

A grounded theory study on midwifery managers' views and experiences of implementing and sustaining continuity of carer models within the UK maternity system.

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A grounded theory study on midwifery managers'
views and experiences of implementing and
sustaining continuity of carer models within the UK
maternity system

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Abstract

Background: Current NHS policy recommends the transition of maternity services towards providing Midwifery Continuity of Carer (MCoCer) models in order to provide quality care for women and their families in the UK. It is known from the literature that quality of care received in the NHS is correlated with the quality of the management. There is no known evidence available for midwifery managers in how to implement and sustain MCoCer through leadership and midwifery management.

Aims: To develop a theoretical framework that is practical, and pragmatic based on the views and experiences of experienced midwifery managers in how to implement and sustain MCoCer models of care within the NHS.

Methods: Semi-structured interviews were conducted with five experienced midwifery managers to elicit views and understanding of the social processes underlying the implementation and sustaining MCoCer. The interviews were manually transcribed and categorised using Charmaz's grounded theory approach which acknowledges the experiences of the researcher. The focus codes were developed into theoretical codes. A core category then emerged.

Outcome: A theoretical framework identifying that in order to achieve meaningful leadership of midwifery in MCoCer models there are pre-requisites from the skills and attributes of the midwifery manager. Midwifery managers require a philosophical underpinning of belief in woman centred care and non-hierarchical transformational management skills alongside the courage to assimilate alternative models of care within the traditional NHS structure. They need to have the capacity to promote and protect the MCoCer model within the service whilst forming a culture that is based on a woman centred approach. This can be achieved through mastering the development of a values-based recruitment and retention policy and through encouraging midwives with previous experience in MCoCer models to develop leadership skills. Through these leadership strategies, the MCoCer model can be encouraged and protected within the service.

Conclusion: MCoCer models are sustainable within the NHS when there is support from the midwifery manager with the appropriate aptitude, skills and attitudes. Managers who have experienced working within a MCoCer model

have an insight into the intricacies of the relationships made between women and midwives and the group practice of midwives. Providing the appropriate support for MCoCer is time consuming and personally demanding for midwifery managers; however, this was shown to be rewarding, bringing meaning to their midwifery career.

Key Words: Midwifery Management, Leadership, Meaningful midwifery, Midwifery continuity of carer, Grounded theory.

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Chapter 1: Introduction

Midwifery continuity of carer (MCoCer) models are being introduced in the National Health Service (NHS) within the UK due to the quality of provision and beneficial outcomes that they achieve. There is an ongoing exploration on how to implement and sustain the models from the midwives' perspective; however, all change requires effective leadership and management. Within midwifery there appears to be insufficient evidence of published literature to inform this change in practice regarding the leadership and management skills required to implement and sustain MCoCer models. This constructivist grounded theory study based on Charmaz's (2014) work addresses this by developing a theoretical framework for midwifery managers. By investigating the views and experiences of midwifery managers who have cultivated a wealth of experience within MCoCer models in clinical practice the development of future service provision within the NHS of MCoCer models is expertly informed.

This chapter provides the background and overview of this thesis. It starts by outlining the terminology and the language used within the thesis. Then the scene is set for the research by exploring the background of midwifery management within the NHS and its consideration when developing MCoCer models. Next the impetus for the research is explored which leads on to the research focus and the rationale for the qualitative approach and grounded theory that was developed. Finally, this chapter concludes with an overview of the structure of the thesis.

1.1 Terminology and language

Within the literature there are confusing and conflicting terminologies used to describe 'managers' or 'leaders' of health care services in the UK and around the world (Jennings et al 2007). Generally, midwifery managers within the NHS are those with the responsibility for service provision, delivery and coordination of maternity care within their health board or trust. Jennings et al (2007) conducted a comprehensive literature review of leadership and

management competences. From the literature they identified 894 competencies related to leadership and management, of which 862 competencies were those exercised by both leaders and managers. This finding therefore suggests that despite the two concepts being 'different' many are common to both roles and functions. The participants in this study were all midwifery managers, managing midwives providing NHS care in the UK who applied leadership principles within their role. Therefore, the following definitions are used:

Manager: This term refers to the person who has been appointed to plan, organise, co-ordinate, supervise, negotiate, evaluate and integrate midwifery care with the use of resources that are made available to them by the organisation. Responsibility is given to managers to ensure that the organisations objectives are achieved, and activities are co-ordinated. Managers need to communicate effectively and be accountable for their actions (Gopee and Galloway 2017). For example, the participants of this study had all held senior midwifery positions, they were responsible for employing in an organised manner, registered midwives, who were competent and equipped to provide safe midwifery care for the women within the health trust.

Leadership: Is one of the roles of managers. It is about being visionary, showing the way forward, anticipating developments, innovating, seeing the bigger picture, as well as focusing on the development of individuals (Gopee and Galloway 2017). Thus, leadership is a dynamic two-way process based on a leader-follower relationship. For example, one of the participants within the study described how she spent time with her obstetric and board colleagues planning the granular detail of the transition to change process in order to create positive energy throughout the health trust for the change in midwifery practice, thus placing leadership as an essential skill for her to use in the transition process.

Thus, a midwifery manager applying leadership principles could be illustrated in the following way:- In order to start the process of getting midwives to engage with MCoCer models, one of the study participants said she knew that the midwives coming together to form the group practice were wanting to care for the women within the health trust who were requesting to birth at

home. The participant knew that the model would require more than just that cohort of women to be cared for; however, decided that since those midwives wanted to encourage normal physiological birth she would use the energy that they were engaging with and initiate a group practice with the model that the midwives had energy for. Thus, she would use her management position to enable a MCoCer model, and she would engage with the midwives in a positive compassionate way to realise their vision for the care that they wanted to provide for women in the trust. She knew that over time the midwives would evolve into caring for a wider cohort of women; however, she also knew it was very important for the other midwives in the trust to witness midwives entering into MCoCer models happily and excited to be able to provide the care that was meaningful to them.

Midwifery continuity of carer (MCoCer): A maternity system that provides a named midwife who follows women throughout pregnancy, birth and the postnatal period, available to all women, both low and high risk and in all settings including obstetric units (Sandall et al 2015).

As proposed by Carboon (1999) the term 'woman' is used as a neutral term for the maternity service users as it reflects maturity, equity and avoids assumptions of class or status. Although acknowledging that transgender parents may request not to be identified as 'woman', this study is adopting a feminist lens because this study and thesis is written by a woman, mainly for women who care for women and therefore, will refer to biological parturient maternity service users as 'women' or 'woman'.

1.2 Midwifery management within a continuity of carer context in the NHS

Midwifery within the NHS is embarking on a transformational change process due to the reforming of care structures led by the Best Start (The Scottish Government 2017) and Better Births (NHS England 2016). The aim is to improve levels of continuity of carer due to the improved outcomes and satisfaction of experiences for women and their babies (Homer et al. 2017; Sandall et al. 2016; Taylor 2015; Waldenström and Turnbull 1998).

Midwifery continuity of carer has been documented by Sandall et al (2016) in their Cochrane review to consistently demonstrate clinically significant benefits in high income countries (Australia, Canada, Ireland and UK) for women and babies. This Cochrane review included 15 randomised trials involving over 17,000 women who had midwife led care and compared them with medically led or shared care. The review included eight trials of women in 'low risk' categories and seven with 'all' risk. There were no trials of purely 'high' risk women. All were in a hospital setting with four having a 'home like setting' intrapartum option for women birthing in the hospital. They identified that women in midwifery continuity of carer models were more likely to have a spontaneous vaginal birth, 15% less likely to have regional anaesthesia and 16% less likely to have an episiotomy. Their babies were 16% less likely to be stillborn, 19% less likely to be miscarried and 24% less likely to be born pre-term. The Cochrane review was included in the development of the quality maternal and newborn care framework published in the *Lancet* midwifery series (Renfrew et al. 2014). In this series continuity of midwifery care was emphasised as being quality provision of midwifery care (Homer et al. 2014; Renfrew et al. 2014). The review was also cited in the World Health Organisation's 2017 report 'WHO recommendations on antenatal care for positive pregnancy experience'. There is currently a trial in London that is ongoing to investigate the outcomes of providing continuity of carer for women with a history of pre-term loss as it may be that women with vulnerabilities are the ones with least access to midwifery-led care and it's positive outcomes yet be the ones who could gain the most (Fernandez Turienzo et al. 2019). In addition to the Cochrane review (Sandall et al 2016) other studies have found similar clinical improvements when considering midwife -led continuity (Homer et al. 2017; Taylor 2015; Page et al. 2001; Waldenström and Turnbull 1998). The Cochrane review also found high ratings of satisfaction of care from women who were provided with continuity of midwifery care; however, due to the variation in measuring satisfaction in the studies it was difficult to conclude which aspects of care increased women's satisfaction with their care (Sandall et al. 2016). It was however, shown by Forster et al (2016) that postnatal care, was rated as more satisfying by women in their comparative study when they received MCoCer.

Thus, with policy and evidence supporting the movement from institutionally focused organisation of midwifery care towards a relational continuity model, a transformative change is required within the NHS. During recent maternity policy developments, women's views were gathered (The Scottish Government 2017; NHS England 2016), women in both Scotland and England consistently reported improved satisfaction with MCoCer or indicated that they wished they could have had this service if it had not been available for them.

Schein (1996) contends that change can produce a fear of the unknown which in this context is valid due to there being an acknowledged skill shortage of midwifery practitioners having exposure and experience in such models (Crowther et al 2016). Although the stimulus for providing MCoCer models was outlined in the Changing Childbirth report (Department of Health (DoH) 1993), there has been no effective national uptake of MCoCer models in the UK (McIntosh and Hunter 2014; Winterton 2013; McCourt and Stevens 2006). Taylor et al (2019) have suggested that pressure on services are due to staffing shortages, with midwives increasingly being unwilling or unable to cover continuity of carer models staffing rotas. When added to the increased birth rate and complexity, medicalisation of childbirth and a lack of a cohesive approach to implementation, the stressful influences that can impact on the failure to change service provision within the NHS can be identified (McInnes, Hollins Martin and McArthur 2018).

Change is a complex process, especially when implemented within a large institution like the NHS, that may have unforeseen and unintended consequences (Boje, Burnes and Hassard 2012). When introducing midwifery-led birth units and stand-alone birth centres it has been found that the maternity services of the NHS can struggle to integrate change that is not medically focused (Walsh et al. 2020). Walsh et al. (2020) uncovered that although clinically conducive to quality care outcomes in terms of lower rates of intervention and higher rates of satisfaction of the women using the birth-centre, there was a difficulty in promoting and defending the midwifery model of care within the institution of the NHS. By being unwilling to embed the service within the main-stream service the birth centres remained vulnerable to financial pressures. They also identified that a lack of leadership to drive

through the change in service created a service that lacked support and became vulnerable to institutional norms and the medical model dictating the status-quo. Cheyne, Kildea and Harris (2019) indicate that in order to evidence sustainability of new models of care such as MCoCer within the NHS, it is vital to consider its acceptability to the midwifery workforce and they state that it should be the midwifery leadership team that ensure successful implementation into practice through ongoing evaluation. This relies on a level of attention and time being given to the model by the midwifery leaders which has been shown by Walsh et al in the NHS birth centre context (Walsh et al. 2020) to not always be the case. This research defends the motivating change theory developed by Breckenridge et al (2019) at the Scottish Improvement Science Collaborating Centre, by ensuring greater humanising of the improvement process and listening to individuals and organisations with successful track records in lasting improvement in MCoCer.

Within NHS institutions, change is not always supported and adequately resourced (Dixon-Woods et al 2014). In part this is due to the NHS being a bureaucratic organisation that is politically sensitive to the motivations of the incumbent political party who dictate the financial resource allocation and priorities to the service. The electorate forms the body of service users and are thus able to voice their expectations of their health service on the politicians in power. This could enable a responsive healthcare system reflective of expectations and needs; however, it is shown that the NHS is a large bureaucratic organisation with a hierarchical system of management who struggle to work cohesively and share best practice as reflected in the 2015 Rose report:

“The NHS must simplify, standardise, and share best practice. The NHS can and must make use of its diversity and scale by sharing experience and best practice.” (Rose 2015 p.59).

In order to share good practice, skills in leadership and organisational management are required. It has been emphasised for some time that the lack of skill within midwifery managers in their managerial practices leads to poor maternity care delivery (Francis 2013; Smith and Dixon 2008). This lack of skill has been reported in having an impact on quality of midwifery care

provision as a result of inattention to midwifery practice and recruitment and retention of staff. It was identified by Ball, Curtis and Kirkham (2002), nearly two decades ago, that one of the key reasons why midwives were leaving the profession was due to unsupportive management. The Royal College of Midwives (RCM) in 2016 reported that there was still a problem with 36% of midwives identifying with having been bullied at work by managerial staff. In 2008 The Healthcare Commission specifically linked poor morale; ineffective, domineering leadership styles; and an overemphasis on financial pressures to poorer care for women. Further, the investigation into poor maternity services in the Francis report (2013) and Kirkup report (2015) highlighted the direct correlation between maternity service failures and a lack of sound leadership. This led to detrimental clinical outcomes for women and babies. Thus, quality of midwifery care hinges upon the managers within the NHS, their effective leadership and collaboration with staff (Kirkup 2015; Hardacre et al 2011).

The management within the maternity system of the NHS has been identified as a key barrier to progress (O'Connell and Downe 2009; Hughes, Deery and Lovatt 2002). Managers and their leadership styles in general, influence the options available to staff in relation to creativity and self-determination (Gopee and Galloway 2017; Armstrong 2012). Considering that MCoCer is being introduced due to the quality of care and improved outcomes it creates (Sandall et al 2016), West et al (2017) have recommended that change is most likely within the sphere of 'compassionate leadership' to be innovative and high quality. It has been agreed that the necessary managerial strategies required within maternity services to embed and sustain MCoCer models are sound management principles, commitment, will, passion and the ability to lead and influence others (Newton, McLachlan and Forster 2016; Homer et al 2019). This intimates that specific leadership principles or qualities need to be enacted for such management to be effective and acceptable.

There is a common theme within the literature that the culture of the organisation is influenced by the support of the leadership and quality of management (Francis 2013; West et al 2017; Mannion and Davies 2018). There is agreement that a culture that supports midwifery-led care and autonomous practice enables the practice of MCoCer models and their

sustainability (Homer et al 2017; Sandall 2015). Moreover, the ability to practice autonomously increases midwives' resilience (Sabzevari and Rad 2019). This appears to be due to the sense of independence and satisfaction midwives feel when using their skills and knowledge, which increases their "sense of usefulness" (Sabzevari and Rad 2019). This link between resilience and autonomy is becoming recognised. Hunter and Warren (2014) found a strong sense of autonomy was essential to resilience. MCoCer models have reportedly made midwives feel more able to practise autonomously (Sandall 2015). Therefore, encouraging more MCoCer models of practice may create a more sustainable midwifery model by improving midwives job satisfaction and resilience towards the current staffing shortages being experienced within UK midwifery (RCM 2019).

Although there is substantial literature exploring midwives' experiences of MCoCer models and their impact (Homer 2016; Edmondson and Walker 2014; Newton et al. 2014; Mollart et al. 2013; Collins et al. 2010), there appears to be no published and accessible literature available on how midwifery managers experience MCoCer models and the impact on them as leaders and the services they manage. A recent qualitative review by Hewitt, Priddis and Dahlen (2019) which is reviewed in Chapter 2, explored the attributes considered useful in midwifery managers from the perspective of experienced Australian midwifery leaders who have previous experience working in MCoCer models. However, this is the only study that has specifically considered midwifery managers and their impact on MCoCer models. Therefore, very little analysis is from the perspective of the leadership or management of MCoCer models, especially when situated within the social, organisational and professional processes of the NHS.

1.3 Impetus for the research: personal reflections

As a midwife I have worked in many NHS institutions throughout the UK. My focus has been to develop meaningful relationships with the women that I care for in order to provide individualised quality care. As a founder member of a caseload practice that contracted into the NHS in South East London, I experienced for many years the reality of autonomous midwifery practice. I

have become aware in my career since, that midwifery managers appear to impact directly on the local culture, vision, and availability of autonomous midwifery models within the health board.

My experience since leaving the caseloading practice has been that MCoCer models are viewed generally negatively by midwives and managers, even when they have no experience of working within the model. I have started to wonder about the reality of achieving continuity of midwifery carer in the NHS when there seems to be very little awareness of what it entails from midwives and managers in order to initiate and sustain it.

I therefore have come to question how the goal of providing high quality relational care is going to work in a clinical setting where there is such limited experience with very little sharing between midwifery managers being apparent.

My experience as a midwife when carrying a caseload was one of support and understanding from the midwifery manager who oversaw the health trust. The following is an example of my personal experience of leadership and management whilst practising as a caseload midwife within the NHS in South East London:

I was caring for a woman having her first baby. Her baby was due that week. Her relationship with her partner was breaking down and her family were in Ireland, so support was an issue for her. She called me on the Monday morning to say she'd been having contractions since 2am but they were not so strong now. I went to see her, assessed her and the baby- they both appeared well, I then carried on my day knowing she would call me if anything changed. She didn't call, so I checked in on her in the evening- she'd had a sleep and had eaten; the contractions had gone. This pattern then continued for the next 3 days. We engaged more frequently as the week went on, with me assessing that all appeared well with her and her baby and providing more emotional support as her resilience was being challenged due to lack of sleep. Finally, in the early hours of Friday morning her waters broke, and her contractions continued. She birthed her son with some help from me, in the birthing pool after a shoulder dystocia (where the baby struggles to be born as the shoulders get impacted on the mother's pelvic

bones). This was a traumatic experience for me as a midwife ending the week with a clinical emergency- one that I'd never faced before- a shoulder dystocia in a pool at home. I transferred the woman and her baby into hospital as I was very concerned that I had broken the clavicle of the baby during the manoeuvre to release him. As her midwife I arrived in the hospital tired, traumatised, concerned and in need of support. I went to see the manager to inform her of the clinical incident. She always kept her door open, I saw she was in, she welcomed me, listened to me, consoled me and said she'd set a date with the obstetric consultant as my fear was that I should have handled the situation differently. I had managed the situation in the pool; however, on reflection thought I should have immediately removed her from the pool- the practicalities of doing so are not quick or easy when the baby's head has been born. She said she thought the clinical care I had given was appropriate; however, we would talk it through the following week. She then followed through with a clinical meeting with me and my midwifery colleagues and an obstetrician we worked closely with, on how we could learn from the incident and if there was anything that could have been done differently. She was supportive, professional, competent and kept us safe in clinical practice. She used her management role to coordinate and her leadership skills to be non-hierarchical and honest in acknowledging her need to learn (as she didn't know the answer either). The baby was well and due to the depth of relationship developed with his mother I can happily report that in her last Christmas card to me she said he had just started to study veterinary medicine! Since leaving that health trust I have not experienced such understanding and skill from a midwifery manager. I am aware that unless those skills are known and transferred the impact on midwives working in MCoCer models could be dramatic.

1.4 Research rationale and approach

While the NHS has focused on reports that change maternity systems to relationally based models (The Scottish Government 2017; NHS England 2016), there is little direct evidence that illuminates what is required from midwifery managers during the task of enabling MCoCer to be achieved and sustained within the NHS. Instead, a multiplicity of factors can be seen to be

influencing the MCoCer agenda, including resource implications, and organisational readiness to change, both of which influence the motivation to implement a new strategic direction.

In the absence of clear direction this skill and knowledge base has the capacity to become locally determined. This would create an absence of sharing of best practice and knowledge recommended in the NHS Rose report (2015). In my current role as a Best Start educator in Scotland, I have engaged with midwives developing MCoCer models; however, the midwifery managers have only requested once, from one health board in Scotland, that they have education tailored to their management needs. Research of innovations in healthcare illustrates the powerful influence of culture and leadership on service matters (West et al 2017), and within midwifery this has been expanded to illustrate the interplay of midwives, women and quality of safe services (Kirkup 2015; Francis 2013). Even within the postgraduate, post registration education sector that I am currently working in, there appears to be little sharing throughout the UK of what each educational package involves. This lack of sharing resources is further complicated by the introduction of private companies being set up by midwives to provide MCoCer education for trusts in England. It could be construed that these midwives have no incentive to share their practice due to fears of losing their competitive advantage. Or it could simply be that no effort has been made to connect the educators and their resources.

There were representations from midwifery managers within the development of the Best start and Better Births reports (The Scottish Government 2017; NHS England 2016); however, the design and implementation of MCoCer models within the NHS have not considered the availability of skilled, appropriate midwifery managers in order to achieve implementation and sustainability of the models being considered. Therefore, it is suggested that to understand the factors and attributes required by midwifery managers to sustain such models will require a qualitative approach to analyse the issues that determine best practice. Such evidence in order to be pertinent and useful, needs to be grounded in the experiences of those NHS managers who have experienced managing this model of care within the social and professional processes of NHS institutions.

In order to create a pragmatic framework to enable clinicians to benefit from the outcomes of this study it was necessary to adopt an approach that focused on the myriad of social processes affecting NHS midwifery leaders. Through this approach an explanatory theory was developed that informed a best practice pragmatic framework. By employing a naturalistic feminist lens this study was able to reveal the reality of being a midwifery manager in the NHS and how MCoCer can be implemented and sustained through exemplary leadership.

1.5 Research aims, question and objectives

The aim of this research was:

To create a pragmatic theoretical framework based on practical experiences of midwifery managers managing sustainable midwifery continuity of carer in the NHS in order to inform other NHS managers about key perspectives in managing MCoCer models.

The research question considered was:

“What are the views and experiences of midwifery managers implementing and sustaining midwifery continuity of carer models within the UK maternity system?”

To answer this question there were four objectives:

1. To conduct a scoping review of the literature and identify what is not yet known and understood with regards managing and leading MCoCer in the NHS.
2. To explore current managerial perceptions in relation to MCoCer by interviewing managers with experience in models that have sustained over time and become embedded in NHS practice.
3. To identify the skill sets, attitudes and attributes that are required by midwifery managers to encourage autonomous MCoCer.
4. To create a framework grounded from midwifery managers perspectives.

1.6 Methodology and research design

A constructivist grounded theory methodology underpins this research. A grounded theory has been used to examine and explain the process of how midwifery managers explore their experiences within MCoCer models.

Grounded Theory is a qualitative methodology originally developed by Glaser and Strauss (1967) then developed into a constructivist Grounded Theory by Charmaz (2014), it is used to develop theory about social processes (e.g. UK maternity systems organisational culture and social processes) that occur within a group of individuals (e.g. experienced midwifery managers).

A qualitative enquiry was chosen as the aim of the question was to achieve an in-depth, individualised and contextually sensitive understanding of the issues (Patton 2015). There are common requirements within grounded theory and constructivist grounded theory which include the coding of data, constant comparative analysis, memo writing, theoretical sampling and integration into theory (Glaser and Strauss 1967; Charmaz 2014). While debate exists regarding the timing of a literature review in a Grounded Theory study, I conducted a scoping literature review prior to commencing the study (McCallin 2003) and then a further review after analysis of the data. The concept of theoretical sensitivity supports the view that the researcher enters the study with some understanding of the topic and the personal ability to interpret, understand and conceptualise the data in order to develop the theory (Strauss and Corbin 1998).

Data collection consisted of individual in-depth semi-structured interviews. The Grounded Theory methods of concurrent data collection and analysis, comparative analysis and theoretical sampling were used. The methodology and research design are explored in detail in chapter three.

As I am passionate about relational continuity of carer in midwifery, having experienced it as both a midwife and a birthing woman; I am unavoidably biased towards this model of providing midwifery care. In order for my voice to be clearly visible in this thesis the pronouns 'I' and 'my' are used. This is congruent with the reflexive grounded theory approach informed by Charmaz (2014) (See chapter 3). My aspiration is that this work contributes to further understanding and effective functioning of MCoCer models and that it can

inform sustainable implementation of MCoCer through appropriately attuned managerial skills and leadership qualities.

1.7 Placement of the Thesis

This research has interviewed participants from England due to no midwifery managers within Scotland having the requisite experience necessary in order to fulfil the selection criteria outlined in section 3.9.2. As emphasised in the introduction there are few participants to draw from due to the uptake of MCoCer models being slow and patchy within the NHS. The devolved powers of health care within Scotland has meant that the system of integration and collaboration of health and social care has developed in Scotland whereas in England a more competitive tendering process has involved the development of Healthcare trusts and clinical commissioning groups. This has made a difference in policy directives in that 'Better Births' (NHS England 2016) aims to encourage external providers whereas 'Best Start' (The Scottish Government 2017) has no incorporation of contracting for external providers. Even though there are some deep political arguments around the structure and ethos of the NHS across the borders within the NHS in the UK it is argued within this thesis that using the experience of those participants wherever they are placed in the UK is valid and valuable in order to enlighten the implementation and sustainability of MCoCer models.

1.8 Structure of the Thesis

The structure of the thesis is as follows:

Chapter 1: Introduction

In this chapter the scale change currently happening within the NHS maternity services is introduced and why it is important to consider midwifery managers and their role in implementing and sustaining MCoCer models.

Chapter 2: Literature review

In this chapter a scoping review was conducted. There is an exploration on how management theories and practice can help to implement change and

sustain new models of care within the NHS. The impact that midwifery managers have on service delivery and change is explored. Additionally, the midwifery culture within the NHS structure and how it impacts on implementing change is discussed.

Chapter 3: Methodology and methods

This chapter describes the underpinning methodology related to the research aims and objectives. Following which the qualitative, grounded theory approach is introduced. The data collection and analysis methods are also discussed along with the ethical considerations.

Chapter 4: Findings and analysis

This chapter presents the findings of the research and relates them to the analysis that developed into the grounded theory that is presented in the following chapter.

Chapter 5: Grounded theory development

The development of the grounded theory that resulted in the theoretical framework is presented.

Chapter 6: Discussion and conclusion

This chapter discusses the relevance of these findings in the context of current literature and presents the conclusions and recommendations of the research.

Chapter 2: Literature Review

In this chapter, a descriptive scoping review of the background and context of managing MCoCer models is explored. This process was completed twice during the study- once prior to data collection and once after in accordance with Charmaz's (2014) constructivist grounded theory (see chapter 3). The chapter starts by outlining the process and justification for the review. Since the aim of the research was to explore midwifery managers views and experiences of implementing and sustaining MCoCer models in the NHS, the theories and frameworks of leadership and change are considered. The evidence of leadership in midwifery and sustaining change in the NHS is then presented. Next the culture within the NHS is discussed in relation to midwifery and leadership and its impact on the implementation of change. A discussion of why MCoCer models are encouraged then follows. Finally, the chapter will explore how the application of personal experiences enhances the capacity to innovate and educate through change thus supporting the NHS in its transformation towards relational models of midwifery care.

2.1 Literature search

A scoping study provides a process for broadly mapping relevant literature pertinent to a study by foregrounding key concepts that underpin the research domain using the main sources and types of evidence available (Mays, Roberts and Popay 2001). Whereas a systematic review focuses on specific questions and study designs, a scoping review, as presented here, is able to address the area of interest in a broader sense incorporating different study designs and articles to build a picture of current understanding that can 'set the scene' in an area in which little has been published. Likewise, a scoping review of the literature is less concerned with assessing and providing a detailed critical appraisal of the quality of included studies but provides a global view of what has been published in the area using a robust scholarly process (Arksey and O'Malley 2005).

2.1.1 Search Strategy

The framework developed by Arksey and O'Malley (2005) was used to produce a rigorous and transparent approach. Through this iterative process the 5 stages of the scoping review were completed as outlined:

2.1.1.1 Stage 1: Identifying the research question

The question being asked was: 'What do midwifery managers perceive as best managerial practices and strategies when considering their own personal experiences managing NHS midwifery continuity of carer models?'. I was aware that, as discussed in the introduction, there is an overlap between management and leadership in terms of practice and theory. Therefore, both terms were used during the search.

2.1.1.2 Stage 2: Identifying relevant studies

In order to uncover any primary studies on midwifery management and leadership within MCoCer, different sources were searched.

Five electronic databases: The Cochrane Library, CINAHL with Full Text, Intermed, MIDIRS and Pubmed. The search terms used were "manage*" /"leaders*" AND "continuity of care*" AND midwi*, "manage*" /"leaders*" AND "caseload*" AND midwi*, "manage*" /"leaders*" AND "relational care*" OR "relational continuity" and midwi* and "manage*" /"leaders*" AND "group practice" AND midwi*.

