School of Nursing and Midwifery

Leading the Way
Leadership and Management Preparation for Midwives: 
A Mixed Methods Evaluation

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A Dissertation submitted as part of the requirements for the 
Degree of Doctorate in Midwifery Practice

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“I may say that this is the greatest factor, the way in which the expedition is equipped, the way in which every difficulty is foreseen, and precautions taken for meeting or avoiding it. Victory awaits him who has everything in order, luck, people call it. Defeat is certain for him who has neglected to take the necessary precautions in time; this is called bad luck.”

(Roald Amundsen 1872 – 1928)
The first explorer to reach the South Pole
Acknowledgements

I am indebted to the following people without whose help I could never have completed this work.

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4. Breedagh Hughes and the RCM teams in Belfast and London for their invaluable support.

5. The midwives who participated in this study giving generously of their time and expertise.

6. My friends who never lost interest and provided ongoing support and coffee.

7. My brothers and sisters who have always kept me grounded, and especially remembering my late parents, my mother who always believed in us, and my father who taught us to question and first introduced us to Amundsen, Scott and Shackleton and the leadership debate.

8. Finally, Conor my son, who has lived this and many other journeys with me!
Abstract

Title: Leadership and Management Preparation for Midwives: a mixed methods evaluation.

Background

Two decades ago, Pashley (1998a) reviewed the literature relating to midwifery leadership and concluded that strong leadership models needed to be developed to ensure future care was women centred. Although there has been significant investment in NHS leadership and management development initiatives in the intervening years, concern has been raised about the impact in relation to quality improvement (Kings Fund, 2011; Kelly and Lee, 2017) and the role of the NHS Leadership Qualities Framework (LQF) (Bolden et al., 2003).

Aim

The aim of this study was twofold. Firstly, to explore senior midwife managers’ experience of leadership and related development in one region of the United Kingdom (UK) and secondly to explore the experiences of midwives who had undertaken leadership or management development.

Methods

This was a mixed methods study utilising survey, interviews and focus groups. All participants were employed in the NHS and ethical approval was granted. In total 69 midwives responded: 18 managers and 38 midwives completed an online questionnaire, 9 were interviewed, and 4 participated in a focus group. Quantitative
data were entered into SPSS and analysed descriptively and using Chi-square where relevant. Qualitative data were transcribed into MS Word and analysed thematically.

**Results/Findings**

Key themes were developed which included preparation for the role, experience of leadership, training, perceptions of leadership and management, characteristics and relevance of LQF (2007).

**Conclusion**

In maternity services, leadership and management are inextricably linked and it was evident that managers and leaders have a key role in talent spotting midwives and influencing career progression. The NHS Leadership Qualities framework (2007) was perceived to be of limited value. Midwives early in their career need support to gain insight and understanding of the management/leadership role. Development programmes need to be supplemented by the lived experience of leadership and management in practice.

**Implications for Practice**

This study has identified that the approach to leadership and management development is limited. There is a need for additional approaches and opportunities to facilitate midwives to develop a range of practical skills in leadership and management.
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<tr>
<td>ABI/INFORM</td>
<td>Database covering business, management, economics and a wide range of related fields.</td>
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<tr>
<td>AFC</td>
<td>Agenda for change. NHS grading and pay system.</td>
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<td>AHPs</td>
<td>Allied health professionals</td>
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<td>CAMHS</td>
<td>Child and adolescent mental health services</td>
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<td>CINAHL</td>
<td>Cumulative Index of Nursing and Allied Health Literature database</td>
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<td>CLP</td>
<td>Clinical leadership programme</td>
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<td>CMB</td>
<td>Central Midwives Board</td>
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<td>DHSS</td>
<td>Department of Health, Social Services and Public Safety</td>
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<tr>
<td>GP</td>
<td>General Practitioner, a doctor based in the community</td>
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<td>GVA</td>
<td>Gross Value Added</td>
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<td>HCC</td>
<td>Health Care Commission</td>
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<td>HEI’s</td>
<td>Higher education institutions</td>
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<td>HMIC</td>
<td>Health Management Information Consortium database</td>
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<td>HoMs</td>
<td>Heads of Midwifery</td>
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<td>HR</td>
<td>Human resources</td>
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<td>HSC</td>
<td>Health and Social Care</td>
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<td>ICM</td>
<td>International Confederation of Midwives</td>
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<tr>
<td>LEO programme</td>
<td>Leading an Empowered Organisation programme</td>
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<tr>
<td>LQF</td>
<td>Leadership Qualities Framework</td>
</tr>
<tr>
<td>MBTI</td>
<td>Myers-Briggs type indicator is an introspective self-report questionnaire to indicate differing psychological preferences in how people perceive the world around them and make decisions</td>
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<tr>
<td>Medline</td>
<td>Database containing journal citations and abstracts for biomedical literature from around the world</td>
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<tr>
<td>MeSH</td>
<td>Medical Subject Headings</td>
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<td>MMAT</td>
<td>Mixed methods appraisal tool</td>
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<td>MMG</td>
<td>Midwife managers’ group</td>
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<td>MSc</td>
<td>Master of Science</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NI</td>
<td>Northern Ireland</td>
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<td>NMC</td>
<td>Nursing and Midwifery Council</td>
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<td>NVQ</td>
<td>National vocational qualifications</td>
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<tr>
<td>PRISMA</td>
<td>Preferred Reporting Items for Systematic Reviews and Meta-Analyses</td>
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<tr>
<td>PsycINFO</td>
<td>Database of abstracts of literature in the field of psychology and related disciplines</td>
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<td>RCM</td>
<td>Royal College of Midwives</td>
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<td>RCNCLP</td>
<td>Royal College of Nursing’s clinical leadership programme</td>
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<tr>
<td>RCT</td>
<td>Randomized controlled trial</td>
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<td>RPA</td>
<td>Review of public administration in Northern Ireland</td>
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<tr>
<td>SIGN</td>
<td>Scottish intercollegiate guidelines network develops evidence based clinical practice guidelines for the (NHS) in Scotland.</td>
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<td>SIP</td>
<td>Service improvement project</td>
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<td>SPSS</td>
<td>Statistical package for the social sciences</td>
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<td>TEV2:</td>
<td>Team excellence version 2 questionnaire</td>
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<td>TLDP:</td>
<td>Trent Leadership Development programme</td>
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<td>UK:</td>
<td>United Kingdom</td>
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<td>UKCC</td>
<td>United Kingdom Central Council for nursing and midwifery</td>
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Chapter 1. Introduction
1.1 Overview

Since the formation of the National Health Service (NHS) in 1948, successive governments have sought to ensure continuous improvement in the quality of care and performance with improved outcomes for patients, while meeting public expectations and controlling costs (Greengross et al., 1999; King’s Fund, 2011). A key component of their strategies has been the search for an effective model of leadership and management. Nevertheless, despite significant attention and investment in leadership and management development, concerns remain that the current leadership model has not achieved the levels of improvement in health care required particularly in maternity services (Darzi, 2008, King’s Fund, 2011, King’s Fund, 2015). A number of successive reviews based on audits of maternity services including site inspections and interviews with women and key stakeholders have concluded that the experiences and outcomes for women have been inconsistent and linked to ineffective midwifery leadership (Healthcare Commission, 2008; Amess and Tyndale-Biscoe, 2014; NHS England, 2016; Kelly and Lee, 2017).

1.2 Background

In 1948, the role and responsibility for managing and leading the NHS at the most senior levels was given to doctors, as they were deemed to have the most experience in delivering health care to the public (Rivett, 2018). This model delivered success in terms of access to health care, improved life expectancy and outcomes, however, as demand surpassed all predictions there was increasing concern about the cost (Harrison and Pollitt, 1994; Rivett, 2018). As a result, by 1984, the government had determined that the medical model was no longer fit for purpose primarily due to a
perception of failure to control costs and therefore introduced a new cohort of general managers to take forward a more business-like model. These managers would complete a specifically designed NHS Graduate Management Training Scheme and, once appointed to an NHS post would focus on performance and finance, thereby freeing the clinical teams up to concentrate on delivering care (Greengross et al., 1999; Edwards, 2016; Rivett, 2018). These general managers gradually replaced clinical professionals in senior management posts across all clinical specialisms (Hague, 1986; King’s Fund, 2011).

With the introduction of general managers came a number of NHS reorganisations all aimed at streamlining the service and reducing demand through encouraging the public to take ownership of their own health. Cost controls and competition were introduced, reporting of performance against targets, development of dashboards to provide service comparisons, in an attempt to demonstrate the achievement of improved efficiency (Greengross et al., 1999; King’s Fund, 2012; King’s Fund 2014). Unfortunately, these transformations failed to take account of the nature of change and unrelenting challenges: scarce resources, major technological advances, workforce issues, increasing patient expectations and changing demographics (Rivett, 2018).

Subsequently, a view began to emerge that the strategy of excluding clinical professionals from management positions was flawed and the lack of clinical leadership was one reason why expected changes were not, and could not be achieved (Ham, 2003; Darzi, 2008; Healthcare Commission, 2008; King’s Fund, 2011; Rivett, 2018). Therefore, it became imperative to actively involve and develop clinicians, the
approach proposed was the inclusion of leadership competencies into education and training for all professions (Darzi, 2008). Consequently, the demand for strong clinical leadership within the NHS across all professional groups began to be promoted as the key to providing modern, efficient, effective and safe services (Ham, 2003; Healthcare Commission, 2008; Darzi, 2008; King’s Fund, 2012; Rivett, 2018). Nevertheless, the absence of managerial developmental pathways for clinical professionals to become managers has ensured they have remained underrepresented in senior positions influencing change (Johnson and Dale, 2011; Kings Fund 2012, West et al., 2015). Fitzgerald et al. (2013) who investigated patterns and impact of clinicians in leadership, highlighted that the role was poorly understood and described it as ‘hybrid’. A series of case studies identified that expertise of clinicians including midwives brought positive benefits including a level of insight crucial to service delivery (Fitzgerald et al., 2013). Conversely, across the UK, there has been an overall reduction in both clinical and management posts due to health service reorganisation (Heenan and Birrell, 2009, King’s Fund, 2011, King’s Fund, 2014).

1.3 Midwifery leadership

In England, there has been a recognised need for strong clinical leadership in midwifery for many years particularly following the transition into the NHS (Pashley, 1998a; Pashley, 1998b). Prior to this, the majority of care to pregnant women were cared for and delivered by midwives often working with General Practitioners (GPs) in community areas, while obstetricians practised within ‘Lying In’ hospitals that were generally used for women with complex needs (Cowell and Wainwright, 1997; Loudon, 2008). Change was inevitable, a falling birth rate combined with pressure
from the Royal College of Obstetrics and Gynaecology resulted in the 1970 NHS review, which recommended that all women should give birth in hospital and thereby changed the direct link, which had existed between women, their communities and midwives (Campbell and MacFarlane, 1994).

The Salmon Report (1966) which was commissioned to raise the profile of the nursing profession compounded the situation. Salmon’s (1966) process ignored midwifery as a separate profession. With the movement of the majority of midwives into the hospital setting and the failure to acknowledge the different professional focus between nursing and midwifery, difficulties were inevitable. The Brigg’s Review (Department of Health, 1972) which examined the role of nurses failed to rectify this situation: it reported almost exclusively on nursing education and career issues with little acknowledgement of midwifery as a separate profession, its unique role with women or its regulatory framework. This conspicuous absence was reinforced in 1979, when the regulator for midwives, the Central Midwives Board (CMB) was stood down, and midwifery regulation became linked to nursing with the formation of a single regulator for both professions the United Kingdom Central Council (UKCC) (Davies and Beach, 2000).

As a result of all these changes midwives struggled to be a visible presence within the NHS organisational structure as highlighted by Pashley (1998a), although it should be noted that this position was not unique to the UK with the WHO commenting on the lack of midwifery visibility globally as a situation which needed addressed (WHO, 2002). Nevertheless, following the maternity service audits in England by the
Healthcare Commission Review (2008), and more recently the National Maternity Review (NHS England, 2016), this lack of visibility has persisted. When Pashley (1998a) reviewed the literature relating to midwifery leadership and management over twenty years ago she emphasised the need for midwives to develop strong leadership models to ensure that the emerging models of women-centred care would be implemented. It was her view that where midwives led and managed services, this could be linked to improved outcomes for women and the promotion of ‘normal’ childbirth. She noted the limitations in the existing organisational structures in the NHS, which restricted midwives from exploiting their full potential as leaders and as a result their appointment to senior managerial positions.

Despite the awareness of these issues, O’Connell and Downe (2009) who undertook a metasynthesis of fourteen studies examining the role of hospital-based midwives in England, could find no evidence of progress in organisational and professional structures with midwives remaining relatively invisible and marginalised in health care policy decision-making. Tingle (2016) has also suggested this may have been a contributing factor to the increase in litigation as women sought redress for failures in the care they received, and a culture of practice described as defensive, creating unrest and instability throughout the midwifery profession and maternity services. In February 2016 following concerns about maternity care the National Maternity Review (NHS England, 2016) collected evidence via consultations and interviews with women, their families, NHS staff and commissioners and produced a report of their findings. The reviewers identified that some progress had been made in the quality of
care experienced by women but there continued to be missed opportunities to improve care and issues linked to lack of effective clinical leadership.

Evidently little had changed since Pashley’s observations (1998a and 1998b), midwives continue to struggle to achieve a profile across the NHS and women have suffered from the effects of that absence (Healthcare Commission, 2008; Amess and Tyndale-Biscoe, 2014; NHS England, 2016; Kelly and Lee, 2017). Despite this continuing lack of visibility midwives maintain the position that they are best placed to lead the maternity service as professionally accountable practitioners who understand the system and importance of women-centred care, a position supported in principle by Ham (2003) retired Chief Executive of the King’s Fund. Professor Ham, in summarising the evidence base, suggested that where the health professionals have a significant amount of control, they are strongly motivated to help people, and therefore will implement changes to services to improve performance.

The findings of a Cochrane Review by Sandall et al. (2016) supports Ham’s position as it demonstrated that outcomes were improved where midwives lead the care. The King’s Fund (2012) have similarly endorsed this stance recognising that those managers who are heavily involved in patient care make a positive difference to outcomes. Divall (2015) in an exploratory case study of midwifery managers’ views on leadership identified a willingness to lead but highlighted the NHS system’s challenges around recognition of the importance of clinical credibility alongside effective leadership. In this increasingly complex health service, midwifery leadership and management were therefore identified as essential elements for effective
professional practice to ensure improved outcomes for women but there was a need to ensure these were developed within an evidence-based framework.

1.4 Northern Ireland policy

From a Northern Ireland perspective, the development and delivery of health policy has tended to reflect local variations of the English system until the devolution of power in 1999 (Greer, 2016). Maternity services policy and provision, for example, was specifically outlined (Circular HSS(SC) 1/96) and based on an English policy document entitled ‘Changing Childbirth’ (DOH, 1993) with the exclusion of one element; the development and introduction of stand-alone midwife-led units (Madden 2007).

Throughout this same period, significant financial and specialist workforce challenges were emerging in the acute hospital sector in Northern Ireland and a new strategic policy to address local need was introduced; Developing Better Services (DHSS, 2002). The policy made a number of recommendations particularly related to maternity services to take account of a decreasing birth rate and concerns relating to the availability of neonatal and anaesthetic expertise in all hospitals but did not reference leadership and management. This was a significant oversight as maternity services were to undergo considerable re-organisation with the reduction of obstetric units and midwives would be required to develop and lead the introduction of new models of midwife-led care, including for the first-time midwife-led units. As a consequence of the restructuring of maternity services, maternity policy began to change. Subsequently following a period of consultation stand-alone community midwifery
units were introduced in 2004, although in the absence of any discussion regarding the preparedness of midwives to implement this radical change (Barrowman and Clarke, 2003; Madden, 2007).

In the meantime, the same financially challenging pressures which had been experienced in England were also emerging in Northern Ireland. However, there was a perception in central government that local politicians were failing to take effective action to control costs and so Parliament passed the Health and Social Care (Reform) Act (Northern Ireland) 2009 (Greer, 2008; Greer, 2016). This act drove wide-ranging service reorganisation across Northern Ireland resulting in the reduction of health Trusts from nineteen to six. In particular, the number of clinical managerial posts reduced which resulted in Heads of Midwifery posts being reduced from eleven to five (Heenan and Birrell, 2009).

As a consequence, the health system embarked on a competitive interviewing process with individuals of similar grades and roles competing for a significantly reduced number of posts. As part of the process, the NHS Leadership Qualities Framework (LQF) (NHS Institute for Innovation & Improvement, 2007) was introduced and applicants were advised that they would be required to demonstrate how they met the skills and attributes outlined. The challenge was that this framework had been developed for use by NHS Trust Board directors and senior leaders and many clinical professionals had little or no introduction to or experience of using the framework or the terms contained within it (Storey and Holti, 2013). As a result, many struggled with the interview process and the number of clinical managers in the system was significantly reduced (Heenan and Birrell, 2009). Anecdotally there continues to be a
view that the Leadership Qualities Framework (LQF) (NHS Institute for Innovation & Improvement, 2007) is of little value however no evidence has been produced to support this position.

These changes added impetus to the ongoing campaign by the RCM in Northern Ireland for the development of a contemporary maternity strategy to ensure the needs of women were central to policymaking. There was a strong perception at that time that the continued failure to prioritise maternity services was a reflection of the lack of importance given to women and the influence of midwives (Madden, 2007). Following a public consultation in 2011, the Minister of Health agreed to establish a working group to develop a policy taking account of wide stakeholder engagement (Madden, 2007). This resulted in a maternity strategy which was produced in 2012 and set standards for maternity services.

The strategy strongly supported the normalisation of childbirth and highlighted the need for development of senior midwifery posts and clinical leadership to change the existing culture within the parameters of safe, high-quality evidence-based care (DHSS, 2012). This was the first of the policy documents to acknowledge the need for building and developing clinical leadership. This strategy coincided with the announcement of yet more wide-ranging NHS reform in Northern Ireland following another major review of the services led by an expert team including the former chief executive of King’s Fund, Chris Ham and presented in the publication of a document entitled; Transforming Your Care (DHSS, 2011).
Transforming Your Care (DHSS, 2011) contained ninety-nine extensive recommendations for change, mainly refocusing services from the acute to community sectors including a Maternity and Child Health strand which re-emphasised the need to deliver against the standards contained within the maternity strategy. Although this policy document referred to workforce and contained one recommendation for clinical leadership development this was solely targeted at GPs (DHSS, 2011). The limited reference in these policy documents confirms that the level of interest reflected in clinical leadership development outlined in the various King Fund reports was not replicated in Northern Ireland (Ham, 2003; Kings Fund, 2011; Kings Fund, 2012; Kings Fund, 2014). This supports the suggestion by Greer (2016) that within Northern Ireland as a result of the ongoing years of political unrest and upheaval in the country, political interest in health services was limited to the strategic level.

1.5 Midwifery leadership in Northern Ireland

In Northern Ireland policy was slow to recognise the need for strong clinical leadership nevertheless gradual change was happening. Following sustained representation from the RCM that midwifery needed to be more visible at strategic and policy level the first midwifery officer post (part-time) was created in the Department of Health in 2002 (Madden, 2007). This was followed by the introduction of a senior midwifery advisory group which included education, practice and professional body representation at the Department of Health with a remit to advise the Chief Nursing Officer on maternity-related issues. This group began to highlight a range of concerns including the need for action on workforce planning and development (Barrowman and Clarke, 2003; Madden, 2007).
In recognition of these and similar issues across the UK, in 2008 the Chief Nursing Officers from the four countries commissioned a review of midwifery which resulted in the document Midwifery 2020 (Department of Health, 2010). They sought to develop a vision for midwives and maternity services and assure themselves that the profession was prepared to deliver care in line with women’s needs and expectation. This work was a collaboration between the four countries, women, all branches of midwifery, the wider multidisciplinary team and key stakeholders. A key recommendation was that midwives needed to be more assertive in promoting their professional image and the profession was set a challenge:

“To develop career pathways which enhance lifelong learning and build capacity and leadership”. Department of Health (2010, p.38).

Nevertheless, despite the importance of clinical leadership being highlighted, there was no progress in Northern Ireland in developing other senior midwifery roles until the publication of the Maternity Strategy (DHSS, 2012) which recommended the introduction of the consultant midwife role. A mid-term review to assess progress in implementing the strategy noted only 2 of the 5 trusts had achieved the recommendation to have a consultant midwife in post (RQIA, 2017). The RQIA report (2017) highlighted several other concerns including midwifery workforce pressures but predicted that further progress would be achieved by the end of the strategy implementation period. However, the review team commented positively on the clinical leadership they had observed during their site visits and engagement with the maternity services.
1.6 Leadership and management

Reflecting on the issue of leadership development it is apparent that the use of the terms, leadership and management in the language of the NHS contributes to an ongoing debate (Coggins, 2005; King’s Fund, 2011). Within the organisational structure, for example, the role of the ward manager or sister is generally considered to be one of leadership with first-line management responsibility as described by Hales et al. (2012):

“Front line senior clinicians, notably ward sisters, who always had a leadership role at ward level, have acquired additional formal managerial responsibilities.” Hales et al. (2012, p.12).

There are a number of other roles within the NHS which are also regarded as dual function, that is both manager and leader, for example, the Chief Executive of a Trust and the Head of Midwifery. Bennis and Nanus (1985) who undertook extensive research into the nature of leadership never accepted the concept of the dual role describing the differences between the two roles as:

“To manage means to bring about, to accomplish, to have charge of, or responsibility for, to conduct. Leading is influencing, guiding in direction, course, action, opinion” Bennis and Nanus (1985, p.21).

Although it was their view that while the focus of managerial and leadership roles may be different, they also accepted that both roles require individuals with similar skills. The difference between these roles was presented as those who deliver operational
services were managers, while the strategic thinkers and visionaries were characteristics of the leaders. Bennis and Nanus (1985) identified over three hundred and fifty definitions of leaderships when they undertook their research into the nature of leadership noting that there was little commonality between them. It has also been argued that leadership, in fact, develops through life experience (Shamir and Eilam, 2005) and can only be enhanced through gaining an understanding of self-awareness and emotional intelligence (Goleman, 1995). Edmonstone and Western (2002, p.43) referred to a “conceptual fuzziness” about the exact nature of leadership. While Burnes and By (2012) exploring the nature of ethical leadership concluded that there is now even less clarity than in the past as a result of the shifting views on which model is best suited to leading organisational change.

Bennis and Nanus (1985) identified four areas of competency which they believed could be learnt by managers, leaders and indeed by anyone within the general population. These areas related to the individuals’ ability to deliver a vision or agenda, communication skills, persistence, risk taking, confidence building and recognition of the need for continual development. The NHS adopted a taught approach to developing managers and leaders primarily through a variety of programmes which focused on these type of topics (West et al., 2015). In an evaluation of one particular leadership development programme, Werrett et al. (2002) identified from both quantitative and qualitative data positive outcomes for participants in both leadership and management skills. Murray (2007), also argues that for an organisation to grow and remain healthy requires certain basic skills in management and leadership to be present, irrespective of the nature of the business of the organisation. Similarly, Divall (2015) concluded
that in midwifery, leadership and management are inseparable, reflecting the hybrid model described by Fitzgerald et al., (2013). Edwards (2016) as chief executive of the influential Nuffield Trust has voiced concerns that this debate has not been helpful, as it diverts attention from the core issue which is to ensure individuals have the skills to fulfil the requirements of their role in a system which needs to provide supervision, time for reflection and peer support while they learn on the job. For the purpose of this thesis the terms, manager and leader, will therefore be considered as interchangeable since the skills required by both frequently overlap.

1.7 Leadership and management development programmes

There is however a lack of consistent research generally to identify what it is that NHS managers and midwives, in particular, need to know to ensure that they can successfully undertake management positions (Byrom and Downe, 2010). This is not surprising when considering the findings of a systematic review of leadership development across the private and public sectors by Hartley and Hinksman (2003) carried out for the NHS. They identified that the support for completing programmes was high but the content was variable and evaluations lacked consistency and robustness. Given the significant investment in leadership and management development programmes this gap is unexpected (King’s Fund, 2011). Similarly, Casey et al. (2011) also highlighted the gap and recommended a proactive approach to evaluating development programmes linked to measurable outcomes to ensure they are meeting the need. Concerns about the ageing profile of midwives at all levels with the potential loss of this existing body of experience is another element to be considered (RCM, 2016). It is an essential aspect of service continuity planning to
ensure effective succession planning and to understand the knowledge and skills required by midwives to manage and lead maternity services. This, in turn, should equip midwives with the skills to make certain women’s views are heard by Trust Boards and Commissioners of Health, ultimately contributing to improved maternal and infant outcomes (Warwick, 2015; Bannon et al., 2017).

There are many opportunities for leadership and management development for midwives in England as reported by Madden (2007) however within Northern Ireland the intervention of choice for midwives to develop the necessary skills required is provided by organisations such as Northern Ireland’s Health and Social Care (HSC) Leadership Centre, or by the Royal College of Midwives (RCM). These programmes are currently based on the Leadership Quality Framework developed by the NHS Institute of Innovation and Improvement (2007) and are delivered through a mixture of lectures and group work in a classroom-based environment. In essence, the concept of the framework whilst developed to support the most senior Trust directors is being used in NI as an assessment tool for interviews. It also provides a structured approach to helping individuals develop their skills and competencies in a number of key domains. It is broadly accepted as having the potential to provide skilled individuals who can participate in, and deliver change to the benefit of both women and the service (Johnston and Dale, 2011; Johnson, 2012).

In considering the three elements of the framework within the context of the definitions described by Bennis and Nanus (1985): setting direction could therefore be viewed in the context of leadership development, delivering the service with the more practical
skills of management while personal qualities are self-evident. In addition, there is a view that the skills to lead (soft skills) cannot be taught but rather must be nurtured: for example, communication, building relationships as opposed to management skills (hard skills) which are teachable and include technical skills, such as financial management or strategic planning (Rubin, 2009; Edwards 2016).

Given that leadership development for nurses and midwives is recognised across the globe as critical to ensuring improvements in patient outcomes, it is imperative programmes are effective (Rumsey and Homer, 2015; Renfrew et al., 2019). Equally the importance of senior midwives holding management and leadership positions creating opportunities to support and encourage younger midwives to develop their skills and abilities as future leaders is emphasised by Coggins (2005). Fitzgerald et al., (2013) identified that where these skills exist, clinical professionals such as midwives can take their place in delivering service change and development. Warwick (2015) has also stressed the importance of adopting a flexible approach to preparing midwives to develop the skills necessary to take on senior management and leadership roles.

1.8 The aim of the thesis

This thesis aims to explore the leadership and management experience of midwifery managers and midwives in Northern Ireland and understanding of the skills required to lead and manage maternity services. The LQF (NHS Institute for Innovation & Improvement, 2007) is the framework currently used to support recruitment of NHS staff and therefore the views and relevance of its usefulness will be explored and used as a basis for framing the findings of the literature review and results from the studies.
The rationale for undertaking this work is to ensure that women receive the best care possible within services designed to meet their needs (Bannon *et al.*, 2017). If the outcome of the work is to influence the thinking on leadership and management of the midwifery profession, then the knowledge that is produced must be easily understood and midwives will identify with the findings, relating outcomes to their practice.

The potential endpoint will be the identification of gaps in the existing development opportunities for midwives and production of recommendations to inform the development of a theoretical programme underpinned by the research process so that the result will be both robust and relevant. In order to understand the views, perspectives, and impact of leadership development on individuals, which is the aim of this thesis, social science methods offer a model which supports exploration of their journeys which could not be achieved using a scientific model (Rees, 2003; Hesse-Biber, 2010).

Critical to this process is the researcher’s assumptions and philosophical beliefs about the nature of ‘being’ and their personal relationship with the issue to be investigated. In considering, and critically appraising the literature on research, there is an abundance of further abstract concepts which also need to be drawn together as part of the jigsaw to assist the researcher in determining the evaluation process to use. This is essential in order to produce answers which can be interpreted, and in turn, arrive at a determination about the effectiveness of the intervention. Creswell (2007) explains that each researcher brings their own experience, beliefs and cultures (i.e. their view of the world) to the design and management of their project and rather than speak of
paradigms (system of beliefs or ideas) he refers to ‘worldviews’. He also links the
worldviews as appropriate, to quantitative, qualitative and mixed method approaches.
In exploring a management and leadership development intervention with midwives,
their subjective views and opinions will be the main aspect of the data collected and
will be considered as part of the evaluation. This is an essential part of the process in
identifying the gaps in current knowledge. While there are distinctions between
qualitative and quantitative research in the literature, that is not to infer that one is
superior in any way from the other, rather the researcher’s worldview will contribute
to the final decision as to which best fits scrutiny of the particular problem or
phenomena being examined.

The study will utilise a mixed methods approach: whilst recognising the majority of
data will be generated in the form of words or narrative, an interpretivist approach,
will be utilised to develop an understanding of the participants and the topic.
Quantitative data relating to demographics and survey data will be analysed within a
statistical framework. As the ultimate aim is to determine whether the leadership and
management development programmes accessed by midwives are meeting their needs,
building on the experience and views of current senior midwifery managers and
midwives who have experienced these programmes, their perspectives and
experiences, will be critical. Use of qualitative methodology will give insight and
depth into the participants’ experiences/perspectives and identify themes which can be
further explored to offer greater insight and knowledge and inform further
evolutionary work around this topic. Quantitative data will provide demographic
information to add richness and context as suggested by Mackenzie and Knipe (2006)
and quantify the views of the midwifery managers and the midwives on the skills and attributes aligned in the NHS Leadership Qualities Framework (NHS Institute for Innovation & Improvement, 2007). The conclusion of this study will add to the body of knowledge and our understanding of the information, experiences and opportunities required for those aspiring to manage or lead the midwifery profession within maternity services.

1.9 Summary
This chapter has provided an overview contextualising how leadership within midwifery and the NHS more broadly, has been historically challenging with specific reference to NI. This has been due to various reform agendas and the lack of emphasis on clinical expertise within NHS management teams. Consequently, with evidence of poorer outcomes, a limited focus on service users and a failure to meet public expectation have contributed to the current position (Storey and Holti, 2013; Kings Fund, 2014). This Thesis will aim to:

- Systematically review the evidence in relation to leadership programmes and reported outcomes,
- Explore the perspectives of midwifery managers in Northern Ireland in relation to their experience of leadership and management including the LQF (2007) (Phase 1),
- Explore the perspectives of midwives in Northern Ireland who have completed a Leadership and Management Development programme facilitated by the HSC Leadership Centre and/or the RCM (Phase 2).
Chapter 2 of this thesis will present a systematic review of the literature to determine, the effectiveness of leadership and/or management developmental interventions on the skills and attributes of NHS employees. Chapter 3 will describe the methodological approach taken for this research study. Chapter 4 will present the findings. Finally, Chapter 5 will provide a discussion of the findings, conclusion and recommendations.
Chapter 2. Systematic Review
2.1 Introduction

The value of competence-based management and leadership development programmes for NHS staff has been discussed extensively (Storey and Holti, 2015). The debate has centred on the belief that while the motivation of individuals might improve, managerial behaviour has not changed (Holman and Hall, 1996; King’s Fund, 2014). The National Health Service (NHS) Graduate Management Training Scheme, in particular, has promoted competency-based programmes as the means to equip graduates and health professionals with the expertise needed to become successful leaders and managers. (Storey and Holti, 2013).

Cowlings et al. (1999) in a qualitative study based on interviews with NHS managers including nurses and doctors, identified five clusters of competencies required for training and development. These competencies formed the basis of a developmental leadership/management framework to be used to provide a structured approach to NHS staff planning their development. The NHS Institute of Innovation and Improvement (2007) further developed this work and produced a diagrammatic framework (Appendix 1). This diagrammatic framework sets out a range of competencies associated with three key areas, setting direction, delivering the service and working with people. The Institute recommendation was that individuals, particularly those aspiring to senior management roles, use the framework as a template to self-assess and identify specific learning needs (NHS Institute of Innovation and Improvement, 2007) building on the NHS appraisal systems.

It is evident that considerable investment and work has gone into the development of leadership and management in the NHS but at the same time, there has been gradual...
recognition of the need for programmes developed specifically for different groups of staff (Hewison and Griffiths, 2004). In response, the NHS Institute of Innovation and Improvement produced additional developmental frameworks. In 2001, a clinical leadership programme for nurses (the LEO programme) developed in the USA was published. In 2007 the LQF was produced specifically for chief executives and senior managers in the NHS, and in 2008 another framework was published aimed at both undergraduate and postgraduate doctors (Large et al., 2005; NHS Institute of Innovation and Improvement, 2007). Leadership and management programmes were then amended to reflect these new models and language (West et al., 2015).

The approach to evaluation of programmes, however, appears to have been inconsistent; baseline measures of leadership effectiveness are absent and a limited attempt to establish or articulate organisational benefits (Storey and Holti, 2013; West et al., 2015; NHS Improvement, 2016). West et al., (2015) suggests that this situation can be linked to the lack of a high academic standard approach in the research which has been undertaken. To date, systematic reviews of the effectiveness of NHS manager or midwifery leadership programmes have not been identified.

2.2 Method

The aim of this review was 1) to determine the effectiveness of leadership and management programmes on developing the skills and attributes of NHS employees 2) to identify factors that influence the effective implementation of programmes. In the context of this review, a manager or leader is defined as a person who is responsible for leading, managing and influencing the work of others (Jordan, 2017). Effectiveness will be considered through establishing the extent to which programmes have resulted
in reported improvements (measured or described) in the management and leadership skills and abilities of the participants, including service improvement and feedback on improvements in care/outcomes. The review will seek to identify relevant primary and secondary research focusing on the impact of the development programmes on staff working within the National Health Service (NHS). Narrative accounts will be included where they contain evidence of evaluation or theoretical reflection demonstrated through the inclusion of objectives, methods and approach to data analyses in the paper as suggested by Aveyard (2014).

A leadership and/or management programme is defined as an intervention designed to develop leadership or management potential. Examples of this type of intervention may include a structured management programme, workplace shadowing, mentoring or coaching. The outcomes of interest were not pre-specified and were reported as in the original studies. Examples of the outcomes of leadership and management development programmes may include the acquisition of new knowledge, development of reflection or problem-solving skills, strategies to lead change, using action learning, staff development or resource management.

2.2.1 Search strategy

The review utilized a systematic approach to ensure that all relevant studies were included (Aveyard, 2014). A search strategy was developed to ensure a rigorous process of searching, retrieval, appraisal, data extraction, data synthesis and interpretation as described by Rees et al. (2010). The review included both qualitative and quantitative research studies.
Electronic searches of relevant databases were conducted using sources accessible via the Queen’s University Belfast Library ‘Q search’ facility. A search of six databases was initially undertaken in July 2016 and updated in January 2019: Medline, Maternity and Infant Care, ABI/Inform, CINAHL, HMIC and PsycINFO. Expert advice was sought from the QUB subject specialist library to confirm the choice of databases. A list was compiled which detailed areas to include as search terms. Medical Subject Heading (MeSH) terms were used where possible and were supplemented by relevant text words or phrases (Appendix 2).

The search strategy was supplemented within the timeframe by a Google scholar search to identify any other relevant papers, reports or published dissertations. To increase the possibility of identifying further literature, the reference lists of all retrieved articles were scoped for additional relevant papers.

2.2.2 Inclusion
All studies which evaluated a leadership and/or management intervention for NHS staff were included. Quantitative approaches included randomized controlled trials (RCTs), controlled before and after studies, cohort or survey studies. Qualitative studies using approaches such as grounded theory, phenomenology, case studies or action research reporting on the perspective or experience of individuals participating in a programme were also included. The search was limited to English language articles published from 1998 and was underpinned by the rationale that it was around this time that it was recognised that midwives would benefit from undertaking managerial development (Pashley, 1998a; Pashley, 1998b).
In summary papers eligible for inclusion were:

- primary research studies
- secondary research studies
- quantitative or qualitative research
- published in the English language
- publications based on UK data
- published from 1998
- included NHS employees

2.2.3 Exclusion

As the focus of this review was leadership and managerial development within the NHS, studies which evaluated management and/or leadership programmes outside the UK or NHS employees were excluded. Also excluded were any leadership/management programmes incorporated into undergraduate programmes as students are not NHS employees and this review aimed to identify programmes relevant to continuing professional development.

Guided by the inclusion and exclusion criteria each of the articles retrieved was screened for relevance by reading the title and abstract. Articles that met the inclusion criteria were selected and detailed in a summary table (Appendix 3). Two reports were obtained in full through contact with the nominated source (GVA and Outcomes UK, 2011; Robinson et al., 2016). Once the full text of each included study was obtained, all were read in full and the relevant data were extracted guided by the use of data extraction forms to ensure consistency and provide a structured means of recording the
relevant data. In developing the forms, a scoping exercise of the literature was completed as suggested by Wright et al. (2007).

2.2.4 Quality appraisal

Quality assessment of the studies identified through the literature review is essential to assess the strength of the evidence presented to answer the question posed by the systematic review (Aveyard, 2014). After careful consideration, the Mixed Methods Appraisal Tool 2011 (MMAT) as described by Souto et al. (2014) was utilised as a framework to guide the critical appraisal of the papers identified as it allowed studies of different methodological designs to be compared using the same appraisal tool and therefore facilitated consistency of approach. They also highlight that it is equally important to note that the quality of method is different from the quality of the reporting (Souto et al., 2014; Hong et al., 2018). The tool presents two screening questions for all types of studies and specific criteria for each of the five categories of study: qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies and mixed methods (table 2.1).
Table 2.1: Mixed Methods Appraisal Tool

<table>
<thead>
<tr>
<th>Types of mixed methods study components or primary studies</th>
<th>Methodological quality criteria (see tutorial for definitions and examples)</th>
<th>Responses</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening questions</strong> (for all types)</td>
<td>• Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?</td>
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<tr>
<td></td>
<td>• Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).</td>
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<tr>
<td></td>
<td><strong>Further appraisal may be not feasible or appropriate when the answer is ‘No’ or ‘Can’t tell’ to one or both screening questions</strong></td>
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<tr>
<td><strong>1. Qualitative</strong></td>
<td>1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?</td>
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<td></td>
<td>1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?</td>
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<td></td>
<td>1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?</td>
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<td></td>
<td>1.4. Is appropriate consideration given to how findings relate to researchers’ influence, e.g., through their interactions with participants?</td>
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<tr>
<td><strong>2. Quantitative randomized controlled (trials)</strong></td>
<td>2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?</td>
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<td></td>
<td>2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?</td>
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<td></td>
<td>2.3. Are there complete outcome data (80% or above)?</td>
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<td></td>
<td>2.4. Is there low withdrawal/drop-out (below 20%)?</td>
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<td><strong>3. Quantitative non-randomized</strong></td>
<td>3.1. Are participants (organizations) recruited in a way that minimizes selection bias?</td>
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<td></td>
<td>3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?</td>
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<td></td>
<td>3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?</td>
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<td></td>
<td>3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?</td>
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<tr>
<td><strong>4. Quantitative descriptive</strong></td>
<td>4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?</td>
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<td></td>
<td>4.2. Is the sample representative of the population understudy?</td>
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<td></td>
<td>4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?</td>
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<tr>
<td></td>
<td>4.4. Is there an acceptable response rate (60% or above)?</td>
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<tr>
<td><strong>5. Mixed methods</strong></td>
<td>5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?</td>
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<td></td>
<td>5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?</td>
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<td></td>
<td>5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?</td>
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</tbody>
</table>

*These two items are not considered as double-barreled items since in mixed methods research, (1) there may be research questions (quantitative research) or research objectives (qualitative research), and (2) data may be integrated, and/or qualitative findings and quantitative results can be integrated.

Source: Souto et al. (2014)
Based on the percentage of criteria identified within the specific category a score for each study may be determined; for example, a score of 25% out of 100% may suggest a weak design whilst 100% would be attributed to a strong design. Whilst recognising the limitation of the scoring system, the tool provided greater ease in comparing the quality of method across different types of studies especially those linked to health (Pace et al., 2011). In addition, the Scottish Intercollegiate Guidelines Network (SIGN 2015) was identified for use to assess any quantitative studies. This tool describes eight levels of evidence with level 1 ++ representing the highest quality of evidence to level 4 allocated for evidence-based on expert opinion (table 2.2). All levels of evidence were included in this review in order to be as inclusive as possible.

**Table 2:2 SIGN (2015)**

<table>
<thead>
<tr>
<th>Levels of evidence</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1**</td>
<td>High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias</td>
</tr>
<tr>
<td>1*</td>
<td>Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias</td>
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<tr>
<td>1</td>
<td>Meta-analyses, systematic reviews, or RCTs with a high risk of bias</td>
</tr>
<tr>
<td>2**</td>
<td>High quality systematic reviews of case control or cohort studies</td>
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<td></td>
<td>High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal</td>
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<tr>
<td>2*</td>
<td>Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal</td>
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<tr>
<td>3</td>
<td>Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal</td>
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<tr>
<td>4</td>
<td>Non-analytic studies, e.g. case reports, case series</td>
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<td></td>
<td>Expert opinion</td>
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**Grades of recommendations**

- **A** At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or
- A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
- **B** A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 1++ or 1+.
- **C** A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 2++
- **D** Evidence level 3 or 4; or extrapolated evidence from studies rated as 2+

**Good practice points**

- Recommended best practice based on the clinical experience of the guideline development group.

2.2.5 Synthesis

A narrative synthesis of the included studies was conducted. The synthesis was conducted in two phases. In the first phase, the papers were organised by programme to explore the evidence on the effectiveness of leadership and/or management development programmes. In the second phase, a number of cross-cutting themes were identified across programmes. The findings were reported in line with PRISMA guidelines (Appendix 3).

