Supervision: a ‘fresh eyes’ approach

Carol Paeglis describes some peer review approaches to supervision and midwifery practice

As the safety of some maternity services comes under the spotlight again (Care Quality Commission (CQC) 2011a; CQC 2011b; Nursing and Midwifery Council (NMC) 2011a) it is timely to be questioning how, as midwives, we can all play our part in keeping the women and babies in our care safe, and the colleagues we work with, supported. In their report of midwifery services at University Hospitals Morecambe Bay NHS Foundation Trust, NMC rightly recommended that supervisors of midwives should consider how they identify and appropriately challenge processes and practices which don’t meet best practice guidance, so that the public can be protected though a positive and proactive culture of raising and escalating concerns. However, as practising midwives, whether in clinical, management, research or teaching roles, we all have a part to play in upholding the NMC (2008) Code and the NHS Constitution, which is underpinned by seven principles (DH 2010). I would suggest that to do this effectively we need to take a ‘fresh eyes’ approach to our personal practice and the context within which we practise.

‘Fresh eyes’ approaches
Reviews: our own practice
All midwives have a named supervisor of midwives; ideally this is someone whom we have had a choice in identifying. A trusting relationship,

Summary
As recent reports question the safety of some maternity services and of the accuracy of identifying risk factors in midwifery practice, this article advocates the use of ‘fresh eyes’ reviews of our own practice, that of our peers and the practice within our organisations. If, as the literature indicates, there is no evidence of sustained transformational change through compliance as opposed to commitment, then our engagement and motivation to adopt ‘fresh eyes’ approaches to our practice, may lead to improved patient outcomes, including rates of mortality.

Keywords
Safety, fresh eyes approaches to care

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Based on respect and confidentiality within the realms of safety, can be the basis for reflecting on our strengths and our developmental needs. In addition, feedback from other colleagues can be gained through peer observations, record keeping audits and shadowing opportunities, to learn from how others work, as part of our continuing professional development.

When should we seek out a new perspective, a ‘fresh eyes’ approach to keep our learning optimal? Are ‘fresh eyes’ systems in place for our risk assessments from booking and during the intrapartum period? Both the recently published Birthplace research study (National Perinatal Epidemiology Unit (NPEU) 2011) and the NMC (2011b) Supervision, support and safety highlight missed opportunities of timely referral during pregnancy and for CTG misinterpretation; hence some services utilise ‘CTG buddying’ or ‘CTG fresh eyes’. Possibly, part of our peer review could be whether we talk up rather than talk down what is possible for women within our services. It is possible that a resource limited service may curtail women’s choices, by making the service – rather than the women - central to our thinking. The link between choice and control and improved outcomes is certainly evident in the literature, with Green et al, for example, urging that:

“Midwives need to know that having high expectations is generally associated with a better outcome for women and that by increasing women’s confidence in themselves, they are not ‘setting them up to fail’”

(Green et al 2003: 25).

Reviews: our colleagues’ practice

Working alongside our colleagues gives us the ideal opportunity to feed back when we observe excellence in practice; to praise and value standards we aspire to. But what about when we observe poor practice, poor behaviour, poor team working, even bullying? We are ‘the culture’ within our organisations and unless we maintain and challenge less than excellent practice, standards can drop. However, in a recent CQC report (2011a), one midwife told the review team:

“Supervisors are also fearful to challenge midwives, especially those who have been here a long time.”

How easy do we find it to give honest feedback to our peers? My observation is that one of the aspects of the preparation of supervisors of midwives (PoSoM) programme that midwives find most challenging, is self- and peer assessment. The PoSoM programmes at the Universities of Leeds and Sheffield utilise self- and peer assessment so that those skills are developed for their later roles as supervisors. Whilst midwives cite supporting midwives as their primary reason for wanting to become supervisors, supervisors are doing a disservice to women, babies and midwives themselves if they don’t highlight minor practice issues before they become more serious. In order to prepare prospective supervisors for their statutory roles in Yorkshire and the Humber LSA, they are allocated a mentor external to the team of supervisors within which they will practise. The aim is to broaden their perspective and to provide them with exposure to different supervisory and midwifery practices, within different organisations. All supervisory investigations are conducted by someone outside the organisation within which the practice concern arose. The evaluation of this initiative is outlined in the Yorkshire and the Humber LSA Annual report (2010). The overall qualitative finding was that the ‘human’ skills of the investigating supervisor are of the utmost importance, whether it be internally or externally led. However, the additional benefits of externally led investigations are that there is:

- no confusion for the midwives or trusts involved that this is a LSA and not a management process
- complete objectivity
- a ‘fresh eyes’ approach to practice issues that might previously have been accepted as ‘custom and practice’
- sharing of good midwifery and supervisory practice and of lessons learned.

Reviews: practice within our maternity units

The CQC’s recent thematic reviews of all maternity and midwifery service providers (CQC 2011b) raised new concerns in about 10 per cent of cases. The reviews focused on the three areas thought to be associated with poorer outcomes: staffing, patient experience and clinical outcomes.

Our responsibilities within The Code (NMC 2008) and the NHS Constitution (DH 2010) are clear in relation to practice and its context. If we are committed to using data ‘intelligently’, no data should come as a surprise. If they do, we should be focusing our efforts and energies into identifying how to utilise the clinical governance forums within our organisations to improve the very outcomes that make
us an ‘outlier’ (because of our normal birth rates and so on).  
NHS West Midlands took a proactive approach to addressing intrapartum stillbirths and perinatal and infant mortality in their region, by commissioning the Perinatal Institute to undertake confidential enquiries into the deaths (WMPI 2010, 2011). They found that in line with other regional and national audits, most intrapartum related deaths were potentially avoidable and most unit based case reviews did not identify the factors contributing to the demise of the babies. This demonstrates the value of external reviews of poor outcomes, which in these cases resulted from an absence of appropriate staffing, support, care pathways and effective referrals.  
In Yorkshire and the Humber LSA, as in most other LSAs, teams external to the trusts visited throughout the LSA audit process, aimed to provide a ‘fresh eyes’ approach to reviewing the standard of both supervisory and midwifery practice observed. Service users, midwives and supervisors learn much from the process, with one recently commenting:  
“As a midwife, to have the opportunity to look at maternity care provision through a different lens is invaluable...The truth is, we are all better at some things than others; to see different ways of doing things can be really motivating – I think it is an invaluable part of keeping care safe and moving forward.”  
Supervisor of Midwives with experience of being audited and being an LSA auditor.

### Table 1 Demonstrating the comparison between commitment and compliance goals

<table>
<thead>
<tr>
<th>Commitment goal</th>
<th>Compliance goal</th>
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<tbody>
<tr>
<td>States a collective improvement goal that everyone can aspire to</td>
<td>States a minimum performance standard that everyone must achieve</td>
</tr>
<tr>
<td>Based on shared goals, values and sense of purpose for co-ordination and control</td>
<td>Uses hierarchy, systems and standard procedures for co-ordination and control</td>
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<td>Delivered through voluntary connections and teams</td>
<td>Delivered through formal accountability structures</td>
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<tr>
<td>Commitment to a common purpose creates energy for delivery</td>
<td>Threat of penalties/sanctions/shame creates momentum for delivery</td>
</tr>
<tr>
<td>The goals are a beginning as momentum and resources for change grow out of them</td>
<td>The targets are an end to be achieved</td>
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</tbody>
</table>

Walton (1985)

Engaged, motivated clinicians perform well and lead to improved patient outcomes, including rates of mortality

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