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

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Figures 1 and 2 are appended to the full text.

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Abstract:

Background: Current UK health policy recommends the transition of maternity services towards provision of Midwifery Continuity of Carer (MCoCer) models. Quality of healthcare is correlated with the quality of leadership and management yet there is little evidence available to identify what is required from midwifery managers when implementing and sustaining MCoCer.

Aim: To develop a theoretical framework that represents midwifery managers' experiences of implementing and sustaining MCoCer models within the UK's National Health Service (NHS).

Methods: Charmaz's grounded theory approach was used for this study. Five experienced UK based midwifery managers were interviewed to elicit views and understanding of the social processes underlying the implementation and sustaining of MCoCer. Interviews were transcribed and analysed and focus codes developed into theoretical codes resulting in an emergent core category.

Findings: The theoretical framework illustrates the core category 'Leading Meaningful Midwifery'. To manage MCoCer models midwifery managers require a trust and belief in woman centred philosophy of care. They need the skills to focus on non-hierarchical transformational leadership and the courage to assimilate alternative models of care into the NHS. Promoting and protecting the MCoCer model within current services is essential whilst forming a culture based on high quality, safe MCoCer.

Discussion: MCoCer models that have sustained within the NHS have had supportive leadership from midwifery managers who have the necessary skills, attitudes, aptitudes and behaviours identified within the findings. Sustainable implementation of MCoCer is achieved through development of a values-based recruitment and retention policy within all areas of

midwifery and encouraging midwives with previous experience in MCoCer or supportive philosophies towards it, to manage the model.

Conclusion: Providing the appropriate support for MCoCer is time consuming and personally demanding for midwifery managers, however, implementing and sustaining MCoCer was shown by participants who valued MCoCer models to be rewarding, bringing meaning to their midwifery leadership.

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

Statement of significance:

Problem	What is already known	What this paper adds
Continuity of carer is being implemented throughout the NHS by midwifery managers with little guidance in how their role can influence the implementation and sustainability of the model.	Midwifery managers are vital agents in influencing the culture of maternity services. The availability and support of MCoCer models are dependent on the collaboration and attention provided to the staff involved.	A theoretical framework for guidance when implementing and sustaining MCoCer identifying key factors that are required from the midwifery manager. Successful implementation and sustaining of the model within the NHS are found when managers have feminist values and woman centred philosophies. They have the courage to support the model and autonomous midwifery, creating quality leadership and bringing personal meaning for themselves.

Introduction

There appears to be limited investigation into NHS midwifery managers yet their leadership is held accountable for the accolades and demeanors of the maternity services they lead (Bannon,

Allerdice and McNeill 2017) [1] . The transformational changes that are occurring within the UK as a result of the Best Start (The Scottish Government 2017) [2] and Better Births (NHS England 2016) [3] policy documents make little reference of midwifery managers, nor do they provide explicit guidance for managing the prescribed changes. A major aim of these transformative changes is for nationwide implementation of continuity of carer in response to the demonstrable improved biomedical outcomes for women and their babies and enhanced satisfaction for women and midwives (Homer et al. 2017; Sandall et al. 2016) [4,5]. Although the stimulus for providing MCoCer models was outlined in the Changing Childbirth report (Department of Health (DoH) 1993) [6], there has until now, been no effective national uptake of MCoCer models in the UK (McIntosh and Hunter 2014; McCourt and Stevens 2006) [7,8] . Maternity care in the NHS is traditionally provided by midwives based in the 'community' or 'hospital', with most births taking place in hospital. Midwives within the community will cover antenatal care, postnatal care and homebirths- with dedicated homebirth teams becoming more popular, whilst hospital-based midwives covering all maternity services within the hospital. Midwives generally do not work in both community and hospital settings at the one time unless within a MCoCer team structure, they rotate to specific areas for periods of time. The availability of MCoCer models is locally driven and organised and the number of midwives a woman meets in her care will depend on the local organisation of services (Sandall et al 2016) [5]. Midwives are employed by an NHS trust in England or NHS board within Scotland with occasional independent midwifery being available where a midwife is not directly employed by the NHS. There have been attempts by midwives to contract into the NHS- The Albany Midwifery practice, Neighbourhood midwives and One-to-One, however they have all been disbanded due to financial or practical arrangements being unsupportive and therefore unviable for the midwives to continue (Francis 2020, Black 2019,Homer et al 2017,) [9,10,4]. There is therefore an acknowledged skill shortage of midwives having exposure and experience in MCoCer models (Crowther et al 2016) [11]. Consequently, few NHS midwifery managers who

are now expected to implement new MCoCer models of care have MCoCer experience which in turn influences the implementation of sustainable MCoCer models [12] (Hewitt, Priddis and Dahlen 2019). In order to be effective any transformation of services to new models must take account of the needs and capabilities of midwives and managers that will be relied upon to implement them.