Reference Lists: All studies reviewed were searched to identify any papers that had not been uncovered by the electronic search in their bibliographies.

Hand- searching of key journals: Through initial searches and primary reading in the subject area.

Existing networks: Expert opinion was sought from supervisors and colleagues with an interest in continuity in order to identify any grey literature or unpublished studies that may involve the appropriate search terms.

A time frame was not imposed, to keep the scope broad. Foreign language material was excluded because of the cost and time involved in translation.

2.1.1.3 Stage 3: study selection

A range of articles were identified that included the search terms previously established. On further screening exclusions were made due to studies not addressing Midwifery/ Management/Leadership/ Continuity of carer. There were primary qualitative studies and reviews that considered leadership or management of midwives in relation to the topic under study but were not investigating the leadership of the model of care or the managers views and experiences. A Critical Appraisal Skills Programme (CASP) (See appendix F) review tool was used to review any papers identified. They were characterized by a diversity of methods and approaches, a wide range of research questions with a range of maternity settings and populations. The three sources that did match the search terms were: One textbook (Homer et al 2019) that directly explored MCoCer models and their sustainability in relation to management in one chapter. One quantitative study by Dawson et al 2016 which explores the views of midwifery managers in implementing caseload midwifery in Australia and one qualitative study by Hewitt, Priddis and Dahlen (2019) considers attributes of Australian leaders to effectively manage MCoCer. All three will be discussed throughout this chapter amongst the wider literature reviewed.

2.1.1.4 Stage 4: Charting the data

The charting approach taken was akin to a narrative review (Pawson 2002), to enable a broad view that could include the use of the CASP tool (See appendix F) due to there being minimal studies that focused on the search terms. The questions posed of the literature remained 'what is known about managing or leading MCoCer models within the NHS', however, it was broadened to include 'what is known about leading or managing MCoCer models'/ 'What is known about midwifery leadership/management'/ 'what is known about the needs of MCoCer models from the leadership/ management'/ 'what is known about change within the NHS'. As all these

questions were able to illuminate the topic under study without being directly what the research was pertaining to uncover.

2.1.1.5 Stage 5: Collating, summarising and reporting the results

The literature was organised thematically which was a challenge due to the diverse and broad nature and overlapping of themes. The concluding themes of each study in relation to leadership or management became the categories for the following report of the literature.

In total 70 pieces of literature were used within this review, they consist of:

- 11 Governmental policy documents
- 11 Discussion papers
- 6 Systematic literature reviews
- 9 Book chapters
- 3 Framework evaluations
- 1 Cochrane review
- 28 Empirical peer reviewed papers
- 1 Symposium

As a scoping review the emphasis is not on the research methodology itself, the focus is on foregrounding key concepts that underpin the research domain however; for the purposes of clarity *Table 1: Empirical Research Studies* provides a guideline for the empirical peer reviewed research used within the literature review chapter alongside the reference: study design, participants, location, focus and the broad context.

Ref:	Design:	Participants:	Location:	Focus:	Context:
BEAKE, S. et al., 2013	Qualitative semi-structured interviews alongside framework analysis	24 women from diverse ethnic backgrounds	UK	Evaluating caseload midwifery in a relatively deprived ethnically diverse inner-city area.	Women have improved quality of care and safer care provided through caseload midwifery irrespective of their ethnic or social background.
BRECKENRIDGE, J. et al., 2019.	Participatory grounded theory approach with three organisations in three workshops	42 staff from leading change organisations	UK	Conceptualising the conditions necessary to facilitate and sustain improvement at scale	change is more likely to be sustained at scale if there is synergy between staff's perceived need and desire for improvement, and the extrinsic motivators for change. Witnessing effective change is motivating for staff and positive outcomes provide a convincing argument for the need to sustain improvement activity. As such, evidence of change becomes evidence for change. This is only possible when there is a flow of trust within organisations that capitalises on positive peer pressure and suppresses infectious negativity. When these conditions are in place, organisations can generate self-proliferating improvement.
BRINTWORTH, K. and SANDALL, J., 2013	Multi-method; Quantitative analysis of homebirth data, alongside interviews	Midwives and stakeholders	UK	Investigating what makes an organisation have a successful home birth service.	Caseload models that are strongly supported and advocated for by senior leaders in midwifery and obstetrics delivered responsive, flexible choice to women.
BRODIE, P., 2002.	Feminist qualitative, thematic analysis of interviews	Midwives	Australia	Addressing the barriers to midwifery	Midwifery in a medicalised organisational model creates less access and choice for women.
BROWNE, J. et al., 2014.	Qualitative thematic analysis	Focus groups with 14 midwives	Australia	Using antenatal communication and specific techniques to encourage women to focus on wellness.	Midwives use strategies to reduce anxiety and focus on wellness in women.
BUCHANAN, D. et al., 2013	Multi-method: Interview, focus groups, management briefings, survey (600 participants), serious incident case studies.	1200 NHS managers in 6 different locations	UK	What changes are occurring within healthcare management and what are their implications	establishing and agreeing and implementing 'defensive' change agendas is a barrier. Change management education is required by managers. Maintaining and enabling environment to support management contributions would be supportive and cost neutral.
BYROM, S. and DOWNE, S., 2010.	Phenomenological interview survey	10 Midwives	UK	Exploring midwives accounts of 'good' leadership and 'good' midwifery.	Skilled competence was a prerequisite for midwifery and emotional capability transformed those aspects into 'good'.
DAWSON, K. et al. 2016	Quantitative survey	149 midwifery managers	Australia	Exploring the availability of caseload midwifery for Australian women and factors associated with implementation and sustainability.	Limited access to caseload midwifery for women. Funding and support are the barriers to implementation.
DEERY, R. and HUGHES, D., 2004	Action Research	Midwifery managers, midwives and obstetricians	UK	Midwifery care is aiming for person-centered, value led practice.	Practice based leadership may aid in establishing person-centered care.
DIXON, L. et al., 2017.	Quantitative survey	1073 Midwives	New Zealand	To explore the psychological wellbeing of midwives whether self-employed or employed.	Self-employed midwives providing caseload care had lower rates of stress and burnout than employed midwives.
DONALD, H., 2012.	Cooperative enquiry	Midwives	New Zealand	Examining the work-life balance of midwives carrying a caseload	Establishing a network of colleagues with similar values and expectations improves caseload working for midwives.

DONNOLLEY, N., et al. 2016.	Participatory action research	47 individual sites midwifery managers	Australia	Requirement to have standard terminology to identify and define models of care to allow for accurate evaluation.	Development of a standard model enables planning, policy development and delivery of maternity services.
EDMONDSON, M.C. and WALKER, S.B., 2014.	Qualitative interview analysis through grounded theory	Seven midwives	Australia	Exploring the midwifery experience of providing caseload midwifery care.	Autonomous midwifery is enabled in caseload care. Working flexibly with supportive work relationships are key to a work life balance.
ENGEL, C., 2003.	Qualitative narrative interviews	Five midwives	New Zealand	The funding and policy of caseload midwifery will dictate the capacity to deliver care	Balance for midwives depends on funding and structure
HEWITT, L., PRIDDIS, H. and DAHLEN, H.G., 2019	Qualitative interpretive approach	Eight midwifery leaders	Australia	To examine the attributes of midwifery leadership required to be an effective midwifery group practice manager.	Midwifery leaders have to stand up for midwives and have transformational leadership qualities
HOMER, C. et al., 2017.	Retrospective analysis	2568 women receiving caseload midwifery care	UK	To examine trends in outcomes for women receiving midwifery continuity of carer	Women receiving continuity when from BAEM backgrounds and social disadvantage have positive outcomes.
HUNTER, B. et al., 2018.	On-line survey	1997 midwives	UK	Concern is raised about the midwifery workforce and workplace environment impacting on health and wellbeing of midwives	Stress, burnout, depression, and anxiety were high among midwives when there were perceived low levels of managerial support.
McCOURT. C. and STEVENS T., 2006.	Large-scale, long term multi perspective evaluation	40 women and 36 caseload midwives interviewed, questionnaires, observation	UK	By not defining the nature and meaning of caseload midwifery, the impact of different models is difficult to interpret.	Continuity of midwifery care is an important means towards achieving women centered care, autonomy and environment.
McGUIRE, C. et al., 2016.	Qualitative exploratory study	21 staff with interview experience	UK	Ensuring appropriate selection of NMAHP candidates enables quality patient care	Values and competency-based interview methods could improve candidate selection.
NEWTON, M. et al., 2014.	Longitudinal survey	163 standard care midwives, 42 caseload midwives	Australia	Considering the impact of providing caseload care on midwives in comparison to standard care provision midwives	Caseload midwives reported lower burnout scores and higher professional satisfaction.
PATTERSON, J., HOLLINS MARTIN, C.J. and KARATZIAS T., 2019.	Interpretive phenomenological analysis	6 midwives and 6 women	UK	To investigate how women and midwives feel during their interactions and what this means to them	Failing to recognise and meet the human needs of both women and midwives, results in poor quality interactions from midwives and poor perception of care provider interaction by women; The quality of relationship is central to positive interactions
RAWNSON, S., 2011.	Longitudinal narrative	Six women	UK	Exploring women's experiences of having a student midwife caseloading during their maternity care	Women highly valued having student consistent contribution during their care.
SANDALL, J. et al 2016.	Cochrane review	17,674 women (15 trials)	Australia, Canada, Ireland UK	To compare midwife led models of care with traditional models	Women were less likely to experience intervention and their babies more likely to be born alive at term.
SIMS, H.P., FARAJ, S. and YUN, S., 2009.	Ethnographic observation and interviews	Trauma centre doctors	USA	Investigation of leadership within different clinical situations	Leaders consider clinical situation to guide leadership style
TAYLOR, B. et al., 2019.	Survey	798 midwives	UK early adopter sites	Exploring the working patterns of providing caseload midwifery that are acceptable to midwives.	Many midwives in the UK report not being willing or able to work in patterns that provide continuity for women.
WALSH, D., 2007.	Ethnographic study	Birth centre midwives	UK	Examining the birth process within a free-standing birth-centre	By creating environmental space alternative discourse and clinical practice occurs.

WALSH, D. et al., 2020.	Case studies	6 NHS trusts	UK	Examining the factors influencing Midwifery unit use.	There are barriers to MU use. Including lack of leadership to drive through change.
WIEGERS, T. A., 2009.	Survey	1248 pregnant women	Netherlands	Investigating the quality of care received by women throughout their care as evaluated through the consumer quality index tool	Women who know their midwife rate their care s higher quality.
WUTZKE, S., BENTON, M. & VERMA R. 2016	Qualitative methods	17 health service managers	Australia	Innovation at scale within healthcare is difficult	Careful planning and implementation that include the tangible and less tangible aspects of change encourage sustainability.

Table 1: Empirical Research articles

2.2 Midwifery management and MCoCer

In midwifery there is a duty to provide evidence-based care (NMC 2018). Due to new practices being introduced and revised, the process of evolutionary change is part of health provision. The transformational change that is referred to in Better Births (NHS England 2016) and Best Start (The Scottish Government 2017) requires a systems change due to the demands of the MCoCer models being different to the traditional model that has been in place in the NHS. Change agents are a vital part of any change and the Royal College of Midwives (RCM) have spent 2019 focused on leadership, acknowledging that within the UK and NHS there has been an identified gap within midwifery of those attributes that improve quality and services through leadership (RCM 2019). The call for more consultant midwives by the RCM in 2019 was a direct response to the lack of midwifery leadership that is currently available throughout the UK for maternity systems to be enhanced and directed (RCM 2019).

The Sheila Kitzinger symposium (Sandall et al 2015) identified that in order to initiate MCoCer models successfully, effective planning, project management, communication, collaboration and teamwork were required. They stated that only by having useful tools in place, and a clear implementation strategy, staff will be able to develop and have organisational ownership of the model. They contend that effective change leaders should lead the proposed implementation which must meet the identified need and be consistent with the organisation and stakeholders' aims. However, these 'effective change leaders' need to have the skills and knowledge and support. They reiterate that monitoring, evaluation and feedback should be built into the models, with incentives, flexibility, and autonomy for those working in the model. They encourage a standardisation, whilst enabling the implementation

to be tailored to the local context. This all requires the necessary human and financial resources including time (Braithwaite 2018). It is imperative that change within maternity care systems are sustainable and efficient in their use of resources therefore acceptable to midwives allowing successful recruitment and retention to the workforce to occur. For example, control of caseload size, working hours and self-management are key organisational principles recognised as important to successful change. However, without a manager who is aware of the needs of the midwives and recruiting for the necessary philosophy and skills the implementation of the model may be in jeopardy.

2.3 Frameworks of management and leadership in change

There are several frameworks suggested within healthcare to enable effective change to occur (Shaw et al 2010). NHS England revised a 2012 change model in 2018 (See figure 1) to be used throughout the service to provide a means for coordinating change. Martin et al (2013) investigated this model by interviewing front line staff within NHS England to see whether the change model was fit for purpose in a healthcare setting. They acknowledged that improvement methodologies such as Plan- Do- Study-Act (PDSA) can be effective on a local level but can fail to follow through on the broader need to share effective change. By interviewing self-selecting users of the model, they reported generally positive findings. The participants reported the model helped them to take a more considered and comprehensive approach to planning their work; however, they were more likely to perceive the 'work as being done' by following the model rather than using the model to aid with the change. Participants were also inclined to avoid the more challenging aspects of the model and therefore not engage with some of the necessary work that was required to embed the change. Martin et al (2013) acknowledge that there is a particular role for senior managers to protect those using the model from the external pressures that will impede the model from being used in its iterative format that it was designed for. There was, however, no consideration within this study to the attributes required by the

change agents or leaders to enable the model to be effective in its practical application.



Figure 1: NHS Change Model 2018

The Scottish improvement journey: a nationwide approach to improvement (see figure 2) was launched by the Scottish government in 2018. It also focuses on large scale change and collaboration whilst encompassing innovation, creativity, design, implementation, and systems change.

The Scottish Improvement Journey

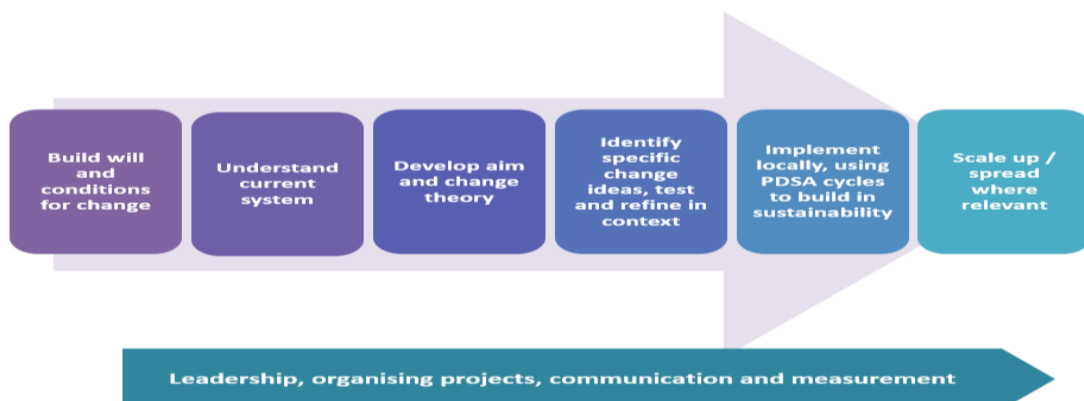


Figure 2: The Scottish Government (2018): The Scottish improvement journey: a nationwide approach to improvement

Once again there appears to be no literature to assess how this model has been used, yet despite this I have witnessed how in Scotland it is being

encouraged as a working model in practice. There is an acknowledgement within Scotland that a framework for management is necessary with the development of the 'leadership and management framework'. This clearly plans for skills and attributes to be gained within the NHS to enable managers to lead (See figure 3).

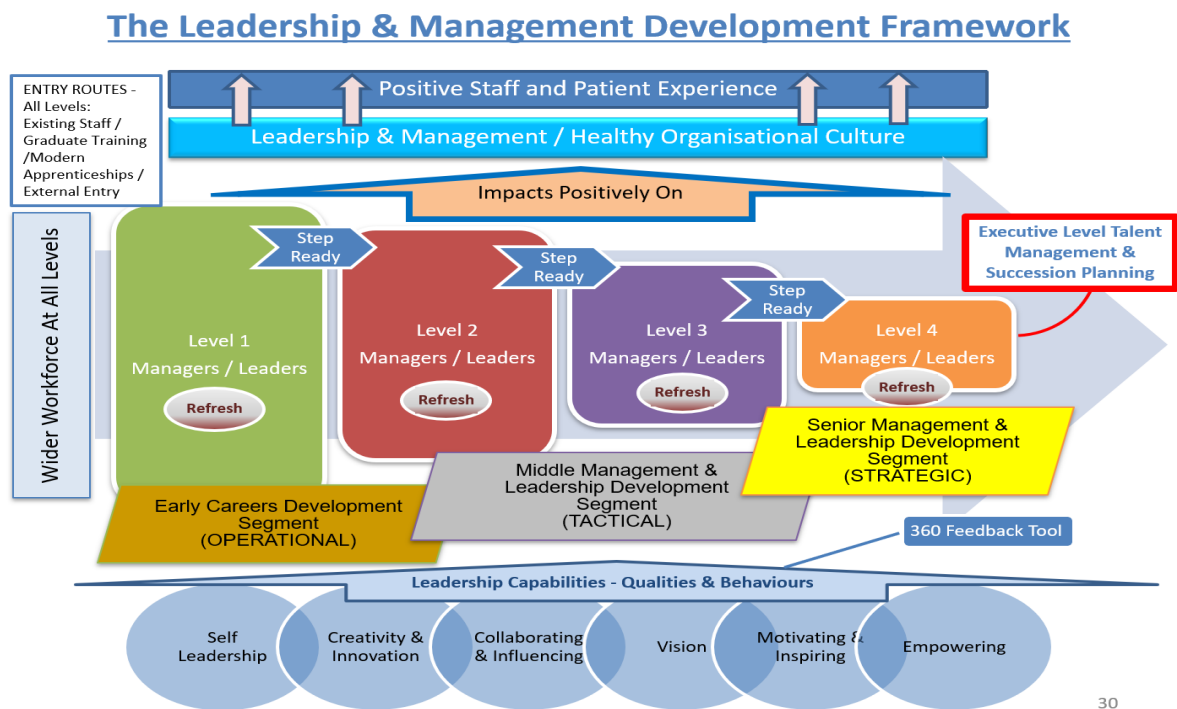


Figure 3: The Scottish Government (2018): The leadership and management development framework

By recognising that there are a variety of models that are being used within the NHS to enable a change in practice to occur, the maternity services have the theoretical resources to draw on to encourage systems change. However, there doesn't appear to be evidence from the Better Births (NHS England 2016) and Best Start (The Scottish Government 2017) documents that these frameworks are being used alongside the policy documents to embed the change in maternity care systems. There also does not appear to be evidence within the frameworks as to how the skills and attributes of the leaders will be recognised as achieved.

2.4 Styles of leadership

McCourt and Stevens (2006) suggest that MCoCer can align midwives primarily with women rather than with an organisation. Therefore, it is anticipated by Homer et al (2019) that a change in thinking and in style of midwifery management is required to effectively manage midwives within a MCoCer model. There are a variety of leadership styles and Homer et al (2019) single out the two most useful styles for midwifery as transformational and transactional.

2.4.1 Transformational Leadership

Hewitt, Priddis and Dahlen (2019) discuss the attributes required by midwifery managers to effectively manage a midwifery group practice. This study was conducted with 8 leaders of midwifery in Australia where the system of care is more varied than in the UK due to the private medical system; however, the findings of the study in terms of actions and attributes can be seen as applicable due to the human qualities of having to manage midwives in models of care being similar irrespective of geographical boundaries. They conclude that transformational leadership qualities with the vision to lead the practice into the future is key. They identify that having the capacity to stand up for midwives and women as an essential attribute that the managers require in order to effectively manage MCoCer. They also suggest that there needs to be effort and discussion around how midwifery managers are educated and supported for this role in order to make MCoCer a sustainable option for the future of maternity services.

Brintworth and Sandall (2013), found that effective change management and support for a positive midwifery culture resulted from an entrepreneurial style of leadership. This style is closely related to transformational leadership.

Renko et al (2012) defines it as encouraging the recognising and exploiting of entrepreneurial opportunities within the organisation. Brintworth and Sandall (2013), a mixed methods study investigating why an inner-city NHS trust had a high homebirth rate, used thematic analysis of semi-structured interviews alongside quantitative analysis of home birth numbers to consider why a homebirth rate was so high in comparison to other trusts in the NHS. They conclude that the support of the Head of midwifery towards woman centred

care and midwifery practice enabled a culture where initiatives could flourish. This has been confirmed in a classic grounded theory study by Breckenridge et al (2019). Breckenridge et al (2019) interviewed 42 health service providers on what sustains change in healthcare. Support from the leaders and managers of the organisation was found to be the critical element for initiation and sustainability of change.

Transformational and entrepreneurial leadership is described by Sims, Faraj and Yun (2009) as ones where the leaders provide motivation to invigorate others to pursue the teams vision. The co-creation of team 'vision' creates a feeling within the members of the team of being valued (Breckenridge et al 2019), this in turn enhances the relationship between the leader and the members of the team. The joint ownership of the vision encourages the team to move towards achieving the vision and increases morale (Giltinane 2013). This empowering of the team by the leader (or role modelling) encourages the team members to develop their own leadership skills and produces increased loyalty towards the organisation, motivation and higher job satisfaction leading to reduced sickness rates and a more positive working environment (Rolfe 2011).

Transformative leaders tend to adopt a democratic approach to leadership (Giltinane 2013). This is explained by Bass (2008) as a situation where workers will seek autonomy and situations to prove themselves and where leaders believe workers are motivated to do well. Whitehead, Weiss and Tappen (2009) suggest that democratic leaders such as transformative leaders, have less control than autocratic leaders because they provide guidance to their followers rather than controlling them. This style of asking questions rather than issuing orders can work well if the followers have adequate skills and knowledge and work well as a team together (Marriner Tomey 2009). Within MCoCer this could be a challenge, as Crowther et al (2017) comment there is a current issue around skill mix and MCoCer models. They suggest that the current lack of the necessary skills within the midwifery profession to practice within MCoCer models, may result in a lack of capacity within the leadership to steer the change. Transformative leaders are consultative, flexible and usually increase motivation and creativity (Whitehead, Weiss and Tappen 2009). However, effective transformational

leadership requires trust between the leader and the followers to enable the followers to do whatever the leader envisions (Giltinane 2013, Ellis 2019). Grimm (2010) suggests that this trust is important as transformational leadership is a style used during change and by using personal qualities of honesty, positivity for their working environment and capacity to listen to others, these leaders are more likely to successfully lead a team through change (Bach and Ellis 2011). Giltinane (2013) suggests for the ever-changing NHS that situational leadership styles are more relevant. This allows for leaders to adopt whichever style is appropriate for individual situations. This resonates with Homer et al (2019) who suggest that being capable of moving between styles is an important element of midwifery management in MCoCer models.

2.4.2 Transactional Leadership

Transactional leadership is a task centred behavioural approach that is recognised by midwives as a common approach to management within the NHS (Ralston 2005). Rather than using motivation as in transformational leadership, these leaders will readily use rewards or sanction to ensure work and change is completed. The followers in this style of leadership are not expected to think innovatively. This style is found where there is adherence to practice standards but not necessarily openness to innovation, thus acceptance of innovation by followers in transactional leadership would be through reward and reinforcement.

Byrom and Downe (2010) describe transactional leadership as 'command and control' in their phenomenological study regarding the qualities that make 'good' midwives and leaders and managers. Through interviewing NHS midwives, and subsequent thematic analysis they conclude that emotional intelligence is the fundamental key to leadership skills which are necessary for developing relationships. Although not considering managers within a relational model of care it is interesting to consider what in general is portrayed as a 'good' leader within midwifery. As with Hunter (2004) and Homer et al (2019) the ability to lead with emotional intelligence appears to be a key component to successful midwifery management. There appears to be a dichotomy if using transactional leadership whilst attempting to motivate for change through emotional intelligence and develop relationships.

2.4.3 Renaissance midwifery management

Aarons et al (2007) studied mental health workers attitudes towards implementing evidence-based practice in relation to the leadership style of their supervisors. Through analysing survey data from over 300 respondents they identified that those employees with a transformational leader were less likely to perceive a gap between their current practices and evidence-based practice. They also correlated positive attributes of transactional leadership style with adoption of evidence-based practice. They exposed a correlation between feeling positive about the leadership style and being more open to adopting evidence-based practice. Unfortunately, this study did not assess actual uptake of evidence -based practice. Homer et al (2019) suggest that a different type of manager is required; a mix of transformational and transactional leadership is required to lead through change towards MCoCer and name it 'Renaissance midwifery management' where the managers are 'knowledgeable, educated or proficient in a wide range of fields' and are able to understand the importance of how relationships assist in identifying and addressing the needs of both women and midwives (Brodie 2013). Homer et al (2019) identify that such a manager needs to have a broad skill base and be able to draw on different theories and experiences in order to have the philosophy that is most likely to create sustainability in the model.

2.5 Leading and sustaining change within the NHS

2.5.1 Values-based leadership

Homer et al (2019) suggest that leaders within midwifery need to have the values that will overarch the philosophy required by the MCoCer model in order to sustain it. Values based recruitment is currently being practiced by Higher Educational Institutions in England but not yet in Scotland (McGuire et al 2016). Callwood, Cooke and Allan (2016) investigated values-based recruitment in midwifery and whether it aligned with what women say is important for them. In their discussion paper they align what women say they want from their midwife to whether professional recruitment documentation and government policy documentation for midwifery policy

encompasses those values. By reviewing the definitions for values-based recruitment and values in healthcare the authors show that women want a 'sustainable emotional' element to their relationships with midwives. They found a lack of connect between what women want and the recruitment of midwives to midwifery roles. They also identify that there was no dimension for this emotional component of values and values -based recruitment within professional and government policy. They acknowledge that the midwife-mother relationship features an emotional dimension which is hard to define and therefore difficult to incorporate into a recruitment framework. This has been further explored by Bevan and Fairman (2018) in social care and the impact that recruiting through values has on the workforce and quality of care provided. They argue that by connecting through values, a strong base is built for collective action for change. This can be identified through Bevan's work with NHS Horizons where there is a collective aim in moving the NHS towards a values-based organisation capable of imbedding transformational change. There is a question around MCoCer where this values-base appears to be implied through a change in organisational practice rather than an explicit goal in itself and therefore being actively recruited for.

2.5.2 Sustaining Change

There are different models of MCoCer in existence and being trialled to evidence effectiveness (Donnolley et al. 2016). The Scottish Government (2017) has recommended a caseloading model within 'The Best Start'. This model is based on women being assigned to a midwife at the beginning of her pregnancy and having her care from either that midwife or her 'buddy' midwife throughout her care. Caseloading practice is the gold standard of care, promoting autonomy and empowerment for women and midwives (Homer et al. 2017; Wieggers 2009). However, the demand for availability from the midwife within the caseload model has decreased its appeal to midwives, managers and within the NHS (Taylor et al 2019). A paucity of structured evaluation has created a knowledge gap within the midwifery community as to which model to use to achieve the benefits for women and midwives reported by Sandall et al (2016) yet are acceptable for more midwives within the NHS (Taylor et al 2019; Newton et al. 2014).

Dixon et al (2017) investigated through surveys the psychological wellbeing of midwives in New Zealand. The midwives in this study worked in New Zealand where there is a choice to work out-with the employed healthcare system and carry a caseload as a self-employed midwife. They concluded that midwives that were employed showed significantly higher levels of work and personal related burnout and anxiety. They did not discuss whether this was due to the work that the midwives were doing in the employed section or whether it was due to being employed and possibly being constrained by the system that was causing the negative psychological outcomes. They state that self-employed midwives carrying a caseload is the system that is most sustainable for midwives in New Zealand when considering psychological welfare. This organisational choice is not readily available to most midwives in the UK due to the problems and expense of securing indemnity insurance (NMC 2018). Therefore, it is difficult to know whether the mind-set of the New Zealand midwives is different due to the social and cultural differences they experience or their capacity to contract in to the medical system and therefore take control of their working environment- a situation vastly different, and therefore difficult for UK midwives to achieve. What is evident is that there is a need for midwives to desire practicing within a MCoCer model which is an essential requirement for any change in practice to occur within the UK's NHS.

