access the support CS provides;
11. Increase the frequency of CS and ensure midwives have equitable access to CS compared to other NHS health professional groups;
12. Evaluate the quality of supervision and reduce the emphasis on attendance;
13. Review the concept of 'cost neutral' provision to provide adequate resource for effective CS to realise the potential savings in reducing staff stress and absence;

14. Undertake an economic evaluation of CS to inform investment decisions.

List of abbreviations

CS	Clinical Supervision
CSO	Chief Scientist Office
CSoM	Clinical Supervisor of Midwives
HoM	Head of Midwifery
LSA	Local Supervising Authority
NES	NHS Education for Scotland
NMC	Nursing and Midwifery Council
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
QATSDD	Quality Assessment Tool for Studies with Diverse Designs
SoM	Supervisor of Midwives

Introduction

In 2017, midwifery supervision was separated from regulation. This meant that the statutory roles and functions associated with Local Supervising Authorities (LSA) were no longer required. From the 1st April 2017, governance of midwifery practice rested solely with employers. The approach taken in Scotland was to implement Clinical Supervision for midwives from 8th January 2018. The University of Dundee was awarded a CSO PhD studentship to undertake the evaluation of the implementation of the new model.

Background

Statutory Supervision of midwives has been enshrined in law in England and Wales since 1902 and in Scotland from 1915 (Reid, 2011). Historically, midwives had been subject to an extra level of local regulation which is unique to them in comparison to other health professions in the United Kingdom. Until 2017, Statutory Supervision was a regulatory and supportive system which was intended to uphold public protection by ensuring good practice and clinical competence in relation to the Nursing and Midwifery Council's (NMC) *'Midwives rules and standards'* (NMC, 2004) and *'The Code – Standards of conduct, performance and ethics for nurses and midwives'* (NMC, 2015).

The need for public protection and the need to support midwives was an uneasy partnership and there was a conflict between the local supervision investigation arrangements and the need for independent and appropriate regulatory action. This conflict was highlighted publicly following the raising of complaints about care failings at a hospital in Morecambe Bay NHS Foundation Trust resulting in the deaths of 11 babies and a mother (PHSO, 2013). In response, the NMC commissioned a full review of the Statutory Supervision of midwives which was carried out by the King's Fund (Baird et al., 2015). In response to this review and a public inquiry, both of which were critical of the dual roles of support and regulation within statutory midwifery supervision, it was recommended that midwifery supervision and regulation should be separated (Kirkup, 2016). Following this, the UK Department of Health (DoH) published a policy paper which outlined the process of separation of regulation and support for midwives (Department of Health, 2016). The NMC agreed to the separation of Statutory Supervision and regulation (NMC, 2016). The new Nursing and Midwifery (Amendment) Order 2017 came into force on 31 March 2017 and removed provision of the local Statutory Supervision arrangements. The responsibility to develop a new Clinical Supervision (CS) model was allocated to each of the Chief Nursing Officers in all four UK countries.

CS for staff in the NHS (although not for midwives who were already subject to Statutory Supervision) began with the Department of Health's *A Vision for the Future* (1993). CS was seen as a supportive but formal process which would enhance both professional practice and quality of care, but unlike training or education, participation in CS would be throughout an entire career (DoH, 1993). CS is a contested and difficult term to define as it has a variety of meanings to

different professions and is delivered in many different ways. This review uses *A Vision for the Future* (DoH, 1993:13) definition of CS as a process of:

> '…professional support and learning, enabling individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations. It is central to the process of learning and the expansion and scope of practice and should be a means of self-assessment, analytical and reflective skill.'

The definition captures the context, process and intended outcomes of CS, resonating with the aims of the review and the research.

Evidence suggests that supporting, valuing and developing staff can contribute positively to outcomes for patients and service users (Scottish Government, 2010; 2013). CS is gaining importance as part of organisational and professional governance and is a quality assurance process created to make sure that standards of care are upheld and improved and that organisations are accountable to the public. The clinical governance process within organisations such as the NHS recognises both protection of the public and the support and development needs of midwives as integral parts (Scottish Government, 2010a). Assuring the public that services they use are of high quality, and they can have safe and effective care delivered by regulated and well-trained staff is central to the plan for maternity services in Scotland. '*The Best Start'* stated that staff delivering services have to be '…empathetic, skilled and well supported to deliver high quality, safe service, every time' (Scottish Government 2017:7).

Supporting staff to develop resilience is central to CS. Resilience is an elusive and often contested concept and like CS '… there is little consensus among researchers about the definition and meaning of the concept' (Shaikh and Kauppi, 2010:155). Neenan (2018:17) defines resilience as:

> '… a set of flexible cognitive, behavioural and emotional responses to acute or chronic adversities which can be unusual or commonplace. These responses can be learnt and are within the grasp of everyone; resilience is not a rare quality given to a chosen few. While many factors affect the development of resilience, the most important one is the attitude you adopt to deal with adversity. Therefore, attitude (meaning) is at the heart of resilience.'

A systematic review of support for health visitors to foster their resilience, Pettit and Stephen (2015) identified positive outcomes as a result of the implementation of restorative CS (Table 1).

Table 1 Outcomes found following implementation of restorative CS

• Positive impact on immediate wellbeing • Help staff feel ‘valued’ by their employers for investing in them and their wellbeing • Influence a significant reduction in stress and burnout • Improve the compassion and job satisfaction of staff • Improve staff retention • Reduce stress levels whilst maintaining compassion • Improve working relationships and team dynamics • Help staff manage work/life balance more effectively • Increase enjoyment and satisfaction related to work Pettit and Stephen (2015)

Clinical Supervision of Midwives in Scotland

Each of the countries have developed their own models of CS for use and details of each of these models is detailed in Appendix 1. The Scottish Government has developed a restorative, resilience-based CS model which is a hybrid of Proctor’s three function model of CS (Proctor, 1988), Page and Wosket’s Cyclical model (2001) and Kolb’s reflective model (1984). Unlike the one-to-one delivery of the previous model of Statutory Supervision, the new model is designed to be delivered in group settings of up to ten with a facilitator and is based on the concepts of reflect, restore and respond (NHS Education for Scotland, 2017).

CS aims to address the emotional needs of midwives and enable them to build resilience and reduce stress. The model facilitates reflection and self-awareness and promotes effective clinical practice through exploring events and feelings. According to Key, Marshall and Hollins Martin (2019) the aims of the model are to: improve the safety and effectiveness of care delivery, support the midwife to develop their clinical practice in line with professional regulation and accountability and develop a system of supervision that cares for midwives' mental health. It is intended to promote reflection on practice in a safe environment so that the learning from reflection can be used to decrease work-related stress. The aim is to promote resilience and improve clinical relationships.

Responsibility for the provision of CS for midwives rests with employers (SGHD, 2017b). NHS Boards are responsible for developing systems and processes for the implementation and delivery of CS. Health Boards can organise the provision of CS according to local needs. This could include group supervision and one-to-one supervision. Heads of Midwifery have responsibility for selecting and appointing Clinical Supervisors of Midwives (CSoMs). CSoMs are expected to demonstrate leadership qualities and have undertaken appropriate education. Key, Marshall and Hollins Martin (2019) describe the process of CS where a contract is drawn up between the CSoM and supervisee. The need for preparation for supervision is also emphasised with the supervisee

reflecting on past supervision how learning from prior sessions has influenced practice. The importance of having time, privacy, and an environment conducive to the supervisory process are also described.

The new model of CS of midwives in Scotland applies to all midwives. CSoMs in the study were recruited from volunteer midwives, some of whom had been Statutory Supervisors. NES provided online training modules for midwives and CSoMs. All midwives were expected to complete Module 1 prior to engaging with CS. The module introduced the concept of CS, the processes and the potential benefits. CSoMs undertook a further 3 modules covering the fundamentals of supervision, effective facilitation and leadership. In the first year of implementing the new model NES provided two-day c workshops nationally to further develop CSoMs to prepare them for their role in implementing restorative supervision.

To inform an evaluation of the new model of CS in Scotland, a systematic review was undertaken with the aim of exploring midwives' experiences of participating in supervision in relation to their support and development needs and their ability to deliver high quality care.

The efficacy of CS in reducing staff stress was tested in Wallbank's (2010) research. Themes of perceived ability to cope, inability to express this with senior colleagues, not wishing to burden colleagues and avoiding occupational health services for fear of negative consequences were highlighted, as were concerns about the high levels of stress observed in the study and the effects this has on staff in both the short and the longer term. The intervention group in this study who participated in CS showed significant differences in subjective stress, where average scores decreased (using the ProQol psychometric tool used to measure compassion satisfaction, burnout and compassion fatigue) in relation to subjective stress (Wallbank, 2010). In a further study by Wallbank (2013) which explored the nature of midwifery stress around loss and managing the emotional demands of the job, providing restorative supervision was found to improve coping strategies and significantly reduce stress, burnout and compassion satisfaction.

The conflict between supporting midwives and regulating them in the older model of Statutory Supervision was highlighted in the study by Rogers and Yearley (2013) which showed that Supervisors of Midwives (SOMs) had concerns about conflict of loyalties to their employing organisations and the ability to meet the demands made of them. In Stapleton et al.'s (1998) study, it was noted that midwives regarded Statutory Supervision as providing protection for them from litigation and complaints, which was echoed in the study by Gaffney (1998) who noted that midwives considered that protection in relation to their own clinical practice was of more importance than public protection. This contrasted with SoMs who believed public protection was the most important element of their role, whilst acknowledging the ongoing conflict with their monitoring and supporting roles (Halksworth et al., 2000).

Most literature in the review concerned midwives, but studies involving the support needs of SoMs were also evident. Roseghini and Olson (2015) ascertained the views of midwives relating to the effectiveness of supervision and understanding of the motivation to become a SoM. Deery

(2005) explored the views and experiences of community midwives in relation to their support needs in clinical practice and found that organisational demands resulted in their needs not being met. Full time roles for SoMs were considered in a study by Nipper and Roseghini (2014) which evaluated the effectiveness of the role of the first full-time SoMs in the London area and concluded that the role was beneficial for both midwives and women accessing maternity services with themes of proactive support for midwives due to availability and visibility in the workplace, improvement in SoMs investigations and no conflict of interest with competing roles, i.e., SoMs or line management role. Midwifery lecturers were considered in a study by Rogers (2002) which evaluated their understanding and experience of supervision. It identified that their experience of supervision was poor, with limited access to a SoM, frequency of contact, as wells as issues with methods and options to contact a SoM.

The theme of supervision to support high quality practice was discussed by Beddall and Carr (2010) in their study of how to empower midwives to promote autonomous midwifery practice and women-focused midwifery care. They concluded that there was enhancement to individual practice and ability to confidently and competently support women's birth choices for normal labour and birth following attendance at supervision meetings and workshops. Stapleton et al.'s (1998) study showed supervision as controlling and disciplining processes for both midwives and SoMs, with tensions around confidentiality and confidence within supervision being identified. Similarly, relationships between SoMs and midwives were often delicate, as because of fears around breaching confidentiality. Cultures of learned helplessness, intimidation, bullying, guilt and blaming were reported by midwives and SoMs. Overall, midwives' perceptions of supervision were almost entirely about protection and not about their support.

