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Evaluating Employer-Led Clinical Supervision for Midwives in Wales:

a mixed-methods national study



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Foreword

As Chief Nursing Officer for Wales, I am delighted to introduce the first national evaluation of the Clinical Supervision for Midwives (CSfM) model in Wales.

Midwifery is a profession that combines clinical expertise, professional judgement and compassionate care at some of the most significant moments in people's lives. It is also a profession delivered within increasingly complex and demanding environments. Supporting the wellbeing, confidence and professional development of our midwifery workforce is therefore essential to ensuring safe, high-quality care for women, babies and families across Wales.

Following the withdrawal of statutory supervision in 2017, Wales took a deliberate and progressive approach by establishing an employer-led model of Clinical Supervision for Midwives. Grounded in reflection, support, psychological safety and professional growth, the model was designed to provide midwives with a trusted space to learn, develop and thrive throughout their careers. This evaluation provides the first national opportunity to understand how that vision has translated into practice.

The findings are encouraging. Across all Health Boards, the evaluation demonstrates a model that is well understood, highly valued and deeply embedded within maternity services. Midwives consistently describe supervision as a source of support, confidence, wellbeing and professional growth. Senior leaders recognise its contribution to workforce sustainability, organisational learning and the delivery of safe, effective and compassionate care. Importantly, the evaluation also highlights the dedication of Clinical Supervisors for Midwives, whose commitment, expertise and relational leadership have been instrumental in establishing and sustaining the model across Wales.

The report also rightly identifies opportunities for further development. As the needs of our workforce and services continue to evolve, we must ensure that supervision remains sustainable, equitable and responsive. The recommendations set out within this report provide a clear and constructive pathway for strengthening the model through greater consistency, strengthened assurance, workforce planning and the continued development of supervisory expertise.

The principles underpinning Clinical Supervision for Midwives align closely with the aspirations set out in my Strategic Vision for Nursing and Midwifery in Wales: a workforce that is valued, empowered, compassionate, evidence-informed and equipped to lead improvement. Supervision creates the conditions for reflective practice, psychological safety, continuous learning and compassionate leadership—all essential foundations for delivering excellent care and fostering healthy workplace cultures.

I would like to thank the midwives, Clinical Supervisors for Midwives, senior leaders, researchers and partners who contributed to this important work. Their commitment to sharing experiences, insights and expertise has created a valuable evidence base that will inform the future development of supervision in Wales.

As we look ahead, this evaluation provides assurance that Wales has established a strong foundation on which to build. By continuing to invest in our people, promote reflective and compassionate practice, and support the wellbeing of our workforce, we can strengthen maternity services and improve outcomes for those who depend on them.



A handwritten signature in black ink that reads "Sue Tranka".

Sue Tranka

Chief Nursing Officer for Wales

Welsh Government

Clinical Supervision for Midwives plays an important role in supporting the midwifery workforce in Wales. This evaluation provides the first national assessment of the employer-led model and offers valuable insight into how supervision is experienced across maternity services.

The findings provide strong evidence that Clinical Supervision for Midwives is making a positive difference. Midwives describe supervision as a trusted space for reflection, support and professional development, helping them to build confidence, maintain wellbeing and navigate the challenges of modern practice.

The evaluation also highlights the wider benefits of the model. Beyond supporting individual midwives, Clinical Supervisors for Midwives contribute to organisational learning, quality improvement and the development of safer services. Their ability to identify themes, share learning and support professional growth is a significant strength.

While the overall findings are positive, the report identifies opportunities to strengthen the model further. Ensuring consistency, supporting supervisory capacity and improving the way impact is evidenced will help sustain and enhance the benefits of supervision across Wales.

I would like to thank all those who contributed to this evaluation. Their experiences, insights and commitment have helped build a clearer understanding of the value of Clinical Supervision for Midwives and will support its continued development for the benefit of midwives, women, babies and families.



Sam Donohue

Executive Director of Nursing,
Health Professions and Quality

Health Education & Improvement Wales

Executive Summary

Purpose

This evaluation presents the first national assessment of the employer-led Clinical Supervision for Midwives (CSfM) model in Wales. Introduced following the removal of statutory supervision in 2017, the model was designed to provide a safe, supportive and non-regulatory space for reflection, professional development and wellbeing.

Although the CSfM model was established before several recent national strategies were published, its purpose and delivery align closely with current Welsh priorities for compassionate leadership, psychological safety, workforce sustainability and continuous learning. These priorities are set out within the [Strategic Perinatal Workforce Plan for Wales \(2025-2028\)](#), the [Quality Statement for Maternity and Neonatal Services](#) and the [Strategic Vision for Nursing and Midwifery 2025-2030](#).

Methods

A mixed methods design was undertaken across all seven Health Boards between September and November 2025.

- ❖ Midwives: 269 midwives completed structured online activities examining understanding, access and perceived value of supervision.
- ❖ Clinical Supervisors for Midwives: 14 supervisors contributed to a digital whiteboard activity mapping role functions, skills, enablers and constraint.
- ❖ Senior Midwifery Leaders: 12 semi structured interviews explored fidelity to the national framework, organisational support and adaptation.
- ❖ Supplementary survey: 289 midwives provided additional insights into accessibility and perceived benefit.

Normalisation Process Theory was used to explore how the model is understood, implemented and experienced in everyday practice, how people work together to make it happen, and whether it is seen as useful and sustainable over time.

Key Findings

Coherence

Across the workforce, clinical supervision is clearly understood as a supportive, reflective model that is distinct from management, appraisal or regulatory oversight. Its purpose and principles are well recognised by midwives, supervisors and senior leaders.

Cognitive Participation

Engagement with supervision is high. Midwives frequently participate beyond minimum requirements, and supervisors invest significant relational effort to maintain accessibility and trust. Senior leaders demonstrate clear commitment through protected time, governance links and continued investment in the model.

Collective Action

The CSfM model is embedded across Wales and is widely valued. However, delivery is influenced by workforce pressures, geography and infrastructure. Supervisors adapt how they work to remain visible and accessible within operational constraints, leading to some operational variation across Health Boards.

Reflexive Monitoring

Midwives consistently reported perceived benefits to wellbeing, confidence and reflective practice, with many describing supervision as supporting their ability to remain in practice during challenging periods.

Supervisors and leaders described ongoing informal appraisal through feedback, reflection and identification of emerging themes, with learning shared locally where appropriate. Use of Key Performance Indicators alongside narrative feedback and workforce intelligence to monitor delivery and perceived impact were reported, although approaches and data maturity varied across Health Boards. Limitations were acknowledged, including inconsistent data systems and limited outcome measures, with interest expressed in more robust and consistent monitoring arrangements.

Fidelity

The CSfM model mostly remains closely aligned with the original Welsh Government guidance. It consistently provides a safe, confidential and impartial space for reflection and professional support. Supervisors deliver both group and individual supervision, maintain clinical credibility and uphold a restorative ethos.

Key Performance Indicator (KPI) measures are largely met, supported by structured reporting and governance arrangements. Some variation is evident in rotational structures and peer review activity.

Adaptability

Health Boards have adapted the model to meet local workforce needs and service pressures. Adaptations include changes to supervisory delivery, stronger links with governance, education, quality improvement activity and expanded contributions to multidisciplinary engagement, wellbeing activities and learning initiatives.

While these developments enhance relevance and responsiveness, they have also introduced variation in scope and delivery across Wales.

Value

This evaluation did not seek to establish causal effectiveness. Instead, it examined perceived value, contribution and role within the wider workforce system.

Experiential value is strong and consistent. Midwives report improved wellbeing, confidence and resilience, and senior leaders associate supervision with strengthened culture, early post-incident support and contributions to safety and governance.

However, this value is not consistently visible at organisational or system level. Current KPIs focus on activity rather than outcomes, limiting the ability to articulate impact within formal planning, assurance and investment processes.

Strengths

- ❖ First national evaluation of the Clinical Supervision for Midwives model in Wales.
- ❖ Comprehensive mixed methods design with high engagement across Health Boards.
- ❖ Triangulated data sources (surveys, interviews and reflective whiteboard activities) enabling system level insight.

Limitations

- ❖ Uneven representation across Health Boards.
- ❖ Reliance on self-reported outcomes.
- ❖ Lack of formal workforce or safety outcome measures to corroborate perceived effects.

Recommendations

The recommendations were developed through structured engagement with key stakeholders. Findings from the evaluation were shared with stakeholders and explored further through an interactive workshop, where participants were invited to propose recommendations informed by the evidence.

Four recommendations emerged from this process:

- ① Standardise and modernise the CSfM model.
- ② Strengthen monitoring and assurance processes.
- ③ Build a sustainable CSfM workforce.
- ④ Create a national development and succession pathway.

Background

This evaluation was undertaken following the [Strategic Perinatal Workforce Plan for Wales \(2025-2028\)](#), which identified review of clinical supervision as a priority for supporting workforce sustainability and safe, high-quality perinatal care. The findings and recommendations from this evaluation will be of interest to maternity service leaders, policy makers, workforce planners and professional bodies.

Clinical supervision is recognised as a core component of safe and effective health care. In midwifery, supervision has a long history in the United Kingdom, originating in the [Midwives Act 1902](#) and later embedded within maternity services through the [Nursing and Midwifery Council's Midwives Rules and Standards](#).

While supervision offered opportunities for reflection and professional support, its dual role as both a supportive and regulatory mechanism became increasingly contested. Critics argued that this arrangement blurred accountability, created conflicts of interest and undermined confidence in the system. These concerns informed the [Nursing and Midwifery Council's 2015 review of midwifery regulation](#), which concluded that statutory supervision was no longer fit for purpose. Statutory arrangements were therefore withdrawn across the UK in 2017. In Wales, this transition led to the introduction of a new employer led model of clinical supervision, with national guidance published in 2019 and subsequent adoption across all Health Boards.

Unlike its statutory predecessor, the new model emphasises professional wellbeing and reflective practice rather than regulation. Clinical Supervisors for Midwives are experienced practitioners appointed internally, supporting professional development through locally informed reflective supervision aligned with compassionate leadership, workforce resilience and quality improvement.

This is the first evaluation of the employer led Clinical Supervision for Midwives model in Wales. Examining how the model operates in practice, how it is experienced by midwives and whether it delivers its intended outcomes is important for informing future workforce and service planning. Clinical supervision is particularly significant in midwifery due to the professional, emotional and ethical demands of the role, delivered within high pressure environments where decisions directly affect women, babies and families.

Wales provides a distinct context for evaluation through its national policy and service structures. Maternity policy emphasises safe, person centred care alongside value-based healthcare principles, within a system experiencing sustained workforce pressure and increasing care complexity. Effective supervision has the potential to provide a structured space for reflection and learning, supporting emotional wellbeing, professional confidence and retention and contributing to the sustained quality of care.

Logic Model

The logic model was developed retrospectively to make explicit the assumptions about how the programme was intended to operate within the [Welsh Government guidance](#), rather than to represent a formally agreed or operational theory of change (Appendix 1). It was used to support assessment of fidelity to the guidance by mapping the intended design and mechanisms of the programme, with outputs and anticipated short, medium- and long-term outcomes inferred from the guidance narrative.

Aims and Evaluation Questions

This evaluation examines how the Clinical Supervision for Midwives model has been implemented and sustained in practice, how it is experienced by midwives and the extent to which it delivers its intended benefits and outcomes. It also explores how the model has been adapted to meet the needs of different organisational contexts, providing evidence to inform national policy and local practice.

The evaluation assessed the model against three principles:

- ① **Fidelity** – the extent to which the model is delivered in line with national guidance.
- ② **Value** – how midwives, CSfMs and leaders perceive its benefits and impact.
- ③ **Adaptability** – how the model has adjusted to address local contexts, CSfM training needs and workforce pressures.

Methods

Design

A mixed-methods design combined structured activity surveys, whiteboard exercises and semi-structured interviews. Questions and methods were informed and shaped in collaboration with stakeholders to minimise participant burden and maximise engagement.

Study population and participant selection

The evaluation was conducted across all seven Health Boards in Wales which provide maternity services and involved clinically based midwives, Clinical Supervisors for Midwives and Senior Midwifery Leaders.

- ❖ Midwives were invited to complete three online structured activities exploring understanding of the Clinical Supervision for Midwives model, access to supervision and perceptions of value.
- ❖ Clinical Supervisors for Midwives contributed to a digital reflective whiteboard exploring role activities, required skills, and enablers and barriers to effective practice. To accommodate differing work patterns and service pressures, each Health Board used a separate whiteboard. Supervisors received brief individual guidance and recorded reflections asynchronously.
- ❖ Senior midwifery leaders participated in interviews examining the purpose of the model within their organisation, alignment with national guidance and organisational support for delivery. Discussions also explored local adaptation, monitoring arrangements and perceived impact on staff, services and organisational priorities.

Recruitment

Engagement of clinically based midwives was maximised by collecting data during local supervision sessions and mandatory training days. Clinical Supervisors for Midwives were informed of the evaluation within the All-Wales Clinical Supervisor's for Midwives Quarterly Forum and Senior Midwifery Leaders via the Directors and Heads of Midwifery Advisory Group. Both Clinical Supervisors for Midwives and Senior Midwifery Leads were also formally invited to contribute via email. All seven health boards were represented.

Supplementary data

In addition, CSfMs shared findings from their national feedback survey conducted in December 2024. This survey, disseminated via maternity social media platforms across Wales, captured midwives' views on access to and engagement with supervision. These data provided a complementary source of insight into midwives' experiences, enriching the primary dataset and strengthened the overall evaluation.

Theoretical Framework

The Clinical Supervision for Midwives (CSfM) model is a complex workforce intervention introduced in response to national policy and professional priorities. Evaluation of such interventions requires consideration not only of outcomes but also of how they are implemented, adopted and sustained in practice. For this reason, Normalisation Process Theory (NPT) was selected as the analytical framework. Other frameworks were considered but did not align as closely with the study's focus on implementation into everyday clinical practice.

Normalisation Process Theory explains how new practices are embedded within routine work and was used to examine how the model was understood, enacted and appraised by midwives, Clinical Supervisors for Midwives and senior midwifery leads. Analysis was structured around four core constructs: coherence, cognitive participation, collective action and reflexive monitoring.

Coherence - How midwives and leaders make sense of the purpose and principles of the CSfM model.

Cognitive participation - How individuals engage with and commit to embedding CSfM services in practice.