2.3 Results

The literature search identified a total of 3022 papers from the electronic search and 9 from other sources e.g. grey literature. Following removal of duplicates (n=176), the remaining titles and abstracts were screened for relevance to the overarching aim: the impact leadership and/or management development programmes have on the skills and attributes of NHS employees. Of these, 2734 titles did not meet the inclusion criteria. The abstracts of 121 papers were obtained and screened for consideration: 85 did not meet the inclusion criteria, for example, were conducted in other countries or the private sector, leaving 36 potential papers. The full text was screened for the 36 potentially eligible papers: 16 were excluded resulting in a total of 20 papers eligible for inclusion in this review. The flow chart in Table 2.3 details the number of papers present at each stage.
Table 2.3: Prisma Research Flow Chart

2.3.1 Quality

The twenty included papers were considerably diverse in the way that programmes were delivered and evaluated. The vast majority of the programmes were based in England reflecting the interest and investment of the Department of Health as they sought to improve service delivery and patient outcomes (King’s Fund, 2011; West et al., 2015; NHS Improvement, 2017). Over 3000 individuals participated in these programmes and represented the full range of NHS employees, however, it must be noted that this was over a 19-year timeframe, with the smallest study based on four participants (Hancock and Campbell, 2006) to the largest of 1050 (Werrett et al., 2002). Not all studies provided exact figures for participants (Woolnough and Faugier,
There was a lack of clarity on whether the focus was to develop leaders or improve their management skills to achieve performance targets within the NHS (Edmonstone and Western, 2002, Hewison and Griffiths, 2004). It could be argued that this lack of clarity has distracted from the much-needed conversation about the effectiveness of existing leadership development (Ham, 2003, King’s Fund, 2011, Divall, 2015). There were no reports of how many of these programmes/interventions were developed or tested. Rather it would appear they were aimed at addressing the latest trends in leadership models or in response to political perceptions (Edwards, 2016). The lack of rigorous designs such as trials to explore effectiveness has therefore limited the quality of the data.

The quality of the evidence was assessed using the mixed methods appraisal tool (MMAT) and the SIGN guidelines (2015). The majority of the papers were allocated a weak or moderate level of evidence. The quality appraisal MMAT score is included in the table of eligible papers (Appendix 3) and ranged from 25% to 75%. The Scottish Intercollegiate Guidelines Network (SIGN 2015) guidelines were used to assess quantitative studies (Appendix 3); for the quantitative aspect of the mixed method studies three were graded as well-conducted and graded as 2 + (Humphris et al., 2004; Walia and Marks-Maran, 2014; Boyd et al., 2016). The primary reasons for the low scores were due to the non-analytical nature of the studies or the level of evidence provided was poor. Evaluations of the programmes were largely based around self-reporting by the participants which although this provided important data in terms of perspectives and experiences, may be viewed as subjective and lacking in rigorous evaluation. (West et al., 2015). The attrition rate from a number of programmes was high (Currie, 1998; Edmonstone and Western, 2002; Large et al., 2005) or key aspects
of the programme were not completed, for example, action plans (Woolnough and Faugier, 2002; Boaden, 2006; Philip and Byrne, 2013, Leeson and Millar, 2013; Ross-Davie et al., 2016).

Key elements of data were limited or missing in a number of studies (Cooper, 2003; Woolnough and Faugier, 2002; Humphris et al., 2004; Hancock and Campbell, 2006; Wing et al., 2004; Philip and Byrne, 2013; Boyd et al., 2016; Barton et al., 2017). The potential for bias between the programme provider and evaluation was not addressed (Large et al., 2005; Mann et al., 2008; Sambrook, 2009). A lack of consistency in programme content and participants was noted (Currie, 1998; Humphris et al., 2004; Large et al., 2005; Boaden, 2006; Ross-Davie et al., 2016).

Use of frameworks was limited with Mann et al. (2008) relying on a medical competency framework to evaluate effectiveness but with no objective measurement, while Walia and Marks-Marlan (2014) used elements of a proposed new version of the Leadership Qualities Framework to inform the development of a leadership module. The limited findings concerning the framework partly reflect the emergence of the LQF in 2007, midway through the period which is the focus of this literature review. Disparity in the length of the programmes and level of content between those aimed at general managers and those provided for clinical teams was noted, for example, the LEO programme which lasted three days (Werrett et al., 2002; Woolnough and Faugier, 2002; Cooper, 2003; Hancock and Campbell, 2006) or the Nye Bevan programme which included 18 face to face teaching days delivered over a year (Robinson et al., 2016).
2.3.2 Phase one: Effectiveness of leadership/management programmes

The included papers all reported on interventions related to leadership development: 10 used a mixed methods approach (Werrett et al., 2002; Cooper, 2003; Wing et al., 2004; Humphris et al., 2004; Large et al., 2005; Boaden, 2006; Mann et al., 2008; Walia and Marks-Marlan, 2014; Boyd et al., 2016; Ross-Davie et al., 2016) and 10 used qualitative methods including interviews and questionnaires (Woolnough and Faugier, 2002; Hancock and Campbell, 2006; Leeson and Millar, 2013; Phillips and Byrne, 2013; Currie, 1998; Edmonstone and Western, 2002; GVA and Outcomes UK, 2011; Sambrook, 2009; Robinson et al., 2016; Barton et al., 2017). The pattern and timing of evaluation were also markedly different, with the majority based on data collected on completion of the programme/intervention (Currie, 1998; Large et al., 2005; Boaden, 2006; Mann et al., 2008; Sambrook, 2009; Walia and Marks-Marlan, 2014; Ross-Davie et al., 2016), 1 month later (Edmonstone and Western, 2002; Barton et al. 2017), 3 months later (Werrett et al., 2002), 6 months later (Woolnough & Faugier, 2002; Humphris et al., 2002; Cooper, 2003), between 3 to 9 months (Leeson and Millar, 2013) at a year (Wing et al., 2004; Boyd, 2016) and one group where the information was not provided (Hancock and Campbell, 2006; GVA & Outcomes, 2011; Philips and Byrne, 2013; Robinson, 2016).

Eighteen of the studies were conducted in England, one was conducted in Wales (Sambrook, 2009) and one in Scotland (Ross-Davie et al. 2016). The sample sizes ranged from 4 participants to 1050 with a broad range of sampling including random, purposive, self-selection or convenience as the main methods of recruiting participants. In total the papers focussed on 23 different leadership interventions: two university modules for NHS staff, seven for generic managers and 14 specifically
designed for clinical teams, primarily nurses. Of the clinical papers, two papers reported on the Royal College of Nursing (RCN) Clinical Leadership programme, four papers reported on the Leading an Empowered Organisation (LEO) programme.

The results of the analysed papers were then grouped with a focus on the intervention to examine in greater detail the effectiveness of the programmes/interventions on the participants: nursing and midwifery specific, bespoke programmes for clinical professionals, generic leadership development, and alternative models of leadership development. In reviewing these papers, the descriptor ‘nurse’ was accepted as referring to nurses, midwives and public health nurses unless stipulated otherwise in keeping with the approach adopted by others (Murphy, 2014).

There were eight studies which described programmes specifically aimed at nurses and midwives of which three were qualitative and five used a mixed method approach reporting on leadership programmes (Appendix 3, p.235-240). Four of the studies identified in the review focused on the evaluation of aspects of the Leading an Empowered Organisation (LEO) programme (Werrett et al., 2002; Woolnough and Faugier, 2002; Cooper, 2003; Hancock and Campbell, 2006). Two studies examined the Royal College of Nursing’s Clinical Leadership programme (RCNCLP) (Wing et al., 2004; Large et al., 2005) one study reported on a programme developed and delivered in a Trust for ward sisters (Phillips and Byrne, 2013) and one reported on a programme for midwives (Ross-Davie et al., 2016). The structure of these programmes varied in structure and duration as presented below (table 2.4).
The participants on the programmes were primarily drawn from nurses who were working at NHS pay bands F and G which reflect roles associated with management responsibilities. Four of the studies also included Allied Health Professionals (AHPs) (Werrett et al., 2002; Woolnough and Faugier, 2002; Wing et al., 2004; Large et al., 2005). Overall, the quality of the papers was mixed due to limitations within the studies such as the attrition rates, poor response rates and lack of detail which therefore limited the ability to generalise findings.

**LEO programme**

Werrett et al. (2002) undertook a mixed method two-phase study to evaluate the impact of the introduction of the LEO programme in the West Midlands in England. The LEO programme as explained by Cooper (2003) was developed in America and introduced...
to the UK in 2001 as part of a government initiative to improve nursing leadership. The programme advocated a transformational style of leadership aiming to develop leaders who inspired and supported their teams to identify and deliver change together.

A survey was administered pre and post programme to a sample of participants. The aim was to gather baseline data which the researchers would use to compare changes in participants’ leadership practices following completion of the programme. They particularly sought views on a range of 33 pre-determined measures of leadership, for example, delivery of patient-centred care, mentorship, empowerment of staff and time management, which one of the authors had previously developed.

In total, 25% (1050/4184) of nurses and AHPs who commenced the programme agreed to participate with 52% (550/1050) completing the pre-course questionnaire. The 550 were also asked to participate in the post-test questionnaire which was administered three months after completion of the programme and 32% (181/550) responded. Some participants did not complete all questions on both phases of the study and these were removed from a number of the relevant aspects of the analysis; the numbers who completed all questions were 522/1050 and 174/550. The study, scored weakly when assessed within the SIGN (2015) and MMAT tools as the ability to make valid comparisons were limited.

The authors compared the pre and post-test responses from the participants who completed both elements to those who completed the pre-test element only (n=174) using a Mann-Whitney U test and found no significant differences (p>0.05). They, therefore, determined that differences in the post-test findings could be accepted. The areas assessed were described as components of leadership: team and management.
issues, staff support and development and self-development. There was a significant difference between the pre and post scores (p<0.05) for all of these factors except for self-development (mean score of 3.61) which indicated some improvement but was not statistically significant. From analyses of the participants’ responses to open questions the authors reported positive benefits, for example, an increase in networking, communication and problem-solving skills. There was a general concern however relating to the implementation of the learning in the workplace because of organisational constraints.

The researchers cautioned against concluding that all changes were linked to the LEO programme as they had identified through the pre-test questionnaire that a number of participants had previously completed a management development programme (n=388). They identified the need for longitudinal review as they concluded the three months’ post-programme review was too soon to determine what changes had been made in service and whether these could be sustained, a view supported by others (Humphries et al., 2004).

While the size and diversity of the participants was a strength of the recruitment process, there is a significant gap in the analysis of what proportion these participants were of the total population and how similar they were to the total population in terms of their roles and responsibilities. In reporting the qualitative data generated from the questionnaires 71/181 (39%) commented positively about the programme delivery but overall, it was difficult to interpret the figures presented concerning overall satisfaction. Findings were mainly presented through narrative interspersed with tables and figures with some inconsistencies between the totals provided. In describing the
pre-test population, the authors report that 80/550 (14.5%) had previously completed formal study on leadership but there was no indication of whether any of this cohort responded to the post-course survey, and thereby potentially influenced the result. The statistical findings offered limited evaluation and no external/objective validation on the benefits to the participants, the health service and patients.

Cooper (2003) utilised a mixed method approach to evaluate the effectiveness of the LEO training programme but from a different perspective; she aimed to compare the pre-existing leadership skills of the participants against the levels they demonstrated on completion of the programme. To improve the robustness of the findings and utilising an educational evaluation approach, a number of themes or “shared constructs” (p.35) were determined following interviews with the teachers and participants. These themes, for example, included questions such as, whether participants who hold a more senior grade gained more from the programme and were used to assess effectiveness.

The questionnaire used was an amalgamation of the Leadership Behaviour Description Questionnaire and the Team Excellence Version 2 questionnaire (TEV2) which the author identified as offering the best tool to measure changes in leadership skills. The questionnaire included 14 statements each linked to a Likert scale (ranging from 1 poor to 5 excellent) as described by Rees (2003). This was shared with managers and team members of the participants before the programme to provide a baseline. The 21 nurses who participated were all working at G grade (team leader grade 7) or above and planned to complete the LEO programme in July 2001. All were invited to complete a pre-programme questionnaire: 71% (15/21) accepted. Those who previously
completed a management development course 40% (6/15) were identified in order to review their responses as a separate group. Between three to six months’ post-programme 71% (15/21) of the participants who agreed to take part in the study also completed a post-programme questionnaire and an interview. Pre- and post-programme questionnaires were also sent to a random selection of the participants’ colleagues and managers (n=77) to gather their observation on the impact of the programme. The pre-programme questionnaire was completed by 49% (38/77) of this group with 39% (30/77) also completing the post-programme questionnaire.

Analysis using Wilcoxon test of the participants’ TEV2 questionnaire responses identified a significant improvement in their leadership performance in several areas: articulating the goal, maintaining organisational objectives, exhibiting trust, presenting challenging opportunities and getting outside support. Their managers and colleagues who returned the post-programme questionnaire identified no overall improvement in the participants’ leadership performance other than in two areas: maintaining organisational objectives (p=0.044) and presenting challenging opportunities (p=0.012).

Cooper (2003) also reported on a number of themes which emerged through the interview process. It was suggested that the programme would be more appropriate for staff at a lower grade such as band 6 nurses and be adjusted to reflect previous management development. Pre-course material would be helpful and the course could be strengthened by the inclusion of other members of the multidisciplinary team and an increase in the ratio of tutors to participants with an agreement that a second tutor is present for each programme. Subject areas which should be considered for inclusion
related to the impact of tensions between nursing and managerial responsibilities for nurse leaders and the challenge of managing conflict.

In conclusion, Cooper (2003) acknowledged the limitations of the sample size. Although the inclusion of team leaders and team members in the study offered a wider perspective, poor response rates and a lack of clarity on the demographic profile and grades of these individuals limits the weighting a reader may give to the findings; this was reflected in the weak quality appraisal classification allocated. As with other studies (Woolnough and Faugier, 2002; Werrett et al., 2002), the three to four-month time frame for post programme data collection is relatively short and therefore issues around sustainability, impact and implementation of change need to be treated with caution.

Woolnough and Faugier (2002) conducted a qualitative follow-up study at six months’ post-LEO programme on a cohort of nurses and AHPs who initially commenced the LEO programme in January 2002. Questionnaires were distributed to all participants commencing the programme; however, the total number of people was not provided. From this cohort, 109 participants agreed to take part in a semi-structured telephone interview. The qualitative approach allowed for the exploration of a number of pre-determined topics which had been agreed between the researchers and the programme facilitators such as the impact on personal leadership styles. Woolnough and Faugier (2002) reported that the majority of these participants highly valued the course and believed it had improved the care delivered to patients and supported them to make advances in service delivery. They also reported on areas such as improved knowledge of leadership styles with 73/109 participants describing improvement in their
capabilities, however, 26/109 reported no improvement. Linking theory to practice and realising the benefits of networking were similarly highlighted as areas of individuals’ improvement.

The one area of concern reported by participants related to the sustainability of the programme as they reported that a number of their organisations failed to put in place preparation and support systems to empower staff to implement changes following completion of the programme. A key product of the LEO programme was the completion of a personal action plan to be used by the participants to support improvements in their performance. However, 36/109 of this study group acknowledged they had not completed a plan, whilst others reported that they had not looked at the plan since returning to the workplace. Based on the participants’ responses, the researchers concluded that the LEO programme empowered participants to reflect on their practice and implement changes within the work setting with practical tools to assist that process.

These findings, however, must be considered within the context of the study quality which was not robust. There was a lack of information on the participants and a failure to clarify whether any of the data related to the AHPs and therefore scored 50% on MMAT. The researchers did acknowledge that while a semi-structured process was followed, this was not rigid and any additional data provided by the participants which linked to the research purpose, were included. Overall, there were limited data provided especially concerning sustainability. While 109 individuals participated in the study no information was provided on the breakdown of the number who were
nurses and AHP’s, characteristics and whether there was a difference in their views, similar to the study reported by Werrett et al., 2002.

Hancock and Campbell (2006) also conducted a follow-up qualitative study to evaluate the impact of the LEO programme in an NHS Trust. A purposive sample of four G grade nurses with managerial responsibility for an NHS clinical area was invited to participate and interviewed specifically about the impact of the LEO programme on themselves, their leadership, their experience and their service. To validate findings, the researchers, in consultation with the four G grade nurses identified eight nurses from each of their clinical areas (total of 32) for interview and to complete a 360° appraisal to provide structure and uniformity to the information collected.

The researchers concluded that the LEO programme had a positive effect on the G grade nurses especially concerning problem-solving, risk-taking and management and leadership styles. These findings followed similar themes to previous papers (Woolnough and Faugier, 2002; Werrett et al., 2002; Cooper 2003). They reported that participants cited organisational culture and their limited sphere of influence as G grades within the Trust’s management hierarchy as barriers to implementing the learning from LEO reflecting the findings of others (Woolnough and Faugier, 2002; Werrett et al., 2002). No information was provided on the length of time since the G grades had completed the programme or on the return rate for the 360° appraisal tool. The sample size was smaller than would be desirable for a rigorous qualitative evaluation.
There was also an absence of detail about the eight nurses identified by each of the four G grades from their clinical areas (total of 32) for interview and to complete the 360° appraisal, this limited the value of the 360° review. It was reported that some of the nurses had not been aware of the LEO programme but there was no indication of numbers, or whether any of them had completed similar programmes.

The absence of this information impacted on the quality (Souto et al., 2014), and therefore the weighting, given to the finding of this study and was reflective of the issues with similar studies in this group (Woolnough and Faugier, 2002; Werrett et al., 2002; Cooper, 2003). Each of these studies also took a slightly different approach to explore the outcomes of the LEO programme but all focused on the impact of the individual’s performance. Given the size of the cohorts who completed the programme the numbers included in the studies were small and mainly concentrated within the first year following the introduction of the programme. Nevertheless, the programme was positively received by participants, the majority of whom reported improvement in their personal skills, for example in communication and networking. The importance of organisations having a learning culture which provided tangible support such as time and resources to programme participants to enable them to implement change was also a consistent theme.

RCN programme

The RCN developed a clinical leadership programme for nurses which was launched in 2003. The programme was developed in response to a realisation that to deliver significant changes and innovation required strong nursing leadership and was supported by the NHS (Large et al., 2005). The programme, based on the concept of
transformational leadership, comprised of a number of elements: action learning, facilitated learning, mentorship and reflection. Birmingham Children’s Hospital introduced the programme during a period of major organisational change and Wing et al. (2004) evaluated the outcomes. The study involved 12 staff (11 nurses and an AHP) who were asked to allocate one day a week of their time to complete the year-long programme which included action learning sets, planning a team-building event and mentoring to support the teaching programme.

The evaluation, using a mixed methods approach, took place a year post programme and included a 360° review, taped stories based on a semi-structured questionnaire and informal interviews with each participant (Wing et al., 2004). The results identified a range of positive changes for example; development of skills in managing conflict and improved communication, based on the participants’ responses. It was reported that the organisation was perceived to be supportive, for example, through facilitating learning opportunities, in contrast to reports from other studies (Hancock and Campbell, 2006; Woolnough and Faugier, 2002; Werrett et al., 2002). The researchers reported that the transformational leadership skills of all participants had developed, especially linked to the organisation of care, highlighting that the improvement was most apparent in the individuals who had engaged fully in the programme; however, no data were provided on how these changes were measured or evaluated.

Despite collecting data from a number of sources there was no information provided on triangulation of the findings, especially relating to the completion of the 360° questionnaire and this limited the interpretation of the results as reflected in the quality appraisal of the study. Two authors were line managers of the participants and one was
directly involved in the delivery of the programme however the potential for bias was not acknowledged. In conclusion, although the researchers reported improvements, they recognised that there may be other factors which could account for these changes.

Large et al. (2005) also conducted an evaluation of the RCN programme using a multiple case study approach where the clinical leaders were the case studies, with leadership development as the central focus of the study. They sought to explore three key areas; the effectiveness of the programme as observed by the patients and other stakeholders, the degree of development experienced by the course participants, and whether the programme offered value for money. The design of the study was clearly presented and the methods of data collection presented in detail. The RCN programme was delivered to nurses, midwives and AHPs, in 80 English Trusts. Each programme required a facilitator who led the programme delivery and each programme had 12 participants who were all clinical leaders. All 80 Trusts were sent a sampling questionnaire from which the researchers identified 16 Trusts to be case study sites. There were two Trusts from eight of the English regions and a mix of acute and community Trusts; a table was provided showing these locations. Within each site one of the programme participants was purposively selected to participate in the study and in turn, each of these participants invited patients to participate in the study although no information was available on the actual number.

In summary, there were 16 programme participants, 26 patients, 30 colleagues, 15 Trust Education Facilitators and 14 Directors of Nursing recruited from the 16 case study sites. The nominated patients were interviewed at the start (n=15), middle (n=8) and end (n=3) of the programme to gather their observations of the programme
participants in practice. The participants’ colleagues were invited for interviews in two cohorts, with 16 participating in a midpoint interview and 14 at the final interview. In addition, stakeholder interviews were held and baseline and post programme questionnaires sent to collect data on observed changes on the participants and the service. The researchers acknowledged a number of logistical difficulties; two participants dropped out of the study through career changes and new matched participants were substituted. While the turnover of patients affected their availability with 16 taking part in the first interview, eight in the second and three in the final interview. No information was provided on the selection process of the participants’ colleagues.

To provide a wider perspective on the impact of the programme a randomly selected sample of 267 participants undertaking the RCN programme in the other 64 Trusts were recruited. These 267 participants were also asked to complete a pre and post programme 360° leadership inventory the aim of which was to measure any change in their leadership development as a result of the programme.

The post programme assessment was in the immediate period following completion of the programme and therefore there was insufficient time to identify real and sustained changes in practice. The response rate to the 360° leadership inventory was varied; with 42% (91/215) responding from the 16 targeted Trusts and 57% (154/267) from the other 64 Trusts. The researcher acknowledged that not all programme participants returned their forms, and information was missing from an undisclosed number. The inclusion of the patients’ perspective was innovative through the use of their stories but it is unclear how this related to the leadership development of the nurses. All
groups, however, reported positively on the impact for patient care with the clinical nurse leaders expressing greater levels of confidence in challenging poor practice. A significant change in their leadership skills measured through a comparison of the mean baseline and post programme self-assessment scores from the 360° leadership inventory (4.6 to 8.4) was reported although this view was not supported by data from colleagues and managers.

None of the researchers declared a conflict of interest yet all were employed by the RCN and had involvement in the programme development. The report was detailed and highlighted several key issues and themes emerging from the data, for example, the nurses were not always facilitated by their Trust to have the necessary time to complete all elements of the programme. There was a reported variation in the quality of aspects of the programme due to the absence of key facilitators. A cost analysis was undertaken using direct staff costs but because of variations in participants, hours of engagement, difficulty in accessing data the final costs were reported as inaccurate. A strength of the study was the comprehensive and inclusive approach through various methods of data collection with a range of participants, however, the potential for bias was not fully addressed.

Due to the various limitations of these papers as demonstrated through the quality appraisal scores (Appendix 3, p.235-240) conclusive evidence that nurses or midwives developed strong and sustained leadership skills following participation in the LEO and RCN programmes was not demonstrated. One reason for this as noted by Werrett et al., (2002) was the short timeframe between the implementation phases of the introduction of the LEO programme across the UK, and evaluations. Generally, the
programme participants felt that their leadership skills had increased, or they achieved improvements in their personal development (Cooper, 2003; Wing et al., 2004; Large et al., 2005; Downey and Wragg, 2009) but effectiveness of the courses on participant, patient and service outcomes was not adequately evaluated.

**Bespoke programme for nurse managers**

Phillips and Byrne (2013) described an approach where a bespoke programme was developed specifically for nurse managers in an NHS Trust in recognition of the importance of leadership in meeting the organisation’s needs. The reason for this particular approach was to provide work-based learning in the organisation, which would, in turn, benefit from the resultant changes in the participants’ thinking and practice. The course comprised of a classroom-based teaching programme (four episodes of two days) and action learning sets. The criteria to attend the programme was based on a requirement for the nurses to have 24-hour accountability for the delivery of care in their area and 24 nurse managers were nominated. Phillip and Byrne (2013) reported that 22 nurses completed all elements of the programme and qualitative data were collected at the end of each teaching session. An anonymous postal questionnaire was also distributed with positive feedback reported. In relation to the action learning sets, positive evaluations were received from 54% (12/22) of the participants.

Although Phillips and Byrne (2013) concluded that the course met its objectives and the action learning sets helped the nurses develop their skills to deliver their leadership role, there was insufficient data provided to support this view. In relation to the
evaluations completed on the taught elements of the programme, five comments were reported in isolation from any other data. No data were provided, for example, about the participants' previous educational opportunities, their years in post, or experience. The sample size and these omissions significantly weaken the weight given to the conclusion and future recommendations and are reflected in the quality appraisal score of 50% (Appendix 3, p. 239). They suggested that for the leadership improvements to be maintained, the nurses who completed the programme should continue to meet regularly, and the programme needs to be extended to other groups within the organisation. They also recognised the need for further longitudinal studies to measure sustainability.

Best start for leadership programme
Ross-Davie et al. (2016) reported on a programme aimed at building the leadership and management capacity of midwives. It was commissioned by the Scottish Government to provide a national approach to succession planning and leadership development. The quality of the study design ensured the collection of a comprehensive range of data, and evaluation was completed by an independent company. The programme commenced in 2012, ran for four years and had three elements; education, coaching and a service improvement project (SIP) which could be either individual or group led (Ross-Davie et al., 2016). During that time the name of the programme changed from Midwifery Leadership Programme to the ‘Best Start Leadership Programme.

A total of 180 health professionals (all programme participants) were recruited to the study, 166 midwives from all aspects and grades of midwifery, including education,
and 12 children’s nurses. Ross-Davie et al. (2016) reported that they, and 38 Heads of Midwifery (HoMs), were invited to participate in the study. Of the participants it was reported that 62% had volunteered to complete the programme, the remainder were nominated by their managers. The participants completed a pre-course questionnaire to identify their learning needs and were provided with a series of on-line worksheets to complete on leadership theories, policy and service improvement. This was followed by two workshop days to support their learning and to facilitate networking. In addition, three hours of one to one coaching was provided in the first two years, rising to five hours, following positive feedback, for the third and fourth years. The programme lasted seven months with a final one-day event when the participants presented their projects along with the submission of a written report outlining their next steps.

At the end of the programme, quantitative data were collected through an online questionnaire while qualitative data were obtained from: evaluation of participants’ posters which presented their service improvement projects, and interviews. The data were analysed by a social research organisation. For the final evaluation, all participants from the four programmes were included, therefore all figures presented from the data were based on 166 participants excluding 15 midwives who partially completed the programme. The response to the online questionnaire over four years was 77% (n=128) and evaluation was based on Kirkpatrick’s framework (1994). Kirkpatrick’s framework (1994) was chosen because it is frequently used in education and focuses on measuring four key elements; reaction, learning, behaviour and results (Ross-Davie et al., 2016). The outcomes reported were positive with 96% (124/128) citing improvements in their knowledge and skills as a result of completing the SIP,
reflecting similar finding by Mann et al. (2008). Additionally, 92% (119/128) reported the project resulted in improvements in their behaviours and the workplace. Of the HoMs, 84% (32/38) were supportive of the project element with 70% in year 1 to 100% in year 4 reporting they had contributed to achieving the services’ strategic aims but provided no detail or examples.

Specific information was provided for 2016, with 56% (22/39) participants reporting improvement in their ability to encourage and support others. The HoMs (32/32) of reported higher levels of confidence in succession planning as a result of their staff completing the programme as compared to 79% in 2013. The cost of participation was estimated to range from £1000 to £1250 taking account of direct costs, such as travel and accommodation, coaching and management support for the SIP (Ross-Davie et al., 2016).

A strength of the study as discussed above was that the evaluation was conducted by an independent research organisation, and in 2015 and 2016, included data from past participants and project implementation staff (n=12). This approach supported the process of ongoing development of the programme to meet identified need. The coaching time increased from three to five hours in years three and four and the method of delivery changed. The structure of the programme remained the same over the four years but no detail was provided on whether content changed. The timeframe for completing the post-programme assessment was not provided. The longitudinal approach and inclusion of past participants in the final assessment was an opportunity to identify sustained changes in practice. Absence of data for all four years, however, limits the usefulness of the information.
This paper was graded as having moderate strength of level 2 evidence (SIGN, 2015) as it provided adjusted odds ratios for known risk factors and group differences, had a large sample size, analyses were based on intention-to-treat model and the racially diverse population increases generalizability. Deductions in the quality appraisal score were due to lack of randomisation and self-selection which can introduce selection bias, and also data collected from the electronic database may be less accurate and less comprehensive than from medical records or patient interviews. The omission of these key elements was reflected in the quality of the study (Appendix 3, p.240) which achieved a SIGN (2015) score of 2.

Bespoke programmes for clinical professionals
A number of alternative leadership programmes were designed and reported; one for general practitioners (Mann et al., 2008); a suite of seven programmes within one study on Child and Adolescent Mental Health Staff (CAMHS) in England (GVA and Outcomes UK, 2011); and one developed specifically for the healthcare staff in one Trust with management responsibilities (Leeson and Millar, 2013) (Appendix 3, p.241-242). These programmes differed in length and outcomes as presented in Table 2.5. Of the three studies, reporting on these programmes, one used a mixed method approach (Mann et al., 2008) and two were qualitative (GVA and Outcomes UK, 2011; Leeson and Millar, 2013). They also differed in term of the quality of their design with Mann et al., (2008) presenting a structured and well-presented approach to the research as opposed to Leeson and Millar (2013) who provided minimal detail to explain their approach.
Mann et al. (2008) described a year-long leadership programme piloted by general practitioners (GPs) who all had practices in Portsmouth, England to support them to introduce service changes. Fourteen individuals (13 GPs and a practice manager) were accepted to undertake the programme which comprised of three modules: leadership theories, service development theories and tools; and planning/implementing a service improvement project. The evaluation included pre- and post-programme self-assessment using the medical leadership competency framework, focus groups, reflective journals and evaluation of specific teaching sessions.

Of the service improvement projects, 85% (12/14) were completed and implemented. Significant changes were reported between the pre- and post-programme self-assessment scores on the Medical Leadership Competency Framework in areas such as team building, networking, service planning, managing people and performance
Reflective journals by the participants were analysed to provide supportive evidence of the improvements identified in the self-improvement scores although no information was provided on the number included. The participants perceived an improvement in knowledge and skills concerning their competence and confidence in leadership although these attributes were not objectively measured. There was no triangulation of these findings or detail on the response rate of the participants, limiting the value of the findings. As with similar papers, the potential for bias was not acknowledged, with the direct involvement in the development and delivery of the programme by three of the six authors, with no evidence provided for any adjustments to minimize the risk of bias. A strength of the study was the use of a standardised framework to assess leadership competency pre- and post-intervention.

GVA and Outcomes UK (2011) adopted a qualitative thematic approach to evaluate course design, delivery, assessment and accreditation, and the organisational impact and outcomes, of seven leadership and management development programmes provided for Child and Adolescent Mental Health Staff (CAMHS). The leadership programmes were those aimed at Tier two and three specialist staff who work in the CAMHS service in England and included general managers and all clinical professionals. The structure of the programmes varied from three days to a year, six had a taught component, with four including action learning as a key element, and references were made to the provision of support through coaching and mentorship but were limited in detail. The themes for evaluation were identified through a review of the literature and consultation with stakeholders. An online invitation to participate in the evaluation process was sent to participants of the seven programmes, 40 responded. The forty participants included representation from all programmes, demographic and
occupational information was provided. Data were collected using online surveys interviews and focus groups.

GVA and Outcomes UK (2011) reported a number of themes: bespoke programmes were positively linked to leadership development, work-based programmes are highly valued, action learning sets are positively viewed by participants, completion of a leadership programme is linked to career progression and accreditation of programmes is of debated value. The authors identified that there were improvements in leadership based on the self-reporting of participants. These could not be verified however as there was a lack of information from managers, or other team members, of observed changes. Negative factors identified related to lack of time for participants to spend on their development, lack of assessment of individuals’ development needs and funding issues. No information was provided on which participants were linked to which courses, and therefore the themes identified can only be considered from a generic level.

Leeson and Millar (2013) evaluated a leadership programme introduced to an NHS Trust in England, which sought to strengthen the leadership and management skills of community healthcare staff. The leadership programme ‘The 7 Habits of Highly Effective People’ had been adopted from the work of Stephen Covey (2004) and developed to reflect an NHS audience rather than the original American business focus. The key subjects delivered included change, managing people and personal reflection. The programme was delivered over two days, followed by six weeks allocated for the completion of a workplace project, the outcomes of which were to be presented to the Trust’s senior management team.
Leeson and Millar (2013) invited 40 nurses and AHPs out of 200 who finished the programme to complete an initial evaluation although no information on the selection process was provided. They reported that the data from this evaluation was positive but provided no detail, however they recognised that a greater level of detail was required to demonstrate the outcomes, including evidence of sustained changes in behaviour. Subsequently, audit questionnaires were sent to 66 participants three months after the programme was completed with a response rate of 25% (17/66) but again no detail was available on the selection method for this cohort. Responses were presented in a series of graphs however as individuals could provide multiple answers for a number of questions, they were of limited value.

Leeson and Millar (2013) acknowledged the poor response rate to their questionnaire and also that all the work-based projects had not been completed. Both authors were linked through employment or partnership with the Trust and held education roles however it is unclear if they were directly involved in the delivery of the programme and the potential for bias was not acknowledged. The study had no input to the evaluation from other stakeholders to add robustness to the findings. There were limitations both in terms of the potential for bias and the lack of detail reported and as a result of these weaknesses a low score of 25% was allocated (Appendix 3. p.242).

Generic leadership development
The introduction and development of generic leadership programmes which occurred in other staff groups in the NHS were also identified. There were four papers included in this subgroup of which two were qualitative: one used an ethnographic approach (Currie, 1998), one used focus group and interviews (Edmonstone and Western, 2002)
and two used mixed methods (Humphris et al., 2004; Boaden, 2006) (Appendix 3, p.243-247). Two of the papers examined the outcomes of an accredited programme (Currie, 1998; Boaden, 2006), while two reviewed general management programmes (Edmonstone and Western, 2002; Humphris et al., 2004). The outlines of these programmes are presented in Table 2.6 below.

### Table 2.6  Generic Models of Leadership Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Aim</th>
<th>Structure of Intervention</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wessex Centre’s Leadership 2 Course Humphris et al. (2004)</td>
<td>To encourage personal reflection on personal strengths to meet local challenges and develop an understanding of leading change and people.</td>
<td>Four residential modules, two days each over five months A follow-up day three months post programme</td>
<td></td>
</tr>
<tr>
<td>Leadership Through Effective Human Resource Management (LIEHRM) Boaden (2006)</td>
<td>To enable both HR professionals and other NHS leaders to become expert in the management and development of people.</td>
<td>Six university based residential modules each two and a half days Two learning set days between modules focused on personal development</td>
<td>Present the service improvement project Develop a service improvement project</td>
</tr>
<tr>
<td>Patient Services Managers Development Programme Currie (1998)</td>
<td>Develop the leadership of middle managers and unlock their potential to lead change.</td>
<td>18 competency based workshops focused on management development over nine months</td>
<td>Demonstrate competent performance through production of a portfolio</td>
</tr>
<tr>
<td>Trent Leadership Development Programme (TLDP)</td>
<td>To encourage a self-development approach for executive directors.</td>
<td>Five action learning sets of seven people over ten months Mentoring Participation in a learning network including workshops</td>
<td></td>
</tr>
<tr>
<td>Northern and Yorkshire Board Level Development programme (NYBLD) Edmonstone &amp; Western (2002)</td>
<td>Leadership development for people at Board level</td>
<td>Year long programme including a launch day A development centre event Taught one to two day modules Action learning sets</td>
<td>A personal development plan</td>
</tr>
</tbody>
</table>

Currie (1998) adopted an ethnographic approach to underpin a case study investigating the changes which occurred following the development and implementation of a programme aimed at middle managers in a hospital in England. There was limited information provided on the study design and rationale which was reflected in the quality appraisal. The programme was developed in a clinical academic partnership to prepare staff for the introduction of major NHS change, the creation of Trusts and the launch of the internal market. The thirty-five nominated participants were described as general managers, clinical services managers and ward sisters and the programme...
was funded by the NHS. Education was delivered through workshops addressing topics such as managing change, managing people, finance and personal effectiveness linked to the development of a portfolio and lasted nine months. Successful completion of the programme resulted in the awarding of a National Vocational Qualification (NVQ) certificate. Data were collected through interviews and observations of the participants and their managers. Data collection was at specific points throughout the programme. The findings reported, included themes which were consistent with similar papers (Smith, 2000), contradictory messages from senior management regarding the desired outcomes, a sense of powerlessness of participants and questioning of the value of the programme itself.

The study had a high attrition rate: only two individuals completed out of the 35. Reasons cited included reluctant participants, ongoing criticism and lack of management support throughout the life of the programme. The limited appreciation of the impact of the challenging context on the findings made generalisation impossible. The study was therefore was assigned a score of 50% (Appendix 3. p.244). Currie (1998) reported that a number of participants believed they had been pressured into the programme, and some felt their development needs were neither identified nor meet. The topics delivered were reported as not relevant, particularly by the clinical staff. There were also reported difficulties for participants with the completion and assessment of the portfolio as well as a lack of consistency with the operational aspects of the programme.

Edmonstone and Western (2002) reported on the evaluation of two leadership development programmes provided and delivered by higher education partners and
funded by the NHS for senior NHS managers. The programmes shared a number of similar elements such as a personal development plan based on agreed competences and action learning sets. To evaluate the programmes, the researchers relied upon an impact evaluation approach as described by Harper and Beacham, (1991). The aim was to capture a breadth of views from participants, providers and programme sponsors on the nature of leadership required by the NHS and bring this data together to determine the impact on individuals and services. A total of 400 participants commenced these programmes between 1997 and 2000, however, no information was provided on how they were selected or on the attrition rates.

Data were collected at specific points throughout the three years through questionnaires and structured interviews, face to face and telephone interviews, with samples drawn from all cohorts and the programme providers. Participant numbers were provided so the denominators used were clear. The evaluation process identified a number of themes especially the need for clarity on leadership and management, describing ‘a conceptual fuzziness’ (Edmonstone and Western 2002, p.43) among all the respondents on the differences between the two. Edmonstone and Western (2002) argued this lack of clarity impacted the content and action learning aspects of the programmes. They also queried the appropriateness of a generic approach to leadership development and argued that greater account needed to be given to the difference between general and professional managers. Edmonstone and Western (2002) recognised that the programmes were not unique but were similar to those provided by organisations such as King’s Fund, the NHS Academy or local in-house providers, and reported that there was a degree of confusion amongst senior managers as to whether there should be specific programmes for different groups or grades of staff.
The authors acknowledged the limitations of the study, especially the lack of baseline data available from the participants, and therefore they were unable to ascribe benefits gained to the organisations. They also raised doubts on the validity of attributing improved outcomes in behaviour and knowledge to the participants as there may be other variables not considered apart from the programme, such as previous management experience, and therefore do not attempt to do so. The paper was graded 75% as it demonstrated a number of strengths including triangulation, the sample size and the multiple methods of data collection (Appendix 3, p.245). The paper raised interesting discussion points on the value of evaluation. The results presented were generic, with insufficient detail provided on the similarity of the two programmes, and how data were integrated and therefore is of limited value which is reflected in the grade of 75%.

Humphris et al. (2004) evaluated the Wessex Courses Centre’s leadership programme for general managers focusing on the impact of participation on the individual, the organisations and return on investment. As part of that process, the authors cited the use of a combination of Kirkpatrick’s evaluation framework (Kirkpatrick 1994) and Phillips and Phillips (2001) amended framework which includes a measure to assess the return on the financial investment aspect of a programme. A mixed method approach was used to maximize the opportunities to collect as much data as possible in keeping with a well-designed study. There were 18 participants, all NHS staff from diverse backgrounds; clinical including consultants, and management, with varying degrees of management experience. The programme lasted for five months of mainly classroom-based learning (four modules of two days each) and a follow-up day three months after completion. Data collection involved participants and their line managers
completing a 360° self-assessment tool before the programme, and semi-structured interviews were completed six months later. Each manager was asked to distribute the self-assessment questionnaire to a team member of the participant.

As with previous studies (Currie, 1988; Smith, 2000) response and attrition were a challenge with 12/18 participants and 9/18 managers responding. Of the nine managers, some had changed throughout the course of the study (no detail was provided) which given the sample size, was problematic in coming to robust conclusions. No information was retrieved from team members due to a failure of some of the managers to forward the 360° questionnaire; this was attributed to a misunderstanding with the communication, lack of interest from the team members and staff changes, however, the reasons were not quantified. The authors also identified issues with maintaining access to the participants and their team members throughout the life of the study.

As the aim of the study was to assess the impact on the individual, the organisations and return on investment, the researchers had, therefore, limited information to draw conclusions, due to the small number of consistent participants. They suggested this was due to staff changes and movement across a number of diverse organisations, and as they were independent of the programme delivery there was no system in place to track the relevant individuals. No information was provided on the numbers they were able to follow-up. As a result, the researchers were unable to compare pre and post programme assessment data. Another key aim of the study was to assess the financial costs related to the programme however the researchers were unable to identify these costs. They reported that individual participants’ learning improved in a number of
areas, but due to the poor engagement by managers there was no collaborative evidence to support these findings.

Boaden (2006) conducted a mixed methods evaluation, based on Kirkpatrick’s framework (1994), of a programme which was originally developed in England for NHS human resource (HR) managers but now included any NHS professional who aspired to become a director, from any country of the UK. The aim of the programme was twofold; leadership development of participants and to explore the broader issues around leadership, development of policy and effective leadership. The programme was delivered through a university using a modular approach, with an option for participants to secure academic accreditation from certificate to Masters level depending on their written submissions linked to a service improvement project (SIP). The six modules were residential, lasting two and a half days with two learning set days between modules one to six, and the SIP. The first three cohorts were included in the evaluation which utilised a similar approach as Humphris et al. (2004) with data collection by questionnaire after each residential and verbal reports following learning sets. At the end of the programme, the participants reviewed and provided additional feedback on the residential aspects. The evaluation also included scores achieved in written submissions and performance at the presentation of the SIP.