The studies range between 1996 and 2019 and reflect the changing model of supervision in midwifery from a more punitive one to a more supportive type, and this is likely to reflect in the experiences and views which midwives have of supervision. Relationships were clearly the main theme from the literature with the ways in which relationships between SoMs and midwives were often fraught with lack of trust, confidence and oppression being described in the studies. Burden and Jones' (2001) evaluation of the changing role of Statutory Supervision indicated that SoMs were seen as more approachable and less likely to be biased towards midwives when they changed their approach to a more supportive and humanistic style in their delivery of supervision. This echoed Demilew's (1996) research which articulated the negative and often poor experiences and problems faced by Independent Midwives, especially in relation to the professional relationships with SoMs, as they worked outside the NHS.

Shennan (1996) found overall negativity identified by power, oppression, control, inability to discuss feelings and expectation of rigid practice were highlighted. This reinforced the importance of relationships in supervision, Gaffney (1998) conducted a study which identified elements considered important in supervision. High ratios of midwives to SoMs meant they were often inaccessible. The ability to choose their own SoMs and positive characteristics of approachability, trustworthiness and clinical credibility of SoMs were also identified as desirable.

Love et al.'s (2017) Australian study objectives were to identify understanding, uptake and perceptions of the impact and experiences of accessing CS and reported improved practice, feeling valued and personal development. The barriers included work related pressures, time out to attend CS as being regarded as an indulgence, as well as misconceptions of the meaning and context of CS. McDaid and Stewart (2002) aimed to explore the perceptions of midwives regarding the role of Statutory Supervision in Northern Ireland and identified cultures of bureaucracy and control in organisations which could be both empowering and authoritarian. The theme of time is recognised in this study, with midwives identifying protection of time to attend supervision as useful.

Supervisory relationships were highlighted by Hughes and Richards (2002) in their study which identified that following a study day, midwives accessed supervision more regularly instead of once a year at their annual review. Development was also evident in the practice of midwives. Within the literature, it was evident that relationships of SoMs and midwives were closely linked with power dynamics, and supervision could be used to control midwives (Halksworth et al., 2000; Stapleton et al., 1998).

Although it was acknowledged that supervisory relationships could be empowering (Halksworth et al., 2000; McDaid and Stewart, 2006; Shennan, 1996) it was also recognised that confidentiality and trust were crucial within relationships between midwives and SoMs (McDaid and Stewart, 2006; Stapleton et al., 1998). Although midwives were critical and were able to identify reactive practice, there were also studies which showed that midwives empathised with issues associated with being a SoMs regarding time allocated to supervise and their other roles (Halksworth et al., 2000; McDaid and Stewart, 2006; Mead and Kirby, 2006).

Conclusion

The review findings showed that the previous model of Statutory Supervision had an inherent conflict relating to its core function of providing both support to and regulation of midwives. The themes to emerge from the studies identified that supervision was seen as important and could be a support to high quality practice. But often, due to lack of understanding of the concept of supervision, it was used as a means of control resulting in poor relationships between SoMs and supervisees and as such had little value with limited time for delivery or participation.

The significance of Statutory Supervision within the literature was evident, but midwives were often uncritical and lacked knowledge of the meaning of supervision (Brintworth, 2014; Gaffney, 1998; Roseghini and Olson, 2015; Stapleton et al., 1998). Completion of an online module prior to participation in CS is now an expectation of all midwives working in clinical practice in Scotland and may improve the understanding of midwives (Scottish Government, 2017).

Relationships between midwives and SoMs were problematic (Burden and Jones, 2001), especially in respect of trust and confidentiality (Demilew, 1996; Gaffney, 1998; Love et al., 2017; McDaid and Stewart, 2002; Roseghini and Olson, 2015; Shennan, 1996; Stapleton et al., 1998). The new model of CS in Scotland (Scottish Government, 2017) uses a group model involving up

to 10 midwives and, by allowing midwives to exert a degree of choice, may improve this. Not all midwives may feel confident or wish to discuss matters regarding practice in groups of potential colleagues. To ensure that midwives have a confidential space to discuss such issues, the option to participate in one-to-one supervision with a CSoM is available on request within the new model in Scotland.

The overriding theme within the studies related to supervision as a means of control. This was evidenced in issues of power, control, oppression and monitoring of midwives by SoMs and raised in many studies (Burden and Jones, 2001; Deery, 2005; Demilew, 1996; Halksworth et al., 2000; McDaid and Stewart, 2002; Shennan, 1996; Stapleton et al., 1998; Wallbank, 2010). With the separation of the role of regulation and support in the older model of Statutory Supervision, the situation where midwives fail to seek support for fear of reprisal should be limited. By encouraging midwives to become CSoMs to deliver a new model based on restorative practice and resilience building, the role becomes that of facilitator and less of problem solver. Encouraging midwives to discuss issues and to find their own answers within the group setting may remove the supervisor/supervisee teaching and instructing dynamic and could restore power to the group by encouraging them to engage in peer support.

Evidence showing a relationship between participation in CS and quality of care was limited. Wallbank (2010; 2013) in her studies highlighted the high levels of burnout and stress which staff were experiencing within midwifery and showed that restorative supervision improved coping strategies in such situations but there was a lack of evidence to demonstrate improvement in clinical care outcomes.

The quality of the literature identified in this review was varied, notably there were few empirical studies. Most of the literature was theoretical with most of the papers appearing to be aimed for use operationally by the profession. It is possible that the evidence base does not reflect contemporary midwifery as new models of CS are being delivered across the UK. It appears that supervision research increased following the publication of Changing Childbirth in 1993 (Dept of Health, 1993a) and thereafter research dwindled in the 2000s.

The studies included contained no literature which explored the scope of supervision meetings and if this had any impact upon midwifery practice. Similarly, within the theme of experiences, the concept of trust was raised in several studies showing that good supervisory relationships with trust can be motivational and empowering but in in poor relationships, lack of trust can result in lack of openness which may impact upon standards of practice and safety. Further research is needed in this area. This study identified that none of the studies related to the new model of CS for midwives in Scotland. Therefore, there is a need for empirical work which will attempt to fill this gap.

Methodolgy

Aims and research questions

The aim of the research was to evaluate the implementation of the new model of employer-led Clinical Supervision for midwives in Scotland.

The initial proposal for the study identified the following four research questions:

1. How is the employer-led model of Clinical Supervision for midwives being implemented across Scotland?
2. What are the effects of the new model on the quality of midwifery practice, clinical decision-making, adherence to national practice standards and experiences of childbearing women?
3. What are the implications of the new model for employers?
4. What changes need to be made to optimise the impact and outcomes of the new model?

These questions will be addressed in the discussion chapter of this report. Considering the timeline for the implementation of CS across all Health Boards in Scotland, along with the findings of the literature review reported in the previous chapter, the following two research questions were developed as realistic for a PhD project:

3. How is the new model of CS of midwives being implemented across Scotland?
4. What are the views and experiences of those participating in the new model of CS?

Study Design

Qualitative methodology was selected as the most appropriate to explore in-depth the implementation and participants' experiences of CS for midwives. A case-study approach was adopted to help understand how the new model of CS was implemented both at an organisational level (meso) and an individual level (micro) (Merriam, 1998). Case study methodology is appropriate to generate in-depth, multi-faceted understanding of complex issues in their real-world context (Burns et al., 2015), using multiple data sources (Yin, 2018; Merriam, 1998) and can address existing gaps in delivery of interventions (Yin, 2018). This study followed Merriam's (1998) approach because the three defining characteristics were relevant to evaluating the implementation of the new model of CS for midwives in Scotland. The three defining characteristics are:

1) *particularistic* i.e., the case study focuses on a particular situation, event, programme or phenomenon;
2) *descriptive* i.e., the case study provides rich, thick description of the phenomenon being studied;
3) *heuristic* i.e., the case study illuminates understanding of the phenomenon being studied.

Selection of cases and participants

The design of the study was a single case i.e., implementation of CS for midwives in Scotland, with three nested sub-cases: Heads of Midwifery (HoMs) and two Health Boards.

The first sub-case comprised HoMs across Scotland and provided an opportunity to explore implementation at a managerial or operational level (meso-level) and to compare approaches to implementation between Health Boards. There are 14 Health Boards in Scotland, each covering a geographical area and each with a HoM in post. The inclusion criterion for this sub-case was a HoM or nominated senior midwife. There was no requirement for the HoM or nominated senior midwife to have participated in CS. It was planned to include HoMs /senior midwife from all 14 Health Boards.

The other sub-cases were two Health Boards (referred to in this report as Site X and Site Y) to understand the experiences of midwives participating in CS (micro-level). The criteria for selection of the two Health Boards were variation in: population size and diversity; the urban/rural context and the number of births per annum. Selection was also influenced by accessibility for data collection as there was limited resource for travel. Additionally, rollout in 'early adopter' Health Boards of the Best Start five-year plan for maternity and neonatal care in Scotland (Scottish Government 2017a) coincided with implementation of CS. As the continuity of carer component of Best Start represented dramatic change in the ways of working for many midwives, it was felt that it was likely to have significant impact on implementation of CS and how it was experienced by midwives. Therefore, a decision was made to select one Best Start early adopter site (Site Y) and one Health Board that was not an early adopter of Best Start (Site X) as the two micro-level sub-cases. The inclusion criteria for participants in Sites X and Y were registered midwives employed by the Health Board who had experienced CS. Within the purposive sample the aim was to include both midwives who were CSoMs and those who were not, as well as some who had previously been Statutory SoMs. Finally, it was intended that midwives with a range of seniority and years of experience as midwives would be included. The target sample was 10-15 midwives in each site giving a total of 20-30 midwives.

Health Board sub-case settings

Site X (sub-case 2) Health Board is a medium-sized geographical area with rural and urban settings, with three large towns and some smaller towns and villages. Maternity services are provided at one hospital site with numerous community settings delivering midwifery services. This Board was not an early adopter of the *Best Start* five-year plan for maternity and neonatal care in Scotland (Scottish Government 2017a).

Site Y (sub-case 3) Health Board covers a medium sized geographical area with rural and urban settings. Maternity services are provided at one central site with many community settings delivering midwifery services. This Board was an early adopter pilot site for the *Best Start* maternity service reform.

Data Collection

Ethical approval was obtained from the University of Dundee (UoD\SNHS\RPG\2019012) and Research and Development permissions were granted by all 14 Health Boards. Data collection took place from August to November 2019.

The HoMs were invited to participate in a semi-structured interview either by telephone or face-to-face. In total, 10 HoMs agreed to participate and were interviewed, seven by telephone and three face-to-face. All interviews were conducted using a topic guide based on the aims, research questions and objectives of the study (see Appendix 9). At the start of each interview, metrics relating to the implementation of CS were gathered.