There are influencing factors that can impact on the capacity for services to change provision towards MCoCer models within the NHS. Midwives are more commonly caring for women with complex needs resulting in increased medicalisation of the maternity services (MBRRACE 2019) [13]. It is also known that there are endemic midwifery shortages due to midwives retiring and a failure to future proof workforce planning alongside a lack of strong midwifery leadership voice (RCM 2019) [14]. Failure to achieve manageable work environments for midwives can lead to traumatic experiences for women in their care (Patterson, Hollins Martin and Karatzias 2019) [15]. Unsurprisingly, Taylor et al (2019) [16] suggest that midwives are increasingly unwilling or unable to cover continuity of carer models staffing rotas. It was suggested by Stevens (2009) [17] that the challenge of how time is viewed within a physiological midwifery model compared to an institutional hierarchical model results in midwives being mostly accepting of the institutional model being the 'norm'. It is imperative for quality of provision when changing maternity systems that midwives' working environments are supported to be freed from their historical legacy and to become sustainable and trustworthy when supporting birthing physiology.

Cheyne, Kildea and Harris (2019) [18] indicate that in order to evidence sustainability of new models of care such as MCoCer within the NHS, it is vital to consider its acceptability to the midwifery workforce and they state that it should be the midwifery leadership team that ensure successful implementation into practice through ongoing evaluation. This relies on dedicated and focused time being given to the model by the midwifery leaders; such focus however has not always been the priority (Walsh et al. 2020) [19]. Although clinically

conducive to quality care outcomes there is a difficulty in promoting and defending the midwifery model of care within the NHS. Walsh and colleagues found that unwillingness to embed birth centre services within the main-stream service kept such services vulnerable to financial pressures. Walsh's research identified that a lack of leadership to drive through the change in the service created a service that lacked support which became vulnerable to institutional norms and biomedical model status quo.

It is apparent that strong effective leadership is required for NHS transformation of services. The relationship of midwifery management and leadership style has been correlated to NHS cultures and retention; therefore, it is imperative to invest in understanding the requirements and functioning of midwifery leaders who champion transformation (McInnes et al 2020) [20]. Yet there is an acknowledged gap in formal education for development of midwifery leaders (Clarke et al 2011) [21]. This article presents a study that explored the views and experiences of midwifery managers who have led, or are leading, sustainable MCoCer models within the NHS informing development of a theoretical framework.

Methods

A qualitative study was undertaken with the aim of achieving an in-depth, individualised and contextually sensitive understanding of the issues (Patton 2015) [22]. A constructivist grounded theory approach informed by Charmaz (2014) [23] was used to develop a theory about the social processes of the UK maternity system culture when actively engaging with MCoCer and the impact of midwifery management. Charmaz emphasises participants implicit meanings and researcher's' constructions of reality and argues that any new knowledge should consider and account for the social context and worlds in which it is constructed. This is distinct from the Grounded Theory that was developed by Glaser and Strauss (Glaser and Strauss 1967) [24], where it was seen to be crucial that the researcher remained objective whilst collecting and analysing data. Charmaz uses the term 'constructivist' to acknowledge subjectivity and the researcher's' involvement in the construction and interpretation of data. As midwife

researchers investigating midwifery leadership and midwifery models of care, the reflexive nature of Charmaz's Constructivist Grounded Theory was appropriate.

Grounded theory is useful when little is known about an area of interest (Hall, McKenna and Griffiths, 2012) [25] and an overt focus on social processes is needed. The aim of this study was to develop an understanding that was pragmatic whilst being grounded in the social processes identified by key participants.

The practical social problem addressed in this study is;

'How do midwifery managers impact on the availability and sustainability of MCoCer models within the NHS?'

