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Supervision - where now?

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Tania McIntosh explores the issues facing midwifery supervision

Midwives are unique among health practitioners within the UK in having a long established and statutory framework of supervision under the governance of the Nursing and Midwifery Council (NMC).

As midwifery supervision changes, we must explore how supervision works brilliantly as support for midwives and for the public, together with the issues and pitfalls that can make it work very badly. Historically supervision has tried to do too many contradictory things. Once these threads are unravelled it is possible to explore how supervision might be re-imagined for the future to provide the framework to protect midwives and the public and to help them to realise their common goals.

Statutory supervision of midwives dates back to the Midwives Act of 1902 which developed a regulatory framework for midwives.[1] supervision was carried out on behalf of the Central Midwives Board, the new regulatory body for midwives. Neither supervisors nor members of the Board had to be midwives. Most were doctors and their role gave them oversight and control of a potentially competitor profession. supervision in its first iteration was designed to coerce and control rather than to support.[2]

Contemporary supervision is intended to protect the general public by providing support to every practising midwife in order to ensure safe practice.[3] On an individual level this takes the form of face to face annual reviews between the midwife and her supervisor, who is also a registered midwife. Ad hoc support and advice is also offered as required. supervisors support midwifery provision within a Trust or area by being on call to offer advice and help in challenging circumstances. However, alongside this role as clinical support, midwifery supervision carries a regulatory remit. supervisors can be called on to investigate the practice of an individual midwife where concerns are raised. It is this aspect of the role which has been found wanting and puts at risk the whole concept of supervision in midwifery. The Kings Fund was commissioned to review midwifery regulation following concerns about the quality of midwifery supervision at Morecombe Bay NHS Foundation Trust following a series of clinical incidents.[4] Their report, which was accepted without demur by the NMC, was that midwifery regulation as it currently stands is not proven to be efficacious and should be dismantled.

When supervision doesn't work

The reasons why supervision was originally developed and the ways in which it has mutated give clues as to how and why it might not work. The most fundamental issue is the duality of the supervisory role. The individual supervisor is challenged with being both supporter and investigator, roles which are mutually

exclusive and hard to separate. The intention is that the supervisor providing support to a midwife should not be the supervisor who conducts any investigation. In practice with small supervisory units the roles are blurred in concept if not in fact. supervisors speak powerfully of their role as supporters, allowing midwives safe spaces to reflect and grow[5] but this nurturing role is not the one that most midwives see or experience in their working lives.[6] The very title 'supervisor' conjures up images of surveillance and control, not of nurturing. This disjoint between theory and practice is exemplified by the status of the supervisor within an organisation. Historically they were above and beyond the midwives they supervised and their role included oversight of personal as well as professional lives.[2] More recently midwifery supervision was viewed as another string to the managerial bow and supervisors were very often also the line managers of those they supervised. This meant that 'support' could easily, and accidentally, be replaced with a managerial need to make sure everyone was toeing the organisational line. It also means that supervisors were not outside the system, able to be impartial, but very much part of it.

Current critiques of midwifery supervision may even have strengthened supervisors in the belief that they need to investigate rigorously and to be seen to be investigating. Anecdotal evidence suggests that midwives are being referred for formal supervision where before Morecombe Bay any issues may have been dealt with more informally. It could be argued that this is a good thing, that it was a lack of rigor which caused problems in the first place and that the public need more protection than supervision was offering. In this reading more investigations signifies success. But it all depends on how and why they are done. In the modern NHS the intention is to move past a culture which blames individuals to one which looks at the ability of the organisation to learn and improve. midwifery supervision focuses right back down on the individual and returns us fairly and squarely to the blame game. Learning in these cases is confined, if it takes place at all, to the registrant who was at fault and the search for wider gains is lost. This all implies that supervision fails because it is punitive and one sided, punishing the individual and protecting the organisation. There is another linked way in which supervision can fail, however, and that is when investigations are performed within that small coterie. In this case transparency and honesty is potentially lost to the need to protect colleagues and friends from a system that is seen as harsh.

When supervision works supervision has been a hostage of its antecedents and of the risk-driven managerial focus of the NHS. However, there are sparks of something more positive in contemporary supervision. As might seem obvious, this mainly revolves around the supportive role of the supervisor. When supervision works it protects the public by giving midwives a safe space in order that learning may take place and for the development and deepening of lines of communication between midwives and with women. Duerden[7] reflected on the power of supervision to support decision making in midwifery. She suggested that in this situation the supervisor performed a myriad of interlinking roles including sounding-board, role model and advocate. These all rely on an open and honest relationship between midwife and supervisor reflecting core NHS values around such things as candour and courage.[8] By directly supporting the individual midwife the supervisor indirectly supports the public.