Data collection in the micro-level sub-cases comprised in-depth face-to face interviews with midwives and non-participant observations. The in-depth interviews aimed to gain understanding of the views and experiences of participating in CS using a conversational style of interviewing. The interviews were guided by a broad topic guide based on the aims, research questions and objectives of the study (see Appendix 10). In total 18 midwives participated (nine from each sub-case site) in a variety of hospital and community locations and one in a midwife's home. The average length of interviews was 45-50 minutes, and they took place from August to November 2019. Non-participant observation was included in the study to improve understanding of the reality of how group CS was delivered and to triangulate with the interview data. Four episodes of non-participant observation were conducted, two in Site X and two in Site Y during October and November 2019. An observational protocol, based on the study aims, research questions and objectives, was developed to focus the observations (see Appendix 11). Following each observation, detailed field notes were documented, and these were analysed along with the interview data.

Data analysis

All the interviews were audio-recorded with the permission of participants and then transcribed verbatim. The total data set comprised transcripts of 28 interviews and field notes and reflections from four non-participant observations. These were all imported into Nvivo 12 qualitative analysis software (NVivo: QSR International, Warrington, UK) which was used to organise and store the data. The data were analysed using the seven steps of the Framework Method described by Gale et al., (2013). These are: transcription; familiarisation; coding; developing a working analytical framework; applying the analytical framework; charting the data in the framework matrix; and interpreting the data.

The findings are presented by sub-cases and themes. The meso-level findings from interviews with HoMs (sub-case 1) are presented first, incorporating views of HoMs from across Scotland. The micro level findings are then presented (sub-cases 2 and 3). As there were many common issues in the data, the micro-level findings from the two sub-cases are combined within the themes. The findings are presented under six overlapping themes:

Theme 1: *preparing to implement CS* addresses recruitment of CSoMs and how CS was promoted to midwives.

Theme 2: *uptake* describes the extent to which midwives participated in CS.

Theme 3: *delivery* highlights the different ways in which CS was planned and delivered. This theme overlaps with theme 2 in that the modes of delivery included strategies to increase uptake.

Theme 4: *function and processes* addresses two central features of the model of CS, namely reflection and resilience-building.

Theme 5: *resources* addresses the resource implications of implementing CS.

Theme 6: *context* explores the impact of the concurrent implementation of the *Best Start* policy and the historical context of the previous model of Statutory Supervision for midwives.

Findings

Sub-case 1: Heads of Midwifery (meso-level)

HoMs from 10 of the 14 Health boards across Scotland took part in semi-structured interviews; seven by telephone and three were face-to-face.

Preparing to implement CS

There were two key components of preparing to implement CS undertaken by HoMs; recruiting and preparation of CSoMs and promoting CS to midwives including encouraging them to undertake the preparatory module.

All HoMs confirmed they had been involved in recruiting CSoMs during the latter part of 2017 following the cessation of the Statutory SoM role. In addition, every HoM indicated they had been successful in the initial stages of CS implementation as all their CSoMs were recruited, fully trained and ready to facilitate CS by the launch date in early 2018. HoMs reported that initially, there were plenty of applicants for CSoMs posts. In some areas, midwifery managers used annual professional development meetings to raise the profile of and encourage applications for the CSoMs role by linking it to future leadership or management roles. However, following the initial surge of enthusiasm, by 2019, the number of applicants had slowed, and a few HoMs indicated difficulties recruiting and retaining CSoMs. In those areas where recruitment of CSoMs was effective, some HoMs commented there was no further preparatory training available for midwives who wanted to become CSoMs:

> *I've been told that there isn't any further training. So, I've got a big group of staff that'd be willing to go and get trained, but I've got nowhere to send them to get trained … and that's my biggest problem at the minute.*

Having recruited CSoMs, HoMs next promoted CS for midwives in their areas. All HoMs reported using email, posters, and weekly briefings to reach their midwives to inform them about the new CS model. Some HoMs used materials provided by NES and the Scottish Government, but the cost of producing promotional materials was said to be prohibitive. In some areas, drop-in sessions were provided by newly trained CSoMs. In some areas, to spark interest and disseminate information, drop-in sessions were provided by newly trained CSoMs. Additionally, most HoMs wrote individually and directly to their midwives to advise them of the forthcoming implementation of CS.

Before attending their first session of CS, all midwives (including HoMs) were required to complete an online preparatory module (Scottish Government, 2017). HoMs were responsible for ensuring that midwives had access to this online module. Some HoMs reported that not all midwives completed the module prior to implementation of CS. There was also uncertainty about the value of the module amongst HoMs.

Uptake

HoMs stated there was an expectation that midwives would attend CS at least once per year and were clear that it was the individual midwife's responsibility to organise attendance, rather than for the employer to pursue midwives to do so. However, during the first year, it became apparent that non-participation was a common issue. A barrier to participation was suggested to be uncertainty among midwives concerning whether attendance at CS was mandatory. Two HoMs expressed frustration as to why it had not been adopted as well as it might have been. During the first year, to improve CS adoption, some HoMs contacted midwives by letter and asked them to rectify non-participation. However, other HoMs required midwives who had not participated in a session to meet with them and discuss their non-participation. Other HoMs aimed to encourage midwives to participate in CS rather than focussing on punitive consequences for non-attendance, and they were optimistic that the implementation would be seen as a positive cultural change:

> *There was a lot of discussion amongst Heads of Midwifery around what would be the punishment for or the HR process for not undertaking supervision … I mean, we'd moved away from that [punitive element] in the statutory model or we were trying to move away from that policing punitive aspect. To take it right back to what's the bad thing that happens to you if you don't go, to me is losing the restorative model in itself. What my hope had been was that people would enjoy it … find a benefit from it, and then they would speak with their peers around that.*

As shown below, the uptake of midwives participating in a session of CS annually in the first year of implementation ranged across Health Boards from 50% - 100%.

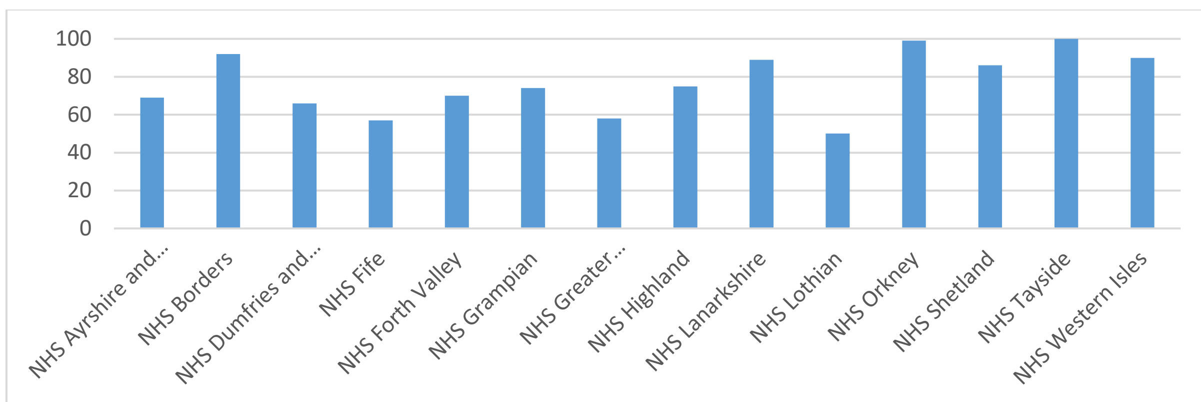

Figure 1 Percentage of midwives participating in a session of CS annually by NHS Board area (Scottish Government, 2019)

In general, smaller Health Boards had higher participation rates. However, HoMs reported that achieving 100% attendance wase challenging particularly for bank and part-time staff. HoMs also suggested that a further challenge to uptake, was time for midwives to attend CS compounded by conflicting policy priorities as well as local mandatory training recommendations. To address lack of uptake, some HoMs indicated that non-attendance at CS would be managed through line management processes.

Other approaches to increasing uptake are reflected in the variation in how CS was delivered described in the next section.

Delivery

The CS model was intended to be delivered predominantly in groups of up to ten midwives facilitated by one or two CSoMs with individual sessions available if requested by a midwife (Scottish Government, 2017).

There was wide variation in HoMs' descriptions of how CS was delivered across Scotland. Some Health Board areas provided CS mostly in groups. While all areas offered one-to-one sessions, but uptake was variable. Although most CS was reported to be delivered in groups, midwives could request an individual one-to-one session with a CSoM of their choice. However, many HoMs indicated that the number of individual CS sessions was not routinely counted during the first eighteen months of CS implementation, making comparisons between areas difficult. In addition, the numbers of individual sessions being recorded may not reflect the actual numbers being delivered because CSoMs may not record all meetings.

In some Health Boards, alongside planned supervision sessions, ad hoc sessions were organised to maximise opportunities for attendance during quieter periods. Ad hoc sessions could be organised at short notice enabling CSoMs to maximise time and resource:

> *When nobody was coming, they started to do them a bit more ad hoc, which is then more difficult to follow through that you've got all the people you need, because it's not opened up to everyone. It's just who's on duty that day.*

Although aware that this was not how CS was intended to be implemented, some HoMs considered it preferable to deliver ad hoc CS rather than have non-participation. While this approach may increase attendance at sessions, it contrasts with the notion that some element of preparation promotes more efficient use of time and of the importance of building trust between CSoMs and supervisees (Key et al., 2019). The HoMs perceived that CS worked better in community settings because it was easier to implement as a regular, scheduled group activity. This supported community midwives to engage in CS frequently with the same group of participants, whereas HoMs stated that their hospital-based midwives often attended sessions where they may not know any other midwives in the group.

In some areas, HoMs elected to provide weekly drop-in CS sessions with group sessions in the morning and individual sessions in the afternoon. These aimed to provide regular access to group

or individual sessions whilst encouraging participation in CS. This approach was intended to promote the perception of CS as an integral part of midwifery practice rather than an occasional event.

There was also variation in how the group sessions were facilitated and the extent to which sessions were structured. Some HoMs reported that structure was important to avoid supervision sessions being a forum for airing complaints.

For some HoMs structure meant pre-determining topics for discussion at supervision sessions. Examples of topics were breastfeeding or bereavement. This contrasts with the intended approach where objectives are set by the supervisees and the CSoM uses a facilitative style to explore the chosen scenario/issue. One HoM recognised this stating:

> *When they arrive, people bring what they want … that was my understanding of supervision actually. I didn't think us deciding the topics was what peer support was about or peer supervision is about.*

Examples were given by HoMs of linking CS with education and training for organisational efficiency and to ensure that it was completed annually. Where this happened, HoMs noted that it was generally integrated into the programme of mandatory midwifery training. This was generally seen as a more efficient use of time and resources compared to providing additional time for midwives to attend.

A further issue for HoMs was the relationship between CS and line management. One HoM suggested the easiest way to implement CS would be to integrate it with a team leader's role (Band 7), albeit recognising the impact this could have on relationships:

> *My preference would be that this model is embedded alongside a Band Seven role and that you would do supervision, CS as a Band Seven for a team as part of your Band Seven role. It's how I see it becoming more embedded, making sure that people actually get it done if that is the requirement from the Scottish perspective. Now, whether that would change the dynamic, I'm sure it would.*

In the context of hierarchical structures, HoMs mostly felt uncomfortable about attending group CS because it was unlikely to provide support for them, and because of the perception that their presence might be viewed with suspicion by other midwives. One HoM had organised a CS session for senior midwives which was so well-received that there were plans to repeat it. Whether to include maternity care assistants was another variation in the delivery of CS with some HoMs choosing to do so whereas other had not considered this:

> *They're part of the general team … we include them in all our training, we include them in our report giving, you know they're part of the team and I feel that they should be involved in it … so why should we exclude anybody from joining the sessions*

Similarly, all HoMs recognised the need to support newly qualified midwives (NQMs). Some HoMs stated they had arrangements to provide separate CS for NQMs, often as part of induction, as well as encouraging NQMs to join regular CS sessions with other midwives if they wanted. Offering both types of CS was considered positive for all midwives, but especially for NQMs because it provided an opportunity for them to speak freely and confidently within their group and encouraged future participation either with their cohort or with other midwives.