Donald (2012), a caseloading midwife herself in New Zealand investigated through cooperative inquiry how to achieve a self-sustainability whilst carrying a caseload as a midwife. She along with 15 other midwives developed a structure that enabled a sharing of experience and ultimately an understanding of how being a caseload midwife could be sustainable for them as women. By acknowledging the underlying feelings that they had of 'having' to be there no matter what for the woman in labour, they were able to develop a community of midwives that they could work with and keep themselves safe in practice. Again this study was based in New Zealand so for UK midwives important to learn that developing networks of midwives to share experiences and practice with is vital for self- sustaining in caseload practice; however, the autonomy that the New Zealand midwives are able to achieve by being self-employed is not currently so available for NHS

midwives. However, the emphasis that Donald (2012) placed on the importance of sharing the workload between midwives in order to make the model sustainable for the midwife is an important element for NHS models to consider. Considering the inter-relationships within the midwives who make up the team, may contribute and provide a basis for, successful sustainability of MCoCer models.

Within the UK Waltham Forest Clinical Commissioning Group (CCG) a policy of 'choice and personalisation' was brought into practice by commissioning the Neighbourhood Midwives to encourage midwifery care where women felt that they were in control of their maternity care (Hankins and Brintworth 2019). Although reporting positive outcomes for women and their care, they closed in January 2019 reporting problems with future funding and commissioning. The Neighbourhood midwives worked as a social enterprise providing care for women in the NHS but were not employed by the NHS. As evidence abounds from the Albany midwifery practice (Homer et al 2017), enterprises set up by midwives who are exploring alternative routes for midwives in the UK to provide care for women in the NHS by contracting into it rather than being directly employed by it, have been thwarted by finances or lack of willing support to invest in providing alternatives in care from commissioning groups to sustain them within the NHS (Wiseman and Holland 2018). Whether this is due to the ingrained social processes within the NHS being unable to tolerate autonomous midwifery practice and the fear of loss of control of those within the institution or a deliberate desire to fracture innovative midwifery care provision remains unknown. There appears to be a recurrent problem of long-term sustainability for models innovating out with the NHS maternity system.

Forster et al (2011) applied the Normalisation Process model to evaluate new models of care within the maternity system of Australia. Due to a significant reason being cited in the literature for failures of MCoCer being midwife dissatisfaction (Brodie 2002), Forster et al (2011) considered why although evidence based, not all practice is implemented or sustained. By understanding the factors that contribute to the legitimacy of an intervention, the use of the normalisation process model enabled an insight into the likelihood that the intervention would be sustainable. By applying the theory

to one randomised controlled trial and not to another, they conclude that organisations would benefit from using a theoretical model to integrate change into practice; however, it does not replace the organisational requirement to create space for the change to occur. This organisational requirement 'to create space' is poorly defined in how this is enacted and by whom.

Thus, it has been explored that sustainability of caseload holding models of care as recommended by Best Start (The Scottish Government 2017) and Better Births (NHS England 2016) in a changing landscape of healthcare could be enhanced by using theoretical models; however, the ability to investigate how the work is enacted by individuals, how it is understood by the staff, and whether they have the skill set to integrate the change may be a predictor to how sustainable the change in organisational practice will be. It can be inferred that any space for change to occur sustainably requires enabling leadership and management that generates a supportive organisational culture.

2.6 NHS Culture and the implementation of change

2.6.1 Leadership and organisational culture

Evidence abounds that the leadership of an organisation will dictate the culture within the organisation (West et al 2014). This is no different in health care where the culture is seen as a key determinant in both how the maternity care system operates, and the quality of care provided (Mannion and Davies 2018).

"The most important determinant of the development and maintenance of an organisation's culture is current and future leadership. Every interaction by every leader at every level shapes the emerging culture of an organisation" (West et al 2014, P4).

The Francis Report (2013) recommended a fundamental culture change in order to improve the quality and safety of care, thus directly linking the organisational culture in the maternity services with the performance of the organisation. The performance of the maternity system is frequently used as

a marker to measure the quality of the system as a whole (de Vries et al 2001). Therefore, midwifery practice and maternity systems leadership play an important part in rating the quality of care within the NHS.

Walsh (2006) argues in his ethnographic study of an NHS free-standing birth centre, that organisational arrangements that pressurise midwives prevent them practising good midwifery care. Unfortunately, after a further 13 years, Walsh et al (2020) have found that access to freestanding midwifery units is unsupported by midwifery leaders and therefore in decline. They claim that 'production line' orthodoxies promoted a form of maternity assembly line in hospitals where women are 'processed' rather than cared for. In contrast care was less process driven in midwifery led units (MLU's) and more woman centred. This led to more relational focused care and having less bureaucracy which enabled the flourishing of entrepreneurial activity. However, Deery and Hughes (2004) claim through their Action research study, using a variety of data gathering methods, in a midwife-led maternity unit in the NHS, that by integrating midwifery practice into a MLU the skills of the midwives were expanded. They also found when a cultural shift was required, that a concept of midwife-led care that was adopted by the midwives, was able to be shared more effectively in the MLU culture. Thus, involving the midwives in the cultural change and emphasizing collaboration and participation was necessary. They did find that the values and practices of the individual midwife is more congruent with the quality of care received than the culture of practice. Gifford, Zammuto and Goodman (2002) examined organisational cultures for obstetric nurses in an American context and found that a 'human relations model' (a form of organisational culture that focuses on group cohesion, aims to build trust and is characterised by openness and honesty) had a positive correlation with increased job satisfaction, lower staff turnover and feelings of empowerment within staff. Gifford, Zammuto and Goodman (2002) recommend that for a culture to embrace a woman centred philosophy there needs to be an improvement on inter-professional communication and understanding; reinforcing the skill base of midwives (eg- active birth workshops); changing the organisation of routines to give time for midwives to be 'with woman'; and involving midwives in strategic planning. Organisational barriers to this philosophy of care were identified as:

a culture of busyness and lack of time; a dominant medical model of birth; interprofessional conflicts and organisational priorities taking precedence over supporting women. The importance of organisational factors on empowering midwifery care are evident.

The RCM launched their 'Caring for You' campaign in 2016 and through survey data identified that one third of midwives' report harassment, bullying or abuse from a manager. Midwives repeatedly report a culture of intimidation and bullying at work (RCM 2019). An institutionalised culture of bullying cannot lead to choice and control for women within a MCoCer model. In the scoping review conducted by Frith et al (2014) the 14 research studies identifying organisational cultures within maternity care, all the studies had explored the cultures through a lens of midwives and none had analysed the perspectives of the managers and leadership within the system in order to encompass the whole system. Thus, there appears to be a weakness within the studies in recognising that within maternity care cultures, leadership should be examined and researched when considering culture and quality of care provision.

2.6.2 Organisational culture and its impact on care

Women and midwives suffer when involved in poor quality interactions (Patterson, Hollins Martin and Karatzias 2019). By investigating the interactions between midwives and women in relation to the woman's perceptions of the midwives' verbal and non-verbal communications, there is a significant association with post-traumatic stress disorder- post childbirth (PTSD-PC). Through interviewing 6 women who had suffered PTSD-PC and 6 midwives who provided intrapartum care, they were able to understand how women and midwives experience interactions through care provision. They only analysed intrapartum care and not over the continuum of care; however, when considering the birth as the traumatic event then it could be reasonable to exclude other points of care. They identified that when women and midwives' human needs are not met, the result is poor quality interactions from midwives and poor perception of care provider interaction by women. They also identified that the women and midwives both indicated that the quality of their relationships were central to positive interactions. One of their recommendations from the research is to challenge the toxic cultures that

currently persist in the maternity services system which undermine the work of midwives and consequently the experience of women being cared for in the NHS. Kirkham (1999) identified 20 years ago that the NHS culture for midwives was one where professional voices were muted in a culture of low morale with the expectation of oppression. She states that empowering women can only happen within a culture of empowerment for midwives and that change can only happen within the maternity structures of the NHS if support is given to those who find security from the existing culture. Improving NHS working environments for midwives to optimise their quality of interaction with women is a necessary reality in the current NHS.

When considering the impact that leadership can effect on NHS culture, it has been suggested by Bannon, Allerdice and McNeill (2017) when reviewing midwifery leadership, that gender, the midwifery profession, organisational changes within the provision of maternity services and management structures within the NHS all impact on the provision of high-quality midwifery management. They argue alongside most feminist literature that until society recognises women as equal to men then management development for women has been and will remain unequal, with men accessing more management opportunities (Miller and Clark 2008). The societal gender roles developing from Aristotle's theory that women were inferior to men has been explained by de Beauvoir (1949) to result in men having the power and women being encapsulated in their inferior status as reproducers- a biological determinate discourse that strips women of autonomy and empowerment in the public world. It is suggested that due to the high proportion of midwives being women, caring for women, that this societal expectation could explain why midwives face barriers to participating in management roles within the maternity services (Donnison 1988; Walsh 2006). This aspect of gender has also been suggested by Donnison (1988) as an explanation for the demise of autonomous practice within midwifery as doctors have been historically been more male and midwives female. Midwives report the reality of becoming managers is stressful due to the long hours, unsustainable workload demands and the lack of support to undertake managerial roles (Buchanan et al 2013). Therefore, by investigating how midwifery leaders can influence the practices and cultures within the NHS

maternity services, quality of care for women is potentially influenced and ultimately improved.

2.7 MCoCer models and their impact

Not all NHS maternity services provide MCoCer models. The institutional decisions and philosophy of the institution impacts on midwifery care in the NHS (Henshall, Taylor and Kenyon 2016). In Henshall, Taylor and Kenyon's (2016) systematic review of what information midwives provided for place of birth conversations with women, organisational pressures and professional norms alongside the influence of colleagues resulted in evidence not being given in an unbiased and rational way in order for women to be able to make an informed choice. By midwives denying women an informed decision-making process in order to satisfy the organisational philosophy an impact of poor-quality practice is initiated from the start of the relationship. Where MCoCer models do exist, there are reports of midwives not being supported in their capacity to provide relational care (Newton, McLachlan and Forster, 2016; Sandall 1997). When institutions remain 'institution focused' rather than 'woman focused' it impacts on the autonomy and ability of the midwives to care for the women in their care (Browne et al. 2014; Edmondson and Walker 2014; McCourt and Stevens 2006; Engel 2003). Newton, McLachlan and Forster (2016) report a dissonance between the needs for autonomy for the midwives working in the MCoCer model in Australia and the reality of how the midwives report workplace behaviours. They conducted a survey that spanned 2 years comparing MCoCer midwives with those providing standard care; the MCoCer midwives reported feeling higher levels of professional satisfaction and support and lower scores for personal and work-related burnout. Several studies report challenges in the reality of integrating autonomous midwifery that is woman focused and can lead to unconventional choices when compared to medicalised acceptance of parameters (Newton McLachlan and Forster 2016; Beake et al. 2013; Rawnsion 2011; Engel 2003). Therefore, the need for alignment between the values of the organisation based on supporting autonomous midwifery.

Dawson et al (2016) surveyed Australian midwifery managers about the prevalence of caseload midwifery within the public maternity system and the factor associated with its implementation and sustainability. With a 63% response rate they were able to identify that around 8% of women within the units responded were accessing caseload midwifery care. The midwifery managers stated that the factors that were influencing the implementation of the models were funding and an interest from staff to work in the model. None of the reflection from the managers was about their skills or philosophy around whether they had a belief of supporting the model and there doesn't appear to be within the survey any questions concerning the midwifery manager's personal ability to deliver on a transformational change project. This survey concludes that funding and support are the main barriers to implementing new models of care; however, they consider the support from midwifery staff not the managerial staff is the barrier. Thus, unless the questions are acknowledged and then asked of the midwifery managers we cannot determine where the fundamental barriers and facilitators to implementation and sustainability of MCoCer lie.

2.8 Personal reflection in the application of change theories

When investigating the views of managers in change there was no research found pertaining to midwifery managers. There is however, research interviewing other healthcare professionals in their views and experiences of implementing and sustaining change. Wutzke, Benton and Verma (2016) interviewed 17 experienced health care managers based in Australia, focusing on what enables and inhibits the wider application of innovations to improve health service delivery. Through semi-structured interviews they identified four main themes that underpinned the successful and sustainable implementation of innovative health initiatives: A sound 'case for change'; Good preparation for change and how to adapt it to different contexts; Good engagement of clinicians, administrators and others; Good support provided through the implementation phase, including having the right people, strategies and structures in place to coordinate implementation across the system. Clinicians real-world experience and insights from practice are essential additions to the knowledge generated through theories and

academic research. This information is necessary to add to the case for change within MCoCer models and to ease the transition within the NHS towards a system where MCoCer models are integrated.

2.9 Summary

This chapter has revealed that midwifery managers role within MCoCer implementation and sustaining within the NHS is complex and relevant within the climate of transitional change currently happening in the UK. There is motivation within the NHS quality improvement and leadership programmes to sustain transformational change in accordance with evidence-based practice and guidelines. However, implementing service change and sustaining it is complex and inconsistent when considering behaviour change. This is particularly evident within the context of MCoCer models.

Quality of service provision is viewed as a crucial aspect to midwife-woman relationships and encounters and is known to happen more readily within a meaningful relationship, but there is no consensus in how to best support this and how to implement sustainable relational based models of care. MCoCer needs to be delivered in a flexible format to suit a range of individual needs and preferences. It has been argued in the literature that MCoCer models require a leadership style that is skilful and experienced to avoid a detrimental impact of transformational change on an already beleaguered and stretched NHS midwifery service.

There is limited literature on the views and experiences of midwifery managers of MCoCer and a knowledge gap is particularly evident. The research described in this thesis therefore aligns with Sandall et al's (2016) recommendation that further research is required to examine how MCoCer models can sustainably be implemented within the NHS. It is also clear that improvement in the quality of midwifery management is required. This study aimed to address the gap and to understand what factors may enhance and hinder the implementation and sustainability of MCoCer models from a managerial leadership perspective.

MCoCer models have been encouraged due to their known benefits for women, their babies and midwives; however, in a review of the literature no

acknowledgement of the impact of the midwifery manager's skills and attributes have been found. There was a need to find out from experienced managers what lessons have been learned from implementing sustainable MCoCer models and what information could help less experienced midwifery managers meet the needs of a MCoCer provision. Hence this research was to create a theoretical framework from the experiences of midwifery managers to inform and support the implementation and sustainability of MCoCer models. To achieve this aim, a constructivist grounded theory approach was adopted.

Chapter 3 Methodology and Research design

This chapter explains and justifies the methodology and research design of the study. The first section focuses on the choice of methodology and presents the underpinning conceptual notions that inform the study. The justification for using a qualitative methodology and the rationale for choosing a constructivist grounded theory methodology in relation to other options begins this section. The development of grounded theory and the two philosophical positions that underpin it- pragmatism and symbolic interactionism are then discussed. This is followed by a survey of the central tenets of achieving trustworthiness in this genre of research and a short conclusion. The second section describes and presents examples of the research design, it describes the method of data collection and analytical approach taken. How the data was analysed, and theory generated is then presented. The chapter concludes with a summary.

Methodology

3.1 Justification for using a qualitative methodology

A qualitative methodology was chosen at the very inception of the study. Until now there have been very few midwives providing continuity of carer and therefore even fewer midwifery managers with MCoCer experience (Hewitt, Priddis and Dahlen 2019). Hall, McKenna and Griffiths (2012) claim that grounded theory is of particular use when little is known about the area of interest. The aim for this study was to develop an understanding that was practical and pragmatic whilst being grounded in the social processes identified by key participants. Whilst reflecting with supervisors we agreed that the new knowledge should be gained through a creative and inductive process as little was known about the processes that were driving the midwifery managers who were implementing and sustaining MCoCer models. Quantitative methods would have obtained a different data set that was objective and measured; however, I wanted to understand this social context

by obtaining rich meaningful data which necessitated conducting in-depth interviews with purposively selected participants.

This study started with an open question being asked based on social processes:

“What are the views and experiences of midwifery managers implementing and sustaining midwifery continuity of carer models within the UK maternity system?”

Accordingly, I sought to learn from the participants of the study how they impacted on the implementation and sustainability of MCoCer models and how they made sense of their leadership/management role. I wanted to answer a practical social problem: How do midwifery managers impact on the availability of MCoCer models within the NHS?

The practical application of developing a useful theoretical framework from the study to provide an insight for midwifery managers on how to support and enhance MCoCer models was a desired outcome. This encouraged the use of grounded theory due to it overtly focusing on social processes thus enabling the building of an explanatory theory that could inform a pragmatic and useful theoretical framework. I employed grounded theory as it:

“seeks to generate a theory which relates to a particular situation forming the focus of the study” (Robson 2011, p146).

As discussed later in the chapter, phenomenology, qualitative enquiry and ethnography could all have been applied to the research area in order to uncover experiences and elucidate findings; however, the desire to develop a theory that was useful for the midwifery workforce in the future was a driving impetus for the research and therefore the starting point for the methodological decision making.

3.2 Constructivist Grounded Theory

The grounded theory methodology used in this study is based on the writing of Charmaz (2014). Charmaz emphasised participants implicit meanings and researcher’s’ constructions of reality (Charmaz 2014). Educated at the

Chicago school under Strauss, Charmaz developed a grounded theory where she argued that any new knowledge should consider and account for the social context and social worlds in which it is constructed. She used the term 'constructivist',

"to acknowledge subjectivity and the researcher's involvement in the construction and interpretation of data" (Charmaz 2014, p.13).

This foundational assumption treats research as a construction and acknowledges that it occurs under specific conditions- which the researcher may not be aware of or of their choosing. As a midwife as well as a researcher studying midwifery managers, it is appropriate that I am aware of my involvement, my presuppositions and place within the profession, my experiences and thus my interpretation in order to place the research in context. I cannot claim to be a neutral observer thus constructivist grounded theory resonated with the research questions being asked and the methods being used to collect data.

3.3 Development of Grounded theory

Grounded theory was developed and published as a sociological methodology by Glaser, a social researcher with a background in positivism and Strauss- a researcher with a background in symbolic interactionism in 1967. It developed into a program of methodological work that extended over several decades (eg Glaser and Strauss 1967; Strauss 1970; Strauss and Corbin 1998; Glaser and Holton 2004). Glaser and Strauss' (1967) book 'The discovery of grounded theory' articulated the methodology and the method that they developed and used in order to generate, as well as verify theory from social research. They moved away from the dominant culture of quantitative research methods in the social sciences. They argued that the principle deductive approaches that were dominant at the time were about testing 'grand theory' (Glaser and Strauss 1967, p.vii) which were often based on deductive assumptions. They argued for a different approach- an inductive one-where theory was generated from the data. They combined the positivism of Glaser's former work and social interactionism from Strauss's work. By combining the methods of codifying qualitative data whilst giving

precedence to the meaning, subjectivity and interaction, the new approach was developed.

The idea that theory emerges from data is central to classical grounded theory. It was seen to be crucial with this approach that the researcher remained objective whilst collecting and analysing data (Glaser and Strauss 1967). The research process should not be influenced by the researcher's beliefs: hence the suggestion that literature is ignored until the emergence of categories from the data so as to not contaminate the concepts by the researchers own personal beliefs. They considered that although coding for a category could lead to confusion, this is where memos should be written to allow the researcher some reflection and allow thinking to reach its most logical conclusions. The result from the process was the identification of categories. This informed another vital element of their approach, which they called theoretical sampling. This is where the researcher decides what data to collect next after analysing the previous data in order to generate a theory. Ultimately theoretical saturation is reached by the researcher, a point where there is enough data to generate a formal theory. The examples in section two outline how this process was applied in this study.

Since the publication of Glaser and Strauss' (1967) seminal text there have been interpretations which include constructivist grounded theory (Charmaz 2014). The original authors themselves have also devised variations due to differing perspectives on analysis (Charmaz 2014, Birks and Mills 2011) and working with other researchers. Strauss and Corbin (1998) argued that the researcher could develop categories prior to analysis of the data, this proved controversial for Glaser; however, the new approach of coding continues to be one of the most popular versions of grounded theory (Stern 1980, Morse et al 2009). However, despite the differing interpretations and methodological developments the underlying basis of the methodology remain, and include, but are not limited to, coding and categorisation of data, concurrent data generation, memo writing, theoretical sampling, constant comparative analysis and theoretical integration (Glaser and Strauss 1967, Charmaz 2014).

3.4 Constructionism, pragmatism, symbolic interactionism and grounded theory

In this section I identify the key sociological ideas and assumptions that underpin Charmaz's (2014) constructivist grounded theory methodology. I consider the possibilities and limitations of grounded theory alongside the alternative approaches that were considered as a methodology prior to commencing the study.

Constructionism

Constructionism is the belief that truth and meaning do not exist in an external world but are created by the subject's interactions with the world (Mays and Pope 1995). Meaning is constructed not discovered, so subjects construct their own meaning in different ways (Kuper, Reeves and Levinson 2008). Therefore, multiple contradictory but equally valid accounts of the world can exist (Charmaz 2014). This epistemology or philosophical underpinning of constructionism developed from the social scientists Max Weber (1864-1920), George Herbert Mead (1863-1931) and Herbert Blumer (1900-1987) whose ideas were all particularly influential in shaping the emergence of grounded theory from the Chicago School of Sociology in the 1960s. Constructionism challenges the objectivist stance found in positivist epistemologies on the creation of new knowledge (Crotty 1998). This contrast is in the form of constructivists arguing that any interpretation of studied phenomenon is itself a construction, whereas the 'objectivity' and facts that are required for the positivist approach are seen to be independent of how people interpret them (Smith, 1998).

Moreover, the theoretical perspectives that are encased by the constructionist approach are interpretivist where we see in the world our own interpretation to it. Symbolic interactionism and pragmatism are the main two interpretivist philosophies that influence grounded theory. This social psychological approach is focused on the meaning of human actions. Grounded theory focuses on human behaviour and perceptions and the factors that influence them. In addition, this is based on the sociological principles and philosophy of pragmatism, as developed by Dewey (1922) and Mead (1934) and

symbolic interactionism as developed by Mead (Charmaz 2014). These perspectives and their relevance are briefly discussed to situate the current study.

Symbolic interactionism

Symbolic interactionism underpins grounded theory as a dynamic theoretical perspective that assumes that prior interactions constitute society and collective life and that they precede the individual and form the conditions in which action and interpretation occur. It assumes that language and symbols play a crucial role in forming and sharing our meanings and actions. The way the symbol is interpreted is due to beliefs and values that are embedded within a cultural group (Blumer 1969). For example, within this study:

Table 2: Symbolic Interactionism

In this study the midwifery manager has a specific role within the context of the UK midwifery profession and NHS.

'... they (Current managers) have to keep a 360-degree vision as to all the people they need to pull in, and influence in order to get the support from.... So, their thinking needs to be wide. I think a lot of midwifery leaders make the mistake of thinking 'this is midwifery' and they have a tunnel vision. But your obstetricians are serious stakeholders. Your paediatricians are serious stakeholders. So, there's the wider stakeholder perspective and there's the internal stakeholder perspective and they've got to work on that. And they've got to make sure that people own this. Because once people own it, they're far less likely to want to destroy it. I mean I always remember at xxx I was so chuffed one day when I heard a cons Obstetrician talking in a lecture about 'our homebirth service' and I thought 'that's it- that's it' she thinks it's hers and that's fabulous! Whereas a lot of midwives are quite defensive about that sort of stuff- obviously she wasn't running it or anything, but I just thought that was great.' (Cathy:15)

Cathy is practising within the context of the NHS. She is the one 'running' the service but there are others who she sees as vital in the cultural environment who give meaning to her actions. The one taking ownership of the service is the obstetrician however, Cathy interprets this as a very positive result of best practice.

Pragmatism

According to Charmaz (2014),

"pragmatism assumes that the value of theory and beliefs rests on effective practical application" (Charmaz 2014, p263).

This is interpreted by Corbin and Strauss (2008) within grounded theory in the belief that knowledge is created through individuals as they act and interact with their environment. As individuals make sense of their actions, consequences are considered. Therefore, individuals act and respond in different ways to different situations based on their interpretations through reflection which is influenced by the individuals past experiences (Corbin and Strauss 2008). Thus, meanings emerge through practical actions to solve problems. For example, in this study:

Table 3: Pragmatism

Through pragmatism I have outlined how Caroline responds to and assimilates her experiences as a manager based on her interpretation of her role. This interpretation is influenced by previous experiences, interactions and self- reflection.

'it's about being slightly not just accepting when you're told you can't, you have to push back and say well why? let's talk about it, let's have a conversation' Caroline:13

Caroline can see external factors influencing the culture of the NHS. She needs the culture to be receptive to different models of practice and therefore identifies how she can practically find ways to introduce new models of care and push at the barriers.

It is therefore argued that the way a manager responds, and views best practice is based on her interpretation of her role. This interpretation is based on her reflection of her own life experiences and how she can influence the change in culture by practically influencing others.

3.5 Justification for using constructivist grounded theory

By choosing to use a constructivist grounded theory informed by Charmaz (2014), theory generation from the insights of the participants of previous and current social processes was possible. I am aware that my experience as a midwife in a MCoCer model is integral to my philosophy and practice and wanted to investigate the phenomenon of how midwifery managers' approach MCoCer models as, my experience reflected that they had a direct influence on the implementation and sustainability of the model. In order to aid the progression of continuity of carer models into the mainstream of NHS maternity care I chose a practical theoretical framework that was derived

from an explanatory theory of the social processes and behaviours of experienced midwifery managers would be of most use. I also needed to be transparent and incorporate my own personal knowledge and experience of being a midwife within a sustainable model of continuity of carer. Several other qualitative methodologies were considered: phenomenology, qualitative descriptive and ethnography.

It was acknowledged that grounded theory and phenomenology are the most common approaches to qualitative research and would fit the purposes of this study (Green and Thorogood 2004). Both assume an interpretivist approach where the researcher explores real-life situations, they both require a close interaction between the researcher and the situation being analysed and both seek to explore individuals' experiences in the context of the worlds in which they live from the epistemological perspectives of understanding context through the realities of experiences (Gray 2018). Thus, they are both congruent with the research question and aims of this study. However, they emerged from quite different origins- phenomenology from philosophy and grounded theory from sociology (Gray 2018). This can be seen in their aims in analysis of the data where phenomenology aims to create insight into the lived experiences of a person, giving a greater understanding and awareness of the subject under study (Grant and Giddings 2002). However, grounded theory aims to develop an explanatory theory by focusing on the social processes of the social world that is to be investigated (Corbin and Strauss 2008). This emergent theory is connected to the reality on how the theory is developed to explain the social processes. Grounded theory and phenomenology are also different in their ontological perspectives thus leading to implications for data collection and analysis. Although a phenomenological approach to the research could have worked well, its outcomes would have been different. My aim was to develop a practical theoretical framework based on an explanatory theory developed from the data. Due to the limited resources currently available for midwifery managers it became apparent that grounded theory was the methodology that was going to provide the most suitable fit with this study's aims and objectives. Qualitative descriptive would have provided a reasonable fit in terms of the aim to obtain rich data and achieve understanding of a phenomena. It is

often used in areas with poorly understood phenomenon to gain insights from informants and focuses on the questions of who, what and where of events or experiences (Patton 2015). However, it is used most often when a straight description of a phenomenon is desired or information is sought to develop and refine questionnaires or interventions (Polit and Beck 2016, Neergaard et al 2009). It was discarded as having a future practical application for midwifery managers in the current climate of change was one of the main driving forces in researching this topic.

Ethnography was also considered and is an approach commonly used for a situational analysis and in-depth study of a particular culture or people (Patton 2015). The researcher in this instance would generally be witness to the area under study and analyse the social cultural environment from their viewpoint by what they observe and hear to uncover what is implicit and explicit in a specific culture. I was limited in terms of time for this study and it was not practical to spend a period of time with the midwifery managers who participated. I also identified some participants who were no longer working in the midwifery managers role and therefore this option was again not feasible. It was important to focus on the key midwifery managers irrespective of whether they were still currently in practice rather than observing them in a practice role. The decision to focus on the social processes for the participants rather than the specific social cultural environment that they were working in highlighted that an ethnographic study was not the best fit for the purposes of this study.