To answer this and enable the development of a theory that could help inform a useful theoretical framework for practitioners a constructivist grounded theory methodology was chosen. This approach is consistent with motivating change theory developed by Breckenridge et al (2019) [26] at the Scottish Improvement Science Collaborating Centre because it ensures greater humanising of the improvement process by listening to individuals and organisations with successful track records in lasting improvement in MCoCer.

Sampling

Participants were purposively sampled. This enabled the theory to be grounded by constantly comparing data against new data (Sbaraini et al 2011) [27]. After each interview gaps were identified, and the next participant sought until theoretical saturation was achieved (Sbaraini et al 2011) [27] and a grounded theory constructed. Eight midwifery managers were invited to participate via email and informed consent to participate was gained. Ultimately only five participants were interviewed due to study saturation being reached. They are well known female midwifery experts, three are currently active in non-clinical roles within midwifery and two are managing midwives within a continuity of carer model. They were purposefully chosen due to their long-term experiences in managing MCoCer models within the NHS which spanned over three decades. All had been involved in implementing policy into practice and

the day-to-day management of midwives in sustainable MCoCer models integrated or within large NHS teaching hospitals. Although the sample appears small it must be noted that there was limited UK wide midwifery leadership experience of managing continuity of carer over time when recruiting for this study. Theoretical saturation is concerned with no new or emergent information gathering happening within the theoretical categories (Charmaz 2014) [23]. By exploring the possibilities of how the data may relate to each other and sampling to discover links between the theoretical codes explored within the categories saturation is achieved. This is not about checking for repetitive themes, rather it is about checking explanations to discover the most plausible theoretical explanation (Charmaz 2014) [23].

Ethics

Ethical approval was given by the Robert Gordon University Ethics committee on 12th Nov 2018. Further IRAS applications (Project ID:255484) and specific ethical approval from each health trust where individual participants were working were gained prior to any data collection. Initial contact was made through an email from the principal investigator who had no personal knowledge of the participants to enable them to decline without any sense of duty to participate. All participants were made aware of the potential for over disclosure of identifiable information (Carpenter 2007) [28] and asked to remove any information that they did not want included in the study from their transcripts prior to analysis. They all reviewed the final study, only one of them chose to have a pseudonym as the others chose to have identifiable ownership over their own views and experiences.

Reflexivity of study team

All authors are midwives with firm feminist philosophies in woman centred evidence-based care. ST and SC have worked in relational continuity models for many years. Through discussing personal experiences, the potential for over-identifying with the organisational culture and the participants experiences was identified and mitigated for by engaging participants in the final analysis (Charmaz 2014) [23].

Data Collection

All participants chose face-to-face interviews. All interviews were conducted by ST and lasted 50 to 90 minutes and were audio recorded for transcribing. Field notes were taken in order to obtain rich data (Charmaz 2014) [23]. The first interview was prompted by a set of semi-structured questions however, as the interviews progressed the structure changed to being more open and the questioning more focused to allow exploration of emerging codes (Charmaz 2014) [23]. When an interview was completed analysis of the data through a process of constant comparative analysis occurred.

Data analysis

Verbatim transcripts were analysed manually by ST. Coding of data was an iterative process completed by ST and verified by SC and AL. Initial coding, where labels are assigned to segments of data to allocate meaning, was through line by line analysis. Participant narratives were fragmented and assigned with pithy descriptive labels, highlighting the meaning (Charmaz, 2014) [23]. In-vivo (verbatim text) codes acted as a significant feature of coding, derived directly from the language of the participants to encapsulate meaning (Charmaz, 2014) [23]. Audio recordings and field note transcripts were then revisited to ensure analysis was reflecting the data providing an opportunity for a secondary layer of analysis; by returning to original sources, initial assumptions made from the coding process were considered and any possible bias addressed (Charmaz 2014) [23]. Initial codes were collated, divided into *implementation* or *sustainability* then into *views* or *experiences* as per the initial research question, enabling focused codes to be created through a gathering and cluster mapping exercise. Through continued comparative analysis codes were revised and refined to develop meaning (Charmaz, 2014) [23]. Theoretical coding involved refining focused codes into theoretical codes that characterised the social reality of the phenomenon which developed the final integrated theory (Charmaz, 2014) [23]. Saturation occurred once no new theoretical insights were derived from analysis, and when new data did not generate further codes.