Collective action - How the CSfM model is enacted through everyday work, systems and relationships.

Reflexive monitoring - How the impact and value of the model is appraised and adapted over time.

Together, these constructs provided a framework for examining fidelity, value and adaptability of the model in practice.

Governance and Ethics

The evaluation was approved as a service evaluation by the Health Education and Improvement Wales Research Governance Group and did not require NHS Research Ethics approval. It was conducted in line with NHS Wales standards for confidentiality, data security and ethical practice. Participants received information about the evaluation and provided verbal consent prior to participation. The work was positioned as developmental, with no implications for appraisal or performance management, and all data were anonymised and reported in aggregate.

Oversight was provided through Health Education and Improvement Wales workforce governance structures, with operational guidance from a Clinical Supervision for Midwives evaluation working group comprising representatives from Health Education and Improvement Wales, NHS Wales, Cardiff University, the All-Wales Clinical Supervision for Midwives Forum, Consultant Midwives and Directors and Heads of Midwifery. Progress updates were provided to the Health Education and Improvement Wales senior leadership team and relevant strategic forums.

Stakeholder Involvement

A national stakeholder group was convened following initial analysis to review findings and inform recommendations. Preliminary results were presented to midwives, Clinical Supervisors for Midwives, Directors and Heads of Midwifery and representatives from policy, professional and academic bodies. The session was used to assess interpretation, gather additional perspectives and co-develop recommendations for practice and policy.

Analysis

Different analytical approaches were applied across data sources.

- ❖ **Survey and activity responses** from midwives were summarised descriptively and reported in aggregate.
- ❖ **Whiteboard reflections** from Clinical Supervisors for Midwives were analysed thematically to explore role activities, skills and enablers and barriers to effective practice.
- ❖ **Interviews** with senior midwifery leaders were transcribed verbatim and analysed thematically using Braun and Clarke's approach.

Findings across all data sources were then integrated using the Normalisation Process Theory constructs to examine fidelity, value and adaptability.

Evaluation Participation

Data collection took place between September and November 2025 and involved midwives, Clinical Supervisors for Midwives (CSfMs) and senior midwifery leaders from all seven health boards in Wales. Supplementary data from the national CSfM survey (December 2024) were integrated to enhanced triangulation of findings.

A total of 269 clinically based midwives participated in one or more of three online reflective activities exploring understanding of the Clinical Supervision for Midwives model, access to supervision and perceived value (Table 1). Data from the values activity also captured work setting and professional grade, enabling analysis of variation across Health Boards, workplace setting and clinical grades (Tables 2 to 4).

Across all health boards, 14 CSfM's contributed to the digital whiteboard activity. Participation was asynchronous, allowing supervisors to record reflections alongside clinical and supervisory commitments and enabling engagement across geographically dispersed teams.

Semi structured interviews were completed with 12 senior midwifery leads, representing all seven Health Boards.

In addition, findings from the All-Wales Clinical Supervision for Midwives feedback survey were included. The survey was disseminated via maternity social media platforms in December 2024 and received 289 responses. Table 5 shows the distribution of this supplementary survey responses across Health Boards. The distribution reflects each Health Board's contribution to the total survey sample, including proportion of the total midwifery workforce within each Health Board that is represented in the survey.

Midwife responses	
Activity	Number of Responses
Roadmap Activity	269
Values Activity	239
Understanding Activity	216

Table 1 - Midwifery participants to activities (Midwife Activities).

Distribution of responses across Health Boards			
Health Board	n	%	% of total HB midwives
A	41	17.2%	11.8%
B	18	7.5%	7.8%
C	74	31.0%	18.9%
D	47	19.7%	20.8%
E	17	7.1%	34.0%
F	26	10.9%	8.5%
G	16	6.7%	5.2%

Table 2 - Distribution of participants across Wales and Health Board participation rates (Midwife Activities).

Distribution of responses across workplace		
Area of Work	n	%
Not Recorded	6	2.5%
Hospital Based	164	68.6%
Community	69	28.9%

Table 3 - Distribution of participants across workplace (Midwife Activities).

Distribution of responses across staff grades		
Grade	n	%
5	55	23.0%
6	133	55.6%
7	35	14.6%
8a	5	2.1%
8b	1	0.4%
Not recorded	10	4.2%

Table 4 - Distribution of participants across staff grades (Midwife Activities).

Supplementary survey			
Health board	n	% Distribution	% HB Participation
A	36	12.5%	10.4%
B	44	15.2%	19.3%
C	48	16.6%	12.3%
D	62	21.5%	27.4%
E	20	6.9%	40.0%
F	43	14.9%	14.1%
G	36	12.5%	11.6%

Table 5 - Distribution of supplementary survey participants across Wales and Health Board participation rates.

Results

Descriptive Findings

Midwife activities and Supplementary Survey

Understanding the CSfM model

The Likert activity demonstrated that midwives had a strong and consistent understanding of the purpose and boundaries of the Clinical Supervision for Midwives model with high levels of agreement that supervision is clearly differentiated from line management and appraisal (Table 6). Almost 90% of respondents agreed or strongly agreed that accessing CSfM helped them understand this distinction, with similar proportions reporting clarity about what participation in supervision involved. Most midwives (85.7%) also agreed that the purpose of CSfM was shared and recognised within their teams, with only a small minority reporting uncertainty.

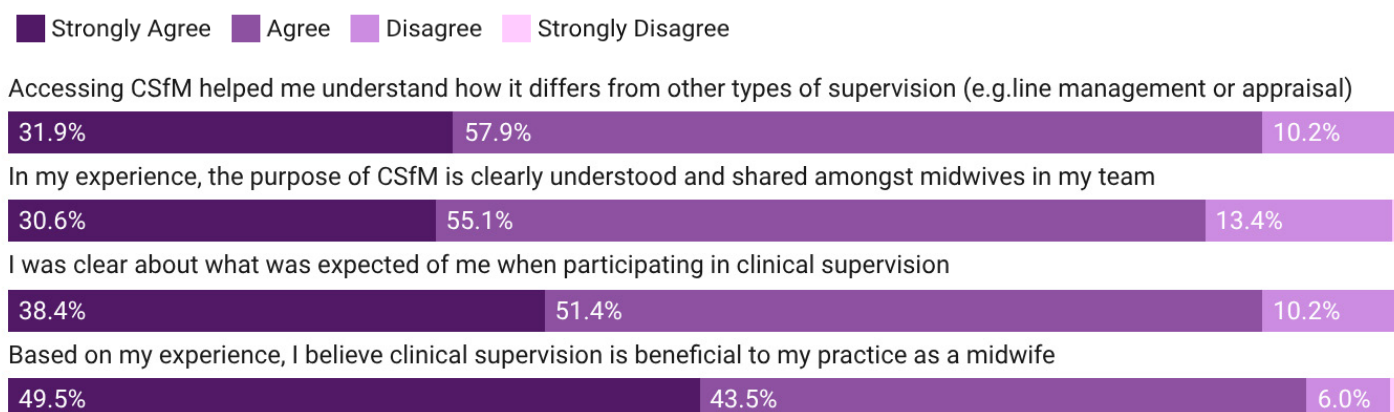


Table 6 - Midwives understanding the Purpose and Function of the CSfM service (Evaluation Activity Likert Scale).

Do you understand the CSfM Role?							
▲	% Yes	n Yes	% Maybe	n Maybe	% No	n No	n Total
Band 5	100%	25	0%	0	0%	0	25
Band 6 < 5 years	84%	46	13%	7	4%	2	55
Band 6 > 5 years	88%	105	10%	12	2%	2	119
Band 7	94%	49	4%	2	2%	1	52
Band 8 >	100%	18	0%	0	0%	0	18
Other	100%	1	0%	0	0%	0	1
Specialist MW	100%	19	0%	0	0%	0	19
Total	91%	263	7%	21	2%	5	289

Table 7 - Midwives understanding of the CSfM Role (Supplementary Survey).

This pattern was reinforced within the supplementary survey (Table 7). Across all bands, 91% (n=263) of midwives reported understanding the CSfM role, with only small proportions selecting ‘maybe’ (7.3%) or ‘no’ (1.7%).

The free text responses in the supplementary survey provided insight to how midwives made sense of the model in practice. Many described CSfMs as supporting quality and safety in clinical practice:

“Supports staff to help improve patient safety and staff wellbeing. Providing high standards of care where clinical excellence can flourish.”

Provides “clinical, professional and personal support to midwives. ensuring standards of work and clinical practice are met, to enable staff to reflect on their practice.”

Midwives also clearly understood CSfM as a pastoral and relational model with supervisors offering “...a safe and confidential environment for midwives to reflect on and discuss their work and reflect on episodes of care within their work. They support midwives in their personal and professional development, with a focus on wellbeing.”

Additional comments emphasised support following difficult experiences, noting that CSfMs:

“Support staff involved in incidents, writing statements, returning to work from maternity/sick/long term leave, if there are areas you are not confident/competent in to work with you and help create a plan, disseminating updates during the sessions, and great listeners of anything you need.”

Educational and developmental elements were evident. Respondents frequently noted that CSfMs “Provides up to date, research-based support and guidance for all midwives” and “encourage personal learning and development amongst the team.”

Supervision relating to the NMC Code of Conduct

Survey data demonstrated agreement on the link between supervision and professional standards (Table 8). Almost 90% of midwives agreed that clinical supervision learning relates back to the NMC Code, with many explaining that supervisors “always bring issues back to the NMC code to ensure good practice and safety”. Only a very small number suggested improvements, such as “could maybe be improved.”

Do you feel Clinical Supervision learning relates back to the NMC Code?



Table 8 - Alignment of Supervision to NMC Code of Conduct (Supplementary Survey)

Engagement and Commitment to the CSfM Model

This section outlines the levels of engagement demonstrated by midwives and explores how willing staff are to participate in supervisory activity. The findings illustrate patterns of commitment, uptake and readiness to seek supervision beyond mandated requirements.

Commitment and engagement levels from midwives for the CSfM service were consistently high (Table 9), with more than 90% of midwives selecting agree or strongly agree across leadership, clarity of access information, encouraged engagement and supervision representing a worthwhile use of their time.

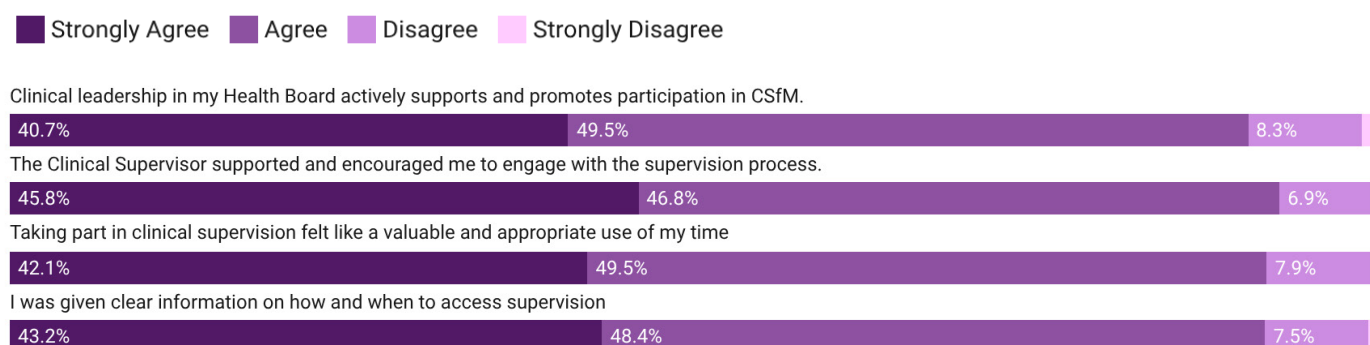


Table 9 - Midwifery Commitment to Supervision (Evaluation Likert Activity)

Working with the CSfM Model

This section reports how supervision operates within day-to-day practice and how effectively it is delivered within the realities of the maternity service. The graphs illustrate the practical work of engagement, visibility and access that underpin the functioning of the model.

Table 10 demonstrates confidence in the operationalisation of clinical supervision in practice. Over 90% of midwives agreed or strongly agreed that Clinical Supervisors demonstrated appropriate knowledge, approach, skills and training. Almost 88% reported that supervision was accessible and compatible with clinical responsibilities and 85% agreed or strongly agreed that organisational time and support enabled the service.

Working with Supervision - Likert Scale

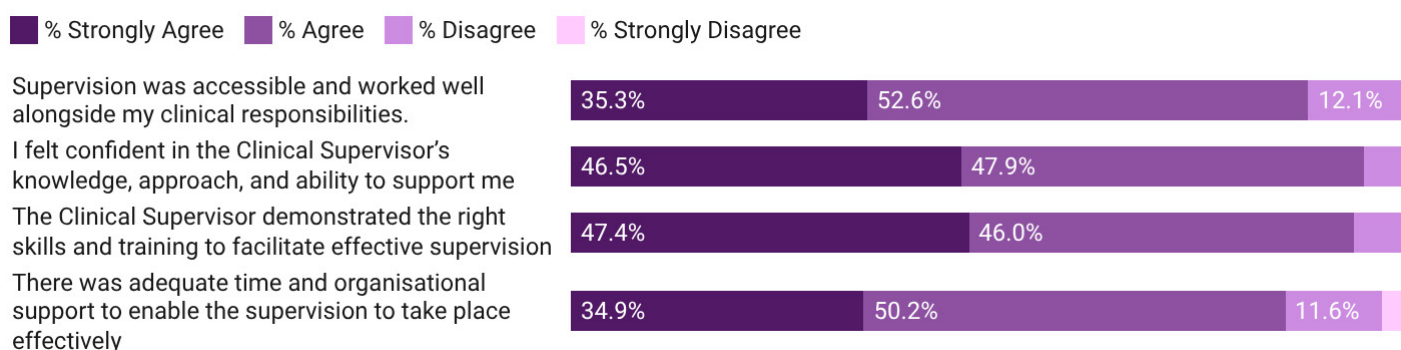


Table 10 - Working with Supervision - Likert Scale

A road map activity asked midwives (n=269) to pinpoint when in their career paths, supervision was either 'accessed', 'not required' or 'needed but not accessed'. Table 11 displays the finding from this activity. As expected, access was highest for group supervision, preceptorship and additional two hours supervision. Additionally, NMC revalidation, clinical guidance and support following traumatic events also commonly reported points of contact.