No detail was provided on the recruitment process or demographics of the participants. There was also reference to two types of participants, an accelerate group (deputy directors), and an advanced group (directors). Boaden (2006) reported that for years one and three the two groups received a similar but not identical programme delivered separately, while due to a smaller number in year two both cohorts were taught
together. In total there were 225 participants with response rates of 63/90 in the first year, 32/45 in the second year and 57/90 in the third year however exact figures for the two cohorts were not provided. The outcomes for the first year were reported as being of benefit based on 50% or more of the respondents giving positive responses, less benefit was reported on a response rate of less than 50% of the respondents but more than 10%. Using that approach improvements for networking in HR, patient focus becoming more central to practice, understanding of the HR agenda and improved confidence are reported.

In studying the overall impact of the programmes, this paper reports that leadership skills and self-awareness had improved, as had awareness of the effect on patients across all groups, based on verbal reports from participants and analysis of the SIP. There was an absence of feedback from line managers, organisations and especially patients, and as the programmes’ aim was not on personal development, this limited the value of these findings. No evidence was provided to support the conclusion that the participants were willing to adopt the research methodology although 70/225 participants indicated they were planning to complete the Master’s element of the programme.

Alternative models of leadership development
This subgroup focuses on a number of studies which reported on alternative approaches to leadership development. There were five papers included, of which two used mixed methods (Walia and Marks-Mar, 2014; Boyd et al., 2016) and three were qualitative (Sambrook, 2009; Robinson et al., 2016; Barton et al., 2017) (Appendix 3 p.247-251). Two of the papers examined the outcomes of university-
based programmes (Sambrook, 2009; Walia and Marks-Maran, 2014), two evaluated newly developed management programmes designed for NHS managers aiming to become trust board directors (Boyd et al., 2016; Robinson et al., 2016) and one explored an intervention aimed at changing leadership approach (Barton et al., 2017).

Summary details of these programmes are presented below (table 2.7).

Table 2.7 Alternative Models of Leadership Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Aim</th>
<th>Structure of Intervention</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership through action learning for health care professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walia &amp; Marks-Maran (2014)</td>
<td>To develop the leadership skills and qualities the participants required for their role</td>
<td>Two-day workshop and completion of Myers Briggs psychometric questionnaire; Six half-day action learning sets</td>
<td>An action plan to address a local systems issue</td>
</tr>
<tr>
<td>NHS Leadership Academy Intersect systems leadership programme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boyd et al. (2016)</td>
<td>To provide systems leadership development for leaders across the public sector</td>
<td>Six residential workshops; first and last for five days the other four for 3 days; Facilitated online discussion; Develop a work-based initiative</td>
<td></td>
</tr>
<tr>
<td>Master's programme in Health &amp; Social Care leadership</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sambrook (2009)</td>
<td>To help managers lead effective health and social services</td>
<td>One year full time or two years part-time; Four core modules</td>
<td>Dissertation on leadership; Award of MSc</td>
</tr>
<tr>
<td>Nye Bevan programme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robinson et al. (2016)</td>
<td>To produce a new leadership community (clinical and non-clinical) with the necessary skills to lead culture change at organisational, regional and national levels</td>
<td>If face-to-face days, including four residential workshops over a year self-directed studying; Evidence of applying learning in the workplace</td>
<td></td>
</tr>
<tr>
<td>Leadership development Intervention for professionals in health and social care</td>
<td>To support leadership groups to work outside culture and climate to respond to a health and social care challenge</td>
<td>Two day residential. Group work Intervention led by an expert panel of HSC. Participants and expert panel given a HSC related imaginary scenario to address.</td>
<td>Groups present their solutions to expert panel</td>
</tr>
</tbody>
</table>

Walia and Marks-Maran (2014) utilised a mixed methods educational evaluation approach previously developed by one of the authors (Marks-Maran et al., 2013) to evaluate a postgraduate leadership development module for nurses and other health care professionals. In particular, they were interested in action learning as an effective mechanism to deliver leadership development and the design of the study reflected the objective. The year-long module had been designed around a proposed new NHS leadership qualities framework and included completion of the Myers-Briggs Type
Indicator (MBTI) questionnaire. The aim was to develop the leadership skills and qualities the participants required for their roles. There were 47 participants, all of whom were employed within the NHS. Participants completed a semi-structured questionnaire following completion of the module. The response rate was 82.9% (n=39) and all participants responded positively that the action learning set structure encouraged networking, participation and reflection on the various aspects of leadership, for example, theories, personal styles and managing in change. The majority 76.5% (n=36) stated it was a key element to the successful completion of the module.

There was no information about the recruitment process to the programme and motivation to participate was unclear. Walia and Marks-Maran (2014) noted that those participants with the most experience were most positive about the benefits of the action learning approach although the evaluations between older and younger age groups were similar. A strength of the study was the independence of the research team from the teaching team and the response rate of the participants. There was a missed opportunity to include the educators’ perspective in the evaluation. The authors recommended that consideration should be given to the use of learning sets for leadership development, reflecting the views of others (Large et al., 2005; Mann et al., 2008).

The Nye Bevan Programme and the NHS Leadership Academy’s Intersect programmes were evaluated in a similar way, to determine the effectiveness of developing essential skills to deliver culture change at regional, national and organisational levels in clinical and non-clinical leaders (Boyd et al., 2016; Robinson
et al., 2016). Both programmes were targeted at senior NHS managers, particularly those expecting to become members of Trust executive teams within the next two years. The Nye Bevan programme was sponsored by the NHS Leadership Academy which also provided the Intersect programme. Both were one-year development interventions including face to face teaching, residential workshops and a requirement to demonstrate the application of learning in practice, peer review and both had an academic written pass or fail assessment.

Boyd et al. (2016) conducted a longitudinal, mixed methods survey of the Intersect programme. The programme aimed to enhance the capability and effectiveness of systems leaders in public services through building capacity, emotional intelligence and transformational leadership skills in response to policy demands (Boyd et al., 2016). Senior managers from hospital, community, social care and the third sector, including medical consultants, applied to complete the programme (n=40). No breakdown was provided of the number or background of NHS staff. The year-long programme comprised of six residential modules, the first and last over five days and the remaining four over three days. The interventions drew on a range of experiences from taught sessions, group work, guest lecturers and visits to venues designed to provoke reflection and conversation, for example participating in a choir. Completion of a reflective diary was recommended and an online forum created to encourage the participants to engage in challenging conversations.

For the evaluation, a matched comparison group was chosen from colleagues working in the same areas as the participants, and three to five observers were nominated by the participants. The researchers, who were independent of the programme
development or delivery, planned the study design to assess the impact on participants, to make recommendations for programme changes and to develop and test tools to assist the Leadership Academy to evaluate future programmes. The methods of data collection used were semi-structured telephone interviews, online surveys and an online discussion forum utilised throughout the programme.

Boyd et al. (2016) aimed to capture as far as possible the real impact and experiences of the participants. Data collection was scheduled throughout the programme and finished 18 months after it was completed. This included a 360° tool which was completed by the participants, the comparison group and the observers early in the programme to provide a baseline and repeated at 18 months. The programme was completed by 97% (39/40) not all of whom responded to the feedback provided by the programme facilitators. The response rate from the matched comparison group was 25% (10/40) however no further details were provided. There was a measured increase in the levels of emotional intelligence using TEIQUE and transformational leadership using MLQ both previously validated instruments, and also in civic capacity based on a tool developed by Boyd et al. (2016).

For statistical analysis, a P value of less than 0.05 was used for the level of significance (p< 0.05). In the presentation of the results of analysis, means were included however actual numbers were absent. The authors reported that when compared to the matched comparison group (n=10) the numbers were too small to indicate significance. No information was provided on responses from the non-comparison group. From a qualitative perspective, the participants reported improvements in their confidence, in working relationships and their use of reflection. They particularly valued the
experience of completing a programme with a very diverse group of individuals from a range of NHS and third sector organisations. The authors concluded that while the programme was positively received and met its objectives, there was a need for further exploration of the ‘lived experience’ of participants. No qualitative information was provided on the views of either the comparison group or the observer group.

Boyd et al. (2016) identified a number of limitations with their study, for example attempting to assess the impact individuals have on their organisations which fails to account for the movement of individuals to new roles in the same, or different organisations. They also highlighted the potential for bias in considering observer feedback as they were selected by participants. The number of tools used to gather data was an issue, along with the time required to engage with these. In particular, the timing of feedback results to the faculty to make programme changes was difficult, and the tension between providing different feedback to participants versus meeting the faculty’s requirements was also a challenge. As changes were made to the programme based on feedback it was noted that further analysis is necessary. The authors also recommended that the tools, and approach for data collection could be refined to reduce the time commitment. Whilst Boyd et al. (2016) noted this programme was free to participants nevertheless there was a liability for a charge of up to 5000 pounds for failing to complete the programme. Potential bias, or whether the charge was enacted, was not discussed.

The majority of developmental leadership programmes/courses appeared to have been internally funded programmes, however, Sambrook (2009), adopted a qualitative constructionist approach to evaluate an MSc programme she developed, specifically
aimed at NHS junior and middle managers, to develop their ability to critically question culture, and lead change. Twenty students completed the modules however the paper reported only on the seven who were NHS managers. The university accredited modules were delivered drawing on adult learning theories and were classroom-based. The content addressed issues such as power and culture, with discussion, collaboration, problem solving and reflection used as mechanisms to develop critical thinking. Data collection included a standard evaluation questionnaire, a specifically designed questionnaire to explore critical pedagogy, class discussion and a focus group, with a third open-ended questionnaire distributed to the six NHS students who completed and submitted dissertations.

The evaluation was limited by several factors; four of the seven NHS participants completed the university’s questionnaire and because of the small number, a second questionnaire was not issued. However, data from the focus group, in which all twenty students participated about the nature of leadership was included. The emerging themes related to culture, improvement in confidence levels, becoming more informed and being able to put new knowledge into practice. Within the NHS cohort, 85% (6/7) reported an increase in their confidence and ‘criticality’ (Sambrook, 2009, p.669) and would recommend the programme to colleagues, but raised concerns that their organisations may not be ready for this type of new thinking and approach.

Sambrook (2009) in the planning of the study acknowledged the challenge posed by both her role as the programme developer, and provider, and attempted to mitigate the risk of her influence through reflexivity and open engagement and discussion with the participants. While the study was clearly presented there were a number of significant
limitations, concerning the role of the investigator (as teacher and researcher), the small number of respondents and the use of the generic university evaluation form for data collection. In addition, the lack of any links with the workplace to crosscheck or test the findings prevents a holistic evaluation of the impact of undertaking a leadership development programme.

Robinson et al. 2016 also used a qualitative approach to evaluate the impact of the Nye Bevan programme which had been running since 2013. The quality of the design utilised was more robust in breadth and depth than that relied on by Sambrook (2009) as reflected in the ascribed grading (75% to 25%) and therefore supported the method of data collection (Appendix 3 p.249-251). The evaluation process began in 2014 and was completed early in 2016. A cohort of 40 participants (12 clinical and 28 non-clinical individuals) was selected from the 539 participants who had commenced the Nye Bevan programme at the time of the evaluation. No information on the selection process or professional background was provided other than for the 40 participants included in the study; those who completed (n=17), those who were part-way through (n=18), those who had failed or withdrawn (n=5).

Data collection was through in-depth interview and nine case studies. The views of others were included. Nine local delivery partners were interviewed, as well as eight stakeholders with a specific link to developing the programme and six learning set advisors. Colleagues and patients were also included although no details were provided on the make-up of this group. The inclusion of these perspectives was however key as researchers were specifically keen to identify changes in the behaviour and attitude of the participants and how these changes impacted on colleagues and staff in the service.
The authors also identified a subset of nine from the cohort of 40 to participate in case studies to identify examples of changes resulting from participation in the programme.

The majority of participants interviewed by the evaluation team were positive in their responses about the programme. Several themes emerged from the data: changes in leadership style practice, changes in working practice, greater patient focus. It was noted that a number of those who had failed or withdrawn stated they had gained some positive benefit. The format of this programme differed from previous programmes as participants were required to bring evidence of their progress through each phase demonstrating engagement with colleagues and service improvement (Robinson et al. 2016). The concept of a new leadership style for NHS was a challenge; some of the participants perceived a lack of readiness in the NHS for a move from the prevailing centralised style of management.

It was reported that the programme teachers (n=9) expressed concern about a disconnection between the taught and the self-directed elements. Although supported by feedback from colleagues and direct reports, it is difficult to assess the strength of the data and its impact, given the lack of detail provided. Robinson et al., (2016) reported improvements in confidence, resilience, interpersonal relationships and a better understanding of leadership. There was a missed opportunity to explore the influence of the participants’ previous management experience or consideration of the bias associated with the included case studies. As it was reported that participants were chosen on the basis of responding positively to the programme, this impacts the results. As with other studies, the majority of analysis is based on self-reporting of changes rather than objective measurement (Mann et al., 2008). Robinson et al.’s (2016) report
also lacked clarity around the timeframe for those who had completed the study and the evaluation.

Other forms of leadership development have emerged and Barton et al. (2017) conducted a qualitative research evaluation approach to one; a case study of a leadership intervention which adopted an innovative approach. The programme consisted of a two-day residential event led by a panel of health and social care (HSC) experts with an interest in leadership development. The aim was to get the participants to reflect on their leadership styles and to adopt a more flexible style. Participants (n=106) were drawn from one NHS region in England and included a representative range of professionals from Band 6 nurses through to medical consultants and Chief Executives. Working within groups the participants were asked to determine the management and leadership approach to a health-care related imaginary scenario.

On day one the ‘panel experts’ provided information, advice and guidance at two points, the aim of which was to get the groups to reflect on the process they were using and to consider alternative approaches. In particular to consider how they were working together as a leadership group. The expert team also reviewed the same scenario and planned their approach. On the second day, the groups presented their solutions to the expert panel and had a debriefing session. No information was provided on the recruitment process or demographics of the cohort. Barton et al. (2017) used a qualitative approach including pre and post online questionnaires, observation by independent assessors, post programme focus groups and three individual interviews. They also included a sample from the team who organised the event (n=4). Ethical approval was obtained.
The authors reported a response rate to the pre-programme questionnaire of 51% (54/106) but specified that the data presented in this report was drawn from the findings of the focus groups (17/106) and the observations of the group work (Barton et al. 2017). It was observed that all groups, including the expert panel, immediately turned the scenario into a problem and sought solutions to solve it (in keeping with the typical task and target focused NHS approach) with senior managers dominating, taking and being allowed to take the lead, and delegating tasks. Initially, no group demonstrated a willingness to think outside the accepted processes or leadership approaches, however, Barton et al. (2017) reported that during the group work reflection and some changes to behaviours took place. During the focus groups, this need to reflect on behaviour, demonstrate insight and be prepared to adopt different approaches was acknowledged. Nevertheless, there was also recognition that these behaviour changes may not be sustainable within the culture of the NHS. Although a number of the groups arrived at a decision regarding the way forward in managing the scenario, they did not present this until they had secured verification or permission from the ‘expert’ panel. This was despite the groups having no knowledge of the experts’ experience in the scenario presented.

The authors acknowledge the limited results provided and therefore the ability to make generalisations but suggest it indicates that the command and control culture is embedded into the target-solution-driven NHS leadership style, highlighting the behaviour of the expert panel, which although aware of the purpose of the scenario also adopted the same approach as the participants (Barton et al. 2017).
2.3.3 Phase two: Identification of cross-cutting themes

During the second phase of analysis, a number of cross-cutting themes were identified across the included studies, which reflect key factors that were reported to have had an impact on the effectiveness of the leadership and management development programmes. These related to the impact of organisational culture (Currie, 1998; Woolnough and Faugier, 2002; Werrett et al., 2002; Edmonstone and Western, 2002; Wing et al., 2004; Hancock and Campbell, 2006; Philips and Byrne, 2013; Barton et al., 2017); influence of the line manager (Currie, 1998; Wing et al., 2004; Humphris et al., 2004; Leeson and Millar, 2013; Philips and Byrne, 2013; Ross-Davie et al., 2016; Barton et al., 2017); communication (Werrett et al., 2002, Cooper, 2003; Wing et al., 2004; Humphris et al., 2004; Hancock and Campbell, 2006; Mann et al., 2008; Leeson and Millar, 2013; Ross-Davie et al., 2016); personal qualities (Werrett et al., 2002; Woolnough and Faugier, 2002; Humphris et al., 2004; Wing et al., 2004; Large et al., 2005; Hancock and Campbell, 2006; Boaden, 2006; Mann et al., 2008; Sambrook, 2009; GVA & Outcomes UK, 2011; Leeson and Millar, 2013; Walia and Marks-Maran, 2014; Ross-Davie et al., 2016; Boyd et al., 2016; Robinson et al., 2016) and professionalism (Currie, 1998; Edmonstone and Western, 2002; Mann et al., 2008; GVA & Outcomes UK, 2011; Philips and Byrne, 2013; Leeson and Millar, 2013; Ross-Davie et al., 2016) which will be discussed in greater detail below.

Organisational culture

Organisational culture was a key factor in leadership development in terms of preparation, work environment and support structures (Currie, 1998; Woolnough and Faugier, 2002; Werrett et al., 2002; Edmonstone and Western, 2002; Wing et al., 2004; Hancock and Campbell, 2006; Philips and Byrne, 2013; Barton et al., 2017). The
importance of a supportive organisational culture to provide an opportunity for participants to reinforce their learning and enable them to translate learning into practice was consistently reported. A number of authors concluded that the absence of such a culture could impact on the sustainability of any personal or service improvements developed through the programme (Werrett et al., 2002; Hancock and Campbell, 2006). This echoed the findings of Woolnough and Faugier (2002) who highlighted the need for organisations to have processes such as designated time to develop and implement projects and formal mentorship in place for participants to develop their skills:

“Support needs to come from the top down. You don’t see senior staff using LEO and that’s a problem”. Woolnough and Faugier, (2002) p.421.

Edmonstone and Western (2002) suggested that clarity was needed about why individuals undertook leadership development. They argued that organisations possibly have an expectation that supporting their staff to develop leadership and management skills will bring benefits in delivering the type of services the NHS and public require, whereas individuals may seek to develop or achieve personal goals and objectives. Humphris et al., (2004) explored the role of the organisation further and identified that while support exists for some individuals or group of individuals specific to their manager, this was different from the concept of what they described as “institutionalised organisational support” p.44. In other words, there needed to be a process in place which automatically provided an infrastructure, for example, the allocation of mentors, and/or time or opportunity to lead on a project or take on a new responsibility. Wing et al. (2004) demonstrated in their study that where the organisation provided time and support to one group of nurses to improve clinical
leadership the outcomes were good, but again, it was noted there was inconsistency in application across the system.

Inconsistencies within the system were also reported by Large et al. (2005). They interviewed Directors of Nursing who reported their organisations were strongly supportive of developing clinical leaders, describing the existence of leadership steering groups or forums to support development through overseeing the implementation of initiatives to improve patient care. However, this was not widely reported to have been experienced by the nurses who participated in the leadership programme. Philips and Byrne (2013) agreed that “a clear leadership framework with identified development opportunities” p.2632 was important to prepare nurses to have the confidence to be effective leaders, but found many worked in isolation without the support mechanisms described by the Directors of Nursing in Large et al. (2005). Walia and Marks-Maran (2014) highlighted in their study that using action learning as a mechanism to develop participants had the potential to be successful but was negatively evaluated by them when linked to delivering organisational change, primarily due to lack of support from the organisation which sought specific outcomes. Considered within the context of the LQF (2007) the focus of leadership development from an organisational perspective was primarily linked to managing and delivering the service, with building personal qualities as an opportunistic outcome for some participants.

Influence of the line manager

Seven studies commented on the influence of the line manager (Currie, 1998; Wing et al., 2004; Humphris et al., 2004; Leeson and Millar, 2013; Philips and Byrne, 2013;
Ross-Davie et al., 2016; Barton et al., 2017). This role was noted to be particularly significant in the studies linked to nursing and midwifery leadership and management development and career progression (Wing et al., 2004, Humphris et al., 2004, Phillips and Byrne, 2013, Ross-Davie et al., 2016). It could be argued that this was linked to a recognition of their responsibility to ensure the development of the professions and succession planning (Phillips and Byrne, 2013; Ross-Davie et al., 2016).

In general, however, the line manager was key in determining who attended leadership development, engagement in the process and attrition rates (Currie, 1998; Philips and Byrne, 2013; Ross-Davie et al., 2016; Barton et al., 2017). Within the context of the LQF (2007), leading change through people developing these skills would be a core element of a line manager’s role. On the one hand, Currie (1998) reported poor compliance and a high rate of attrition from his study; this was considered to be due to participants being directed to undertake the programme by their management team and an absence of assessed need. This was in contrast to Wing et al. (2004) who reported that when specific needs have been identified by management and dedicated time set aside with support in place, the programme appeared to be more effective:

“I realise I can’t do it all on my own and recognise the benefits in supporting the team members to do it themselves” Wing et al. (2004) p.29.

Line managers’ support was therefore seen to be key to ensuring the success of a programme by nominating participants, and providing the time and space required to develop and deliver work-based projects (Leeson and Millar, 2013; Ross-Davie et al., 2016). Humphris et al. (2004) however, found that the level of support described by
managers was not reflected in the reported experience of the participants highlighting that verbal support is not enough for effective implementation without putting in place mechanisms to ensure dedicated time and support to participate in leadership programmes.

Communication

Eight studies highlighted the importance of communication; (Werrett et al., 2002; Cooper, 2003; Wing et al., 2004; Humphris et al., 2004; Hancock and Campbell, 2006; Mann et al., 2008; Leeson and Millar, 2013; Ross-Davie et al., 2016). This theme also included other elements relating to communication such as networking, sharing the vision and feedback, all of which link to elements of the LQF (2007). This was articulated and valued because of the opportunity to meet other people from across the NHS. Participants in the LEO programme consistently reported improved skills in communication and networking, linking these to improvements in managing people (Werrett et al., 2002; Woolnough and Faugier, 2002; Cooper, 2003; Large et al., 2005; Hancock and Campbell, 2006). Similarly Wing et al. (2004) with one participant reporting:

“It’s all about communication, isn’t it? If people don’t talk to each other, how can they sort things out? I’ve sorted out so many things this year because I’ve talked to people and caught things before, they’ve become huge problems”. Wing et al. (2004) p.30.

Werrett et al. (2002) considered that the inclusion of other members of the multidisciplinary team within the leadership programme was a key feature in encouraging future networking. While Large et al. (2005) also identified similar
improvements in communication and networking between colleagues, team members and senior managers in their study. Programme participants articulated a change in their behaviour citing increased confidence to manage people and to reach out to colleagues working in a similar role to share knowledge or seek information. Working together on developing quality initiatives to improve patient care was a reflection of networking in action (Boaden, 2006). Listening, a skill associated with communication was reported as improved in Leeson and Millar’s (2013) study. The importance of developing communication skills was not limited to between team members and colleagues but included patients and families (Mann et al., 2008; Robinson et al., 2016). This was particularly relevant to improving service delivery and patient outcomes as well as managing conflict (Humphris et al., 2004).

Personal qualities
Overall 15 of the studies reported changes related to personal qualities (Werrett et al., 2002; Woolnough and Faugier, 2002; Humphris et al., 2004; Wing et al., 2004; Large et al., 2005; Hancock and Campbell, 2006; Boaden, 2006; Mann et al., 2008; Sambrook, 2009; GVA & Outcomes UK, 2011; Leeson and Millar, 2013; Walia and Marks-Maran, 2014; Ross-Davie et al., 2016; Boyd et al., 2016; Robinson et al., 2016)
The central element of the LQF (2007) is personal qualities, and self-awareness, in particular, emerged as a theme where participants described improvement (Large et al., 2005; Boaden, 2006; Mann et al., 2008; Walia and Marks-Maran, 2014). They also reported development in their ability to support others within their teams (Humphris et al., 2004; Mann et al., 2008; Ross-Davie et al., 2016).
In several of the studies, the participants cited improved use of reflection as a positive benefit, especially in relation to their leadership styles and working with others (Humphris et al., 2004; Leeson and Millar, 2013; Walia and Marks-Maran, 2014; Boyd et al., 2016). Qualitative and quantitative data supported these aspects of personal development (Werrett et al. 2002; Wing et al., 2004; Large et al., 2005; Mann et al., 2008; Walia and Marks-Maran, 2014). Although specific self-assessment psychometric tools were included in a number of other programmes to assess personal characteristics, no evidence of usefulness was identified. Many of these studies included small numbers so caution with interpretation is recommended (Humphris et al., 2004, Large et al., 2005, Walia and Marks-Maran, 2014). However, Robinson et al. (2016) reported:

“for some participants, it was the changes they had seen in their own understanding of themselves (and from that, understanding their sphere of influence and impact on their organisation) which stood out for them”


Robinson et al. (2016) also noted improvements in resilience linked to relationships and understanding of leadership while Boyd et al. (2016) identified increased levels in emotional intelligence amongst participants based on qualitative data.

Professionalism

The links between professionalism and the impact of leadership development were reported in seven studies, and although not explicitly referenced within the LQF (2007) was highly important to participants (Currie, 1998; Edmonstone and Western, 2002; Mann et al., 2008; GVA & Outcomes UK, 2011; Philips and Byrne, 2013; Leeson and
Millar, 2013; Ross-Davie et al., 2016). The studies reported a view that those practising clinically, holding departmental lead roles, needed leadership development as they were not equipped to deliver the scale of change required (Philips and Byrne, 2013; Leeson and Millar, 2013). Explicit tension between leadership development, responsibility and accountability as a regulated professional also emerged in four studies (Currie, 1998; Edmonstone and Western, 2002; GVA & Outcomes UK, 2011; Ross-Davie et al., 2016). Currie (1998) noted that the clinical professionals included in her study had a high attrition rate linked to their view that the generic management approach took no account of their professional values. This position was also supported by Edmonstone and Western’s (2002) findings:

“there would seem to be a need to recognise the realities of a profession-based organisation such as the NHS and to accommodate and reflected the diverse interests and concerns of the various interested constituencies”. Edmonstone and Western (2002) p.44.

Mann et al. (2008) suggest that programmes aimed at supporting clinical professionals are more likely to result in service changes which impact directly on improving patient care. Similarly, the participants who accessed the CAMHS programmes valued them because they were perceived to support their professional roles and opportunities although these views were not substantiated by managers (GVA and Outcomes UK’s, 2011). While Ross-Davie et al. (2016) reported midwives in their study felt more confident about their role, this study was the only one to explicitly link a programme to succession planning for managerial roles.
2.4 Summary

The aim of this review was 1) to determine the effectiveness of leadership and management programmes on developing the skills and attributes of NHS employees 2) to identify factors that influence the effective implementation of programmes. From the twenty studies reviewed, there is limited evidence of the effective impact of undertaking a leadership programme in an NHS setting. In addition, a number of cross-cutting themes were identified which provided an understanding of the barriers which impact on the translation of learning into practice. Exploration of these themes within the framework of the LQF (NHS Institute for Innovation & Improvement, 2007) demonstrated links to the development of management skills and personal qualities. However, while some studies referred to improved understanding of leadership there was no evidence of the development of skills in setting direction. The majority of participants reported personal skills acquired included communication, problem-solving, appreciating the views of others and leadership development, although these were mainly reported using non-objective methods and with limited use of standardised measurement tools.

This review has demonstrated a lack of consistency in the approaches to developing leaders and managers, thus limiting the synthesis. There are a number of issues which impact on the quality of the evaluations. Frequently the researcher was connected to the programme development or delivery, which was not always explicitly acknowledged. There was often no acknowledgement of the diversity of experience and quality of each individual’s leadership and management skills journey or the variation in their work environment.
When evaluating the programmes, qualitative approaches were frequently adopted. As a means to understanding the often-subjective experience of the participants, it does not allow for the measurement of the effectiveness of the programmes/interventions and therefore limits clarity on the wider impact (Rees, 2003). One of the strengths therefore of the review was the number of studies which used multiple methods of data collection in an attempt to triangulate data from several sources, although equally, this creates a complex research evaluation. In order to evaluate fully the impact of leadership development on individual participants and to service provision, it is essential to use consistent and validated measures alongside qualitative approaches (Storey and Holti, 2013).

Although not the focus of this review, the lack of consistent research to establish an understanding of the key elements of leadership and management programmes or existing evaluation frameworks was highlighted. It is important to note that the LQF (2007) was not available during the time when 50% of these studies were conducted. It was therefore not surprising that the terminology contained within the LQF, for example setting direction, was not explicitly used. However, a number of the cross-cutting themes identified resonate with the language used in the framework; for example, communication is an essential component of leading change through people, collaborative working and effective influencing. The majority of the programmes also contained elements which were designed to develop practical managerial skills in service delivery, for example, project development and implementation, although not specially referenced in the LQF framework (2007).
Only one study was identified which focused on midwives, highlighting the limited evidence in this area. Midwives, in particular, have been criticised over the last decade for failures in management and leadership which have been directly correlated with poor outcomes for women (Health Care Commission 2008; National Maternity Review, 2016; Tingle, 2016). O’Connell and Downe (2009) highlighted the lack of visibility of midwives in leadership and management positions and it would seem the same may be true of leadership development programmes. This lack of evidence highlights the gap in understanding about the areas of knowledge and skills that midwives need to become future managers and leaders and which this thesis will seek to address.

The proposed research aims to explore NHS leadership and management development within the context of midwifery in Northern Ireland. In particular, to understand the journey and experiences of midwifery managers and midwives to determine whether leadership and development programmes are beneficial, what elements are essential, and to identify gaps in leadership and management development. It will also explore what essentials are experienced by participants of the programmes in Northern Ireland. In addition, the use and relevance of the LQF (NHS Institute for Innovation & Improvement, 2007) will be explored.
Chapter 3. Methods
3.1 Introduction

The literature review reported in Chapter two sought to establish whether the leadership and/or management development programmes which are used within the NHS have any useful effect on the skills and attributes of NHS employees and to identify whether any consistent elements or approaches were utilised. The review identified evidence of some benefits following the completion of leadership/management interventions, however, the variation across studies limited definitive conclusion about what works. In particular, the scarcity of evidence on the development of midwives has highlighted a gap in knowledge about leadership and management programmes specific to midwifery. The rationale for this study is to further explore leadership and management development from a midwifery perspective, given the identified evidence gap. This chapter presents in detail the research approach used in this study to identify those gaps. It describes the research design and methods employed to address the aims and objectives of the study, including the data collection and analysis methods. Ethical considerations will also be discussed.

3.2 Aims and Objectives

3.2.1 Overall aim

This thesis aims to explore the experience of midwifery managers and midwives of their leadership and management journey and increase understanding of the skills required to lead and manage maternity services. Based on these findings, to investigate the preparedness of midwives who have undergone the existing programmes in NI (the HSC Nursing and Midwifery Leadership programme and the RCM’s leadership development programme) to be future leaders and managers of maternity services.
3.2.2 Objectives

Phase 1: to undertake a survey and conduct interviews with midwifery managers to:

- Describe their management and leadership experience and development.
- Investigate their perspectives on the key attributes of what a programme to prepare midwives for a senior role in maternity services should contain.
- Establish whether gaps exist and explore their perspectives on the relevance of the NHS Leadership Qualities Framework (2007) to leadership and management development.

Phase 2: to undertake a survey and conduct focus group interviews with midwives who have completed a Leadership and Management Development programme facilitated by the HSC Leadership Centre and/or the RCM to:

- Explore their perspectives on the impact of the programme on their levels of personal and professional confidence,
- Investigate their perspectives on whether the core skills and attributes identified by the senior midwives in phase 1 were addressed through the programme and explore their perspectives on the relevance of the NHS Leadership Qualities Framework (2007),
- Examine whether completion of the programme has impacted on their career aspirations.

3.3 Theoretical framework

The challenge in undertaking research is to ensure that all aspects of the process from recruitment of the participants, through the data collection and evaluation, stand
scrutiny as valid and unbiased (Creswell, 2007). As this research follows a developmental approach to measuring outcomes relating to aspects of, and progression in, leadership and management Broom and Willis (2007) would suggest an interpretivist approach. The perspective of constructivism in particular, which argues that humans generate knowledge and meaning from an interaction between their experiences and their ideas, was determined to be more appropriate for examining this particular subject. As Creswell (2007) explains, this approach lends itself to the area of research where the researcher seeks to explore the views, opinions and experiences of individuals (the midwives) relating to their leadership and management development.

3.4 Design

A mixed methods design using an online survey, semi-structured face to face interviews and focus group interview were employed as data collection methods. The justification for this is guided by the forms of data collection and an understanding of mixed methods as an approach which involves gathering quantitative and qualitative data that is both numerical and textual from questionnaires, interviews and focus groups as suggested by Mackenzie and Knipe (2006). The method of data collection also allows for the use of the results from one sample i.e. the first phase, to develop the tool for the second phase (Green and Browne, 2005). These methods, therefore, assist in gaining a more robust insight into the perspectives of both current and future midwifery managers/leaders and thereby add value to the conclusion and recommendations (Rees, 2003; Mason, 2006). The mixed methods approach which is often linked to social science research has gained recognition within the health professions, with the inclusion of words to analyse as well as numbers (Rees, 2003;
Porter, 2007). Kirkham (1998) utilised this model of research to examine midwives’ experiences of supervision, and how it influenced their practice, similar to the current study.

The use of a mixed methods approach has also been utilised by others in health care, for example, to explore student and staff perspectives on the evaluation of facets of education assessment (Dearnley and Meddings, 2007). Edmonstone and Western (2002) who have undertaken evaluation of leadership development programmes, concur this is an appropriate method to obtain the level of analysis needed to begin to explore the assumptions made around the value of management and leadership programmes.

### 3.5 Research settings

This study was set in a region of the UK (Northern Ireland) and the participants were all midwives employed within the NHS. There were two defined groups of participants. The midwifery managers included in phase one were senior midwives employed at Agenda for Change (AFC) pay band 8a and above, who held a maternity management post and were members of the RCM’s Midwife Managers Group (MMG). Band 8a and above is the AFC grade for professional managers within the NHS. The second phase included midwives working in clinical settings at AFC pay bands 6 and 7, who were members of the RCM and had completed a leadership and management development programme provided by the HSC Leadership Centre or the RCM. Band 6 midwives provide all aspects of care to pregnant women whether in hospital or community and may take the lead in particular pieces of work or projects, such as developing guidelines. Midwives employed at band 7 generally hold a first-line
management post for a ward or department or lead an aspect of service, for example, ultrasound screening or bereavement.

3.6 Ethical considerations

A key element of any research process is the consideration of ethical issues. Foremost is the need to ensure the safety of participants and therefore being clear about the nature of the intervention, the recruitment process, securing consent and ensuring confidentiality (Rees, 2003, Creswell 2007). There are many reasons for this, not least reports of flawed research including harm to participants, for example, the New Scientist highlighted an issue of higher levels of bias where drug companies fund the research (Bhattacharya, 2003).

In addition, given the researcher’s history as a senior midwife within maternity services, it was essential to take steps to reduce the possibility of midwives feeling pressurised to participate in the study. Access was therefore negotiated with the Royal College of Midwives (RCM) who agreed to act as gatekeeper as advocated by Rees (2003) to reduce this likelihood. The RCM is the professional organisation and trade union for midwives in the United Kingdom, with dedicated offices in each of the four countries. They engage widely with their membership through branch meetings, forums, regular email communications, seminars and study days. Also, as there is no register available to identify who has completed leadership and management programmes accessing the midwives in Northern Ireland through the RCM’s circulation list offered the most pragmatic approach.
While there is no risk of physical harm from participating in this type of study there is the possibility of other risks, for example, reputational harm, and therefore an application for the first phase was submitted to the University’s School of Nursing and Midwifery Research Committee. Approval was granted on the 25th March 2015 (Appendix 4). Following completion of the first phase of the study, an application was submitted for the next phase, with approval granted on the 20th April 2016 (Appendix 5). Given that the midwifery community in Northern Ireland is small and participants are entitled to be appreciated for their contribution, the researcher has also been mindful of the principle of confidentiality whilst writing up the final report.

3.7 Methods

The project comprised of two separate phases, each with two aspects and was planned to take place over 18 months to meet the objectives as outlined above. Both phases were intrinsically linked as the information gained through both phase 1a and 1b was fundamental to the development of the tool used in phase two of the study. An overview of the process can be found in Appendix 6. Before commencing the study and following ethical approval, the online questionnaire for phase one was developed, tested and uploaded ready for circulation. The questionnaire contained a range of questions requiring numerical and narrative answers. This had been developed based on review of the literature, personal experience and collaboration with senior managers and colleagues.
3.7.1 Overview

The aim of the first phase was to collect quantitative and qualitative data from the midwifery managers in relation to their role, experience, views on the skills and attributes outlined in the NHS Leadership Qualities Framework (NHS Institute for Innovation & Improvement, 2007) and their perspective on which managerial and leadership skills are essential for future managers and leaders. An overview of the skills and attributes of the NHS LQF framework (2007), which is the accepted model in regular use within the NHS, can be found in Appendix 1.

Using data generated from phase one, the aim of the second phase was also to gather quantitative and qualitative data on the perspectives of midwives who had completed the Leadership Nurse and Midwives Development programme provided by the HSC Leadership Centre or the RCM, on whether the core skills and attributes identified by the senior midwives were addressed through these programme/s. The midwives’ views on the impact of the programme on their levels of personal and professional confidence were also explored.

3.7.2 Sample

Thompson (1999) recommends that where there is a combination of qualitative and quantitative methods, the issue of sampling should be guided by the questions to be answered through the research process as opposed to the need to set sample size. Given the importance of gathering in-depth perspectives on the essential elements that a programme to prepare midwives for a senior role in maternity services should contain, and to explore the perspectives of those midwives completing the current programme, this was the approach used. It has been acknowledged that the depth and richness of
the qualitative data obtained is key as opposed to solely focusing on sample size (Morse, 2000; Rees, 2003; Silverman, 2010).

3.7.3 Selection and inclusion criteria

**Inclusion Criteria for phase one:** Midwifery managers employed at pay band 8a and above, who held a maternity management post and were members of the RCM’s Midwife Managers Group (MMG). Band 8a and above is the Agenda for Change grade for professional managers within the NHS.

**Exclusion Criteria:** No exclusion criteria specified other than self-exclusion or not meeting inclusion criteria.

**Inclusion Criteria for phase two:** Midwives working in clinical settings at AFC pay bands 6 and 7, who were members of the RCM and had completed a leadership and management development programme provided by the HSC Leadership Centre or the RCM.

**Exclusion Criteria:** No exclusion criteria specified other than self-exclusion or not meeting inclusion criteria.

3.7.4 Data collection

In keeping with the mixed methods design, the collection of quantitative and qualitative data from the midwifery managers and the midwives included survey, semi-structured face to face interviews and focus group interview, and detailed below.
3.7.4.1 Phase One

An invitation pack including a letter of invitation (Appendix 7) and an information leaflet (Appendix 8) was distributed by the Royal College of Midwives (RCM) to the members of the Midwife Managers Group (MMG) in August 2015. Those who responded were sent a link to an online questionnaire (phase 1a). The questionnaire (Appendix 9) utilised qualitative and quantitative methods of data collection. The first section of the questionnaire requested the midwifery managers to provide demographic information relating to their management/leadership journey such as their length of time qualified as a midwife, length of time in a managerial/leadership role and information on their management/leadership development (Appendix 9). The questionnaire then invited qualitative responses to questions about the reasons for undertaking the programme and to obtain the midwifery managers’ views on the knowledge and skills required by a manager/leader.

The second part of the questionnaire focused on the defined list of skills and attributes the NHS Institute for Improvement and Development (2007) suggest are essential for management and leadership development and effectiveness (Appendix 1). Participants were asked to allocate a level of importance (along a 5-point Likert scale) against these ten skills and five attributes. Completion of the questionnaire took approximately half an hour and was anonymised, however, it included an invitation to participate in an interview, and if they consent to be contacted by the researcher, to provide contact details.

The interviews were arranged at a date, time and location to suit the participants and consent was obtained (Appendix 10). The interview was semi-structured as
recommended by Morse and Field (1996) in order to secure a greater and richer depth of information through clarifying the responses from the questionnaire and also an exploration of the core topics (Appendix 11), as identified from the data obtained from the online questionnaire. Semi-structured interviews enabled the researcher to ask consistent questions of the research sample, while the inclusion of open-ended questions facilitated the opportunity for participants to stray from topics defined by the researcher, providing additional insight into the subject area as suggested by Silverman (2010). The aim was to complete at least nine interviews which would represent over 50% of the midwifery managers. The interviews were tape-recorded with permission from the participants.

The advantage of interviews is the immediacy of the information gathered and the reduction in misunderstandings from the responses to the questionnaire, however, caution is required to reduce the possibility of personal knowledge of the participants by the interviewer, which may influence the answers (Rees, 2003). On the other hand, Dwyer and Buckle (2009) would argue strongly that having an insider perspective can bring benefits to a study, because of the knowledge base and situational awareness the researcher brings, which can provide assurance to the participants. As recommended by Silverman (2010) analysis of data commenced early in the process to test out methods, findings and concepts as this information was required for the second phase and the development of the midwives’ questionnaire.

3.7.4.2 Phase two

There were 1116 midwives’ names held on the Royal College of Midwives’ (RCM) email circulation list of members in Northern Ireland at the time of the study, all of
whom were sent information about the study (appendices 13 and 14). Data obtained from the Provider Support Unit, which hosts the HSC leadership programme for nurses and midwives had indicated approximately 50 midwives had completed the programme over the previous five years. Figures were not available for completion of the RCM leadership course because of data protection requirements.