Some HoMs continued the practice (from Statutory Supervision) of allocating CSoMs to midwives with the proviso that staff knew they could approach any CSoM for CS. Using this hybrid approach was said to work well in some areas. Not all HoMs had considered or favoured the allocation of CSoMs, and for some, this was because of the resource and governance implications:

> *I wouldn't [support the allocation of CSoMs] I tell you why, because the previous model they were given an allowance. They were given dedicated time […]. It came with a whole infrastructure of governance around it which has all gone away and in order to do that, I would have to introduce all that governance back in again.*

Functions and processes of CS.

Supporting midwives to build resilience is a central aim of the new model of CS and reflection is an integral component of this (Scottish Government, 2017). The interview data suggested that reflection was an important part of midwifery practice and something which happened throughout the working day. However, HoMs acknowledged that it was not a concept which every midwife recognised. Being able to formalise and embed reflective practice in the workplace was identified as a positive aspect of implementing CS and supporting managers. The HoMs thought that CS could support their workforce to improve and sustain high quality midwifery care. Although said to be valued by HoMs, opportunities to attend CS and participate in reflection could be affected by a high workload, operational pressures, and lack of resources. The HoMs explained how different teams in their areas worked hard to embed CS as a restorative and resilience-building platform. For example, in one small health board area, the value of reflecting in CS as a team who worked together was highlighted:

> *The community teams … they've actually kept it quite local … reflecting on actually what's happening in practice. So, it might be reflecting on incidents that have happened, it might be reflecting on complex cases that they're managing, but they generally all tend to come together as a team to reflect on practice as it's happening.*

All HoMs commented that they felt optimistic about implementing CS to build resilience within their workforce including benefits to both midwives and the organisation. One HoM suggested that CS could support midwives to understand the impact on others of their behaviour and communication styles.

The levels of support perceived to be provided by CS varied across the HoMs, but all gave examples of how CS supported their staff. For example, one HoM said:

> *They really, really love the supervision, as in this is a supportive mechanism to make sure women are kept safe and then that investigation of poor practice sits with someone else. I think that is the huge difference for us and that's why more people are embracing that.*

There was further discussion of using CS to reflect on practice issues and cases. One HoM reflected on a situation where she offered a bespoke CS session after a case that attracted media attention:

> *The team involved also had almost like a group session with a clinical Supervisor. The feedback from them following that was that they really felt that it had helped. It had been really good to sit and just reflect on things and talk things through … I think when we have events or cases that are quite traumatic for the midwives, that they've been involved in … in this case it was actually a good outcome. But there was quite a lot of media attention round it and press and I think it was just really, really difficult for the midwives. So, in that situation, they felt that it had really supported them.*

However, other HoMs commented that there was a culture of fear within midwifery where staff feel they will be blamed if they are open about making mistakes. All HoMs acknowledged that reflecting on practice issues and mistakes in groups could be challenging for midwives. To alleviate this and ensure CS was an appropriate forum, one HoM tried to create an environment that was safe, open and transparent, encouraging candid reflection and conversations about the positive and negative elements of situations that could be problematic:

> *I'd gone to the Supervisors and said could you speak to the staff involved and see if they would be willing to have something where it's a mixed group of people to have this conversation … I kinda want to sort of demonstrate that we do sometimes make mistakes. But only half the group would want to engage, and I thought that was quite interesting because they still had that punitive thing. It's an interesting thing because I think … midwives are always scared of doing some doing something wrong and getting the blame.*

The HoMs understood that mistrust was a key challenge. At an organisational level, HoMs frequently stated they aimed to ensure midwives had trust in CS. A few HoMs suggested there had been initial scepticism from midwives about CS because there were suggestions that implementing it was a way of gathering information about them. Similarly, concerns about the information disclosed in CS had been brought to the attention of many HoMs. Although HoMs viewed confidentiality as integral, one HoM questioned whether this position was realistic:

I think the Supervisors make it very clear before they even start the session that whatever is said is confidential, it has not to be discussed out with the room. That so, I think they set the ground rules before they actually have the session you know. It's a group of women we work with, of course people will say things outside the room.

Resource issues

HoMs described lack of resource as having an impact on the feasibility of implementing CS. Issues identified by HoMs included lack of funding to deliver CS, which meant CS implementation was challenging. Similarly, HoMs described managing expectations of the implementation of CS as problematic within the limited resources available. The lack of accountability for the administration associated with CS was highlighted on many occasions by HoMs as further work delegated to CSoMs or other administrative staff.

During the interviews, HoMs agreed that providing support to CSoMs was not always prioritised. Participants were aware of the limited time provided to CSoMs to prepare for sessions and complete associated administrative tasks. This was said to have resulted in some CSoMs leaving the role after the first year of the implementation due to lack of support. Many HoMs had not considered providing support or presumed that CSoMs would support and supervise themselves.

Context

Two key contextual issue impacting on implementation of CS were the concurrent implementation of the *Best Start* policy and comparisons made with the previous policy of Statutory Supervision for midwives. The challenges involved in delivering *Best Start* alongside implementing CS were highlighted frequently during interviews with HoMs. CS was suggested as a supportive mechanism that could help build resilience and support staff to deal with changes incurred due to the two new policies. These included the effect on midwives caused by new ways of working, changes in their work environments and the role they were expected to fulfil as part of *Best Start*. HoMs reported that the challenges of delivering *Best Start* were raised frequently in CS. Therefore, in some areas, the implementation of CS was explicitly used to deliver information and provide an opportunity for staff to raise issues about *Best Start*. This meant that *Best Start* could overshadow other topics in CS:

I think there was a lack of understanding, there was positivity as well as negativity. So, a bit of a mixture, probably more negative if I'm being honest with you than positive. But then as the time went on last year, the one thing they all wanted to speak about was Best Start … So, we had the Best Start topic for everything so that it gave people that chance to speak … we could talk about that, and then we could move on from there. I think Best Start took over the majority of the sessions because people were unhappy

Statutory Supervision was a topic that HoMs referred to, made comparisons with, and had strong views about, which may have been because most participants had substantial experience of

Statutory Supervision and previously had been SoMs. However, there were differing views among the HoMs, when comparing Statutory Supervision with CS. Although Statutory Supervision was often viewed as punitive, some participants cited valuable and respected parts which they felt could have been retained.

> *When it was in statute, it was always seen as quite special thing. I think we've missed a trick. I think what we didn't do was hang on to what was really good about it.*

The valuable components of the previous approach to supervision were suggested to be the ongoing individual relationship between the SoM and supervisee and the opportunity to access support from a duty SoM 24 hours a day. One HoM described how Statutory Supervision blended into the working environment more easily than CS now does:

> *We had Statutory Supervision before, so everybody had to do it … most folk were on shift and popped out to do a supervision … Merged into the workforce if you like. Where this is separate sessions. Folk have to come in you know, its just well … it's quite a lot*

Sub-cases 2 and 3

Overview of case sites and participants

Site X had not yet started to deliver *Best Start* during the study, although it was due to be implemented shortly after the fieldwork was completed. Nine midwives were recruited to the study providing a relatively diverse sample in terms of age, job role, midwifery grade, length of experience as a midwife, locality of practice, and those who were also trained and practising as CSoMs. Of the nine participants, four worked in the community and five in the hospital setting; four were CSoMs of whom three had also been SoMs and one participant had been a SoM but was not a CSoM. Eight participants had participated in group CS and one in an individual session.

Best Start policy had recently been implemented in Site Y resulting in changes to midwifery practice. Nine midwives were recruited to the study: six hospital midwives and three community midwives. Only one participant was a CSoM who also had been a SoM, six other participants had been SoMs. All participants had participated in group CS.

Preparation for implementing CS

Most participants in Site X reported they had received information about CS implementation via work email, which included an invitation to complete an introductory online module provided by NES (2017). Similarly, in Site Y, most participants recalled hearing about CS when advertised in the midwifery unit staff briefings, posters within the workplace, and through introductory sessions provided during the transition from Statutory Supervision to CS. Some participants' first recollection of CS was during the recruitment drive for CSoMs. In both sites, none of the more recently qualified participants had considered becoming a CSoM, although most were eligible to do so.

Before attending CS, all midwives had to complete an online module. There were different views of the effectiveness of the module with some midwives saying they felt well-prepared. However, some participants from Site Y were critical of the preparatory module reporting they had no memory of the content. There was evidence in the interviews of preconceived ideas about CS. The CSoMs reported they had to refute such views describing a culture of resistance to the new model, which added to the challenges of CS implementation.

> *It's people's buy in, so whether they buy into it or not … where they think it's just that hocus pocus nonsense of actually having to talk to people, airy fairy … you know these are the words, wishy washy, that touch feely stuff. Because that stuff comes out … some people are not comfortable with that and that's okay.*

Uptake

The CSoM participants described making concerted efforts to reinforce CS implementation and improve uptake by encouraging attendance and promoting CS as positively as possible with midwives and managers. Participants in Site X agreed that once midwives attended their first session, future attendance was more likely. One participant in Site X felt that adoption of CS was successful, and that uptake would improve over time:

> *I think we rolled it out quite gently because we had to, we knew we had to break down some sort of barriers and feed it in drip feed it and I think that actually worked. Now that the ball's rolling, I think it'll take a few years … I do think it needs to be more regular, although we are offering what we can at the moment, so I do think it is positive.*

One strategy to improve uptake mentioned by participants was midwifery line managers discussing attendance at CS during a midwife's Personal Development Planning annual session or appraisal.

Consistent with the views of the HoMs, there was confusion in both sites among midwives about whether attending CS was mandatory. During the interviews, all participants said they were aware that they had to attend at least one CS session annually but could attend further sessions if they wanted (in both case sites, this would have to be in their own time). Despite this, most participants indicated they would not want to attend more than one session, nor would they want to return to the workplace during their time off to attend a further session. All participants acknowledged it was their responsibility to organise and attend CS sessions. Both sites collected data to evidence annual attendance at CS by midwives. However, one CSoM questioned whether this was in the accordance with the concept of CS.

> *It's not in statute, I don't think it's really anyone's business whether somebody's come to CS or not. I actually do have genuine concern about tables being kept that are monitoring whether people come for supervision or how many times they've come … it's almost an infringement of the whole concept of CS.*

In Site Y, an online booking system for CS allowed midwives to choose a suitable date and weekly sessions were available throughout most of the year. This made it the midwife's responsibility to book CS, not their managers. However, participants in Site Y indicated that it was imperative to sign up quickly for a session because there were limited places and consequences for failing to attend:

> *One of my colleagues was off sick, and she missed hers [CS]. The next thing you know she gets an email, you've not attended CS, you need to meet with management … (laughs). So, she had to go up and explain why she was off sick, and then got booked in. They said you need to perform this every year, so it very much felt like if you don't go, you're gonna be punished for not going to CS.*

There was no indication in Site X from any participant that there would be any punitive outcome for midwives if they failed to attend CS.