3.6 Trustworthiness

It has been suggested that constructivist theory demands a different criterion in order to distinguish quality from those inherited from traditional social science (Lincoln and Guba 1985). By using criteria defined for qualitative data rather than ones formed for quantitative and experimental design, a judgement of the qualitative study does not result in it being judged as inferior (Patton 2015). Lincoln and Guba (1986) used the term trustworthiness as a parallel to the term rigour. This encompasses the credibility (internal validity), transferability (external validity), dependability

(reliability) and conformability (objectivity) of the research and the interpretations of the data. In order to ensure the trustworthiness of the study I involved the participants of the research in the analysis and interpretation of the data by asking them to reflect and comment on the chapters of analysis, development of the grounded theory and the discussion and conclusion, thus maintaining credibility in the interpretation and quality in the analysis. The theoretical framework created is transferable in terms of reaching saturation of the data. It needs to be acknowledged that the sample size was five and therefore limited in its transferability; however, there were congruent similarities among the participants in the categories that they discussed. Ensuring the process was logical, traceable and documented all created a dependability of the research findings. Confirmability was achieved by having regular supervision sessions with my two supervisors to check on the interpretation and categorising. Thus, it was at every step thought about and acted upon that the quality of the research would create credible findings and interpretations that through careful attention I established trustworthiness.

In addition, together with my supervisors we considered our own beliefs prior to starting the study. All of us are midwives. All of us have a firm philosophy in women centred care and providing evidence-based care such as relational based continuity of carer. Both myself and one of my supervisors have worked as caseload holding midwives for many years of our career and have a strong belief in the benefits of providing this model of care for women and midwives. We discussed the personal experiences that we have had and how they could influence the potential for over-identifying with the organisational culture and the participants experiences. This was acknowledged and mitigated for by passing the analysis and final chapters back to the participants for confirmability of the study's results and conclusions.

3.7 Summary of methodology

From the beginning of the study the research question was requiring a qualitative enquiry with interviews as the data collection tool. By choosing a qualitative method I was able to gather meaningful rich data. The

methodology of constructivist grounded theory was decided upon due to the consideration of other methodologies- principally phenomenology, qualitative descriptive and ethnography not fulfilling the aims of the study which were to develop a pragmatic and useful theoretical framework based on social processes. The implementation of MCoCer models in the NHS where relatively few midwives have experience in them demanded insight and a practical application. Constructivist grounded theory was decided upon as this enabled researcher involvement. Due to my personal experience I have an in-depth knowledge of the lived experience and would therefore potentially struggle to disengage with my previous learning. Constructivist grounded theory has its roots in sociology with an interpretivist background along with pragmatic and symbolic interactionist philosophies. The social processes that are in play enable an interpretation and construction of meaning regarding the midwifery management and leadership that is being used within MCoCer. By enabling their voices to be heard through the methodology the theory that is developed is grounded in their experiences. Constructivist grounded theory was an enabler to find gaps in the patterns of midwifery managers and develop a more pragmatic useful outcome in the form of a theoretical framework from the analysis.

Research Design

3.8 Ethical considerations

The guiding principles of first do no harm and reciprocity were used when considering ethical approval (Gray 2018). Ethical approval was required and sought for this study. Approval was given by the Robert Gordon University Ethics committee on 12th Nov 2018 (see appendix A). Further IRAS applications and specific ethical approval from each health trust where individual participants were working were gained prior to any data collection (see appendix B). There were 2 participants who were recently retired from working within the NHS and therefore were able to be interviewed whilst waiting for the IRAS approval for the employed managers.

The main ethical considerations in this study related to the process of informed consent and ensuring confidentiality where requested. The core ethical concern of protecting the participants from harm (Department of Health 2009) was the underpinning premise. All participants were made aware of the potential for over disclosure of identifiable information (Carpenter 2007) and to this end, they were all sent their transcripts prior to any analysis and asked to remove any information that they did not want included in the study. There were very minor changes made by participants to two of the transcripts in order to clarify sentences. Although this member checking is not required within constructivist grounded theory it was important to me as a midwife and feminist that the participants had a sense of trust and control over their own information. It was important to me that I kept participants (all were women) central to the study throughout and that their narratives were honoured in a way that maintained and safeguarded a sense of trust and agency for them. By ensuring that they had time to review their transcripts and consider what was to be analysed, this made sure that they did not feel that they had over disclosed and were having any regrets about what they had said in the interview. The interviews involved personal experiences and personal views, so had the potential for over disclosure. Each participant was contacted again prior to the study's completion on confidentiality issues and any aspect of text that may identify them. Their consent was gained (See appendix C and D). The Data protection Act 2018 was applied throughout the study ensuring that the participants information was safe and kept confidential.

3.8.1 Informed consent

Once a potential participant was identified they were contacted by me, via email (Appendix C) to introduce them to the study and invite them to reply if interested in being interviewed. Every midwifery manager that was contacted responded positively and was willing to participate. Each potential participant that replied to the email was then sent the participant information sheet (PIS)(Appendix D) and asked to contact either myself or one of my supervisors with any questions and if willing to be part of the research study to identify possible available times.

All participants currently working in the NHS required a site specific IRAS application which was completed prior to interview dates being arranged. Once all ethical approvals were in place a conversation via email occurred between me and the participant to discuss the PIS and the consent form (appendix E) to confirm that the participant agreed to the interview being used for the study.

Prior to the interview commencing and once face to face I asked the participants to sign a consent form and discussed again the potential for identifying conversations. The distinction between anonymity and confidentiality was discussed and reinforced. No participants declined participation. I had known 2 interviewees personally whilst I had been a caseload midwife in London prior to 2001; however, I am not currently linked professionally to any of the participants.

The location of the interviews was chosen by the participant for their ease of participation. Rowley (2012) identifies that by enabling ease of participation participants are more likely to feel safe and be willing to develop a rapport. It was necessary that the recording of the interview was without too much background noise. Two interviews were in homes, two in café's and one in a clinical interview room. A third party who was not involved in the research always knew where I was during the interview. Contact with the third party was made prior to the interview and once it was completed to maintain safety.

Due to time constraints of the study it was proposed that between four to six interviews would take place. As this was a grounded theory study saturation of codes in the data was sought. This was achieved after an eventual sample size of five participants where no new codes were emerging.

3.9 Data Collection and recruitment

3.9.1 Purposive and theoretical sampling and theoretical saturation

I am currently employed as a midwife educator working in Scotland. The study was supported by a Scottish university. The participants midwifery management experiences were mostly in England. There have been moves

within England to encourage continuity of carer models since the early 1990's; however, there has not been the same move in practice in Scotland (Murphy-Black 1992). The placing of the participants was pragmatic in that there were no midwifery managers within Scotland with relevant sustained experience. By interviewing participants from England, the data generated was rich in experience and time. Hence the participants were recruited in line with grounded theory's purposeful sampling method (Charmaz 2014), that is the participants were recruited as they met specific inclusion criteria. The participants were able to bring personal and professional opinions, views, specific knowledge and particular perspectives. They were able to provide a reflection of the socio-political context (i.e.- UK maternity system). The participants were all able to articulate and discuss the intimacies of managing continuity of carer models.

Identification of potential participants was through personal knowledge of the managers role and practice. A brainstorm with my two supervisors and a midwifery manager who currently works within the managerial sector of midwifery was able to identify the managers who were appropriate to interview. Purposive and snowball sampling occurred from the first interview where the participants started to advise who would be worth approaching to interview. This has been identified by Gray (2018) as an appropriate way to achieve access to insider knowledge of a small sample group. Thus, a focused purposive sampling of midwifery managers was enabled by this technique.

Grounded theory requires a careful selection of participants to gain theoretical sampling, where through coding, comparison and memo-writing any gaps in the data through analysis can be identified and revealed. Then by selecting participants who are able to inform the gaps in the data, uncertainties can be clarified, and interpretations tested. This enables the theory to be built by constantly comparing data against new data (Sbaraini et al 2011). This happened after each interview where the gaps were identified, and the next participant sought. Theoretical saturation was where the participants were not saying anything new (Sbaraini et al 2011) and the explanatory theory developed by analysing the categories that had been identified.

3.9.2 Rationale for inclusion and exclusion criteria

The inclusion and exclusion criteria were developed to ensure that the managers participating in the study were able to discuss the question with knowledge and experience. It was imperative that the participants understood the MCoCer model of care provision. The decision to use 2 years or more was to access experiences of sustainability of such models. By choosing those with sustained experience the capacity of 'how' to initiate and sustain the model was illuminated.

3.9.2.1 Inclusion criteria

The inclusion criteria were set as:

- Midwifery Manager in the UK setting
- Experience of managing midwives working in a sustainable continuity of carer model
- Sustainable defined for the purposes of the study as 2 years or more to encourage embedded knowledge gained over time
- Experience may be past (may be retired) or current allowing sample size to be expanded

3.9.2.2 Exclusion Criteria

The exclusion criteria were set as:

- Midwifery managers without relevant experience in managing midwives in a continuity of carer model
- Midwifery manager under any form of professional investigation
- Midwifery manager with any managerial responsibility for any member of the research team to minimize conflict
- Any manager who declines involvement

3.9.2.3 Descriptions of the participants

Of the five participants interviewed, three were currently active in non-clinical roles within midwifery and two were currently managing midwives within a continuity of carer model. Two of the managers had been involved in managing midwives at the same health trust but at different times. It was decided not to interview any further managers from this trust to ensure

diversity of experience. They had all been midwives for over 15 years and four out of the five of them had post graduate qualifications. Their experience was based on western midwifery modes of care where they had all spent the majority of their careers. Their experiences of managing MCoCer models spanned over three decades. All the participants had worked in a managerial role within large teaching hospitals where they were responsible for the strategic decisions of implementing policy into practice and the day-to-day management of midwives.

3.10 Maintaining confidentiality

Due to there being limited expertise within UK MCoCer midwifery management, it was made explicit to the managers before they agreed to participate in the study that something they may say in the interview could potentially identify them. In attempts to minimise this possibility name places and locations alongside pseudonyms were used to facilitate a degree of anonymity although this was difficult due to the nature of the population being studied- all participants were cognizant of this from the beginning of their involvement.

All participants were asked to choose pseudonyms. At no point were the pseudonyms stored in the same place as the signed consent forms. All interviews were transcribed verbatim by me prior to data analysis. However, at the end of the study when asked what name they would like used in the final thesis, only 1 choose a pseudonym, the others chose to be identifiable.

3.11 Researcher involvement

Mann (2016) describes how researchers within qualitative studies require reflexivity and that both the research and the researcher is shaped by the study. As a researcher and midwife, it was necessary that the participants could trust me and that I could trust the information that they were discussing with me. This basis came from the NMC code of professional standards (NMC 2018) of maintaining professional standards. I was aware how my ability to be curious about the interviewees changed as I became

more immersed in the analysis of the transcripts. I started this study as a reflective midwife intrigued to explore the role of MCoCer managers and ended the study as a reflective midwife researcher who was able to interpret and explore meanings and key concepts. I was aware of the potential bias that I was bringing to the study and reflected with my supervisory team throughout the research process about assumptions being made.

3.12 Data Collection

Individual semi-structured interviews were the method of data collection used in this study. Mitchell (2014) suggests that semi-structured interviews are appropriate where researchers seek to understand participants experiences through their own words and perspectives. Adams (2010) reports the craft required to become a good interviewer involves listening skills and emotional control in order to conduct effective interviews that yield quality data and protects the participants. As a reflexive researcher after conducting the first interview I was aware that I was not using probing questions enough and was analysing and agreeing rather than staying curious. After a supervisory session with the transcript of that interview I was able to reflect and change my style of interviewing and obtained a deeper insight into the participants views and experiences.

3.12.1 Interviews

Face to face interviews were held in a location chosen by the participant. Interviews were aimed to be around 1 hour. Interviews lasted between 50 and 90 minutes. They were audio recorded and notes were taken in order to obtain rich data (Strauss and Corbin 1998). As this was a constructivist grounded theory study the questions developed alongside the analysis of the data and questioning did change in response to the process of constant comparative analysis. The first interview was prompted by a set of pre-determined open questions (See Appendix F); however, as the interviews progressed the structure changed to being more open and the questioning more focused to allow exploration of emerging codes (Charmaz 2014).

3.12.2 Memo writing

A key component of the grounded theory method is the writing of memos (Corbin and Strauss 2008, Charmaz 2014). Memo writing was used throughout the study and drew on guidance provided by Charmaz (2014) to explain, enhance and direct the data collection and analysis process. Free writing- the process of engaging in automatic writing on a subject was employed to make meaningful connections between data sets and develop a reflexive attitude to analysis (see table 3).

Presenteeism: Participants are repeatedly referring to how they need to 'be seen' in the unit, but it's not the presenteeism that is spoken about in the nursing literature, it's about them being part of the community of midwives. They all want to understand what is happening to the midwives and are choosing to interact on a daily basis and make themselves available whenever they are required. When possible, they are still looking after women. There's no sense that they want to manage from a distance- they all want to still be in the middle making meaning for themselves and the midwives. They all still strongly identify with being a midwife. They seem to be going with 'be the change you want to see'.

Identity +beliefs +being present = trustworthy change leadership

Midwife+ woman centred philosophy + actively engaging =supportive

Table 4:Free writing

These tools became an important part of the analytical process and were used to draw conclusions on theoretical direction. After each interview and during transcription memos were written around the concepts that were emerging.

The skill of being more conceptual rather than factual was one that I am still developing as a researcher. This was where my supervision sessions became invaluable in making sense of the descriptive codes and categories that were initially generated.

3.13 Analysis and generation of grounded theory

All data was coded manually by me and discussed with the supervisory team. This involved a volume of paper and computer files; however, it allowed me

to be immersed in the data. The following sections account for how the constant comparison method was used throughout initial coding, focussed coding and theoretical coding. Examples are provided to demonstrate how data sets, codes and categories progressed until theoretical sufficiency occurred.

3.14 Coding the data and Constant comparative analysis

3.14.1 Initial Coding

Initial coding is the preliminary stage of data analysis, where labels are assigned to segments of data to allocate meaning. Line by line analysis was used as a strategy to fragment participant narratives with labels, highlighting the meaning (Charmaz, 2014). Initial labels were mostly pithy descriptions. In-vivo (verbatim text) codes acted as a significant feature of coding, derived directly from the language of the participants to encapsulate meaning (Charmaz, 2006). As early data patterns were identified and initial codes created, audio recordings and field note transcripts were revisited to ensure analysis was reflecting the data. This provided a second layer of analysis to explore the meanings that were implicit in the interviews. By returning to original sources, initial assumptions made from the coding process were considered and any possible bias addressed (Strauss and Corbin 1998). Deep immersion in data, and repeated reading of transcripts, fostered sensitivity towards the participants perceptions and views of managing MCoCer settings, enabling a full picture to develop of their views, and how such views impacted on action. Colour coding within transcripts was used initially to group together common themes and create initial codes. (See table 4).

Table 5: Developing initial codes from the transcripts.

It was changing the culture. This was my main piece of work when I was a professor... we all worked together, we had meetings all the time, we were doing walk about, we knew what was going on. We also had a steering group with xx from NCT, xx who was Prof of Obst and Health sciences at Leeds, and xx and a statistician and xx who eventually came in as a reader. You know, leading the research. So it was adopting a philosophy and a policy that we all accepted. And at times I would say 'you know I don't know if that's going to work and then someone else would say 'yes, it's going to work, we've worked it out'. You know it was worked out in great detail before we started- how many births there would be- we had 40 births per midwife. They would usually end up doing 38 as women would move etc etc. It came to about 37 ½ hours a week. There was very little call out at night. Basically, it was a very very good package for women and for midwives. And it would be relevant now a day. You know the geographically based midwife is really workable, it's really feasible and the key to it is the management has to be supportive and not controlling.

Yellow (the requirements of culture change), red (practicalities of sustainability), green (practicalities of implementation), light blue (status and influence), purple (teamwork and dynamics of support) and dark blue (Future implementation/ relevance).

These initial codes were collated, divided into implementation or sustainability then into views and experiences enabling focused codes to be created through a gathering and cluster mapping exercise (See table 5). As focused codes were developed, initial codes were revisited and refined through continued comparative analysis. Cluster diagramming became a useful approach to draw together the concepts, providing a pictorial form to strengthen theoretical category development.

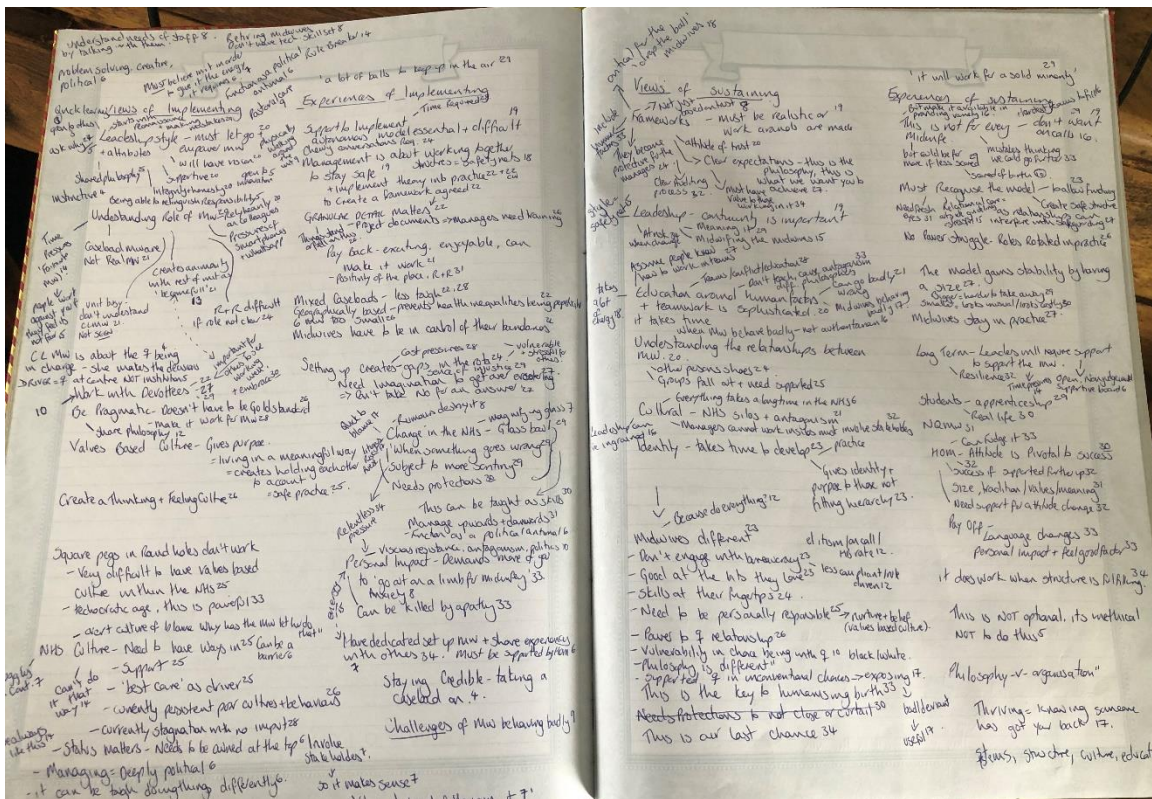


Figure 4: Cluster Mapping

3.14.2 Focused Coding

The second stage of coding was an iterative process that required refining the analysis to synthesize the initial codes that had been generated through the mapping exercise to develop meaning (Charmaz, 2006). There was an element of having to derive meaning from the subtle underplay of codes as analysis progressed. It was important to revisit the research question at this point to organise the codes to prevent the study data becoming unmanageable. Focused coding continued through constant comparative analysis and was continued alongside theoretical coding until all theoretical codes were identified.

3.14.3 Theoretical Coding

Theoretical coding involved refining focused codes into theoretical codes that characterised the social reality of the phenomenon (Charmaz, 1990). It provides an insight into the relationship between codes in order to develop an integrated theory (Charmaz, 2006). A period of intensive comparative analysis was a defining feature of this stage of the analysis to discover the

social process. The theoretical code 'Trusting in woman centred philosophy of care' is used to illustrate how such analytical processes occurred:

Participants drew on previously learnt 'lessons' through their midwifery careers and this shaped how they viewed the MCoCer model and its implementation. The influence that 'belief' had on MCoCer implementation and their expectations of the managerial role within the service was highlighted. This suggested that previously formed experiences influenced current thoughts and actions. Focus coding of how the belief of the manager becomes inherent in the implementation of the MCoCer model and the impact that the personal philosophy has on the leadership of the maternity service and ultimately the delivery of continuity. Therefore, the focus codes of 'It starts with belief' ' You have to put it right' 'Understanding what it means to provide relational care' and 'The NHS culture for midwives and managers' all developed into the theoretical code 'trusting in woman centred philosophy of care'.

Table 6: Theoretical code formation

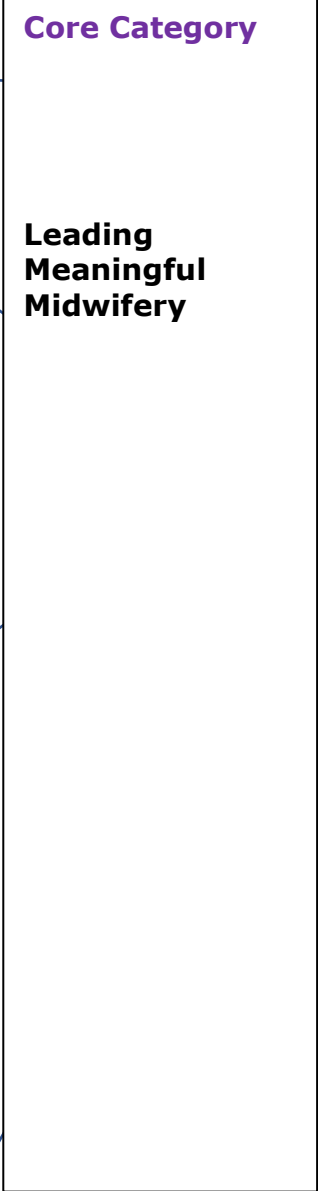
3.14.4 Theoretical Saturation

Theoretical saturation is generally accepted as a fundamental feature of grounded theory that signals study completion. Saturation occurs once no new theoretical insights can be derived from analysis, and new data can no longer generate original codes (Glaser and Strauss, 1967). The assumption that exhaustion can be reached within the sample has been questioned by Glaser (1992) and Dey (2004). Howarth, Warne and Haigh (2012) suggests that saturating concepts within the study rather than saturating through sample size is a more appropriate way to achieve completion of a constructivist study. As the study progressed, focused coding identified recurrent conceptual patterns, with comparative analysis continuing until textual analysis ceased to generate new insights.

Table 3.6 provides a pictorial representation of the initial research question boundaries of views and experiences of implementing and sustaining MCoCer and how the focused codes, theoretical codes and core category relate to each other.

Table 5: Relationship of codes to categories

	Focus codes	Theoretical code
Views of implementing	It starts with belief	Trusting in woman centred philosophy of care
	You have to put it right	
	Understanding what it means to provide relational care	
	The NHS culture for midwives and managers	
Experiences of implementing	Willingness to support	Transformative leadership enabling assimilation of alternative frameworks of care.
	Frameworks are vital	
	Being the safety net	
Views of sustaining	Continuity of leadership matters	Promotion and protection of values- based midwifery and a woman centred culture.
	The framework is your friend	
	We don't teach human factors	
	Understanding MCoCer midwives and being less rule bound	
	Is it the philosophy, the midwives or the model?	
Experiences of sustaining.	Chosing your culture	Mastery of high quality, safe midwifery continuity of carer models
	Can we build it? Yes we can!	
	Being a custodian	
	Living outside the box	



3.15 Summary

This chapter has presented the underpinning methodology that informed the research design. A qualitative study using the constructivist grounded theory methodology has been described including epistemological and ontological positioning, as well as a rationale of why other qualitative methodologies were not employed. The development of grounded theory from its origin to current application has been explored. Examination of how constructivist grounded theory and related methods were concurrent with the aims of this study has been presented. The iterative nature of data collection consisting of in-depth, semi-structured interviews has been described. Using a variety of written and visual examples the comparative systematic analysis was explained highlighting how this led to theoretical sampling with a search for variation in the studied categories to generate a substantive resultant theory. The next chapter presents the data analysis and the basis for theory generation.

Chapter 4: Findings

This chapter presents the findings that emerged from the data analysis and formed the theoretical codes. Throughout data collection, participants shared rich and detailed perceptions and reflections, based on experiences they had encountered as midwifery managers and being midwives in MCoCer models. The data revealed how managing midwives is a complex process influenced by a variety of factors that the participants perceived to be of significance. There was, however, an acknowledgement by all participants that through a series of interlinking factors and actions MCoCer models of care, within the NHS, are both achievable and sustainable. Through constant comparative analysis of the data an overarching congruence between the participant interview data led to four theoretical codes interlinked by a core category (See figure 5). Although Chamaz (2014) does not suggest that a core category is necessary within constructivist grounded theory and that the identification of the social processes are the aim of the study, within this study a core category did emerge in a way that helped foreground what participants reported as fundamentally important.

The research question (See Chapter 1) sought the views and experiences of midwifery managers of implementing and sustaining MCoCer. It was difficult to isolate experiences of implementation from sustainability. Participants often conflated these notions when narrating their experiences. The findings are presented under two sections along with their two interlinked parts for sake of clarity:

Section one: Implementing

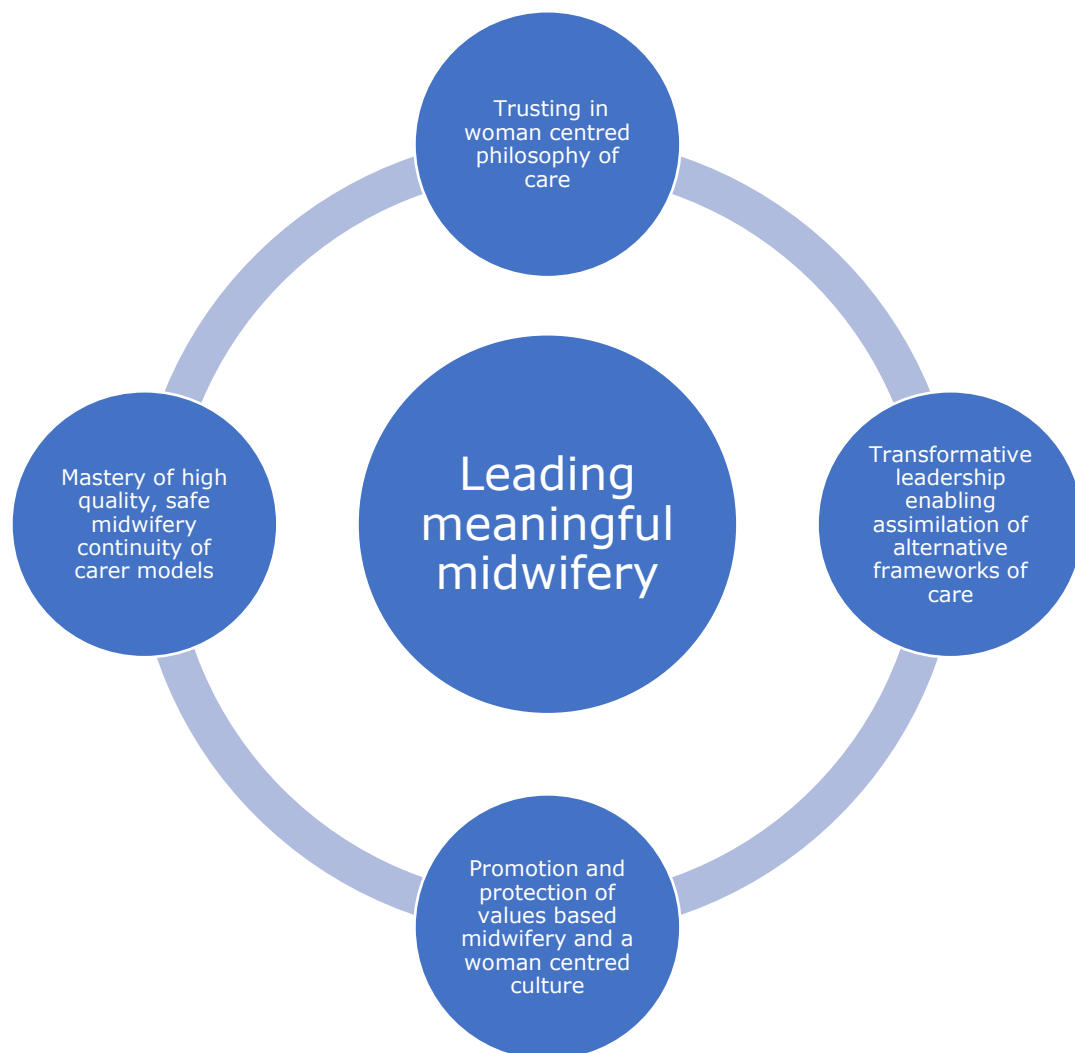
- Views of implementing
- Experiences of implementing

Section two: Sustaining

- Views of sustaining
- Experiences of sustaining

The focus codes are brought together in this chapter into emergent theoretical codes . The resultant theoretical codes and core category are discussed in the following chapter, as a guide these theoretical codes and the core category are represented in figure 5 below.