Trustworthiness

Charmaz (2014) [23] proposes four main quality criteria for the trustworthiness of constructivist grounded theory studies. This encompasses the credibility, originality, resonance and usefulness of the research and the interpretations of the data. To ensure the study's credibility, sufficient relevant data was gathered to ask incisive questions of it and make systematic comparisons throughout the research process to develop a thorough analysis. Originality took the form of the participants being involved in the analysis and interpretation of the data to offer new insights into the recognized problem, providing a fresh conceptualization and establishing the significance of the analysis. Resonance was demonstrated by providing insights into the concepts that were constructed by illuminating the participants experience through revisiting the data transcripts and probing questions being used to explore deeper into the meaning for the participants into what their experience meant to them. Usefulness was ensured by exploring the participants understanding of their everyday lives as midwifery managers forming a foundation for further research and practice.

Findings

The data revealed how managing midwives is a complex process influenced by a variety of factors that the participants perceived to be of significance. There was however an acknowledgement by all participants that through a series of interlinking factors and actions MCoCer models of care, within the NHS, are both achievable and sustainable. Through constant comparative analysis an overarching congruence between the five participants interview data led to four theoretical codes interlinked by a core category (See figure 1). Although Chamaz (2014) [23] does not suggest that a core category is necessary, a core category did emerge in a way that helped foreground what participants reported as fundamentally important.

SEE FIGURE ONE

Each theoretical code was formed from focus codes that were collated from views and experiences of either implementing or sustaining MCoCer as identified in figure 2.

SEE FIGURE TWO

Theoretical Code: Trusting in a woman centred philosophy of care

The four focus codes within views of implementation are encapsulated by the theoretical code 'Trusting in a woman centred philosophy of care'. These focus codes identify that the participants have a deep understanding of what MCoCer entails for everyone involved and how their leadership and behaviours influence and support the midwives and model within a culture of scrutiny.

A 'woman centred philosophy of care' for the participants means a basis of feminist values and caring for the midwives so that they can in turn care for the women. They deeply trust that this way forward for midwives and the maternity services is their responsibility to enable as it is the basis for quality provision. Four of the participants have worked in MCoCer models as midwives "*It has to make sense to and work for the midwives practising that way*" (Annie). They believe in providing choice and control for women which leads to the vision to create and support a structure for it. The participants acknowledge that in order to implement MCoCer models they need to recognise the realities of what it means to provide relational care as a midwife in an NHS context and how important supportive leadership is within the model. "*I think you have to believe in it. Because if you ultimately don't believe in the model and think it is worth defending why would you put any energy into trying to make it work?*" (Caroline).

The basis of a woman centred philosophy is identified by participants as a trusting relationship that is developed over time through repeated contact between a woman and a midwife. This relationship is viewed as having the capacity to lead to more 'unconventional' choices and the boundaries of institutional 'norms' being questioned and challenged. Caroline reflected on how these impact on the midwife "*I think there's something around this dynamic of vulnerability for midwives. And I think the model is less vulnerable than the culture. I do think*

that midwives are more exposed when women make choices that wouldn't be agreed with". Midwives supporting women's choices within a hierarchical system prone to bullying and feeling more isolated and pressured by the cultural 'norms' was identified as a vulnerability within the model. The deep understanding of relational complexities and intricacies helped the participants support the midwives working within the MCoCer model by having the courage to support autonomous midwifery.

The participants recognise, support and invest in the importance of the midwife-to-midwife team relations *"we've made the assumptions that people know how to work in teams when actually midwives have always worked in a very hierarchical structure*" (Cathy). The realities of having an open, honest and fair culture where midwives are able to trust in professional relationships and share values as a maternity service is a vital way of promoting a woman centred philosophy.