Participants in Site X were keen to show they had attended CS, and this was seen as like evidencing attendance at mandatory midwifery training. Although CS was considered by participants to be a positive, supportive mechanism for midwives, 17 participants suggested that participating in CS was a 'tick box exercise'. The following quote was typical:

> *You do question the value of it from that point of view, it's almost like a tick-box exercise. Because CS in the real world, as in nursing and midwifery, well nursing and with AHPs and everybody … It's like a pre-defined six sessions with a contract, with follow through, with actions, that type of thing. Within midwifery it's not that … it is a bit of a tick-box exercise this one-off session … if you have attended then you've ticked that box, haven't you?*

Delivery

In Site X, CS was delivered both in groups and in one-to-one sessions. All participants knew that regular group sessions were organised and advertised in advance to allow choice and attendance at sessions most suitable for them. However, the groups were not fixed i.e., they comprised different midwives each time which did not provide opportunity to continue discussions or identify progress or develop trust with the same group members. One CSoM highlighted the lack of opportunity to follow-up with midwives, issues discussed during a group supervision session. In Site X, during quiet periods when there was capacity for staff to attend, unplanned ad hoc group CS sessions were held at short notice. There was some enthusiasm for these ad hoc CS sessions from a few midwives and CSoMs. However, although ad hoc delivery was intended to increase midwives' opportunities to attend at least one session per year, some midwives reported feeling unhappy with this approach.

> *The last session I had was particularly important to be run because I was mopping up people who hadn't been to a session before. I don't think ad hoc works. We can't continue to deliver it in the ad hoc manner that it is delivered*

in currently. We've dipped our toe in the water, we've got it going. It now needs to grow and become a better activity

There were also doubts expressed about asking midwives to attend CS during meal breaks.

Trying to release staff that way is very workload dependent. We are very accommodating … it's like bring your lunch or bring your breakfast, but is that correct? They should actually be taking their break properly rather than sitting through a CS session.

Although the preferred delivery method in Site X was by groups, midwives could request one-to-one CS with a CSoM of their choice. Three participants reported that one-to-one delivery was not offered in the introductory information or CS group sessions. It appeared that not all midwives were aware that they could have one-to-one CS.

The CSoMs said they supported one-to-one sessions and understood the benefits, however, lack of time available to deliver them made this unachievable. Nonetheless, some CSoMs were keen to facilitate CS in smaller groups because of the perceived benefits for participants and facilitators.

The one-to-ones I find are far more organic. We can kinda sit down with a cup of tea and have a nice chat … I can also remember because it's a one-to-one, I can remember what people spoke to me about the last time.

Similarly, one-to-one sessions were said to be preferable to group CS for some participants. One CSoM found that it may be difficult to raise specific issues in a group or group dynamics may be problematic:

Sometimes what happens is you have somebody that really won't engage … you have these kinds of awkward silences. You have to respect that because some people are not comfortable speaking in a group. The other side of it may be their issue is so big that that's not an appropriate forum

The length of CS sessions could also be an issue. In Site X, CS sessions lasted for one hour. However, during a non-participant observation, it was noted that the time available was compromised by several factors as shown in the following field note excerpt:

Before the session begins, a midwife's phone rings and she takes the call and then steps outside to talk … although the ground rules do say that mobile phones should be off or on silent and should not interrupt the session. Although due to start at 1000 hrs, the CSoM begins CS at 1024 hrs by welcoming everybody and asks everyone to introduce themselves.

The CSoM started with a PowerPoint presentation of about 5 minutes in length in which she explained CS. Included were explanations of support and resilience and why they are important to staff and that sessions are mandatory - at least one session (either group or 1-1 in a year). Next the CSoM was very clear about the room being a safe space for staff where they needed to adhere to rules and boundaries which were explained. These related to confidentiality and how people were encouraged to express themselves whilst considering others and their right to privacy and anonymity. The participants were asked if they had completed the online module required prior to participation to which they all said they had done it. This took about 12 minutes and was interrupted by some participants arriving late meaning it had to in part be repeated.

Later … at 1100 hrs, the CSoM informed participants that it was the end of the session (it had lasted from start to finish for 26 minutes due to CS being part of a training day, some participants had to go to other training sessions organised to begin at 1100 hrs).

In Site Y, CS was also predominantly facilitated in groups; the groups were not fixed and comprised different participants each time. However, in Site Y, there were more planned, advertised CS sessions available for midwives to choose from compared to Site X. In Site Y, CS was offered on a specified afternoon of most weeks throughout the year. Details of forthcoming CS sessions were available online, providing the names of those who would also be attending, and which CSoMs would facilitate each session. No participants mentioned ad hoc sessions in Site Y. Additionally, in Site Y, topics were identified for some CS sessions, and these were advertised in advance. The topics e.g., *Best Start*, post-partum haemorrhage, bereavement, provided information for midwives to support learning and improve knowledge in key areas. Some participants suggested they preferred to have advanced knowledge of the subjects to be discussed. However, other participants indicated they struggled to feel comfortable or gain anything from CS sessions:

> *It [CS] was just a … wee chat basically about what was going on in the place. It wasn't structured at all about a theme or anything. I got to meet girls I hadn't seen for a wee while, they came in from community and it was just really a moaning session about the place. So, I didn't get anything from it at all, and comparing it to what I did as a Supervisor ….*

In contrast, some participants preferred the informal approach suggesting it was 'less daunting' than Statutory Supervision.

In Site Y, records of CS suggested that in 2018-2019, less than 1% was delivered as individual sessions, although one CSoM reported she had facilitated several individual sessions. Like Site Y,

there appeared to be lack of awareness about the availability of individual supervision sessions with one midwife commenting:

> *I didn't even know that [the opportunity to have a one-to-one session of CS] until you told me that. There is a list that you can phone, but I didn't realise you could meet up with them one-to-one…… I would have had a one-to-one a year ago … its quite sad that I've heard that from you, rather than the area that I've worked in for two years.*

However, one CSoM participant from Site Y described being asked by a manager to meet with a midwife considered by the manager to be 'in need of CS'. Although the CSoM reported that the one-to-one meetings with this midwife were positive, the CSoM was concerned about spending so much time with one person. The knowledge, skills and experience of CSoMs were highlighted by some participants in Site Y as an issue that may inhibit participants from requesting one-to-one CS. Of particular concern to some midwives, was that CSoMs may have had insufficient midwifery experience to understand their concerns:

> *For me, it would be experience and place of work if I'm honest because obviously with the change that's happening within Scotland with Best Start, I think I'd probably go for a midwife who has got a lot of ward experience but has come out to Best Start or has worked … in all areas because they'll understand exactly what my concerns would be.*

Functions and processes of CS

Midwives were positive about the benefits of reflection for their practice and there was enthusiasm about the opportunity to reflect together in a group. While participants discussed reflection as a practice that they undertake continually, CS was perceived to formalise discussions about practice compared to informal methods commonly used in the workplace.

> *Often we end up reflecting at the desk, if everybody's at the tea trolley and even though it's more casual, it won't obviously only be work topics that are discussed, but often you've got a few people you can throw ideas off of. If you decide to take that opportunity, you end up making your own CS opportunities with people who may have nothing to do with CS.*

The findings show that some CSoMs had reservations about their knowledge of the model of supervision that was being implemented and whether it was being delivered as intended. One participant suggested that the way she was asked to deliver it in Site Y did not seem to fit with what she had learned on the two-day training programme by NES. Similarly, in Site X another participant, while feeling she understood the model well, said she lacked confidence to facilitate it and would have welcomed further support. CSoMs would have liked formal arrangements for reflecting on their roles as facilitators of reflection, but these did not seem to be available within their health boards. Some had attended a one-off national event held in 2019 where clinical

Supervisors were invited to share practice and receive updates about CS implementation in other health boards.

> *We're sort of flapping about if you like, hoping that we're delivering it well because we've not had any supervision as Supervisors. I think it would be very helpful to go somewhere and just hear what other areas are doing.*

There did not appear to be any formal CS for CSoMs concerning their role with informal arrangements being the only source of reflection and support.

Midwives were also positive about the potential for CS to build resilience. In both sites, participants agreed that resilience was a fundamental element of CS that could be supportive and protective of the challenges associated with midwives' roles. Participants suggested that CS provided an excellent opportunity to bring midwives together from different settings to share practice and thereby build resilience.

> *I think it [CS] did make you realise all the stresses that other people had … that was quite good in that everybody's got stresses. It teaches you how other people manage things which is quite good cos sometimes you maybe try that the next time and that's the whole thing it's about isn't it? It's about coping mechanisms so … we'll try one thing one way, and if it doesnae work, I'm trying it another way.*

The opportunity to reflect and build resilience through CS was linked by participants to quality of care. Participants explained how CS was used to highlight good practice and share helpful and positive experiences. Additionally, being able to discuss individual practice in CS sessions was identified as important. One example was provided of a newly qualified midwife reflecting on an incident and being given positive feedback about her practice.

However, there were barriers to midwives being open and honest when reflecting and sharing practical experiences during group CS. Barriers included lack of trust among midwives they did not know well, and fear of being judged as not coping or blamed for mistakes. This led one participant to question whether group CS was a suitable forum for resilience-building.

> *The whole purpose of it is to make you resilient … allow you to open up and discuss how you feel. I don't think in that setting [CS in groups] people are being honest and telling people how they feel. Because it almost comes across like you're not coping if you say that things are difficult, and you find things a challenge. I think there's a lot of people that wouldn't open up and openly say that in that setting. So, if they're not being honest, what benefit is it to them?*

CSoMs felt there was insufficient time during CS sessions for participants to fully explore situations they had encountered. During a CS session, midwives should be facilitated to talk about a situation, consider what they did, why they did it, and what they might do differently the

next time, all of which is time-consuming. The CSoM role is intended to facilitate CS to ensure a strong focus on the participant coming to their own resolution. However, one CSoM in Site X explained that she sometimes helped and guided midwives because time was limited, and she wanted to be helpful.

> *Not being able to signpost and not being able to physically help people, I wasn't sure about that. However, I still practise with the new model, but I still do signpost people because I feel if I know there's information out there that's gonna help them in a situation, I'm not gonna hold that back.*

This lack of time and lack of trust led some participants to question the value of CS for them. For example, some midwives reported that they struggled to feel comfortable or gain anything from the sessions. This could result in remaining silent during the discussion or providing an answer only when directly asked a question.

> *I think everybody spoke but the person who was leading asked us individually a question that we had to answer … you're probably saying stuff for the sake of saying stuff rather than having something to talk about when you're asked a question.*

Resource issues

The key issue for midwives was lack of time to deliver and attend CS. Examples were cited of having to cancel delivering or attending booked sessions due to service demands and staff shortages. This could be perceived by participants that CS was not a priority, and it was thereby devalued. Not all participants could attend CS during their working day, and some said they had been offered overtime pay to attend CS in their own time. However, they felt they did not want to return to the workplace on their days off.