The midwives who responded to the email invitation from the RCM were forwarded an email link to the online questionnaire in April 2016 (phase 2a). The questionnaire (Appendix 12) had been developed to take account of the data gathered during Phases 1a and 1b and employed qualitative and quantitative methods of data collection. The first section of the questionnaire sought demographic information relating to the midwives’ management/leadership journey such as the length of time qualified as a midwife, the development courses they had completed and when. The second part of the questionnaire explored perspectives about the usefulness of the course, the impact on professional development, knowledge of the NHS Leadership Qualities Framework (2007) and how they would rate themselves against it. Finally, the midwives were asked to consider whether they considered their line managers’ role one of leadership, management or both.

In this way, it was anticipated that the questionnaire data would provide a representative response by seeking the perspectives of all midwives in NI who have completed one, or both, of the leadership programmes. The questionnaire was anonymised however included an invitation to individuals to participate in a focus group and if they consent, to be contacted by the researcher, to provide contact details.
(phase 2b). An information leaflet (Appendix 15) was distributed to the midwives who consented to participate.

Focus group interviews had been selected as they provide the opportunity to capture a range of views and allow the exploration of the diversity of individuals’ experience (Rees, 2003). In particular, the midwives’ perception on levels of personal and professional confidence, and the skills and attributes as outlined in the NHS Qualities Framework (NHS Institute for Innovation & Improvement, 2007), as well as their views and perspectives on the impact of the current programme were the issues to be investigated. The focus group was arranged for a date, time and venue to suit the participants in October 2016 and four of the seven respondents attended. Additional information (Appendix 15) and a consent form (Appendix 16) were shared with the participants in order to ensure they were clear on the process. The focus group was audio-recorded and an additional researcher was present to take notes to aid analysis at a later stage. The focus group lasted for 2 hours.

Carlsen and Glenton (2011), who reviewed the literature relating to the role of focus groups in research, noted that the sample usually refers to the numbers of groups rather than the numbers in the group. They suggest that there should be no less than four participants and no more than 12; as seven midwives indicated they would participate in a focus group interview; an information leaflet was shared with them (Appendix 15) and consent form signed (Appendix 16). The focus group was arranged at a time, date and location agreed by all. It was expected that this number would achieve a good group dynamic and therefore a rich source of data, as discussed by Carey (1994). The focus group was held on the 19th of October 2016. Before commencing the
participants had the opportunity to reaffirm their involvement and to sign a consent form which clarified that their responses would be tape-recorded but that these would not be linked to them individually in any way. As recommended by Carey (1994), in order to be effective, a topic guide had been developed (Appendix 17) and the focus group leader was supported by an observer who took notes of the discussion to supplement the tape-recording.

3.8 Data analysis

Bowers et al. (2011) drew attention to the importance of ensuring that different methods have their own analytical approach, which is appropriate in a mixed methods approach. Quantitative data obtained from both sets of online questionnaires, for example relating to years of experience as a midwife and years held in a post at senior management level, was entered on into Statistical Package for the Social Sciences (SPSS) and analysed using descriptive statistics with \( \chi^2 \) test (chi-squared) for discrete variables. A P value of <0.05 was set for the level of significance. Narrative responses were extracted. Interview and focus group data were transcribed into MS Word and analysed thematically.

Qualitative research allows the researcher to examine statements made by the participants and to explore these further, drilling down through the data to form themes in a way which is not possible with a quantitative model. Creswell (2007) recommends a systematic process to manage the data and identify the key themes through coding the text, then subsequently grouping the codes to assist with the development of themes. The approach to data analysis was therefore undertaken using a thematic approach, as described by Morse and Field (1996) with codes and themes developed
directly from the transcript data. The interview data were transcribed by the researcher to aid familiarisation and then using highlighters and coloured pens, words and phrases in the text were highlighted and then grouped under themes. These groups were reviewed again and themes confirmed. Throughout the study, these were revisited to reaffirm that they were an accurate reflection of the data. This process as described by Maguire and Delahunt (2017) guided the identification of similar codes and generation of themes.

Once the thematic analysis was completed, the key themes emerging from phase one as described above were used to inform an interview schedule to guide the semi-structured interviews (Appendix 7). On completion of phase 1b, data entry and analysis as described above was completed to identify the themes which informed the development of the questionnaire for phase 2a. By basing the questionnaire on phase one data it was also anticipated that this would provide valuable data on a broad range of skills and attributes, based on theory, research and practice (Appendix 8).

Following the analysis of the data, key themes emerged which were used to develop a topic guide for the data collection for phase 2b, the focus group (Appendix 9). The focus group data was subsequently transcribed verbatim, by the researcher and analysed through reading and re-reading of transcripts to enable the researcher to become familiar with the data as previously described using a thematic analysis approach (Morse and Field, 1996; Maguire and Delahunt, 2017). Data were grouped according to topic, again using manual methods allowing further identification of themes. Following coding, data were themed to reflect the overall sense of the data and the relationships between the themes. Related categories were then merged into
themes using an iterative process. The themes for both phases were discussed and compared with research supervisors to verify the accuracy of the codes. Through writing up and presenting the data, examples of quotes were identified to support the theme.

3.9 Reflexivity

Reflexivity is an essential aspect of qualitative research to assist the researcher to assess their impact on the study (Creswell, 2007; Berger, 2015). This is particularly relevant as researchers often bring their own views to the research process and must be aware of their potential influence (Creswell 2007). The focus of this study is the development of leadership and management for midwives and in a career spanning 38 years the researcher held a number of management and leadership posts until retirement in October 2015. Having striven throughout that career to ensure women were the centre of the service, increasing concerns highlighted in the media, about the quality of care women were experiencing in maternity services in England, with weakness in midwifery leadership identified as a contributing factor, caused the researcher to reflect on why this was happening (Healthcare Commission, 2008; Francis, 2013; Kirkup, 2015; NHS England, 2016). It was also an important element of the researcher’s role as a manager to invest in the development of midwives, both clinically and managerially, to ensure they had the knowledge and skills required to maintain safe services. This included succession planning.

In addition, at an early age, the researcher was introduced to and inspired by, the story of Roald Amundsen, the Norwegian explorer who was the first person to reach the South Pole in 1911 (Mee, 1960). He accomplished this feat through his precise
approach to planning which included living with the native people, the Inuits (Mee, 1960), to learn from them how to survive in the harsh environment. He then led his team, achieved his goal and brought everyone safely home, unlike Scott or Shackleton who are often cited as exemplars of leadership. The researcher had sought throughout her career to adhere to Amundsen’s style of leadership. It is that history which influenced the subject of this study into leadership and management, which the researcher pursued through part-time study.

On appointment to the first of a number of managerial posts in 1982, the researcher had not completed any type of study or education specific to developing management skills. At that time the practice was for the department manager to identify a midwife who had established her expertise through a defined number of years’ clinical practice, and had good relationships with colleagues, and encourage her to apply for an upcoming post. The assumption was that these were indicators of ability to lead and manage the midwifery team and the demands of a ward; there were no other essential criteria apart from, ‘a common-sense approach’. This was the accepted standard and was a model based on the concept of ‘doing’ rather than ‘knowing’ and was the favoured position within the nursing and midwifery professions (Swanson and Chapman, 1994).

Northern Ireland is a small country and midwifery is a small profession, primarily based in five Trusts, and therefore senior midwives in positions of influence become well known. The benefit of knowing the system, therefore, had advantages and disadvantages. In developing the research design, consideration was given to the existing relationship and knowledge the potential participants had of the researcher.
As a senior manager the researcher was a member of the same midwife managers’ forum as one group of participants (the senior midwives) and as a service manager and supervisor of midwives also encouraged and supported many of the second group of participants (the midwives), to access the HSC programme facilitated by the HSC Leadership Centre and the RCM’s leadership development course.

There were some challenges with this approach as this group are known personally to the researcher and while that may not have influenced recruitment, it was imperative to ensure that it did not impact on the collection and analysis of the data. To reduce the possibility of what Dwyer and Buckle (2009) refer to as “undue influence” (p.59), the data was discussed in the interim with the supervisors and the data analysis was reviewed by all members. Morse and Field (1996) have also highlighted the importance of the researcher understanding their role so as to reduce the potential to cause any confusion or conflict. The awareness of these relationships was a key factor in developing the methods of data collection, especially in relation to the midwives (band 6 and 7’s) who may feel inhibited from expressing their views (Boyle, 1994; Rees, 2003). In addition, when developing the application for ethical approval, the researcher was mindful of the potential for topics to be raised which may cause discomfort or upset, especially within the midwives who could have concerns about the power and influence of the researcher. It was therefore decided at the first stage to use an anonymous semi-structured survey as the approach to collect data with the RCM identified as the gatekeeper.

The RCM had two functions: they held an email circulation list and were, therefore, able to send information and a link to the survey directly to their members and
secondly, they agreed to provide support and advice to any participant who required this. In this way, the researcher only became aware of those individuals who responded and agreed to participate in the study at the interview and focus group phases. It is not possible to definitively determine the impact of the researcher’s knowledge and role on the response rate, but it is recognised that some midwives may not have wished to take part as they knew the researcher personally or professionally.

The potential for bias in interviewing and focus group was also considered, as previously discussed, due to the concern that the participants may say what they thought the researcher might want to hear (Dwyer and Buckle, 2009). The midwifery profession in NI is a small community and it is possible the researcher was known to the midwifery managers and midwives in the sample. Therefore, awareness of this influence on the participants was essential, and steps were taken to reduce this possibility (Rees, 2003; Dwyer and Buckle, 2009). The research supervisors were key to the process, both challenging the researcher to reflect on these issues and her awareness of self and role.

As Oltmann (2016) recognised there can also be advantages in this knowledge as it is not possible for the researcher to be completely outside the research, and there are strengths in understanding the system and knowing individuals so they may feel relaxed and free to express their views. In addition, participants were able to determine where and when the interview took place and could opt out at any point with the assurance of confidentiality and anonymity. Fundamentally, however, the role of trust in the researcher is key and, as described by Kerasidou (2017), linked to professional integrity and credibility. In order to reduce the possibility of the researcher asking
leading questions and to ensure a degree of consistency, an interview schedule was developed to guide the questioning and the interviews were taped. In managing the focus group, a topic guide was developed and one of the supervisors was present as the note taker. For both the interviews and the focus group this kept the conversations centred on the study which was helpful to both the researcher and the participants. For the focus group aspect of the study, the venue, time and date were as agreed with the participants and a supervisor was present as the observer and notetaker. She sat behind the group and did not participate. Nevertheless, her presence provided a level of assurance to the researcher that the process was robust, especially when reflecting on the notes and the transcript of the recording.

In analysing the data, the researcher was conscious, as identified by Creswell (2007), that the purpose of the study was to hear the voices and views of the participants and to understand them within the context of this study. As highlighted by Romm (2013), and noted above, the researcher and the supervision team continuously reflected on her potential to impact on every stage of the data collection process, including the construction of the survey questionnaires. It was therefore clearly understood by the researcher that it was essential not to share her views, so as not to influence the outcomes. Nevertheless, the knowledge the researcher had of the maternity services was helpful as there was an understanding of the context and system in which the midwives practised and the processes in place within the service. Terminology used needed no explanation, and there was a benefit even from a practical perspective when negotiating interview space and times. The use of the mixed methods approach, with data obtained from the surveys, analysed using SPSS, combined with the taped
transcripts of the interviews and the field notes from the focus group, being systematically themed and shared with the supervisors supported this process.

From March 2017 to April 2018 the researcher had the opportunity to lead a twinning project between the Croatian Ministry of Health and the United Kingdom, funded by the European Union. The project aimed to improve the quality of education of graduate nurses and midwives in Croatia, by the development and introduction of a mentoring system at a national level, in line with the requirements of the European Union’s Directive 2005/36/EC (Bannon and Matijašić-Bodalec, 2020). It was also an opportunity to observe leadership and management practices in a medically led and managed health system, where the general management approach has not been adopted, with a particular interest on the impact in maternity services. During that year the researcher reflected and reviewed midwifery leadership, facilitating continued engagement with the topic (Bannon et al., 2017).

3.10 Summary

This chapter has presented the methodology and rationale employed to answer the research question outlined in section 1.6. The aims and objectives, identification and recruitment of these participants, as well as the data collection approaches, are detailed and presented. The process, justification and stages for obtaining ethical approval are described. The next chapter presents the findings from Phases one and two.
Chapter 4. Results
4.1 Introduction

This chapter reports on the findings of both phases of the study and, as described in the methods chapter, data collection used both qualitative and quantitative methods. The first phase sought to establish the core elements a management and leadership programme for midwives should contain to prepare them for senior managerial roles, from the perspectives of senior midwifery managers, and also the relevance of the NHS LQF (2007) to that process. The second phase aimed to determine if these core elements are experienced by midwives who have completed the existing programmes in Northern Ireland. The results are presented chronologically for each phase including survey data and interviews with midwifery managers and survey and focus group interviews with midwives.

4.2 Phase One: perspectives of midwifery managers

The findings relating to phase one are presented below, commencing with the demographic information. The data is organised around the perspectives reported by the midwifery managers to answer the questions posed relating to the leadership and management preparation of future midwife leaders and managers.

4.2.1 Online questionnaire results

In the following section, the data collected through online survey is presented, including descriptive statistics, chi-square test was used where indicted to determine any significant association between variables. The information provided outlines the leadership and management development journeys experienced by the midwifery managers, while the narrative responses extracted from the survey provides additional
background and context which gives a depth to the findings which the figures alone could not have conveyed.

4.2.1.1 Response and Demographics

Members of the RCM midwife managers group (n=15) all of whom held midwifery managers’ positions were sent information about the study by the RCM. The online questionnaire was opened on 27th August 2015 and closed 12th October 2015. All managers completed the survey. On completion of the online questionnaire, 60% (n=9) of the 15 midwifery managers agreed to participate in a semi-structured interview to provide more detail and explanation around their experiences and views as leaders and managers, through the collection of qualitative data.

Findings from the questionnaire indicated that the midwifery and management experience of these participants commenced with a G grade or band 7 sister’s post (presented in table 4.1) as the first step on a management career pathway within the NHS. All held senior midwifery manager posts at the time of this study, for example as Heads of Midwifery, with the majority 80% (n=12) describing their role as both leading and managing maternity services, 26% (n=2) as leading and 13% (n=1) as managing.

<table>
<thead>
<tr>
<th>Table 4.1. Midwifery managers’ demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
</tr>
<tr>
<td>Experience as a midwife</td>
</tr>
<tr>
<td>First obtained a management post (G grade/Band 7)</td>
</tr>
<tr>
<td>Experience at H grade/Band 8a and above</td>
</tr>
</tbody>
</table>
4.2.1.2 Experience of leadership and management development

All but one 93% (n=14), of the midwifery managers, had completed a management and leadership development programme or intervention; four were bespoke programmes provided by individual Trusts, eight attended the HSC Leadership Centre, one was a module in a post-graduate programme and one was a King’s Fund leadership programme for senior managers. None of the participants had completed these programmes at the time of appointment to their first management post. The midwifery managers reported the time frame for completion of the programme/intervention was from the year of first appointment (n=2) up to 25 years (n=1) later, with a median of 4.5 years. The one person who had not completed any management and leadership development has held a management post for 11 years and had completed a quality improvement programme. This did not appear to be due to the lack of programmes as the participants indicated that these were completed between 1980 and 2013. The majority of the midwifery managers were supported to complete leadership development, 80% (n=12) by their line manager, while 13% (n=2) self-nominated.

The managers described a range of additional leadership and development opportunities they had experienced, involving such activities as completion of the midwifery supervision programme, shadowing senior midwife role models including the line manager, secondment opportunities and involvement in regional work or projects. In addition, leadership and management development at higher education institutions, through the completion of a degree or master’s programmes, was completed by four managers.
The demographic data provided by the midwifery managers confirmed their level of experience in managing and leading maternity services. The following section provides greater detail on the knowledge, skills and attributes they believe a leadership and management programme for midwives should deliver.

4.2.1.3 Learning on the job

Reflecting on their own development, 73% (n=11) of the midwife managers reported they acquired the necessary skills to manage through learning on the job, drawing on their own lived experiences. The midwifery managers also identified a range of other support mechanisms they were able to draw on to meet the challenges they faced, as listed in table 4.2, with some citing more than one element. However, a number of the midwifery managers 20% (n=3) reported that learning on the job did not mean this was right, or equated to a good experience.

Table 4.2. Midwifery managers’ development

<table>
<thead>
<tr>
<th>Support mechanism</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watching and learning</td>
<td>11</td>
<td>73%</td>
</tr>
<tr>
<td>Support from senior managers</td>
<td>2</td>
<td>13%</td>
</tr>
<tr>
<td>Mentored</td>
<td>2</td>
<td>13%</td>
</tr>
<tr>
<td>Shadowing</td>
<td>2</td>
<td>13%</td>
</tr>
<tr>
<td>Advice and support of colleagues</td>
<td>4</td>
<td>26%</td>
</tr>
<tr>
<td>External professional networks</td>
<td>4</td>
<td>26%</td>
</tr>
<tr>
<td>Professional development (courses, study days, conferences)</td>
<td>6</td>
<td>40%</td>
</tr>
</tbody>
</table>

4.2.1.4 Challenges

In order to set the context and provide a greater understanding of the knowledge and skills required, the midwifery managers reported on the key challenges they face in the role. The importance of being self–aware, recognising personal weaknesses and strengthen was noted by some, 26% (n=4), as impacting on their management style
and ability to cope. The area of people management was cited most frequently by 80% (n=12), with reference to tensions between increasing staff expectations and home responsibilities and maintaining service provision. Within the same theme, capability 13% (n=2), and managing conflict 20% (n=3) were highlighted. Equally, working in partnership with multidisciplinary team colleagues required skills of negotiation and mediation to maintain positive relationships, and were also linked to managing clinical performance and behaviour. Ensuring targets linked to performance and finance are achieved without impacting on the safety of women at the centre of care was identified by 60% (n=9). Accountability and being held to account, not just by the NMC but by others, for example, senior managers in the Trust, Health Board, Department of Health and local commissioning groups were part of the lived experience noted by four midwifery managers. Time management featured particularly in both delivering the requirements of the role, and implementing change as mentioned by 26% (n=4) with one manager of twenty-six years noting the role was;

“...suffocated by bureaucracy and one cannot concentrate on service delivery”
Manager 10.

4.2.1.5 The NHS Leadership Qualities Framework (2007)

The diagrammatic framework produced by the NHS Institute of Innovation and Improvement (2007) to assist with management and leadership development (Appendix 1) lists a range of skills and attributes which are viewed as essential for people aspiring to lead and manage in the NHS. These skills and attributes are divided between three areas: setting direction (leadership), delivering the service (management) and personal qualities. The Institute recommends that individuals use the framework as a template against which they can develop their leadership, by self-
assessing the gaps in their skills and knowledge and targeting their learning needs accordingly. The midwifery managers were asked to review the skills identified in this framework based on their experience, and using a Likert scale rate the importance of each element. There was little variation in responses, with a marked degree of consistency in the responses. The midwifery managers denoted a degree of importance to each skill with none rated as of little importance. The median score for the skills of collaborative working, empowering others, holding to account and leading change through people (management skills) was five, with a median of four for the remaining skills. The summary findings concerning management skills are presented in Table 4.3 and leadership skills in Table 4.4. Notably, all but one manager rated empowering others as a skill of great importance.

Table 4.3  Management skills – Managers’ grading of importance

![Chart showing managers' grading of importance for various skills]

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Reflecting on whether any skills were missing from the framework, six midwife managers suggested additions; for example, self-awareness linked to the ability to critically analyse own performance, to take and give constructive feedback, listening, integrity, act as a good role model, using reflection to influence future ways of managing, and resourcefulness. These skills were denoted with scores of four and five indicating a high level of importance, however, this also demonstrates a difference of interpretation between a skill and an attribute. A number of skills, for example, self-awareness and integrity, are already defined in the NHS LQF (2007) as attributes.

The managers were also asked to review and rate each of the attributes identified in the framework based on their experience and rate the importance of each. There was greater consistency in the range of responses with a median of five (table 4.5).
Five managers also suggested a number of additions to the list of attributes. There was little consistency in the range of attributes suggested, which included professional integrity, confidence, self-discipline, enthusiastic and perceptive. Three managers added an attribute ‘around managing staff’ which they rated as of high level of importance.

The managers rating on the importance of the skills and attributes of the NHS LQF (2007) were compared by $x^2$ test (chi-squared) for discrete variables. A P value of $<0.05$ was used for the level of significance. No statistically significant difference was identified except for those managers with more years of experience (21 years and over) who valued the attribute of resilience more ($p = 0.041$).
4.2.2 Interviews with midwifery managers

Nine of the 15 participants agreed to face to face interview. The interviews lasted between 45 minutes and an hour. Data collection commenced in November 2015 and was completed in January 2016. Data from interviews are presented in relation to themes identified: the experience of the leadership role, perceptions on management and leadership, pressures of the job, personal characteristics, preparation for the job and relevance of NHS LQF (2007).

4.2.2.1 Experience of the leadership role

The midwifery managers who participated in the interviews described various aspects of their roles, including a diverse range of responsibilities. All nine described themselves as leading the midwives and managing the maternity service or an aspect of it, for example, community midwifery services; three midwifery managers also identified wider responsibilities which included nursing and gynaecology services.

The requirement of the posts reflected the multi-faceted nature of these roles, including reference to clinical skills and expertise, with an emphasis on planning and managing, as explained by one manager:

“I see my current leadership role as having primarily been a midwife and as leading the maternity service, but I suppose it’s much broader than that. I provide leadership in performance targets, financial management, and budgetary controls, leading in complaints, timescales, HEIs, and even in the HR processes. I would see my role at a higher level, a more strategic level”

Manager I (34 years).
When the managers were asked how they assessed their experience as leaders and managers, the responses were diverse with a number of interesting perspectives;

“I felt my leadership was probably good and it was a good experience. The only aspect that I wasn’t particularly happy with was finance, most of the other experiences I was open to.” Manager E (37 years),

“I have a lot to learn and will continue to ...” Manager F (22 years),

“I didn’t want to go back into management. The first year I found hard because it wasn’t exactly what I wanted, but then I got into the role and discovered, well actually I can do it” Manager G (23 years),

“Sometimes I think as a leader I’m not doing as good a job as I should, but I still think I’m a good all-round person, and I think people do look up to me” Manager I (34 years).

4.2.2.2 Perceptions of management and leadership

The discussion about whether the role is one of leadership and/or management highlighted the lack of clarity which exists. In exploring with the midwifery managers whether they perceive a difference between leaders or managers, there was a clear view that the roles required them to be both, but with differences and overlaps between the two. As one participant explained;

“...you are managing people but in a broader context, you are a clinical leader” Manager A (23 years).
On further probing, leadership was described in terms of thoughtfulness and reflection, with the notion that the individual must have, and be able to articulate, a clear vision, strategic thinking and have the ability to lead people. This link with people was a consistent thread;

“*The leader sees the bigger picture and is able to bring the team along with them.*” Manager C (28 years),

“As a leader, you want to be seen by your staff, and people around you, as being able to have forward-thinking, aspirations …” Manager D (30 years),

“Someone who can drive and make other people do what they want them to do.” Manager E (37 years),

“From a leadership perspective, in my mind, that’s about leading nursing and midwifery within the maternity services with relation to service development, staff development, quality initiatives, and an attempt to achieve a state of readiness as to how our service is going to change” Manager F (22 years),

“Leadership is about people and about communicating, sharing and about stepping up and bringing the others from behind.” Manager I (34 years).

In contrast, the management aspect was linked more explicitly with skills, and firmly embedded in performance management. Their views were very specific as outlined below;

“A manager is someone who will keep any institute they are in running smoothly and make sure that they meet the targets....” Manager E (37 years),
“...management to me is results-driven, managing your budgets. It’s about very specific things and quantifiable outcomes....” Manager I (34 years),

“...that’s where you have to manage your resources, and the staff are the most expensive and the most important one you’ve got.” Manager B (29 years).

Not all respondents agreed with these interpretations, three managers brought differing perspectives and emphasis to the discussion, reflecting a less determined view of absolute differences between the two roles;

“Your heart and your head feel two different things. Whereas with leadership you can go with your heart, a wee bit more sympathetic, with management you are thinking I am managing this situation.” Manager A (23 years),

“...I do feel that there are a lot of overlaps in relation to leadership and management but I think it goes back to personal skills and personal attributes. I would probably identify myself as a leader with management responsibility...” Manager F (22 years),

“Management you can learn, it’s a skill of managing people. Leadership is something you develop.” Manager H (28 years).

4.2.2.3 Pressure of the role

In thinking about barriers to ‘getting the job done’ the pressure of time was a reoccurring issue, with managers describing managing the pressure of competing demands as often taking precedence, and extending beyond their regular working
hours. These demands varied from the day to day management of emails to producing business cases with instances such as;

“I would have a lot of work to do after hours and pick up emails and that at night.” Manager C (28 years),

“...firefighting, dealing with shortage of staff, busyness of service and pressure from all, above and beyond and below and sideways, and therefore you prioritise the safety of the patient...” Manager D (30 years),

“We are placed in situations with short notice and required to produce fairly successful solutions in a very quick period of time.” Manager F (22 years).

The consequence of dealing with competing pressures in managing the service was also identified as having an impact on how well the managers were able to perform their role and support their teams;

“I do feel that once you go to band 7, even before band 7, there is not much support unless you have a good manager...” Manager C (28 years),

“...and therefore, you have to strip away and lose the time and energy that you would like to spend coaching and developing staff” Manager D (30 years),

“If you manage in a particular way, you’re going to get the targets but is your service static, is your quality static? And if you lead, is your service evolving and improving quality and developing ...” Manager F (22 years).
Managing budgets and balancing financial pressures was a challenge which the midwifery managers considered to be almost beyond their control, yet were skills they needed to have to achieve their organisation’s and manager’s requirements;

“…we’re reducing your funding by that much, nobody ever explained any of that, you just have to get on with it ...” Manager E (37 years),

“Well you have no money, very little staff, and you have to work with what you’ve got”. Manager G (23 years),

“…it’s a more concrete target-driven number struggle with money.” Manager I (34 years).

The area of people management, however, was highlighted as the most challenging by all the managers. One, in particular, was clear that the role is almost entirely about working with people;

“If you can’t manage people, don’t go near management. That is 90% of the job. And if you’re not good at it, or at least half good at it, don’t go near it. It’s bad for your team, and it’s bad for you. You’ll stress yourself to the point of destruction” Manager H (28 years),

The managers emphasized the importance of being approachable as a significant part of their role and responsibility, and critical to developing their staff;

“…to encourage them, to guide them along, you know you nearly feel like a mother” Midwife A (23 years),
“The door is always open, staff have all sorts of crisis from personal to work crisis, to help support them ...” Midwife B (29 years).

“...ward sisters come to me with a problem, I give them the opportunity to think about what to do because there is so many people telling you what to do, but there are not very many people telling you how to do it” Manager C (28 years).

Equally the area of people management was a source of frustration, with comments such as;

“We have so many, the public and our staff need so much management now that probably we didn’t need to do before, their needs and wants with a lot of higher expectations...” Manager C (28 years),

“...the manager’s role, you can see how people are blinkered, it’s me and nothing else, they forget they are even working in a service and it’s about being fair and equal” Manager G (23 years).

The theme of loneliness emerged as contributing to the pressure of the role, as described by these managers;

“Talking to a lot of my colleagues we do work in isolation, it’s a lonely place” Manager C (28 years),

“You’re not in a team anymore, you are one person, on your own” Manager F (22 years).
“It is a very isolated role I think once you are in that position” Manager G (23 years).

4.2.2.4 Personal characteristics

In exploring how the midwifery managers coped with these roles, there was a consensus on the importance of a number of personal characteristics which were viewed as being key to success. These included; integrity, self-belief, motivated, trustworthiness and being approachable. In particular, all but one referred to this awareness of self, as demonstrated in these examples;

“...self-belief. You certainly have to be aware that you could actually do the job” Manager E (37 years),

“Where is the practical recipe for toughening up and getting on with it? It’s about supporting each other and our own awareness ...” Manager F (22 years),

“...and being in a leadership role you need to be very self-aware ...” Manager G (23 years).

The importance of being a midwife and continuing to remember that was highly valued, demonstrated below;

“I think it’s still something I would be passionate about, to try to juggle the two” Manager A (23 years).
“...lot of us came into midwifery to do the clinical and hands-on stuff, that was the passion to be with the women” Manager H (28 years).

This link with clinical expertise in order to inspire confidence in the wider team and being effective as a manager was acknowledged;

“You have to have that clinical recognition and credibility. You have to have the management credibility before you can develop into a leader” Manager H (28 years),

“...being seen as a role model, having credibility” Manager I (34 years).

Building resilience, or being resilient, was identified as an essential characteristic in order to deal with the demand, challenges and expectations of the role;

“You also need to be resilient enough to take the knocks with the good points. And you need to not take many things personally whenever they happen.” Manager E (37 years),

“I notice there are now courses about developing resilience and I would say eight or none years ago I would have thought I was very resilient, but when you come into the lead midwives posts you discover that you’re maybe not that resilient at all because you’re not in a team anymore” Manager F (22 years).
4.2.2.5 Preparation for the job

The areas of succession planning and leadership, and individual preparation to take on these senior roles, were explored with managers. The role of current or previous line managers was identified as significant. These individuals were seen to be key in identifying, encouraging and inspiring midwives to take opportunities to develop their leadership and management capabilities and provide ongoing support, as described below;

“My previous manager hopefully saw elements in my personality and in my practice and offered me opportunities and which I took” Manager B (29 years),

Nevertheless, as one manager commented despite referring to the support, she had from her line manager her preparation was limited;

“...it was a case of hitting the ground running” Manager B (29 years).

A number of the managers remained positive about the role of the line manager in succession planning; not just for the impact on their careers, but as an acceptable method for identifying potential managers from across the team;

“There is not much support unless you have a very good manager and it’s the managers who are picking out the people” Midwife C (28 years),

“...the senior management give you the confidence ...” Manager E (37 years),

“Well I had opportunities to shadow, but a lot of it’s around your role models as well. I had very good role models” Manager H (28 years),
“The role of the line manager is critical in encouraging people to get the confidence to take the next step” Manager I (34 years).

The managers also highlighted the importance of the timing of development interventions, including programmes, whilst acknowledging constraints linked to staffing levels. In their view, identifying midwives early in their careers to begin development with practical experience and nominating for programmes was important, and it is a key aspect of their role, to create opportunities, to identify and encourage the midwives in the same way as many reported they had been supported;

“There are very young enthusiastic smart intelligent midwives that we work with, and I think it is important to nurture that.” Manager A (23 years),

“Some of them, the direct entry midwives, I can individually think in my head are going to go far. It would be wonderful to pick them up and put them on the road to succession but I don’t think the whole structure of the service and the logistics actually gives you that opportunity” Manager D (30 years),

“What we need to do, and what I have been doing, is nearly earmarking people that I feel yes, they are junior but ...” Manager G (23 years).

However, as one manager reported, targeting specific midwives as practised in the past, is no longer acceptable as described below;

“Now, unfortunately, it can’t be a tap on the shoulder and say ‘do you want to do this for three months’ you’ve got to go through the whole process.” Manager H (28 years).
Whilst another was clear that the opportunities afforded to her were offered more widely:

“I know the opportunities were offered not only to me, I would not say it was a person selected thing but the opportunities were presented and I certainly grabbed them” Manager B (29 years).

There was also an acknowledgement by a number of managers that not all midwives were interested in progressing to management roles, with comments such as;

“...with young midwives, I sometimes feel there is a lack of enthusiasm” Manager A (23 years),

“...not everyone is there to manage, and not everyone can have an overview of the whole unit, nor want it either ...” Manager E (37 years),

“A lot of people do not want to do management roles” Manager G (23 years).

One manager commented that some midwives seemed to prefer to attend courses on leadership development as opposed to gaining practical experience;

“They want to run before they can walk and just get courses ...” Manager B (29 years).

The importance of midwives understanding, and being clear about the purpose of the role, was another area highlighted, especially in relation to change management, service improvement and meeting needs;
“Whilst it’s personal development it also has to be enhancing the care they are
giving to our babies and families, in some way improving our service ...”
Manager B (29 years),

“They don’t see how it’s improving the care of a woman, or baby” Manager F
(22 years),

“Help me to understand that people tick differently and that when you are
managing people you must speak differently, expect that different people are
going to achieve things differently because of their type” Manager H (28
years).

A number of managers spoke about the importance of having to learn a ‘new’ language
in order to work within the management world;

“I didn’t know what these people were talking about but the more you go, about
six months down the line it does fall into place” Manager A (23 years),

“I might not use the terminology, but I am sure when I’m talking to midwives”
Manager C (30 years),

“Whereas I used to be frightened as people talked in a language that you didn’t
understand.” Manager I (34 years).

There was acknowledgement of the need for formal education on the theory of
management and leadership, although a difference in view on whether that should be
before, or after, gaining practical experience, and whether or not practical sessions should be included in these programmes, as identified below;

“*I do think it was to theory-based with a lot of focus on the academic side, whereas to me doing role play or having a video or something like that would have helped.*” Manager C (28 years),

“*Management programmes that give them some kind of insight but they get a project and they do something different from their clinical role and it gives them a flavour*” Manager H (28 years),

“*They have their classes, theory and lectures, but then they have to put it into their own practice and relate it.*” Manager I (34 years).

A number of the managers explained that their views were also informed by the effectiveness of programmes they had experienced;

“*There was a LEO course, it was very helpful for introducing you to people, and for telling you what the National Health wants from you. But to me, there weren’t an awful lot of specifics. They taught you about interviewing and being nice to and appreciating your staff, and the role that the management have, but not the practical skills*” Manager E (37 years),

“*I have been on the leadership course [the LEO programme], the one that went around all the buildings, that course, you know the regional one, I was on that and it was very good as well, but even then I don’t think I knew exactly what a manager’s role was, doing the governance role and shadowing the Head of*
Midwifery, really helped because I could see the bigger picture” Manager G (23 years).

“It gives you an opportunity to look at yourself and gives you a context. That helped me understand that people tick differently. When you are managing people, you have to speak differently, expect a different way that people are going to achieve things differently because of their type. That clicked. That was a bit of a light bulb moment.” Manager H (28 years).

Asking the question of how midwives should be prepared and developed to become managers and leaders resulted in a range of views. The need for the midwives to take advantage of opportunistic learning, not just in management but wider service issues was a key feature in the responses;

“...Management courses, we were offered them as a group at a particular seniority, some would take the opportunity and others didn’t, I did” Manager B (29 years),

“People need exposure to much more strategic view of the service and what the links are to Department, education, the public, the media, politics, you know” Manager D (30 years).

In exploring what the managers considered to be ‘learning opportunities’ provoked the most discussion. They all regarded their role as needing to be supportive, encouraging and facilitative;
“It’s about nurturing people, telling them not to fear” Manager I (34 years).

In their view, midwives primarily gained knowledge of the theories of leadership, insight into the NHS, and networking from programmes but didn’t experience any practical situations or skills. In particular, managers referred to lack of skills around report writing, managing finances (especially budgets), dealing with complaints, taking the lead on a project, networking with others and generally being exposed to the wider maternity service issues. All felt this approach should be provided through mentoring, shadowing and acting up, drawing on their own experiences, and highlighted that midwives prefer practicality. These types of opportunities they suggested provide midwives with a lived experience of the manager-leader role and to enable them to get an insight they would not have during their day to day work;

“There should be a place for the more practical things as well, not just sitting learning the theory but being out there and being exposed to the more practical side of things” Manager A (23 years),

“So, I think anything that’s in place needs to be practical, needs to show its worth, show its relevance, that entails exposing midwives to things that they aren’t necessarily exposed to in their day-to-day work, things like quality improvement initiatives …” Manager F (22 years),

“The acting role is a brilliant opportunity for people to test the water. We would use it quite a bit. You are testing them and they are testing themselves to see whether it is something they want to do. Sometimes it works out. Sometimes it doesn’t” Manager H (28 years).
4.2.2.6 Relevance of the LQF (2007): midwifery managers’ view

In considering their views on the NHS LQF (2007) and its usefulness, the midwifery managers confirmed they were aware of it, but gave it different weightings in their responses in respect of relevance, with one manager commenting;

“I hadn’t come across them until nine years ago when RPA came in” Manager I (34 years).

The managers mainly described using it as a tool to guide their own, and staff’s, preparation for interviews, and occasionally to guide the interview process but their perception of its usefulness was summarised by one manager;

“I think it [the framework] sits outside the service, rather than in the service”
Manager D (30 years).

The framework was perceived as difficult to apply, within the experience of the managers, who identified a number of issues;

“...in terms of relevance and how do you measure your own self-belief, how do you measure your own self-awareness, how do you measure your own resilience, I always found it difficult” Manager F (22 years).

“Sometimes I think frameworks are a bit complicated, maybe it’s ourselves that make them complicated or maybe again that can be a lack of experience on my part” Manager A (23 years),
“Through time they have made sense looking back but initially I thought they were airy-fairy” Manager I (34 years).

Some of the views were more constructive with one manager commenting;

“I know a lot of people think it’s theory, theory, theory but sometimes some of the theories are very good to help you in your work” Manager G (23 years).

Whilst another commented that;

“It [the framework] kind of breaks up what the role is about, and the attributes you need in order to do it” Manager H (28 years).

4.3 Phase two: midwives’ perspectives

In the following section, the data collected from the midwives through the online survey is presented, including descriptive statistics. The data provides insight into the midwives’ experience of leadership and management development. Through the narrative responses, they have contributed perspectives on the leadership and management role of the midwifery manager. The findings from the focus group provides further depth and understanding of these perspectives. Themes emerging included; experience of leadership and management development, career progression, perceptions of leaders and managers and relevance of LQF (2007).
4.3.1. Online questionnaire results

The findings are presented below, commencing with the demographic information. The data is organised around the perspectives reported by the midwives to answer the questions posed relating to their leadership and management preparation, including their views on the NHS LQF (2007).

4.3.1.1 Response and demographics

The email invitation (Appendix 13) from the RCM was opened by 340 midwives of whom 38 replied and agreed to take part. All were sent an information leaflet (Appendix 14) and a link to an online questionnaire (Appendix 12). The online questionnaire was opened in May 2016 and closed in August 2016. On completion of the online survey, 18% (n=7) of the 38 midwives agreed to participate in a focus group to explore their perspectives on developing an effective leadership/management development programme to meet the identified needs of midwives and the impact of the leadership development on their personal and professional confidence.

All midwives (n=38) who completed the online questionnaire had met the criteria having completed a management course at either the HSC Leadership Centre, the RCM or both (table 4.6).
The midwives who completed the questionnaire had also a broad range of experience as demonstrated in table 4.7. At the time of completing the programme, 20 (52.6%) held a management post at band 7, including three holding temporary ‘acting’ band 7 positions, and 18 (47.4%) were practising midwives with no direct management responsibilities.

Table 4.6. Programme attended

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSC Leadership centre</td>
<td>34</td>
<td>89.4</td>
</tr>
<tr>
<td>RCM</td>
<td>2</td>
<td>5.3</td>
</tr>
<tr>
<td>Both</td>
<td>2</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The midwives who completed the questionnaire had also a broad range of experience as demonstrated in table 4.7. At the time of completing the programme, 20 (52.6%) held a management post at band 7, including three holding temporary ‘acting’ band 7 positions, and 18 (47.4%) were practising midwives with no direct management responsibilities.

Table 4.7. Midwives’ demographics

<table>
<thead>
<tr>
<th></th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience as a midwife</td>
<td>26 years</td>
<td>12 - 40 years</td>
</tr>
<tr>
<td>Experience at time of completing the programme</td>
<td>17 years</td>
<td>6 – 33 years</td>
</tr>
</tbody>
</table>

4.3.1.2 Experience of management and leadership development

The source of nomination to attend the leadership development programme was varied; 65% (n=25) were nominated by a line manager, 10% (n=4) self-nominated, 7% (=3) were supported by practice educators, 5% (n=2) were nominated by supervisors of midwives and the remaining 10% (n=4) did not provide an answer.

In addition, a range of informal opportunities to gain insight into the management role had been experienced by 68% (n=26) of the participants before completing formal
development, as presented in table 4.8. As demonstrated, a number of respondents experienced the full range available, whilst others had one or more aspects. Those who held a management linked post had greater experience than the band 6 midwives. The opportunity to ‘act up’ and/or leading a project were most frequently cited. The types of projects identified included leading on the introduction of new guidelines, gathering data for audit, and supporting the implementation of the maternity strategy (DHSS, 2012).

Table 4.8. Management experience prior to the programme

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Act up</th>
<th>Shadowing</th>
<th>Lead a project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 7 or equiv.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>3</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>3</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Band 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>1</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>x</td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>x</td>
<td></td>
<td>x</td>
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<tr>
<td>2</td>
<td>x</td>
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<td>1</td>
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<td>x</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total = 26</td>
<td>18</td>
<td>10</td>
<td>18</td>
</tr>
</tbody>
</table>

Reflecting on management and leadership development since completion of the initial programme, 44% (n=17) of midwives reported the completion of additional development opportunities; 27% (n=5/18) of band 6 and 60% (n=12/20) of band 7 (or equivalent) midwives respectively. An extensive range of courses and study days were cited and were from a variety of providers; Trusts, professional organisations, the HSC Leadership centre and universities. The majority of respondents had completed at least
one programme/course. Within Trusts, leadership days and programmes were offered and completed by 7% (n=3), for example, the Institute of Leadership and Management Course. The RCM and Royal College of Nursing (RCN) provided leadership programmes and each was completed by one person. One band 7 referred to a bespoke three-week induction programme to her new role as part of her management development. A number of midwives completed leadership and management development post-registration either as part of academic study 7% (n=3), or the Supervisor of Midwives’ course, 10% (n=4) which is a level three module.

The majority of the midwives who completed the programme 86% (n=33), used free text to cite a range of positive aspects which has helped to expand their knowledge and understanding, as demonstrated in table 4.9, with most including more than one reason. Only 7% (n=3) indicated they enjoyed all aspects of the course.