Recruitment to MCoCer models is identified as difficult, not only because of an ageing workforce, but also because of the conflict between midwives in practice. The MCoCer model requires a desire for relationships to be created and valued; however, the data revealed tensions and inherent difficulties in building positive midwife-midwife relationships within the same health trust due to the MCoCer model midwives being labelled as deviant or 'other'. MCoCer midwives are valued by the traditional model midwives when they are acknowledged as best placed for individual woman with specific needs or requests that the traditional model is not able to fulfil. This has the potential to cause conflict and challenges in how the MCoCer midwives are perceived and the challenges of working together as a service. Cathy explains how important midwifery managers are as they have the power to influence and change the NHS culture and can promote MCoCer acceptance and normalisation "*Once people own it, they're far less likely to want to destroy it. I mean I always remember at [Health Trust] I was so chuffed one day when I heard [consultant obstetrician] talking in a lecture about 'our homebirth service' and I thought' that's it- that's it' she thinks it's hers and that's fabulous!"*. It is suggested

by Annie that the NHS is too rule bound and MCoCer in the NHS is possibly unworkable because of this, and thus could more easily be delivered from outside the NHS culture "*midwives say they can't do it- "no, no, they'll get burnt-out, it won't work", but that's because they're looking at it through the prism of a traditional way of delivering care and I agree, I agree with them 100%. You can't do it easily through the traditional model*". All the participants assimilated MCoCer into the current NHS maternity structure whilst running other traditional models. Participants discuss the constraints imposed by NHS structures and culture when implementing a change in practice and express how they adopt managerial styles that support the woman centred philosophy to be embedded which enables implementation of MCoCer. A principle vulnerability of MCoCer was identified as the requirement to have staff with the right philosophy.

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

Within this code, the three focus codes related to how the participants have integrated the MCoCer model within the NHS traditional framework of maternity care provision. This integration requires energy, effort, determination and specific behaviours from them because as Caroline said "*if you're not quite that bothered by it, and you don't quite believe in it and there are a lot of dissenting voices you can do a huge amount by apathy in the NHS or you can block an awful lot by apathy, because there's always another job… If that's your biggest job, to get this done, you have to spend a lot of time and energy to get it done, when actually you still have a service to run".* This determination for integration drives the leadership behavours of the participants.

Participants remain credible as midwives within their service as well as using their managerial status to empower the midwives to take control of their work and organise it in a sustainable manner. They stay connected to their staff by being visible, having regular meetings with them, talking with them and taking an interest in them as well as occassionally carrying their

own small caseload of women, whilst at the same time working with the board level members in order to gain support for the change in practice: "*I knew what I was talking about, I'd worked in it, I'd set it up before, I knew the organisational principles, I knew what we were trying to achieve, and we all shared it*" (Lesley).

Assimilation of the new model is in conjunction with detailed logistical planning to enable the positive functioning: "*the longer I am in the NHS, the more I think things stand or fall on the little bits of granular detail, it's not whether you've got the big idea for the MCoCer, it's whether you can figure out how you get the bloods back from the GP surgery*" (Caroline). Certain aspects were seen as beneficial to models: e.g. having more than six midwives in a group practice, having a mixed risk geographically based caseload and not using the midwives for busy times within the unit unless absolutely necessary. Apathetic management, rumours, not investing in supporting the midwives through time and finances and midwives not cohesing as a team were viewed as destructive influences, Annie describes her observations, *"[managers need to] ringfence the midwives time and really value the importance of the group practice identity developing. They need to be autonomous, but they can't be elitist. This is just another way of being a midwife, it gives you an identity and a purpose and for those midwives who don't fit in easily to the hierarchy and bureaucracy of the NHS it's absolutely another option*".

The sustainable basis is identified as: setting a framework of personal responsibilities, group responsibilities and service responsibilities. This is supported by the midwifery management through reflection, reviewing and monitoring, Cathy reflects on her expereinces, *'I think what maybe happened in some of those less able groups is that they did drop the ball. So, you would have in those groups far more behaviour like ringing up the labour ward and saying "none of us are on-call tonight", whereas in some of the groups, that just didn't really happen. So that was about being very clear right at the beginning about what the expectation was in terms of responsibilities of the team and the responsibilities of the wider service. And what I say now when I'm talking to midwifery leaders is set your expectations very clearly, because if you do that and*

then you monitor them, and if you then do that and you do have a say a group or a midwife, who is shown by the data, not to be complying then it is easier to then manage that person or that group. And I think what I learned was that if this is going to be sustainable without somebody who has got very high leadership energy that framework is critical'. Through their personal flexible style of management and philosophy the participants create a reality of MCoCer models sitting alongside other models of midwifery care and functioning within the NHS. The participants used a non-hierarchical transformative style of leadership.