Supervision Access

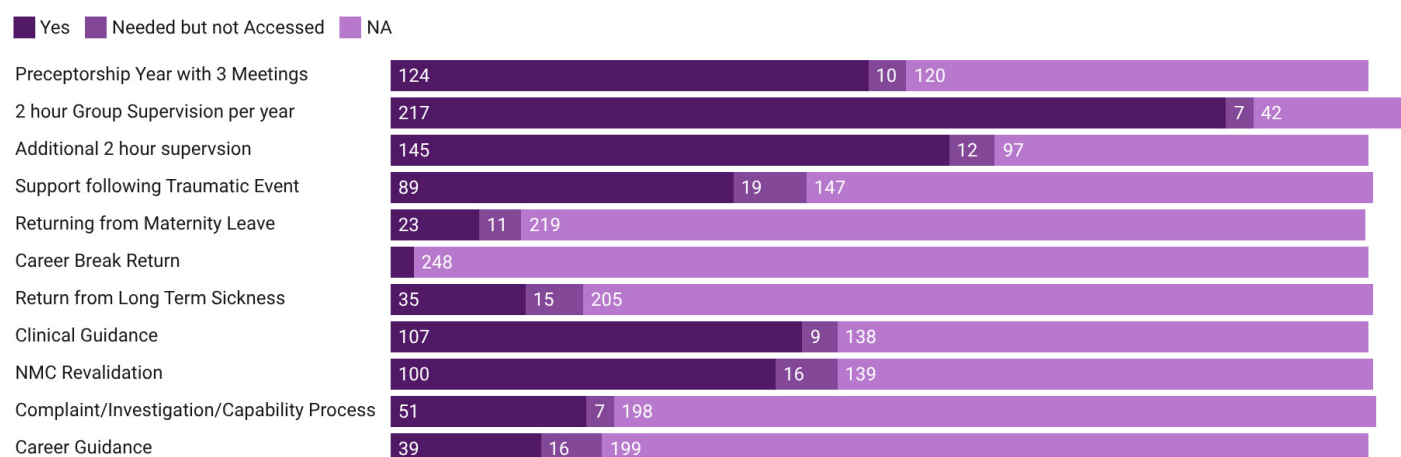


Table 11 - Engagement with supervision during key career points (Evaluation Roadmap Activity)

To explore unmet need more clearly, responses indicating that supervision was not required were removed (Table 12). Across all categories, reported access to supervision was high. The highest proportions of unmet need were recorded for returning from maternity leave (32.4%, n=11), return from long term sickness (30.0%, n=15) and career guidance (29.1% n=16). Given the small number of respondents in some categories, these proportions highlight areas of potential unmet need but should not be over-interpreted.

% Accessed v Needed but not Accessed

■ % Yes ■ % Needed but not accessed

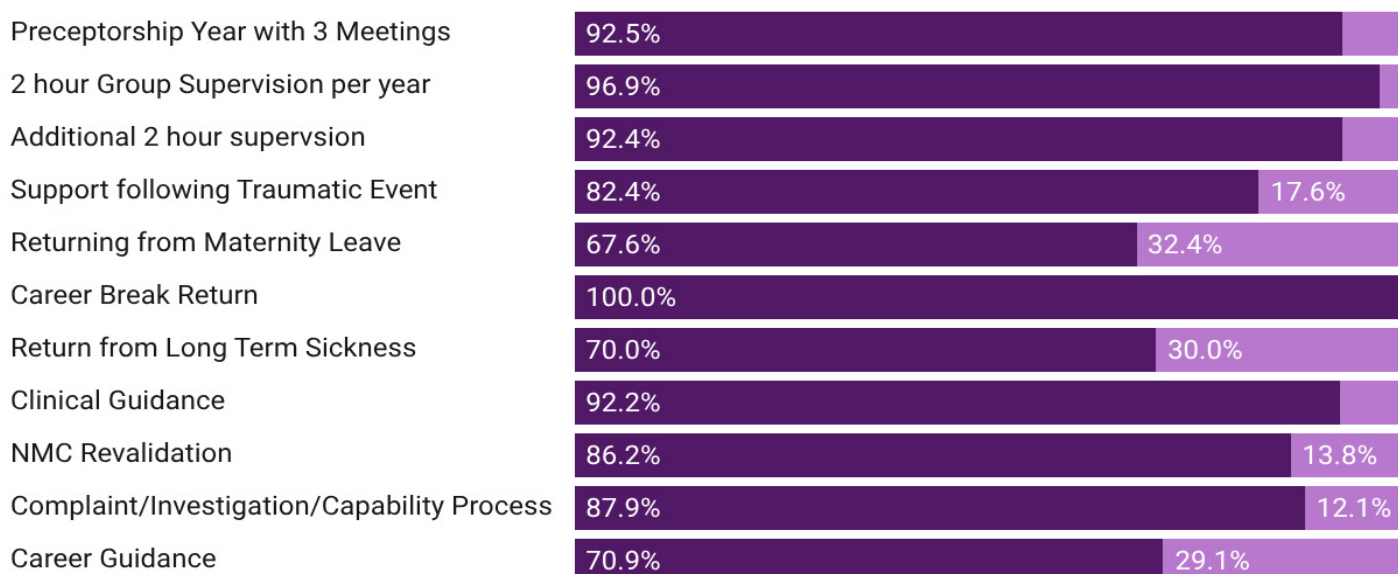


Table 12 – Supervision accessed v needed but not accessed (Roadmap Activity)

Among midwife participants 87.7% felt that group supervision supported reflective practice with 69.6% accessing supervision outside of mandatory group supervision sessions (Table 13).

Reflection following supervision and Access outside of Mandated Supervision

■ No ■ Yes ■ Maybe

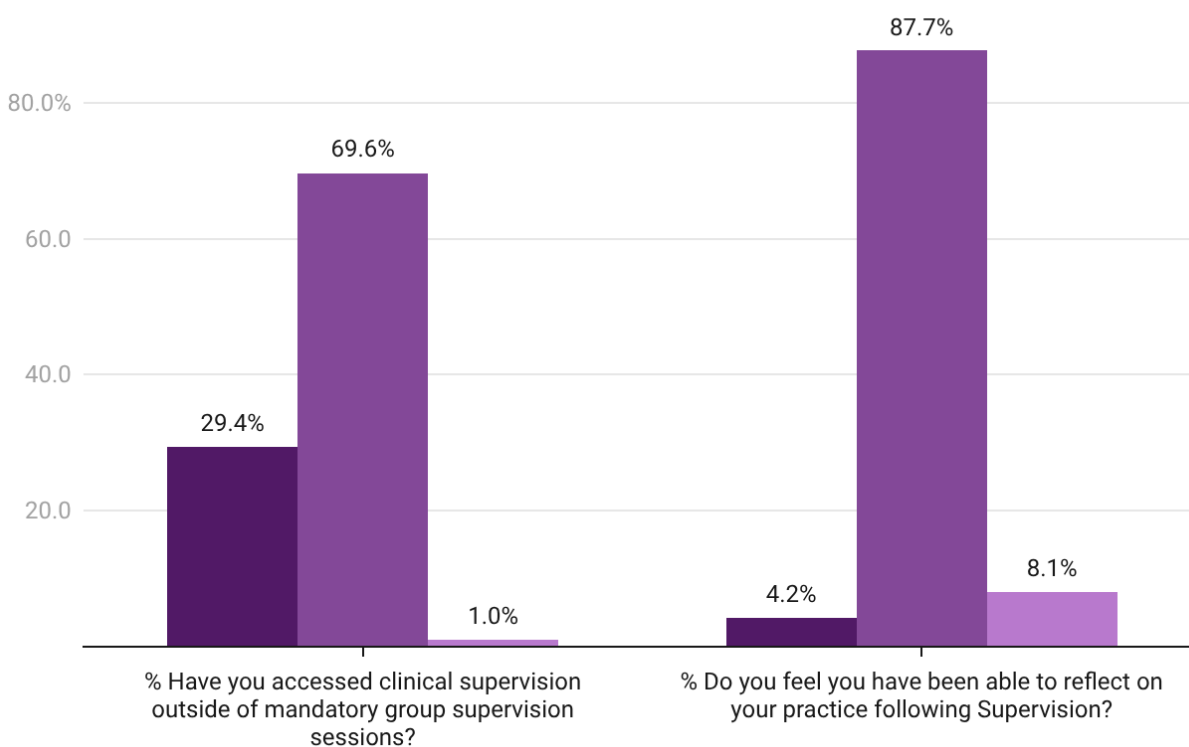


Table 13 – Reflective Practice during supervision and access outside mandated supervision

Valuing and Appraising the CSfM Service

This section reports how midwives appraised the impact of supervision on wellbeing, confidence and professional practice.

Survey findings showed consistently positive appraisal of the CSfM model (Table 14). The strongest endorsement related to everyday supervisory experience, with 89.7% of respondents agreeing or strongly agreeing that midwives in their area speak positively about supervision. Slightly lower proportions reported feeling encouraged to provide feedback (85.5 %) or having clear routes for feedback within their Health Board (80.9%). While overall appraisal remained high, these differences suggest that mechanisms for structured feedback are less consistently embedded than the day-to-day supervisory experience.

Appraising the CSfM Service

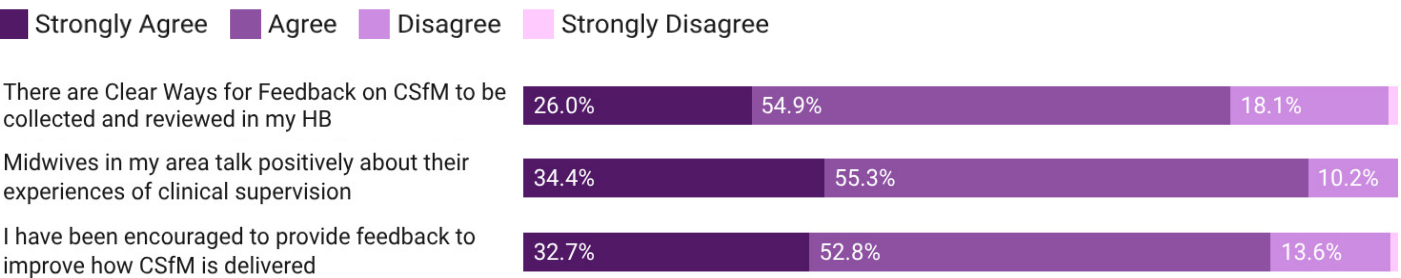


Table 14 – Midwifery appraisal of the CSfM Model (Evaluation Likert Activity)

Within the supplementary survey data, 90% of respondents reported valuing their CSfM service (Table 15). The associated free text comments reinforced this finding, with midwives frequently describing supervision as essential to safe practice, learning and professional support. This included the relational and emotional value of the role, describing CSfMs as providing support distinct from managerial care and offering a safe, confidential space for reflection.

“The pastoral care that your manager cannot provide”

“a safe space to offload in confidence”

“The constant support you need”

Their accessibility was frequently praised, with midwives noting that supervisors are “very present and around if you need them,” “always available to support” and “very accessible and responsive to requests for help.” The service was also valued for its impact on confidence, clinical skills and professional development, with midwives reporting “invaluable teaching, revision and clinical support for all grades,” “regular interesting opportunities for study” and “excellent innovative and engaging support.”

Several midwives described the role as central during times of personal or professional difficulty, explaining that supervisors “dramatically eased my transition back to work after maternity leave” and were “a huge part of the midwifery team” during emotionally demanding circumstances.

Only a small number identified concerns, including variation in visibility or instances where the service felt punitive, although these views were infrequent. Overall, comments across the full dataset portray clinical supervisors as an indispensable source of emotional support, reflective space and expert guidance, with many midwives stating that they “could not do my role without them” and that the support offered is “invaluable for staff.”

Do you value your CSfM Service?

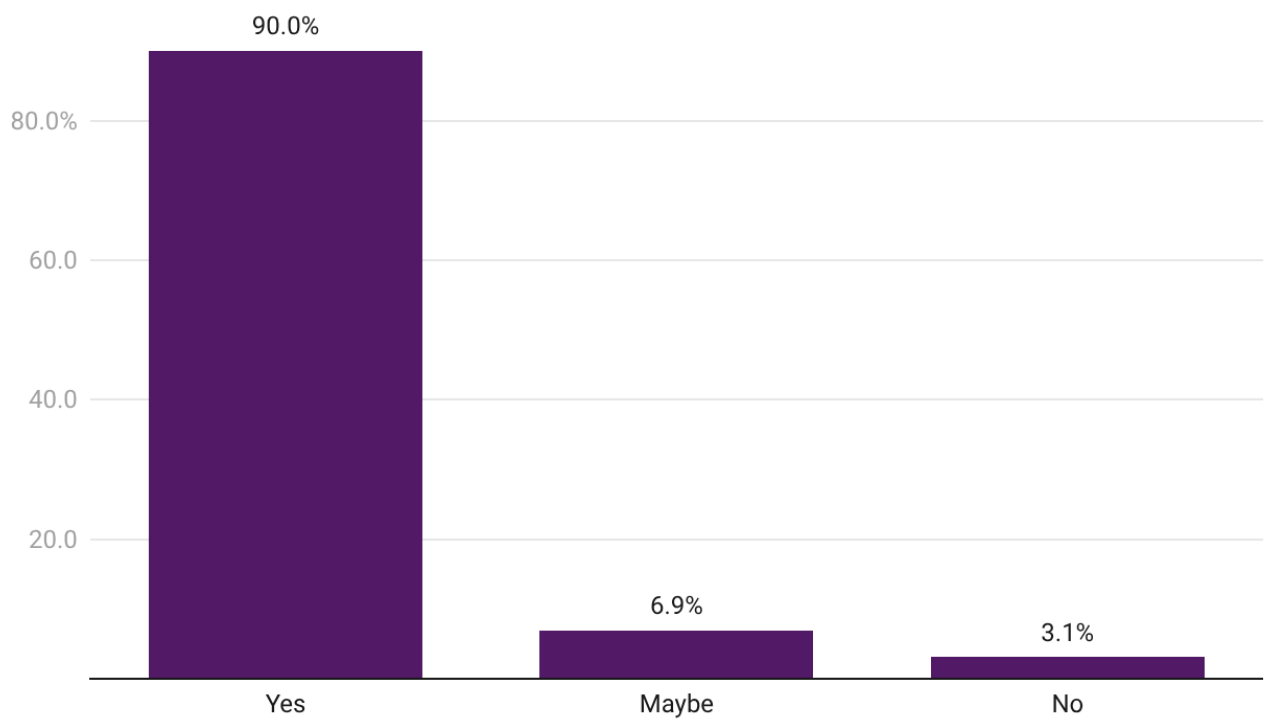


Table 15 – Midwives Valuing the CSfM Service (Supplementary Survey)

The supplementary survey indicated that 58.7% of respondents reported receiving supervisory support that contributed to their decision in retaining in their role (Table 16). Free text comments reflected this finding, with midwives describing how access to supervision supported them during periods of professional and personal challenge.