Table 4.9. Positive aspects

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Networking</td>
<td>15</td>
</tr>
<tr>
<td>Management &amp; Leadership theory</td>
<td>4</td>
</tr>
<tr>
<td>Learning about NHS structures</td>
<td>4</td>
</tr>
<tr>
<td>Identifying personal management style</td>
<td>3</td>
</tr>
<tr>
<td>Guest speakers</td>
<td>3</td>
</tr>
<tr>
<td>Group working</td>
<td>3</td>
</tr>
<tr>
<td>Learning about managing change</td>
<td>2</td>
</tr>
</tbody>
</table>

Respondents were asked to identify any aspects of their programme they would change, and gaps which need to be addressed and 71% (n=27) responded. Comments were provided by 50% (n=19) who cited a broad number of issues, with themes emerging on the need for allocation of time in the clinical area to manage the demands of the programme, 7% (n=3), and the need for more practical examples of managing
situations, 7% (n=3). The challenges of managing staff however were cited as the most challenging aspect of the role and were viewed as an essential practical aspect;

“I would like to see more on dealing with difficult people and personalities.”

Midwife no.23 (Band 6).

4.3.1.3 Career progression

Following completion of the programme, 76% (n=29) of the midwives described a range of opportunities they experienced to build on their new knowledge, including 5% (n=2), both band 7, who had previously reported no opportunity to gain additional management and leadership experience before completing the initial programme. The overall pattern of experience highlighted that the band 7s had the widest range of new experiences. Across all grades, the main opportunity to develop (n=22) was leading a project (table 4.10) as part of their role, for example, developing the guidance to support the introduction of a new policy.

Table 4.10. Management experience following the programme

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Act up</th>
<th>Shadowing</th>
<th>Lead a project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 7 or equiv.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>1</td>
<td>x</td>
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<td>2</td>
<td>x</td>
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<tr>
<td>5</td>
<td></td>
<td>x</td>
<td></td>
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<td>4</td>
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<td></td>
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<tr>
<td>1</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Band 6</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>x</td>
<td></td>
<td></td>
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<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>9</td>
<td>20</td>
</tr>
</tbody>
</table>
Participants were invited to consider the impact on their career pathway and whether they had considered applying for promotion. 64% (n=22) of the midwives reported they had, and of these, nine midwives had secured a post, whilst another had passed the interview process for a band 7 post and had been on a waiting list which unfortunately expired before a post became available.

Of those who had not considered further career progression, 35% (n=12), a number of reasons were cited; 10% (n=4) explained that they held, or previously held management posts at grade 7 or above and preferred to continue in their present role, with one commenting:

“I have held senior management roles in the past and I am happy at this current level where I believe I can make my experience and confidence be more effective” Midwife no.34 (Band 7).

Other reasons mentioned for not applying for a management post included a desire to maintain a clinical role (n=2), a need to maintain work-life balance (n=1), working part-time (n=1), lack of interest (n=1), lack of experience (n=1), non-availability of a suitable post n= (1), and lack of encouragement (n=1). One midwife (no.2), stated that she believed others were “favoured and groomed for management” and didn’t believe the current system was “fair” and therefore saw no point in making an application.

4.3.1.4 Manager or leader

The midwives were asked to reflect on their line manager’s role, 81% (n=31) responded as demonstrated in table 4.11 below, with the majority (n=20) considering the role as both leader and manager.
The midwives in their narrative responses 78% (n=30) explained their views. The midwives who regarded the role as leader and manager regarded this as essential;

“The two have to go” hand in hand” Midwife no.29 (Band 6)

This was linked with line managers’ visibility and requirement to manage staff, in terms of identifying midwives’ potential early, providing encouragement, inspiring confidence, and leading by example.

The midwives who described the role as one of managing, commented on the lack of the senior midwife’s visibility and engagement in the day to day aspects of the maternity services, reacting to situations instead of leading; one midwife’s comment encapsulated this as;

“Looking above, more than within” Midwife no.34 (Band 7).

Only one of this group of respondents provided positive comments in relation to the role of her manager, describing her support in a number of areas;

“Our team leader has led us in creating a community-based booking ultrasound clinic, manages us as a team by promoting fairness and respect for others in our small environment” Midwife no.37 (Band 6).
The two midwives who viewed the role as leading only were both band 7 and again referred to the importance of visibility of midwifery, especially at senior levels.

There was a link made by the midwives between innovation and change, with strong leadership, professional credibility, and motivation. They commented on the need for the person to be fearless, to take risks and to have a vision. Within the commentary, the role of the leader/manager was linked with the need to ensure safe standards of service centred on women. Almost half, 45% (n= 9), of the midwives reported being reassured and positive where they have confidence in the abilities of the senior midwife including having an ability to successfully manage people. The following comment from one midwife reflects a summary of the comments;

“Managing effectively shows what leadership qualities the individual has. Effective management promotes confidence in one’s abilities and has a positive effect on staff. The converse is also true” Midwife no. 38 (Band 7).

4.3.1.5. Relevance of the LQF (2007) – Midwives’ views

The midwives were asked about their knowledge of the NHS LQF’s (2007) list of skills; 81% (n=31) responded, of whom 39% (n=15) confirmed they were aware of them. Of these midwives, 40% (n=6) reported gaining this knowledge as part of interview preparation, while 26% (n=4) learnt of them whilst attending the HSC leadership course and 13% (n=2) through Trust sources.

Within the context of their management development, the midwives were asked to rate the level of their own knowledge and proficiency against each element of the framework, using a 5-point Likert scale where one was no ability and five was fully
proficient. The summary findings concerning management skills are presented in Table 4.12, and leadership skills in Table 4.13. As demonstrated in Table 4.12, all midwives (n=31) rated themselves as having at least some ability in the areas of collaborative working and empowering others. A number of midwives (n=1 to 3) reported for both leadership and management as having no ability in any but these two skills; those who reported a lack of proficiency in the other eight skills, especially in the areas of effective and strategic influencing and broad scanning (leadership skills), were all midwives holding band 6 posts no band 7 reported a lack of proficiency in any skill.

Table 4.12. Summary of midwives’ reported proficiency in management skills
Additionally, midwives were asked whether skills were missing from the list, and a number were identified by 41% (n=13) of respondents. This was a diverse range of additional skills including; communication (n=3), time management (n=2), networking, using evidence-based practice, negotiation skills, dealing with difficult people and personal development. Two skills identified as missing in the NHS LQF (2007) are included in the list of attributes; personal integrity (n=3) and resilience (n=3).

The midwives were asked about their knowledge of the NHS LQF’s (2007) list of attributes; 73% (n=28) responded, of whom 34% (n=13) confirmed they were aware of them. All the respondents indicated they had some degree of proficiency in each of the six attributes, although one midwife reported that her self-belief was poorly developed (table 4.14)
The midwives were asked if any additional attributes should be added to this list, and a number were identified by four of the midwives including professionalism, personal effectiveness and managing conflict. Also mentioned were communication and dealing with difficult people; these had previously been identified by some midwives as missing from the list of skills, indicating the different interpretations of skills and attributes.

In comparing the responses of the midwives, no statistically significant difference was found in relationship to the years of experience and proficiency. However, when comparing the views of all the midwives (the managers n=15 and the midwives n=31), a marginally statistically significant difference was identified (p = 0.049), midwives
with over 30 years’ experience did not think resilience was as important as those with fewer years’ experience.

4.3.2 Focus group with midwives

Following analysis of the data collated from the survey completed in Phase 2a, key themes identified were used to develop an interview schedule to guide the data collection for Phase 2b (Appendix 17). In particular, midwives’ perception of levels of personal and professional confidence and also on the skills and attributes as outlined in the NHS Qualities Framework (NHS Institute for Innovation & Improvement 2007) were investigated.

Data from the focus group are presented in relation to the themes identified; preparation for the role; training; the application/relevance of the NHS LQF (2007) and personal attributes.

4.3.2.1 Demographics

The four midwives who participated in the focus group (phase 2b) had between 30 to 35 years’ experience as midwives (median of 32 years) and all four were over 50 years of age. Two were midwives specialising in particular aspects of practice and two held management positions, with the managers holding their posts for a median of 22 years.

4.3.2.2 Preparation for the role

When reflecting on the preparation they received to lead and manage, the midwives described their experiences; both the strengths and opportunities of the approaches and
the gaps. In doing so, there was an acknowledgement that this process started during pre-registration training:

“Remember when you did your management module or management allocation or whatever at the end of nursing, and I still remember that day – I will never forget it – because the sister handed me the keys and said ‘you’re running the ward today’” Midwife X (34 years),

“There was an established system where I trained that once you became a staff nurse, the expectation was that you would do first-line management” Midwife Z (30 years).

4.3.2.3 Experience

Reflecting on their experience of leadership and management development in midwifery generated a lot of discussion, and identified a lack of formal process. In particular, the role of managers and colleagues were seen as key, primarily through creating and facilitating opportunities and leading by example, but with no evidence of clear processes for identifying midwives for development. The midwives considered that there were strong role models available, including the Royal College of Midwives, which was identified as providing an important resource from which a number of them had received support;

“We are very fortunate in Northern Ireland to have such good role models...”
Midwife Y (34 years),

“It was a real skill on behalf of that manager, but none of us ever applied for a sister’s post but we were being developed and we didn’t call it that...”
Midwife Z (30 years),

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“At the time I didn’t see it but in retrospect, I could see that deep down you had more to offer; somebody saw it in me before I saw it in myself.” Midwife W (35 years).

The midwives also acknowledged they had experienced negative effects when the person of influence was not supportive and the subsequent detrimental impacted;

“I don’t know because I was constantly wound up and tense in her presence and I don’t think I ever got to see qualities in her that I could define as good, I could only see qualities that had a negative impact on me.” Midwife Y (34 years).

“Her feet spoke volumes, she never needed to say a word and when she walked like a normal person with quiet shoes you thought ‘ok the world’s a normal place today’, then it was [makes clicking/knocking sound] and it wasn’t necessary but it had an impact, you just went ‘I’m going to avoid her!’” Midwife Z (30 years).

Support was an element which the midwives valued, and received in a number of ways from managers, colleagues, peer groups and mentors;

“You do need that encouragement” Midwife X (34 years),

“...one of the things we didn’t talk about is the support of a small group of people as well” Midwife Y (34 years).
Obstetricians were also perceived as supportive, with a recognition of the changing relationship at clinical level, although it seems that at senior management level, they continue to command greater influence than midwives;

“It’s not on the day to day, on the floor so to speak where we work in teams and handovers and all of that, you know we work very collaboratively and together…… where you’re maybe at boardroom level, or at a trust level, or at a directorate level, where you’ve clinical directors in a ‘head-off’ position, and they really should have equal standing – one’s leading the midwifery profession and one’s leading a medical college…” Midwife Z (30 years).

4.3.2.4 Strengths and opportunities

The importance of the inclusion and exposure of midwives at all levels, internally and externally to the organisation, were recognised as significant, in order to create change and to overcome some of the existing barriers whilst recognising that not everyone will be motivated to change;

“They need exposed to that and they need to know that world exists, and we don’t just talk to them when there is a vacancy for a manager’s post …” Midwife Z (30 years),

“…leading the service for that profession for someone who’s clinically leading that service and there needs to be that respect and that working together, but I think it comes in at a different level – I don’t think that will really influence management/leadership at department level or board level.” Midwife Y (30 years).
“...back in a clinical area, can you get anyone to listen to you? Because you’re coming back really excited about it and because your colleague hasn’t been to it, they just don’t either want to listen to you or understand why you are absolutely inspired.” Midwife W (35 years).

There was a consensus view that the first stage in progressing to manage was encouragement and mentoring:

“To function at ward level, function with off-duty, function with dealing with complaints – to some people that just doesn’t come naturally; so, it’s those basic things that they also need to have... like along with shadowing senior people they need to shadow a sister to learn” Midwife Z (30 years).

4.3.2.5 Gaps

There were a number of points made about the gaps in preparing midwives, including the culture of the organisation and the failure of development opportunities to take account of the changing nature of the wider NHS;

“I think it is back to the organisational culture and where they fit – is it a team this way or is it a team this way? It’s about respect, it’s about working together” Midwife Z (30 years),

“To me, if you’re trying to do your daytime job as well ... to me, it would be money well spent if you just took the person out and said here’s your job now, you’ve got the programme and if you complete that we’ll go on ahead after that, and then build on it.” Midwife W (35 years).
“…is there any point in training you or giving you this very inspirational type of management or leadership training if the organisation’s culture doesn’t allow you to use it when you’re in the post.” Midwife X (34 years),

“As an F grade you were sent on the course and you were never allowed to be anything more than the tick on the box” Midwife Y (30 years).

There was strong support for a formal means by which organisations could create opportunities for midwives to observe and learn, utilising methods such as coaching, shadowing, mentoring and ‘acting up’. This was based on the recognition that working in a management and/or leadership role requires an individual to be grounded in basic principles, and have an understanding of the different approach and language required;

“that they [organisations] see the value of exposing their future leaders, their staff, their development to an opportunity to shadow or have an exchange with another unit or colleague, whether it’s within Northern Ireland or outside of it; and don’t see that as a challenge that’s going to cost them money but an opportunity …” Midwife Z (30 years),

“They need to shadow a sister to learn…” Midwife Y (30 years).

The midwives reported a lack of knowledge and exposure to the financial and business aspects of managing, despite an understanding of the importance of this aspect to service delivery; for example, being asked to produce a business case with no idea how to progress this;
“At the beginning of my midwifery career, I was in England, and it was the world of Mr Sainsbury managing the Health Service, you know the general manager scenario came in, and I walked into a storeroom on a ward and everything was priced! It was literally like a supermarket – bedpans, maternity pads” Midwife Z (30 years).

There was, however, acknowledgement of the need to take responsibility and learn;

“Finance is a massive gap; I did that online thing because you learn, people learn the language that gets the result” Midwife W (35 years).

The midwives highlighted the impact of the NHS Review of Public Administration across the region in 2007 which led to the creation of Health Care Trusts. In turn, this led to the introduction of a new approach to interviews for management/leadership roles. This was identified as a potential issue which impacted on career opportunities and role preparation;

“The one thing I think is missing, certainly in the last 5 years of my career was that none of the management courses were competency-based and yet when you moved into probably the last 10 years everything you were reading, and interviews you went for, were competency-based.” Midwife Y (30 years),

“Well a lot of people were under the Review of Public Administration with the system that was used to reduce numbers and select the managers that would continue to manage the service …it wasn’t how they competed for their posts in the past, how they prepared” Midwife X (34 years).
4.3.3 Training.

Reflecting on leadership and management development and the necessary skills and knowledge required for a managerial role, midwives agreed there were a number of approaches, all with benefits and gaps.

4.3.3.1 Education programmes

There was a consensus that post-registration education programmes provided the opportunity to meet other health and social care staff, to listen and learn from them and to form networks. These were of benefit particularly for future working both in terms of relationships and influence;

“...multi-disciplinary – I found these more beneficial; I found I was so blinkered in my thinking ‘I’m a midwife, I’m a midwife, I’m a midwife manager’ and yet when they were sharing things, I thought that would actually work in my area” Midwife W (35 years),

“The other reason I’m thinking multidisciplinary is because when you start meeting people at Trust level, you’re not meeting with midwives and it’s a whole different negotiating skill” Midwife X (34 years).

Gaining an understanding of the theories of management and leadership was viewed as important, especially when linked with managing people, as it supported the managers in examining their own approaches and answered unspoken questions they had;
“Without that exposure, some of our management or leadership styles are almost instinctive because it’s learned, you know you’ve observed others and it’s not really grounded in fact” Midwife Z (30 years),

“...for me, that helped me understand people that I manage like band 7s because you’re looking at that theory and you’re thinking, well that is why she reacted the way she did or that’s why she didn’t react, and equally I think well how do I get the best out of her” Midwife W (35 years),

“...the learning you get from that sharing and direction is huge because you take a different insight into things” Midwife Y (30 years).

The inclusion of the broader aspects of management in the service, such as managing change and working within a multi-professional system, were noted to be useful as the participants became more self-aware and developed skills which they were able to implement in situations they faced;

“...as part of the Leadership and management course you were asked to think about something you were participative in that effected change or something you did well like a project or whatever and you go off and you actually learn a lot about yourself” Midwife Z (30 years),

“...so, I got very aware of costings and how to organise things.” Midwife W (35 years),

“I do think the multi-professional, multi-disciplinary aspect of what we do definitely has an impact, whether it’s in language or in processes or in thinking or whatever but it has definitely impact” Midwife Z (30 years).
Although midwives were very clear about the importance of resource and finance issues, there were differing views on whether the information provided on budgetary and financial management were at the appropriate level and detail in education programmes;

“I don’t want to be bogged down with budgets and business plans but I want to make a difference to this group of women who use our service” Midwife X (34 years),

“I had to work out the cost scenario before I presented it to [named] – expiry dates, cost and how many you would use and [named] said ‘where did you learn that?’ well that was my management course” Midwife Y (30 years).

The inclusion of practical examples and application to maternity services was highlighted and viewed by the midwives as a significant gap in the programme. They reflected on the benefits they had gained in the past from observing or participating in practical sessions in managing clinical situations;

“... even when you were sitting and looking at scenarios and how you would adapt with it you would think ‘Oh my word, I hadn’t thought of that aspect’ so that was very relevant and very helpful” Midwife W (35 years),

“Scenarios are brilliant for getting a practical application for how you deal with a situation and I think, as midwives, we are very good at dealing with situations because we are trained to respond in an emergency” Midwife Z (30 years).
The completion of the management development programme was however perceived as of limited value in the preparation of the midwives for a role in management. The majority agreed it provided an insight into the role, and contributed to further information on career options;

“You get inspired but then what are you going to do with it? Like back in a clinical area? Can you get anyone to listen to you?” Midwife W (35 years),

“... it whets your appetite; and you make a decision is this the career direction that I want to go in or am I going to use this knowledge to make me better at where I’m at because I like doing what I do and I’m open to new learning, new skills and new development” Midwife Z (30 years).

The need for education programmes to be supplemented with practical examples of management and leading was a recurrent theme. All of the midwives related their own experiences of the challenges of dealing with situations in the absence of an understanding of the processes involved. In particular, midwives reported there is a tendency for years of midwifery experience to be viewed as absolute i.e. more years equals more experience, but in reality, this experience can differ significantly from one role to another;

“We spend 3 years learning to be a midwife so why do we expect people to be able to manage overnight, which is what we do.” Midwife W (35 years),

“We had 23 years’ midwifery but no management experience, and we got all these policies and documents and we wrote a scenario, which was probably like a business case...” Midwife Z (30 years),
“If your management experience is coordinating a busy labour ward, the skills you use may be very different from someone who’s organising a massive antenatal department” Midwife Y (30 years).

Participants were asked about the future preparation of midwives for leadership and management roles and had a number of suggestions to address the current gaps and strengthen leadership and management development;

“The one thing I think is missing, certainly in the last 5 years of my career was that none of the management courses were competency-based and yet when you moved into probably the last 10 years everything you were reading and interviews you went for were competency-based! But there was no learning that I had received that prepared me for that” Midwife X (34 years),

“New Horizons is actually a way where a band 6 can now see what’s going on all the different levels of jobs and that will mean, in my eyes, the girls who really want to start moving on to band 7 will be aware of what else is there, what other roles are there, how they influence and impact on a field of work and whether they want to be going up to 7.” Midwife W (35 years).

4.3.4 Clarity between management and leadership

There was no consensus on the traits that identify managers and leaders and how this relates to development and training. The midwives discussed the various approaches they had observed and experienced. There was an emerging view as the discussion progressed that it was possible to be a manager without being a leader, but of the two,
leadership was more highly rated. Management was linked to skills development and operational issues whilst leadership appeared to be reflected more in charisma and vision;

“*I suppose I see a good leader as someone who, even though they might have difficulty with that person, you can rise above it and treat that person with dignity and respect and value their contribution, bring them along.*” Midwife W (35 years),

“*...there are some people who are excellent at managing situations, managing processes, managing budgets, managing services but I don’t necessarily look at them and think ‘wow I really want to be them’; a leader to me is somebody that is inspirational, has drive, and exudes something that you are affected by*” Midwife Z (30) years,

“*...with leadership you have born leaders and they don’t even realise they are born leaders, and I think that is very different from the manager, the manager can be trained into being a manager but you can be a manager and never actually be a really good leader.*” Midwife X (34 years).

4.3.5 Personal attributes

Considering the role of midwife leader and manager prompted discussion on whether there are key characteristics an individual should display in order to fulfil the role. Words such as approachable, inspiring and credible were all cited as significant attributes for a manager and leader, however, the key themes emerging were concerning confidence, expectations and influences.
4.3.5.1 Confidence

Being confident and inspiring confidence, as a manager/leader, was viewed as essential both at an individual level and for the wider midwifery profession. Finding opportunities to build confidence was perceived as fundamental, and examples included input from line managers and accessing the right training and development;

“... once you achieve the skills and feel comfortable in that area, you can have the freedom to develop it in a different direction if you feel that any further studies that you’ve done in management, that you can come back and make changes” Midwife W (35 years),

“... she (the ward manager) didn’t have to do that but it really gave me a boost and I thought ‘ok I’m now part of this team’ and there’s potential there.” Midwife Z (30 years),

“... having an opportunity to go through the interview process, but maybe the interview process is not as strict and formal as maybe going for a sister’s post but it’s introducing them to interview situations and they’re developing skills that when they move to the next level, they will have more confidence ... “Midwife X (34 years).

4.3.5.2 Expectation regarding the role

The pressure and demands of the management post were identified as challenging and needed ‘good’ leadership;

“...because that’s what you want to do as a good leader or manager, you want to bring back the best for your bit of the world. ” Midwife X (34 years),
“I suppose I see a good leader as someone who, even though they might have difficulty with that person, you can rise above it and treat that person with dignity and respect and value their contribution, bring them along” Midwife W (35 years),

“Another quality of a good leader, when they can see your potential and they are not frightened or threatened by it and think ‘that’s worth developing’; and that is a real quality of leadership” Midwife Z (30 years).

4.3.5.3 Influences

Two of the midwives also highlighted the challenges between organisational influences or requirements and the personal aspiration of being a manager/leader;

“... there can be a conflict in being a manager and a leader, because you may aspire to be a certain type of leader but your organisation expects you to be a different type of manager .... you nearly have to set aside what your desire is as a leader in order to be the manager that your organisation needs you or wants you or forces you to be ...” Midwife W (35 years),

“...there needs to be almost a triangle – yourself, what was required for the job and what the organisation can provide for you to get you established in the position; because you applying for the job, that doesn’t make you a manager or a leader that day – you’re starting on a journey and you’re going to make mistakes.” Midwife Z (30 years).
4.3.6 Relevance of the LQF (2007)

The relevance of the NHS Leadership Qualities Framework and its application in practice occurred primarily for interview preparation, especially when the Trusts were going through reorganisation and change;

“...but it’s introducing them to interview situations and they’re developing skills that when they move to the next level, they will have more confidence”

Midwife X (34 years).

“If you’re applying for leadership, see the personal qualities – I think you actually have to acknowledge all of those first of all, or else you’re not going to be applying for a management post; because you wouldn’t set yourself up for a management post if you weren’t self-aware of your own abilities.”

Midwife Y (30 years).

The majority of midwives described the framework and its elements in a negative manner, referring to the lack of clarity about the language used, application to their role and an inability to measure or assess many of the qualities;

“How do you actually live them, you know political astuteness, where do you get that from – is it your general knowledge or…” Midwife W (35 years),

“...if you understand what intellectual flexibility is; I find that some of that language is off-putting because it might be that people are going ‘do I have that? I don’t know what that is” Midwife Z (30 years).
The issue of language was explored in the discussion and the midwives agreed that although it was unfamiliar in clinical practice, in the wider management system it is essential to learn and use, relevant language and terminology, otherwise, the impact could be a failure to properly represent the service;

“... that’s what I think about intellectual flexibility that you can move in a different world; a different language and you can learn a different way of thinking and a different vocabulary” Midwife Y (30 years),

“...you get that from going to strategic type meetings and you actually need a lot of it, if not you will flounder, the service that you’re representing will flounder” Midwife W (35 years),

“...but we have to be equally aware so that language is now part of our world, and that’s why this here, for a lot of people, is alien language; for those in the management world it’s not.” Midwife Z (30 years).

4.4 Summary

In this chapter, the analysis of the results from both phases of the study has been presented. These will be examined and discussed in greater detail in chapter five.
Chapter 5. Discussion
5.1 Introduction

This thesis aimed to explore NHS leadership and management development within the context of midwifery in Northern Ireland. In particular, to understand the journey and experiences of midwifery managers and midwives, to determine whether leadership and development programmes are beneficial and to identify gaps in leadership and management development. This chapter will draw together existing literature and data generated from midwifery managers and midwives who took part in this study, in a critical discussion with reference to the context of midwifery leadership in the NHS currently.

The discussion will be guided by the study objectives as stated below:

- Systematically review the evidence in relation to leadership programmes and reported outcomes,
- Explore the perspectives of midwifery managers in Northern Ireland in relation to their experience of leadership and management including the LQF (2007) (Phase 1),
- Explore the perspectives of midwives in Northern Ireland who have completed a Leadership and Management Development programme facilitated by the HSC Leadership Centre and/or the RCM (Phase 2).

5.2 Overview

The NHS has invested significant resource to provide a range of leadership and management development programmes to ensure that health care meets the needs of the public, with limited success, particularly in maternity services (Darzi, 2008, King’s Fund, 2015). In reviewing the literature, as presented in chapter 2 to determine the
effectiveness of leadership and management programmes on developing the skills and attributes of NHS employees and identification of cross-cutting themes, it is evident there is a range of problems. There was significant variation in the quality of the evaluations, and in particular, there was limited evidence of the impact of undertaking a leadership programme. Although the majority of participants across studies reported improvements in a range of personal skills, these were mainly reported using non-objective methods and with limited use of standardised measurement tools.

There was also an absence of any report on the key elements a leadership and management programme/intervention should contain. In addition, only one programme was identified which was developed solely for midwives (Ross-Davie et al., 2016). In the current study, however, the lack of a midwifery specific programme was not identified by the participants as a key issue. Significantly, their views echoed wider concerns expressed by other programme participants, over many years, about the lack of inclusion of practical aspects to support skills development, the absence of follow-up in the practise areas and the impact of organisational culture (Werrett et al., 2002; Woolnough and Faugier, 2002; Phillips and Byrne, 2013; Walia and Marks, 2014). It also underlined the crucial gap in information about the knowledge and skills needed to become effective future managers and leaders in the NHS. This may also explain why, despite programme providers aiming to ensure service improvement, criticism continues about the failure to improve outcomes (Storey and Holti, 2013; Kings Fund, 2014; NHS England, 2016).

This chapter presents the findings from the data generated in the study, which are discussed within the context of the literature review findings from Chapter 2 and with
reference to current evidence and context. In order to fully discuss the findings in a structured manner, these will be addressed sequentially under the following headings:

- Perceptions of Leadership/Management Programmes;
- Experience of leadership development;
- Culture;
- Characteristics of midwifery leaders;

5.3 Perceptions of leadership/management programmes

Describing their experience of leadership and management programmes, through online survey and during interviews, the midwifery managers were mainly positive about the programmes they had completed, although several constraints and barriers were acknowledged. While each individual’s experience was unique, they reported similar patterns and approaches to developing the range of skills and knowledge they needed to undertake their roles, with half completing the same education programme at the HSC Leadership Centre. The introduction to theories of management and leadership during programmes was valued, as these aided understanding of their own styles and behaviours, especially their impact on others. In addition, they reported gaining an insight into what the NHS expected from them. Having the opportunity to meet and network with colleagues who had similar roles and responsibilities across the NHS were all positive aspects and highly rated.

The midwives’ views were comparable, and in particular, they also appreciated the inclusion of members of the wider multidisciplinary team in the programme and the opportunity to share learning and experiences. The majority of the midwives cited a
range of positive aspects, including networking, and learning about NHS structures and theories of leadership. Despite attending the programme post-appointment or late in their career pathway, the participants still valued the experience. This is in keeping with the literature review, as discussed in chapter two. In particular, they self-reported improvements in personal skills such as self-awareness and communication (Werrett et al., 2002; Woolnough and Faugier, 2002; Humphris et al., 2004; Wing et al., 2004; Large et al., 2005; Hancock and Campbell, 2006; Boaden, 2006; Mann et al., 2008; Sambrook, 2009; GVA & Outcomes UK, 2011; Leeson and Millar, 2013; Walia and Marks-Mar an, 2014; Ross-Davie et al., 2016; Boyd et al., 2016; Robinson et al., 2016).

Reflecting on the programme content, both the midwifery managers and the midwives in this study supported the inclusion of knowledge on the theories of leadership and of valuing staff. In addition, gaining insight into NHS structures and processes and networking were beneficial, but they stressed the absence of essential education and development on a range of practical managerial skills. The midwifery managers listed these as report writing, negotiation skills, managing finances and budgets, managing performance, managing people, writing business cases, and responding to complaints, all of which were significant gaps. The absence of an agreed system within the workplace to provide follow-up and to support the development of these skills was highlighted. They also stated that although these limitations were identified, they felt powerless to affect change as they had no forum to do so, and therefore continued to nominate midwives to undertake the programme. The midwives agreed that there had been no opportunity to develop practical skills, either during the programme or within their organisations, citing managing people as a particular challenge. They viewed
managing people as a fundamental challenge, not just as managers but as team members, and therefore a significant gap. This reflects similar views identified in the systematic review undertaken in chapter two.

Several papers recognised the need for inclusion of practical elements in order to support the participants to translate their learning into practice (Currie, 1998; Cooper, 2003; Mann et al., 2008; Leeson and Millar, 2013). It was also noted that where practical skills development were included in programmes, paradoxically this was the element which was often not completed, or there was an absence of a report on whether skills development took place (Cooper, 2003; Woolnough and Faugier, 2002; Humphris et al., 2004; Wing et al., 2004; Hancock and Campbell, 2006; Boaden, 2006; Philip and Byrne, 2013, Leeson and Millar, 2013; Ross-Davie et al., 2016; Boyd et al., 2016; Barton et al., 2017). It was a weakness in the studies that where there was a reference to practical skills development there was an omission in the papers of any description of an assessment process or objective feedback. This is of concern as practical skills development was identified over twenty years ago (Holman and Hall, 1996; Currie, 1998; Pashley, 1998a). This gap needs to be attended to if we are to address ongoing concerns that leaders and managers are not achieving the standards expected by the NHS (West et al., 2015).

It was notable from the literature review that the most frequently used method of evaluation cited was self-reporting by the participants at the time of programme completion with a lack of reference to any theoretical framework. Although self-reporting is important in terms of perspectives and experiences, it can only be viewed as subjective and lacks any follow-up to demonstrate sustained improvement. West et
*al.*, (2015) in a report into health care leadership development commissioned by the King’s Fund, highlighted the absence of an academic standard approach in the research which has been undertaken. This is also reflected in Hartley and Hinksman’s (2003) earlier systematic review of leadership development across all sectors, including the NHS, which concluded that leadership and development was;

“a field of enquiry high on exhortation and low on evaluation”

(Hartley and Hinksman, 2003 p.40).

The findings from the systematic literature review raise fundamental questions about how midwives can develop the range of skills they need. There continues to be an assumption that they can be acquired through the current programme design and approach, as there is little evidence concerning the limitations of these programmes. Despite this, both groups of participants in this study emphasised that leadership and management programmes should remain a part of a range of personal development opportunities accessed by midwives, with no concerns expressed about the timing of access. They highlighted the impact on their own, and others development, and despite the criticisms, they echo the views of others who believe that continuing to invest in these programmes is the right thing to do (King’s Fund, 2011; Ham, 2014). From a strategic perspective, this group of midwifery managers restated that they did not have the opportunity to feedback on the limitations experienced or input into the content of the programmes. They also reported an absence of any service needs assessment, at either individual or organisational levels which has been acknowledged as a significant gap (O’Neill, 2017). They recognised nevertheless, that to ensure the gap in terms of skills development is addressed, some action on their part is needed to create the types
of opportunities midwives need, echoing similar views from other influential groups (King’s Fund, 2011; Edwards, 2016; RCM, 2019).

5.4 Experience of leadership development

The data relating to the lived experience of leadership and management development encompassed both formal and informal opportunities, as reported by the midwifery managers and midwives. Within that context, the preparation for a role about which there is ongoing debate as to its function, that is, whether it is as a leader or manager or both, the absence of development in managing people and financial and budgetary management will be explored in subsequent sections.

5.4.1 Formal and informal development

The formal programmes as described above were limited, with issues around the timing, content and effectiveness. The informal opportunities involved a range of activities including completion of the midwifery supervision programme, observing and shadowing senior midwife role models (particularly the line manager), secondment opportunities and involvement in regional work or projects. It was evident that the midwifery managers valued informal opportunities as the main method by which they acquired the skills to fulfil their roles, providing the practical element missing from their programmes. Nevertheless, they also recognised a range of issues with this approach. These were described as ad hoc, unstructured and dependent on several variables, in particular, the level of managerial support and expertise. On further exploration, during interview, managers remained positive that learning on the job had merit, despite agreeing that it was not necessarily the best, or only, way to develop, or even a ‘good’ experience as it lacked uniformity. Significantly, they
reported these development experiences took place after their appointment to a senior post, which they recollected made the transition to their new post overly challenging. This was notable because it suggests that individuals were promoted to leadership/management positions with no preparation and no evidence of any competency or skills in these areas. However, the midwifery managers now consider these ‘learning on the job’ opportunities as essential to succession planning; a means to encourage midwives and support them to build their confidence and skills base prior to applying for a post. In the managers’ view, it provides the midwives with the opportunity to have experience based in reality, instead of being taught abstract concepts. They also believe it allows individuals to reflect on whether or not they would have the attributes required for this type of role before accepting a post they would dislike, or for which they are not suited.

The midwives, in contrast to the managers, reported that they had the opportunity to complete the formal programme, whether they held a management post or not, and had access to a similar breadth of informal development. This suggests that the midwifery managers are following through on their beliefs with actions. Yet the midwives also echoed the experience of the managers, which was that the approach had limitations due to the lack of process, lack of agreement on specific areas for development with set objectives and learning outcomes, and no agreed measurement of achievement.

The absence of a clear rationale and plan for undertaking leadership development without identified learning outcomes was also highlighted within the literature as a significant omission, particularly when exploring effectiveness (Edmonstone and Western, 2002; Philips and Byrne, 2013). Concern has also been raised about
attempting to deliver a range of skills development to a group of individuals without taking account of their existing knowledge and skills (Boyd et al., 2016; Robinson et al., 2016). The literature review highlighted the lack of a coherent strategy for delivering service change and facilitating succession planning, as a direct consequence of the practice of randomly allocating individuals for leadership development in the absence of any personally identified need or request (Currie, 1998; Edmonstone and Western, 2002; Woolnough and Faugier, 2002; Hancock and Campbell, 2006; Boaden, 2006).

When considered within the context of the timing of formal leadership and management development the managers, as previously noted, highlighted that this had rarely taken place before their appointment. As noted previously it was often a struggle to transition to their new role and they recognised it may initially have impacted on how effective they were viewed by the team. The midwifery managers described the contradiction of working in a system which requires staff to gain skills in leadership and management, but fails to have resources and processes in place to support them to build on their education post programme, a constraint described by others in the literature review (Woolnough and Faugier, 2002; Werrett et al. 2002; Cooper, 2003; Humphries et al., 2004; O’Connell and Downe, 2009). The midwifery managers were clearly frustrated with a situation where there was an inherent lack of recognition of the support needed when learning on the job or any understanding of the knowledge gap, clinicians needed to bridge to achieve the same level of expertise as general manager colleagues. This was compounded by the lack of inclusion in the programmes they experienced, of fundamental topics and skills essential for their role, and the
failure of their managers to use any form of training needs analysis to direct them to an appropriate programme such as that described by O’Neill (2017).

Considering the key practical skills viewed as missing, the managers primarily described these as management related, but which they maintain could be learnt. They identified, as reported earlier; people management, time management, budgetary and financial management, performance management and safety all of which are perceived as core skills to fulfil their roles. Reviewing their own development, the managers recognised that there were additional opportunities which could be utilised to supplement learning on the job. They suggested a number of mechanisms, for example, they would have welcomed the opportunity to gain experience through role-play, video, coaching, and mentoring. Based on the systematic review of the literature relating to delivery methods in a range of leadership and management programmes, it would seem that these are infrequently used (Edmonstone and Western, 2002, Ross-Davie et al., 2016).

In reality, programmes tended to be delivered through lectures in classrooms with a focus on leadership and related topics developed in response to government imperatives or specific organisational needs, as highlighted in the literature (Werrett et al., 2002; Edmonstone and Western, 2002; Large et al., 2005; Philips and Byrne, 2013; Boyd et al., 2016; Robinson et al., 2016). The one practical element reported was action learning which was linked to the development of leadership or project development skills, but with limited success (Edmonstone and Western, 2002; Humphris et al., 2004; GVA and Outcomes UK, 2011; Phillips and Byrne, 2013). There was an absence of recognition or appreciation that those from clinical
backgrounds need to develop a broad range of practical skills required to function effectively, as outlined by midwifery managers such as the production of business cases, or negotiating with and influencing, health care commissioners and policymakers as identified by Edmonstone and Western (2002). A position the midwives in this study understandably viewed as unreasonable.

The midwifery managers reported that many of these skills could be learnt, citing the types of opportunities outlined above. They argued that these would provide midwives with a lived experience of the leader-manager role and afford them an insight they could not access during day to day clinical work. They acknowledged that to achieve this would require the midwives to be supernumerary, but point out that maternity workforce planning tools do not take account of this aspect of professional development (Health Education England, 2019). This in part explains why these models of work-based-learning are often unstructured and dependent on a number of variables, in particular, the level of managerial support and expertise, but they have been an accepted approach within the NHS (Boyd et al., 2016).

Learning through ‘hands-on’ experience is familiar to midwives, both pre- and post-registration, and is regularly utilised for acquiring clinical skills using various models (Andrews and Willis, 1999; NHS Scotland, 2013; Yarber et al., 2015). The difference, however, is that the development of clinical skills is supported by well-established and tested systems which include clear objectives and outcomes, dedicated mentors with input from external education experts and ongoing monitoring of the quality of education delivery and attainment (Chenery-Morris, 2014). Philip and Byrne’s (2013) findings would support this, reporting an incidental finding in their study that mentors
fulfilled a positive role, offering ad hoc guidance to the programme participants in relation to learning opportunities and providing career advice. It could be argued that if this type of model were applied to the development of a postgraduate midwifery leadership programme, with set objectives and support from a named individual, then it would be more successful and certainly worth evaluating. In addition, it would be open for scrutiny to ensure equitable access. Whilst other methods, such as action learning sets, have been used to develop individuals in management and leadership skills through reflection and support from within a group of peers, these have had limited success and are often not completed (Edmonstone and Western, 2002; Humphris et al., 2004; GVA and Outcomes UK, 2011; Phillips and Byrne, 2013).

Both the midwifery managers and the midwives reported that there was an opportunity to create a different experience for midwives in the future. They pointed to their own introduction to leadership and management during pre-registration education. Recent changes in pre-registration education by the Nursing and Midwifery Council (NMC) has also promoted the responsibility for registrants (nurses and midwives) to demonstrate leadership, including this as one of five domains required to achieve registration as a midwife (NMC, 2019). The inclusion of leadership as a specific domain, highlights and promotes the importance of midwives seeing themselves as leaders, understanding the dimensions of leadership and sowing the seeds in undergraduate education for future practice (Buckwell-Nutt et al., 2014; Carragher and Gormley, 2016). This reflects an approach which has already been adopted in some undergraduate nursing programmes in the UK (Buckwell-Nutt et al., 2014) and globally (Middleton, 2013). Leicester University has implemented a four-year Master in Science Midwifery pre-registration programme, the first of its kind, which includes
a specific focus on leadership in clinical practice, education and research (MIDIRS, 2017).

The midwifery managers and midwives highlighted the potential to include structured direction on leadership and management development into the induction packs they provide for newly qualified midwives, as a mechanism to promote awareness and aid understanding of the system and the teams in which they plan to practice, echoing the NMC’s (2019) current approach. They emphasised the need to ensure that the development of leadership and management skills would be valued in the same way as clinical skills, as once gained they are transferable, and acquiring them widens the pathway for midwives to consider other roles within the NHS. They suggested that a requirement by the NMC for registrants to demonstrate an understanding of leadership, supported by the midwife demonstrating their contribution to the planning and delivery of maternity care, would go some way to ensuring this happens (Divall, 2015; NMC, 2019). The midwifery managers considered that such a requirement is achievable. They pointed to their own experiences of personal development and growth which assisted them in their career pathway; for example, working within commissioning, leading in governance, through which they acquired a range of transferable skills, built their networks and raised their profile in the Trust. They firmly believed that a structured career pathway which supports midwives to understand leadership and develop practical skills of management is necessary.

This need to prepare clinical midwives for these wider responsibilities echoes similar findings from the literature (West et al., 2015; Divall, 2015; Warwick, 2015). Given the global acknowledgement that midwifery leadership is critical to ensuring
improvements in women’s outcomes are achieved, it could be argued that the development of this type of approach is imperative (Rumsey and Homer, 2015; WHO, 2016; Renfrew et al., 2019). Ultimately this would also have the potential to raise the visibility and capability of midwives across the NHS, in the same way, that the medical profession has developed its leadership profile (Darzi, 2008; Miller and Clark, 2008).