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

The five focus codes contained within this theoretical code are practical and philosophical. The participants' views of sustaining the model led them to discover that it can 'morph' into something quite different if not sustained through a lens of vigilance and commitment to the original values and philosophy. This requirement for support is essential to the sustainability of the model and is required to defend it within a culture that can be antagonistic and highly scrutinising. A principle vulnerability was identified as being an outlying model with high levels of scrutiny. Having a committed leader who stayed in the same managerial post to support the MCoCer model was a protective factor as individuals influence and transform the values and philosophy of the culture. Annie describes this need for protective committed leadership, "*In the NHS I think it's more at risk of being disbanded, you know, different management comes in, a different structure, a different person, and your protectors in the system have gone. That's why I thought that having small independent organisations that could really work closely and collaboratively with the NHS might be a really good alternative*". Participants leadership style is values based- where they value the philosophy of the midwives and they want the midwives to be in control of their choices. Much in the same way that Caroline describes the "*seeping of power and control"* from the midwives to the women, the participants engage with the midwives expecting them to being autonomous and in control of

their working lives "*but I am a great fan of stepping back and letting people get on with things and stepping in if you need to- which I think is kind of a midwife thing to do as well*" (Caroline). The investment of the MCoCer midwives in the bureaucracy of the hospital system is identified as different, which in turn challenges the embedded NHS culture. This creates managerial challenges as a midwifery manager having to support both cohorts of midwives. The participants are themselves challenging the embedded culture in order to implement the outlying MCoCer model, Lesley describes the resistance she found on her first attempt to introduce the model, "*and the resistance to it, I just can't describe the personal resistance to me, the antagonism and the politics of setting this up*". Caroline emphasised that by only changing the day-to-day organisation of the midwives workstream, the outcomes would be unlikely to change. Participants recognise that it is through transforming the underlying culture and philosophy that change in outcomes is possible "*I don't think it's about the model I think it's about the philosophy of care. Because I think the philosophy of care that I observed being offered in caseload practices was very much about a seeping of power and control to women. About supporting them in making decisions whatever those decisions were and that is not how midwives' practice typically on a day-to-day basis in standard models. So, whether the continuity outcomes that are so different are a proxy for actually this is how midwives who work in certain ways, who choose to organise themselves in certain ways, it's actually not about how they organisationally manage their time but the philosophy of care that they offer to the women and their approach and that's what makes the difference. I think that's probably an underestimated contributor to the outcomes"* (Caroline). The aim for Annie was to eventually embed a culture that encompassed all midwives despite the MCoCer model negative perceptions "*It will be seen as an alternative way of working and those midwives will be holistically skilled… because you do every aspect of midwifery in caseloading, I think you become a different sort of midwife*". Vicki identified that her management style flexed accordingly in order to sustain the midwives in the model "*support them in that first couple of years- it's not just the first fortnight, it's as they get*

to know each other and have a shared vision cause they'll meet their peak in activity and they'll all have a fall out because everyone got upset, and be there to bring it back and get over that hump". By valuing and focusing on their strengths over time the participants support the midwives to sustain the model.

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

The four focus codes that form 'mastery of high quality safe MCoCer' were developed through the participants experiences of sustaining the model. The participants expressed how daunting and overwhelming it felt at times when implementing and sustaining the model, however Cathy also described finding the challenges exciting and rewarding when she witnessed sustained change in practice" *it takes a lot of energy from the leader. It is not easy to keep small groups of midwives going. And I think midwifery leaders in a way they sort of go for the easy life, if we do things down this line, and we do it in a certain way, that's simplest, if it's easiest to have everyone working 12 hour shifts, as opposed to flexible working. In my view that needs turned on its head- I do agree that it's hard work managing flexible systems, but it pays off in the long run. Whether it's through recruitment and retention or it's just the positivity of the place*".