Figure 5: Theoretical model of Leading meaningful midwifery



In order to concentrate on the findings, this chapter does not refer to the surrounding literature and instead focuses on the direct quotations from the participants. Chamaz (2014) suggests that presenting the findings in this way gives a voice to the participants and supports the credibility of the research. The participants are named and then identified by the page location within the transcript, for example, participant Caroline page 2 is identified as Caroline:2.

Section one: Implementing

4.1 Views of implementing

This section discusses the 4 focus codes that coalesced into the theoretical code 'Trusting in woman centred philosophy of care' (Table 7).

Focus codes	Theoretical code
It starts with belief	Trusting in woman centred philosophy of care
You have to put it right	
Understanding what it means to provide relational care	
The NHS culture for midwives and managers	

Table 7: Focus codes for Trusting in woman centred philosophy of care

These focus codes all impact on the implementation of the model. They show a strong belief in building relationships and a commitment to the managerial role in enabling MCoCer model to be available for midwives and women. Participants discussed how they used different skills and qualities alongside their style of management to obtain innovation and change in the NHS culture whilst normalising MCoCer. They described how integrity in the belief of both the philosophy of the model and the practice of autonomous midwifery was essential for its implementation. Each focus code is presented with supporting data.

4.1.1 It starts with belief

The participants spoke about enjoying working in a maternity service with MCoCer and defined what MCoCer is:

'So, some of the teams practiced case loading (4 teams named) and there were a variety of teams doing team midwifery, but I'm very clear that they were not case loading, they were doing team midwifery'
Caroline:1

It was clear to them that MCoCer models were where women knew their midwife who was with them in labour and postnatally as they had developed a relationship during the antenatal period, they referred to it as caseload/ careload or group practice midwifery. They felt comfortable with the philosophy and relational aspect of midwifery and were compelled to lead this way:

'I think what I'm suggesting is, what I'm thinking is, this sort of instinctive, "this is the way to do things", which I think for some reason I just naturally do' Cathy:8

Having this personal philosophy was important, it meant that as managers they supported and defended the midwives and model; this was integral to their role:

'Well I think what was definitely clear was that I supported the midwifery practices. So, it was about me', Cathy:4

They spoke of personal philosophies of feminist values, of woman centred care and how women should be cared for when having a baby, they voiced how important relational care was in enabling choice and control in decision making:

'So my entire life has been about caseload midwifery, I experienced it myself as a woman having babies..... it absolutely opened my eyes up to the importance for the woman of being in charge- being the one who makes the decisions' Annie:1.

Cathy described her philosophy:

'well I suppose I'd always felt I'd never really understood any other driver for maternity care other than the woman is at the centre' Cathy:2.

All the participants situated themselves within their local context in describing their career paths and how they became managers of a MCoCer maternity service. They described how their learning had been developed from a clinical midwifery base, sharpened through time and influenced by others:

'it's information gathering, it's reconnaissance isn't it, it's what's going on? What's around? What is there? What do I know? What don't I know? And making mistakes' Caroline:2

When they had had personal experience as a midwife in a MCoCer model they referred its importance to their ability to manage one. They expressed how this enabled an insightful and knowledgeable sharing to happen with others:

'I knew what I was talking about, I'd worked in it, I'd set it up before, I knew the organisational principles, I knew what we were trying to achieve and we all shared it' Lesley:5.

This personal belief and drive for care within the NHS to be relational and woman centred underpinned their energy to implement the model:

'I think you have to believe in it. Because if you ultimately don't believe in the model and think it is worth defending why would you put any energy into trying to make it work?' Caroline:9

Personal drivers of wanting to support MCoCer models by using their role as a midwifery manager and having an underpinning of woman centred philosophy of care were repeated throughout the interviews. Having previous (or current) experience providing caseloading midwifery alongside energy, drive and commitment to support autonomous midwifery in a relational model within the NHS were evident. Amongst all participants a shared appreciation that it begins with a sense of belief in the model and an unshakable conviction of the positive outcomes the model has for women and midwives was continually emphasised.

4.1.2 You have to put it right

The participants identified the skills, qualities and behaviours that they developed and felt were important for their role. They expressed the need to be a good problem solver and a quick learner. Having the ability to be a change agent by negotiating through authentic, honest communication developed them into being visionary implementors:

'you need someone who is prepared to problem solve. You need someone who is prepared to take a position that may be at odds with your colleagues, but you have to do that in a fairly political way, cause as I say you have to keep on working with people' Caroline:9

Participants spoke of leadership behaviours and qualities that worked with their style of inclusivity and choice and how that changed depending on the midwives that were implementing the MCoCer model:

'with the groups that had emerged from the energy of the midwives themselves it was a very very different, almost managerial contract, right from the start, and I think this is fundamental to managing MCoCer. It's basically not management, its leadership, and fundamentally you have to set the contract, which is the number of midwives who will look after the number of women, and the expectations as to what that is going to deliver. That is about the simplest in terms of what you need to do' Cathy:3

Vicki identified that trusting communication between herself and staff underpinned her role:

'I think what I've found is that once people understand, and they understand that if we get it right as managers and leaders, they will have more control over their work life balance and they will have more

autonomy, but we have to meet that. If we say that that is what will happen, then it is within our gift to make sure that we really do let them control their own rosters and their own diaries and not micromanage and that there's trust there' Vicki:7

Trusting midwives to work autonomously and solve their own problems was described as a necessary part of the model's implementation:

'The key to it is the management has to be supportive, and not controlling' Lesley:3

Thus, by encouraging individual accountability for practice they were able to directly impact the initiation of MCoCer:

"It has to make sense to and work for the midwives practising that way"
Annie:3

This element of trust and using their personal qualities and skills to create a relationship with the midwives that was based on getting it right for them, as well as for the women they were caring for, was an important factor in changing the system and implementing MCoCer midwives.

4.1.3 Understanding what it means to provide relational care

The participants expressed how they developed a relationship with the midwives. Caroline felt that the pastoral care element of her workload was an essential aspect that enabled her to manage MCoCer:

' I think it's a really really important part of the job, and it enables you to manage the service because you understand your staff and so you can make things work for them' Caroline:6

By understanding the needs of the midwives, the participants were able to support them appropriately. They also understood that the relationships developed between midwives and women were different to the traditional models of care:

'Handing over the power that should reside in the woman is long overdue. Midwives who successfully work in this way are not in a power relationship with the women in the first place' Annie:11

Supporting the woman was recognised as an aim of the model and within that, women made unconventional choices out-with accepted guidelines. This was identified as more likely to happen in MCoCer which had an impact on the midwives and their working environment:

'I think there's something around this dynamic of vulnerability for midwives. And I think the model is less vulnerable than the culture. I do think that midwives are more exposed when women make choices that wouldn't be agreed with' Caroline:10

Participants discussed how this can feel from a midwife's perspective due to the culture in the NHS:

'there was a real fear element sometimes, and if you let that runaway with you, that would become very stressful, because we did sometimes go out on a limb to support women making choices 'outside the guidelines' ' Annie:15

Understanding that MCoCer models created different dynamics within the group of midwives working together due to their reliance on each other organisationally and emotionally when caring for women in this way was necessary:

'I think we've made the assumptions that people know how to work in teams when actually midwives have always worked in a very hierarchical structure.' Cathy:5

It took time, learning and effort to change towards this way of working. It was important to develop an authentic team who knew how to work together:

'it's about a culture of learning So, it's a culture of learning that goes over the whole service. And that goes down to the small group practice that is working together. To work together functionally not a pseudo team a proper team' Lesley:7

Creating boundaries for midwives around a relational model of care was identified as difficult. Smartphones and negotiating technology when caring for women was highlighted by Annie as changing the social expectations and landscape of care:

'smartphones are now such an intrusive part of our daily lives, you know when I started doing this, we had pagers and pagers are not as intrusive as smart phones, midwives nowadays have WhatsApp groups coming out their bloody ears- all their women are setting up WhatsApp groups, they are bombarded if they allow it from morning until night, so actually there is a lot of work that is required around being really clear about where your boundaries are when you are off call and when you are not. And I think the pressures on midwives nowadays are very different to how they were, not just in terms of the number of women but just all that stuff that comes at you' Annie:6

Both Annie and Vicki who currently hold a caseload expressed concern about technological demands. Vicki thought the impact of them appeared more onerous for older midwives in the current workforce:

'we need to really consider the groups of midwives that we have within our services now and the ageing workforce and are they the people that we want to focus on when they have maybe 2 years to retirement.... Do we really want to push them potentially into something that they may not want to do and may not have not the midwifery skill set but the technology skill set to meet the needs of a 25-35 year old woman of today who might not want to talk on the phone a lot but wants to send emails about their worries before their appointment' Vicki:1

Recruitment and retention into the MCoCer models was described as challenging for many reasons, (explored in more detail later). In order to implement the model it was thought necessary to start by working with midwives who wanted to work in this way:

'we went through a phase of losing several midwives who realised it wasn't what they were expecting or wanted , so the other big piece of work that we had just embarked on before we closed was how you do values based recruitment and selection? because that is the other key aspect of this. Cause its no-good saying to a midwife that thinks 'oh I really want to get to know women and have a lovely time... you know... just floating around and 'oh it's going to be lovely'.... Very quickly finds out it's also very hard at times and it takes commitment and resilience, so it is very important how you describe it through the recruitment process and how you select for the things that you really want your midwives to be? Well you do it through values actually' Annie:12

The participants acknowledged that in order to implement MCoCer models they needed to recognise the realities of what it means to provide relational care as a midwife in an NHS context. Understanding that the relationship between the midwife and woman is different, that unconventional choices are more likely to be explored, that boundaries are difficult to implement and that that requires midwife to midwife team support as well as managerial support. Recruitment can be difficult, not only because of an ageing workforce, but because the midwives require appropriate boundaries to maintain a work-life balance. Therefore the participants understood that the model requires a desire for relationships to be created and valued; however, the data revealed tensions and inherent difficulties in building positive midwife-woman relationships within the NHS organisational culture.

4.1.4 The NHS culture for midwives and managers

The perceptions of staff not working within a MCoCer model of what was involved when midwives were working in a MCoCer model generally created tension. Presenteeism was discussed and MCoCer midwives were sometimes viewed by other midwives as 'not real midwives' where culturally within the NHS there is an expectation of work happening in a maternity unit where colleagues can be seen. This created a need for the participants to set managerial boundaries around the MCoCer models to enable them to be protected in how the model required the midwives to work:

'I found it quite easy to manage and support the teams, a bit harder to manage the differences between different parts of the unit, so you know, "we're really busy today on labour ward, your teams..... can you not just ask them to come in and help?...." "I hear you're busy today, but they're also busy out there on the community- just because you can't see them doesn't mean they're not working"' Vicki:4

The participants identified that there was a sense of the midwives being different and also behaving differently and being treated differently within the unit. They recognised this and supported the midwives through this challenge:

'they knew that they would be grumbled about in whatever way that was, but then would also ring them up and say we've got a really difficult case can you look after this woman? So, there was dissonance there for them as well, on the one hand you're telling me that I'm bad because you're labelling me as deviant, but when that deviance works to your advantage it's all fine and well. So that used to make them frustrated which I can understand' Caroline:9

The potential for isolation for MCoCer midwives can lead to barriers to implementation within the unit if non-MCoCer midwives see the workload as unfair and also that the MCoCer are not an equal part of the whole unit:

'I think there was perhaps an element where the teams were seen more as team players and the caseload were seen as slightly different and slightly special. And I think at times that was not necessarily always helpful because if you're not in that case loading model and you are working very hard in a team and you're wondering why your team of midwives carry a caseload of 300 + women and yet the case loading teams are saying 'we're full' and sending women back to clinic you might very well not think 'well this is not quite right is it?'. So that's a challenge, I think that when those pagers went off it was the teams who would respond rather than the caseload holders. On the few occasions that it happened it was the team midwives that went in... so they felt

more engaged with the wider community of the trust than I think the case leading midwives did' Caroline:4

The participants discussed the endemic NHS culture and how it impacted on implementing MCoCer. Even though Cathy describes an NHS culture where she felt able to implement MCoCer with support she recognised that it was still a challenge to implement MCoCer:

'but I felt I worked with a group of paediatricians/obstetricians/ anaesthetists and indeed managers who were very open to listening to me. Now how much of that was due to my own determination... but I think I've been relatively lucky to work with good positive cultures'
Cathy:8

Yet others described an often inflexible, static culture that relied on maintaining a status quo rather than considering change:

'a lot of the time you're told "oh no! you can't do that" when actually if you poke hard enough you realise there's no reason other than that its cause "we've always done it like this"... over and over again you find that' Caroline:14.

This awareness of their surrounding culture in the NHS also influenced their actions:

'it's about being slightly not just accepting when you're told you can't, you have to push back and say well why? let's talk about it, let's have a conversation' Caroline:13

The environments that they spoke about being conducive to implementation were ones where they could find support both from the midwives wanting to work in the model but also from the board level. It was expressed how important the support for implementation from those with decision making power in the NHS was:

'maybe the directors of midwifery and heads of midwifery don't have to plan and implement it, but they have to support those that are, it's so very very important' Vicki:13.

Cathy explained how important those with the power to influence and change the NHS culture were for the model to be accepted and normalised :

'they've got to make sure that people own this. Because once people own it, they're far less likely to want to destroy it. I mean I always remember at XXX I was so chuffed one day when I heard XX (cons Obstetrician) talking in a lecture about ' our homebirth service' and I thought' that's it- that's it' she thinks it's hers and that's fabulous! Whereas a lot of midwives are quite defensive about that sort of stuff. Obviously, she wasn't running it or anything, but I just thought that was great' Cathy:12

Caroline used her position to challenge the rules in order to create a space for the change in practice:

'find out what the rules are so you can break them- so you can find out how to break them.... (Laughs)... Break them within accepted tolerances...'Caroline:14.

It was suggested by Annie that the NHS was too rule bound and MCoCer in the NHS was possibly unworkable because of this, and thus could more easily be delivered from outside the NHS culture:

'midwives say they can't do it- "no, no, they'll get burnt-out, it won't work", but that's because they're looking at it through the prism of a traditional way of delivering care and I agree, I agree with them 100%. You can't do it easily through the traditional model' Annie:8

Participants were fully aware of the constraints imposed by the current NHS structures and culture when implementing a change in practice and expressed how they adopted managerial styles that supported the woman centred philosophy to be embedded and enabled implementation of MCoCer.

4.2 Experiences of Implementing

This section encompasses the 3 focus codes that coalesced into the theoretical code 'Transformative leadership enabling assimilation of alternative frameworks of care' (Table 8).

Focus codes	Theoretical code
Willingness to support	Transformative leadership enabling assimilation of alternative frameworks of care.
Frameworks are vital	
Being the safety net	

Table 8: Focus codes for Transformative leadership enabling assimilation of alternative frameworks of care.

The participants spoke about specific areas during implementation of MCoCer that they viewed as either of organisational or strategic importance. The sustainability of the MCoCer model was often referred back to experiences they had in implementation. 'Willingness to support' explains how the participants maintained connection with the workforce and how they turned the theory of MCoCer into practice. 'Frameworks are vital' is the focused code that encompasses the importance of planning and developing a framework for the MCoCer model and how the participants used them. The code 'Being the

safety net' discusses the impact that creating a relational model within the NHS had on the implementation and on the participants. The theoretical code 'Transformative leadership enabling assimilation of alternative frameworks of care' is where the focus codes coalesce how the managers experienced implementing and ultimately focused their efforts to sustain the MCoCer model which is explored further in the sustainability section later in the chapter.

4.2.1 Willingness to support

As discussed in 'views of implementation', the participants reflected upon their practice and spoke about how important the relationship that they had with the midwives was in order to integrate MCoCer. This enabled them to create a space within the organisation in providing care that was not from the traditional mould. Vicki and Annie who were carrying caseloads as part of their roles saw it as a way to stay credible within the organisation and with the other midwives in order to provide support:

'I think it's really important that as leaders we lead by example and we shouldn't ask people to do something that we're not willing to do ourselves.....and some of my colleagues will fiercely disagree with the ability to potentially do that bit. I look after 10 women a year, and I would take THE most complex, and let the team tell me.... so I'd take the woman who has had 4 babies removed.... Or the woman who could be found wandering the streets having a psychotic episode. But it kept me up to date, it kept me understanding what all the content of the referrals were. So when somebody new came for advice I could really give them that expertise' Vicki:4

They assimilated change in practice by remaining engaged with the practical aspect of the service. The participants chose pragmatic supportive routes for implementing new groups:

'I can't be elitist about the gold standard model because I'm not going to get that many midwives to work that way, so I've had to also take a bit of a breath and say how do you want to do it? So, once we know who our 6 midwives are, we get them together and let them plan it, we let them plan how their off duty will look.' Vicki:11

Supporting the implementation was discussed as being time consuming and demanding on the participants. They spoke of enjoying the challenge but also worrying about how the inequity of their time would be perceived within the unit whilst potentially creating a work pressure on the staff not involved in the MCoCer model:

'and it's a really good opportunity to make everybody feel valued because some people have been stagnated doing something the same way and haven't felt like they've had much input. Because we're not all of a sudden going to turn the community into a bunch of continuity teams that will provide care through the intrapartum period because some of our midwives will never do it and that's ok, you know. I'll take the people with me that really want to do it to start with and those that need a bit of convincing, they'll be in the next phase, and we'll get as far as we can get. But what we also have to recognise is when a lot of time and energy has been focused on the midwives that are going into the continuity teams, what about everyone else? cause they're still working as hard and they've lost Betty and Annie off their rota and feel some sense of injustice. So, it's a lot of balls to keep up in the air' Vicki:9

The participants recognised that supporting the implementation sometimes detracted from other parts of the service:

'I was certainly quite vulnerable to that sort of accusation that these were my favourite midwives.... that these were the midwives that I was looking after most' Cathy:11

However, the participants recognised when those with decision making power were not supportive there was a potential for MCoCer within the NHS to be easily side-lined:

'And also, if you're not quite that bothered by it, and you don't quite believe in it and there are a lot of dissenting voices you can do a huge amount by apathy in the NHS or you can block an awful lot by apathy, because there's always another job... If that's your biggest job, to get this done, you have to spend a lot of time and energy to get it done, when actually you still have a service to run' Caroline:12

Thus the willingness to be present, stay credible and support the midwives both in practical terms by planning and meeting with them and also enabling a culture where midwives can choose how they work aided implementation. The participants were able to create an emotional safe space within the organisation where changes could be accommodated and enacted.

4.2.2. Frameworks are vital

The participants all agreed that having a robust framework that was produced in the planning process was a vital element to implementation and functioning of MCoCer. The participants used leadership skills in setting the contract so that everyone was clear about expectations:

'we really worked very hard to make that a collaborative thing, it wasn't like we were going -all right guys, so these are the guidelines this is what you have to follow: so we would come up with some guidelines, largely based on NICE, try and keep it simple, we would share that

among the midwives, they would make comments, it would come back, so it would go through iterations like that, so everything about XX as we developed it was very much about the working conditions for the midwives. It was organised by them and run by them' Annie:3

The importance of the midwives having the practicalities that supported their ability to be midwives was vital but one of the most difficult aspects to implementation:

'the longer I am in the NHS, the more I think things stand or fall on the little bits of granular detail, it's not whether you've got the big idea for the MCoCer, it's whether you can figure out how you get the bloods back from the GP surgery' Caroline:12

There was a recognition that the framework could only work if the midwives were working well together and not forming a 'pseudo team' as mentioned previously. Therefore, support around the implementation of the group of midwives and allowing time for group cohesion was provided:

'I think the ringfencing; however, it is done, is a really important part of it. If you don't ringfence their time and really value the importance of the group practice identity developing. They need to be autonomous, but they can't be elitist. This is just another way of being a midwife, it gives you an identity and a purpose and for those midwives who don't fit in easily to the hierarchy and bureaucracy of the NHS it's absolutely another option' Annie:12

The framework enabled the participants to trust the midwives as it provided the clarity around the expectations:

'your team will support each other and cover in these circumstances' so in a way what you're doing to people is not just saying give everybody your trust- just trust everybody willy nilly... actually the truth of the matter is that sometimes you do end up disappointed, so what you're doing is setting the framework so that you can say to people I trust you to deliver within this framework and you're giving them some support' Cathy:7

Within the framework the participants spoke about the practicalities that lead to the most robust form of MCoCer model. These were having more than 6 midwives in a group, having geographically based mixed risk caseloads and being aware not to perpetuate health inequalities by placing the group practices in areas of high demand from women who are less likely to suffer from health inequalities. These were seen as ideals and sometimes had to be worked towards once the unit had integrated the MCoCer model as it was more important to get the model running positively than perfectly:

'If you ask me to make it sustainable we should all be looking after a mixed risk a caseload, because then you could just put them all over the community but we're at the start... and we aren't- we have to get people to buy in to the vision and if the vision is that they want to do the homebirths...., we are probably going to have to change that a few years down the line but I recognise that and I'm going to roll with that for now, cause we need to get it up and going to get the rest of the service to see it working well'. Vicki:11

The participants agreed that there was minimal requests for help from the midwives carrying caseloads to help in the unit during busy times. The importance of safeguarding the model and the midwives who were working within it was universal. By recognising that the on-call element for the midwives was stressful, it was not to be abused. Sometimes by being the referral point prior to calling in the caseload midwife, they changed the units behaviour. The framework was used to support this:

'I think everyone talking about continuity recognises the importance of that issue. That if every time you're on-call you're up because you are dragged into something else it falls over very quickly. People get burnt out very quickly because, you've got to have the on calls where you're not called out' Caroline:3

All the participants were very flexible and practical in their approach to the implementation phase and described how important the planning of the midwifery working frameworks were for successful implementation.

4.2.3 Being the safety net

Once the framework was agreed, the participants referred to how important the document then became in agreeing standards and acting as a safety net, both in implementation and sustaining phases:

'I think what maybe happened in some of those less able groups is that they did drop the ball. So, you would have in those groups far more behaviour like ringing up the labour ward and saying none of us are on-call tonight, whereas in some of the groups, that just didn't really happen. So that was about being very clear right at the beginning about what the expectation was in terms of responsibilities of the team and the responsibilities of the wider service. And what I say now when I'm talking to midwifery leaders is set your expectations very clearly, because if you do that and then you monitor them, and if you then do that and you do have a say a group or a midwife, who is shown by the data, not to be complying then it is easier to then manage that person or that group. And I think what I learned over my rather sort of chaotic, innovative, hopefully achieving years at XXX was that if this is going to be sustainable without somebody who has got very high leadership energy that framework is critical' Cathy:7

Safety nets were provided by the participants by staying connected to the workforce through communicating values and sharing practice. The participants integrated the values-based system of relational care into the NHS; however, it was described as something that required time and energy to embed. The NHS culture was at times resistant and participants spoke of requiring skills of conflict resolution and courage from them:

'It is all about purpose, have you got a shared purpose, what are your values? What are your belief systems? And if they are aligned and if you can come up with a series of values that you can all put your name to'
Annie:7

This integration of midwives working together in a culture based on values was seen as the safety net that held the model to account and created safe practice:

'a way of working that really delivers in terms of quality and safety because they hold each other to account all the time, that's the thing about it. They're living in a very sort of meaningful way, day by day they're living these values, they're living the purpose of the organisation' Annie:7

There was an agreement between the participants that there was a balancing act to getting the midwives within the model to be self-organising and fulfilling the role of autonomous midwives whilst at the same time complying with the regulatory framework. Caroline describes her leadership style being akin to her midwifery style:

'but I am a great fan of stepping back and letting people get on with things and stepping in if you need to- which I think is kind of a midwife thing to do as well- it's interesting isn't it?' Caroline:1

However, the safety net was provided by having structure within the framework of the model:

'How to hand over the reins in running their team, in a way that didn't overwhelm them, that gave them proper structures to do it, and enabled us to still point to the world around us and say there is enough governance, there is enough regulatory oversight, we can tick all those boxes as well and I think that's quite a difficult balance to manage'
Annie:6.

The participants all spoke about when the groups of midwives struggled to work together how difficult it became to maintain a safety net:

'I found it very enjoyable, I didn't find it hard to manage, apart from my 6 month blip of 'Oh my God, holey macaroni, would you all just, you're

big grown women, would you just behave and be nice to each other and do the job', Vicki:5

The participants agreed that the experiences of implementing MCoCer was challenging at times and to be successful the midwifery manager requires support from the board as well as a peer group in order to be able to implement a relational model of care. The experiences of implementing MCoCer within the NHS highlights the contextual challenges participants encounter in leading change calling upon a particular style of leadership.

Section two: Sustaining

4.3 Views of sustaining

This section encompasses the five focus codes that emerged as the theoretical code 'Promotion and protection of values based midwifery and a woman centred culture' (Table 9).

Focus codes	Theoretical code
Continuity of leadership matters	Promotion and protection of values-based midwifery and a woman centred culture.
The framework is your friend	
We don't teach human factors	
Understanding MCoCer midwives and being less rule bound	
Is it the philosophy, the midwives or the model?	

Table 9: Focus codes for 'Promotion and protection of values based midwifery and a woman centered culture'

These codes all impact on the sustaining of the model. The codes emphasise how the introduction of MCoCer did produce antagonism at times and a level of scrutiny that was not afforded to other areas of the maternity services. The participants identify that due to working within a level of trust there has to be a way to keep a balance and check on midwives who are challenging the system. They described how important it is for a team to learn to function well together and this is essential for sustainability. They explore how they worked with the midwives who wanted to work within the MCoCer models and then discuss how difficult it is to disentangle the factors impacting on the outcomes of midwives working in this way. But ultimately the participants are

sustaining the model through managerially promoting and protecting the values and philosophy.

4.3.1 Continuity of leadership matters:

It was identified that midwives benefit from continuity of leadership through change. The increased scrutiny that change created and the antagonism that was displayed at times required a steady presence of a supportive leader.

Vicki was clear that the career movements between managers made a difference to how the model ended up running over time:

'there's something about inherited teams and the change of managers over the years and people setting things up and how something that was originally set up can be morphed into something that doesn't continue to have the same philosophy that it was set up on originally. And we see that a lot in maternity, you get some new leader in, who wants to shake the place up, I mean shake it up if it needs to be but don't fix something that isn't broken, and then they go! And that I really struggle with', Vicki:3.

Annie thought that the change in managers could be detrimental to managing MCoCer within the NHS and perhaps this created another vulnerability within the NHS culture:

'I don't know the answer to whether you can create what we had in X within the NHS. Then I think it's more at risk of being disbanded, you know, different management comes in, a different structure, a different person, and your protectors in the system have gone. That's why I thought that having small independent organisations that could really work closely and collaboratively with the NHS might be a really good alternative' Annie:12

The participants agreed that initiating MCoCer models took time and created pressures on the unit and therefore there was scrutiny as it was integrated into the system of maternity care:

'when you set up something new, it was as if you were under a magnifying glass' Lesley:5.

Lesley described the first time she developed MCoCer models over two decades ago, she experienced overt resistance, with midwives and doctors being antagonistic by verbally and behaviourally undermining the model:

'if anything went wrong I had to be on top of it all the time or rumours would go flying' Lesley:1, because 'rumours will just destroy it' Lesley:6.

Others agreed that this resulted in a personal sense of fear and anxiety when leading a MCoCer model:

'the anxiety came from not knowing what the wider system would do to us. It is supposed to be a no-blame culture, but I have to say, it doesn't feel like that yet' Annie:15.

Being the outlier within a NHS service that resists change was personally challenging for the participants, Lesley's experience was mixed as it spanned over time. Her early experience without support from the wider culture was difficult:

'the cost to me was very very great because it was so vicious' Lesley:5, 'and the resistance to it, I just can't describe the personal resistance to me, the antagonism and the politics of setting this up.... It was as if I'd come in and said 'I want to kill babies'' Lesley:1

Lesley's description of her experiences of alienation are a potent indication of the resolute leadership required to initiate change in a resistant organisational culture. The participants expressed that it was especially difficult at times to manage the service when personal attacks were made. They found personal and professional support networks were essential for these times.