Comments included that support “definitely helped me not to step away from midwifery” and that “just knowing I have a kind person to talk to about issues has kept me from leaving my role.”

Newly qualified midwives described supervision as particularly critical in early practice, with one noting that without their supervisor “I do not feel I would still be working for the <Health Board>.”

Others reported that structured support during difficult periods, such as when “hitting a professional and personal wall,” helped them remain in post, while another described overcoming thoughts of leaving the profession because of supervisory support. Practical reassurance during transitions, including return from maternity leave, long term absence and return to practice, was described as stabilising and confidence building, reducing the risk of attrition. Additional comments emphasised the broader contribution of supervision to retention, including recognition that midwifery is a challenging profession where “without good supervision many more of us would leave the profession far too soon.” Although a small number expressed neutral views or felt their own motivation was the main factor in staying, the overall narrative shows that supervisory support was a significant protective role in retaining midwives during both routine and high stress periods of their careers.

When you have received CSfM support - do you think this has supported you to retain your current role?

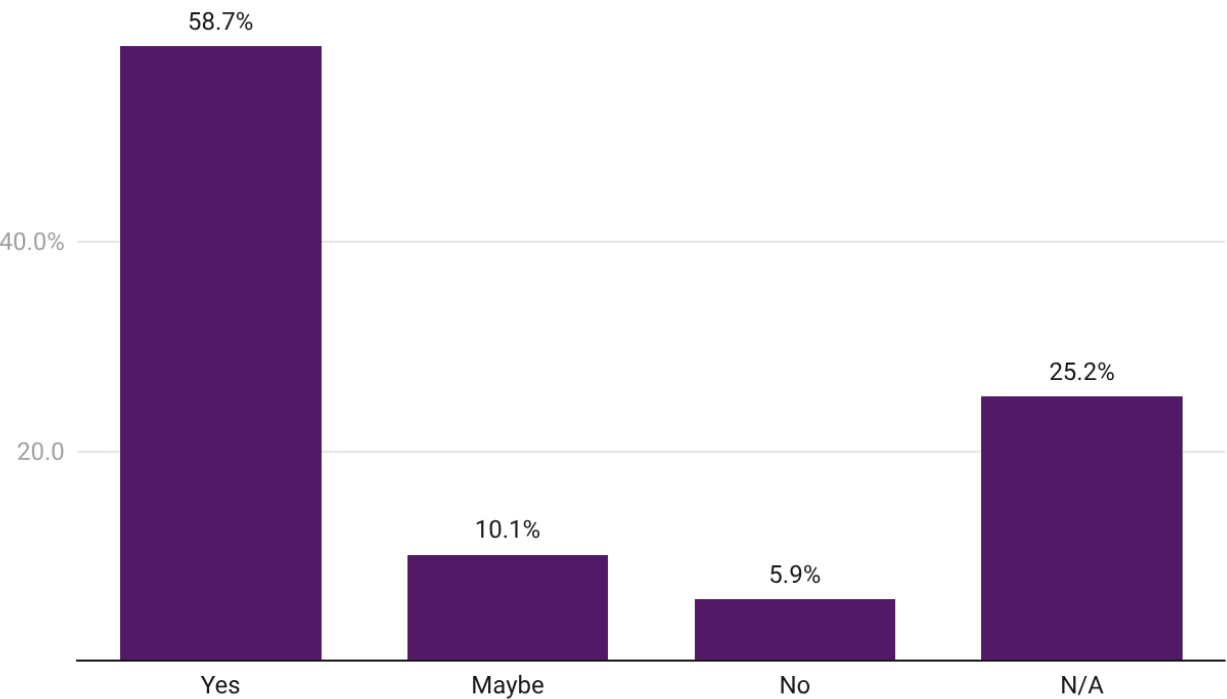


Table 16 – CSfM Support affecting Retention (Supplementary Survey)

Among respondents 83% reported that CSfM support improved their wellbeing (Table 17). Comments show how closely this is linked to feeling heard, valued and less alone at work. Midwives frequently described the service as an additional layer of support in a highly emotive profession that “helps mental health,” offers “opportunity to debrief and have support independent from management” and “allows a space for reflection” which improves personal wellbeing. Many emphasised the impact on stress and anxiety, explaining that “sharing concerns alleviates anxiety and stress” and that knowing there is “someone you can talk to who will provide such positive and helpful support really reduces my stress levels around work.”

Respondents highlighted structured activities such as wellbeing walks, team engagement and dedicated sessions which “improve morale on the unit,” provide “multiple opportunities to support my wellbeing individually and in group settings” and that “staff wellbeing has massively improved... by getting management to place higher priority on staff wellbeing.” For some, this support was described as pivotal at times of personal or professional difficulty, with midwives reporting that they had “found my love for midwifery again” after their mental health was at risk, that time with supervisors “benefited me and gave me strength to continue my role” and that without regular check ins during stress and burnout they might not have returned to work.

The importance of a safe, confidential and non-judgemental space recurred throughout the data, with one midwife describing supervision as “a debrief that puts your head straight and promotes mental health wellbeing” and another stating that being able to “vent without judgement can help to find solutions to problems rationally.”

A very small number of respondents felt that wellbeing input was limited or inconsistent, noting that supervisors were not always visible or that “they do not do anything for our wellbeing” in the current format, and one midwife reported never feeling supported. Overall, most comments depict CSfM as a vital wellbeing resource that provides advocacy, reassurance and practical support, with midwives describing the service as “invaluable” and a “vital resource for midwives” in managing the emotional demands of practice.

Do you feel that CSfM supports improves wellbeing?

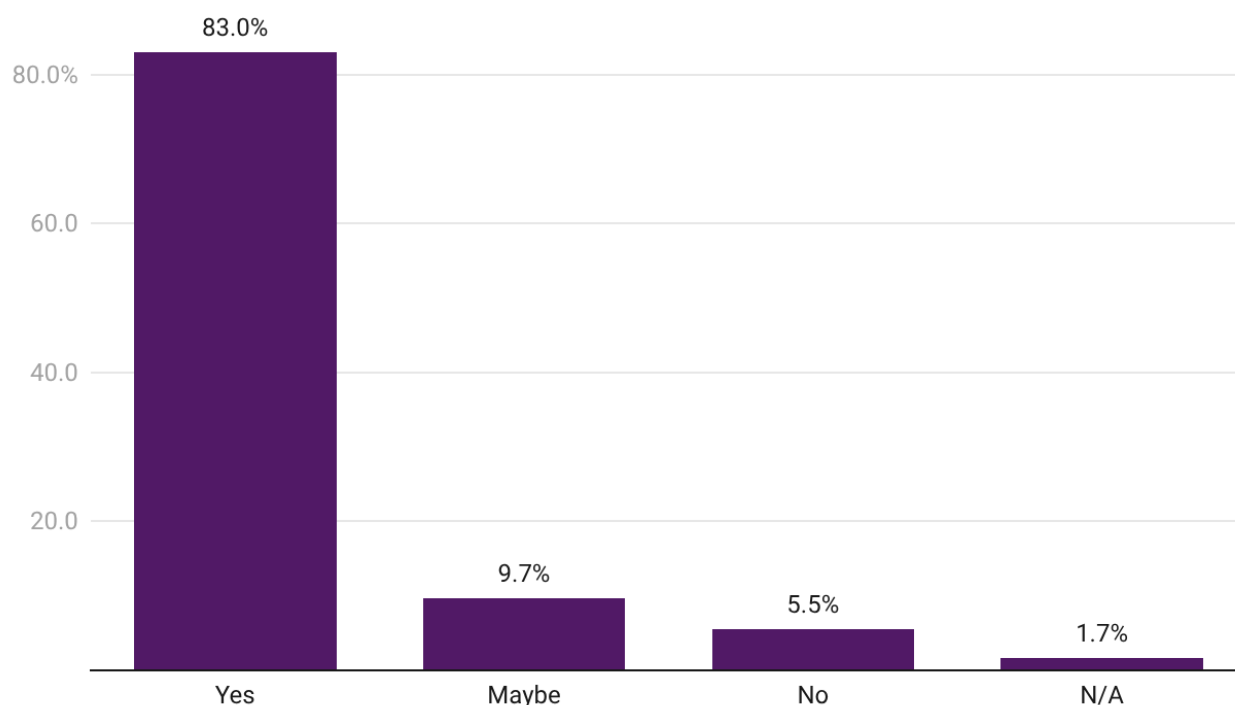


Table 17 – CSfM Support affecting Wellbeing (Supplementary Survey)

Of the supplementary survey respondents, 78.8% reported that CSfM support improved their professional practice (Table 18) with a strong emphasis on staying up to date, reflective learning and confidence building. Midwives consistently described supervision as a key source of current information, noting that supervisors “keep us up to date with new evolving changes” and provide “regular outstanding current updates and refreshers” that help maintain safe and effective practice. Many valued the structured learning opportunities on offer, including training sessions, hot topic updates and lunch and learn events, which “really improved many aspects of my practice” and ensured that “without them, I would really struggle to keep up to date with all changes in practice.”

Reflective discussions were repeatedly highlighted as central to professional development, with respondents explaining that supervision “helps you to reflect and improve,” “reinforced my practice” and provided supportive space to examine complex or difficult cases. Several comments described the role of supervisors in building confidence and practical skills, including support with suturing, navigating documentation errors and progressing from band 5 to band 6.

Supervisors were also seen as valuable sign posters to development opportunities and as knowledgeable colleagues who “point you in all the right directions.” While a small number felt input could be limited or variable, the overall narrative demonstrates that CSfM support plays a significant role in helping midwives remain competent, confident and contemporaneous in an environment of continual change.

Do you feel that CSfM service support you have received has helped improve your professional practice?

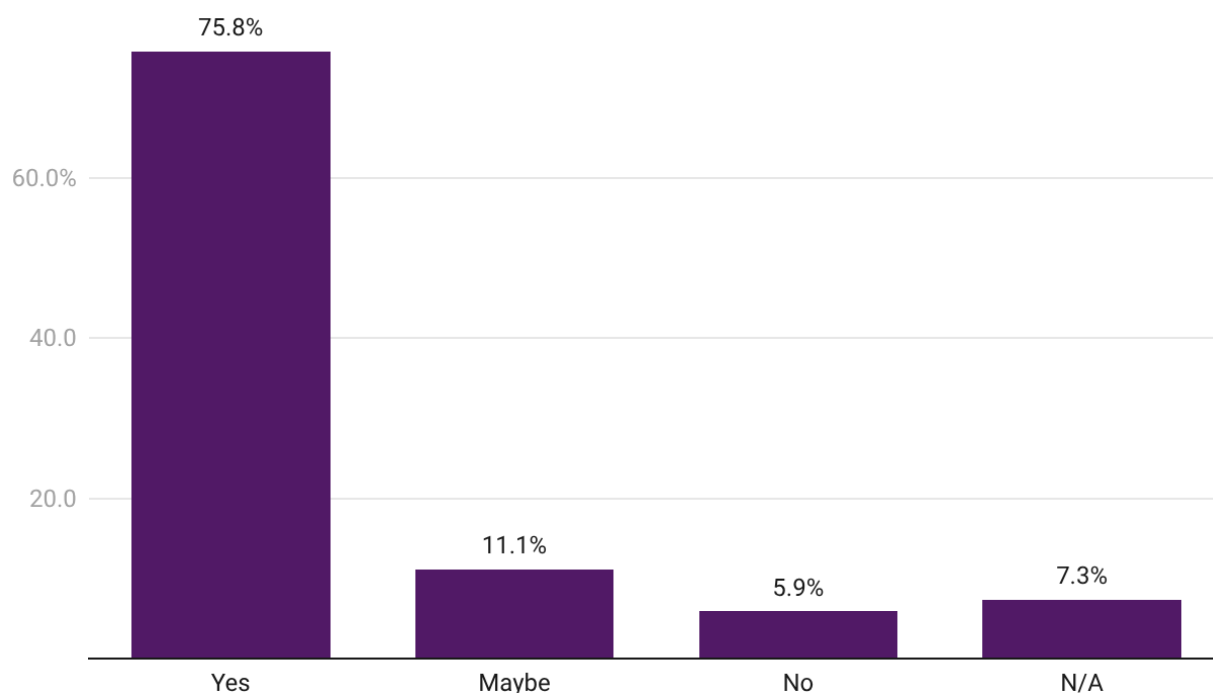


Table 18 – CSfM Support affecting Professional Practice (Supplementary Survey)

The values activity indicated that midwives reported consistently high benefit across a wide range of supervisory functions (Table 19). The strongest areas were peer support and shared experience (91.1%), challenge and reflection on practice (81.9%) and support for learning commitments (73.3%). Midwives also reported substantial value in solving problems within a safe and confidential space (68.5%), managing work demands (67.5%) and taking action following reflective discussions (68.2%). Lower levels of reported benefit were evident for problem solving skills, feedback separate from management and developmental goal setting, although these remained positive overall.