The mastery is gained by rooting the model within the culture and organisation to the point where other stakeholders (such as the obstetricians and board members) feel an ownership of the model. The participants acknowledge that they are aware that they are viewed as different to other NHS midwifery managers and empathise for those without the skill and experience in leading MCoCer and the task ahead of them. Cathy describes her leadership style when confronted by challenges, "*to keep that vision going through tough times whether that is financial, or the one time that a serious incident emerges from a practice incident. So often when that happens everything just caves, but you need to be the head of midwifery that goes 'but hang on a minute we had a serious incident on the labour ward yesterday and we didn't close the obstetric service' whereas midwifery leaders are often part of 'the fear'. So, we also need to give our midwifery leaders the skills. And it does boil down to practical tools- you know …. What do*

you do when you have the one poor home birth outcome- what are the things you say and what are the things you don't say? And I think a lot of midwifery leaders don't know how to make the case for developing the MCoCer models, they don't know how to talk about effectiveness of healthcare, they don't know how to talk about efficiency of healthcare, they don't know what language to use. So, I think all those skills can be taught". Participants had imagination, creativity and vision to engage the midwives in the change in practice and invent new ways of developing MCoCer models and therefore organise maternity services around their personal managerial style and behaviours.

Recruitment and retention of midwives into the model is difficult and Caroline thought may be compounded by racial tensions due to the vulnerabilities that midwives can feel when supporting women in unconventional choices, "*midwives from Afro-Caribbean backgrounds, because of the personal experience that they have, with the low levels of micro aggression and racism that they experience on a day to day basis*" can feel uncomfortable in a situation of being in an outlying highly scrutinised model of care.

The participants achieved mastery of safe high quality sustainable MCoCer provision, that worked for midwives and women; Vicki kept questioning, "*how can we make it work for more midwives? and I think continuity models work more when there's not the on-call element. So, we have to look at how the women who would traditionally be having their baby in the obstetric unit- how we might see them through our central antenatal clinic and work even more closely alongside the obstetrician and then they run a line on the labour ward rota*". By imagining and implementing alternatives and integrating students into MCoCer models the participants actively paid attention to and planned a sustainable workforce.

Building a MCoCer model that is integrated into the service enables financial scrutiny to be lessened. A principle vulnerability of the MCoCer model was identified as being an isolated cost pressure that was not integrated into the NHS service.

Being a midwifery manager who is able to sit on the edge of conventional managerial practice and engage with alternatives is imperative. Making it flexible and broad enough to accommodate midwives needs and requirements with variations in the on-call element, as well as exposing student midwives to learning in MCoCer models is seen to be the basis for sustainability.

Core category: Leading meaningful midwifery

By constant comparative analysis 'leading meaningful midwifery' emerged as the core category (see Figure 1). There is a core thread throughout all the participants interviews that by working hard to develop a midwifery service based on autonomous midwifery and trusting relationships, meaning was being brought into practice. The participants had a desire to build and maintain MCoCer that is achievable and sustainable through their style of leadership "*And there is a way of doing it, I believe. Where these midwives can engage within the wider system and thrive, and part of that thriving is knowing someone has got your back, so you've got a strong team, and knowing you've got a strong team*" (Annie).

Lesley feels strongly that social organisational change within the NHS can be frequently dismissed due to the current dominant institutionalised medical culture, "*this is the most important development in maternity services over recent decades. You know, this is the key to humanising birth, to giving quality safe births. Not all midwives want to practice in this way but the power of it is absolutely tremendous and we destroy that power by controlling midwives*". It is important to acknowledge that the participants display courage and willingness to challenge the traditional system whilst having determination to persevere in supporting autonomous midwifery even when it is stressful for them. Creating a meaningful fulfilling working environment for the midwives and managers that produces improvements in quality of care and outcomes for women is the underlying premise of the participants. However, the philosophy of practice is vital to how the NHS will integrate the model: "*We don't teach people how to work in teams, we don't teach things like that. We don't teach them how to manage*

conflict appropriately. We're all just bumbling along butting up against each other, getting on each other's nerves with our different philosophies" (Caroline).

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

Discussion

The study illuminates' practices that enabled MCoCer to be sustainable through midwifery leadership. Specific skill sets, attitudes and behaviours were identified. Midwifery managers who enable and encourage MCoCer in the NHS do so under challenging conditions of scrutiny and a maternity culture that is averse to change.