The CSoMs reported that they were required to facilitate CS within an hour, and sessions needed to be delivered punctually because participants often had to return to their work. However, one facilitator described the challenge of remaining within the allocated time whilst keeping people engaged in the session.

> *It's the winding down that I find sometimes quite difficult. I'm very aware as I get to five to the hour … I think it's important that you end well, that people feel that they've got to a place where they can go away and work in their own heads or they walk away thinking I got to say that. I don't want people to see me looking at my watch either.*

Other participants commented that the lack of time meant that discussions were superficial. Participants were aware of the tension between trying to deliver CS so that it was meaningful and achieved its goals within limited resources. However, a frequent view was that one session a year was insufficient and was perceived as a token gesture.

Many participants said they would approach their line manager for support rather than CS fulfilling this function and this was especially the case for newly-qualified midwives. Some participants made comparisons with other health professions such as Allied Health Professionals and Family Nurse Practitioners who were said to have a minimum for 4-6 sessions of CS each year.

> *Well, how come AHPs get that time to build into their diary? If I'm really being optimistic, midwives should all get time. It should be a minimum four to six sessions a year facilitated that we all get time for and there would be great value in that. Realistically, I understand that is probably never going to happen. Midwives are a small group, but because we are lumped with the nurses, that's a huge group. So hence whatever happens with nursing and midwifery, it comes together and economically it can't be done. It doesn't happen, and I think that's the sad truth of it going forward with this once a year, tick box kind of approach*

A further resource issue for participants in Site Y was lack of suitable space in which to facilitate CS. One CSoM highlighted that the lack of resource meant that CS was reliant on the good will of the Supervisors, citing examples of out-of-pocket expenses such as providing refreshments, travel and parking, as well as facilitating sessions on days off without getting the time back.

The CSoMs highlighted additional resource challenges for themselves. One was the lack of time to devote to their CSoM role, which had to be juggled with their primary role as a midwife. Some CSoMs highlighted the inequity of how CSoMs who were previously SoMs continue to be paid the SoM allowance.

Context

Two contextual issues impacted significantly on views and experiences of CS. One, applying only to Site Y, was the implementation of the *Best Start* policy. The other was comparison between the new model of CS and the previous model of Statutory Supervision which featured in accounts from both sites.

Participants in Site Y described many challenges associated with the implementation of the *Best Start* policy and the need for support. CS was viewed by some as a mechanism to provide that support.

> *We definitely need it [CS] because the job is getting harder and harder and harder and as Best Start comes in, all the challenges are going to change … There are going to be decisions made that might be the wrong decision, that somebody has to live with that.*

There was a perception from midwives who were core staff (i.e., working in the hospital) that the focus of support was directed to *Best Start* midwives.

> *The core staff have been abandoned for the Best Start. There's been nobody supporting the core staff, but the Best Start get their opportunity to go to meetings and share the information they've got and learn and talk to the challenges they have when they come into the hospital*

This impacted on CS as it was said to be dominated by *Best Start* to the dissatisfaction of some participants. One CSoM was aware of this.

> *Best Start has started here and it's rolling out. From the girls that are doing it, we're getting positive feedback which is great … but to begin with every session was just a moan fest about Best Start.*

This suggests that, in Site Y, midwives needed opportunities to express their feelings and gain information about *Best Start*. However, this resulted in CS being perceived as a platform to express discontent rather than its intended function to facilitate reflection and build resilience. In Site X, *Best Start* was rarely mentioned in interviews.

There was a consistent pattern in the interviews of comparing CS with Statutory Supervision. Those who had experienced Statutory Supervision overwhelmingly said they felt it was more valued, respected, trusted and personal than CS. Some participants felt they had lost an important layer of support from, and a relationship with a SoM they felt confident to approach with any problems.

> *Not having that one-to-one where you are looking at your personal development and issues that are surrounding midwifery and things … it is a missed opportunity. Statutory Supervision offered something else, that extra supportive level was great, and I think it was really valued by a lot of midwives … You have that privacy, and you have that trust and that was really valuable.*

Critical elements that midwives valued in Statutory Supervision were an ongoing relationship with a SoM which enabled trust and private one-to-one conversations. This was compared to CS where some midwives felt they were unable to raise issues within a group setting. There was also a view that Statutory Supervision impacted on midwives' autonomy and that a critical safety net for midwives and their employing organisations had been lost.

> *We were a safety net for the midwives, an absolute safety net. If something happened clinically … and we were looking through case notes reviewing the incident, if there was something at all about that midwife's practice, her Supervisor of Midwives would go and have a chat with her, and we could nip things in the bud. Now what happens is if something has happened that we might not even know about, the public, and they've always had the right to go straight to the NMC, but the public go straight to the NMC, go straight to an investigation.*

Some participants felt that compared to Statutory Supervision, CS lacked structure with some describing it as a 'wee chat'.

Not all participants had experienced Statutory Supervision, although they all reported having heard of it, but were divided in their opinions. This included the previous practice of allocating a SoM to each midwife and preference of being able to choose a CSoM was expressed by some.

Discussion

In this section, the findings of the evaluation are discussed, addressing the four research questions identified in the methods section. This includes exploring implications for policy and practice and proposing recommendations to improve implementation of CS for midwives. Finally, the strengths and limitations of the evaluation are appraised. Throughout this section, the findings are discussed in the context of Scottish Government and NES guidance and positions papers concerning CS for midwives in Scotland.

Research question 1: How is the employer-led model of supervision being implemented across Scotland?

This evaluation, covering 10 health boards, showed that CS was fully implemented across Scotland. As the new model is employer-led, midwifery managers assumed responsibility for its management and operation (NES 2021a; Key et al., 2019). To this end, HoMs invested time and effort to ensure it started successfully. This included facilitating recruitment and training of CSoMs and promoting CS to all midwives in preparation for launch in 2018. The reported initial enthusiasm among midwives to be CSoMs, suggests a positive attitude to new model. A key challenge at the outset was ensuring that all midwives completed the preparatory training module prior to implementation.

Variation in uptake of CS across health boards suggests that reported strategies to promote uptake were not always successful. Participants reported administrative challenges, particularly in relation to recording individual CS, implying that uptake may be greater than the routine health board data reports. However, the data is also problematic in that its focus is on participation in one CS session per year. This focus, and the strategies employed by HoMs to increase uptake (ranging from contacting all midwives individually to recourse to line management processes), contributed to the perception of CS as a 'tick box exercise'. This was confirmed by the views of many of the participating midwives. This is contrary to the principles of the restorative model. While there is no evidence on the ideal frequency of supervision (Pollock et 2017), a NES Position Statement (2021b) provides an exemplar of restorative CS taking place three times annually (p20). Unsurprisingly, the key barrier to uptake of CS was said to be lack of protected time for both CSoMs and participating midwives. It was notable that midwives in one of our case study sites perceived a punitive outcome of non-engagement with CS. While this may not have been intended, it could highlight a mismatch between the hierarchical structure and culture of the NHS and the central tenets of restorative CS.

Our participants reported multiple approaches to delivering CS including scheduled and unscheduled, weekly drop-in sessions, group and individual sessions and linking CS to mandatory training days. The rationale for these different formats appeared to be providing opportunity for all midwives to attend at least one session per year. Our findings suggested that group supervision was the predominant mode of delivery across Scotland. Many midwives appeared to be unaware that individual supervision was available and CSoMs, while acknowledging the benefits of individual supervision, reported that they did not have capacity to provide it. The group supervision sessions appeared mostly not to have fixed membership. Key et al., (2019:656) stated that "groups are often fixed, with change of members negotiated democratically". We found no evidence of this; rather where there were fixed groups, it was because it was expedient for smaller teams of midwives who worked together to have CS together e.g., in community teams. The consequence of inter-changing membership was a lack of trust among midwives within CS groups which inhibited the opportunity for open discussion and reflection. Thus, the intention of CS to be a safe space to explore issues within midwifery practice (NES 2021a) was compromised.

A critical issue raised by participants related to the perceived lack of structure of many group CS sessions, which for some, cast doubt over the benefit of attending. Some participants described CS sessions as opportunities for airing complaints. One of our case study sites addressed this through designating 'topics' for discussion at each session. While this approach was appreciated by some midwives, it would seem to more akin to teaching than restorative CS. It was notable that none of our participants mentioned use of a structured reflection framework, which Key et al., (2019) suggest is central to effective CS. One reason for this may be that CSoMs lack skills, confidence and ongoing assessment and support needed to facilitate structured reflection (West et al., 2020). Feedback from CSoMs indicated that they would have liked more time, support and ongoing preparation to deliver CS. Time for each session may also be an inhibiting factor. Although most CS sessions were scheduled for one hour as evidence suggests is ideal (Dawson 2013), our observational data showed this could be compromised by service demands e.g., participants arriving late, leaving early and being distracted by other responsibilities.

This evaluation found that participants were overwhelmingly positive about the model of restorative CS and its central processes of reflection and resilience-building. Reflection was viewed as central to midwifery practice, and CS was seen to formalise what frequently occurred informally in day-to-day practice. Similarly, participants were also positive about the potential for CS to build resilience, acknowledging the demands of their roles. The data for this evaluation was generated before the Covid-19 pandemic and we know that midwives in Scotland, like all health professionals, have faced increasing challenges and stress (Black et al., 2022). Therefore, CS could have an even greater role to play in building resilience in the midwifery workforce. However, for this to be realised, barriers to meaningful reflection, such as lack of trust, lack of time, and fear of blame within the NHS culture need to be addressed.

The implementation of CS coincided with the implementation of a major change in the way maternity and neonatal services are delivered across Scotland i.e., the *Best Start* policy (The Scottish Government 2017). This influenced perceptions of CS such that HoMs viewed it as potentially a supportive mechanism to help staff deal with change. However, midwives and CSoMs in our case study of an early adopter site for *Best Start* suggested that it dominated, mostly as a platform to express discontent. This suggests that an opportunity was missed to use CS to its full potential to support staff through a significant change in working practices. An important role for CSoMs should be to help midwives to reflect on negative feelings in a constructive way (Social Care Institute of Excellence, 2013)

Inevitably, perceptions of the new model of CS were influenced by some participants' experiences of the previous model of Statutory Supervision. The key elements that were missed were a one-to-one relationship with a named SoM, and a more structured approach to supervision meetings. Effective supervision requires supportive relationships between supervisors and supervisees including development of trust (NES, 2021b). As can be seen from our findings, developing trusting relationships when supervision is provided in groups of up to ten midwives is challenging. In this context, it is unsurprising that some midwives express a preference for a one-to-one relationship with a named CSoM. This mirrors the evidence that outcomes are optimised when women can develop a relationship with a midwife in continuity of care models (Sandall et al., 2016).

Research question 2: What are the effects of the new model on the quality of midwifery practice, clinical decision-making, adherence to national practice standards and experiences of childbearing women?