As the midwifery managers reflected on their experiences of leadership development during interview, an unexpected topic emerged concerning a sense of loneliness and linked to intermittent feelings of isolation. The managers viewed this as a natural consequence of the transition from the clinical team to the management/leadership role, reflecting findings that this is part of the reason these roles are not attractive to clinicians (Storey and Holti, 2013; West et al., 2015; Divall, 2015). As identified in the LQF (2007), self-awareness and belief were reported as key. The managers refer to a range of individual strategies, including a determination not to take negative views from others as a personal judgement, and drawing on their networks as their means of coping. The problem was compounded by the pressure of time, which impacted on every aspect of their role. They reported having little or no time to be visible, to work with their teams to identify learning needs, to support learning or even to reflect and plan service development or innovation, the types of activities expected by midwives from effective leaders and managers.

This is a major tension for the midwifery managers and should be for organisations, given the identified links between poor outcomes for women and visibility of senior midwives (Healthcare Commission Review, 2008; NHS England, 2016). As evidenced in both the systematic review and the general literature senior midwives are frequently
reminded of their professional responsibility to explain to senior Trust colleagues the value to the safety of women, and the service, when they maintain their clinical credibility and visibility (Wing et al., 2004, Humphris et al., 2004; King’s Fund, 2011; West et al., 2015; Ross-Davie et al., 2016) and clinical evidence (Byrom and Downe, 2010; Divall, 2015). The RCM’s new leadership strategy offers a pathway to assist with this process (RCM, 2019).

When discussing their experiences of leadership and management development the participants identified a range of other issues which, whilst not highlighted in the literature, were significant to them. The issues which included the debate about the definition of the role itself and core aspects of their responsibilities, including managing people and managing budgets, generated a level of discussion which went to the heart of the role complexity and their views on the development needs required to deliver it.

5.4.2 Leadership or management

The midwifery managers who participated in this study were clear on their purpose, describing a multifaceted role as midwife, manager and leader. This understanding was shared by the majority of the midwives. Exploring the reasons for the attempts to segregate the different elements of the role; leadership from clinical leadership, leader from manager, manager from midwife, reflected the misperceptions which have existed for many years around the understanding of these senior clinical management roles and support the findings of others (Currie, 1998; Edmonstone and Western, 2002; Byrom and Downe, 2010; Fitzgerald et al., 2013; Divall, 2015). Others are equally clear that leadership and management are very different, explaining that the role of a
manager is to focus on performance and finance, while clinicians lead teams and concentrate on delivering care (Greengross et al., 1999; Rivett, 2018). In reality, the debate about leadership and management in the NHS has been fairly continuous since the introduction of general management (Hague, 1986; King’s Fund, 2011; Edwards, 2016).

When reflecting on the elements of their role during interview, it was interesting to note that the midwifery managers used softer language describing their leadership almost as intuitive, while management was described within a range of skills they had learnt. They spoke of leading people and managing services, with leadership linked to the ‘heart' and management to the ‘head'. Reflecting the evidence of others, as summarised by West et al. (2015), they perceived the leadership elements of their role to be centred in working with people, having a vision, communicating that vision, and inspiring teams to implement the required changes. The aspects of their role as managers were clearly defined, and associated with operational activities such as performance targets, financial and budgetary responsibility, investigating complaints, and HR processes, but inextricably linked to leading.

Focusing, therefore, on the concept of leadership alone, without reference or link to management is not helpful for midwives, as it has been acknowledged that both elements are integral in maternity services (Byrom and Downe, 2010; Divall, 2015). Authors such as the King’s Fund (2011) and Edwards (2016) have cautioned that to view them as separate is unhelpful and divisive, with Johnson (2012) and Warwick (2015) going further, suggesting that it may be detrimental to women’s care. Given the ongoing debate and numerous definitions since the seminal work of Bennis and Nanus
(1985), through to the findings of Burnes and By (2012), it is not an issue that will be easily resolved. For midwifery, the key issue of importance is to ensure that the preparation for a hybrid role as leaders and managers within maternity services is comprehensive and effective (Pashley, 1998a; Murray, 2007; Byrom and Downe, 2010; Fitzgerald et al., 2013; Divall, 2015).

5.4.3 People management

The challenge of people management was a recurrent subject on several levels. This was also an area where the participants in this study reported experiencing the greatest change during their careers, and for which they were ill-prepared. The midwifery managers described the tension between being approachable and visible to provide support and advice, which they viewed as key to the role, and being too accessible, which encroached on their limited time. At interview, they reported that there was an expectation that they [the managers] could solve all problems, in particular, personal issues, without wider appreciation or acknowledgement of the manager’s responsibility to put women and service provision first. Exploring this topic at interview highlighted a sense of frustration, with managers reporting a virtually impossible challenge trying to manage the competing priorities of the individuals, the team and their managers while keeping the focus on women. The managers regarded this as an aspect of the role where they struggled to assess their competence, as generally feedback was limited and therefore, they tended to rely on colleagues and line managers to keep them appraised of their performance.

In an environment where midwifery had been criticised for a culture of bullying (Gillen et al., 2004), leading to a high attrition rate from the profession (Curtis et al.,
2006), it is perhaps not surprising that the area of people management causes such levels of concern. The midwives in Curtis et al.’s (2006) study identified midwifery managers as mainly responsible for the majority of the bullying, whilst the managers themselves accepted that bullying was an issue, but alluded to a wider organisational culture and overly sensitive midwives as other influences. Nevertheless, the midwives in this study raised other points of concern and frustration in having to adjust their working patterns to the challenges of working with colleagues who they viewed as prioritising their personal time and family commitments over the needs of the team and women. This, in part, may explain why they cited the need for skills development to deal with people whom they described as having ‘difficult’ personalities. The rationale for some of these challenges would seem to be connected to midwifery as a woman-dominated profession (Donnison, 1988, Walsh 2006), especially when linked to career choice and development (Porter 1992; Behrend et al., 2007). The views of midwives and midwifery managers in this study concur with Divall’s (2015) position that human resource management is an area of expertise in which midwives need assistance and guidance, or risk being viewed by their teams as lacking integrity and credibility.

5.4.4 Finance and budget management

Finance and budget management was another area where the midwifery managers consistently reported feeling less in control due to limited development and experience. Exploring these views highlighted the conflict and concerns they had, particularly when viewed through the lens of professional accountability. The managers described the overwhelming impact that managing resources, especially finance, had on every aspect of how maternity services are run. This was also a theme
emerging from the midwives who participated in the focus group. They reported that
the level of development they received related to managing budgets and finance was
variable, and for some, not to a level required to effectively manage. The midwives
were clear in their expectation that midwifery managers should be making financial
decisions within the context of women’s safety, but had concerns this did not always
happen. The managers shared this concern as they reported on the struggle to meet
Trust targets linked to finance without impacting on the safety of women, and believed
there was little appreciation of this tension at Trust board level. It is ironic, therefore,
that one of the suggested reasons for the drive to empower clinical managers is to
improve the quality of care and safety of patients in the NHS in the face of a number
of damaging reports (Roebuck, 2011; Brodie, 2013; King’s Fund, 2015; NHS England,
2016). Alternatively, given the struggle described by the managers to manage the
service within the limited resources available, it is unlikely that given more power and
authority they will achieve financial balance, as it fails to address the underlying issue
of financial deficit (Rivett, 2018).

5.5 Culture

The participants described the role and culture of the organisations (Trusts) as core to
leadership and management development in numerous ways. The organisations set the
tone and environment in which they practise and they referred to the need to fit into
the organisational culture in order to progress in their careers. The midwifery managers
explained that wider organisational exposure and familiarity with management
language or processes were necessary to achieving visibility and credibility in that
arena, and therefore to have the opportunity to exert influence. They also described the
importance (and pressure) of meeting the expectations of the Trust in fulfilling the
function of their role. This was perceived to be a potential source of personal conflict, where the organisation has one view of a leader or manager whilst the manager aspires to have a different style. The midwives endorsed these views, referring to the culture of the organisation as key to accessing leadership and management programmes, the creation of learning opportunities and facilitating the implementation of learning into practice.

Although the perception was that organisations articulated a need to have individuals able to manage, it was reported by the participants that the lack of formal mechanisms was a barrier to achieving this outcome. There were consistent findings across participants that the reasons for this absence were complex, with the midwifery managers citing resource issues, including staffing levels and workload, precluding them from offering options for development as a regular event. Nevertheless, the midwifery managers accepted, that for individuals who have completed these programmes, there should be access to a system which ensured they are supported to consolidate and implement their learning.

The midwives agreed, but they highlighted the absence of any attempt to allocate them time away from their clinical role to put the learning into practice, reflecting similar findings from the literature (Woolnough and Faugier, 2002; Werrett et al., 2002; Hancock and Campbell, 2006). The midwives regarded this absence of support as a clear contradiction between not only the organisation but the NHS, in general, says it wants and what it is prepared to do to achieve it. The lack of ongoing work-based support in organisations was a recurring theme reported in the literature review as part of the reason why programmes have not achieved expected improvement, especially
in patients’ outcomes (Edmonstone and Western, 2002; Walia and Marks-Maran, 2014; West et al., 2015), or sustained performance, highlighted through a number of reviews (Darzi, 2008; King’s Fund, 2011). Conversely, the literature reports that when Trusts have support systems in place, their teams are more effective as leaders, and it demonstrates a real commitment to leadership development (Wing et al., 2004; Large et al., 2005).

These findings highlighted a consistent view that organisations were not clear about their expectation of the types of leadership they hoped would result from their investment in leadership and management development (Edmonstone and Western, 2002; Large et al., 2005; Philips and Byrne, 2013). The midwifery managers believed that they have the responsibility in their role within the organisation to be supportive and encourage staff development, and therefore should put systems and processes in place but, due to resource constraints, are unable to do so. Humphris et al., (2004) on the other hand argues that it is principally the organisation’s responsibility to ensure it has proper systems in place to support the managers. Given that the NHS has had a clear strategic vision for the development of effective leadership and management over many years and invested heavily in organisations to deliver this, there is little doubt the failure to address this gap is a conundrum. Nevertheless, there is a marked disparity between the rhetoric and the lived experience of the participants in this regard. The need for work-based support systems has been well documented, particularly by influential organisations, and yet no action has been taken to implement change (Hartley and Bennington, 2011; King’s Fund 2014; NHS Leadership Academy, 2014; NHS Leadership Academy, 2016).
The NHS (King’s Fund, 2012) has acknowledged, to some extent, these negative views, particularly in the political, media and public domains, and as discussed, has sought a new direction of leadership and management. They have built on the recommendations of others and proposed a shift in the culture from a general manager model to one which explicitly seeks to include and support clinical staff to take a place in the management and leadership of the system (Darzi, 2008; King’s Fund, 2011). This has resulted in the introduction of a new concept, collective leadership, refocusing organisations’ management systems from general management lead to one of partnership with clinical leaders to improve patient care and outcomes through their combined skills (King’s Fund, 2014).

The policy, however, remains silent on how this change will be achieved within the current organisations’ leadership and management structures and staffing levels. This is of concern given that according to the findings of this study and the available literature, many of the organisations within the NHS have to date, failed to systematically identify and provide tangible support for leadership development for clinical teams (Currie, 1998; Darzi, 2008; King’s Fund, 2012; Storey and Holti, 2013; West et al., 2015). This disparity comes into clear focus when considering the different experience of general management trainees who gain their NHS leadership and management expertise through a two-year full-time post-graduate programme including theory and supernumerary practice (Harrison and Pollitt, 1994; Greengross et al., 1999). Compare this to the time and academic level of those programmes provided for clinical teams. As highlighted in the literature review, the LEO programme for nurses, midwives and AHPs lasted 3 days (Werrett et al., 2002; Woolnough and Faugier, 2002; Cooper, 2003; Hancock and Campbell, 2006), while
the Nye Bevan programme for senior managers who have already gained considerable service experience, included 18 face to face teaching days and residential workshops delivered over a year (Robinson et al., 2016). It is not possible, therefore, for clinical teams to acquire anything like the level of knowledge and skills required, especially when they do not have operational management experience on which to build. Therefore, as Edwards (2016) suggests, this approach is highly unlikely to succeed.

Nevertheless, the message persists to clinicians, pre- and post-registration, including from regulators, that they are leaders, and places accountability on them, not just for their practice, but for wider service delivery. The policy documents, whilst recognising the different tension for clinical teams (King's Fund, 2012; King's Fund, 2015; NHS Improvement, 2019), fail to address these key barriers to change; most notably the culture of the organisations, the need to review the impact on the workforce and the identification of additional investment to support clinical professionals to undertake the requisite training and development. For clinical staff to maintain their skills would, as mentioned, require workforce adjustments to ensure an individual’s clinical practice is covered by others, whilst ensuring they have time to ensure day to day management work continues. There has been some recognition of this need, with a limited system in place to develop medical leadership and management (Mann et al., 2008). It could, however, be argued that this is reflective of the value the NHS has placed in the medical profession, but it now needs to be extended to embrace other clinical professionals (Ham, 2003; Darzi, 2008). As Hewison and Griffiths (2004) cautioned, the consequence of failing to transform the NHS’s views and perceptions of nurses and midwives may result in a continued lack of the type of clinical leadership sought. The slow progress for example, in implementing the recommendations of key policy
documents commissioned to improve nursing and midwifery profiles and impact, is evident (DOH, 2010; NHS England, 2016; DHSS, 2020).

There is also an absence of evidence of progress in achieving the new model of leadership and management, and therefore to substantiate whether the improvements predicted will be achieved, understandable given the short timeframe since the latest recommendations. Nevertheless, there is still an explicit determination across the system for the active inclusion of clinical staff in a shared leadership and management system, but an absence of any process which addresses the need to value and support clinical professionals to retain clinical skills and expertise (King’s Fund, 2012; Storey and Holti, 2013; West et al., 2015, RCM, 2019). For clinical staff to maintain their professional skills as required by their regulators, workforce adjustments would be necessary as mentioned earlier, to ensure individuals’ clinical practice is covered by others, whilst providing them with the opportunity to build day to day management expertise. There has been minimal recognition of this requirement, with a limited system in place to develop medical leadership and management as described by Mann et al., (2008), but this would need to be extended to embrace other professionals if the NHS is serious in its desire to achieve change. This is further complicated by a lack of knowledge on whether the focus on developing leaders and promoting the concept of leadership, will improve the management skills of individuals and achieve the performance targets required by the organisations within the NHS (Edmonstone and Western, 2002; Coggins, 2005; King’s Fund, 2011; NHS Improvement, 2016).

In this study, midwifery managers were clear they have a responsibility for succession planning and to ensure that midwives are prepared to engage in a competitive
recruitment environment, whilst acknowledging there will always be tension within the wider system for individuals who complete the required development but are unable to secure a post. Of the midwives in this study, for example, almost two-thirds had applied for new positions following completion of the programme, however less than half of these were successful. Another group of the midwives were clear that they would not consider career progression, citing a range of reasons including the desire to remain in clinical practice, highlighting the perception of management/leadership roles as removed or separated from the clinical field. This was despite being positive about the knowledge they gained from the programme. Notably, a number of the midwives had previously held management posts at grade 7 or above and preferred to relinquish them, reflecting the findings of others that these posts are not always attractive (King’s Fund, 2014; Edwards, 2016). The reasons reported included the challenges for women managing their family commitments, work-life balance, and a general view that the posts are not valued. As highlighted by a number of authors, it is not enough to invest in developing staff; there needs to be an understanding of these potential barriers and the wider organisational issues of culture and hierarchies need to be addressed if the expected result is to be achieved (Hewison and Griffiths, 2004; Miller and Clark 2008; Divall, 2015).

Realistically there is also a finite number of posts available given the size of the NHS in Northern Ireland, which is a significant constraint to midwives pursuing a career pathway in management and leadership. Whether or not the determination to improve the numbers of clinical professionals in management, as outlined by the King’s Fund (2012), will change this position is, as yet, unclear, but the reduction in management posts is not unique across the NHS, as highlighted by Robinson et al. (2016). It must
be acknowledged, however, that within NHS Scotland (2004) a more active approach to the development of clinical staff has been promoted, with associated investment particularly for midwifery, as reported by Ross-Davie et al., (2016).

One of the drivers for undertaking this study was the consistent identification of ineffective midwifery leadership and concerns about visibility (Healthcare Commission, 2008; Amess and Tyndale-Biscoe, 2014; NHS England, 2016; Kelly and Lee, 2017). In particular, inextricably linked to the culture of the NHS, has been the consistent reporting for over two decades of the absence of midwives at senior levels, despite recommendations that strong midwifery leadership should be central to women’s care (Pashley, 1998a; Healthcare Commission Review, 2008; O’Connell and Downe, 2009; NHS England, 2016, DHSS, 2020). The key organisation providing NHS leadership development programmes in Northern Ireland, for example, did not make any distinction between nurses and midwives. The systematic review of the literature identified only one programme developed for midwives (Ross-Davie et al., 2016), and while midwives may have participated in a number of the other programmes (Werrett et al., 2002; Woolnough and Faugier, 2002; Wing et al., 2004; Large et al., 2005), this highlights the lack of specific focus on midwifery, resulting in limited evidence overall.

This is particularly important for succession planning, given the reduction in midwifery management posts and flatter organisational structures following NHS restructuring (Heenan and Birrell, 2009) and also as outlined by the RCM (2019). In recognition of the ongoing pressures within the NHS in NI and the need for robust future planning, the Minister of Health established a nursing and midwifery taskforce
in 2018. The aim was to review the challenges for nurses and midwives delivering health and social services over the next fifteen years and make recommendations on how to make the best use of their knowledge, skills and expertise. The report was published by the Department of Health (DHSS) in March 2020 and was wide-ranging. Significant to this study was the finding of one workstream which reported issues of visibility of nurses and midwives in senior management positions and the lack of career and managerial opportunities for both professions. As a result, a recommendation has been made to develop a leadership framework for these two professions and identify investment in leadership development for each professional group, however, no implementation plan has been announced. Given the long-standing and explicit NHS policy and investment to engage and develop clinicians to lead and manage, action is required to ensure that the culture of the NHS recognises all clinical professionals. (Ham, 2003; Darzi, 2008; King’s Fund, 2011; King’s Fund, 2012; King’s Fund’s, 2014; NHS Leadership Academy, 2014).

5.6 **Characteristics of midwifery leaders**

The participants in this study described various characteristics associated with midwife leaders. These elements are explored below and include personal qualities, the line manager, and communication and networking.

5.6.1 **Personal qualities**

Personal qualities emerged as a consistent feature of the midwifery managers’ response when considering the suitability of individuals to be leaders and managers, drawing on their life observations and experiences. This was of particular interest, as of the three aspects of the LQF (2007), personal qualities were at the core (Appendix
1). The managers rated self-awareness as an essential characteristic as, in their view, it enabled individuals to have insight into their behaviour and its impact on others. In addition, this was linked to integrity, trustworthiness and being approachable, which were all regarded as necessary. Hand in hand with these attributes was the importance of understanding responsibility and professional accountability. These were perceived as integral to strong professional leadership associated with clinical credibility, in order to keep women safe and effect change. They commented on the need to be fearless, to be visionary and willing to take risks. The types of characteristics identified by the midwifery managers reflected the views and findings of others over many decades, both in general (Bennis and Nanus, 1985; Murray, 2007; Walker et al., 2011; Jordan, 2017), and specific to midwives (Pashley, 1998a; Pashley, 1998b; Byrom and Downe, 2010; Divall, 2015). Whether this range of characteristics can be developed, links into the much wider and historic debate regarding leader or manager, and whether characteristics are innate in the individuals or can be learnt (Bennis and Nanus, 1985; Hartley and Hinksman, 2003; Hartley and Benington, 2011; King’s Fund, 2014; King’s Fund, 2015).

Within the NHS, numerous other characteristics are recognised as equally significant, and need to be viewed within the context of whether the focus is on an individual or a team; the leadership style being promoted; organisational needs, and the complexity of the NHS (Hewison and Griffiths, 2004; King’s Fund, 2011; King’s Fund, 2015). It was an attempt to encapsulate these characteristics and style of ‘successful’ leaders which informed the development of the LQF (2007) (Storey and Holti, 2013), however, there was an absence of any direction as to how these could be assessed or achieved. This is not surprising given the lack of consensus between management
educators, with one school of thought that individuals need to have some basic personality traits on which to build leadership (Doh, 2017), as opposed to another school who believe the right support systems encourage leadership to develop (Daniels, 2015). This aspect of development has, however, not been completely ignored, as investment has been made in the use of self-assessment psychometric tools as part of a number of programmes included in the literature review (Humphris et al., 2004; Large et al., 2005; Walia and Marks-Marap, 2014), but with no evidence emerging of usefulness.

Nevertheless, the issue of who is motivated to aspire to progress as a leader and manager is heavily influenced by personal choice. In this study, a number of midwives indicated, for a range of reasons, that despite having been nominated to complete a leadership development programme they did not intend to pursue this career option. This does not mean they were not suitable for leadership/management roles but rather can be seen as a demonstration of their self-awareness. As indicated by the managers, it is better for individuals to carefully consider the reality of these posts and reject them, as opposed to accepting a post and subsequently struggle with the responsibilities.

In addition, resilience emerged from the online survey as an attribute that was highly valued by both groups of participants, for themselves and their teams. Reflecting on the experience of loneliness, the midwifery managers emphasised the importance of being able to cope with the demands of their role. In particular, they identified being resilient as a key characteristic, which if not present needs to be developed, echoing similar findings by Hunter and Warren (2014). Analysis of the data indicated that
within the midwife manager group those with more years of experience (21 years and over) value the attribute of resilience more than their colleagues (p = 0.041), and when comparing the responses of the combined groups (managers and midwives) those with under 30 years’ experience also considered it important (p=0.049). This resonates with the findings of Hunter and Warren (2014) in the first study of resilience in midwifery which identified it as a key feature in the ability of midwives to cope in difficult situations, particularly valued by those with over 15 years’ experience. Of note in this study, midwifery managers shared that although they valued resilience, the concept in relation to midwifery was of recent origin. Participants were clear, irrespective of the name given to the characteristic, midwives face challenges and pressures, whether clinical or managerial and need to have the ability to cope. There was a recognition that the ability to lead in difficult situations should be developed as part of leadership and management preparation. This position is supported by the work of Goleman (1995) who, studying a group of senior managers, reported that where they failed to understand the link between their negative behaviour and staff, the impact was poorer performance, attendance, decision making and morale.

In reviewing the literature in chapter two, reference to the development of skills in this area have begun to emerge, although without explanation as to why resilience has been included. Robinson et al. (2016) for example, reported improvements in resilience, linked to relationships and understanding of leadership, following completion of the Nye Bevan Programme. Similarly, the Intersect programme sought to improve leadership capability through developing emotional intelligence among other key elements, with Boyd et al. (2016) reporting increased levels in emotional intelligence amongst participants following completion. More importantly, there is
consensus in the literature that, as outlined in the LQF (2007), to be an effective leader individuals need to have a range of personal characteristics including self-awareness, self-belief and empathy, especially within the context of the challenges of people management which has been highlighted consistently (Byrom and Downe, 2010; Hartley and Benington, 2011; Divall, 2015). The question remains as to whether these characteristics can be developed, and if so, how.

5.6.2 The line manager
From within the wider ongoing organisational discourse, the role and character of the line manager emerged as crucial, particularly the need to be approachable. From the data in this study, it was widely acknowledged that they are highly influential, both in relation to talent spotting and encouraging midwives and as role models demonstrating the skills required to lead and manage. The majority of the midwifery managers in this study identified their own line managers or midwifery supervisors as having the most influence on their own leadership and management style. These were managers who had been instrumental in starting them on their career pathway or were currently supporting them to fulfil their role. The midwifery managers perceived their own role as key, acting as the gatekeeper to career progression, describing the importance of nurturing their teams. Within that context, they recognised that not everyone wanted, or should, pursue leadership and management development.

The midwives agreed with this position and reported that the initial decision about which midwives are nominated or encouraged to develop their leadership and management capabilities, was primarily made by their line managers. It was noted that the line managers were also essential to ensuring the provision of ongoing support,
replicating similar findings from the literature review (Currie, 1998; Philips and Byrne, 2013; Ross-Davie et al., 2016; Barton et al., 2017). Furthermore, the systematic review identified this as a particular feature of nursing and midwifery, linked to a recognition of their professional responsibility to ensure the development of the professions and succession planning (Wing et al., 2004; Humphris et al., 2004; Phillips and Byrne, 2013; Ross-Davie et al., 2016). However, other influential groups have also documented the significance of the line manager in talent spotting and developing their teams, stressing the need for this approach (King’s Fund; 2012; NHS Leadership Academy, 2014; NHS Leadership Academy, 2016). In addition, considering the descriptors outlined in the LQF (2007), developing people to deliver change is a core element of any line manager’s role.

As line managers, the ability to create learning opportunities within the workplace was reported as a constant challenge, but the managerial study participants agreed that, where possible, they tried to provide the time and space required for their teams to develop a range of skills necessary for a leadership-management role. This was endorsed by the midwives, who reported a variation of line management support, in keeping with similar findings from the literature (Leeson and Millar, 2013; Ross-Davie et al., 2016). Humphris et al. (2004), on the other hand, identified a divergence between line managers’ perceptions of their support and their staff’s lived experience.

Within this context, however, the managers suggested that part of the problem was the lack of understanding about the purpose and pressures of the leadership-management role, in particular, driving forward and delivering a vision for maternity services. Nevertheless, there was consistency in the list of skills the managers outlined as
essential and those reported as gaps by the midwives which encompassed all aspects of people management and service delivery. This was one area where the managers cited a possible future use of the LQF (2007) in breaking down the elements of their role to aid understanding of the scope and diversity they face.

In considering future need, and how midwives will be recruited, the midwifery managers remained convinced that taking the lead and identifying midwives early in their careers is a key function of their role as line managers, a view endorsed and promoted by NHS Improvement (2016). In this document, NHS Improvement (2016) recommends talent spotting as a mechanism to identify future managers. Furthermore, the managers considered this targeting as an opportunity to allow midwives to consider whether management and leadership was a career option they were suited to, but emphasized that the invitation must be open to all, to increase awareness and knowledge of the system. While Werrett et al. (2002) raised issues about this approach, stressing the importance of basing development plans on individuals’ identified learning needs, and ensuring commitment to ongoing organisational support, the managers’ views have merit.

In addition, when considering the characteristics of a leader, the midwifery managers in this study described a range of skills and features they deemed important, and which were supported by the literature (Werrett et al., 2002; Cooper, 2003; Wing et al., 2004; Humphris et al., 2004; Hancock and Campbell, 2006; Mann et al., 2008; Leeson and Millar, 2013; Ross-Davie et al., 2016). This included communication, teamworking, negotiation, problem-solving, managing expectations and conflict, which in their experience, midwives required. The absence of this range of skills being developed
through the existing programmes and the variable engagement of line managers in supporting and assessing participants highlights the fragmented approach which persists despite the continuing rhetoric on the need to develop clinical staff to become effective managers in the NHS (NHS Connecting for Health, 2011; King’s Fund, 2015; NHS Improvement, 2018), and despite the consistent identification of these issues over the last 20 years (Holman and Hall, 1996; Pashley, 1998a; Hartley and Hinksman, 2003; NHS Improvement, 2018).

5.6.3 Communication and networking

Communication emerged as crucial when exploring leadership and management development with the participants in this study, whether they were discussing development in general, the skills required to be a leader and manager, or a particular programme. At a basic level, they acknowledged that communication was key to how midwives engaged with women and colleagues, never mind acquiring knowledge on a range of issues including the theories of leadership, as well as insight into the NHS structures and processes. The managers explained, however, that to be a leader requires expert skills in communication in order to effectively share your vision to ensure the team’s support and engagement. Both groups of participants reported improvements in their own communication as one of the core outcomes of the leadership and management programmes. Exploring this theme with the midwifery managers during interview, being expert in communication was linked to those areas they deemed to be challenging, managing people and the day to day management of emails, through to producing business cases.
Networking was also identified by midwifery managers and midwives as inseparable from the theme of communication and was the most frequently cited benefit of the development programmes. The managers cited developing networks through secondment opportunities and involvement in projects, as providing a sense of connectivity outside their usual working areas. The midwives agreed that they had benefitted from engagement with colleagues outside the organisation through the programme and when involved in projects these also contributed to the formation of networks to draw on later. The discussion about changes in the level of communication skill the managers and midwives reported was interesting, as these self-reported changes were accepted, but with no evidence as to how this was demonstrated. These findings included an acknowledgement that listening skills are equally important and a skill they used throughout their clinical career. Notably, when reflecting on whether any skills or attributes were missing from the LQF (2007), the participants identified communication, listening and networking all as omissions.

Development of communication skills and networking were equally cited as positive outcomes of leadership and management programmes in the literature, particularly when managing people and conflict, although detail was lacking on how this was measured (Werrett et al., 2002; Woolnough and Faugier, 2002; Cooper, 2003; Wing et al., 2004; Large et al., 2005; Hancock and Campbell, 2006). Further evidence of similar confusion about language and descriptors was expressed by the participants in this study around the definitions of skills and attributes, with a number of participants in these studies considering improvements in communication and networking as elements of personal skills development (Werrett et al., 2002; Cooper, 2003; Wing et al., 2004; Humphris et al., 2004; Hancock and Campbell, 2006; Mann et al., 2008;
Leeson and Millar, 2013; Ross-Davie et al., 2016). In one study the skill of listening was specifically reported as improved, but no details of how this was measured were provided (Leeson and Millar, 2013).

When reviewing service delivery and patient outcomes strong leadership with a focus on communication skills has been mentioned as a means to achieve and sustain improvements supporting the view of the midwifery managers (Humphris et al., 2004; Darzi, 2008). While others have highlighted that skills of communication are also an indication of leadership style (Roebuck, 2011; Divall, 2015). The challenge is to understand what aspects of communication can be further developed and how, as the literature is silent on core aspects necessary for the leadership/management role, for example, developing writing skills for business cases, complaint responses or briefing papers. Training for managing public relations exercises such as participating in a media interview is equally relevant. Within the NHS numerous other characteristics are also recognised as equally significant, and these need to be viewed together and included in the development of leadership and management (Hewison and Griffiths, 2004; King’s Fund, 2011; West et al., 2015).

5.7 Relevance of the NHS Leadership Qualities Framework (2007).

A key strand of this study was to understand how valuable the NHS LQF (2007) was to the study participants, considering the level of importance it has acquired within the NHS in Northern Ireland. It was introduced as the main tool to guide the appointment of clinical and non-clinical managers who would drive forward the major organisational change and reform agenda in Northern Ireland, as discussed in chapter one. Applicants were required to demonstrate to the interview panels how they met
the skills and attributes outlined in the framework, which covered the areas of leadership, management and personal qualities. All the midwifery managers confirmed that until the RPA recruitment process, they were unaware of the framework. Since then, several of them have used it but none had formal training in its use.

Reviewing the range of skills and attributes contained within the framework, the midwifery managers rated them as being of some level of importance, demonstrating consistency in their responses. In exploring their views at interview, it was clear however, the framework remained irrelevant to their day to day role. In reality, it has continued to be a tool they use to either prepare themselves or others for interview. The midwifery managers also identified a concern that the absence of a means to assess themselves, or others, against the three key elements of the framework further limited its usefulness. When the online survey assessment of the core elements was assigned to either leadership or management skills in order to provide greater scrutiny, it was evident that the midwifery managers placed a consistent degree of importance on midwives’ need to develop management skills (table 4.3), demonstrating a less determined view about leadership skills, as identified in the LQF (2007) (table 4.4).

Despite having completed a leadership/management development programme, only one-third of midwives who responded to the survey were aware of the framework, and of these midwives, the main reason was again related to its use as a tool to guide interview preparation. They explained that they found the framework, and the terms used as unhelpful. Responses from both groups of participants demonstrated confusion around the meaning of attributes and skills; for example, self-awareness was defined as an attribute in the framework but reported as a skill, similarly the attribute of
integrity. Both groups of participants expressed the view that the language and descriptors used were unfamiliar and difficult to relate to practice, a view supported by others with expertise in leadership development and communication (Farrington, 2011; Storey and Holti, 2013).

There is limited reference to frameworks in general, and the LQF (2007), in particular, in the literature reviewed. However, considering that the LQF was published in 2007 it is understandable that it did not have a profile across the period under review. There was, however, a limited inclusion of elements of the LQF (2007) to either inform programme development or as an aspect of evaluation, but not as a guide to identifying personal learning needs (Philips and Byrne, 2013; Walia and Marks-Marar, 2014; Mann et al., 2008). It is unclear why this may be the case, but perhaps the answer is, as suggested by the participants of this study, that the language used in the framework is unfamiliar and never used by them on a daily basis. This reflects a comment made by Farrington (2011) who explored communication in the NHS and has drawn attention to the confusion around language, including definitions and terms used which he referred to as ‘jargon’, and linked it to negative impacts on patients;

"In extremis, jargon can be interpreted as an integral part of an excessively managerial culture within the NHS – a culture that has not only failed to improve productivity despite massively increased levels of investment, but has contributed to widespread and serious neglect of patients' needs." (Farrington, 2011, p.233).

Nevertheless, both midwifery managers and midwives acknowledged that it was important if they expect to be accepted within management circles, that they should
use the appropriate language. In the managers’ view, this was no different from the need to use clinical language when discussing a clinical problem, reflecting similar views expressed by Divall (2015).

As a result of the continuing drive to improve leadership, the NHS Institute for Innovation & Improvement commissioned research to develop a new competency-based leadership model for the NHS in 2003. The LQF (2007) framework resulted and was recommended as part of the mechanism to prepare those aspiring to become senior directors and chief executives in the NHS (NHS Institute for Innovation & Improvement, 2003; Storey and Holti, 2013).

The promotion of frameworks has continued despite concerns about their usefulness. Bolden et al. (2003), in a review of leadership theory and competency frameworks, queried the generic application of the LQF (2007) across all grades of leaders and managers, especially as no account was taken of differing roles, responsibilities, and experiences. West et al., (2015), in a review commissioned into leadership development by the King’s Fund, also found no evidence of improvements in patient care as a result of their use. Regardless of these views and reports, frameworks continue to be recommended as a tool to support development in leadership (NHS Leadership Academy, 2014; O’Neill, 2017). Of the papers reviewed in chapter two, there was limited inclusion of frameworks and their usefulness (Mann et al. 2008; Walia and Marks-Marlan, 2014). Nevertheless, as the NHS seeks a new model of leadership (King’s Fund, 2011; King’s Fund, 2014) the key elements and characteristics presented in the NHS Leadership Qualities Framework (2007) have not
changed, and continue to influence the structure and content of programmes (Storey and Holti, 2013; NHS Improvement, 2019).

So, while the leadership framework may have many champions, it is clear that it’s translation to practice continues to be challenging, and in the absence of robust evidence to support its effectiveness, it is uncertain how beneficial it may be, particularly to those in first-line and middle management posts (Roebuck, 2011; West et al., 2015). From the data obtained in this study, it was clear that the LQF (2007) was not integrated into the leadership and management role or development, and was referred to in a tokenistic way. However, participants identified the lack of professionalism as an element of the LQF, which may explain the lack of meaningful engagement with it as a framework.

The issue of professional identity permeated throughout the study. It was the strongly held position of the midwifery managers that they were first and foremost midwives, accountable for their practice, with the overwhelming majority perceiving their role as leaders managing maternity services echoing the findings of others (Byrom and Downe, 2010; Divall, 2015). By management, they described a range of practical skills and tools to ensure they were able to deliver the vision for women and maternity services. From the perspective of all the participants' leadership, management, and professional integrity are inextricably linked for midwives. Although the importance of engaging with and being able to function within the wider system was recognised as essential to progress services.
The rationale for this position was grounded in the view that it is critical for women, the maternity service, and the profession, that a midwife should hold the lead management role, as recommended in a number of reports (Healthcare Commission Review, 2008; DHSS, 2020). This was based on their understanding of maternity services which aim to support women to experience normal physiological pregnancy and birth, led by midwives with medical interventions only when indicated, and the importance of a strong professional leader displaying and inspiring confidence, in order to deliver innovation and change responsive to the women’s needs.

The midwives fully endorsed the midwifery managers’ position. They equally viewed leadership and management as integral and agreed with the midwifery managers’ views on the importance of maintaining clinical credibility and midwifery identity. The midwives’ perspective included the use of words such as integrity, credibility and visibility, aligning professional behaviours with inspiring confidence and assurance when elaborating on their answers. In addition, they aligned these characteristics and values with ensuring safe standards of service and care centred on women, supporting the position that it was essential to be managed and led by leaders in whom there is confidence, trust and support.

Both groups were strongly of the view that maintaining clinical expertise was a key element in leadership and management for a number of reasons; it supported decision making, an understanding of the clinical situation and pressures, and an ability to provide advice and guidance to the midwives. As identified in the literature, the visibility of the midwifery manager in the clinical area is a core element to confidence-building in the team (Byrom and Downe, 2010; Divall, 2015).
It was not surprising, therefore, that the absence of professionalism from the list of attributes contained in the LQF (2007) was viewed negatively by the participants. This was deemed a reflection of their struggle to understand the function of the framework, as they also queried the generic approach to leadership development, arguing that it was inappropriate and was limited in meeting their needs. This conflict was also recognised in the literature, with the suggestion that there needs to be greater clarity between the development needs of general, and clinical, professional managers (Currie, 1998; Edmonstone and Western, 2002; GVA & Outcomes UK, 2011; Philips and Byrne, 2013; Ross-Davie et al., 2016). However, the midwife managers and midwives acknowledged that in reality, there were wider aspects of the role which they also required, particularly if they are to take their place in the collaborative leadership model suggested for the future, a point reinforced in the literature review (GVA and Outcomes, 2011; Philips and Byrne, 2013; Leeson and Millar, 2013).

There was a recognition among the midwife managers that while they did eventually acquire the skills needed to lead, there continues to be a lack of understanding of the multi-faceted nature of their role, by general manager colleagues. There was a level of acceptance that as a midwife in this type of role, there was an inevitable tension between maintaining professional standards and meeting an organisation’s expectations which they believe will continue until there is clarity and understanding of their role. Within the literature review in chapter two, the explicit tension between leadership development, responsibility, and accountability as a regulated professional was also recognised (Currie, 1998; Edmonstone and Western, 2002; GVA & Outcomes UK, 2011; Ross-Davie et al., 2016). Fitzgerald et al. (2013), exploring the nature of leadership in the NHS, concluded that clinical leadership roles should be
viewed as hybrids because of the need to have both clinical expertise and leadership and management skills.

Although not using the term hybrid, the midwifery literature has described this position over many years, seeking to provide a degree of understanding about the differences between maternity care and acute services in the NHS (Pashley, 1998a; Murray, 2007; Byrom and Downe, 2010; Divall, 2015). While the system has acknowledged this need in the commissioned report Midwifery 2020 (Department of Health, 2010), with an explicit requirement for the development of clear pathways and leadership development for midwives, the absence of an action plan and financial investment is further evidence of a system which lacks understanding. The failure of this message to have been acted on, however, may well be linked to the continued failure for the voices of women to be heard at the highest levels within Trusts (NHS England, 2016).

Nevertheless, there may be an indication of change, with the influential King’s Fund calling for additional support for clinicians in leadership roles (King’s Fund, 2014). In Scotland for example, the Department of Health has funded the development and implementation of leadership for midwives (Ross-Davie et al., 2016). A recently published report in NI into the challenges facing nurses and midwives in the future (DHSS, 2020) reported issues of lack of visibility of nurses and midwives in senior management positions and the lack of career and managerial opportunities for both professions across the NHS. The RCM has taken the initiative and built on the findings from midwifery research to develop a suite of programmes tailored to the needs of all grades of staff within midwifery; from maternity support workers to Heads of Midwifery (Divall, 2015; Ross-Davie et al., 2016; RCM, 2019). As with other new
initiatives in the NHS the evidence of acceptance will be the development of an action plan and the level of funding released by the NHS to secure places for their teams, and the ability of the service to release them. Notably, the Chief Nursing Officer in Northern Ireland has already taken action and commissioned the delivery of the RCM leadership programme for senior midwives from across all aspects of the profession (personal communication).

5.8 Study limitations

The professional-managerial role of the researcher was both a strength and a weakness of this study. The subject is one which has been a lived experience, and although now a retired midwife and no longer in a position of authority or influence, nevertheless, the potential for research bias is acknowledged. Measures were taken to overcome this limitation, as described in Chapter 3, and the relationship with participants was carefully marshalled to ensure the voices of the participants were heard, recorded, and analysed accurately.

A strength of this study was that it focused on an aspect of a subject which, while widely researched and evaluated, has been addressed in a very limited way, with specific reference to midwifery. The review of the literature confirmed this position, highlighting the gaps in the effectiveness of leadership and development programmes, particularly in relation to midwifery. This study has sought to address that gap, by exploring the perspectives of both midwifery managers and midwives in identifying what it is that midwives need to do to prepare and be successful as leaders. Within that journey exploring the purpose and position of the NHS LQF (2007) was a key element.
The results provide insight and a greater understanding of the experience of midwives of leadership and management within maternity services in Northern Ireland.

Due to the part-time status of the researcher, the timeframe for completing the study was extended. This extended timeframe was used to support the researcher to take up other opportunities, including voluntary work supporting midwifery services in Uganda to develop a standard for mentorship and aspects of leadership (Kemp et al., 2018), and to lead a European Union project on mentoring for nurses and midwives in Croatia (Bannon and Matijašić-Bodalec, 2021). During the European Union project, there was an opportunity to observe the challenges in leadership experienced by midwives working within a hospital-based, medically led system, and where there were no mechanisms for women’s voices to be heard. The researcher also participated in the development and delivery of a midwifery leadership programme for newly qualified midwives in Bangladesh, where midwifery has been re-introduced as a separate profession. While extending the timeframe of the study may be perceived as a limitation, these opportunities have further informed the researcher’s thinking on the leadership and management development midwives need to have, to ensure they can function effectively in the many-faceted health system within which they work.

