Advocating and Educating for Quality improvement: A-EQUIP Implementation in Greater Manchester and Eastern Cheshire

Purpose of Paper

This paper describes the implementation of an employer-led A-EQUIP model and role of the Professional Midwifery Advocate (PMA) across Greater Manchester and Eastern Cheshire (GMEC) Local Maternity and Neonatal System (LMNS).

1. Background

1.1.1 The A-EQUIP model of clinical supervision is employer-led and not statutory. It is non-regulatory and does not investigate practice concerns, impose interim practice orders or any regulatory matters relating to the Nursing & Midwifery Council.

1.1.2 Following a series of discussions with Greater Manchester Directors of Nursing and Midwifery, it was agreed to update the responsive approach to the implementation of A-EQUIP, which remains tailored to the context of GMEC.

1.1.3 The transition from the statutory model to the employer-led GMEC A-EQUIP model of clinical supervision has been an iterative process, using an incremental approach and now that the framework has been in place for some time, it was deemed necessary to update the PMA GM Framework to reflect the changing PMA landscape. The LMNS will work with providers to flexibly review the organisational and workforce requirements across the Conurbation.

1.1.4 The Regional maternity lead role will support GMEC Strategic Clinical Network (SCN) to implement and deliver this employer-led approach to A-EQUIP.

1.1.5 Representatives from both the trust and education setting have worked collaboratively to update the GM framework.

2. Key Themes of the GMEC Model & National PMA Principles

- Education and Development (Formative)
- Monitoring, Evaluation and Quality control (Normative)
- Clinical Supervision (Restorative)
- Personal action for Quality Improvement

Please note: four New Principles for the National Implementation have been identified and these include Leadership, PMA Staffing and succession planning, PMA Training and facilitating the AEQUIP model such as holding restorative circles, career conversations and collating PMA data.

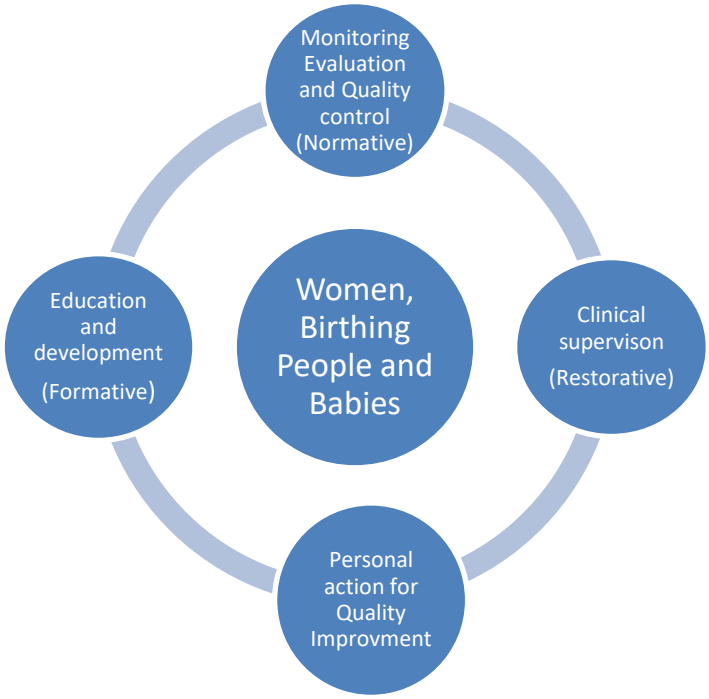

Fig.1. A-EQUIP Model (NHSE 2017) (Modified to be inclusive 2024)

3. Operational details for each key theme for GMEC – these also include the new four key principles

3.1 Education and Development (Formative)

With the support of the Professional Midwifery Advocate (PMA – see Appendix 1 for role descriptors), all midwives will explore opportunities to develop direct links to personal and professional development, building on the links between appraisal and revalidation.

3.1.1 All provider sites across GMEC will provide midwives with access to the following opportunities to ensure midwives feel valued at all stages of their career:

- Practice Assessor/Supervisor compliance and Preceptorship review(s)
- Preceptorship programmes
- Annual Appraisal
- Revalidation process including reflection and signposting towards Continuous Professional Development considering career development and retention.

3.1.2 Across the LMNS, there will be evidence of:

- Employment regulation including maintenance of professional registration and standards, ensuring midwives have revalidated and paid their annual registration fee.
- Midwifery training needs analysis, which recognises the continuous professional development through compliance with the Core Competency Framework.
- Encouragement to be involved in Communities of Practice such as the North West PMA Network and attendance at annual CPD events.

- Participation in the development of Clinical Standards and Pathways. Responsibility for this will lie with the clinical network and provider organisations.