A key purpose of CS is to support continuous professional development of midwives to enhance the quality of maternity care and thereby to improve outcomes for women and infants (Key et al., 2019; NES, 2021b). This evaluation found that some midwives perceived the potential for CS to improve their practice, particularly through the reflective component of the model. This is consistent with the regulator of midwives, the Nursing and Midwifery Council, requirements that midwives participate in supervision, and in team and individual reflection to enhance practice (NMC, 2019; p27). Furthermore, there is evidence that effective supervision improves staff wellbeing, which in turn improves quality of care (West & Coia, 2019; West and Dawson, 2018). However, our evaluation highlights that the way in which CS for midwives has been implemented, for example midwives attending group supervision annually, significantly undermines CS realising this potential. In its current format, it is difficult to see the mechanism by which CS could have an impact on quality of midwifery practice and the experiences of women and babies. Midwives have expressed the need to develop trusting relationships to enable them to have confidence to share their experiences and allow them to benefit from CS. Midwives in this study missed the opportunity for a one-to-one relationship with a named supervisor which allowed them to share experiences and concerns. CSoMs have revealed that they would benefit from support and resources to enable them to be able to facilitate effective clinical supervision, including ongoing development and the opportunity to share experiences with other CSoMs.

It should also be noted that the evaluation took place during the second year of implementation, and that a longer time could be needed to judge effectiveness. Although the model is described in detail (NES 2017) and is based on theoretical principles and frameworks (NES, 2021a), it does not appear to be underpinned by a theory of change/logic model explicating over what timeframe these outcomes are anticipated to be achieved.

Research question 3: What are the implications of the new model for employers?

In contrast to the previous model of Statutory Supervision, employing health boards are responsible for implementing CS for their midwifery workforce. There is potential for significant benefit to employers of implementing CS fully in accordance with NES position statements and guidance (NES, 2021a; NES, 2021b). These benefits potentially include better staff wellbeing and lower stress levels and burnout, reduced sickness and absence and improved staff retention. As discussed above, there are potential benefits for improved quality of care and better outcomes for women and babies which could also result in fewer complaints and less litigation. In the current climate, when healthcare staff are under unprecedented pressure (West et al., 2020; Black et al., 2022), effective CS is critical.

It is encouraging that our evaluation found enthusiasm for the concept of restorative supervision, however, the model needs to be fully implemented to achieve the benefits. Our findings suggest this will require substantial investment in terms of protected time for midwives to engage meaningfully in CS more than once a year in either small, fixed groups or individually. Even more critical is investment in CSoMs so that they develop the skills, have effective support and time to deliver the model as intended. West et al. (2020) suggest that training for CSoMs is evaluated and that there is regular assessment of the quality of supervision. This should be the responsibility of employers, possibly in collaboration with NES. CSoMs need to have access to regular CS for themselves to avoid burnout.

It is important for employers to recognise that CS is not a panacea for improving staff wellbeing and clinical care, and that attention to organisational processes and culture is needed. According to the Care Quality Commission (2013) CS should be valued within the organisational culture and align to good practice in recruitment, induction and training.

Research question 4: What changes need to be made to optimise the impact and outcomes of the new model?

The findings informed the recommendations – see the Recommendations section below.

Strengths of the evaluation

A key strength of this study was the use of case study methodology to explore in-depth how CS for midwives in Scotland was implemented and the experiences of those taking part. The study included the views of HoMs from across Scotland providing a comprehensive understanding of implementation at a meso-level. At a micro-level, the use of individual interviews and observation contributed to ensuring trustworthiness of the findings. A robust approach to data analysis was implemented and the provision of verbatim quotes authenticates the findings.

Limitations

Limitations include that the data were generated in 2019 providing a snapshot of implementation prior to the Covid-19 pandemic. The pressure on NHS staff, including midwives, are known to have increased significantly during the pandemic are likely to have made the challenges of providing and participating in CS greater than in our findings. Four health boards did not participate in case study 1 and there may have been specific issues affecting those four health boards that are not represented in these findings. The number of midwives participating in the micro-level case studies was small, although the sample size was typical of in—depth qualitative work. It may be that midwives who were most motivated to participate had specific concerns, or positive experiences that they wished to share.

Conclusions

The findings of this evaluation highlight that HoMs invested substantial effort in implementing the new model of CS. Initially there was enthusiasm among midwives to be CSoMs and good participation from most midwives. The evaluation participants were mostly positive about the potential for CS to build resilience and improve midwifery practice. The challenges of implementation were mainly related to lack of time for providing and participating in CS. The lack of ongoing support for CSoMs to develop and maintain skills of facilitating group reflection was a significant barrier to its successful implementation. The emphasis by employers on midwives attending CS once a year resulted in it being perceived by most as a 'tick box' exercise. The predominant mode of delivering CS in open groups prevented midwives feeling safe to reflect openly on their practice. For the new model to realise its potential, there should be sufficient investment to address these challenges. As highlighted in the recommendations, this would include better support for CSoMs and protected time for CSoMs and midwives to engage meaningfully in regular supervision are needed, as well as time and resources for training and evaluation.

Recommendations

Based on this evaluation we propose that the following recommendations to optimise impact and outcomes of CS are considered:

1. Reinforce to midwives and employers, CS for midwives as facilitative, restorative and supportive;
2. Implement a programme of ongoing education and support for CSoMs to ensure they develop and maintain skills to facilitate reflection, using a reflective cycle, for groups and individuals and regularly evaluate the education and support;
3. Ensure that CSoMs have access to regular supervision;
4. Provide a national forum for CSoMs to share experiences, challenges and good practice;

5. Refresh the preparatory training module for midwives to participate in CS with increased emphasis on midwives' responsibility to set the agenda for supervision and participate in reflection;
6. Protect time for midwives and CSoMs to participate meaningfully in CS without disruption from workload pressures;
7. Raise awareness that CS can be provided individually or in groups according to the individual midwife's preference;
8. Develop systems and processes to ensure that midwives are able to develop a meaningful relationship with a CSoM and to have the opportunity for one-to-one sessions where privacy is required.
9. Where supervision occurs in groups, facilitate midwives to form fixed supervision groups to develop trust and encourage open reflection on practice issues;
10. Consider offering HoMs supervision either on a one-to-one basis or with a group of managers to ensure that they are able to access the support CS provides;
11. Increase the frequency of CS and ensure midwives have equitable access to CS compared to other NHS health professional groups;
12. Evaluate the quality of supervision and reduce the emphasis on attendance;
13. Review the concept of 'cost neutral' provision to provide adequate resource for effective CS to realise the potential savings in reducing staff stress and absence;
14. Undertake an economic evaluation of CS to inform investment decisions.

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Appendix 1 Models of Clinical Supervision in UK

ENGLAND
In England, the new model adopted is called A-EQUIP (Advocating for Education and Quality Improvement) which has three elements including education and development, personal action for quality improvement and restorative CS. Each of the elements can be accessed individually but it is expected they will be utilised collectively (NHS England, 2017). The A-EQUIP model aims to deliver a continuous improvement process which '…values midwives, enhances health and wellbeing, builds personal and professional resilience and contributes to the provision of high quality care and quality improvement' (Ariss et al.,., 2017:59). The new model aligns with the objectives of *Better Births* (NHS England, 2015) and theoretically is inspired by the three elements of Proctor's (1988) three function model of CS; formative, normative and restorative and Hawkins and Shohet's (2012) adaption of the model. In Proctor's (1988) model, the formative element relates to increasing knowledge and skills, the normative element to managerial processes of monitoring and evaluation and the restorative element to support required to enhance wellbeing and health. However, in the A-EQUIP model, the formative and restorative elements are included, but the normative one is not as this is included in employer's organisational governance process. As in the Scottish model, there is no mention of 24 hour access to a SOM in the new A-EQUIP model (NHS England, 2017).

WALES
Wales have elected to deliver a CS for Midwives (CSfM) model which is similar to their previous Future Proofing Model of Supervision launched in 2014 by the Health Inspectorate Wales, and is based on the core principles of Statutory Supervision (HIW, 2017). Delivery will be in conjunction with implementation of key performance indicators to encourage good practice and shared learning (HIW, 2017). This model delivers group supervision and is based on an action learning approach where supervision is facilitated by SoMs who are employed full time in the role (with 20% clinical commitment) on 18 month rotations (Ness and Richards, 2014). The new model incorporates regular 'surgeries', continuing professional development and group supervision sessions for midwives available on a drop in basis. The model recommends supervision for midwives four times per annum (at least two of which are to be group sessions) and continues to provide access to a Supervisor 24 hours a day, seven days a week for advice and support.

NORTHERN IRELAND
In Northern Ireland, work is underway to design a single Nursing, Midwifery and Safeguarding (Children) Supervision framework unlike the other three countries of the UK which deliver a model exclusively for midwives (NIPEC, 2017). In the interim period until legislation is passed, midwives will continue with a model similar to Statutory Supervision with a named Supervisor, a Supervisory review once a year and have 24 hours a day, seven days a week access to an experienced clinical midwife for professional advice. This interim model differs in that the regulatory element has been removed although SOMs will support supervisees as requested including in relation to revalidation (NIPEC, 2017). Until the current political situation in Northern Ireland is resolved, there is no working government to make the legislative changes required.

Appendix 2: Themes and subthemes

Themes - 1 Importance of supervision 2 Supervision as support to high quality practice 3 Supervision as means of control 4 Relationships 5 Time 6 Lack of understanding/ confusion

Study	Name of article	Sub-Theme	Th	Sub-Theme	Th	Sub-Theme	Th	Sub-Theme	Th	Sub-Theme	Th
1	Bedall and Carr (2010)	Enhanced practice	2	Proactive SV	1						
2	Brintworth (2014)	Personal opportunities	1	Support needed	2	Time not enough	5				
3	Burden and Jones (1999)	Role confusion	6								
4	Burden and Jones (2001)	Supportive changes to SV	4	SoM more approachable	4						
5	Deery (2006)	Time and time management	5	Organisational change and context	3	Priority of work	6	Lack of skill for SV	6		
6	Demilew (1996)	Unsupportive, punitive, negative experiences	3	Lack of trust	4						
7	Gaffney (1998)	Importance of SV	1	Inaccessibility of SOMs	4	Choice of SoM	4	Trust and credibility of SoM	4		
8	Halksworth et al.,. (2000)	Role and function of SV less punitive more supportive	3	Time	5	Relationships and characteristics of SOM	4	Public protection	1	Reactive not proactive	1
9	Hughes and Richards (2002)	More access to SV	1	Developments in practice	2						
10	Love et al.,. (2017)	Barriers to access of SV	6	SoMs credibility and trust	4	Benefits of SV	1	Time to participate	5	Misunderstandings of SV	6