Received Values

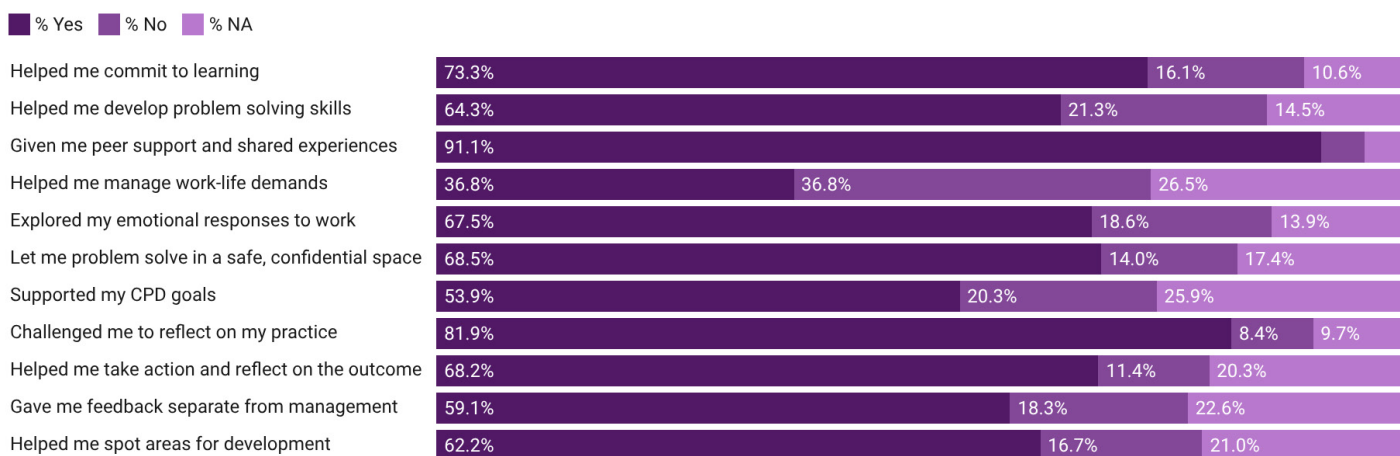


Table 19 – Values received from supervision (Evaluation Picture Card activity)

Wildcard Value

A free text wildcard question invited midwives to describe any additional value they perceived the CSfM service to provide or should provide that was not captured elsewhere in the activity values.

Midwives frequently referred to CSfM input during periods of vulnerability and transition, including following traumatic clinical events, bereavement, return from maternity leave or prolonged absence and early career adjustment. Support was described in terms of emotional containment, reassurance and presence rather than structured supervisory processes.

Responses also highlighted relational availability and advocacy. Midwives described valuing supervisors who were accessible and approachable outside scheduled supervision, and referenced the importance of having an impartial, non-managerial point of contact to raise concerns and discuss organisational issues. This was described as operating alongside reflective supervision.

Additional contributions not specified within the guidance included informal clinical advice and contextual and organisational guidance. These elements were described in relation to connection and professional isolation, particularly during periods of change or re-entry to the workforce.

Where reduced visibility, limited capacity or reliance on remote contact were described, midwives reported supervision as less accessible and more procedural.

Clinical Supervisor for Midwives

Clinical Supervisors for Midwives across Wales completed a structured digital whiteboard exercise documenting supervisory activities, skills and factors affecting delivery of the role (Appendix 2).

Activities undertaken

Comparison of mapped activity with Welsh Government guidance shows close alignment with the intended model. Supervisors described activities including reflective practice, emotional and professional support, group and individual supervision, preceptorship support, governance linkage, learning from incidents, supporting staff undergoing investigations and maintenance of clinical credibility through a defined clinical component.

Certain activities demonstrated a more peripheral relationship to the specified framework. These included contribution to organisational communication, leadership activity and quality improvement work. A smaller number of activities fell outside the defined scope, including operational roles, routine training delivery and digital implementation training.

Skills required for the role

The mapped skills illustrate the breadth and complexity of the supervisory role, extending well beyond what is covered within any single training route. Although certain domains reflect established postgraduate curricula, many of the capabilities described by supervisors relate to advanced interpersonal, operational and system level functions that are not routinely taught or assessed.

These include relational communication, psychological containment, attuned interpersonal work, digital and analytical competence, service coordination, governance literacy and confident navigation of organisational systems. The distribution of skills across relational, operational and clinical domains demonstrates that the supervisory role draws on a wide and diverse capability set that extends beyond formally defined clinical competencies. These skills span areas not consistently represented within existing educational or training structures.

Facilitators and barriers to delivery

Supervisors identified enablers including protected time, confidential space, suitable infrastructure and access to continuing professional development. Clear leadership communication, role clarity and visible organisational support were also described as important to delivery.

Barriers included limited protected time, clinical pull, workforce pressures and ambiguity around role boundaries. Supervisors also reported cultural and communication challenges, alongside practical constraints such as inadequate workspace, limited private rooms and geographical dispersion.

Support needs

Supervisors identified the need for clearer role definition, structured induction and ongoing development, consistent governance arrangements and improved organisational support. Practical requirements included protected time, confidential space, administrative resources and sufficient workforce capacity. Access to senior support and psychological and wellbeing resources was also described.

Senior Midwife Interviews - Results

To examine how the Clinical Supervision for Midwives model is interpreted and enacted at a strategic level, interviews were undertaken with senior midwifery leaders across all Health Boards in Wales. These interviews provided insight into how the model is understood, supported and operationalised within different organisational contexts. The analysis explored five core areas: the role and identity of CSfMs and the organisational commitment underpinning the model, the extent of fidelity alongside patterns of adaptation and variance, approaches to impact, monitoring

and evaluation, the operational pressures that shape delivery, and the training, preparation and continuing professional development required for supervisors to meet the demands of the role.

CSfM Role, Identity and Organisational Commitment

Senior leaders consistently positioned Clinical Supervisors for Midwives as a core supportive function that enables midwives to provide safe, high-quality care rather than as a regulatory or managerial arm. The role was repeatedly described as “for midwives” rather than “of them,” with a core purpose “to support midwives in work to provide the best possible care... to the best of their ability.” Supervisors were seen as the “supportive network” around clinical midwives and a crucial resource for the senior team itself.

A strong, shared identity as a supportive, impartial and clinically credible resource runs through the accounts. Leaders emphasised that supervisors are separate from line management, which creates psychological safety and “fresh eyes” that staff can trust. Many contrasted the current model with earlier punitive supervision arrangements and welcomed the shift toward reflective, coaching orientated support that is “with staff rather than of them.” Clinical credibility was viewed as non-negotiable. Supervisors who remain visible in practice and are confident in contemporary clinical care were seen as better able to support midwives and command respect, whereas limited confidence in practice was thought to inhibit meaningful supervision.

Organisationally, supervisors were described as “a key focal point” that links governance, learning, experience and safety from “floor to board” and as something “we could not do without.” They sit on high level committees, contribute to risk and incident discussions and, in some health boards, are integral to MDT review and staff support after complex cases. Line management models vary. Some Heads of Midwifery hold direct line management of supervisors to maintain a reciprocal flow of intelligence from the shop floor, while others locate supervisors within experience teams to preserve independence and “fresh eyes.” Monthly 1:1’s between Heads of Midwifery and CSfM’s, structured meetings and clear reporting routes were described as important mechanisms to maintain alignment and provide supervisors with their own support.

Despite financial pressures and the non-statutory status of the model, leaders portrayed a high level of organisational commitment, “really heavily invested in that role,” with “100%... commitment to keeping them,” despite “the financial challenges that we’ve got”. Many spoke about actively protecting posts, securing additional funding and regarding removal of supervision as “unthinkable” or likely to be “frowned upon.” Interest in the posts was described as strong, with diverse applicants viewing the role as a “unique experience” and a “launchpad” for broader careers. One lead acknowledged that supervisors could experience the role as “no man’s land” – “you’re not management and you don’t want to be seen as management... you’re not clinical anymore either... it can be quite isolating.”

Some leaders described ongoing ambiguity about the boundaries of the role. In some services supervisors were pulled into tasks that align more with trade union, rostering or general problem-solving functions, which risks diluting the core purpose and confusing staff about where to take concerns. There were risks identified that if not well governed the role could “undermine the leadership and management structure,” particularly where line management is unclear or accountability is weak. Leaders stressed the need for clear expectations, job plans and performance management to keep the role within its intended scope. Several leaders noted ongoing work to tackle residual perceptions of supervision, “there are still the old narrative ways that supervision is punitive” and to address misunderstandings “... the slight nuance of saying of and for, I can’t decide whether I think that was a big enough change, because I mean, say it quickly, it might just slip up.”

Although these challenges were minimal, leaders were clear that they do not diminish the value, intent or their commitment of the model. Several described how clarity, communication and consistent senior oversight help keep the role anchored to its purpose, with supervisors viewed as “a very supportive model,” “clinically credible” and “really core to the delivery of our safe and effective service.” Across Health Boards, the prevailing message was that overall, the role as highly valued, well regarded and central to professional support. As one leader summarised, “we could not do without them,” capturing a strong organisational commitment to a model that is seen as integral to midwifery practice and to the wider culture of learning and improvement.

Fidelity, variation and adaptation

Fidelity to the CSfM Model

Senior leaders considered that Clinical Supervisors for Midwives are delivering the model as set out in the national framework. One lead summarised this position as “we ensure we are still delivering what the directive is within that clinical framework” and described the way supervisors work as “very much aligned to that model of care.”

Participants described good adherence to the structural requirements of the model, including supervision hours and ratios. Leaders referred to the “minimum of four hours” which is “achieved almost 100%”. Ratios were also seen as compliant, with one service reporting that “if it is one to 125, then... we would fit that”. Some leaders acknowledged work underway to meet ratios.

Accounts showed that the core activities of the model are being delivered. Supervisors were described as providing group supervision that brings “a vast variety of things to discuss,” supporting “civility, human factors, even EDI” and offering “education, training, support.” They contribute to mandatory training and protected learning time so that services can “achieve some of those compliances around the standards trying to meet the supervision” and are “very much involved in the preceptor education” and national programmes. Leaders emphasised that supervisors maintain the reflective core of the

model through a “safe space where staff can come together and learn and grow but can be reflective in that space” where staff can be “really open and honest.” Several mentioned routine group supervisions, lunch and learn sessions and themed activities, including “tea and talk themes” drawn from risk learning. Structured feedback loops featured prominently, with supervisors presenting themes to committees and linking concerns into action planning.

Fidelity to the restorative, supportive intent of the model was strongly evident. Leaders described supervision as having moved “from that space of being a place where there is corrective learning to be a place of education and improvement,” aligned with “just culture” that “talks about the system and not the people.” Supervisors were seen as “so invested” and “so clinically accessible” that midwives “know that there is someone to go to, where they are.” Support following adverse events was described as “much smoother without having to formally put people on action plans.” The model was repeatedly characterised as “very less punitive,” and one leader noted they had “not ever heard that there is anything in the way of punitive.” Supervisors were seen as a “safety net... a forum, a safe space” and in some areas as “the big cwtch” for staff.

Where rotational cycles were retained, this was framed as fidelity to the original framework. One leader stated, “we have kept to the three years because you have got to be up to date and fresh eyes.”

The model’s specification around key transition points was visible across accounts. Supervisors were described as working “really well with the newly qualified” and being central to the “preceptorship programme” which is “evaluated sort of almost continuously.” They help identify newly qualified midwives “who may need additional support, so we do not wait until they get on an action plan” and were “really positive in identifying” the need for support for staff returning from maternity leave. One senior leader reported that newly qualified midwives often say, “I could not have done it without the supervisors and having the supervisor there made me feel safe to go to work.”

Examples of fidelity extended to workforce visibility and professional advocacy. Leaders described supervisors who “are visible in all our areas,” who “bridge the gap between the front line and the managers” and who are “viewed as that professional advocate.” Supervisors were also seen as important contributors to system learning, with one noting “they get a lot of insight very quickly into that space” and another highlighting their ability to “drive change.”

Many leaders believed that delivery of the model was achievable. Several explicitly stated that there were “no issues,” that supervision had been “embraced” and that it is now “really well embedded.” Many viewed supervision as integral to safe, compassionate maternity care, summed up by the observation that the role enables supervisors “to support women to have the best, safe care and experience.”

Adaptation, variation and drift

Alongside strong claims of core fidelity, senior leaders described a model that has clearly adapted over time. Several explicitly framed this as evolution. One noted that clinical supervision “has grown so much from what it was initially designed to be.” Others used similar language, describing how the model has “morphed” and “become so much more.” For one Health Board, this was experienced as a positive transition where supervision has “with time transitioned into more what the team think it needs to be or what suits the needs of the midwives... rather than working to an exact prescribed framework”, followed immediately by the reassurance that “that is not a negative thing”.

Changes to workforce configuration was evident with one senior leader described their Health Board as “an outlier because we have midwives in permanent posts” and another explained that permanent contracts “have worked really well” with midwives developing “really established relationships” over many years. Suggestions that hybrid approaches could be considered, “two permanent and one rotational post might have been a good way to go.” Variation was evident across Health Boards as activities were interpreted locally as part of the guidance. Leaders described some of this activity as a natural development of the role within local systems, contributing to organisational development and culture work, including involvement in PADRs, revalidation and mediation, as well as leading civility and behavioural work within PROMPT and fetal surveillance teaching. In several Health Boards supervisors were embedded within governance structures, attending quality and safety meetings, supporting audits and influencing service-level action planning.

Some welcomed this expansion, noting that the framework “has grown beyond whatever it was intended to be” and that the role “has grown as a result” of emerging needs. Others were more cautious, suggesting that parts of local delivery “possibly extend beyond the guidance in some parts.” One senior midwife questioned whether “we have lost our way a little bit to the original assumptions or my expectation.”

There was marked variation in how the clinical component of the CSfM role was interpreted and enacted. In some services, supervisors described undertaking birth reflections, supporting NIPE activity, providing ad hoc clinical support such as covering lunch breaks, responding to periods of high clinical acuity, or working alongside midwives in practice-adjacent roles rather than delivering direct care, for example: “You might not be directly delivering that care, but actually it’s about you supporting the midwife to improve that care in that environment”.

Some services have deliberately expanded beyond midwifery, “We have MDT lunch and learn sessions as well”, “They were supporting families and user experience, not just staff support”, “Our clinical supervisor runs a think tank where midwife, healthcare, domestic, doctor, whatever, can all get in a room and say I have had this really good idea” and “... They support more than midwives now. They do support more of the perinatal team because they’re involved.” This has generated initiatives such as the lithotomy challenge and a dedicated feeding room for staff.

Innovation and quality improvement have flourished in some areas and are a major source of intentional adaptation. Supervisors were described as “involved in a lot of the improvement work” and “clinically visible but also strategically influential.” Examples included the development of a maternity specific fluid balance chart with guideline and a project to redesign pressure area care tools.

Governance structures have also adapted. Several Health Boards reported that quality and safety meetings and supervision reporting routes are being “revamped,” with new slide decks, agendas and cycles of monthly, three monthly and six-monthly review. Supervisors now lead structured documentation audits that feed into wider assurance systems and contribute to a “much more just service where learning and improvement becomes the focus around the system and not individuals.” At the same time, some leaders expressed uncertainty about national alignment, commenting that the framework “has not been revisited to check and challenge performance against the original documents” and that significant variation now exists between Health Boards including differences in whether posts are substantive, rotational and in how the clinical component is enacted.