There was a disparity around problem solving and building of resilience in the team. Annie described the tensions between how the MCoCer was aiming to run and how the midwives within it expected it to run due to their expectations being based around the behaviour in the NHS culture:

'a lot of the challenges were to do with many of the midwives coming in of course were not independent midwives they were used to working in the NHS and sometimes they would just say "I just want a manager to tell me what to do..." laughs.... And we'd say 'tough'! But the difficulty was that when there were problems that's just quite an easy role to fall into – becoming their manager and instructing them what to do, to tell them this, they have to do that, so there were lots of those ongoing tensions' Annie:5

The participants had experienced how important it was that they used their role and status alongside courage to maintain a steady supportive presence in order to sustain the MCoCer model within the NHS culture and provide a continuous values-based culture based on their leadership.

4.3.2 The framework is your friend

Cathy reflected that a framework that was robust created an inbuilt protection for the midwifery manager to deal with any managerial issues around MCoCer models:

'I think if we want to have the leaders in place who have the skills that are needed we do have to advise them how to almost (I am not sure this is the right word) protect themselves from when things aren't going right' ... 'set your expectations very clearly, because if you do that and then you monitor them, and if you then do that and you do have a say a group or a midwife, who is shown by the data, not to be complying then it is easier to then manage that person or that group' Cathy:8

The participants used the frameworks that were agreed at the planning stage to sustain and maintain rigour and safety in the model and thus support autonomous midwifery practice:

'And we had a very sad case where a woman who had acute fatty liver where her midwife did not follow that up, and actually it was the same person with a few things, so you work and you support, but actually if you cannot be autonomous as a midwife and practice autonomously and fulfil your responsibilities in having that wide ranging freedom, where you're out there and you've got your 32 women a year, and you tell me if you need my help and I'm there, but we need to think about how we can put some safety nets in place' Vicki:5

The participants used this safety net in the framework to deal with the challenges that they had to cope with. They recounted stories of midwives falsely claiming for expenses or not attending to their workload:

'They just have to do the job well, it doesn't matter what time of day or night if it fits with the woman and it fits with you together as the midwife, just do the job well. So, if you want to be at home ironing during the day but then you do your appointments later in the afternoon then that's fine. But you can't be at home ironing all day when it's your day on-call and there's a woman on labour ward' Vicki:2.

This was difficult for the participants who reported:

' Once the trust has been broken it's quite hard not to be sceptical' Vicki:5.

Pragmatic checks were implemented by the participants within the MCoCer models due to their experiences of managing midwives; however, they agreed this behaviour was not necessarily a MCoCer model issue and was encountered within the whole service:

'You know, you trust people and sometimes people don't repay that trust, but you can't make too much of that because if there were 130 staff and 3 of them did it over 3 years and all the rest didn't' Caroline:3.

Having robust structures in order to maintain a level of scrutiny and monitoring of working practice was accepted. It was also discussed how the forming of the team working together and supporting each other helped in monitoring. This was developed through time and by committing to support the MCoCer model:

'support them in that first couple of years- it's not just the first fortnight, it's as they get to know each other, have a shared vision and they'll meet their peak in activity and they'll all have a fall out because everyone got upset, and be there to bring it back and get over that hump' Vicki:13

The participants were able to share experiences of when midwives had not been professional and working to the agreed framework. They stressed how important it was for the sustainability of the model that there was a framework agreed to refer to in these times to enable them to outline where the role and responsibility of each person lies. However, they expressed that through time and by supporting the development of the midwifery team, that the midwifery managerial role makes a difference in the sustainability of the model.

4.3.3 We don't teach human factors

The participants referred to how we are not teaching midwives relational aspects of how to work together in teams. This resulted in recounting times when midwives were not managing to work within MCoCer models due to their lack of ability to work within a team:

'There was something about those teams learning to work together. You can't just shove 6 people in a room and expect them to get on with it. I think it takes a long time to work out team dynamics and to understand that if you form quite a strong cohesive bond as a group and then you disagree with something that is going on within the group and how you're going to manage that intelligently. So, all of that is quite sophisticated team working, we just don't bother to teach people things like that. We teach them how to take blood pressures and palpate, but we don't teach them that human factors type stuff' Caroline:11

'I think they need to have the support that teaches them how to deal with conflict. I think they need support in how to resolve and come to a consensus on issues, and as the leader at XXX what was interesting to me looking at the groups of midwives was that they weren't very good at that. And even in the most theoretically best models, I think there

was often one person who was pulling the strings or one person who was not being very giving, for example, where 'well I can't do my clinic today' or she'd never be the one who covered' Cathy:4

Annie discussed how important their coaching system was that included their purpose and values document was in helping form a cohesive team:

'it also went into the ways in which you work together, how you manage conflict, how you manage meetings together. Every element of the organisation was covered by this document. It built in peer to peer support, as well as holding each other to account, but in a way that supported individuals to have difficult conversations, not through blame but through reflective practice and open honest discussion. It is a really exciting way of working' Annie:7

Cathy reflected on how she dealt with conflict was not in the command and control style of leadership:

'I had an optimistic, hopeful (actually most people are adults and if they're not then there's something going on) approach. But I suspect the common managerial approach in midwifery is to just become more authoritarian with people' Cathy:6

Supporting an inclusive non-hierarchical culture that knows the importance of human factors was important. Support was provided through robust systems and realistic supportive midwifery guidelines:

'if the system doesn't work then busy people will find work rounds and then the work rounds make things go wrong, but most of the time the work rounds are ok , but it's just occasionally that they fall over and then you say but you haven't followed the guideline, but nobody has been following that guideline for years. And that's all about individual blaming because it's much easier to say that midwife didn't follow the guideline, rather than say we've got a rubbish guideline and how can we expect them to follow that guideline and manage in that situation is actually unreasonable' Caroline:14

The success of the model relies on midwives being willing to continue to work within it. When conflict arises within the team it has been the experience of the participants that it can be a difficult situation to manage. By recognising that there are sociological processes at play within the hierarchy and culture of the NHS, the participants were able to acknowledge and manage MCoCer models. They developed skills that enabled a non-hierarchical leadership behaviour to support the MCoCer autonomous midwives.

4.3.4 Understanding MCoCer midwives and being less rule bound

The participants intimated that the midwives working in the model were different from the midwives working in the maternity unit and this had implications for them as managers:

'They were 'other'....., you then have harder work on occasions with them. The people that worked in teams tended to be more rule bound, more compliant, not just with the whole bureaucracy of the hospital, the churning out of stuff from HR, but also the clinical rules, the unspoken rules as well as the overt guidelines, therefore they are seen as being, more part of the team, the teams are more 'team' ... the caseload are more 'other' and different, and when things are more 'other' and different they are more threatening' Caroline:8

Annie described the realities of how this presented itself for her as the manager who had a responsibility for compliance with process and procedure:

'if you are truly trying to develop a self-managing organisation you absolutely have to put your money where your mouth is, because of course the other challenges around all of this work, around any of these set ups, these models, is that midwives love the bits they love: which is the freedom to do things the way they want to do it, but they didn't necessarily like all the bits that came with it. They didn't always fill in the birth register in straight away, they had to manage and monitor spreadsheets, they had to share out all the roles that were also part of being genuinely self-managing and that was part of the tension, it was really about sitting down and having these quite chewy conversations, about what they needed to come up with in order to meet the required level of continuity, because at the end of the day this was a continuity pilot, so the continuity element had to trump everything else really' Annie:5

The participants acknowledged that the midwives working in MCoCer models provided care that resulted in different outcomes. The element that the midwives were different was explored further with Caroline, Annie and Vicki. For example, as Caroline discussed 'elitism' as being exclusive:

'I think there is an element of elitism, feeling that they were elite because they did so much more on call, and they were doing the continuity. And those quite frankly, those teams had homebirth rates of 30-40% so they were doing something quite different, so the teams still had higher homebirth rates than the national average, but they were around 5% probably' Caroline:4.

Vicki described the MCoCer midwives as:

'very satisfied, very proud of what she does, and what her statistics tell her about the care she gives, and the majority of them are very well

rounded clinicians who have their skills at their fingertips- so yes, elite, but that's a good thing' .Vicki:10

Annie emphasised the distinctiveness MCoCer midwives:

'It will be seen as an alternative way of working and those midwives will be holistically skilled... because you do every aspect of midwifery in caseloading, I think you become a different sort of midwife' Annie:10.

The participants had experienced that the midwives who want to work in a relational model with women seem to be different to the ones that want to work in the traditional NHS models. This was acknowledged as requiring a different way of managing in order to sustain the midwives in the model. By valuing their strengths and focus they supported these midwives to sustain the model.

4.3.5 Is it the philosophy, the midwives or the model?

The participants identified that the midwives who chose to work within the MCoCer models shared the philosophy of woman centred care. These midwives were the ones who implemented MCoCer and thus had different outcomes in their practice. The philosophy of care was inextricably linked to the outcomes:

'I don't think it's about the model I think it's about the philosophy of care. Because I think the philosophy of care that I observed being offered in caseload practices was very much about a seeping of power and control to women. About supporting them in making decisions whatever those decisions were and that is not how midwives' practice typically on a day to day basis in standard models. So whether the continuity outcomes that are so different as I said earlier are a proxy for actually this is how midwives who work in certain ways, who choose to organise themselves in certain ways, it's actually not about how they organisationally manage their time but the philosophy of care that they offer to the women and their approach and that's what makes the difference. I think that's probably an underestimated contributor to the outcomes' Caroline:10.

This 'seeping of power' was mentioned by Caroline, Annie and Lesley when identifying with the relationship that was developed in MCoCer models:

'probably the outcomes of MCoCer arise from both relationship-based care: the care mediated through human relationship and a shared philosophy' Lesley:6.

The participants agreed that the sharing of philosophy and values became even more important when more than 2 midwives were sharing the care. For the woman this created informational continuity and for the midwives it

created a safety in practice by feeling able to share in values and have a sense of worth in the model that they were developing that was sustainable for them:

'there was something about the organisational aspect of it that was so much more than just being a caseload midwife, you know we were well on the way to creating something that has real value. And it's that that will make this sustainable in the longer term definitely for me' Annie:9

The participants agreed that the sharing of a woman centred philosophy was important to the model for recruitment, retention and outcomes. That the midwives who shared this philosophy preferred working in relational model and therefore sustained working in a MCoCer model.

4.4 Experiences of Sustaining

This section encompasses the 4 focus codes that emerged as the theoretical code 'Mastery of high quality, safe midwifery continuity of carer models' (Table 10).

Focus codes	Theoretical code
Choosing your culture	Mastery of high quality, safe midwifery continuity of carer models
Can we build it? Yes we can!	
Being a custodian	
Living outside the box	

Table 10: Focus codes for Mastery of high quality, safe midwifery continuity of carer models

This section presents the participants experiences and reflections on how the sustainability was affected by the influence of culture, other people and personal resilience as it developed. It encompasses the way that the participants described how they felt and behaved and what impact that had on the sustainability of MCoCer within their maternity unit. It explores how the participants used the system that was developed to build the model and to maintain sustainability. The thoughts that the participants have towards the other midwifery managers within the UK who are currently struggling with how to initiate and sustain MCoCer are included. It concludes with personal reflections on themselves in relation to managing MCoCer.

4.4.1 Choosing your culture

The principle of choice and control was present within the participants decisions to support the MCoCer models. They influenced the culture with their management style in providing choice and control for the midwives:

'and one of the things I discovered at XXX was that it takes a lot of energy from the leader. It is not easy to keep small groups of midwives going. And I think midwifery leaders in a way they sort of go for the easy life, if we do things down this line, and we do it in a certain way, that's simplest, if it's easiest to have everyone working 12 hour shifts, as opposed to flexible working. In my view that needs turned on its head- I do agree that it's hard work managing flexible systems, but it pays off in the long run. Whether it's through recruitment and retention or it's just the positivity of the place' Cathy:5

Creating a culture where communication flowed and midwives were listened to enabled a change in clinical culture by changing the personal behaviour, therefore influencing the professional culture in the unit where responsibility was encouraged:

'It has got a lot to do with leadership, you need leaders throughout a whole organisation, everybody needs to be leader actually and they need to take responsibility, and midwifery managers need to be prepared to relinquish that power and that's a real challenge when you are accountable externally for organisational delivery' Annie:8

The participants expressed how difficult it was to integrate MCoCer into unreceptive NHS cultures and described it as having silos. Lesley describes how important it is to have local cultural knowledge and be prepared for resistance:

'I had no idea about these closed groups in the wards and departments and the Labour ward in particular and the antagonism that it would create' Lesley:5

Lesley's most recent experience of integrating a MCoCer model into the NHS was very different as she had support from the surrounding stakeholders to help influence the culture. The participants used their own drive and energy alongside support from other stakeholders whilst engaging the midwives who wanted to work in the model to initiate and ultimately sustain it. As they gained experience, they initiated models with midwives who had less enthusiasm for the models and identified that this created new challenges for them as midwifery managers:

'so when we decided we would have a group of midwives linked to a GP practice we used the midwives who were already going in there and doing antenatal clinic, so they were harder to work with cause they were not all continuity of carer devotees' Cathy:6

The participants were pragmatic and knew that not all midwives wanted to be MCoCer midwives and considered whether the dominant medicalised model and philosophy was impacting upon the initiation and the sustainability of supporting MCoCer:

'But I think that midwives are actively frightened. Other research has talked about that- 'it's my PIN on the line, she is going to lose me my registration' I think midwives do not see it as a very positive thing to support women in that way they see it as a very threatening at their end' Caroline:10.

Caroline discussed the racial mix of midwives practising within the MCoCer models. Annie and Vicki were encouraged to explore ethnic diversity; however, they identified the differences in the teams of midwives were more influenced by caring responsibilities rather than racial mix, this is an interesting observation; however, as all participants were white, the racial sensitivities of MCoCer models requires further investigation:

'xxx has a really diverse population, but the midwives working in the caseload practice were less diverse than the midwives working in the teams. More white midwives. And I spoke to a midwife from an afro-Caribbean background for whom I have a great deal of respect and we were talking about this, about the offering choice and about following the rules, and I spoke about this observation and she said that midwives from Afro-Caribbean backgrounds, because of the experience that they have, with the low levels of micro aggression and racism that they experience on a day to day basis, one of the ways that they learn to manage is by being very compliant and rule bound because what those midwives do is that when midwives look after women who make choices that are unconventional the midwives are as exposed in the system that doesn't agree with the choice that has been made as the woman and for a midwife from an Afro-Caribbean background that is not a comfortable place to be so you don't put yourself in that position' Caroline:10.

The experience of midwives being vulnerable in supporting women in an unsupportive NHS culture was discussed. There was an awareness around how the midwife can be blamed in a culture that assumes compliance and permissions:

'It's that discourse isn't it- 'why has the midwife let her do that' It's that discourse. You hear that 'why hasn't the midwife told her' Caroline:10.

The participants described a systematic behaviour of blame within the NHS which acted as a deterrent for midwives to support women's choices and thus less likely when the midwife herself felt vulnerable to scrutiny through culturally being exposed to racism.

Developing a culture within the NHS that was inclusive, flexible and open to change was the key to the participants sustaining the MCoCer model. It was seen as a moral imperative to provide MCoCer due to the strong evidence base surrounding the quality and safety of care that it provides:

'I'm saying to them it would be unethical to not to try and do this. If we look at induction of labour or something and some big randomised controlled trial comes out and we look at it and it's a good one the next thing we know is that we're immediately changing our policy on induction of labour. Whereas MCoCer despite the evidence base people seem to think they have the permission not to do it, but I think that is an unteachable bit. I think you need to always be holding onto the fact that your care should be woman centred not institution centred etc and it should be evidence based' Cathy:12

Despite these organisational and cultural barriers participants mastered how to influence the NHS culture in order to sustain the MCoCer models.

4.4.2 Can we build it? Yes we can!

There was a strategic mindset of the participants to build the model to the point where it became an integral part of the service and therefore less vulnerable to financial scrutiny. This required planning, involving stakeholders and energy. The participants spoke about it being complex and hard work that demanded resilience:

'and one of the things that I think that's really important is that there are enough of them. So even when I was there with this mishmash of teams doing all different models it was you couldn't pick them off because there were so many teams you had to have a justification for picking them off one by one whereas I think a lot of these case loading pilots- if they are on their own, they're really easy to pick off, they're low hanging fruit when you're looking at 'I need to make a cost pressure' well actually I've had to put 6 midwives in there and I haven't moved a WTE off anywhere off any budget, so actually you're just costing me money and I think there is that thing about you reach a critical mass where suddenly the model gets a stability just by having a size. That's one thing that makes them vulnerable in the beginning' Caroline:5

Providing choice for midwives within a maternity service was a key aspect to integrating and sustaining the model in the NHS:

'everyone wanted to work on labour ward and one of the things that I think sustained the community was that we had such a variety of models. I think that that coupled with there being so much of it in that there were variants. A midwife might be working in a team model and think I'm not getting enough continuity I want to go into a caseload model. Or she might think when she's in a caseload model- I don't want to do this much on call when I'm doing my master's so she might move into a team model, so it was self-sustaining' Caroline:5

This openness to providing movement between different ways of working was important yet the difficulty in recruiting into the MCoCer model was acknowledged and recognised as a threat to sustainability:

'because some people just do not want to have a phone when they leave the building..... (it causes) A massive amount of resistance, fear and anxiety and stress in people's lives' Vicki:12

Vicki discussed how important it was to grow the model for the future and develop alternatives that had no 'on-call' element:

'how can we make it work for more midwives? and I think continuity models work more when there's not the on-call element. So we have to look at how the women who would traditionally be having their baby in the obstetric unit- the obstetric medicine women, how we might see them through our central antenatal clinics because they are so complex and work even more closely alongside the obstetrician and then they run a line on the labour ward rota' Vicki:12

The participants indicated that midwifery students were also a key element to future strong sustainable services:

'being able to get across that this way of working is both rewarding and doable and hard at timesit is a realistic and stretching option for far more midwives than currently think that caseload holding is not for them cause I think a lot of midwives are scared, they're scared of birth, they're scared of responsibility, if you've trained up through the NHS system, and you're told as new midwives are all the time, you've got to consolidate your skills on the labour ward, that's one of the quickest ways of putting midwives off normal birth actually so the eventual way that this should become self-sustaining is that you start to take on student midwives, you have a proper apprenticeship, they see this in action and then they can come out and be those midwives, that's how you will eventually arrive at a tipping point of caseloading 'comfortable in their own skin' type midwives , it may never be the majority, but it will be a solid minority of midwives who are both comfortable to work in this way and really value it and are able to do it actually' Annie:10

The participants indicated that personal support for themselves was necessary to continue having drive and energy to sustain the model:

'the value of having a board with critical friends was really important. These were people whom I trusted, and I could say things to, and I could admit things to, and they wouldn't judge me' Annie:16

Building a model that was integrated enough into the service enabled financial scrutiny to be lessened. Making it flexible and broad enough to accommodate midwives needs and requirements with variations in the on-call element, as well as exposing student midwives to learning in MCoCer models were seen to be the basis for sustainability.

4.4.3 Being a custodian

The participants had empathy for the managers who were currently in post and not knowing how to establish MCoCer:

'the kind of leadership and the flexibility is then the ability to duck and dive and to keep that vision going through tough times whether that is financial, or the one time that a serious incident emerges from a practice incident. So often when that happens everything just caves, but you need to be the HOM that goes 'but hang on a minute we had a serious incident on the labour ward yesterday and we didn't close the obstetric service' where as midwifery leaders are often part of 'the fear'. So, we also need to- I think, give our mw leaders the skills. And it does boil down to practical tools- you know What do you do when you have the one poor home birth outcome- what are the things you say and what are the things you don't say? And I think a lot of midwifery leaders don't even know how to make the case for developing the MCoCer models, they don't know how to talk about effectiveness of healthcare, they don't know how to talk about efficiency of healthcare, they don't know what language to use. So, I think all those skills can be taught' Cathy:15

Lesley intimated that within the NHS there is the capacity to distort information if the midwifery managers are not engaging with the philosophy or believe in the benefit of MCoCer then figures may not be representative of the facts:

'The trouble is there's ways to fudge it' Lesley:9

The participants had achieved something that few midwifery managers had. The participants described skills and a unique outlook that are seemingly not universally available within the NHS. They acknowledged that without someone skilled in midwifery management and MCoCer, the model could be subject to very different influences and its sustainability threatened.

4.4.4 Living outside the box

The participants wanted to provide MCoCer models for women and midwives. They acknowledged what satisfaction it gave them personally to see value through their work and see it making a difference. It was however, heavy with responsibility:

'at times I would want to leave, and I would think ' I just can't bear this anymore' and then I would meet a woman who had had a known midwife, and the way she talked to me about her care, "and when I saw my midwives' face come through the door". It brings tears to me even now, there was a woman who had a premature birth, a really really difficult experience and she talked about the minute her midwife walked through the door and she saw her familiar face and what it meant to her. So that kept me going, And the midwives would tell me how exciting it was' Lesley:5

In order to sustain the MCoCer all the participants shared an element of having to live with the uncertainty of change and find resilience to support what they believed in. By staying strong as an outlier within the maternity services they enabled sustainable MCoCer models:

'And there is a way of doing it, I believe. Where these midwives can engage within the wider system and thrive, and part of that thriving is knowing someone has got your back, so you've got a strong team, and knowing you've got a strong team' Annie:11

It could be construed that the participants had mastered how to be midwifery managers to MCoCer midwives akin to how midwives support women to have choice and control through their maternity experiences- in a sense participants were midwifing the MCoCer midwives who they managed.

4.5 Summary

This chapter has outlined the views and experiences of the participants implementing and sustaining MCoCer. The impact of creating a change in practice that has influenced the sociological processes of how care is provided and the power dynamic shifting from midwife to woman and manager to midwife has been explored. The active decision to integrate woman centred care into the NHS created a need to safeguard and promote the alternative culture that was being developed by the introduction of MCoCer.

The recognition that by starting with the philosophical underpinning of woman centred care the participants were able to change the organisational systems within the NHS maternity system to accommodate a model that brought a new dynamic of choice and control both for women and midwives.

This came at a personal cost of having to have courage to invest their time and energy in an organisation that was resistant and at times difficult to change; however, all participants explained how the positive impact on the women and the culture in the unit was changed for the better.

MCoCer was seen to have potential to integrate a solid minority of holistically skilled midwives into an alternative way of providing maternity care in the NHS. The introduction of MCoCer into an institution appears to engender possibilities for improving choice and autonomy for midwives providing opportunities to bring forth more meaning and satisfaction into the NHS midwifery practice culture.

Chapter 5 discusses the emergent theoretical codes and core category.

Chapter 5: Developing a Grounded theory

This chapter outlines the development of the grounded theory. Data analysis and an outline of the construction of the four theoretical codes that emerged from the focused codes has been presented in chapter four. Each of the four theoretical codes is presented in turn prior to the core category. The core category 'leading meaningful midwifery' was developed from the four theoretical codes that emerged within the study. The grounded theory that has been derived explains how the participants have developed their skills and behaviours in response to their experiences to become experts in how to implement and sustain MCoCer models.

5.1 Theoretical Code: Trusting in woman centred philosophy of care

The four focus codes within views of implementation were encapsulated by the theoretical code 'Trusting in women centred philosophy of care'. These focus codes identify that the participants had a deep understanding of what MCoCer entailed in terms of relational working between midwives and between midwives and women, and what it delivered in terms of outcomes for women and babies and midwives. Most of the participants had worked this way as midwives. They shared a philosophy of women centred care and belief in providing choice and control for women which led to the vision to create and support a structure for it. They were adept at managing across all levels in order to gain support for the change in practice and were skilled at developing trustworthy relationships. They actively used their role to support midwives implementing MCoCer acknowledging the team dynamics that they had to develop. The participants engaged with wider stakeholders and encouraged a woman centred culture for midwives as women as well as women using the service across the whole maternity unit. They were politically astute and organisationally knowledgeable and through such awareness were able to develop a suitable non-hierarchical management style.

5.2 Theoretical Code: Transformative leadership enabling the assimilation of alternative frameworks of care

Within this code the three focus codes related to how the participants had integrated the MCoCer model within the NHS traditional framework of maternity care provision. This integration required energy, effort, thought and specific behaviours from them. They stayed credible as midwives within their service as well as using their managerial status to empower the midwives to take control of their work and organise it so that it would be sustainable for them. They did this by staying connected to their staff by being visible, having meetings with them, talking with them and taking an interest in them whilst at the same time working with the board level members to disseminate the change in practice. They shaped the culture of their organisations with their interactions.

The participants emphasised that the logistical planning of the new framework was vital to enable the functioning of it. They knew what they found to have worked- e.g. having more than six midwives in a group practice, having a mixed risk geographically based caseload and not using the midwives for busy times within the unit unless absolutely necessary. They also knew that it could be destroyed by apathetic management, rumours, not investing in supporting the midwives through time and finances for it and by midwives not cohesing as a team.

The basis of setting a framework of personal responsibilities, group responsibilities and service responsibilities that could be supported by the midwifery management through reflection, reviewing and monitoring was their aim in their management style which led to the sustainability of the MCoCer model within the NHS.

The result was that through their personal style of management and philosophy they created a possibility of MCoCer models sitting alongside other models of midwifery care and functioning within the NHS. What was called upon was a non-hierarchical transformative style of leadership.

5.3 Theoretical code: Promotion and protection of values-based midwifery and a woman centred culture

The five focus codes contained within this theoretical code were both practical and philosophical. The participants views of sustaining the model led them to discover that it can 'morph' into something quite different if not sustained through a lens of vigilance and commitment to the original values and philosophy. This support was an essential requirement for the sustainability of the model and was required to defend it within a culture that could be antagonistic towards it and scrutinized its outcomes.

The leadership that they spoke about was one that was based on values-where they valued the philosophy of the midwives and they wanted the midwives to be in control of their choices. Much in the same way that they describe the 'seeping of power and control' from the midwives to the women they spoke about having a relationship as a manager where they wanted the midwives to be in control of their working lives. This 'midwifing the midwives' was a style that they all appeared to naturally end up achieving through their personal and professional values.

The participants spoke about the lack of investment of the MCoCer midwives in the bureaucracy of the hospital systems. This challenged the embedded NHS culture; however, the participants were themselves challenging the embedded culture in order to implement the outlying MCoCer model.

The participants were implementing MCoCer into the NHS culture and integrating it into the system by transforming the values and philosophy of the culture. It was acknowledged that just by changing the day to day organisation of the midwives workstream the outcomes would be unlikely to change. Participants recognised that it was through transforming the underlying culture and philosophy that change in outcomes was possible.

5.4 Theoretical code: Mastery of high quality, safe midwifery continuity of carer models

The four focus codes that form 'mastery of high quality safe MCoCer' were developed through the participants experiences of sustaining the model. The participants expressed how daunting and overwhelming at times it was when implementing and sustaining the model; however, they also described finding the challenges exciting and rewarding when they witnessed sustained change in practice. The mastery was gained by rooting the model within the culture and organisation to the point where other stakeholders (such as the obstetricians and board members) felt an ownership of the model. They acknowledged that they were aware that other midwifery managers appeared to function and behave differently within the NHS. They displayed empathy for those without the skill and experience in leading MCoCer and the task ahead of them, but also scepticism that some other midwifery managers would be able to implement and sustain the MCoCer model within the current hierarchical culture of the NHS. Without having the imagination, creativity and vision to engage the midwives in the change in practice and invent new ways of developing MCoCer models this way of organising maternity services may always be vulnerable to personal managerial style and behaviours.

The participants reflected that recruitment and retention of midwives into the model was difficult and compounded by racial tensions with the vulnerabilities that midwives can feel when supporting women in unconventional choices.

However, the moral imperative to achieve mastery of safe high quality sustainable MCoCer provision, that worked for midwives and women, was one that was evident throughout the participant's narrated experiences.

5.5 Developing a core category of Leading meaningful midwifery

By constant comparative analysis 'leading meaningful midwifery' emerged as the core category for the grounded theory. There was a core thread throughout all the participants interviews that they were working hard to develop a way of working that had meaning- for them, the midwives they were managing and the women who were having babies within their service.

The participants had a desire to build and maintain MCoCer but also wanted it to be realistic and not share a vision that was either unachievable or represent unrealistic expectations of what it entailed. The participants expressed a commensal relationship with their style of leadership and the sustainability of the model.