11	McDaid and Stewart (2002)	Specialist SoM	1	Agents of control, power, lack of trust and openness	3	Ambiguity of SV and lack of understanding	6	Time	5	Choice of SoM	4
12	Mead and Kirby (2006)	Time	5	Misunderstanding categories of SV	6						
13	Mead et al.,. (2006)	Preparation to be SoM improvements	1								
14	Nipper and Roseghini (2014)	Full time SoM	1	Improvement in quality of SoM duties	1	Benefit for MW and women	2	No conflict of interest when full time	5		
15	Rogers (2002)	Access to SoM	1	Choice of SoM	4	Support available and contact frequency	1				
16	Rogers and Yearley (2013)	Conflict of loyalties	3	Organisation needs v women's needs	3	Public protection role not supporting	3				
17	Roseghini and Olson (2015)	Valuable as support	1	SoM qualities needed	4	Access to SV	1	Choice of SoM	4		
18	Shennan (1996)	Support was negative experience	3	Power and control issues	3						
19	Stapleton et al.,. (1998)	SV as professional characteristic	1	Wide range of understanding of SV	6	Control and discipline all about public protection	3	Confidence and trust	4	Power, control and oppression	3
20	Wallbank (2010)	Inability to cope and not able to share	4	CS effective in reducing stress	2	Fear of engaging in supportive services	2	Large numbers of staff affected by stress	2		
21	Wallbank (2013)	Clinical concern for more than 50%	1	Organisation context important	1	Restorative SV improved stress	1				

22	Merits (2019)	Time pressures to attend	5	Fixed groups helped trust	4	Stresses associated with midwifery	1	Improvements and empowerment	2	Improvements in dealing with complicated cases	2

SUPPORT AND DEVELOPMENT NEEDS	QUALITY OF CARE	EXPERIENCES
Proactive SV 1	Enhanced practice 1	Time 2
Personal opportunities 2	Priority of work 5	Role confusion 3
Support 2	Public protection 8	SoM approachability 4
Changes to support 4	Reactive nor proactive 8	Time 5
Lack of skills for SV 5	Development in practice 9	Organisational context 5
Importance of SV 7	SoM specialist 11	Unsupportive 6
Supportive elements 8	Quality improvement 14	Lack of trust 6
Benefits of SV 10	Conflict of support v protection 14	Choice of SoM 7
Misunderstanding of SV 10	Benefits for women and mw 14	Trust 7
Lack of understanding 11	Conflict of loyalties 16	Time 8
Misunderstanding 12	support v protection 16	Relationships 8
Preparation of SOM 13	Organisation v women needs 16	Barriers to access 10
Full time SOM 14	Professional characteristic 19	Credibility and trust 10
Frequency of contact 15	Public protection first 19	Time 10
Access 15	Fear of engaging in support services 20	Time 11
More access to SV 9	Organisational context important 21	Choice of SoM 11
Inaccessible SOM 7	Improvements in dealing with complicated cases 22	Trust and power 11
Valuable 17		Time 12
Access 17		Choice of SoM 15

Negative support issues 18		Choice of SoM 17
Wide range of understanding 19		Qualities of SoM 17
Inability to cope 20		Power and control 18
CS reducing stress 20		Power and oppression 19
Restorative CS improved stress 21		Affected by stress 20
Stresses associated with midwifery 22		Clinical concern 21
Improvement and empowerment 22		Time 22
		Fixed groups 22

Appendix 3 Heads of Midwifery Interview Topic Guide

Operational details relating to the implementation:

- Numbers of CSoMs available in area
- frequency of sessions offered
- numbers of midwives attending for sessions
- information about practicalities of delivering sessions
- availability of one to one session if required
- drop in session availability
- administration of attendance and participation in new model
- training of CSoMs, recruitment of CSoMs
- supervision of CSoMs
- ability to release staff to attend sessions and provide backfill to support attendance

Topic

- **Acceptability** of the new clinical supervision model from the meso (Health Board) level;

  How are you delivering the new model in this area?
  Are midwives attending well? If not, how are you encouraging midwives to participate?
  How do you manage to ensure that all midwives attend a session per year, do you have a system in place to do this? If so, can you tell me about how this is set up and who has responsibility for this?

- **Adoption** of the new model of clinical supervision;

  How are the midwives in this area encouraged to participate?
  How has the new model been adopted by the staff, both midwives and CSoMs and have there been any issues around attendance when implementing either positive or negative you can think of?

- **Appropriateness** of the new model of clinical supervision;

  The new model is resilience based. How relevant is the new model in terms of improving and supporting resilience? Have you seen any evidence of improvements in resilience, such as decreased sickness rates, or less turnover of staff as a result of the implementation?
  How do you feel about the frequency of the sessions of the new model of CS being offered?
  If there was a culture of staff perceiving clinical supervision as something that has to be done and another thing to tick off, what steps would you take to manage that?

Giving staff a choice of facilitator delivering the sessions may be a strength of the new model as previously research showed that in statutory supervision, midwives often complained that they had no ability to move easily if there were issues in the supervisory relationship. Are there a choice of sessions offered in your area to midwives? If not, is this something that may be considered?
Do you think staff understand the differences between the statutory supervision and the new model?

- **Feasibility** of implementation of the new model of clinical supervision;

  How do you manage to ensure staff are able to attend sessions offered, do you provide protected time?
  How many sessions of clinical supervision are staff to attend per year?
  The costs of the new model are lower than the previous system. How have the costs involved with the delivery of the session in the last year been in comparison to what was budgeted?
  Have there been more hours required than budgeted for?
  Have there been requests for one to one session?
  How do you manage those sessions in this area?
  Are midwives allowed to attend during working hours or do they have to use their own time?
  Are you keeping administrative records about attendance, sessions offered and such like, and who is responsible for keeping those?
  Have you managed to recruit sufficient numbers of CSoMs and have you continued to recruit and train more throughout the first year?
  Have any resigned from being a CSoM?

- **Fidelity** (degree to which the model is delivered as it was designed) of the new model of clinical supervision;

  The new model is expected to develop resilience by using the concepts of reflect, restore and respond. How are these central components of CS being facilitated, are staff being shown how to do this?
  Are there positive things which are happening in your area relating to the implementation of the new model? If so, can you tell me more about them?
  Are there any barriers to the new model being delivered as it was intended? If so, could you tell me more about them?
  How are you able to develop knowledge and share practice about the new model out with your own health board area with other HoMs?

  Is there anything else you would like to ask me?

  Thank you for your time and for agreeing to take part.

Appendix 4 Midwives' Interview Topic Guide

- Acceptability of the new CS model from the micro (midwife/CSoM) level.

How do you feel about taking part in the new model and can you tell me a bit about how you have experienced participating in it?
What parts of this new model are you happy to participate in?
Have one to one sessions been made available without asking for them?

- Adoption of the new model of CS.

Tell me more about how the new model of CS has been 'sold' to you in your workplace.
Tell me about how you found out about the new model of CS in your area and what instructions and information were you given about attending?

- Feasibility of implementation of the new model of CS.

Can you describe the most important parts of the new model of CS for you?
The new model is delivered with the aim of contributing to improved services and supporting you in your practice by improving resilience.
How do you feel about this?
Do you think this has made any impact on your ability to do so?
How do you feel the new model of CS has supported you? If not, can you tell me more?
Do you feel the CS sessions are offered frequently enough, or would you like to attend more often? If you do want to attend more often, can you tell me more about that?
Are there positive things which are happening in your area relating to the new model of CS? If so, can you tell me more about them?
Are there any barriers to you attending CS as it was intended in groups in the workplace? If so, could you tell me more about them?

- Fidelity (degree to which the model is delivered as it was designed) of the new model of CS.

The CS model is designed to build resilience by encouraging participants to reflect, restore and review.
How have you experienced these elements of the new model?
The new model is expected to be able to develop resilience in relation to midwives by looking at the three areas of reflect, restore, respond. How do you feel you can achieve this or not?
How has the new model of CS implementation felt to you?
You have an understanding of what to expect having completed the online module prior to participating.
Has taking part been as you expected it would be? If it has not been as expected, can you tell me why that has been in your experience?

Is there anything else you would like to discuss?
Thank you for taking part.

Appendix 5 Non participant observation guide

Non-Participant Observation	Date Place
AREAS OF INTEREST	OBSERVATIONS
Date of observation/Time/Length of CS session/ People (Numbers/Ages/Roles)	
Room layout with participants (draw plan) Furniture/Seating Plan/Temperature/Windows/Room use normally	
Mood/Tone/Interruptions/Awkward silences/Disagreements/Behaviours between participants/ Points of perceived tension/ Body language/Gestures/Level of Engagement	
Discussion topics	
How did I feel	
Acceptability Adoption Feasibility Fidelity	

Appendix 6 Poster presented to International Confederation of Midwives Triennial Virtual Congress June 2021

The evaluation of the implementation of a new model of clinical supervision for midwives in Scotland: a qualitative case study.

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Background

- Following a public inquiry (Kirkup, 2016), Statutory Supervision of Midwives was abolished across the UK.
- In Scotland, a new employer-led model of clinical supervision (CS) (see Figure 1) was introduced in 2018
- The new model's core elements 'Respond, Reflect and Restore' (Figure 2) were designed to support and develop midwives and to improve the quality of care for women and babies (Scottish Government, 2017).

Figure 2 Core elements of CS model (Scottish Government, 2017)

Aims

1. To discover how the new model of CS for midwives is being implemented across Scotland
2. To understand the views and experiences of those participating

Methods

- The evaluation used Proctor et al.'s (2011) Taxonomy of Implementation Outcomes to explore **acceptability, feasibility adoption appropriateness** and **fidelity** (see Figure 3)
- Qualitative case studies comprised
  - 10 semi-structured interviews with senior midwifery managers (meso level)
  - 18 in-depth semi-structured interviews with midwives and 4 non-participant observations of CS being implemented (micro level).
- Case sites were 2 NHS Health Boards in Scotland.
- Analysis used the Framework Method (Gale et al., 2013).

Results

Figure 3 Implementation Outcomes with illustrative quotes from interviews

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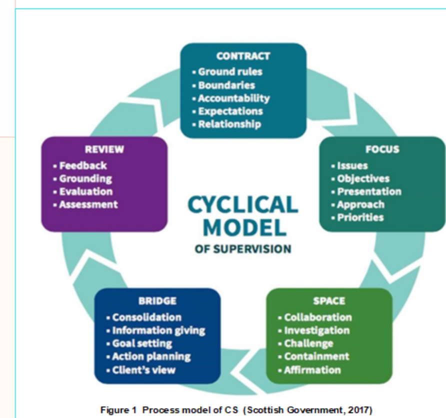

Figure 1 Process model of CS (Scottish Government, 2017)

Discussion

- Findings from this study showed there were wide-ranging and differing views between and within micro and meso levels about the implementation of CS.
- CS had been implemented in both case sites, however, there were substantial variations in how it was facilitated which affected the fidelity of the model. For example, in one site, there was evidence of use of local teams and ad hoc sessions in smaller groups for CS. In contrast, there were weekly sessions in the other site where community, hospital and specialist midwives attended together.
- The amount of **time and resources** allocated to CS implementation impacted its feasibility and acceptability to those delivering and receiving CS. Examples included a lack of staff to cover midwives attending CS during the working day, numbers of sessions able to be offered to staff and organised support for CS facilitators.
- CS was frequently associated with training instead of being seen as a separate supportive intervention for midwives, which affected its appropriateness. This meant that CS was often considered a **tick box** exercise and something to be evidenced alongside other mandatory midwifery training, which influenced its adoption and fidelity.
- Finally, CS groups can have up to ten midwives participating who may not know each other. Concerns were identified this may affect ability to **trust** other group members with any information shared, or that confidentiality may be breached out with clinical supervision due to groups that were not fixed. This shaped a number of the outcomes including feasibility, appropriateness and acceptability.

References
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