Finally, leaders repeatedly linked adaptation to context. Several pointed to the impact of the COVID pandemic which “totally altered how we operate as systems and as professional groups and functions” and to local histories of special measures and organisational change that shape what is possible. Many were proud of local interpretation, with one stating “I feel really proud of the way that we have interpreted that document locally,” while also recognising that services now look different across Wales and “will never be the same” from one Health Board to another.

Operational Pressures and Structural Constraints

Operational pressures and structural constraints were described as a constant backdrop to delivering the CSfM model, shaping both what is realistically achievable and how the role is experienced. Leaders repeatedly linked shortfalls in delivery to wider resourcing and system pressures rather than a lack of will. Several referred to “huge pressures on staffing” and sickness, with one leader noting it would be “disingenuous” to claim full delivery “because we just haven’t got the people in the role.” In some areas, supervisors are “stretched... with very little manpower” across three sites an hour apart. One senior lead acknowledged that the clinical supervisor establishment in their health board was below what was prescribed in framework ratio but finding it “really tough internally” to secure additional WTE when supervision no longer sits in statute.

Time and capacity were persistent constraints. Leaders described the four-hour of supervision per midwife annually as “really difficult to achieve” across large workforces, with challenges to release staff in high clinical acuity for group supervision and supervisors themselves sometimes pulled into escalation work or clinical cover, as with “anyone with a specialist role.” Geography and infrastructure added further strain: several Health Boards are “geographically massive” with multi-site services, limited office space and pressure to minimise travel, leading to heavy reliance on virtual platforms that can dilute the “deep and meaningful connection” supervision is meant to offer.

The emotional load of the work was also foregrounded: supervisors “sit listening to lots of people who’ve got lots of concerns,” often in an “environment that’s tired.” Their pastoral focus can be “difficult to afford in a challenging operational scenario” where day-to-day demands “override the ability to really provide that deep and meaningful connection across the workforce.” Despite this, leaders stressed that pressures reflect circumstances rather than a lack of vision; many continued to protect supervisory time, offer flexible working (including home-working days to avoid constant clinical pull) and seek additional investment, even while acknowledging that “we’re definitely not doing enough” yet.

Training, Preparation and Continuous Professional Development (CPD) for CSfMs

Senior leaders described training, preparation and ongoing CPD for CSfMs as a mix of formal education, experiential learning and informal support, with clear progress but persistent gaps. Many sites have historically relied on supervisors “doing the level 7” clinical supervision / leadership modules and then “work[ing] alongside the ones who are already working...” to be prepared for the role.

There was strong agreement that the contemporary role requires a broader skill set than leadership alone. Leaders emphasised “softer skills” for trauma-informed, pastoral work – “being trauma informed is an absolute must... I’d love to see them go on counselling courses because they are the first line,” as well as confidence with investigations, Cardiotocography (CTG) interpretation and translating NMC standards into everyday practice conversations. Some also highlighted practical capabilities such as IT literacy to analyse data and reporting.

Despite financial constraints, many organisations reported actively “support[ing] our individual supervisors with their training... externally and internally,” using HEIW-funded or master’s-level modules, leadership academies and targeted courses (e.g. civility, human factors, Newborn and Infant Physical Examination, Professional Midwifery Advocate) to fill identified gaps. Supervisors are encouraged to identify their own development needs through appraisals and regular meetings, and some services explicitly position the role as a “launchpad” that builds a “toolbox” of skills for future career progression. Overall, leaders expressed a desire to “make sure that they’re supported and developed to be able to do that role” with “the right education and training and... time to facilitate them.”

Impact, Monitoring and Evaluation

Senior leaders overwhelmingly described the impact of the Clinical Supervision for Midwives (CSfM) model as highly positive through informal qualitative communication. Many framed it as “an invaluable service” that midwives “really value” and would be “bereft” without, with several asserting “there is nothing negative to say from it” and that the impact on staff is “massive.” Supervision was perceived to support wellbeing,

retention and workforce stability, with reports of falling attrition and vacancy rates and “very low” turnover in the early years post-qualification. Leaders felt it makes staff “believe that they’re valued because someone’s coming out to help them in a time of need” and contributes to “a much more cohesive workforce.” Externally, the model is recognised and “complimented on” beyond maternity, with supervisors receiving Greatix commendations, peer-nominated awards and positive mention in inspection reports.

Activity monitoring is consistent across Wales, but outcome monitoring remains underdeveloped. Most services track the proportion of midwives receiving four-hour of supervision, supervisor ratios and attendance through dashboards, databases, annual reports and monthly KPI reviews. Supervisors also undertake local audits and session evaluations, collate themed feedback, and issue regular surveys on staff experience and expectations. Yet leaders acknowledged that much of the impact is evidenced through “softer” signals such as informal feedback, emails of thanks, high voluntary uptake (some midwives accruing 40–50 hours of supervision) and staff attending sessions in their own time.

At the same time, several participants were candid that current approaches fall short of a mature, outcome-focused evaluation framework. Some questioned whether repeated audits are being meaningfully reviewed or translated into improvement work. Others described data capture as “almost a pointless data collection” when it focuses on counts without a “quality lens”, calling for a standardised all-Wales tool with clear objectives, benchmarking and stronger use of both quantitative and qualitative evidence to demonstrate how supervision is changing practice, culture and outcomes over time.

NPT Analysis

Coherence

Coherence refers to the extent to which midwives, Clinical Supervisors for Midwives and senior leaders share an understanding of the purpose and scope of the Clinical Supervision for Midwives model.

Across the dataset, participants described a consistent understanding of the model. Midwives distinguished supervision clearly from appraisal, management and regulatory processes, describing it as a confidential reflective space focused on professional development, emotional support and alignment with professional standards.

Survey responses and free text comments showed strong recognition of the role of Clinical Supervisors for Midwives as accessible and impartial sources of guidance, particularly at key career points such as preceptorship, return to practice and following adverse events.

The supplementary survey reinforced this shared understanding, with midwives frequently referencing safety, wellbeing, reflective practice and professional confidence. Many also described supervision as supporting professional accountability through reference to the Nursing and Midwifery Council Code, while remaining separate from managerial oversight.

Senior leaders articulated a similar conceptual framing. Interviews described supervision as a supportive and developmental mechanism intended to enable safe practice in high pressure environments, distinct from regulatory or performance management functions. Leaders consistently differentiated the current employer led model from previous statutory arrangements.

A small number of participants reported occasional misconceptions, most commonly among staff with limited exposure to the current model or residual assumptions linked to statutory supervision. These instances were uncommon within the dataset.

Cognitive Participation

Cognitive participation reflects how midwives, Clinical Supervisors for Midwives and senior midwifery leaders engage with, commit to and sustain the Clinical Supervision for Midwives model in practice.

Midwives described consistent engagement with supervision. Survey responses showed high agreement that supervisors actively encourage participation and that leadership endorsement supports engagement. Many midwives accessed supervision beyond mandated hours, particularly receiving value during preceptorship, return to practice, adverse events and periods of emotional strain. Free text comments described supervisors as accessible and trusted, supporting ongoing participation.

Clinical Supervisors for Midwives described a range of actions to support engagement, including maintaining visibility in clinical areas, proactive contact during periods of increased pressure and flexible approaches to group and individual supervision. Supervisors reported adapting working patterns to reach staff across multiple sites and sustain continuity of contact.

Senior midwifery leaders described organisational support for engagement with supervision. Interview data referred to visible leadership endorsement, regular contact with supervisors and integration of supervision within organisational structures. Some leaders described actions taken to maintain supervisory capacity during organisational change, including protecting supervisory time and maintaining dedicated roles.

Constraints to participation were also identified. Supervisors and leaders reported limitations related to supervisory capacity, geographical dispersion and variable access for staff working across sites. A small number of midwives reported unmet need at specific transition points, including return from maternity leave.

Collective Action

Collective action describes how the Clinical Supervision for Midwives model is enacted within everyday practice and the operational conditions that support or constrain delivery.

Across the dataset, supervision was described as visible and routinely enacted within maternity services. Midwives reported accessing supervision regularly across their professional career for reflective discussion, emotional support and professional guidance.

Clinical Supervisors for Midwives described undertaking a broad range of activities to deliver the model, including group and individual supervision, reflective facilitation, emotional support and contribution to governance and learning processes. Supervisors reported adapting working patterns to maintain accessibility across multiple sites and to respond flexibly to service pressures, including fluctuating demand and workforce turnover.

Senior leaders described providing organisational structures to support delivery, including protected supervisory time, access to appropriate space and integration of supervisors within safety, learning and governance arrangements. Supervisors were positioned within organisational forums and contributed to learning and improvement activity, although the extent of this integration varied across Health Boards.

Barriers to delivery were consistently reported. Supervisors and leaders described capacity constraints related to limited supervisory hours, clinical pull, staffing shortages and large geographical footprints. Practical challenges included inconsistent access to confidential space, difficulties releasing midwives from clinical areas and variable visibility across sites. The reported reduced access to supervision at key transition points, such as return from maternity leave, reflecting pressure on supervisory capacity rather than lack of engagement.

Variation in employment models and line management arrangements was also described, contributing to differences in how supervision was operationalised across Health Boards.

Reflexive Monitoring

Reflexive monitoring describes how the impact and value of the Clinical Supervision for Midwives model are appraised by midwives, supervisors and senior leaders, and how this appraisal informs ongoing adjustment.

Midwives described regular appraisal of supervision through their lived experience of accessing support. Across the evaluation activities and the supplementary survey, most midwives reported perceived benefits relating to wellbeing, confidence and reflective practice. Free text responses frequently referred to supervision as supporting continued practice during emotionally or clinically challenging periods.

Clinical Supervisors for Midwives described ongoing appraisal through informal feedback, observation and reflective discussion. Supervisors reported identifying emerging themes from supervision, responding following adverse events and tailoring support for specific groups, including newly qualified staff, returners and those experiencing emotional strain. Supervisors also described sharing learning themes within organisational forums where appropriate.

Senior leaders described formal and informal approaches to monitoring. All Health Boards reported use of Key Performance Indicators to track delivery, supported by recording of supervision hours and routine reporting. Leaders also referred to narrative feedback from staff, supervisory insights and workforce indicators to inform local understanding of impact. Approaches to monitoring and the level of detail available varied across Health Boards.

Leaders and supervisors identified limitations in current monitoring arrangements, including variation in data systems and incomplete oversight of outcomes with some describing interest in more consistent measures to support local and national review.

Discussion

This evaluation examines how the CSfM model is understood, enacted and appraised across all seven Health Boards in Wales. Using Normalisation Process Theory, the analysis explored alignment with national expectations, local adaptation and perceived value. Overall, the findings indicate a model that is conceptually clear, relationally driven and widely valued, but delivered within a context of significant variation and workforce pressure.

Cross Construct Synthesis

Taken together, the four NPT constructs show that the model has become embedded through shared understanding, sustained relational work and adaptive practice. Strong coherence was evident across midwives, supervisors and senior leaders, with consistent interpretation of supervision as a supportive, reflective and non-punitive mechanism. This shared meaning underpinned high levels of cognitive participation, with midwives actively engaging in supervision, supervisors investing considerable relational effort and

leaders legitimising the model through organisational endorsement and protection of supervisory time.

Collective action demonstrates that supervision is enacted routinely in practice, but that delivery is shaped by structural constraints including capacity, staffing pressures and geographical dispersion. While supervisors continue to deliver core functions despite these challenges, enactment relies heavily on individual commitment and relational labour, resulting in variation across Health Boards.

Reflexive monitoring shows strong experiential appraisal of supervision, with staff consistently describing benefit. However, formal monitoring remains focused on delivery rather than outcome. This limits the ability of organisations to evidence impact, creating a disconnect between lived experience and system level intelligence to inform planning or investment.

Across all constructs, a consistent pattern emerges. The model is well understood, widely engaged with and culturally valued. Its sustainability, however, is constrained by variable capacity, inconsistent structures and limited outcome measurement. Strengthening these elements would support greater consistency and resilience of the model across Wales.

Fidelity

Fidelity to the core principles and intended functions of the All-Wales Clinical Supervision for Midwives model was evident across Health Boards (Appendix 3). Senior leaders consistently articulated alignment with the model's purpose and ethos, emphasising the provision of a safe, confidential and professionally credible space for reflection and support.

Supervisors were described as delivering the reflective, developmental and supportive functions set out in national guidance, with a clear and consistently maintained boundary between clinical supervision and managerial or regulatory oversight. Psychological safety, impartiality and confidentiality were widely recognised by midwives as defining features of the model.

Delivery of the model's core mechanisms was broadly consistent across Wales. Group and individual reflective supervision were routinely provided, alongside support for reflective practice, maintenance of clinical credibility and professional independence. These functions were supported through protected supervisory time, structured reporting arrangements, KPI monitoring and links with governance, education and quality systems, although the consistency of these arrangements varied across Health Boards. Taken together, this pattern of delivery indicates fidelity at the level of the model's intended mechanisms of action, consistent with the guidance's expectation that clinical supervision contributes to organisational learning and service improvement. KPI monitoring arrangements were sustained across Health Boards, supported by dashboards and annual reporting processes.

While KPIs 1 to 5 continued to be routinely monitored, KPI 6 relating to external peer review was no longer undertaken in the form specified within national guidance. In its place, peer review activity was conducted internally within Health Boards by agreement with Directors and Heads of Midwifery, with outputs summarised through formal reporting mechanisms. This represents non-adherence to the specified national peer review requirement, alongside local adaptation of assurance processes that preserved internal review and reporting functions.

Variation was evident in employment arrangements. National guidance describes Clinical Supervisors for Midwives as full time rotational posts for a minimum of three years, with review thereafter and an option to return to clinical practice. Extension beyond the initial three-year period is therefore consistent with the guidance. However, in some Health Boards, substantive CSfM posts were established without a defined rotational endpoint. While these arrangements diverge from a structural feature of the national model, available data indicate that the core supervisory activities and mechanisms continued to be delivered. As rotational status is a structural feature of the model rather than a core mechanism of action, this pattern is best understood as structural variation in implementation rather than erosion of fidelity to the model's intended function.