A further limitation was that the sample size of the survey was small, due to the difficulty in identifying midwives who had completed nursing and midwifery development programmes. The HSC Leadership Centre did not differentiate between nurses and midwives, and figures were not available for the RCM leadership course. The role of the RCM as gatekeeper assured as wide a pool of midwives as possible were included, although there may be some midwives who are not members of the
organisation and therefore will have been missed. The relatively small sample of midwives who did participate may be perceived as limiting the findings, however, it is comparable to response rates from other professional groups (Morris et al., 2001; Hill, 2006). Nevertheless, the survey provided a valuable standardised response to participants’ experiences and provided a breadth of information that complemented the more in-depth information from the focus groups and interviews. Focus group attendance was smaller than expected, although a recognised limitation of this process (Rees, 2003; Silverman, 2010).

5.9 Implications for future research

This study set out to explore the perspective of current midwifery managers and potential managers, in relation to leadership and development in Northern Ireland. The study identified many positive aspects concerning preparation for leadership, but also highlighted a number of aspects which would benefit from further research. The literature review in chapter two highlighted diversity in definitions of leadership, while Ross-Davie et al. (2016) was the only study to describe the use of training needs analysis to inform programme content. This position goes some way to explain the inconsistent approaches to achieving and measuring programme outcomes. The evaluations lacked robustness, with an absence of standardised measurement, and no evidence of consideration of the individual’s leadership and management journey and variation in their professional background.

The NHS has strongly supported the inclusion of clinicians into leadership and management, particularly over the last ten years (DHSS, 2010; King’s Fund, 2011; King’s Fund 2014), and has invested heavily in their development. Further research is
required into the uptake of educational programmes, and by which professionals. This is of particular importance to ensuring that all professional groups are reflected in the profile of managers and leaders within Trusts, and the diversity of services represented, to reduce the likelihood of poor outcomes, as described by Francis (2013) and Kirkup (2015).

Equally, workforce planning was identified as a barrier to change, and this needs to be reviewed and adjusted to take account of the need to support work-based opportunities for both clinical and leadership development. There is an acknowledged complexity in attempting to measure impact on participants who have completed leadership and management development programmes, in terms of both their individual uniqueness and movement around the NHS (Humphries et al., 2004; Large et al., 2005). Key to this process is the need for rigorous baseline assessment and the development of an individualised action plan, with timelines and assessment features to demonstrate progress, as described by O’Neill (2017). As identified in the literature review, design of the evaluation needs to be robust, using objective, standardised, measurement tools and should be undertaken both in the immediate post-programme period and at set points in the future, to assess sustainability. The design should also include a qualitative component to ensure the evaluation is approached from a holistic perspective.

In the longer term, it will be essential to examine the impact of leadership development in the NHS, following the introduction of specific education for undergraduate midwifery students as proposed by the NMC (2019), and the implementation of initiatives such as the programme as described by Buckwell-Nutt et al. (2014). The
study findings have identified a range of benefits for midwives in completing leadership and management development, but the opportunities to attend are limited with no clear process of recruitment. The emphasis on raising the profile of leadership and management at undergraduate level can only benefit the profession, but post-registration needs to build systematically on this, with structured career pathways. This is not to say all midwives will be motivated to transition from a clinical role to a management role, but rather skills of leadership are relevant for all those who practice, as described by the NMC (2019). Individuals who achieve leadership/management positions often had not obtained appropriate development and lacked organisational support to adjust to the new role, therefore the implementation of ongoing development post registration will be key.

There is also a need for systematically reviewing and reporting on progress in implementing recommendations from key policy documents, in particular those linked to leadership and management development of clinical professionals, such as the recent nursing and midwifery review (DHSS, 2020). Given the role of organisations and culture in developing staff, as identified in the systematic review of the literature, they must be integral to these reviews to ensure system change and improved visibility is secured, recognising that this is a shared journey.

5.10 Recommendations

It was evident from this study that midwives were expected to transition very quickly to leadership and management roles, with variable levels of support. To ensure that women are to receive quality services which are safe and effective, midwives need to be adequately prepared before undertaking a leadership role. The decision of the NMC
(2019) to consolidate leadership development into undergraduate midwifery programmes creates an opportunity for the profession to build on this knowledge base and to strengthen postgraduate programmes. It is recognised that ‘learning on the job’ is an important aspect which needs to be extended and formalised to encourage sustainability, resilience and excellence in midwifery leadership. As a result of the findings of this thesis, there are a number of recommendations outlined below:

- Collaborative working between programme developers and experienced clinicians to develop leadership programmes based on evidence and best practice, with robust evaluations where possible.

- Leadership and management development programmes need to acknowledge the difference between general and hybrid management models, using agreed definitions on leadership and management and contain clear objectives and measurable outcomes.

- Educational providers or HSCT’s should maintain a database on the uptake of programmes by individual professional groups to ensure future evaluations can be conducted which are profession-specific, providing assurance that no profession or gender is disproportionately represented.

- Build on personal work with the RCM to ensure the findings of this study are shared across professional and management networks to highlight the importance of early and sustained development in the identified practical skills required to supplement undergraduate and postgraduate programmes, including the importance of the need to maintain clinical credibility.

- Nominate midwives to complete a profession-specific leadership development programme which will allow them to develop the range of knowledge, skills
and networks necessary to understand the unique aspects of maternity services in Northern Ireland.

- Advocate for evaluation of midwifery leadership programmes. If provided at country level, there would be greater potential for integrating robust evaluations as it could be designed as part of the programme and encourage dissemination of findings to add to the evidence base.

5.11 Conclusion

The focus of this thesis was to explore the experience of midwifery managers and midwives in Northern Ireland of their leadership and management journey and to identify the perceived skills required to lead and manage maternity services. The findings have provided insight into their experiences and identified areas for future leadership and management development which, if addressed, have the potential to strengthen midwives' skills and abilities in this area. The systematic review in chapter two highlighted a lack of objective evidence in relation to the effectiveness of NHS leadership development programmes, which was mainly due to the design and reporting of evaluations. Despite this, the majority of studies reported positive experiences and enhanced personal development from participants. The literature review reinforced the lack of visibility of midwifery as a separate profession due to the continued practice of the term ‘nurses’ being used as an overarching descriptor for both professional groups.

The role of culture and organisations were identified in the systematic review, and in this study, to have a significant role in ensuring that systems were put in place to support the translation of learning to practice. The development of robust,
individualised training needs analysis tools is required, to provide baselines against which training progress can be measured. Creative and innovative approaches to developing individuals to acquire the range of practical skills needed for effective leadership and management roles, need to be supported by the allocation of resources. The recent nursing and midwifery review (DHSS, 2020) identified the need for sustained leadership development, however considering the findings of this study, it will be important to integrate appropriate evaluations in order to evidence impact on the provision of healthcare.

This study has demonstrated that the approach to leadership and management development is not optimal, limiting the value for midwives and the wider midwifery profession. Changes to the existing approaches are essential to enable all midwives to embrace and develop leadership skills. Midwives who progress to managerial roles need to have appropriate preparation to ensure they can adequately represent the voices of women and ensure the development of maternity services at the most senior levels within the NHS.
“It always seems impossible until it’s done”

(Nelson Mandela 1918 – 2013)
last accessed online 29 May 2019


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Appendices
The NHS Institute of Innovation and Improvement (2007) have developed a framework which identifies the desirable core skills and attributes of senior NHS leaders/managers as outlined below. The skills within the framework are themed into two areas, one relating to setting strategic direction and the other focuses on the operational aspect of the service. These include:

Seizing the future, intellectual flexibility, broad scanning, political astuteness, drive for results, collaborative working, effective and strategic influencing, empowering others, holding to account and leading change through people.

The personal attributes required are identified as self-belief, self-awareness, self-management, drive for improvement and personal integrity and are central to the model.
### MeSH terms

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<th>Outcomes</th>
<th>Coaching</th>
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<td>self-belief, self-awareness, self-management</td>
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## Summary of Eligible Studies

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<th>Authors, (Publication Year), Location</th>
<th>Purpose</th>
<th>Design, sample and theoretical frameworks</th>
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<th>Strengths/ Limitations</th>
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<tr>
<td>Werret \textit{et al.} (2002), England</td>
<td>An evaluation of the first phase of the \textit{Leading as Empowered Organisation} (LEO) Leadership programme to identify changes in practice. (1st of 4 papers reviewing the LEO programme)</td>
<td>Mixed methods pre and post-test survey collecting quantitative &amp; qualitative data. August 2001 to February 2002. 4184 (Nurses, midwives and health visitors &amp; AHP) invited to participate: 1050 accepted.</td>
<td>Leading an Empowered Organisation (LEO) programme. 3 days</td>
<td>350/1050 completed pre-test questionnaire with 522 completing all questions. 388/550 had completed some form of management training prior to LEO. 181/550 completed post-test questionnaire with 174 completing all questions. Post-test significant difference identified in all areas, following attendance at LEO where p&lt;0.05.</td>
<td><strong>Strengths</strong> Size and diversity of group. The reliability of the questionnaire was determined by comparing the characteristics, pre and post data. A coefficient alpha of 0.97 confirmed the reliability of the questionnaire. <strong>Limitations</strong> Response rate for pre-test. Short timescale post programme 3 months to determine sustained impact. Over 50% loss to follow up.</td>
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1. *The Mixed methods appraisal tool (MMAT) (2011)* presents 2 screening questions for all types of studies and specific criteria for each of the 5 categories of study: qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies and mixed methods. Based on the percentage of criteria identified within the specific category (4 criteria per category) a score for each study may be determined, for example a score of 25% out of 100% may suggest a weak design whilst 100% would be attributed to a strong design. For mixed methods the score allocated cannot be greater than the weakest component of the design.

2. **The Scottish Intercollegiate Guidelines Network (SIGN 2015) guidelines** was identified for use to assess any quantitative studies, this tool describes eight levels of evidence with level 1 ++ representing the highest quality of evidence to level 4 allocated for evidence based on expert opinion.
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<tr>
<td>Cooper (2003), England</td>
<td>To evaluate the outcomes from the NHS leadership development programme: Leading an Empowered Organisation (LEO). (2nd of 4 papers reviewing the LEO programme)</td>
<td>Mixed methods prospective case study in 2001 examining pre and post programme leadership skills. Pre and post course quantitative analysis with interpretative methodological support based on an illuminative evaluation model. Pre and post programme questionnaires sent to 21 nurse leaders participating in the programme and invited for interview 3-4 months post completion of programme. 77 team members/colleagues (randomly selected) invited to complete pre and post programme questionnaires.</td>
<td>Leading an Empowered Organisation (LEO) programme 3 days</td>
<td>71% (15/21) participated in an interview and post course questionnaire. Statistically significant improvement in the 15 participants leadership performance (self-reported) p=0.016. Leadership attributes identified from interviews: • Communication • Feedback • Flexibility • Problem solving • Sharing the vision 49% (38/77) of managers and colleagues completed the pre-training questionnaire. 39% (30/77) completed the post training questionnaire Peers reported improvement in their leaders in two areas which were statistically significant – maintaining organisational objectives (p = 0.044) and presenting challenging opportunities (p=0.015). Concluded that changes are needed to the programme such as the provision of pre-course material, the inclusion of role play and the development of a post course mentorship support.</td>
<td>Strengths: Detailed analysis. Inclusion of team members and line managers’ perspective. Limitations: Lack of information on the type of previous management experience. Limited ability to generalise findings.</td>
<td>50% / 2 <strong>SIGN</strong></td>
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<td>Woolnough &amp; Faugier (2002), England</td>
<td>A preliminary study to accumulate evidence regarding the impact of the LEO programme. (3rd of 4 papers reviewing the LEO programme)</td>
<td>Qualitative study using semi-structured telephone interviews. 109 individuals out of a larger cohort (nurses and AHPs) who completed LEO and who responded to an invitation sent to all participants (total numbers not known) to be part of a 6 month follow-up (January 2002).</td>
<td>Leading an Empowered Organisation (LEO) programme. Develop a personal action</td>
<td>73/109 reported that they benefited from the LEO programme as their leadership skills improved, while 26/109 reported no improvement and rated the programme poor. 36/109 did not complete the personal action plan exercises while others reported that they had not referred to it since completing the programme. Concluded that organisations need to provide more support to ensure sustainability of improvements and engagement with clinical staff.</td>
<td>Strengths: Large number for telephone interviews. Limitations: No demographic information for this cohort. Response to career development excluded AHPs. Other figures presented included AHPs.</td>
<td>50%</td>
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<td>Hancock &amp; Campbell (2006), England</td>
<td>To evaluate the impact of the Leading an Empowered Organisation (LEO) programme on the role of grade G nurses and their colleagues in one Trust. (4th of 4 papers reviewing the LEO programme)</td>
<td>Qualitative research using interviews and 360° research evaluation approach. A purposive sample of 4 grade G nurses and each nominated 8 colleagues (sample of 36). Following analysis of the first set of data collected G grades interviewed (4).</td>
<td>Leading an Empowered Organisation (LEO) programme 3-day course (on site)</td>
<td>The authors reported that the LEO programme positively impacted on the G grades approach to their role: 1. implementation of principles of LEO dependent on individual’s characteristics 2. problem solving skills and communication 3. management and leadership styles. Barriers to applying the LEO values was impacted by the culture in the organisation.</td>
<td>Strengths: Attempt to triangulate findings. Small sample of programme participants (n=2). Limitations: Lack of demographic details on sample in order determine generalisation of the results. Impact reported by colleagues was by nominated individuals. No information on timescale between completion of programme and data collection.</td>
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<td><strong>Wing et al. (2004)</strong> England</td>
<td>An evaluation of the RCN clinical leadership programme.</td>
<td>Mixed methods evaluation based on Pre and 1-year post programme design. 12 clinical leaders (11 nurses and 1 AHP) nominated to complete the programme by managers. 360° reviews. Taped stories based on a semi-structured questionnaire and one to one informal interview.</td>
<td>RCN clinical leadership programme 1 day a week for a year with workshops and action learning sets Plan a team building event</td>
<td>Reported changes in leadership style, confidence and communication. 12/12 reported improved awareness of behaviours and attitudes in their team members. Changes also in leadership styles, influence within their organisation and improved communications reported. The author concluded that although a number of changes had taken place, they may not relate to the RCN programme.</td>
<td>Strengths: Descriptive narrative on impact and outcomes. Limitations: Reporting of data limited with lack of detail on all data collection elements.</td>
<td>50% / <strong>2</strong></td>
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<tr>
<td><strong>Large et al. (2005) England</strong></td>
<td>To establish how key stakeholders perceived the effectiveness and acceptability of Phase 3 of the RCN Clinical Leadership Programme (CLP).</td>
<td>A multiple-case study approach using mixed methods evaluation. 80 English NHS Trusts taking part in the programme. 360° leadership inventory pre and post to a randomly selected sample of clinical leaders (n=267). Purposively sample of 16 clinical nurse leaders’ case studies from 16 Trusts, 30 colleagues interviewed twice and in addition 267 clinical leaders from the other 64 sites to complete 360° leadership inventory. (Nurses, midwives and AHPs) 96 related stakeholders - series of qualitative interviews with key stakeholders (143).</td>
<td>The Royal College of Nursing (RCN) Clinical Leadership Programme (CLP) 12 clinical leaders supported by a clinical facilitator over 12 months in work environment. Development of personal learning plan.</td>
<td>360° leadership inventory 57% (154/267) responded from 80 Trusts excluding 16 targeted sites. 360° leadership inventory specifically for 16 sites - 42% (91/215) responded and 57% (154/267) from the other 64 Trusts. Colleague interviews 53% (16/30) at midpoint and 46% (14/30) final interview. Clinical leaders reported positive changes in their leadership capabilities supported by the triangulation data from the case study sites. Clinical leaders reported improvement to the provision of patient care and increasing team effectiveness.</td>
<td>Strengths: Methodology well presented with triangulation of findings including patient input. Sample reflecting all clinical area. Limitations: All the researchers were part of the CLP whose objectivity may be compromised. The original sample of 16 clinical leaders changed throughout the programme. Lack of clarity relating to the statistically denominators used for some</td>
<td>75% / <strong>2</strong></td>
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<td>Phillips &amp; Byrne (2013), England</td>
<td>To report on a leadership programme for ward managers in an NHS Trust.</td>
<td>Qualitative approach utilising anonymous postal questionnaire on action learning set and module evaluation. Cohort of 24 ward sisters (medical, surgical and paediatric nurses).</td>
<td>Tailored programme for ward managers (4 modules x 2 days) Action learning set</td>
<td>The authors presented a minimal level of data. 22/24 completed the programme, comments from evaluation of the taught element cited improved awareness of contribution of their role in the organisation, greater awareness of teams as a resource, improvement in intervention styles. 21/24 presented the work-based project. 12/24 responded to postal questionnaire and all evaluated the learning sets positively. Further longitudinal studies are needed and leadership development needs to be extended to other groups within the organisation.</td>
<td>Strengths: Explanation Clear rationale provided Limitations: Reporting of data limited with lack of detail especially on the taught element.</td>
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Qualitative papers: Bespoke programme for Nurses

28 patients identified for interview to ascertain their observation of clinical leadership. Data collection from April 2001 to December 2002.

Patient response: 57% (15/26) first interview, 30% (8/26) midpoint and 11% (3/26) final interviews. An incidental finding related to the variation in the amount of time participants spent on programme related activities. The conceptual framework of the CLP was recommended as one method of supporting leadership development. Aspects of the analysis dealing with the subgroup. Cost analysis not achieved.
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<tr>
<td>Ross-Davie et al. (2016) Scotland</td>
<td>An evaluation of the development, implementation and impact of a midwifery leadership development programme.</td>
<td>A mixed methods longitudinal evaluation from 2012 to 2016 examining changes in leadership capacity utilizing Kirkpatrick’s framework (1994). 166 midwives (all grades and both clinical and education represented) from across Scotland volunteered or were allocated a place and 12 children’s nurses for the last 2 programmes. 62% of the participants volunteered for the programme the remainder were nominated by their manager. Post course online questionnaire sent to participants, HoMs and in 2015 and 2016 to previous participants Annual written evaluations Analysis of project posters and reports In-depth interviews with stakeholders, participants, past participants and project implementation staff (n=12) Data collection from 2012 to 2016.</td>
<td>Midwifery Leadership programme (2012-14) evolved into the ‘Best Start Leadership Programme’ (2014-16) (Programme duration 7 months) 2 education and networking days Pre-course questionnaire and worksheets Community of practice website Quality improvement (individual or team) 3-5 hours individual coaching Final 1-day event</td>
<td>It was reported based on feedback from participants the coaching time increased from 3-5 hours in years 3 and 4 and method of delivery changed but the structure of the programme remained the same over 4 years. Response rates for the online questionnaire reported between 68% and 77% of participants. Service change was achieved through the SIPs completed each year. 77% (128/166) completed the post programme online questionnaire. 96% (124/128) enjoyed the SIP 93% (120/128) learnt something new 89% (115/128) reported the SIP improved their confidence as a leader. 92% (119/128) reported the project improved own behaviours and workplace. In 2016, 56% (22/39) participants reported improvement in ability to encourage and support others In 2016, 100% (32/32) of HoMs reported the programme improved their confidence in succession planning compared to 79% in 2013.</td>
<td>75% / 2 Annual evaluation conducted by independent research organisation measuring reaction, learning, behaviour and results Inclusion of team members and line managers’ perspective. Costing exercise completed Inclusion of team members and line managers’ perspective.</td>
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<td><strong>Bespoke programmes for clinical professionals</strong></td>
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<td><strong>Mixed Methods papers</strong></td>
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<td>Mann et al. (2008) England</td>
<td>Evaluation of a leadership programme piloted in general practice.</td>
<td>Mixed methods approach using the Medical Leadership Competency Framework (self-assessment rating scale with 80 items grouped under 5 domains), reflective accounts and focus groups and completion of a service improvement.</td>
<td>Bespoke modules including learning sets Learning contract to include undertaking a service improvement project</td>
<td>12/14 (85.71%) participants introduced service improvement which had a positive impact on patient care. Post programme statistically significant findings which demonstrated improvement of 33.80 (p&lt; 0.01) The main areas identified were; 1. bring team along in making changes, 2. improving self-awareness, 3. improved understanding of team working 4. change in thinking from reactive to proactive Commitment to involving patients in changes.</td>
<td><strong>Strengths</strong> Use of the medical leadership competency framework. <strong>Limitations</strong> Design weakness as programme developed by 2 of the authors &amp; delivered by another. All involved in the evaluation. Discrepancy in data, evaluation and publication refers 2006 however within the report reference to the programme completing in 2005. Email sent to author seeking clarity who acknowledged awareness of the issues but had decided not to seek amendment.</td>
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<td>GVA &amp; Outcomes UK (2011) England</td>
<td>Evaluation of the effectiveness of leadership development programmes for the CAMHS workforce.</td>
<td>Qualitative (thematic) approach with 12 primary themes identified through literature review and consultation with stakeholders</td>
<td>7 bespoke leadership development programmes delivered in England for the Child and</td>
<td>Thematic analysis with related subthemes provided against each of the 12 identified themes. Percentages responses from stakeholders, service managers and</td>
<td><strong>Strengths</strong> A strategic focussed summary overview of a number of programmes covering a wider number of relevant themes.</td>
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<td>Lesson &amp; Miller (2013), England</td>
<td>Evaluation of a leadership and management programme for first line nursing and AHP managers in an NHS Trust.</td>
<td>Qualitative approach utilising a post programme evaluation and anonymous postal questionnaire. 40 participants invited to complete initial post programme evaluation. Anonymous postal questionnaire sent to 66 programme participants 3-8 months post programme evaluation</td>
<td>7 Habits of Highly Effective People programme (adapted for healthcare staff) 2 days At 6 weeks post programme to undertake and present a leadership challenge</td>
<td>Reporting of a selection of 4 positive comments from the initial evaluation. 25% (17/68) response to postal questionnaire 16/17 the course met their expectations 8/17 helped improved reflection on self as a leader 6/17 improved skills in listening to others 3/17 ended the link to theory and practice Not all participants completed the leadership challenge – no data provided</td>
<td>Strengths: Awareness and consideration given to the limitations of data collected immediately post programme. Limitations: Attendance at the course was compulsory. All leadership challenges not completed. Poor response rate 11% for one aspect of the evaluation.</td>
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<td>Review of literature to direct evaluation. Limitations: No information of the selection of the participants or the selection of the sample size. No information when the participants completed the programmes and limited value in determining impact. Results cannot be extrapolated.</td>
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<td>Humphris et al. (2004), England</td>
<td>An evaluation of the Wessex Courses Centre’s leadership development programme including return on investment.</td>
<td>Mixed methods, exploratory case study approach utilising a modified version of Kirkpatrick’s framework (1994). Quantitative data collected using a Likert scale (range 0-4) and qualitative feedback. Pre and post course design. 360° Leadership Quality Framework (LQF) self-assessment tool. Semi structured interviews 6 months post course with participants (18) (multidisciplinary) vs managers. All participants nominated to attend programme by managers. Questionnaire sent to participants their manager and a member of their team (54 individuals).</td>
<td>Leadership development programme (5-month course) Action learning sets Follow up day 3 months post course</td>
<td>No pre-course needs assessment Development of nonspecific skills main reason for managers (6/18) sending participants to the programme. Response rates 12/18 participants and 9/18 managers. Participants reporting visibility as a leader improved (5/18). Learning was improved in a number of areas: + Participants’ confidence + learning new skills + Better use of reflection Ability to appreciate others perspectives.</td>
<td>Strengths: Independent researchers. Questionnaire piloted for suitability. Validated scale to assess impact on individuals. Limitations: Poor response rate linked to non-availability of participants. Unable to match sufficient participants to manager data. Unable to establish value for money outcome.</td>
<td>75%/2</td>
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<td>Boaden (2006), England</td>
<td>To provide a critical analysis of a leadership development intervention provided for NHS staff</td>
<td>Mixed methods evaluation of the first 3 cohorts based on Kirkpatrick’s framework (1994). Data collection by questionnaire after each residential, verbal reports following learning sets. Results of assessed work. Participants from across 4 countries primarily Human Resource (HR) staff (n=225). In years 1 and 3 participants</td>
<td>Leadership Through Effective Human Resource Management (LTEHRM) University based modules (6 each 2.5 days residential)</td>
<td>Response rates: Year 1: 63/80 Year 2: 32/45 Year 3: 57/80 It was reported that the outcomes for year 1 had been achieved for the following areas based on responses of over 50% + Improved networking in HR.</td>
<td>Strengths: Researcher acknowledged limitations with the statistical data and that the analysis focused on positive outcomes only. Various method of data collection 4 country sample.</td>
<td>50%/3</td>
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<td>subdivided into an accelerate group (deputy directors or an advanced group (directors)). No information on the recruitment process. Opportunity to progress to academic accreditation</td>
<td>2 learning set days between modules Develop and report a service improvement project (SIP)</td>
<td>• Patient focus is central to practice • Understanding of HR agenda • Improved confidence Across all groups leadership skills and self-awareness had improved and awareness of impact on patients based on verbal reports and analysis of the SIP. 70/225 participants progressing to MSc at time of report</td>
<td>Limitations Variation in programme delivered between accelerated and advanced group not addressed in interpreting data No triangulation of results Researcher links to the educational institution providing the programme not addressed.</td>
<td><strong>SIGN</strong></td>
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<tr>
<td>Currie (1998) England</td>
<td>To assess whether a generic approach to management development is appropriate for the NHS.</td>
<td>Case study using an ethnomorphic approach (before &amp; after study) with observation visits and interviews. 14 pre-programme interviews with senior Trust managers to develop a framework for analysis. 35 participants (multidisciplinary) service managers) nominated to programme. Post programme 25 informal interviews with participants &amp; other stakeholders.</td>
<td>Management development programme (16 workshops over nine months) which included developing a portfolio Award of an NVQ Certificate</td>
<td>2/35 completing after 18 months and receiving a certificate. High attrition rate with 12/35 partially completing the programme Effectiveness of management education based on observations and interviews with the programme facilitators and participants raise the following issues; 1. there is flawed assumption management development can be applied generically to all groups 2. the ability of participants to opt out failure to recognise the gap between the competing values of professionals and managers in the context of changing cultures</td>
<td>Strengths Use of a processual approach to understand change. Limitations High dropout rate. 2 individuals completed the programme. Generalisations not possible.</td>
<td>50%</td>
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Qualitative papers:
<table>
<thead>
<tr>
<th>Authors, (Publication Year), Location</th>
<th>Purpose</th>
<th>Design, sample and theoretical frameworks</th>
<th>Intervention</th>
<th>Results</th>
<th>Strengths/ Limitations</th>
<th>Quality appraisal</th>
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<tbody>
<tr>
<td>Edmonstone &amp; Western (2002) England</td>
<td>To evaluate two leadership programmes.</td>
<td>Qualitative evaluation of two regionally based programmes. 1) TLD Programme 200 participants (3 cohorts) NHS Directors. 26 one to one interviews. 32 structured interviews with participants and sponsors took place over the three years. A focus group of participants' and facilitators. Facilitators to submit a written response. Discussions with the NHS development unit. 2) NYBLD programme 200 participants (2 cohorts) NHS Directors. Structured questionnaire to all participants. One to one interview with 4 participants 3 stakeholders, a facilitator and a sponsor.</td>
<td>Trent Leadership Development Programme (TLD) Action learning sets Mentoring Participation in a learning network Northern and Yorkshire Board Level Development programme (NYBLD) One day launch A development centre event Taught programme</td>
<td>These evaluations were completed between 1997 and 2000. NYBLD programme - no data was provided on the response to the structured questionnaire Structured questionnaire to all participants. Seven themes were identified from all methods of data collection;  - The need for a common vision of leadership  - Design issues must reflect leadership theory  - The need to lead leadership development effectively  - The need to ensure programmes are tailored to staff need  - Flexibility in programme content and delivery  - Impact of travel time  - The question of individual or organisational benefit</td>
<td>Strengths:  - Triangulation.  - Large sample size.  - Multiple methods of data collection. Limitations:  - Results focused on generic finding from the evaluation process. Insufficient detail on the similarity of the two programmes and on how data was integrated.</td>
<td><strong>SIGN</strong></td>
</tr>
<tr>
<td>Authors, (Publication Year), Location</td>
<td>Purpose</td>
<td>Design, sample and theoretical frameworks</td>
<td>Intervention</td>
<td>Results</td>
<td>Strengths/ Limitations</td>
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<tr>
<td>Walse &amp; Marks–Maran (2014) England</td>
<td>Evaluation of the use of action learning sets for leadership development within a leadership module for health care professionals.</td>
<td>Mixed methods based on an educational evaluation framework and focused on student engagement, value, impact, sustainability. Survey using 3 open ended questions, 3 demographic questions and 28 Likert style questions. Health and social care professionals who self-selected undertook the module n=47.</td>
<td>Leadership through Action Learning module (over 1 year) based on the Dept. of Health Leadership Framework including a 2-day workshop including completion of Myers Briggs psychometric questionnaire. 6 ½ day learning sets.</td>
<td>There was evidence of participants from clinical professional back grounds opting out from both programmes and the authors concluded there needs to be reconstruction of the professional diversity in the management development.</td>
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**Alternative models of leadership development**

**Mixed Methods papers**

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<tr>
<th>Authors, (Publication Year), Location</th>
<th>Purpose</th>
<th>Design, sample and theoretical frameworks</th>
<th>Intervention</th>
<th>Results</th>
<th>Strengths/ Limitations</th>
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</thead>
<tbody>
<tr>
<td>Walse &amp; Marks–Maran (2014) England</td>
<td>Evaluation of the use of action learning sets for leadership development within a leadership module for health care professionals.</td>
<td>Mixed methods based on an educational evaluation framework and focused on student engagement, value, impact, sustainability. Survey using 3 open ended questions, 3 demographic questions and 28 Likert style questions. Health and social care professionals who self-selected undertook the module n=47.</td>
<td>Leadership through Action Learning module (over 1 year) based on the Dept. of Health Leadership Framework including a 2-day workshop including completion of Myers Briggs psychometric questionnaire. 6 ½ day learning sets.</td>
<td>Using Cronbach’s alpha coefficient to test reliability there was no significant difference between length of experience and student engagement, value, impact and sustainability. 35:47 agreed and 4:47 somewhat agreed that the action learning set helped learning with leadership development of skills and qualities, self-awareness/insight, confidence, awareness of others, managing change. Of the 39:47 who responded 20 agreed and 19 somewhat agreed that the action learning set was the most valuable part of the module despite a difference in years of experience. Likert style questions showed high reliability; Cronbach alpha co efficient of 0.880.</td>
<td><strong>Strengths</strong> Researchers were independent of module teachers. Study conducted in line with ethical principles, Systematic approach to qualitative analysis provided and linked with quantitative findings. <strong>Limitations</strong> Timeframe for the completion of the post programme evaluation not provided.</td>
</tr>
<tr>
<td>Authors, (Publication Year), Location</td>
<td>Purpose</td>
<td>Design, Sample and Theoretical Frameworks</td>
<td>Intervention</td>
<td>Results</td>
<td>Strengths/ Limitations</td>
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| Boyd et al. (2016) England           | Post programme evaluation report of the NHS Leadership Academy: Intersect systems leadership programme. | Longitudinal, mixed methods surveys focused on:  
- emotional intelligence  
- transformational leadership  
- civic capacity.  
40 participants (cross sector public and third sector, senior managers and clinicians)  
10/40 team members and colleagues participated in the comparison group.  
Matched comparison group of team members/ colleagues working in the same area as the participant.  
3. 5 observers nominated by the participants.  
Data collection was informed by the development of a programme theory.  
360° tool was completed early in the programme and at 18 months.  
Semi-structured telephone interview analysis of online postings and structured on-line discussions between each module.  
Baseline survey of participants, observers and comparison group about emotional intelligence repeated at 6 months module. | Six 3-5-day residential workshops  
Facilitated online discussion  
Progress a work-based initiative | 39/40 completed the programme  
Quantitative findings pre and post programme demonstrated a statistically significant (p < 0.05) increase in:  
1. levels of emotional intelligence;  
2. transformational leadership  
3. civic capacity.  
Insufficient data to demonstrate whether this was statistically significant when compared to the comparison group.  
Qualitative finding 25/39 interviews reported a number of impacts:  
1. improvements in self-confidence,  
2. improvements in relationships within the system,  
3. self-awareness through reflection and reflective capacity  
4. valuing diversity  
Unable to attribute particular changes to specific parts of the programme but rather to the programme as a whole.  
14 (7 were NHS staff) selected for interview at 6 months and reflected the diversity of the participants, 11 of these responded to request for second interview 6-month post programme. | Strengths:  
Researchers were independent  
Results from each stage informed future module development.  
Limitations:  
Incomplete data for some aspects of the analysis.  
6 months post programme no interviews with comparator group due to poor response and therefore comparisons and discussion on all work-based elements in particular cannot be made.  
Statistically analysis no number given for comparator group although means were presented. |
<table>
<thead>
<tr>
<th>Author(s), (Publication Year), Location</th>
<th>Purpose</th>
<th>Design, sample and theoretical frameworks</th>
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<th>Results</th>
<th>Strengths/ Limitations</th>
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<tbody>
<tr>
<td>Sambrook (2009), Wales</td>
<td>To evaluate the development of critical thinking skills in NHS managers and health professionals who completed a new master's programme in Health &amp; Social Care leadership.</td>
<td>Qualitative research, Constructionist design using anonymous standard university module evaluation questionnaires (Likert type questions and open-ended questions) and a specifically designed anonymous questionnaire examining evidence of critical pedagogy. 7 NHS managers and health professionals. Focus group – 20 (all participants on MSc programme).</td>
<td>4 core modules and a dissertation of an MSc programme in Health &amp; Social Care leadership</td>
<td>Qualitative data from questionnaire Reported themes 6/7 MSc students reported 1. being more informed critical managers, 2. improved ability to question and challenge others, 3. able to use knowledge in practice Introduction of critical pedagogy into management development may have success but queries whether this is an approach the NHS is ready for.</td>
<td>Strengths: Methodological approach clearly presented. Submission of participants' responses electronically to preserve their anonymity. Limitations: Potential for bias by the author who was module leader and teacher; on 3 of the 4 core modules was recognised and actions taken to reduce risk. Evaluation tool may not have been designed to the research question i.e. generic university evaluation. Confusion in the presentation of results.</td>
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<tr>
<td>Authors, (Publication Year), Location</td>
<td>Purpose</td>
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<td>Intervention</td>
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<td>Robinson et al., England (2016)</td>
<td>Evaluation to determine to what extent the Nye Bevan programme is meeting its learning outcomes.</td>
<td>Qualitative method with in-depth interviews of 40 participants included those who completed (17), some part-way through (18), and a small number who had failed or withdrawn (5) and in-depth case studies of nine participants, focusing on wider impact.</td>
<td>One-year development intervention 18 face-to-face days, including four residential workshops. Self-directed additional time to studying; evidence of applying learning in their workplace.</td>
<td>Qualitative finding based on 40 interviews (12 clinical &amp; 28 non-clinical staff). 24 chose to complete programme, 12 were recommended and 4 were opportunistic. 25 (76%) said programme met or exceeded their expectations, six suggested it partially met expectations (18%). Participants reported a number of impacts including: 1. improvements in decision making, 2. ability to improve work environment, 3. ability to work within team, 4. engagement with patients &amp; families, 5. knowledge to support leadership. 9 case studies of individuals who reported positive impacts on their practice. Exploration of set advisors’ perceptions of the programme reported the learning set experience was very important to participants. 3/6 identified a design tension between the two approaches used in the programme—self-managed learning and competency development/assessment.</td>
<td>Strengths: Structured approach aiming to include 40 participants, other stakeholders: colleagues, patients and service users, the organisation, and the wider health and social care system. 9/40 case studies provided depth to support data. Limitations: No analysis of previous management development. Analysis is based on self-reflections with most participants producing examples for most of the objectives (no numbers). Selection of case studies to demonstrate positive findings only, therefore potential to overreach findings. Feedback from colleagues, and direct reports provided for case study group only.</td>
</tr>
<tr>
<td>Authors, (Publication Year), Location</td>
<td>Purpose</td>
<td>Design, sample and theoretical frameworks</td>
<td>Intervention</td>
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<td>Barton et al. (2017), England</td>
<td>To report on a case study of a leadership development initiative for professionals in health and social care which aims to help them become reflective and flexible leaders.</td>
<td>Qualitative research using pre and post online questionnaire, non-participative observation, post programme focus groups and 3 individual interviews. Health &amp; Social Care (HSC) providers in one region in England were asked to nominate participants. 105 individuals, including a representative range of HSC professionals from Band 6 nurses to Chief Executives. 4 members of the organising team and stakeholders were interviewed.</td>
<td>Two day residential intervention led by a panel of HSC experts with an interest in leadership development. Day one: participants divided into groups, they and expert panel given a HSC-related imaginary scenario to address. Twice during the day, the ‘panel experts’ provided additional information, advice and guidance. Day two:</td>
<td>The report concluded that the aims of the programme to create a new style of leader for the NHS is making progress towards improving services, most satisfied patients, and improved staff engagement with services in the wider NHS became more ‘joined up’ and receptive to change and innovation.</td>
<td>Strengths: Independent observers Multiple methods of data collection. Acknowledgement of the limited results provided</td>
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<td>54/105 responded to the pre programme questionnaire. Findings from focus group and observation presented. 17/105 participated in focus groups. All groups turned scenario into a problem and sought solutions to solve it as keeping with the expected task-focused expert-led NHS approach with senior managers delegating tasks. Senior leaders seen as ‘expert’ even though there was no evidence of their expertise in the scenarios presented. Expert panel adopted same approach as the working group, turning scenario into a problem and sought solutions to solve it. Groups sought advice from expert panel and withheld presenting their solutions until panel verified their decisions even though they had no knowledge of the experts’ experience in the scenario presented.</td>
<td>Limitations: Analysis is provided on observation and focus groups only No demographic information describing details on the diversity of the participants and therefore difficult to interpret the findings.</td>
<td>75%</td>
</tr>
<tr>
<td>Authors, (Publication Year), Location</td>
<td>Purpose</td>
<td>Design, sample and theoretical frameworks</td>
<td>Intervention</td>
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<td>Groups present their solutions to expert panel and debriefing session.</td>
<td>Participants realised that it was not about skills but insight into management and leadership and the need to think outside current structures and approaches and different ways of working.</td>
<td></td>
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</table>
26 March 2015

Ref: 10.EBannon.04.15.M4.V3

Elizabeth Bannon
School of Nursing and Midwifery
Queen's University Belfast
Medical Biology Centre
97 Lisburn Road
Belfast BT9 7BL

Dear Elizabeth

SCHOOL RESEARCH ETHICS COMMITTEE

RE: A mixed methods study to evaluate the current management and leadership development programme accessed by midwives

Thank you for your recent submission to the School of Nursing and Midwifery Research Ethics Committee. I wish to advise you that your application has been approved and you can now commence with your study. This approval has been given by Chair’s Action as agreed at the last meeting.

To complete the Research Governance process, you should complete the Gov 3 form (request for sponsorship of a research project) and forward this along with your protocol to Ms Louise Dunlop at the Research Governance Policy Office. In addition, please ensure the project is recorded on the PURE system.

Yours sincerely

[Signature]

Dr Oliver Perpa
Chair, School Research Ethics Committee
School of Nursing & Midwifery

cc Dr Fiona Alderdice
File copy
Appendix 5

Letter of approval Phase 2

20 April 2016
Ref: 34.EBannon.05.16.M8.V4

Elizabeth Bannon
School of Nursing and Midwifery
Queen’s University Belfast
Medical Biology Centre
97 Lisburn Road
Belfast BT9 7BL

Dear Elizabeth,

SCHOOL RESEARCH ETHICS COMMITTEE

RE: Leading the Way (Phase 2a and 2b)

Thank you for your recent submission to the School of Nursing and Midwifery Research Ethics Committee. I wish to advise you that your application has been approved and you can now commence with your study. This approval has been given by Chair’s Action as agreed at the last meeting.

To complete the Research Governance process, you should complete the Gov 3 form (request for sponsorship of a research project) and forward this along with your protocol to Ms Louise Dunlop at the Research Governance Policy Office.

Yours sincerely

[Signature]

Dr Oliver Perrin
Chair, School Research Ethics Committee
School of Nursing & Midwifery

cc Professor Fiona Alerdine
File copy
Research schedule

Appendix 6

Development of Protocol

Preparation of ethics application & submission Phase 1a & 1b

Phase 1a - distribution of survey to senior midwives

Analysis of data from survey and development of interview schedule

Phase 2a
distribution of survey to midwives

Preparation of ethics application & submission Phase 2a & 2b

Analysis of data and development of survey for Phase 2

Phase 1b
Interviews with senior midwives

Analysis of data from survey and identification of themes to inform focus groups

Phase 2b
Focus groups

Data entry

Data analysis

Thesis writing

Feb 2017 - May 2018
EU project in Croatia
Letter of invitation Phase 1a

Leading the Way - An exploratory study

Nursing & Midwifery Research Unit,
Queen’s University Belfast
Medical Biology Centre
97 Lisburn Road
Belfast
BT9 7BL

30th March 2015

Dear Participant,

We would like to invite you to take part in a research study exploring the management and leadership development needs of midwives who have achieved a senior managerial or advisory role in the NHS. This project will include a survey and interview.

We would like to invite you as a senior midwife to participate in the survey and, if you choose, a follow-up interview to discuss your perspective on the management and leadership development needs of midwives in Northern Ireland. It is important to include your voice and experiences of management and leadership development in this project to identify what is relevant for lead midwives of the future. The data from the survey and interviews will be used to inform the development of a tool to measure the effectiveness of current management and development programmes.

The survey and interviews will take place in Northern Ireland and will be facilitated by members of the project team. Following completion of the questionnaire, respondents who indicate they are happy to participate in an interview will be contacted. It is expected that the interview will take 30 - 45 minutes and will be held in a location convenient for those wishing to participate. We have received ethics approval (QUB SREC 15/16) to ensure accountability and transparency for this study. Data collected will be anonymised, stored securely and only accessible by members of the project team.

We would be delighted to hear from you; please contact any member of the research team below if you would like to take part and we look forward to hearing your perspective.