Warwick[9] described the value of supervisors in supporting change and in working with midwives

delivering team based caseload models of care. More recently the One to One service on the Wirral has used models of supervision which privilege honesty and open dialogue; discussion and decision is based on the triad of woman, midwife and supervisor.

The idea of supervisor as supporter and advocate appears uncomplicatedly positive, but the more 'punitive' side of supervision can also have powerful strengths. Davidson and Raynor[10] wrote about the experience of being under supervised practice following an episode of poor clinical practice and an investigation. For the individual midwife to be deemed to need 'retraining' in some aspect of practice can be a huge blow to confidence. This blow can itself be detrimental to learning and growth indicating the uphill battle some midwives face psychologically to rebuild their confidence and their practice after an investigation. Davidson and Raynor turned this on its head by reflecting on the power of supervised practice to give space for reflection and learning and to allow the midwife to step back from the coal-face and actively to engage with what it means to be a confident and competent practitioner. Done well supervised practice can make, rather than break, a midwife.

In the future?

Debate around midwifery supervision has intensified since Morecombe Bay. Following the Kings Fund report the NMC recommended the dismantling of supervision and legislation is being developed to make this a reality. As yet the post-supervision landscape is foggy, with little sense of what will replace it. The pulling apart of the regulatory/investigatory function from that of advocacy and support are certainly overdue. It is to be assumed that regulation will remain with the NMC in some capacity leaving the four countries of the UK free to develop their own versions of clinical supervision for midwives.

There are many examples of clinical supervision in other health professions[11]. Midwives remain unique, however, in that they work with a population who are generally well and who are able to exercise a high degree of autonomy in decision making around their care. The power of clinical supervision arguably lies in its ability to bring together midwives and women outside the administrative framework of the NHS. Doe[12] has suggested that supervisors could support women more directly through the use of social media. Gowers (personal communication) reflects on the power of storytelling among midwives and supervisors. This reinforces ideas of courage and honesty, but also highlights the need for midwives to have a safe space to reflect, to listen and to learn.

To reflect this change in emphasis a strong signal would be sent by abandoning the name 'supervision' to something more redolent of support. This would remove any lingering sense that the role has a punitive function. By their very title midwives are expected to be 'with woman' during the childbearing year. In order to give to women and to provide strength, support and advocacy, midwives themselves need a place where they can be supported. Peer-to-peer clinical support should be 'with midwife' rather than 'with management' or 'with organisation'. By supporting and empowering midwives we can support and empower women.

Tania McIntosh is Principal Lecturer in midwifery and Assistant Head of School University of Brighton

References

1. McIntosh T (2012) A social history of maternity care, Abingdon: Routledge.
2. Heagerty BV (1996) 'Reassessing the guilty: the Midwives Act and the control of English midwives in the early twentieth century.' In: M Kirkham, ed, supervision of Midwives. Hale: Books for Midwives Press. 13-27.
3. NMC (2012) Midwives Rules and Standards, London: NMC.
4. Baird et al (2015) midwifery regulation in the United Kingdom. The Kings Fund, London.
5. Kirkham M, ed, (1996) supervision of Midwives. Hale: Books for Midwives Press.
6. Henshaw AM, Clarke D, Long AF (2013) 'Midwives and supervisors of midwives' perceptions of the statutory supervision of midwifery within the United Kingdom: a systematic review' midwifery 29 (1):75-85.
7. Duerden JM (2005) 'supporting decision making through supervision' in M Raynor, J Marshall and A Sullivan eds Decision making in midwifery practice Edinburgh: Elsevier. 157-168.
8. NHS (2013) Our culture of compassionate care. www.england.nhs.uk/wp-content/uploads/2012/12/6c-a5-leaflet.pdf.
9. Warwick C (1996) 'supervision and Practice Change at King's' In: M Kirkham, ed, supervision of Midwives. Hale: Books for Midwives Press. 102-113.
10. Davidson S and Raynor M (2012) supervised Practice, The Practising Midwife Sept 2012: 34-36.
11. CQC (2013) supporting effective clinical supervision www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_ supporting_informationeffective_ clinical_supervision_for_publication.pdf.
12. Doe H (2014) 'A social media debate: engaging supervisors of midwives with vulnerable adults' MIDIRS midwifery Digest 23 (3) 281- 284.