Adaptability

Adaptability refers to the ways in which Health Boards modified delivery arrangements in response to local contexts while preserving the core intent and functions of the model. It emerged as a defining feature of the Welsh model. High fidelity to mechanisms can coexist with structural variation and while fidelity to the core supervisory mechanisms of the CSfM model was largely maintained, adaptations in delivery were evident in response to local workforce needs, service configurations and system pressures.

Supervisors and senior leaders described adapting delivery to address specific workforce circumstances. Supervision was modified through variation in timing, location and mode of delivery to maintain access across acute, community and hybrid service models. This included informal on the ground contact and corridor conversations to provide timely support, lunch and learn sessions and themed group supervision to enable reflective learning within clinical environments.

Responsive one to one supervision was also used to support staff returning from extended leave, newly qualified midwives and staff following adverse events. Supervisors described further adaptation through timely debriefs, wellbeing focused support and flexible use of group forums to share learning arising from incidents and governance processes. These adaptations were viewed as necessary to sustain access to supervision and ensure relevance across diverse service contexts.

Organisational arrangements were also adapted to support delivery, with supervisors integrated into governance, civility and culture programmes. Locally developed approaches, such as themed reflective sessions, documentation audits and multidisciplinary learning forums, were used to align supervision with local priorities. Variation was observed in how the clinical component of the role was enacted, with some supervisors contributing to activities such as newborn examinations or reflective birth discussions in response to locally identified service needs.

The capacity to adapt delivery in these ways was underpinned by a broad and complex skill set. Supervisors drew on advanced relational and communication capabilities, operational and system level expertise and maintenance of clinical credibility alongside governance and quality functions. Evidence relating to training, preparation and continuing professional development suggests that these capabilities extend beyond leadership alone, encompassing trauma informed interpersonal work, operational confidence and knowledge of governance and regulatory processes. Adaptability therefore depended on supervisors operating across multiple domains of practice rather than within a narrowly defined supervisory remit.

While these adaptations enhanced responsiveness and sustainability, they also contributed to variation in role scope, visibility and delivery across Wales. Senior leaders identified a need for refreshed national guidance to sustain flexibility while supporting greater consistency and equity across Health Boards.

Experienced Value of Clinical Supervision

Experienced value was consistently and strongly reported across all data sources. Midwives described supervision as improving wellbeing, confidence, resilience and reflective capacity, with many attributing continued practice or retention to supervisory support during periods of challenge. Senior leaders associated supervision with strengthened culture, early support following incidents and meaningful contribution to governance and safety processes.

Despite this strong experiential value, benefits are not consistently visible at organisational or system level. The current KPI framework prioritises activity and coverage and does not capture several intended outputs articulated within the national guidance, constraining routine evidence of impact beyond delivery metrics. As a result, the value of supervision is well understood locally but is less clearly articulated within formal planning and investment processes.

Workforce context and sustainability

Set within the wider maternity workforce context in Wales, the findings highlight clinical supervision as a stabilising mechanism during sustained system pressure. While the model is valued and resilient in practice, its sustainability is contingent on sufficient supervisory capacity, consistent organisational arrangements and improved system level intelligence to inform workforce planning.

Summary

This report presents the first national evaluation of the employer-led Clinical Supervision for Midwives (CSfM) model in Wales. Overall, the evaluation demonstrates that the employer led Clinical Supervision for Midwives model delivers clear professional, emotional and organisational value. The model is conceptually robust, widely accepted and embedded within routine practice, with strong alignment to the intent and definitions set out in national guidance.

Across Health Boards, most elements of the model are either fully implemented or actively developed, with limited variation in interpretation or delivery. Impact is most evident in relation to wellbeing, professional confidence and workforce retention. However, long term sustainability will depend on addressing structural constraints and strengthening outcome measurement so that the model is consistently recognised, protected and resourced across Wales.

Strengths and Limitations

Strengths

This is a national mixed methods evaluation of the employer led Clinical Supervision for Midwives model across all seven Health Boards in Wales, providing system level insight into implementation, experience and adaptation. Use of multiple data sources, including surveys, a reflective whiteboard exercise, interviews and a supplementary national midwifery survey, enabled triangulation and strengthened credibility. Representation from all Health Boards across midwives, Clinical Supervisors for Midwives and senior leaders ensured a broad range of organisational contexts were captured.

Participation from Clinical Supervisors for Midwives and senior leaders across all Health Boards enabled detailed examination of role delivery, organisational support and system adaptation. Rich qualitative data provided insight into relational, emotional and cultural dimensions of supervision that are not readily captured through activity measures alone. Application of Normalisation Process Theory offered a robust analytical framework, and alignment with national policy and workforce priorities enhances relevance for service planning and strategic decision making.

Limitations

Representation across Health Boards was uneven in both the activity survey and the supplementary survey, with participation ranging from 5 to 40 percent of each Board's midwifery workforce. Although all Health Boards contributed data, this variability means that some organisational contexts are more strongly reflected than others. While consistent patterns across datasets provide some reassurance, interpretation should recognise that Boards with higher participation are likely to exert greater influence on quantitative distributions.

The achieved sample of 269 midwives within the midwifery activities represented 14.3% of the Welsh midwifery workforce, which is acceptable for national service evaluation.

As with all voluntary participation studies, response bias is possible, with participants potentially holding stronger positive or negative views. Recruitment approaches sought to address this and maximise inclusivity by the recruitment of participants via existing mandatory training days and local supervision sessions. For supervisors and senior leaders, small absolute numbers reflect the size of these professional groups in Wales, meaning individual experiences may have proportionally greater influence on qualitative themes.

The evaluation relied primarily on self-reported data. Perceived improvements in wellbeing, confidence or practice cannot be independently verified and may be influenced by recall, local culture or recent experiences. The evaluation did not include direct outcome measures such as sickness absence, retention trajectories, incident rates or service quality indicators, which are influenced by multiple factors and fall beyond the scope of a service evaluation design.

In addition, routine outcome data specific to the Clinical Supervision for Midwives model are not consistently collected, and the national KPI framework focuses on activity rather than effect. The evaluation therefore reports experiential benefit rather than quantifiable system impact. While substantial variation across Health Boards was identified, the study did not include comparative case analysis to explore causal relationships between context and effectiveness.

Overall, these limitations do not undermine the core findings but highlight the need for cautious interpretation of quantitative proportions and point to opportunities for more outcome focused and methodologically diverse evaluation in future.

Recommendations

These recommendations have been developed through structured engagement with a multi-professional stakeholder group and are aligned with the Chief Nursing Officer's Strategic Vision for Nursing and Midwifery 2025–2030. The Vision articulates a national ambition for a valued, empowered and sustainable nursing and midwifery workforce, underpinned by compassionate leadership, psychological safety, professional autonomy and evidence-informed practice.

The evaluation clearly demonstrates the experiential value of clinical supervision for midwives across learning, professional practice, wellbeing and retention. It also identifies benefits for senior leaders, positioning Clinical Supervision for Midwives as a practical mechanism to support the delivery of complex, high risk maternity services.

Accordingly, these recommendations recognise the strengths of the CSfM model and are focused on its protection and long-term sustainability.

① **Standardise and modernise the CSfM model**

To promote clarity and safeguard the model from role drift - introduce a refreshed national CSfM framework that clearly defines identity and the minimum standards for role, purpose and boundaries allowing clear guidance on flexibility for local access and delivery. Ensure all midwives, including those outside Health Boards, have equitable access.

② **Strengthen monitoring and assurance processes**

Develop a national outcome-focused KPIs with solutions for consistent data capture and visibility. Define clear reporting lines, accountability and escalation processes. A review of KPI 6 is needed to ensure the peer-review requirement is fit for current practice.

③ **Build a sustainable CSfM workforce**

Review of the national workforce model that reflects service size, complexity and geography. This includes the 1:125 ratio to ensure protected time for supervision taking account of increasing clinical acuity, student and NQM supervision demand and support for staff during key transition points such as support for return from maternity leave and other vulnerable career points. Ensure access to peer and wellbeing support for CSfM's.

④ **Create a national development and succession pathway**

Establish a consistent development route for CSfMs, including Level 7 preparation, induction and mentoring with a focus on key elements such as trauma informed practice, governance literacy and reflective facilitation.

Conclusion

This evaluation demonstrates the clear value and impact of the Clinical Supervision for Midwives model in Wales. CSfM is widely recognised and trusted by midwives and senior leaders as a critical space for reflection, support and professional development. The sustained commitment of supervisors and the wider maternity workforce have been central to establishing the model across Health Boards and embedding it within practice.

The findings also identify areas where greater clarity, consistency and structural support are required to secure long term sustainability and equity of provision. Variability in implementation, capacity and role boundaries risks undermining impact if not addressed. The recommendations in this report draw directly on the lived experience of those delivering and receiving supervision and provide a clear, collective direction for strengthening the model.

By consolidating existing strengths and responding decisively to the challenges identified, there is a significant opportunity to enhance the reach, sustainability and effectiveness of the CSfM model.

Acknowledgements

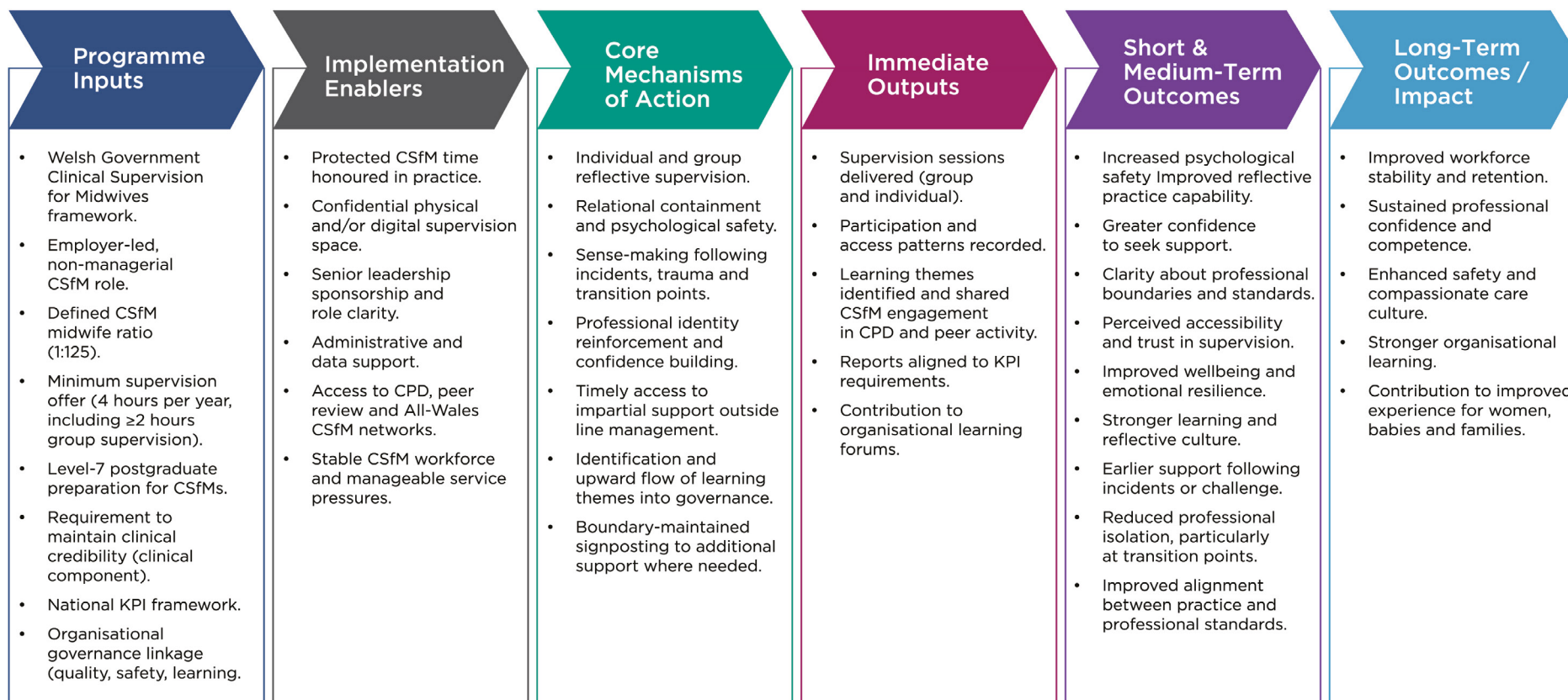
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Artificial intelligence was used to support initial coding of interview extracts. All outputs were reviewed by the researcher, with subtheme development and final theming undertaken by a human analyst. Artificial intelligence was also used to support development of the logic model and to assist with concision in reducing sections of the evaluation.

Appendix

Appendix 1 – Logic Model



Immediate Outputs

Supervision sessions delivered (group and individual), participation and access patterns recorded, learning themes identified and shared CSfM engagement in CPD and peer activity, reports aligned to KPI requirements, contribution to organisational learning forums.

Short & Medium Term Outcomes

Increased psychological safety improved reflective practice capability, greater confidence to seek support, clarity about professional boundaries and standards, perceived accessibility and trust in supervision, improved wellbeing and emotional resilience, stronger learning and reflective culture, earlier support following incidents or challenge, reduced professional isolation, particularly at transition points. Improved alignment between practice and professional standards.