3.2 Personal Action for Quality Improvement

Recognising the increasing complexity of healthcare requires midwives to be familiar with and contribute to Quality Improvement. Personal action for Quality Improvement is a function that aims to ensure that, with support from the PMA, improving quality becomes an intrinsic part of a midwife's role and builds capacity and capability for improvement across the maternity system.

3.2.1 Across GMEC all providers will ensure:

- Midwives have access to employer-led improving quality approaches, such as the Ward Accreditation process and Quality programmes.
- Midwives will be signposted to and supported by the PMAs in their contribution and participation in clinical audit, research and implementation of report findings, for example, Quality and Safety of Maternity Care (Balogon et al, 2025), Better Births (National Maternity Review, 2016) and dashboard data.
- Midwives will engage with local Quality Improvement programmes to increase their skills in the use of Quality Improvement approaches and methodologies.
- In line with Patient Safety Incidence Response Framework (PSIRF), there is a culture of learning from incidents in practice, e.g. sharing key themes and lessons learned from clinical practice incidents and understanding themes from complaints, creating an inclusive culture and promoting civility.
- Services are shaped using service user and staff feedback, e.g. utilising the National surveys and themes from the local Maternity Voices Partnership.
- Integration of the recognition of the wider Public Health agenda into core midwifery practice and awareness of the wider determinants of health, e.g. antenatal and newborn screening, perinatal mental health, smoking cessation, nutrition and raised Body Mass Index in pregnancy, care of vulnerable women and access to maternity care, immunisation and infant feeding.

3.3 Monitoring Evaluation and Quality control (Normative)

3.3.1 Across GMEC all providers will have frameworks in place which give assurance for Governance, Workforce and Professional Registration, e.g.:

- Risk and incident analysis, reporting to the GMEC Maternity SCN dashboard
- Contracts of employment
- Role descriptions (including PMA)
- Models of values and behaviours
- Appraisal & Revalidation
- Data collection for PMA dashboard

3.4 Clinical Supervision (Restorative)

3.4.1 Restorative Clinical supervision will be rolled out in the trust setting, linked to the availability and access to training for PMAs.

3.4.2 Each provider in GMEC will be encouraged to apply for NHS England funding to support either short course places or part-funding towards the long course. Each provider should strive towards achieving a ratio of 1 PMA: 20 staff/students. There will be a database of current numbers of qualified PMAs and their activity. This is captured via Provider Workforce Returns (See Appendix 2 for SOP).

3.4.3 Clinical Restorative supervision sessions will be offered to all midwives. This will be offered either as a group session or as a one to one. In addition, access to an individual session for any midwife will be available as the need arises. Trusts will work with the LMNS to review the offer across all bands of midwives, student midwives and our MCAs and MSWs.

3.4.4 Each Trust across the LMNS will offer protected time to midwives in the identified cohort above to access Clinical Restorative supervision. Each provider should locally determine how much protected time the PMAs are offered dependent on PMA to staff ratio but there should be evidence of protected time across the PMA team.

3.4.6 PMAs across providers can offer a buddy system in which PMAs receive support from each other and the development of PMA Networks is encouraged.

3.4.7 The role of the PMA:

- The PMA role is designed to deploy the A-EQUIP model
- At gold standard, NHSE mandates suggest that PMAs are offered 7.5 hours per month protected time to undertake the role. GM Trusts can determine if this can be facilitated dependent on the number of PMAs available and clinical needs.
- The ratio for PMA: Staff is to be no less than 1 PMA: 20 members of staff. This ratio can include HCA's and students should the PMA numbers permit. Some trusts may decide to run separate restorative circles for students and other staff members that are not included in the ratio.
- A role descriptor has been completed and should be utilised across GMEC Appendix 1). This incorporates tasks, functions and standards required to deliver the A-EQUIP model. This includes protected time of 7.5 hours per month, and this should be adopted where possible.

3.4.8 Selection and Education :

- The GMEC Directors and Heads of Midwifery (DoMs and HoMs) have worked in partnership with the Lead Midwife for Education (LME) for Salford, Manchester and Bolton Universities to develop an educational framework for PMAs. The HEI's have agreed to add content that introduces and integrates the AEQUIP model and PMA principles into the pre-registration curricula across GM.

- To undertake the role of the PMA, a midwife must successfully complete a PMA programme of education. If midwives choose to be educated in the GM region, the PMA course is offered currently by the University of Salford.
- The PMA will be appointed by the HoM on the provider sites, using Trust HR processes or via self nomination.
- Those midwives who aspire to be PMAs should demonstrate the following characteristics:

    - Registered Midwife
    - Educated to BSc/Equivalent level in midwifery, including those educated via the apprenticeship route
    - Leadership skills
    - Professional credibility

Once selected, the aspiring PMA will undertake a programme of learning at an agreed Higher Education Institution (HEI). The University of Salford will continue to offer a Level 7 PMA and leadership programme.