They identified three principal vulnerabilities in the implementation and sustainability of the model;

- willingness or availability of staff with the right philosophy,
- being identifiable as a cost pressure in a small project and
- being under more scrutiny in general within the service as an outlying entity.

There was also a cultural vulnerability of supporting women's choices within a relational model of care and the pressure created for the midwives within a hierarchical system prone to bullying by feeling more isolated from the cultural 'norms' in supporting choice. Participants stressed the importance of supporting midwifery managers implementing the model.

'I think if you do something different everyone looks at you, so you can have a series of bad outcomes on labour ward but because labour ward has accepted that sometimes things go wrong it's ok. But when something goes wrong in a case loading practice then suddenly everyone's much more interested and engaged in it, so I think very few people remember that most babies that get into trouble do so on the labour ward' Caroline:8

The participants discussed the importance of developing the leadership within the maternity system to enable the growth of the model. Recruitment to managerial positions are key to the quality of care provided and the culture in maternity unit. The education of those managers needs to be considered so they have the tools required to lead the service with a woman centered philosophy.

'We need to actually give people the tools. The specific competencies, the what to say, how to use the evidence, how to write a business case, and what to do when things go wrong. Whose doors to knock at, it's that ability to manage upwards as well as downwards' Cathy:8

Lesley reflected that in the beginning one of her mistakes was:

'Thinking that we could go further than we could' Lesley:4

Lesley's experience spanned two decades, and she learned how important it was for the whole of the maternity service to support and value the MCoCer model. This dramatically changed her experience when implementing MCoCer in a receptive culture and being able to impart its relevance and importance:

'the board should know about it; they should get reports on it. I mean this is like, imagine you were getting the most up to date MRI scanner- everyone would know about it, it would be in the papers... well, this is probably more important than that... and it's because it's about people and relationships- because we're in a technocratic age, we don't realise how powerful it is' Lesley:9

The participants brought a sociological perspective into their sharing of experiences recognising that social organisational change within the NHS can be dismissed due to the current dominant culture not being based on relational care:

'this is the most important development in maternity services over recent decades. You know, this is the key to humanising birth, to giving quality safe births. Not all midwives want to practice in this way but the power of it is absolutely tremendous and we destroy that power by controlling midwives' Lesley:5

This change involved the participants and required them to challenge the system and behave differently. They had to have courage and be determined to persevere in supporting autonomous midwifery. This was in many ways more demanding on the participants:

'you were going out on a limb more about midwifery. So, in that situation if you weren't going to stand up for midwifery then yeah, you would have to let other people call the shots, but if you're going to stand up for midwifery then yeah it does ask more of you' Caroline:8

The participants acknowledged that implementing and sustaining MCoCer demanded a different way of behaving and thinking and ultimately managing midwives from them:

'However,, if you start to think differently, and you think in this way of creating a structure and a model and a way of working that is deeply fulfilling for the midwives then it can work- it does work, I've seen it work' Annie:8

'It's actually really exciting because it's setting up a modern management structure. Systems, structure, culture and continuing education' Lesley:10

Creating a meaningful working environment for the midwives and managers that produced improvements in quality of care and outcomes for women was

the underlying premise of the participants, yet the philosophy of what was underlying the practice was what would deem the outcome:

'We don't teach people how to work in teams, we don't teach things like that we don't teach them how to manage conflict appropriately. We're all just bumbling along butting up against each other, getting on each other's nerves with our different philosophies' Caroline:11

The urgency of implementing MCoCer models was outlined by Vicki who said:

'My ultimate feeling is that if we don't get this right this time, it's never going to come around again, so we have to work really hard to get the implementation right and sustainability right' Vicki:10.

By bringing together the four theoretical codes into a core category the model holds the values and creates a theory that is meaningful for midwifery managers and midwives when implementing and sustaining MCoCer. This core category relates directly to meaningful midwifery and is why the participants agreed to be interviewed. Participants were passionate about how they can make a difference every day in their midwifery colleagues working lives, how they pro-actively pursued creating meaning through a philosophy of woman-centred midwifery services that are informed by feminist values. They were energised by the prospect of enabling autonomous midwifery, encouraging professional choice in ways of working and a desire for implementing and sustaining evidence-based safe high quality maternity care provision.

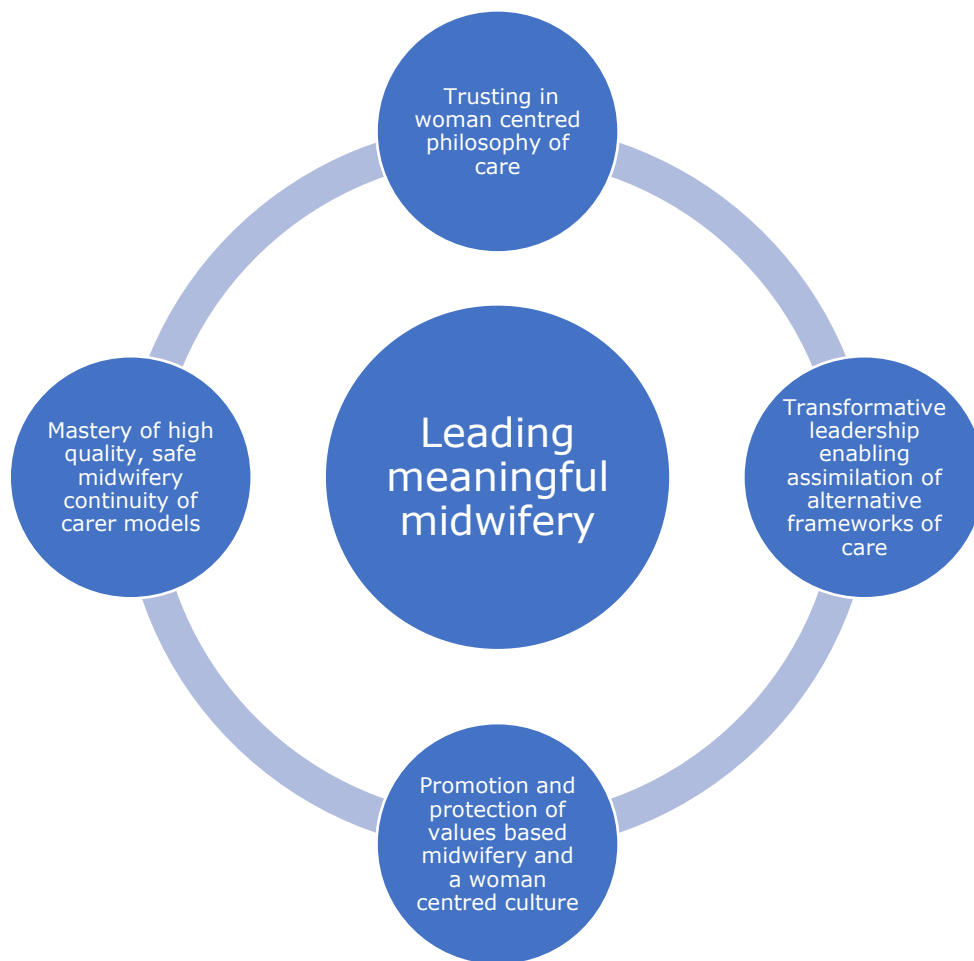


Figure 5 :Theoretical model of Leading meaningful midwifery

5.6 Summary

This chapter provided an account of how the four theoretical codes and the core category developed as the outcome of analysis. The process of analytical coding and emergence of theoretical codes has been described. Study findings highlighted that the midwifery managers who implement and sustain MCoCer are highly motivated, driven, practice-based midwives who care passionately about supporting autonomous midwifery. They have a clear woman centred philosophy and desire to enact this philosophy through sharing their vision and promoting relational care with women. By displaying a collective leadership style that is transformative through behaviours and leadership, the participants developed frameworks and safety nets to implement MCoCer. The participants identified that there was a need for

midwifery managers to provide continuity for the midwives through MCoCer due to the midwives requiring support which is more meaningful when there is a deep personal understanding of the model. It has also been identified how through perseverance and personal resilience midwifery managers can sustain a culture transformation within the NHS to incorporate new models of provision. They achieved this by engaging with the wider stakeholders of the maternity services to share their vision for midwifery and quality care provision for women. The core category brings the theoretical codes together and emphasises the thread of making meaning for midwifery managers and leaders. By creating positive, inclusive and evidence focused working environments for autonomous midwives, the participants lead their maternity services towards a cultural shift that changed how midwifery was enabled and women were cared for. They did this through their knowledge as midwives themselves which influenced and impacted on the midwives they managed in MCoCer models which in turn influenced how women were cared for. They personally identified with evidence based, autonomous midwifery practice and how it benefits women birthing in the NHS and actively promoted this wherever they had the power to do so. By embracing compassion for the meaningful experience of being an autonomous midwife, the participants were able to implement and sustain MCoCer models.

Chapter 6: Discussion and conclusion

The planned outcome of this study was the creation of a theoretical framework grounded in the experiences and perspectives of experienced UK midwifery managers in MCoCer models. It was anticipated that the theoretical framework could be used by midwifery managers who have little to no MCoCer management experience in their own services and therefore was to be pragmatic and practical in order to improve future service provision. Therefore, by asking the research question 'What do midwifery managers perceive as best managerial practices and strategies when considering their own personal experiences managing NHS midwifery continuity of carer models?' the aim was to inform future service provision from positive sustained experience that would enable lessons to be learned and pit-falls illuminated.

In summary, the findings indicate that MCoCer models require a midwifery manager with a woman centred philosophy and a relationally focused set of leadership skills. When this is based on a belief in MCoCer and its benefits, the midwifery managers lead the service through change in the NHS more sustainably. By recognising the support required by midwives, midwifery managers can create a service that has choice for midwives and women and enables autonomous midwifery practice to be a reality in MCoCer models. By creating a working environment and culture that has woman centred values leads to a working life that has meaning for the midwives providing the care and the managers leading it. Due to the values-based nature that underpins the MCoCer, there is an importance of continuity of management personnel. This supports the implementation of MCoCer and creates a long-term stability. Sustainability of the MCoCer model requires repeated and sustained interest and support from the midwifery manager to enable recruitment and healthy functioning of the group practices of midwives forming to provide the care. Without such attuned managerial support, the midwives find maintaining a healthy working environment an ongoing challenge.

This chapter explores each of the research objectives in relation to the findings of this study and their contexts within the broader literature. First, the discussion explores the skills, attitudes and attributes required by

midwifery managers for implementing and sustaining MCoCer models. Next, the managerial factors that enhance and hinder the implementation and have impact on the sustainability of the MCoCer models are discussed. Limitations of this study are discussed with recommendations for policy, education, organisations and future research. The chapter ends with my own reflections and a summary.

6.1 Successful midwifery managers within the MCoCer model.

6.1.1 Attitudes: Philosophy of care

Having a woman centred philosophy underpinned the attitude of the participants. Maternity services leadership and its accompanying philosophy of practice has been given much attention regarding the quality of care that is produced within the cultures that it creates (Francis 2013; West et al 2015). The participants in this study agreed that their personal support and philosophy of practice needed to align with the goal of providing woman centred continuity. The importance of the managerial and leadership goals being a determinant of the quality of care outcome is confirmed by previous health and managerial research (West et al 2015). However, this study has determined that the need for this alignment is not apparently considered when developing MCoCer policy which impacts on NHS practice change directives, such as The Best Start (The Scottish Government 2017) and Better Births (NHS England 2016).

Philosophy of care is regarded as integral to practice; however, both policy documents, Best Start (The Scottish Government 2017) and Better Births (NHS England 2016), make no contingency plans for how the philosophy will be integrated into the current medicalised and hierarchical culture of NHS practice. The findings from this study suggest that organisational models do not in themselves change philosophy of care. This has been shown in other areas of organisational research (Gilley, Dean and Bierema 2008) where a philosophical change is an individual act rather than external practice change. Moreover, the participants philosophy of care was the impetus for the implementation of the MCoCer model and a key strength in supporting the sustainability of the MCoCer according to participant's experiences and

perspectives in this current study. Participants referred to their own personal philosophies being a driving force for them to work within a MCoCer model thus valuing and supporting midwives to practice in this way when they were in a managerial role. Consequently, it was their personal professional philosophies that enabled implementation not the organisational practice of MCoCer models that led to the enactment of the philosophy.

In the wider context of managerial theories, it is suggested that when leading others through change, creating meaning through shared values enhances the commitment and performance of those at work within organisations (Poole and Van de Ven 2004). This has been identified by Cramer and Hunter (2019) in their thematic literature review as integral to the working conditions in midwifery. They suggest that poor emotional wellbeing in midwives correlates with not achieving continuity of carer amongst other organisational causes such as low staffing, high workload, poor support from colleagues in challenging clinical situations and low clinical autonomy. Indeed, poor psycho-emotional wellbeing has repercussions on care delivery. For example, Patterson, Hollins Martin and Karatzias (2019) found through interpretive phenomenological analysis of interviews from women and midwives that women are more likely to experience trauma when cared for by midwives who experience poor emotional wellbeing and lack of organisational support. Hence the need for NHS midwifery managers to encourage the creation of a culture of practice based around a woman centred philosophy where the individual midwife feels valued. This helps ensure a midwife identifies with the positive culture at work creating potential for improved safe practice for women being cared for within the maternity services. In other words, to provide tactful compassionate midwifery care to women and their families, midwives need to be cared for in a compassionate organisation (Davies, Crowther and Hunter 2019). In such an organisational mood, meaning is brought into practice.

Hunter (2010) contends in her paper contrasting the knowledge surrounding the emotional work of midwives from a decade previously to currently, that by bringing value and meaning into the workplace individuals are enabled to find joy in their working lives. This joy and passion for midwifery work is frequently referred to for midwives as their 'vocation' or 'calling' rather than

their employment. Hunter et al (2018) analysed just under 2000 responses to their questionnaire about working environments for midwives, and concludes that an emotional connection can be enhanced and celebrated by having midwifery managers who recognise the importance of working in a values-based organisation that encourages supportive flexible working that values the individual alongside their position as an employee. By investigating midwifery managers, this study has highlighted that when midwifery managers value and respect women and centre the support they provide through their role towards the workforce, they enable choice and control- for both the midwife and the woman in their care. By providing this flexible, evidence-based environment, midwifery managers are more likely to successfully implement and sustain MCoCer models. This is due to the midwives within those cultures having agency over their own working lives and therefore feeling enabled and supported by the manager to provide high quality care. This need for self-determination and supportive leadership persistently arises in the literature (Crowther et al 2016; Gilkison et al 2015; Patterson, Hollins Martin and Katazias 2019).

There appears to be little examination of the factors within MCoCer that create the positive outcomes for women and babies in current literature. It seems difficult to isolate whether the midwives who have a strong desire to work in this way approach their midwifery practice with an innate philosophy of woman centred care and that by developing a relationship on these terms delivers better clinical outcomes. As the model becomes more widespread there will be more information available to analyse whether the organising of midwives in a MCoCer model can in itself produce the improved outcomes or change philosophy (Sandall et al 2016). It remains unclear if it is purely woman-centred philosophical orientation that creates the difference in satisfaction and improved working life for midwives- this too requires further investigation (Homer et al 2019). This current study asserts that midwifery managers who successfully implement and sustain MCoCer models are focused on maintaining a compassionate woman centred philosophy themselves and expect and promote it from the workforce that they manage.

In an exploration of availability and willingness of midwives to work in MCoCer models this study did uncover that there are questions to be asked

around cultural challenges for midwives from black and ethnic origins (BAEM – Black And Ethnic Minorities). It was suggested by Caroline that these midwives are under-represented in MCoCer models as they may experience tensions with the prospect of working within a system that does not easily sit within organisational boundaries due to their personal experiences of racism and their possible preference to conform to convention. This could have an impact on the racial mix of midwives caring for women in MCoCer models and be detrimental to the recruitment and retention of MCoCer models.

Hardeman, Medina and KozhimAnnieil (2016) discuss that care for black women in America is preferable from a black midwife to prevent structural racism. Unfortunately, the adverse effects of racial and ethnic differences extend beyond personal preference and desire for access to MCoCer from a person of the same race/ ethnic background to overt disparity in biomedical outcomes. The MBRRACE-UK report (2019) states that black and ethnically diverse women birthing in the UK are five times more likely to die during their maternity episodes. Persistent poverty and inequalities are identified within the MBRRACE-UK report as impacting on the maternity outcomes for these women. It is therefore important that these women are provided with the highest quality of care and there is a consensus that the highest quality of care *is* MCoCer (Sandall et al 2016). It is suggested from this study that there could be a need to encourage engagement with black and ethnically diverse midwives to consider working in MCoCer models. It is known that recruitment in your own image is more likely, and therefore having MCoCer midwives who are white recruiting for the model may skew the cultural diversity of the midwifery pool available. Further exploration of this topic is required in future research. Encouraging ethnic diversity among MCoCer midwives would be a positive force in encouraging safe quality midwifery practice for women with diverse ethnicity in the UK to improve poor outcomes in this population. Although BAME was not the focus of this study, or explicitly developed in the thesis, it is important to acknowledge that this is an area that requires further examination in further research.

6.1.2 Skill set: Relationally focused leadership

Within the wider managerial and leadership context it has been suggested that when supporting the implementation of change the leader is a key player in whether the change is successful (West et al 2017).

Gopee and Galloway (2017) suggest that leaders should be skilled in certain change management behaviours including being able to assess personal knowledge continuously as well as upskilling and updating alongside being able to see advantages in the change over existing practices. However, there is no suggestion within the midwifery literature associated with MCoCer about how these attributes can be determined. In addition, UK midwifery education is including leadership theories and change management in midwifery courses but not appearing to recruit from a values-based ethos from the outset (McGuire et al 2016). McGuire et al (2016) used a multi method study to investigate the use of values-based questioning in an NMAHP (Nursing, Midwifery and Allied Health Professionals) interview setting. They assert that using this interview technique enabled an insight into the motivations of candidates that traditional interviewing missed. Once working in placement, midwifery students are exposed to cultures that are not supporting values-based leadership and MCoCer models due to most of the NHS not practicing MCoCer models, thus producing a theory: practice gap in learning. According to the RCM (2019) most midwifery managers within the NHS have not been educated in a grounding of leadership and change management skills. Thus Dawson and Andriopoulos's (2017) assertion that change is often a political process becomes more likely, due to having a climate where a large bureaucratic institution (the NHS) is making policy decisions based on the evidence of beneficence but not on how the workers within the institution will interpret and apply the changes.

Transformational management is a theory that resonates with how this study analysed the skill set of the participants. It is a leadership style that is widely advocated within health and social care settings (Gopee and Galloway 2017). Fischer (2016) suggest that the positive influence on organisational culture and improved outcomes is substantial when considering nursing care. Holly and Igwee (2011) identify transformational leadership as encouraging new ideas, having individual consideration for followers, providing inspirational

motivation, stimulating creativity, transmitting optimism and significance for tasks in hand, providing a sense of direction in attaining organisational goals, providing role models and examples of performance and instilling pride and motivation. The participants in this study identified with the importance of these qualities. This style leads to intellectual stimulation and the ability to become an exemplary leader (Kouzes and Posner 2017). The findings of this study, within the context of midwifery leadership, suggests that NHS midwifery managers require an exemplary skill set in order to achieve the effective management of MCoCer. Study participants all exhibited the skills identified as necessary to build a successful relationship with the midwives within the maternity services that they had responsibility for and encourage a positive culture that enabled a transformation to occur. Consideration should be given to the necessary skill set exhibited by the participants when implementing and sustaining MCoCer models as by overlooking such fundamental requirements may challenge the model further than if consideration is given to them at the planning stage.

The findings of this study suggest that it is vital to provide service commissioners and policy makers with evidence around the importance of the leader managing the maternity service and their skill set in relation to the implementing and sustaining MCoCer within the NHS. Similar to the findings of Hewitt, Priddis and Dahlen (2019)'s study, who describe the need for midwifery leaders to have certain attributes and skills in transformative leadership, participants in this study exhibited having transformational leadership qualities with the vision to lead the practice into the future as a key motivator for continuing to support MCoCer models in the NHS. Congruent with Kouzes and Posner (2017), this study asserts that the intellectual stimulation that the participants found from implementing and sustaining MCoCer within the NHS with a transformational style of management, motivated them as individuals to have the courage to stand up for midwifery through the challenging times. This motivation enabled them to thrive in their position as managers in both the implementation and the sustainability aspects of the model.

6.1.3 Attributes: belief in the model

Consistent with Hewitt, Priddis and Dahlen's (2019) work, this research confirms that managers of midwives who are working in a MCoCer model are required to clearly demonstrate a belief in the model. Hewitt, Priddis and Dahlen (2019) describe it as 'Holding the ground for midwifery, for women' where the midwifery managers need to protect, guard, promote and safeguard the service. If we interpret safeguarding as actions that allow something, in this case, relational continuity of midwife carer, to continue over time in the current NHS organisation, then the imperative to protect such a model involves a myriad of strategies to sustain such change including resolute, well attuned transformational leadership. Yet, it is worth considering that there are a small number of midwifery leaders with the experience of managing MCoCer models. Therefore, there could be a homogenising effect of those leaders creating an environment that is based on similar experiences to each other. It could be suggested that those who have sought out specific experiences as leaders due to their preference for midwifery to be practiced in an autonomous way have identified similar impressions and experiences as each other and therefore limited the scope of the study. However, it is clear from this study that in order to successfully support autonomous midwifery practice within a MCoCer model, a midwifery manager who has the grounding of believing in the models' worth is necessary.

Hewitt, Priddis and Dahlen's (2019) study confers with this study that midwifery managers who understand the intricacies of the midwife/ woman relationship encourage the humanising of birth by establishing MCoCer and support sustainable services based on relational care for women and their midwives. The support of midwives for practicing in this way enables a working environment that works for midwives and thus underpins quality provision of care. By being a skilled manager that can facilitate the development of their staff the participants were able to encourage the understanding and practising of a non-mainstream service. The participants in this study required a thorough and intimate knowledge of MCoCer models and were able to promote and defend the model within the current NHS organisational culture through these skills and attributes.

6.2 Managerial factors that may enhance or hinder implementation and sustainability

6.2.1 Challenging the existing status quo and using managerial privilege

Participants related the importance of being willing to safeguard MCoCer, a non-mainstream service, within mainstream maternity services. They recognised the vulnerability of having a service that may not be understood by other members of staff or could be and was resisted by some staff. The importance of the culture within the unit was a vital part of recognising how to integrate MCoCer into the service. The semi-structured questions asked in interview were not directly related to the NHS culture within maternity services. Yet, participants linked their leadership behaviours as partly required due to integrating a change within the culture of the NHS. It is suggested from the findings of this study, that in order to have a positive integration of MCoCer, the managers of the service must recognise the culture as something to influence and role model their expectations in order to form a positive, supportive one. They must be able to influence the organisation's cultural behaviours by having an open and honest relationship with the midwives that are working in the service, be respected by them and have developed positive relationships with the members of the board of the hospital in order to influence change and garner financial support for the MCoCer transition to practice.

This is consistent with the finding of McCourt et al's (2018) ethnographic study on alongside midwifery units which suggested that establishing a trusting relationship within the unit's staff when leading change was important in the sustainability of the model. Furthermore, the intra-professional tensions that have been reported within the NHS maternity culture by the Francis report (2013) were highlighted within this study in terms of there being a need for collective working and collaboration when change in service is planned. Consequently, the building of relationships was repeatedly mentioned by participants as a key component of managing, leading, planning and sustaining the MCoCer model.

By creating a cultural change where there is choice and control exerted by midwives over their working life and their human needs met at work, the

impact is one of quality care provision (Patterson, Hollins Martin and Katazias 2019). As stated previously, this need for self-determination and autonomy is essential in successful MCoCer models of care (Homer et al 2019). This is not described by the participants as an easy task to initiate or maintain, moreover it is described as an essential one prerequisite to sustain the change in practice to MCoCer within the whole maternity service. With the ongoing endemic culture in contemporary NHS maternity services being described as bullying and negative (RCM 2016) the impact of cultural change from individualistic to collaborative and transactional to relational, requires a hierarchical managerial system to behave in a non-hierarchical way. This calls for transformative, compassionate and meaningful leadership with a clearly articulated vision.

6.2.2. Giving voice to the vision

The participants used their communication skills to advocate for autonomous midwifery. They recognised a need to use their position as managers to change practice and enable MCoCer models to support midwives and women in the service. They stood by their vision and used their communication skills to transition the services to benefit those with less power to enact change. By using the power that they had as managers within a hierarchical organisation, the participants were able to action a vision that they cared about in order to benefit midwives and women who required a voice. The participants demonstrated a passion and care for midwifery and woman-centred services and were motivated to create an impact on service delivery in their organisations for the benefit of women and their families. Their midwifery mindset of relational care and a passion for developing relationships and caring for women in a compassionate way determined and strengthened their voice.

It has been shown by Menke et al (2014) that involving midwives in the organisational planning of MCoCer models creates a more sustainable workforce. However, Deery (2005) outlined how midwives in their study when creating a change in organisational supervision, disengaged and were difficult to work with when attempting to co-create a change in practice. More

recently Pace (2019) has illustrated how using participatory action research techniques to implement change to MCoCer in the Scottish NHS was welcomed because it provided a voice for midwives and facilitated self-determined practice change.

The need for a voice resonates with the work of Leap and Hunter (2013) where acknowledgement of a hierarchical structure and the positions of power that are afforded to those within the NHS are more likely to be male and medical (NHS Digital 2018). Midwifery is generally a female workforce looking after women (NHS Digital 2018). The gender roles of female midwifery managers giving voice at board level negotiating structures on behalf of a female workforce to care for birthing women is a role that needs preparation and support (Homer et al 2019). The participants in this study all sought support from colleagues and others in positions of status to advance their navigation through the bureaucratic structure.

Therefore, having midwifery managers who have the skills and courage to communicate and contend with the innate structure of the NHS to stand up for autonomous midwifery practice is an essential requirement to implement and sustain MCoCer models within the NHS.

6.2.3 Sustaining the model through mastery

Participants were all dedicated to the managerial role and the provision of MCoCer models. There was a need for energy to be provided from them for the implementation and sustainability of MCoCer. The requirement for determination to support and protect the model was demanding on a personal level. There was a parallel with their aim for the women in the service to be cared for compassionately in relational models of care and the seeping of power from them as managers to the midwives so that they could be autonomous practitioners within a hierarchical institution. By delivering the outcomes that mattered to themselves they were able to sustain a level of fortitude and energy to maintain the model.

It appears from this study that having midwifery managers who have personal direct experience of working in a MCoCer model enhances their ability to understand what the supportive role of a midwifery manager for

MCoCer entails. They understood how the life of a midwife differed from those working in the traditional models of care. By describing the midwives who chose to work in this model as different or 'other' there is an implication that the participants in this study may also identify with being 'other' as they were once those midwives working in such ways. This appears to be both stimulating in how the managerial style of those individuals translated into practice by being non-hierarchical, but also challenging in their innate understanding of the relational model and its difficulty in fitting into the individualistic and highly structured culture of the NHS. For the participants the personal passion and drive for relational care was collaborative and they wanted to make a difference, but they also found it draining in terms of the personal energy that it required. The juxtaposition of requiring collaboration of philosophies in order to provide individualised care alongside the individualistic nature of leading a transformative change programme was a constant challenge. The participants identified that being 'other' was a vulnerability, therefore they lived in a vulnerable place as midwifery managers. It was in their nature to develop relationships, this enabled authentic understanding and choice in a culture where unconventionality was supported.

This unconventional behaviour was discussed by the participants in relation to supporting women with their choices. It can also be seen in the managers supporting the midwives in unconventional models that do not conform to system 'norms' despite being condoned by evidence and policy. There was a need to control the parameters of the working environment so that the managers could function in their role whilst preserving the choice for midwives to work autonomously in MCoCer models, this took time and effort. This finding concurs with Menke et al (2014) who recognised that large institutions such as the NHS, require rule bound compliance to provide accountability. Usually a command and control style of leadership will be adopted in pressurised situations (Edmondson 2019). This can lead to a blame culture with hostility and scapegoating of outliers such as those midwives working within a MCoCer model. Therefore, the participants gained mastery by developing their skills and repeatedly being courageous in their defence of autonomous midwifery models within the NHS.