Appendix 2 – Clinical Supervisor for Midwives Whiteboard

Activities Undertaken by CSfM's		
CSfM Activities		
Professional Support, Advocacy & Wellbeing (66)	Professional Development & Career Support (19)	Revalidation & PADRs, 1:1 Supervision & Reflection, Career & Development Support, Capability & Workplan Support, Birth Reflections, Debriefing & Incident Support, Supporting staff undergoing Investigations, Reflective Learning & Review, Emotional & Pastoral Support, Wellbeing & Resilience, Signposting & Practical Support, Wellbeing Structures, Return-to-Work Support, KIT & Reintegration, Advocacy & Representation, First Point of Contact, Staff Voice & Feedback.
	Reflective Practice, Debriefing & Events Processing (19)	
	Emotional Support, Wellbeing & Psychological Safety (14)	
	Advocacy, Voice & Representation (7)	
	Return to Work, Kit & Transitional Support (7)	

CSfM Activities		
Education, Teaching, Preceptorship & Professional Development (55)	Mandatory, Emergency & Clinical Skills Development (11)	Group Supervision & Facilitated Learning, Mandatory Training Delivery, PROMPT / NLS / RCUK / Skills Drills, Clinical Skills Teaching (incl. Suturing), Student Teaching & University Sessions, Student Supervision & Competency Support, Induction & Early Career Support, Preceptorship Support & Supervision, 1:1 Competency Reviews (Band 5 / NQMs), Preceptorship Forums & Programme Coordination, Teaching & Learning Activities, Interactive Learning Methods, Professional Development & Learning Opportunities, RCM Learning Rep Role, Practice Development Linkage, QI & Critical Analysis Support.
	Preceptorship, NMQ Support & Early Career Development (11)	
	Group Supervision & Facilitated Learning Spaces (11)	
	Teaching & Education Delivery (9)	
	Professional Development & Leadership (8)	
	Workforce Induction & orientation (3)	
Governance, Risk, Safety & Clinical Standards (42)	Risk & Governance Linkage (11)	Risk & Governance Liaison, Clinical Governance Meeting Participation, Incident Review & Learning Dissemination, Audit & Documentation Quality, Guideline Development & Dissemination, NMC Code, Professionalism & Safe Practice, Triangulation of Themes (Patient-Staff-Organisation), MDT Supervision on Emerging Themes, Data Analysis & Quarterly Reporting, Medication Error Review & BESS Scoring, Record-Keeping Standards (incl. NIPE Records), Safe Care Advocacy.
	Audit & Documentation Quality (11)	
	Incident Review, Response & Learning (10)	
	Professional Standards, NMC code & Role Modelling (8)	
	Guideline Development, Review & Dissemination (3)	

CSfM Activities		
Organisational Interface, Communication & System Leadership (23)	Representation in Forums and Meetings (16)	Staff-Management Interface & Upward Feedback, Understanding Culture & Feeding Insights to Leadership, Representation at Divisional & Maternity Meetings, Chairing / Leading Professional Forums (Local & National), Cross-Site / Transfer Meeting Participation, National Leadership Roles & All-Wales Forum Involvement, Communication & Newsletter Production, Presenting at Health Board / System Meetings.
	Organisational Communication & Upward Feedback (5)	
	Strategic & Operational Leadership (2)	
Quality Improvement, Service Development & Digital Implementation Support (16)	Improving Services & Efficiencies (10)	Quality Improvement Projects & Initiatives, Service Improvement & Workforce Future proofing, Supporting Staff QI & Teaching, Digital Maternity Implementation Support, Civility, EDI & Culture Workshops, Streamlining & Promoting Maternity Services Teamworking & Collaborative Improvement, OFW Support Forums
	Culture Programmes (4)	
	Digital Implementation Support (1)	
Clinical Credibility, Practice Support & On-the-Ground Presence (16)	Direct Clinical Practice (5)	Clinical Practice Support When Needed, Acuity & Operational Support, Responsive Advice & Troubleshooting, Supporting Practice Concerns & Issues, Maintaining Clinical Credibility (Working Clinically), Community Team Engagement, Informal Corridor / Ad-hoc Staff Contact.
	On the Ground Visibility and Clinical Practice (4)	
	Practical Guidance (4)	
	Community Teams Support (2)	
	Maintaining Clinical Credibility (1)	

Skills Required

Skills

Relational, Emotional and Communication Skills (67)	Relational Communication and Interpersonal Skills (11)	Communication that enables effective supervisory relationships through active listening, civil dialogue and skilled management of sensitive or complex conversations.
	Compassionate Relational Support (10)	Provision of coaching, mentorship and compassionate leadership that cultivates civility, supports wellbeing and strengthens midwives' professional development.
	Professional Integrity and Boundaries (9)	Upholding confidentiality, ethical conduct and appropriate boundaries to maintain trust and psychological safety.
	Psychological Safety and Resilience (8)	Ensuring emotional containment and safety through trauma-informed practice, resilience and calm decision making.
	Reflective and Self-aware Practice (7)	Using self-reflection, awareness of bias and openness to feedback to support reflective learning and professional development.
	Relational Insight (9)	Perceptive understanding of others' needs, situational awareness and attuned relational responses that strengthen supervisory rapport.
	Relational Support and Compassionate Practice	Providing empathic, caring and non-judgemental support that helps midwives navigate emotional, professional and wellbeing challenge.

Skills		
Operational and System Leadership (67)	Operational and Strategic Communication (4)	Using structured, purposeful communication to convey information, support coordination and enable system-wide engagement.
	Digital and Analytical Competence (9)	Use of digital systems, data and analytical tools to support operational oversight and informed decision making.
	Educational Delivery and Facilitation (9)	Designing and delivering teaching, group facilitation and supervisory learning activities that support staff development.
	Leadership Capability (14)	Demonstrating strategic, developmental and motivational leadership to guide teams and influence service priorities.
	Professional Processes and Staff Support (10)	Managing operational processes such as RCA support, conflict resolution, appraisal and workforce procedures for effective practice.
	Quality Improvement (13)	Applying human factors, QI methodologies and safety principles to enhance systems, processes and service outcomes.
	Service Coordination and System Delivery (8)	Organising workflow, managing time, coordinating teams and adapting to operational demands across the service.

Skills		
Professional Credibility and Clinical Expertise (31)	Analytical and Critical Thinking Skills (3)	Using analytical reasoning, critical thinking and problem solving to support safe clinical and supervisory decisions.
	Clinical Expertise and Professional Credibility (15)	Drawing on substantial clinical experience, professional competence and autonomous judgement to provide credible supervisory support.
	Equity and Inclusion Knowledge for Practice (3)	Understanding and applying EDI principles to promote equitable, inclusive and culturally responsive midwifery practice.
	Governance, Standards and Safety Knowledge (5)	Knowledge of governance structures, just culture principles and professional standards to guide safe and accountable practice.
	Organisational and System Literacy (5)	Understanding organisational structures, pathways, roles and resources to navigate and support staff within the wider system.

Facilitators	
Support from Senior Leadership (24)	Supportive senior and line management, feeling valued and recognised by leaders, regular open communication, autonomy in delivering the role, clear organisational structures (mandated hours, JD/spec, pay banding, PADR), support for development and external engagement, practical support (e.g., travel expenses).
Protected Time & Practical Role Conditions (17)	Protected time, protected admin time, allocated time, confidential space, access to laptops and phones, remote-working capability, equipment to work across geographical areas and the ability to order stock.
Peer Support and Professional Networks (15)	CSfM Wales Forum, local CSfM colleagues, health board colleagues, training course colleagues, RCM leadership support.
Multidisciplinary and Specialist Support (12)	Clinical psychologist support, consultant midwife support, specialist and MDT colleagues, university and education support, (Preceptor Lead Midwife, LME, HEIW), governance and leadership support, wellbeing team support, MDT forums.
Emotional, Psychological & Reflective (6)	Feeling valued, listened to and recognised, regular reflective catchups with line managers, psychologist support (e.g., bi-monthly meetings), positive engagement and support from midwives/workforce.
Training, CPD & Professional Development (5)	Advocacy module, CPD support including university modules, University engagement opportunities, evidence base, additional training opportunities.

Barriers		
Role Clarity, Identity & Boundaries (28)	Lack of Role Clarity and Understanding (11)	Staff misunderstanding and misinterpretation of the role. Limited awareness of role function and remit, ambiguity around expectations and boundaries, perceived lack of respect or recognition, underutilisation of role capability.
	Role structure, secondment and stability (10)	Secondment arrangements limiting continuity, embedding and relationship-building, unclear or inconsistent contractual structures affecting stability and familiarity with the role, lack of substantive status reducing perceived credibility, need for structured job planning to support role consolidation.
	Role boundaries and identity (7)	Ambiguity and lack of clarity around role expectations and boundaries, drift into operational or managerial tasks, especially during clinical pressures, confusion or conflation with other supervisory or management roles, conflicting expectations about the purpose and scope of the role.
Capacity, Workload and Workforce Constraints (22)	Capacity, time and workload (18)	Insufficient capacity and protected time, with clinical pull and competing demands reducing supervisory availability, service pressures, staffing gaps and workload preventing both CSfMs and midwives from fully engaging in supervision, high KPI burden and the complexity and breadth of the role creating excessive demands and efficiency challenges.

Barriers		
Capacity, Workload and Workforce Constraints (22)	Ratios and capacity limits (2)	Unrealistic staffing ratios for the geography, complexity and distributed community bases.
	Workforce pressures (2)	Contextual pressures within maternity services. Workforce shortages impacting supervision.
Organisational Culture, Support and Communication (17)	Organisational support, culture and communication (16)	Variation in behaviours, mixed engagement and resistance to change, communication gaps and exclusion from key information loops, process and system issues (documentation, notifications, job evaluation), cultural legacy concerns and misalignment with senior management.
	Engagement and visibility (1)	Visibility in clinical areas.
Practical, Infrastructural and Geographical Conditions (13)	Practical, infrastructural and geographical barriers (11)	No protected or consistent workspace, limited storage and lack of private rooms, difficulty finding space on shift, reducing accessibility for midwives, large geographical area and dispersed bases limiting physical visibility.
	Financial or resource limitations (2)	Limited financial support for CPD, conferences and meetings.

Needs		
Professional Capability, Identity and Wellbeing (53)	Training, Education and Development (24)	Structured induction, mentorship, Level-7 education, digital/QI/ coaching skills, trauma-informed training, and ongoing CPD opportunities.
	Role Identity, Title and Professional Differentiation (11)	Clear job title that reflects role, unique uniform.
	Supportive Relationships and communication, coaching and wider Communication (11)	Regular senior check-ins, strong communication, coaching and wider professional connections.
	Psychological & Wellbeing support (7)	Psych supervision, boundary and compassion fatigue support, speaking up safely, wellbeing training, Just Culture and cross-HB shadowing.
Structures, Governance and Role Alignment (50)	Structural Clarity, Role Alignment and Model Stability (43)	Clear organisational structure, aligned model & governance, substantive roles, job planning, and appropriate ratios/KPIs clear structure, defined processes, psychological-safety ownership, aligned model & governance, job planning.
	Operational Processes and Job Planning (6)	Clear structure, defined processes. psychological-safety ownership, aligned model & governance, job planning.

Needs		
Capacity, Infrastructure and Workforce Conditions (15)	Workspace, Environment and Infrastructure (11)	Protected confidential workspace, dedicated private areas, admin/ support resources. structured time for supervision.
	Workforce Capacity, Staffing Ratios and Time (4)	Alignment to CSfM: midwife ratios and sufficient WTE/ time to deliver the role effectively.

Appendix 3 – Alignment of CSfM Delivery with Welsh Government Guidance (2019): Evaluation Interpretation

This matrix draws on implementation-science fidelity principles to map guidance expectations to system evidence. It is not a compliance audit but an interpretive fidelity assessment.

Guidance expectation (2019)	What the guidance intends	Evidence from the evaluation	Fidelity judgement	Interpretation
Purpose and ethos	Supportive, restorative, reflective supervision; distinct from management and regulation; psychologically safe and confidential.	Strong, consistent understanding across midwives, CSfMs and senior leaders; repeated emphasis on safety, confidentiality, impartiality and non-punitive intent.	High	Clear conceptual fidelity across all datasets.
Boundary from management and regulation	CSfM must not function as performance management, appraisal or disciplinary mechanism.	Midwives and leaders consistently distinguish CSfM from line management; only rare exceptions reported and treated as risks.	High	Boundary maintenance is explicit and well evidenced.

Guidance expectation (2019)	What the guidance intends	Evidence from the evaluation	Fidelity judgement	Interpretation
Core supervisory functions	Group and 1:1 supervision; reflective practice; professional development; emotional support.	Routine delivery of group and individual supervision; robust evidence of reflective, developmental and pastoral work.	High	Fidelity at the level of core function and mechanism.
Psychological safety and confidentiality	Safe space for reflection and disclosure.	Widely reported by midwives as defining features of the service.	High	Central to model identity in practice.
Support at key transition points	Targeted support for newly qualified midwives, returners and staff following incidents.	Robust evidence of prioritised support during preceptorship, return from leave and following adverse events.	Moderate-high	Support is prioritised but not uniformly delivered across all contexts.
Clinical credibility	Supervisors must maintain professional credibility.	Clinical credibility repeatedly described as essential; variation in how the clinical component is enacted.	Moderate	Principle upheld; operationalisation varies locally.
Clinical component of role	Defined clinical element to support credibility.	Wide variation (birth reflections, NIPE support, practice-adjacent activity); limited national clarity.	Moderate	Guidance is non-specific; variation acknowledged.

Guidance expectation (2019)	What the guidance intends	Evidence from the evaluation	Fidelity judgement	Interpretation
Rotational model (minimum 3 years)	Full-time rotational posts with review and option to return to clinical practice.	Extensions beyond 3 years common; some substantive posts without defined rotation.	Low-moderate (structural)	Extension beyond 3 years consistent with guidance; permanent posts diverge structurally but preserve function.
Protected supervisory time	Dedicated time to deliver supervision.	Leaders describe active protection of CSfM time despite pressure.	Moderate-high	Constrained by workforce pressure and service acuity rather than lack of organisational commitment.
Governance and organisational learning links	Supervision contributes to learning, safety and improvement.	Robust evidence of governance integration, thematic feedback and learning loops.	High	Often exceeds what is specified.
Key Performance Indicators (KPIs 1-5)	Monitor access, coverage and delivery.	KPIs 1-5 routinely monitored via dashboards and reports.	High	Activity monitoring embedded.
External peer review (KPI 6)	Annual external peer review of CSfM services.	External peer review no longer undertaken as specified; internal alternatives used.	Low	Alteration to specified national requirement.
Outcome and impact monitoring	Implicit expectation of contribution to wellbeing, learning and sustainability.	Strong experiential evidence but limited formal outcome capture; KPIs focus on activity.	Moderate	System-level gap between intent and measurement.

Guidance expectation (2019)	What the guidance intends	Evidence from the evaluation	Fidelity judgement	Interpretation
Adaptability to local context	Local flexibility while preserving core intent.	Extensive local adaptation in structure, delivery and scope.	High (by intent)	Adaptation preserved core principles but increased variation in role scope, visibility and delivery across Health Boards.
Level 7 academic preparation for CSfMs	CSfMs to complete, or be working towards, a minimum 20-credit Level 7 module in clinical leadership and supervision.	Most CSfMs reported completion of, or progression towards Level 7 preparation: variation evident in timing, routes and local interpretation of equivalence.	Moderate-high (structural)	Requirement upheld, though implemented flexibly through differing educational pathways and timelines.

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