3.4.9 Governance:

- Employers across GMEC will be responsible for holding training records in line with the Trust Human Resources (HR) processes
- Space for meetings, records, related documents, notes and outcomes must be facilitated and held locally on each provider site
- There will be an audit trail for individuals meeting their PMA
- Midwives in GMEC must maintain their individual Trust-agreed appraisal revalidation and confirmer processes alongside any PMA contacts
- PMAs will have no direct responsibility for clinical governance or on call
- The number of PMAs in each provider service will be reported to the Provider Workforce Returns and the GMEC Maternity SCN

4. A-EQUIP Outcome Measures

4.1 PMA data is now collected via the Provider Workforce Returns (See Appendix 2 for SOP) for those working in NHS Trust settings. Non-NHS settings should submit their PMA activity data by the completing the following form each month https://forms.office.com/e/ssnDn5GQJ2. NHS England then compiles this information onto their dashboard. This information should be presented to the LMNS annually to ensure the framework is in line with current PMA practice.

5. Next Steps

5.1 The LMNS will support providers in conversations to support funding of the model going forward

5.2 Providers will work with together to ensure all midwives in GMEC have:

- Appropriate induction, continuous personal and professional development, clinical supervision, training and instruction
- A detailed appraisal using a recognised HR framework
- Access to professional leadership

References:

Balogon, B., Gheera, M., Harker, R., Garratt, K., Parkin, E. (2025). *Quality and safety of maternity care (England)*. House of Commons Library. CBP-9815.pdf

NHS England. Better Births. *Improving Outcomes of Maternity Services in England. A Five Year Forward View for Maternity Care*. London: NHS England; 2016

Appendix 1:

Sessional Professional Midwifery Advocate- Role Descriptor

Introduction

The role of the Sessional Professional Midwifery Advocates (PMA) is to provide support for maternity staff, including Restorative Clinical Supervision (RCS), education, development, monitoring and evaluation of service provision, and quality improvement (QI), using a robust QI methodology and a systemic approach to improve services. The PMA service aims to facilitate a continuous improvement process, based on the A-EQUIP Model, that values all maternity staff, supporting and building their personal and professional resilience, and contributing to the provision of high-quality care that is provided to all women, birthing people, babies, and their families.

The Trusts with Lead PMAs co-ordinate the team to deploy the A-EQUIP model with the sessional PMAs being supported to undertake the PMA training and the recommendation is that, once qualified, the PMAs receive 7.5 hours/month of protected time to perform the role with support of their line manager, and that the working of this protected time is agreed between the Lead PMA, Sessional PMA and their manager. Where Trusts have no Lead PMA, the agreement is between the Sessional PMA and their line manager.

Purpose

The role descriptor is intended to support line managers, Lead PMAs (where applicable) and Sessional PMAs to adequately undertake the role. The agreement is in line with the recommendation that the Sessional PMA works a protected 7.5 hours/month, with commitment given to roles and responsibilities, as highlighted below. These hours are intended to support all maternity staff.

Roles and responsibilities

Roles and responsibilities of a Sessional PMA include.

- Provide Restorative Clinical Supervision (RCS) including individual/group sessions as well as planned/ad hoc 'corridor conversations'.
- Be visible, for example, providing a daily walkabout as 'PMA of the Day'.
- Attend team meetings, for example, the annual National PMA conference, Regional monthly PMA forums including Away Days.
- CPD online learning and supportive studies sessions for example, PMA psychological booster sessions.
- Support reflection and development, including career conversations and revalidation.
- Be involved with and deliver QI initiatives, for example, culture and civility workshops, 'drop-in' sessions, and 'career cafes.'
- Supporting maternity staff to undertake roles within establishing and continuing services, for example, the Birth Reflections Service.
- Supporting maternity staff with QI projects.
- Supporting preceptees, new starter and internationally educated midwives.
- Involvement with post-incident support.
- Involvement with providing PMA service updates at Mandatory training/PROMPT.
- Support for PMAs in training, providing shadowing opportunities.
- PMAs should be supported by their line manager to participate in any relevant CPD opportunities and training available to them.
- Collation of PMA activity data (including themes) in preparation for monthly submission.

With permission and thanks to the Princess Alexandra Hospital's Lead PMA, Louise Portsmouth & Lead PNA, Silpa Dhaneesh, December 2023.

Appendix 2:
PMA Data Collection SOP

PMA Activity Data Collection SOP Mast

Appendix 3:
Link to PMA Data for non NHS settings:
https://forms.office.com/pages/responsepage.aspx?id=slTDN7CF9UeyIge0jXdO456lKe5pSVhLmgIFSrlcCm9UREdOMTJSUlZOWlFMUk42OElUWkRHSE9TSy4u&route=shorturl