6.2.4 Making meaning from leading

Contributing to the greater good is a deep and fundamental human need (Rogers 2004). By offering a clear path and a vision these exceptional leaders were able to create a more positive future for all. They did this by using their skills in leadership to support MCoCer models through challenges by planning and integrating the models into the NHS system of maternity care. This was the result of working and believing in the care provided through continuity of relationships. They tackled poor behaviour and modelled a compassionate approach towards the staff through putting people first and having an open and honest culture. Having this as a basis became apparent in their approach to implementing and sustaining the MCoCer model. They understood the need to make work matter to others in a meaningful way.

Cummings et al (2018) systematic review of nursing working environments confirmed that relational and transformational leadership is required by leaders within the health services to create job satisfaction in the workplace. Having a belief in people and relationships is essential in changing the culture, which is necessary within the NHS, therefore thinking differently is essential. Without a belief in the primacy of relationships, MCoCer will fail to develop the relational aspect of the midwifery role that is considered protective in the model. Considering human factors thinking and concern for employees as people was seen by Cummings et al (2018) as an essential attribute for leaders, to maintain recruitment and retention in healthcare.

Carr et al (2019) also concur and state that inclusion in the workplace is necessary for team working. By enabling an outlying group of midwives to work within the NHS and provide good quality relational care, MCoCer leadership can encourage team focus and meaningful inclusion at work by preventing exclusion of this cohort of midwives. By being seen to openly support this cohort of midwives, participants created a safe culture where there was encouragement to learn and develop together.

It can be construed that overall, this study has found that midwifery managers who have compassion and drive to implement MCoCer will encourage autonomous development of midwifery. By earning respect from

the midwives and maternity stakeholders, these participants had the courage to take the road less travelled. This does make meaning for those working in the maternity services and supports and encourages MCoCer services to be implemented and sustained. This meaningful environment is a sustainable way to provide MCoCer models in the NHS.

6.3 Reflection of strengths and limitations of the research.

Due to the limited time frame for this research, this was a small-scale study conducted with five participants. MCoCer models within the UK NHS organisation has a complex and relatively short history and this is reflected in the limited population of potential participants. Purposive sampling was therefore used to recruit participants with the appropriate experience. There were expressions of interest from a further three potential participants who had the relevant experience; however, two were from the same health trust as some of the study participants and it was felt important to gain wider views rather than concentrate on one trust with a succession of highly motivated midwifery managers. The participant named Annie was actively identified as a divergent experience due to her experience in contracting into the NHS and therefore identifying with NHS bureaucracy and hierarchy in a different way by being outside the system. The challenge in having a breadth of experience across borders and health boards is due to the nature of the models where implementation has been sparse, and experience limited to the few rather than the many as identified by Homer (2016). It was very encouraging that every midwifery manager contacted was very enthusiastic to share their experience and those who participated actively engaged in prolonged engagement with this study, willingly reviewing and reflecting on the analysis and theoretical framework.

A potential limitation of this study is that the findings and theoretical framework presented may only reflect the perceptions of those involved and may not be generalisable, the framework could be tested as a guide in future studies. Although this was a small study with a small sample the framework does provide insight into the qualities of effective leadership of midwifery continuity of carer. The role that constructivist grounded theory played in the

analysis may also make the focus of the study purely midwifery based and not generalisable to wider continuity models within the health service. A larger study repeating the semi-structured interviews with a greater diversity of experience and contexts would have allowed for more extensive data collection as well as including those who have a more recent experience of initiating the MCoCer model without any prior involvement in continuity of carer models. This may have enabled further comparative analysis and potentially enriched the final theoretical framework. Furthermore, had time allowed, it may have been appropriate to gather stakeholder views such as midwives and chief executives to enable an in-depth analysis of factors arising within the data which would have enhanced the grounding of the theory. It would also have been interesting to create a focus group with the participants in which a collective theoretical framework could have been produced through group consensus.

This study was not able to investigate the structural issues arising within health boards where MCoCer had been initiated and not sustained, the scope of such a study would have been unmanageable within the time frame of this piece of work. It was also unable to consider the structural impact of the wider executive team and their recruitment to midwifery positions and support provided to them. It can only be identified that the participants of the study had all been recruited to the managerial positions and that they had brought with them their own philosophy and previous experiences in order to illuminate their roles. The participants had arrived at their positions within midwifery through their own merit and therefore it is assumed had the skills and behaviours that the trusts were desiring to recruit for. Examination of the structural issues within the NHS regarding the barriers and facilitators to implementation and sustainability of MCoCer is required to further understand the issues involved. This could be addressed by other methodologies, for example institutional ethnography which would involve multiple stakeholders and examination of social relations, social organisation and the managerial governance practices which coordinate frontline midwives.

My approach and appreciation of the domain has altered in the process of the study. At the start participants shared their views and experiences during

data collection, initially I captured these experiences from the perspective of a midwifery colleague. As the research process proceeded specifically after the transcription of the first interview and commencing analysis, I observed how I gradually transitioned from midwife and colleague to researcher. This impacted on the ongoing data collection interviews and analysis. I started to understand the social processes and was able to view them from different angles- both my own and the participants. By immersing myself in the data, I realised when reflecting on the data, that the analysis was becoming more grounded within the stories of the participants and therefore truer to what was being said instead of reliance on the ubiquitous discourses and rhetoric currently shaping midwifery services. This changed with each subsequent interview and moved me towards being more exploratory and inquisitive around ideas and concepts surfacing in the data analysis itself. I realised that by facilitating this conversation with each participant I was able to focus towards where their values lay and what that meant to them.

Despite the limitations, the research reported in this thesis provides a unique insight into the views and experiences of midwifery managers when managing MCoCer models within the NHS in the UK which had not previously been explored in the literature. It contributes to the evidence base of how to implement and sustain MCoCer models in the future. Furthermore, it is the first known research reported to have gained the insights of midwifery managers within the NHS in the UK as to how to achieve stability and sustainability in such a changing landscape of providing continuity of carer for women in the mainstream services in the UK.

6.4 Conclusion

The aim of this study was to develop a theoretical framework, grounded in the views and experiences of experienced midwifery managers to inform the development of sustainable practice around the implementation of MCoCer models. The theoretical framework derived is based on the data provided by the participants and has been presented and discussed in relation to how MCoCer models can be implemented, supported and sustained.

In order to influence change, further evaluation and development of the theoretical framework is required, however the framework informs further focused work. The theoretical framework can be developed and used by maternity policy makers, health board recruitment teams and midwifery practitioners to reflect, recruit and develop leaders within midwifery to support the policy directive of implementing MCoCer models. Thus, the theoretical framework can be utilised either as it has been developed or as a basis for further research and development to aid the understanding of the vital role that the midwifery manager plays within the implementation and sustainability of MCoCer models within midwifery. This framework has the potential to be transferable to other health settings if developed in other contexts as the findings are important for all relational models of care.

The use of Charmaz's grounded theory methodology in this study has provided evidence of its utility as a pragmatic approach for developing theories that can inform midwifery and maternity services which can be developed further. Application of this methodological approach in this study has effectively constructed a grounded theory that expands our knowledge base of midwifery management and leadership within MCoCer models.

6.5 Recommendations

6.5.1 Policy recommendations

When developing policy concerning organisational change the skill set of the managerial oversight should be considered and recruited for to enable implementation of change. Policy makers and health boards should consider the skills, attitudes and attributes of the midwifery managers alongside their previous clinical experience to ensure effective implementation and sustainability of MCoCer models. This study has highlighted that midwives who have practiced in MCoCer models have insight and strong determination alongside commitment to sustain the model so may be better placed in managerial positions of leadership and consultancy roles to support the implementation of MCoCer models in a sustainable way.

6.5.2 Practice recommendations

The recognition of including the theoretical framework developed in this study in recruitment of midwives and midwifery managers and within guidance for institutions nationally should be developed to ensure consistent approaches that can be supported and evaluated. Midwifery managers should be recruited based on their capability of being able to safeguard the MCoCer model. They should be able to knowingly support the midwives working within the model in order to lead a meaningful way of working within midwifery. By engaging the workforce of the NHS in education into relational care and creating a kinder and more compassionate environment towards each other. This involves having the skills and behaviour sets to be able to manage complex team dynamics and protecting an outlying maternity service until it becomes more mainstream.

6.5.3 Educational recommendations

It would be prudent for educational providers and policy makers to provide resources that upskill towards the expert leadership practices required- this could be a course created for example by the RCM that is accredited, with sessions provided by facilitators, such as those who participated in this study who know the NHS landscape well. Non-hierarchical and transformational management styles was identified as fitting with the requirements of MCoCer models and should be included in all midwifery pre and post registration educational programmes, including midwifery management and leadership development. Universities within the UK should also consider recruitment to midwifery programmes through a values-based recruitment model to include philosophical drivers and attitudes of candidates towards MCoCer models of care and consider the theoretical framework developed within this study. Only in this way will succession planning and long-term sustainability of leadership of this model be assured.

6.5.4 Future research recommendations

Midwifery managers require further study to evaluate their impact, particularly within MCoCer models of care on implementation and sustainability of the models. The theoretical framework developed from the grounded theory facilitates the initial knowledge base development on the views and experiences of midwifery managers. Based on these findings future research could test the theoretical framework within a policy making situation or recruitment selection process within MCoCer models and a wider midwifery context. This would include developing values-based recruitment to include philosophical drivers and attitudes of candidates towards MCoCer models of care. The recommendations for further research are:

- To validate and help generalise the theory developed a Delphi study could be done with a much broader population of managers, perhaps including managers from overseas where there is also experiences of initiating and sustaining MCoCer, such as New Zealand where MCoCer has been at the core of maternity services for 30 years, also parts of Canada, Australia and Netherlands.
- Examination of the structural issues within the NHS regarding the barriers and facilitators to initiation and sustainability of MCoCer to further understand the leadership issues involved. This could be addressed by other methodologies, for example, institutional ethnography which would involve multiple stakeholders and examination of social relations, social organisation and the managerial governance practices which coordinate frontline midwives.
- A participatory action research, using co-operative inquiry with current midwifery leaders which involves cycles of reflective discussion-based groups and individual and collective transformative practice changes in their own area of jurisdiction. This is a bottom up approach to transforming services by working with and not on people and the theory developed in this study could be the basis of starting such an inquiry with leaders not currently exposed or experience in MCoCer.
- Examination of the facilitators and barriers for midwives from a BAEM background to participate in MCoCer models especially when recruiting through mixed methods study of surveys and interviews to ensure

equality of access for midwives to practice within MCoCer models and women to access appropriate quality care.

- Examination of initial recruitment to midwifery through Higher Educational Institutes (HEI's) through the theoretical framework generated in this research, due to the expectation for future midwives to work in continuity models throughout their career. Implementing the current policy of Best Start (The Scottish Government 2017) and Better Births (NHS England 2016) requires succession planning. Only by recruiting midwives with the values required for leading MCoCer models, will the workforce be changed and culture for sustainability encouraged.

6.5.5 NHS Organisational recommendations

The findings reported in this thesis have highlighted the need for midwifery managers to be considered when implementing sustainable MCoCer. For MCoCer models to be successful, policy directives need to consider the skills, attitudes and attributes of midwifery managers towards MCoCer. The NHS organisations should support midwifery managers through developing maternity services with adequate upskilling and education to enable them to support the midwives working within MCoCer models. The challenges midwifery managers face alongside the improvements that they can impact upon within MCoCer models should not be underestimated therefore it is suggested that recruitment to midwifery and midwifery management positions should include a framework of assessing values and support for MCoCer models. The necessary provisions to support the midwifery managers to support the midwives working within MCoCer models need to be acknowledged and acted upon within the NHS. The structured mentoring of up and coming leaders within the NHS should be considered whilst the practice theory gap remains, as currently there are few experienced midwives in positions of leadership who have personal experience of providing MCoCer models of care.

6.6 How this study has transformed me

This study started for me with a real-world problem: being surrounded in the NHS by midwives and managers who had no experience in a MCoCer model whilst having a policy document dictating the model of choice within the next 5 years would be the gold standard caseload MCoCer model. I had a desire to make a difference to the midwives that I was working with as I believe that unless the model is working for the midwife it won't work for the woman. I knew that my positive experience of working in the model in south east London was directly related to having a midwifery manager who understood, supported, encouraged and promoted that way of working. Therefore, I started to try and bridge the gap from experienced to novice midwifery manager in continuity of carer models. Through the study I have become aware of the similarities of what birthing women need from midwives, to what midwives need from NHS managers, and in turn what those NHS midwifery managers need in order to support the service. The relational aspect that drives me to be compassionate and caring doesn't change as I change my role within midwifery; I would suggest that this drive applies to most midwives. Likewise, I desire to go to work and make a difference to those I care for, and it appears to work best when I am able to create a meaningful existence for myself whatever my role. I would assume this is the case for all my midwifery colleagues. This has been how I find myself as a researcher, having the need to involve the participants and give them control over their information. In this reflexive mode, I find myself grateful for Charmaz's (2014) grounded theory methodology.

I have become aware of how to discuss leadership and compassion in relation to the midwifery managers role and now incorporate it into the workshops that I run for midwives. I have changed the way I present the options of MCoCer models to midwives and midwifery managers in Scotland to encourage positive relationships with each other and understanding the roles that need to be fulfilled for implementation and sustainability to occur. I have become a more compassionate and aware educator for the midwives in Scotland.

6.7 Summary

Finally, this study suggests that midwifery managers who have experience in working in MCoCer models as midwives have a profound understanding of the intricacies of the models. When midwifery managers possess the appropriate skills, attributes, attitudes, and experience to support the MCoCer models, they become sustainable within the NHS. By having a practical base in midwifery and understanding the needs of the midwives alongside the emotional intelligence to value the humanistic benefits of relational care, midwifery managers can develop compassionate managerial oversight that can and does enhance the quality of meaningful care that women receive from their service. This benefits the workforce as well as the users of maternity care. By encouraging the creativity of those managers who promote autonomous midwifery practice and educating them in how to use transformational styles of management they are intellectually stimulated and lead the NHS into sustainable ways of working. This requires the recruitment of midwives and those in managerial positions to be developed through a values-based theoretical framework to inspire leaders in meaningful midwifery.

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Appendix A: SERP Approval



Sarah Turner

MRes student

School of Nursing and Midwifery

Robert Gordon University

26th September 2018

SERP reference number: 18-17

Dear Sarah

A grounded theory study on midwifery managers' views and experiences of implementing and sustaining continuity of carer models within the UK maternity system.

The School of Nursing and Midwifery Ethics Review panel has now reviewed amended versions of the above research proposal and supporting documents. Please find details of the outcome and recommended actions below.

Your proposal has been approved. You may go ahead with your research, providing approval from any relevant external committee/s has been obtained.

Where the project involves NHS staff, approval through the NHS R&D Office must be obtained.

It has been noted that have made contact with NHS R&D and will require multi-site IRAS application for any current NHS employees that are participating in your study. Members of the School Panel can advise on this process if necessary.

One further comment: It is recommended you stick to the wording of the HRA statement. You substitute 'we' for 'they' in your PIS. This makes it look like you aren't in control of how the data for your study is stored and used.

Yours sincerely,

Panel member 1 Pauline Donaldson

Position held: SERP member

Panel member 2 Audrey I. Stephen

Position held: SERP convenor If you require further information please contact the Panel Convenor, Audrey Stephen, on 01224 263150.

Dr Audrey Stephen

School of Nursing and Midwifery

Robert Gordon University

Garthdee Road

Aberdeen

AB10 7QG

Email: NM-Serp@rgu.ac.uk

Appendix B: IRAS Approval

Sarah Turner

Midwifery Lecturer Robert Gordon University

Faculty of Health and Social Care,

Robert Gordon University

Garthdee Road

Aberdeen AB10 7AQ

Email: hra.approval@nhs.net Research-permissions@wales.nhs.uk

07 December 2018

Dear Sarah Turner

Study title: A grounded theory study on midwifery managers' views and experiences of implementing and sustaining continuity of carer models within the UK maternity system'

IRAS project ID: 255484 Sponsor Robert Gordon University

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales? You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales will not be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as: You have contacted participating NHS organisations (see below for details) The NHS organisation has not provided a reason as to why they cannot participate The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

HRA and Health and Care Research Wales (HCRW) Approval Letter

IRAS project ID 255484

If not already done so, you should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. After entering your IRAS ID you will be able to access a password protected document (password: Redhouse1). The password is updated on a monthly basis so please obtain the relevant contact information as soon as possible; please do not hesitate to contact me should you encounter any issues.

Commencing research activities at any NHS organisation before providing them with the full local information pack and allowing them the agreed duration to opt-out, or to request additional time (unless you have received from their R&D department notification that you may commence), is a breach of the terms of HRA and HCRW Approval. Further information is provided in the "summary of assessment" section towards the end of this document.

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland? HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant

national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations? HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your nonNHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study? The attached document "After HRA Approval – guidance for sponsors and investigators" gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including: Registration of Research Notifying amendments Notifying the end of the study The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter? You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Ms Jill Johnston Tel: 01224 262693 Email: j.johnston4@rgu.ac.uk

Who should I contact for further information? Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 255484. Please quote this on all correspondence.

Yours sincerely

Kevin Ahmed Assessor

Telephone: 0207 104 8171 Email: hra.approval@nhs.net

Copy to: Ms Jill Johnston, Sponsor Contact, Robert Gordon University Ms Susan Ridge, R&D Contact, Grampian Health Board Dr Annie Lau, Chief Investigator, Robert Gordon University

Appendix C: Initial email contact



Are you a Midwifery Manager who has at least 2 years' experience managing
Midwives who are providing continuity of carer?

If so.... would you be prepared to join a small research study?

Sarah Turner (MRes Student) from Robert Gordon University is looking for
willing participants to be interviewed for her study:

'A GROUNDED THEORY STUDY ON MIDWIFERY MANAGERS' VIEWS AND EXPERIENCES OF
IMPLEMENTING AND SUSTAINING CONTINUITY OF CARER MODELS WITHIN THE UK'

It would involve an up to a 1-hour interview at your convenience to talk
about your experiences.

If interested, please contact either:

Study Coordinator: Sarah Turner, MRes Student, RGU. Tel: [REDACTED].
[REDACTED]

Principle Supervisor: Dr Susan Crowther, Professor of Midwifery, RGU. Tel: [REDACTED]
[REDACTED]

Appendix D: Participant Information Sheet



Participant Information Sheet

Study Title:

'A grounded theory study on midwifery managers' views and experiences of implementing and sustaining NHS continuity of carer models'

Introduction:

You are invited to participate in this study as you are a midwifery manager (past or presently) with at least 2 years' experience in managing midwives who are providing continuity of carer. Before deciding whether to take part or not, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information sheet, (version: ii) carefully and discuss it with others if you wish. Please ask a member of the research team (listed at the end) if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This research project is to identify the specific issues that managers encounter when managing midwives who are working within continuity of carer models. There is currently little direct evidence that illuminates how managers should approach the task of enabling midwifery continuity of carer to be achieved and sustained within the NHS. In the absence of clear direction this skill and knowledge base has the capacity to become locally determined. This would create an absence of sharing of best practice and knowledge. To help understand the barriers and facilitators of implementing and sustaining midwifery continuity of carer models it is crucial to hear the voices of managers who have had experience in this area of midwifery practice. By obtaining managers' experiential evidence grounded in the practice realities of the NHS, pragmatic and in-depth findings will hopefully provide a workable framework for other NHS managers. This study focuses on your views and experiences of being a midwifery manager with such responsibilities.

Why have I been invited to participate?

You are invited to participate as you are a midwifery manager who has the relevant experience.

Do I have to take part?

No. It is up to you to decide whether or not to take part in an interview. If you decide to take part, you are still free to withdraw at any time and without giving a reason. However, anonymised data collected and used to formulate the final theoretical framework after your first interview cannot be deleted. To protect your wishes if you want to withdraw the research team will ensure that all your interview data is anonymised. Although it is acknowledged that confidential information will be shared during your interview the nature of the study is that confidential data will not be required for the final outcome of the study.

What would taking part involve?

If you decide to participate you will be asked to sign a consent form and participate in an interview up to an hour long. The interview will be at a time and place convenient to you. It can be done via skype if preferred. The interview responses will be coded through grounded theory with the potential that the researcher will ask you to respond to the themes generated. It is anticipated that the interviews will take place between September 2018 and April 2019.

If you agree to be interviewed, I (Sarah) will contact you by telephone to answer any questions and arrange a suitable time and place for the interview. Before any interview begins any questions or concerns will be addressed by myself and a consent form will need to be signed and dated. The interview will be audio-recorded for research purposes only. No personal identifying details will be transcribed from the recordings. Following your permission and consent to audio-record the interview we will begin; an interview will last for approximately 30 to 60 minutes. The recordings of interviews will be confidential and anonymous. Any names which you mention will be changed when the interview is typed out. You can choose a false (pseudonym) name for yourself if you wish. Information will be stored securely, and password protected and used only for research purposes within the research team. You can stop the interview at any point or ask for the recorder to be switched off. You can also ask for specific speech to be removed or changed at any time.

What are the possible benefits to taking part?

You will have the opportunity to share your experiences as a midwifery manager/leader within the NHS managing midwifery continuity of carer practice. However, this study does not presume any personal benefits to you. The aim of the study is to better inform health professional views on midwifery continuity of care provision. The findings of this project are likely to benefit colleagues who need to manage sustainable continuity of carer practice in the NHS, currently and in the future. Your participation will provide guidance in supporting them. Your participation is therefore an opportunity to help enhance midwifery knowledge by disseminating best practice in order to help transition of the wider midwifery community towards a sustainable model of Midwifery continuity of carer.

What are the possible risks and disadvantages of taking part?

Due to the small number of managers with specialised knowledge you may be identifiable in the study even though the responses will be anonymised.

Will my taking part in the study be kept confidential?

All information which we collect about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it.

Data protection and transparency

Robert Gordon University (RGU) is the sponsor for this study based in Aberdeen, Scotland. They will be using the information gained from you in order to undertake this study and will act as the data controller for this study. This means that they are responsible for looking after your information and using it properly. RGU University will keep identifiable information about you for 10 years after the study has finished until 2027. You can find out more about how they use your

information at - <https://www3.rgu.ac.uk/about/governance/information-governance/privacy-policy/>?

As a university they use personally identifiable information to conduct research to improve health, care and services. As a publicly funded organisation, they have to ensure that it is in the public interest when they use personally identifiable information from people who have agreed to take part in research. This means that when you agree to take part in a research study, RGU will use your data in the ways needed to conduct and analyze the research study. Your rights to access, change or move your information are limited, as they need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, RGU will keep the information about you that they have already obtained. To safeguard your rights, they will use the minimum personally identifiable information possible.

Health and care research should serve the public interest, which means that RGU have to demonstrate that their research serves the interests of society as a whole. They do this by following the UK Policy Framework for Health and Social Care Research.

If you wish to raise a complaint on how RGU have handled your personal data, you can contact their Data Protection Officer who will investigate the matter. If you are not satisfied with their response or believe they are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO).

RGU's Data Protection Officer is Jane Williams and you can contact her at:

████████████████████.

What will happen to the results of the research study?

This study is being supported by The Robert Gordon University in Aberdeen and is part of a Masters in research (MRes) study. It has been given ethical approval by the board at the university (see below).

The results of this study will be available in a report and published in a health service journal and relevant midwifery journals. Results of the study will be presented and disseminated at health service and academic conferences. Direct quotes from your interviews will be used in these reports although the research team will ensure all identifying data and personal information about you is removed and made anonymous. You will be provided with an executive summary of the final report and any publications arising from the study will be made known to you.

Funding: This MRes study is funded by the school of Nursing and Midwifery RGU University.

Ethics: School Ethics Review Panel (SERP) at RGU approval granted xxxxxx.
Reference number: xxxxx

For further information about the research please contact one of the following in the research team.

Contacts:

- Study Coordinator: Sarah Turner, MRes Student, RGU. [REDACTED]
- Principle Supervisor: Dr Susan Crowther, Professor of Midwifery, RGU. Tel: [REDACTED]
- [Research supervisor: Dr Annie Lau xxxxxxxx](#)

If you want to participate in this research please email Sarah Turner on:

[REDACTED]

byTBC.

Appendix E: Consent Form



IRAS ID:

Participant Name for this study:

CONSENT FORM

Title of Project: A grounded theory study on midwifery managers' views and experiences of implementing and sustaining NHS continuity of carer models

Name of Researcher: Sarah Turner, Phone:

Email:

Please
initial
box

1. I confirm that I have read the information sheet (version: ii) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I understand that the information collected from my interview will be used to support other research in the future and may be shared anonymously with other researchers.
4. I agree to take part in the above study.
5. I agree to the interview being recorded.
6. I understand that relevant sections of and data collected during the study, may be looked at by individuals from the Robert Gordon University, from regulatory authorities or from the NHS Board and/or Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my research data.

Name of Participant Date Signature

Name of Person
taking consent (researcher) Date Signature

Appendix F: Interview Schedule

Interview Schedule:

1/ Set up phase: Introduce myself and the plan for the interview- To include:

- i- Provide opportunity to respond to any questions related to the PIS and study as a whole and check understanding of the participant of what is involved
- ii- Get consent form signed electronically and sent back by email prior to interview if skype call or in person if face to face.
- iii- Ensure technologies (skype/recording devices) are functioning for both participant and researcher.
- iv- Reiterate that the interview will last no longer than 1 hour.
- v- The interview can be paused (for comfort) or/and terminated at any point by the participant.

2/ Indicative questions- will be open ended and responsive to participant but will start with:

- i- Please could you tell me about your experience in managing a maternity system that has midwives who provide continuity of carer?
- ii- How did you set up the MCoCer model in your organisation? What was your role?
- iii- Do you find that there are specific requirements made of you in that role? Can you describe examples of these specific requirements?
- iv- Is there a difference in how you have to manage midwives who are working in that system? Can you give examples of these differences?
- v- What has been your approach to managing continuity of care midwives in the NHS?
- vi- How have you organised and facilitated MCoCer models to be sustainable?
- vii- Can you give examples of when your management strategies and approaches helped sustain the model?
- viii- Can you give examples of when your management strategies and approaches may not have helped the MoCer model?
- ix- What would you do differently if you were to begin setting up a MCoCer practice within a maternity service you were managing now?
- x- How did you make the MCoCer model sustainable?
- xi- What makes this model of midwifery practice arrangement sustainable for the midwives, managers and organisation? Examples?
- xii- What makes this model of midwifery practice arrangement unsustainable for the midwives, managers and organisation? Examples?
- xiii- Is there anything that you think midwifery managers about to embark on having midwives working in a continuity model should be aware of or do?
- xiv- What advice would you give to manager colleagues?

Other probes can include:

- You said xxxxxxx, can you tell me more about how that worked (or did not work)?
- That sounded like a challenge, how did you manage that situation?
- Can you tell me more about xxxx?
- Tell me a time when xxxx
- What do you mean by xxxxxxx?
- Can you give me another example of xxxxxx?
- How did that work?
- How did that feel?
- How did you work through xxxxxx?

Appendix G: CASP Tool



www.casp-uk.net
info@casp-uk.net
3 Summerhouse Pavilion, Middle
Way Oxford OX2 7LG



CASP Checklist: 10 questions to help you make sense of a Qualitative research.

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- 1. Are the results of the study valid? (Section A)
- 2. What are the results? (Section B)
- 3. Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "Yes" it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of hint/prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the space provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The Core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'users' guides to the medical literature 3594 (adapted from Guyatt GH, Sackett DL and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the working format with which it would be used. Clear that users overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate. Referencing: we recommend using the Harvard style citation, i.e. - Critical Appraisal Skills Programme (2018). CASP (most name of checklist) - Qualitative Checklist [online]. Available at: URL. Accessed: Date Accessed.

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Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?
- Yes
Can't Tell
No

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?
- Yes
Can't Tell
No

HINT: Consider
- If the research seeks to understand or illuminate the actions and/or subjective experiences of people in situations
- In qualitative research, the right methodology for extracting the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?
- Yes
Can't Tell
No

HINT: Consider
- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:



8. Was the data analysis sufficiently rigorous?

- Yes
Can't Tell
No

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used, if so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

- Yes
Can't Tell
No

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:



Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature)
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

5

6



4. Was the recruitment strategy appropriate to the aims of the research?

- Yes
Can't Tell
No

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

- Yes
Can't Tell
No

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indicator of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study, if so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:



6. Has the relationship between researcher and participants been adequately considered?

- Yes
Can't Tell
No

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

- Yes
Can't Tell
No

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