Regards,

Project Team Members
Eile Brennan e.brennan@qub.ac.uk
Janny McNail j.mcnail@qub.ac.uk
Fiona Alderidge f.a.alderidge@qub.ac.uk

Version: 1 03/11/14
What will happen to the results of the study?

The information you give me will be collated with that from other participants. A report will be produced based on the findings with the aim of developing an effective management/leadership development programme to meet the identified needs of midwives. The results may also be published in academic or professional journals. No one will be individually identified from the data collected or published.

Who is organising the study?

The study has been organised by Dr J McNeill, Professor F Alderdice and Elizabeth Bannon (postgraduate student)
And supported by the School of Nursing & Midwifery, QUB
and Mrs Broadagh Hughes Royal College of Midwifery

Who has reviewed the study?

The School of Nursing & Midwifery Research Ethics Committee, QUB have reviewed and approved the study.

Supervisors

Dr Jenny McNeill & Professor Fiona Alderdice,
Nursing & Midwifery Research Unit,
School of Nursing and Midwifery,
Queen’s University Belfast

Contact Details

If you have any questions about the study or would like further details please contact:
Eliz Bannon ☎ 07893137961 _mail: ebannon01@qub.ac.uk
Jenny McNeill: ☎ 02890974812 _mail: j.mcneill@qub.ac.uk

Version 3 23/1/2015

Leading the Way: A survey into management development for midwives (Phase 1a)

We would like to invite you to take part in a research study exploring the leadership and management development of midwives who have achieve a senior managerial role in the maternity service. Before you decide whether or not to take part, 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 carefully and ask if there is anything that is not clear or if you would like more information – there are contact details of the project team at the end of the leaflet.
What is the purpose of this study?

Concerns have been raised across the midwifery profession about the readiness of midwives to undertake senior roles at strategic and operational levels. This project is seeking in Phase 1: to undertake a survey (phase 1a) and conduct interviews (phase 1b) with senior midwives to explore their leadership and management experience in particular their perspective on the key attributes that a programme to prepare midwives for a senior role in maternity services should contain. Establish whether gaps exist and explore their perspectives on the attributes of the NHS Leadership Qualities Framework (2007).

Why have I been chosen?

All midwife managers who are members of the Royal College of Midwives’ Strategic Midwifery Advisory Group (Northern Ireland Branch) have been invited to participate.

Do I Have to take part?

It is up to you to decide whether or not to take part. You have been sent this information leaflet and consent form. If you decide to take part please return the signed consent form to the RCM office. Please be aware that you are still free to withdraw at any time from the study and without giving a reason.

What will happen to me if I take part?

You will be invited to complete a questionnaire and you will also have the option to attend a follow up interview.

The questionnaire can be completed online or on a hard copy.

If you choose to participate in a follow up interview this will take place in a location suitable to you.

This process will be completely confidential and information obtained will be anonymised.

Confidentiality

All the information you give will be kept strictly confidential. The information you give will be anonymised to protect the identity of participants. Taking part in this study is entirely voluntary and you do not have to take part if you do not want to, however I would greatly value your participation.
Questionnaire Phase 1a

Leading the Way (Phase 1a)

Using lived experience to invest in the future - An Exploratory Study

Dear Colleague

Concerns have been raised across the profession about the readiness of midwives to undertake senior roles at strategic and operational levels as many of the current post holders retire. I am writing to invite you to participate in a short exploratory study which is aimed at gathering information about your personal development and the challenges you met on your journey to become a senior midwifery manager/leader. I have attached a short questionnaire and I would appreciate if you could take the time to complete it. This will take approximately 15 - 30 minutes.

All information obtained during the course of this study will be anonymised so that it cannot be traced back to an individual.

It is hoped to use the knowledge gained from this study to compare it to the current leadership development programmes accessed by midwives.

About you

What year did you qualify as a midwife? _______

What year were you appointed to your first management role at G Grade/?? _______

What year were you appointed to a senior management role at H Grade/8a or above? _______

When did you first complete a management/leadership development programme? _______

Title of programme ____________________________________________

Was this an in house programme or external provider? Please specify _________
Who suggested you undertake this programme? Please specify

Self-nomination ☐

Line manager ☐

Other ☐

What other opportunities had you which helped you to develop in your leadership and management role? Please specify below

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Reflecting on your knowledge & skills as a leader/manager

What aspects of your role challenged you most? _________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

How did you gain the skills and knowledge necessary to meet these challenges?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Which of these best described the prime function of your role?  To manage ☐

To lead ☐

Both ☐
Succession planning

Based on your experience, please rate the following skills by circling the number opposite each factor, where 1 represents the least importance and 5 the greatest importance, in terms of their relevance to an individual aspiring to become a leader/manager.

Skills *(NHS Institute for Innovation and Improvement, 2007)*

<table>
<thead>
<tr>
<th>Please circle number that applies</th>
<th>Little importance</th>
<th>Great importance</th>
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<tr>
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<td>1 2 3 4 5</td>
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<tr>
<td>Seizing the future</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>Intellectual flexibility</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>Broad scanning</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>Political astuteness</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>Drive for results</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>Collaborative working</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>Effective and strategic influencing</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Empowering others</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>Holding to account</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>Leading change through people</td>
<td>1 2 3 4 5</td>
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</table>
Are there any skills missing from this list? Please specify

Yes
No

If yes please add them to the table below and please rate the skills by circling the number opposite each factor, where 1 represents the least importance and 5 the greatest importance, in terms of their relevance to an individual aspiring to become a leader/manager.

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<thead>
<tr>
<th>Additional Skills (Please circle number that applies)</th>
<th>Little importance</th>
<th>Great importance</th>
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<td>1 2 3 4 5</td>
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<td>1 2 3 4 5</td>
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</table>

Based on your experience please rate the following attributes by circling the number opposite each factor, where 1 represents the least importance and 5 the greatest importance, in terms of their relevance to an individual aspiring to become a leader/manager.

**Attributes** (NHS Institute for Innovation and Improvement, 2007)

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<tr>
<th>Please circle number that applies</th>
<th>Little importance</th>
<th>Great importance</th>
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<tbody>
<tr>
<td>Self-belief</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Self-awareness</td>
<td>1 2 3 4 5</td>
<td></td>
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<td>Self-management</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>Drive for improvement</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>Personal integrity</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
Are there any attributes missing from this list? Please specify

Yes [Blank]  
No [Blank]

If yes please add them to the table below and please rate the attributes by circling the number opposite each factor, where 1 represents the least importance and 5 the greatest importance, in terms of their relevance to an individual aspiring to become a leader/manager.

<table>
<thead>
<tr>
<th>Additional attributes</th>
<th>Little importance</th>
<th>Great importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please circle number that applies</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
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<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

Thank you for completing this questionnaire

We would be keen to explore in more depth your perspective as a senior midwife manager on your experiences and views on the key components of an effective leadership and management development programme which would require us to conduct some semi interviews (phase 1b).

Would you be willing to be take part in a short 30 - 45 minute taped semi structured interview based on your answers to the questions in order to explore or explain further your thinking on the preparation midwives will need?

Yes [Blank]  
No [Blank]

If Yes please provide your name, a contact number and/or an email address below:

________________________________________

________________________________________

23 January 2015 v3
Page 5
# Consent form – Interview

## Consent Form

**Title of Project:** Leading the Way – Interview (*Phase 1b*)

**Chief Investigator:** Professor Fiona Alderdice

**Study Number:**

1. I confirm that I have read, or had read to me, and understand the information sheet dated 23/01/2015, version 3 for the above study. I have had the opportunity to ask questions and these have been answered fully.

2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason and without my legal rights being affected.

3. I understand the study is being conducted by researchers from Queen's University Belfast and that my personal information will be held securely on University premises and handled in accordance with the provisions of the Data Protection Act 1998.

4. I understand that data collected as part of this study may be looked at by authorized individuals from Queen's University Belfast where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information.

5. I agree to take part in the above study.

6. I understand that the information I provide may be published as a report. Confidentiality and anonymity will be maintained and it will not be possible to identify me from any publications.

7. I understand the interview will be tape recorded and there is a possibility of direct quotation being used in publications.

---

**Participant Identification Number:**

**Name of Participant (please print)**

<table>
<thead>
<tr>
<th>Name of Person Taking Consent (Please print)</th>
</tr>
</thead>
</table>

**Signature**

**Date**

**Signature**

**Date**

Researcher Contact details: Elizabeth Bannon. E Mail: elizabethbannon01@qub.ac.uk

Mobile Number: 07803137081

29 January 15 v2
Appendix 11

Topic Guide Phase 1b

Leading the Way (Phase 1b)

Topic Guide

Key prompts:

Tell me about your current leadership role?

Was there anything you wanted to say about your leadership or management experience which you were not able to address in the questionnaire?

Was there a particular experience in your career which influenced you to take on a leadership or management role?

How meaningful are the NHS framework attributes?

How meaningful are the NHS framework skills?

Is this the right approach?

What would you like to see put in place for the training and mentorships for managers of the future?

Reflecting on your career was there a particular experience which supported your development to take on a leadership/management role?

What is your view about there being a difference between leadership and management?

Any other issues/points you wish to add?
Questionnaire Phase 2a

Leading the Way (Phase 2a)

Using lived experience to invest in the future - An Exploratory Study

Dear Colleague

Concerns have been raised across the profession about the readiness of midwives to undertake senior roles at strategic and operational levels as many of the current post holders retire. I am writing to invite you to participate in a short exploratory study which is aimed at gathering information about the nursing and midwifery leadership and management programme you have completed with the Beeches Education Centre or RCM. In particular it would be helpful to understand how helpful you found the course, what impact this had on your professional development and whether you have completed any additional training to address gaps or pursue additional opportunities. I have attached a short questionnaire and I would appreciate if you could take the time to complete it. This will take approximately 15 - 30 minutes.

All information obtained during the course of this study will be anonymised so that it cannot be traced back to an individual.

It is hoped to use the knowledge gained from this study to inform management and leadership development programmes for the future.

About you

What year did you qualify as a midwife? __________

When did you complete the management/leadership development programme provided by the Beeches Education Centre or RCM? __________

What grade were you? __________
Previous management experience prior to undertaking the course

Had you opportunities to ‘act up’ into a more senior role?  
Yes ☐  No ☐

Had you any opportunities to shadow a manager in your service?  
Yes ☐  No ☐

Had you any opportunities to lead or participate on a service related project?  
Yes ☐  No ☐

Who suggested you undertake this programme? Please specify  
Self-nomination ☐  Line manager ☐  Other ☐

What aspects of the course did you enjoy? Please explain

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Where any aspects of the course you would have liked to have changed?

________________________________________________________________________
________________________________________________________________________

16 February 2016 v3
List below any other management/leadership training you have received


Since completing the programme(s)

Had you an opportunities to ‘act up’ into a more senior role?  
Yes ☐
No ☐

Had you any opportunities to shadow a manager in your service?  
Yes ☐
No ☐

Had you any opportunities to lead or participate on a service related project?  
Yes ☐
No ☐

Have you considered applying for a management role?  
Yes ☐
No ☐

If no, why not?


If yes, have you secured a post?  
Yes ☐ ☐  
No ☐ ☐

**Personal Development**

Thinking about your development to date have you come across the NHS Institute for Innovation and Improvement Skills (2007)?  
Yes ☐ ☐  
No ☐ ☐

If yes when?

________________________________________________________________________

________________________________________________________________________

**Skills**

Please see the NHS Institute's skills listed below. Thinking about your own development consider where you would place the level of your own knowledge circling the number opposite each factor, where 1 represents no ability and 5 fully proficient.

<table>
<thead>
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<th>Please circle number that applies</th>
<th>No ability</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Fully proficient</th>
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<td>Political astuteness</td>
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<td>2</td>
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<td>Effective and strategic influencing</td>
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<td>Empowering others</td>
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<td>Leading change through people</td>
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</table>

Are there any skills missing from this list? Please specify  

| Yes | No |

If yes please add them to the table below and please rate your level of skill by circling the number opposite each factor, where 1 represents no ability and 5 fully proficient.

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<th>Additional Skills</th>
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</thead>
<tbody>
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<td></td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

Thinking about your development to date have you come across the NHS Institute for Innovation and Improvement attributes (2007)?

| Yes | No |

16 February 2016 v3
If yes when?

Attributes

Please see the NHS Institute’s skills listed below. Thinking about your own development consider at what level you would place yourself circling the number opposite each factor, where 1 represents not developed and 5 fully developed?

<table>
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<td>Drive for improvement</td>
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<td>2</td>
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<td>2</td>
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<tr>
<td>Resilience</td>
<td>1</td>
<td>2</td>
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</tbody>
</table>

Are there any attributes missing from this list? Please specify

Yes [ ]
No [ ]

If yes please add them to the table below and consider at what level you would place yourself circling the number opposite each factor, where 1 represents not developed and 5 fully developed?.
<table>
<thead>
<tr>
<th>Additional attributes</th>
<th>Not developed</th>
<th>Fully developed</th>
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<td>1  2  3  4  5</td>
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<td></td>
<td>1  2  3  4  5</td>
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</tr>
<tr>
<td>Thinking about your line manager which of these best described the prime function of their role?</td>
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<tr>
<td>To lead</td>
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<td>Both</td>
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<tr>
<td>Please explain</td>
<td></td>
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</tbody>
</table>

Thank you for completing this questionnaire

We would be keen to explore in more depth your perspective on your experiences and views on the key components of an effective leadership and management development programme which would require us to conduct some focus groups interviews (phase 2b).

Would you be willing to be take part in a taped focus group interview with a number of your peers who have also completed the nursing and midwifery leadership and management programme in order to explore or explain further your thinking on the preparation midwives will need? See below
Phase 2b – A Focus Group Interview

If you are willing to participate in the interview please provide your name, contact number and email address separately by post or email to Mrs Elizabeth Bannon at

School of Nursing and Midwifery,
Queen’s University Belfast,
Medical Biology Centre,
97 Lisburn Road
Belfast BT9 7BL

or email sbannon01@qub.ac.uk
Leading the Way - An exploratory study

Nursing & Midwifery Research Unit,
Queen’s University Belfast
Medical Biology Centre
97 Lisburn Road
Belfast
BT9 7BL

29 April 2015

Dear Colleague,

We would like to invite you to take part in a research study exploring the management and leadership development of midwives in the NHS. This project will include a survey (phase 2a) and focus group interviews (phase 2b).

Have you completed the Beeches Leadership and Management Development programme and/or the RCM programme? If so, would you be willing to participate in the survey and, if you choose, a follow-up focus group interview to discuss your perspective on the management and leadership development needs of midwives in Northern Ireland. It is important to include your voices and experiences of management and leadership development in this project to identify what is relevant for lead midwives of the future. The data from the survey and focus group interviews will be used to inform the development of a tool to measure the effectiveness of current management and development programmes.

The survey and focus group interviews will take place in Northern Ireland and will be facilitated by members of the project team. Following completion of the questionnaire, respondents who indicate they are happy to participate in a focus group interview will be contacted. It is expected that the focus group interview will take 45 minutes and will be held in a location convenient for those wishing to participate. We have received ethics approval (QUB REC-20 April 2016). Data collected will be anonymised, stored securely for 5 years and only accessible by members of the project team.

We would be delighted to hear from you. Please reply to the email or contact any member of the research team below if you would like to take part and we look forward to hearing your perspective.

Regards,

Project Team Members
Elizabeth Bannon: ebannon01@qub.ac.uk
Jenny McGee: jmcrew@qub.ac.uk
Fiona Alderdice: f.aalderdice@qub.ac.uk

*Version 4 29/04/16*
What will happen to the results of the study?

The information you give me will be collated with that from other participants. A report will be produced based on the findings, with the aim of developing an effective management/leadership development programme to meet the identified needs of midwives. The results may also be published in academic and/or professional journals. Every effort will be made to ensure no one will be individually identified from the data collected or published.

Who is organising the study?

The study has been organised by Professor F Alderdice, Dr J McNeill and Elizabeth Bannon (postgraduate student) and supported by the School of Nursing & Midwifery, QUB and Mrs Brodagh Hughes Royal College of Midwives.

Who has reviewed the study?

The School of Nursing & Midwifery Research Ethics Committee, QUB have reviewed and approved the study.

Supervisors

Professor Fiona Alderdice & Dr Jenny McNeill,
School of Nursing and Midwifery,
Queen’s University Belfast

Contact Details

If you have any questions, concerns or complaints about this study or would like further details please contact:
Elizabeth Bannon ☎️ 07893137961 ✉️ email: ebannon01@qub.ac.uk
Jenny McNeill ☎️ 02890974812 ✉️ email: jmceNeill@qub.ac.uk

Version 4 29/04/2016

Leading the Way: A survey into management development for midwives (Phase 2a)

We would like to invite you to take part in a research study exploring the leadership and management development of midwives. Before you decide whether or not to take part, 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 carefully. If there is anything that is not clear or, if you would like more information please ask a member of the project team. Their contact details are at the end of the leaflet.
What is the purpose of this study?

Concerns have been raised across the midwifery profession about the readiness of midwives to undertake senior roles at strategic and operational levels. This project is the second phase of a two part study. The first phase included a survey (phase 1a) and interviews (phase 1b) with senior midwives to gain their perspective on the key attributes that a programme to prepare midwives for a senior role in maternity services should contain. This aspect of the study (phase 2a) aims to explore midwives' perspectives of the impact of the programme on their levels of personal and professional confidence, whether the core skills and attributes identified by the senior midwives were addressed through the programme and how this has impacted on your career aspirations.

Why have I been chosen? All midwives who have completed the Nursing & Midwifery Management and leadership Programme at the Beeches or the RCM Leadership development programme and are members of the Royal College of Midwives (Northern Ireland) have been invited to participate.

Do I Have to take part?

You have been sent this information leaflet to help you to decide and to advise that the survey will be sent out via the RCM in the next two weeks. Taking part in this study is entirely voluntary, you do not have to take part if you do not want to. I would however greatly value your participation.

Please be aware that should you choose to take part you are still free to withdraw at any time from the study without giving a reason however any information you provide in response to the survey will be retained.

What will happen to me if I take part?

You will be invited to complete a survey (phase 2a) and you will also have the option to attend a follow up focus group interview (phase 2b). The survey can be completed online through a Survey Monkey. The link will be sent to your email address. If you prefer a hard copy this will be sent to you. You can then return the completed questionnaire to the RCM (a stamped addressed envelope will be provided).

If you choose to participate in a follow up focus group interview this will take place in a location suitable to you.

This process will be completely confidential and information obtained will be anonymised.

Confidentiality

All the information you give will be kept strictly confidential.

Complaints

Should you have any issues or concerns about the ethical aspects of this study please contact

Dr O Perra
Chair of Ethic Committee
School of Nursing & Midwifery, Queen’s University Belfast
Medical Biology Centre
97 Lisburn Road
Belfast
BT9 7BL

277
What will happen to the results of the study?

The information you give me will be collated with that from other participants. A report will be produced based on the findings with the aim of developing an effective leadership/management development programme to meet the identified needs of midwives. The results may also be published in academic and/or professional journals. Every effort will be made to ensure no one will be individually identified from the data collected or published.

Who is organising the study?

The study has been organised by Professor F Alderdice, Dr J McNeill and Elizabeth Bannon (postgraduate student) and supported by the School of Nursing & Midwifery, QUB and Mrs Breedagh Hughes, Royal College of Midwives.

Who has reviewed the study?

The School of Nursing & Midwifery Research Ethics Committee, QUB have reviewed and approved the study.

Supervisors

Professor Fiona Alderdice & Dr Jenny McNeill, School of Nursing and Midwifery, Queen’s University Belfast

Contact Details

If you have any questions, concerns or complaints about the study or would like further details please contact:
Elizabeth Bannon  ☎ 07893137961  email: eabannon01@qub.ac.uk
Jenny McNeill  ☎ 02890974812  email: j.mcnell@qub.ac.uk

Leading the Way: Focus Group interview into management development for midwives (Phase 2b)

We would like to invite you to take part in phase 2b of a research study exploring the leadership and management development of midwives. Before you decide whether or not to take part, 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 carefully. If there is anything that is not clear or, if you would like more information please ask a member of the project team. Their contact details are at the end of the leaflet.
What is the purpose of this study?

Concerns have been raised across the midwifery profession about the readiness of midwives to undertake senior roles at strategic and operational levels. This project is seeking to

- Establish what leadership/management development programmes have been completed by senior midwives in NI
- Measure their effectiveness
- Establish whether gaps exist.

I would also like to explore the perspectives of the midwives who have completed a leadership and management course at the Beeches or the RCM.

Why have I been chosen?

All midwives who have completed a leadership and management course at the Beeches or the RCM and are members of the Royal College of Midwives (RCM) have been invited to participate.

Do I have to take part?

It is up to you to decide whether or not to take part. You have been sent this information leaflet to help you to decide. If you do decide to take part I will ask you to sign a consent form at the beginning of the focus group session. Please be aware that you are still free to withdraw at any time from the study and without giving a reason.

What will happen to me if I take part?

You will be invited to attend a Focus Group interview (phase 2b) based on the information obtained from the survey (phase 2a) previously completed by yourself and other midwives.

The Focus Group interview will take place in a location suitable to you if you choose to take part and will last 45 minutes.

The researcher will record the interview and take notes throughout to facilitate analysis at a later stage.

Confidentiality

All the information you give will be kept strictly confidential.

Taking part in this study is entirely voluntary and you do not have to take part if you do not want to, however I would greatly value your participation. While every effort will be made to ensure confidentiality as this is a focus group discussion, other participants will also be advised of the importance of not disclosing information disclosed during the interview.

Complaints

Should you have any issues or concerns about the ethical aspects of this study please contact:

Dr O Peria
Chair of Ethic Committee
School of Nursing & Midwifery,
Queen's University Belfast
Medical Biology Centre
97 Lisburn Road
Belfast BT9 7BL
Appendix 16

Consent form - Focus Group

CONFIDENTIAL

CONSENT FORM

Participant's Copy

<table>
<thead>
<tr>
<th>Title of Project:</th>
<th>Leading the Way – Focus Group Interview (Phase 2b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Investigator:</td>
<td>Professor Fiona Alcornice</td>
</tr>
<tr>
<td>Study Number:</td>
<td></td>
</tr>
</tbody>
</table>

1. I confirm that I have read, or had read to me, and understand the information sheet dated 28/04/10, version 4 for the above study. I have had the opportunity to ask questions and these have been answered fully.

2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason and without my legal rights being affected. In the event that I withdraw from the study I understand that any information I have provided will be retained.

3. I understand the study is being conducted by researchers from Queen’s University Belfast and that my personal information will be held securely on University premises and handled in accordance with the provisions of the Data Protection Act 1998.

4. I understand that data collected as part of this study may be looked at by authorized individuals from Queen’s University Belfast where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information.

5. I agree to take part in the above study.

6. I understand that every effort will be made to ensure no one will be individually identified from the data collected or published.

7. I agree to the interview being tape recorded and there is a possibility of direct quotation being used in publications.

8. In the event any information is shared which may endanger patient safety or constitute misconduct, it is essential you understand that this will be reported to the LSA Midwifery Officer.

A signed copy of this form will be provided to participants.

Name of Participant (please print) ___________________________ Signature ___________________________ Date ________

Name of Researcher (please print) ____________________________ Signature ____________________________ Date ________

Contact details: Elizabeth Bannon E Mail: ebannon01@qub.ac.uk Mobile Number: 07803137961

28 April 2016 v4
Appendix 17

Focus group topic guide Phase 2b

Leading the Way (Phase 2b)
Topic Guide

Key prompts:
Who has influenced you most to consider developing your management skills?
Was there anything you wanted to say about acquiring leadership or management experience?
Was there a particular experience in your career which influenced you to consider a leadership or management role?
How helpful was it to have the opportunity to act up/shadow a manager/lead on a project?
What other opportunities have you had to develop management skills?
Thinking about the programme you completed what was the best thing about it?
What was the weakest thing about it?
Are there other opportunities you would like?
Would you refer to the NHS framework attributes and skills?
What would you like to see put in place for the training and mentorships for managers of the future?
What would attract you to become a manager/leader in your service?
What is your view about there being a difference between leadership and management?
How long did the management development programme last?
Role of annual appraisal?
Any other issues/points you wish to add?
A review of midwifery leadership

Despite frequent reports criticising leadership skills in the profession, midwives have dedicated many years to increasing representation at the highest level. Elizabeth Maria Bannan, Fiona Alderdice and Jennifer McNeill explore the many decades of progress.

Manchester coroner Lisa Hawmi identified ‘poor midwifery leadership and staffing levels as well as ambiguities in the Trust’s guidelines’ (Gray, 2016) as key factors in the death of a newborn baby when reviewing the case. These concerns are reflective of the findings in numerous reports into maternity services in England (Healthcare Commission, 2008; Francis, 2013; Kirkup, 2015; National Maternity Review, 2016). In a review of maternity services, the Healthcare Commission (2008) specifically linked poor morale, ineffective, scrutinising leadership styles and an overemphasis on financial pressures with poorer care for women. Midwife managers in particular have been perceived as lacking the necessary skills to lead and manage the maternity services, thereby impacting on the quality of care delivered (Smith and Dixon, 2008). While there has been progress in improving maternity outcomes, Annes and Sydhie-Store (2014) have reported that outcomes and quality of care remain inconsistent for women across all Trusts in England, with an 80% rise in maternity claims over the last 5 years.

These are difficult times for midwives, who have sought to improve their leadership and managerial skills over many decades in order to provide quality maternity services for women. In 1964, the Royal College of Midwives (RCM) advocated for the role of a midwifery matron (Cowell and Wainwright, 1981), highlighting the importance of attracting and retaining leaders in the profession and in the newly emerging maternity hospital system. The RCM recommended that courses should be developed specifically for midwives to prepare them for leadership roles, but evidence suggests that this recommendation was never fully implemented, and midwifery literature has continued to highlight concerns at the gap (Coggins, 2005; Johnson and Dale, 2011). Given the overwhelming evidence for the link between strong and effective leadership and high quality care (Warwick, 2015), it is clear these concerns must be addressed.

The aim of this article is to review a range of issues that have potentially affected the development of midwifery leaders and managers, namely gender, the profession of midwifery, organisational changes in the provision of maternity services, and management structures within the NHS. These issues will be addressed in the following sections, concluding with some consideration as to how the profession may move forward.

Gender

In general terms, the issue of gender and its effect on the career and management opportunities afforded to women in both corporate and organisational arenas has
Professional

For midwives, while career progression from a clinical to a managerial role has often resulted in improved working patterns, moving from shift work to more regular hours, the reality of undertaking these roles often does not improve midwives’ work-life balance.

been commented on in the literature for more than 20 years (Weyer, 2007). Weyer (2007) describes the effect of the so-called ‘glass ceiling’, and acknowledges that, while some progress has been made to breach this barrier, it is limited, and unlikely to disappear until women are regarded by society as equal to men. Veale and Gold (1998) in their study identified the disparity between the numbers of men and women who were able to access management development, with men having more opportunity than women. Working mothers in particular reported difficulty balancing domestic responsibilities with inflexible working patterns. Millar and Clark (2008) found similar disparities a decade later. In addition, it has been highlighted that women before they would benefit from women-only development schemes due to different managerial approaches (Ewen and Ferguson, 1995; Veale and Gold, 1998; Millar and Clark, 2008).

The impact of gender on career choices and opportunities is not unique to the UK. Machupa and Tsvika (2003), for example, in an exploration of the barriers women faced securing leadership positions in the education system in South Africa, identified that women were underrepresented in senior management positions. They suggested that this could be directly linked to a society which has two sets of rules, one for men and one for women, in keeping with a view expressed by the French feministe Simone de Beauvoir (1949), more than 50 years earlier.

De Beauvoir concluded that the role and function of women in society was informed with reference to men who held the position of power, which, as she asserted, was the result of Aristotle’s theory that women were inferior to men. A concept that, she argued, has never really been discredited or rejected by society and has therefore affected women’s life choices. She encapsulated her view in the following way:

‘Woman? Very simple, says the jokers of simple formulas: she is a woman, as every; she is female—this word is sufficient to define her.’ de Beauvoir (1949: 33)

It is within this wider societal context the role of the midwife is considered. Midwives—whose title means ‘with woman’—are mainly women, and focus on providing care to other women. It has been suggested that these facts provide one possible explanation as to why midwives face barriers to fully participating in the management of maternity services (Downing, 1988; Walsh, 2006).

In part, de Beauvoir (1949) was accurate in the effect of gender on career choice and progression: has been well documented (Porter, 1992; Behrend et al., 2007). Porter (1992) discussed how gender influenced nurses’ working lives in the NHS, and concluded that it was one of the most important issues in their professional practice. Porter (1992) noted that, although female nurses were becoming more assertive, they were still some way from achieving equality, given the complex and changing power relationship between female nurses, male doctors and greater numbers of male nurses. Midwives have been particularly affected by the issue of gender. Historically, as women, they were the care provider for women until the middle ages, when men began to take an interest in the practice of midwifery (Downing, 1988; Driee 2002). Since that time, it seems that midwives have continued to struggle to maintain their role as autonomous practitioners and experts in normal pregnancy and childbirth (Elstein and English, 1973; Downing, 1988).

The interprofessional gender issues identified are equally applicable to other professions and countries. Millar and Clark’s (2008) study of gender issues in the medical profession concluded that there were issues of discrimination against women, finding, for example, that trainee working patterns caused conflict for women as they sought to achieve a balance between their professional and personal lives. When combined with the culture of the health service, Millar and Clark (2008) concluded that this also affected career progression for women who attempted to combine motherhood with the practice of medicine. Conversely, for midwives, while career progression from clinical to a managerial role has often resulted in improved working patterns, moving from shift work to more regular hours, the reality of undertaking these roles often does not improve midwives’ work-life balance, due to the long hours, unsuitable workload demands, and lack of support to undertake the role (Buchanan et al., 2013).

The profession of midwifery

It would, however, be wrong to suggest that the sole explanation for midwives’ failure to develop the necessary skills to manage maternity services is related to their gender. Other commentators (Hughes et al., 2002; O’Connell and Dowse, 2009) have identified further challenges, such as the management system within the NHS, as a key barrier to progress. The
Healthcare Commission (2008) also drew attention to the organizational structure of the NUS and reflected that the structure itself significantly contributed to the absence of midwives at senior positions. To understand why this may be the case, it is necessary to look back at the history of midwives and their journey into the NUS.

The role of the midwife is considered to have existed before records began (Donnison, 1988), with knowledge handed down through the generations from mother to daughter. The first book of knowledge available to midwives was written by Soranus, the Greek physician, in the second century and was used for the next fourteen centuries (Sweet, 1980). Midwives were an integral part of society practicing without restriction until the middle ages, when the first indication of a desire by others to manage or control midwives' practice emerged (Donnison, 1988). It is unclear what specifically instigated the movement to control midwives' practice during the middle ages; however, reference to the fear of witchcraft and the role midwives held as wise women and healers has been suggested (Ehrenreich and English, 1973). Donnison (1988) proposes that it was linked to concern about the 'safety of the unborn baby should it die during childbirth without being baptised. Nevertheless, the Christian Church in Europe was politically strong in the middle ages and the bishops (who were male), used their power to require midwives to be licensed by the Church, which included swearing an oath to practice in accordance with Christian beliefs. It has been suggested that this was the beginning of the male (medical) challenge to the relationship between midwives and women, with a view to establishing men's authority and control (Ehrenreich and English, 1973; Donnison, 1988).

Women nevertheless continued to be the key providers of maternity care until the beginning of the eighteenth century when a more fundamental development of the male role within childbirth began to emerge (Sweet, 1988; Donnison, 1988). London (2008) suggests that, while the introduction of forceps and knowledge of machine are often cited as the reason for men's involvement in midwifery, in reality, it was probably the opportunity to gain paid employment. Irrespective of the reason, men 'midwives' were increasingly engaged by the men to provide their care. As the power of the Church declined across Europe, the power of the medical profession grew and midwives became increasingly marginalized (Donnison, 1988). In England, although obstetrics was not viewed as a medical specialty, male midwives were able to access education and to develop their skills and knowledge including the use of forceps and thereby able to make a living (Donnison, 1988; London, 2008). As a consequence, the majority of female midwives were uneducated, unregulated, and generally used by women from the poorer classes.

A small number of women, such as Zepherina Veitch and Rosalind Pigot (Cowell and Warnwright, 1981), were able to access education and they became increasingly concerned about the variations in the standard of care provided to women. They set out to secure education and legislation for midwives through the formation of the Matron's Aid Society to improve maternal outcomes (Cowell and Warnwright, 1981), and secured the Midwife's Act in 1902 in England and Wales (Donnison, 1988). The Act protected the title of midwife and established the principle that only a trained midwife or medical practitioner could care for a woman in childbirth. It set the direction for midwifery regulation for the next 70 years, with the establishment of the Central Midwives Board (CMB) and the supervision of midwifery practice to ensure the safety of women. This model of supervision was also seen as providing midwifery leadership and an element of control for the profession, as midwives engaged in annual discussion and audit of their practice (Lloyd, 2019).

Organizational changes in the provision of maternity care

By 1948, and following the birth of the NUS, midwives were responsible for the majority of deliveries (mostly home births) in an organized and regulated system of maternity care (Cowell and Warnwright, 1981; London, 2008). Midwives often worked with GPs in community areas, while obstetricians practiced within 'lying-in' hospitals that were generally used for women with complex needs.

The NUS, with the principle of 'care, at the point of delivery', meant that women were able to choose their caregiver without concern about cost. Initially, this led to tension between midwives and GPs as they competed for the women's service; however, gradually, this changed as women opted for care by midwives with support provided by the GP (Loudon, 2008; Donnison, 1988).

The focus of Government policy to increase efficiency in the NHS, improve hospital bed usage and address a falling birth rate, combined with pressure from the Royal College of Obstetricians, resulted in the 1970 NHS review, which recommended that all women should give birth in hospital, despite the lack of any evidence to support this policy direction (Campbell and MacFarlane, 1994). This was also reflected in a shift of emphasis, from the wellbeing of the mother to the outcomes for the baby. As O'Sullivan (2006) describes, maternal mortality had improved significantly throughout the second half of the twentieth century as a result of factors such as improved housing, nutrition, employment and antenatal care. With the development of knowledge about neonatal care, drugs and technology, more could be done for babies born prematurely or with health problems.
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Before regulatory changes in the 1970s, hospital births tended to be the exception, rather than the norm.

For midwives, the system in which they practised was fundamentally changed. The Salmon Report (Salmon, 1966), which was commissioned to raise the profile of the nursing profession in hospital management, compounded the situation, and Salmon ignored midwifery as a separate profession. With the movement of the majority of midwives into the hospital setting, and the failure to acknowledge the different professional focuses of nursing and midwifery, difficulties were inevitable. The influential report of the Committee on Nursing (Department of Health, 1972) which was established to review the role of nurses and midwives and was chaired by Ada Briggs, focused almost exclusively on nurses' roles, education and career issues, with almost no acknowledgement of midwifery or its professional supervisory framework.

Midwifery regulation today
This compositional absence was reinvented in 1979 when the CMB, the regulator for midwives, was stood down and midwifery regulation became linked to nursing with the formation of a single regulator for both professions, the United Kingdom Central Council (UKCC) (Borzy and Hunter, 2012). This fundamental failure to acknowledge the differing focus and populations of each profession has continued today with the establishment of the Nursing and Midwifery Council (NMC), successor body to the UKCC, in 2002. The NMC recommended the removal of statutory midwifery supervision from legislation, as it was perceived to be an additional level of regulation—which nurses do not have. Despite evidence of the positive effect that supervision has on midwifery leadership and on the safety of women, its continuation was not accepted and the legislation has been amended accordingly (Mercfield, 2017). As a result of these changes, midwives have struggled to be a visible presence within the NHS organisational structure (Healthcare Commission, 2008; National Maternity Review, 2016) and there has therefore been a clear mechanism for maternity issues to be raised at Trust board, with the resultant lack of impact on women’s care.

Management structures within the NHS
Originally, Government policy gave the key role in leading the new NHS to doctors (Whitney, 1988). GPs were to be the gatekeepers for the public to access the NHS, and the method of referral from doctor to doctor secured their position as the most influential people in the service (Harrison and Pollitt, 1994). This system made...
no provision for women to contact their local midwife directly as they had in the past (Worth, 2002), and as midwives had no voice at the managerial table, there was no opportunity to influence decision. The situation was compounded by hospital information systems, which were established to identify medical productivity through patient activity, cooled under the medical consultant to whom they were referred. As a result, the provision of midwifery care was not visible in the returns.

Since 1996, however, each Government in turn has faced increasing costs, complexity and demands from the NHS, which led to a complete re-organisation of management arrangements and the introduction of a general management structure in 1994. The general manager was to take overall ownership and accountability and, while not clearly articulated, the former pattern of medical-led management was stood down (Harrison and Potten, 1994). In the Government's view, a general manager with no clinical affiliation would ensure that the NHS was managed effectively and within budget (Harrison and Potten, 1994). Subsequently, the NHS Graduate Management Training Scheme was introduced, to target individuals who were destined for NHS management posts (Hague, 1985). The scheme, which has evolved over the years, takes approximately two years to complete, during which the participants are facilitated to get the widest possible exposure to all aspects of the NHS. Sandbrook (2009) would suggest that these management trainees are encouraged to believe that health professionals do not have the skills to manage the NHS, irrespective of their clinical expertise. The Healthcare Commission (2008) identified, however, that the strategy of excluding health professionals from management positions was flawed and did not deliver the expected changes. Nevertheless, with the absence of managerial developmental pathways for clinical professionals to become managers, they remain unlikely to attain appointments to senior positions where they could influence change (Johnson and Dale, 2011).

Moving forward

The most recent review of maternity services, Better Births (National Maternity Review, 2016) restated the need for improved leadership, management and team working within the maternity service, in order to improve outcomes and women’s experiences. In light of women’s continuing negative experiences, as highlighted by Avenell and Tyndale-Biscoe (2014), this recommendation must be implemented. As midwives hold a unique role working with women, they are well placed to make a real and sustainable difference to the health of the mother and her family at a local level. Through role managing and leading maternity services, they can use this knowledge strategically to influence policy and service direction.

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Handy et al (1988) explored how other countries addressed these challenges and identified various models, for example, in Germany, where having an in-depth knowledge of a profession was perceived as advantageous in obtaining senior management positions. Chris Harri (The King’s Fund, 2011) also recommended a new approach, highlighting that the failure to develop clinical professionals to manage and lead within the NIS in a sustained way has resulted in poor care. The recent maternity review in England (National Maternity Review, 2016b) reinforces this position, linking the lack of clinical leadership with poor outcomes for women.

Preparing midwives for management

Handy et al (1988) recommended that development opportunities must be set within midwives’ experiences, and identified evidence of good outcomes where programmes were based on internal learning opportunities. An integral part of any management development intervention for midwives must ensure they understand the language and structure of the system in which they practice, in order to build managerial competences and ability. The language is necessarily different to clinical practice, with a focus on finance and resources, workforce planning, modernisation, safety and quality. Midwives need to increase their knowledge of the broader corporate management issues, and in order to develop and understand the integration of policy direction and commissioning, they need to take opportunities to experience the wider health care system. Observing and acquiring skills of negotiation, persuasion, influence and political astuteness need to be acknowledged as essential components of midwives’ leadership and management development within the NHS.

Key aspects of maternity services are currently delivered in the acute hospital environment, but this is only one aspect of the wider public health arena in which midwives practice. As identified in Midwifery 2020 (Chief Nursing Officer for England et al, 2010), the drive is to develop community-based models for the future. The initial findings from ongoing research by the
Key points

- The effectiveness of midwifery leadership has been a recurrent theme in reports published over a number of years.
- Midwifery managers in particular have been singled out as lacking the necessary skills for effective leadership, despite midwives striving for many years to improve outcomes for women.
- As a profession with a large female workforce, midwives have historically faced challenges to their autonomy and authority, including today’s problem of the ‘glass ceiling’.
- Changes to the organisation and regulation of maternity care have resulted in greater focus on GPs, and the inclusion of midwives from hospital records into systems and managerial environments.
- The National Maternity Review has stated the need for midwives to learn management skills, to enable midwives’ experiences to be heard.

The continuing effect of gender

While the issue of the ‘glass ceiling’ should not be an obstacle to midwives’ progress on the basis of gender, the evidence would suggest that this may still be a factor for women seeking management positions within the NHS—especially in the context of family commitments, whether as mothers, carers or partners (Millar and Clark, 2008; Warwick, 2015). Coggin (2005) suggested that these barriers could be overcome through the creation of work-based learning opportunities, which could incorporate mentorship, role-modelling and coaching into management and leadership development. Warwick (2015) has emphasised how important it is that the NHS recognise that new models and greater flexibility are needed in developing managers and leaders for the future, to ensure that midwives will be enabled to fully contribute.

Conclusion

The real challenge and measure of success will now be for midwives to secure appointment to senior management positions, and to demonstrate their ability to fulfil all aspects of those positions, especially managing change, which Paytley (1998) suggests is a key element of leadership and management. As identified through a number of reports, midwives and maternity services need to be adaptable and open to change (Annen and Youndall-Biscoe, 2014; National Maternity Review, 2016). Recent publicity around the NCM and decision to end its campaign for normal birth attracted a high level of challenging media attention (Harley, 2017). The Chief Executive of the NCM (a midwife) offered an exemplary role model for how to manage a difficult situation, maintaining professionalism by accepting responsibility for the need for change but keeping the focus firmly on the safety of women and babies and improving practice. Given the National Maternity Review’s (2016) recommendation that there should be a focus on maternity services participating at Trust level, it is vital that midwives identify and learn from strong role models in order to build this.

Midwives cannot rewrite history, but must learn from it, demonstrating their willingness to complete management and leadership development programmes and question the system. Once they secure promotion, equipped with the requisite knowledge and skills, the challenge will be for midwives to have their voices heard, ultimately contributing to improved maternal and infant outcomes.