In summary, the findings indicate that MCoCer models require a midwifery manager with a woman centred philosophy and a relationally focused set of leadership skills. When this is based on a belief in MCoCer and its benefits, the midwifery managers lead the service through change in the NHS more sustainably. By recognising the support required by midwives, midwifery managers can create a service that has choice for midwives and women and enables autonomous midwifery practice to be a reality. By creating a working environment and culture that has woman centred values leads to a working life that has meaning for the midwives providing the care and for the managers leading it. Due to the values-based nature that underpins MCoCer, there is an importance of continuity of management personnel. This supports the implementation of MCoCer and creates a long-term stability. Sustainability of the

MCoCer model requires repeated and sustained interest and support from the midwifery manager to enable recruitment and healthy functioning of the group practices of midwives forming to provide the care. Without such attuned managerial support, the midwives find maintaining a healthy working environment an ongoing challenge.

Trusting in a woman centred philosophy of care: Required Attitudes

Midwifery managers who successfully implement and sustain MCoCer models are focused on maintaining a compassionate woman centred philosophy themselves and expect and promote it from the workforce that they manage. The importance of the managerial and leadership goals being a determinant of the quality of care outcome is confirmed by previous health and managerial research (West et al 2017) [29]. However, this study has determined that the need for this alignment is not overtly considered when developing MCoCer policy which impacts on NHS practice change directives, such as The Best Start (The Scottish Government 2017) [2] and Better Births (NHS England 2016) [3]. Philosophy of care is regarded as integral to practice, however, neither Best Start or Better Births make any contingency plans for how a new model that is based on a woman centred philosophy of care will be integrated into the current institutional medicalised and hierarchical culture of NHS practice.

Findings from this study suggest that organisational models do not in themselves change philosophy of care. This has been shown in other areas of organisational research (Gilley, Dean and Bierema 2008) [30] where a philosophical change is an individual act rather than external practice change. Moreover, for participants, philosophy of care was the impetus for the implementation of the MCoCer model and a key strength in supporting the sustainability of the model. Participants referred to their own personal philosophies being a driving force for them to work within a MCoCer model thus valuing and supporting midwives to practice in this way when in a managerial role. Consequently, it was participants' personal professional philosophies that enabled implementation not the organisational practice of MCoCer models that led to the enactment of the philosophy.

In the wider context of managerial theories, it is suggested that when leading others through change, creating meaning through shared values enhances the commitment and performance of those at work within organisations (Poole and Van de Ven 2004) [31]. This has been identified by Cramer and Hunter (2019) [32] as integral to the working conditions in midwifery. Cramer and Hunter suggest that poor emotional wellbeing in midwives correlates with not achieving continuity of carer amongst other organisational causes. Indeed, it has been shown that poor psycho-emotional wellbeing has repercussions on care delivery. For example, Patterson, Hollins Martin and Karatzias (2019) [15] found that women are more likely to experience trauma when cared for by midwives who experience poor emotional wellbeing and lack of organisational support. Hence the need for NHS midwifery managers to nurture a culture of practice based upon woman centred philosophy where individual midwives feel valued. This helps ensure a midwife identifies with the positive culture at work creating potential for improved safe practice for women being cared for within the maternity services. In other words, to provide tactful compassionate midwifery care to women and their families, midwives need to be cared for in a compassionate organisation (Davies, Crowther and Hunter 2019) [33]. In such an organisational mood, meaning is brought into practice.

Hunter et al (2018) [34] conclude that an emotional connection can be enhanced and celebrated by having midwifery managers who recognise the importance of working in a values-based organisation that encourages supportive flexible working that values the individual alongside their position as an employee. This study highlights that when midwifery managers value and respect women and centre their leadership proactively on supporting the midwifery workforce, the maternity organisation is experienced as enabling and facilitative of choice and control - for both the midwife and the woman in their care. As a consequence of this flexible, evidence-based environment, midwifery managers are more likely to successfully implement and sustain MCoCer models. The need for self-determination and supportive leadership persistently arises in the literature [15, 11,35] (Patterson, Hollins Martin and Katazias

2019; Crowther et al 2016; Gilkison et al 2015;). This study concurs suggesting that an enabling flexible leadership style for MCoCer changes organisational dynamics helping midwives experience greater agency over their own working lives.

In an exploration of availability and willingness of midwives to work in MCoCer models, this study did uncover that there are questions to be asked around cultural challenges for black and minority ethnic midwives. It was suggested by Caroline that these midwives are under-represented in MCoCer models as they may experience tensions with the prospect of working within a system that does not easily sit within organisational boundaries due to their personal experiences of racism. This could have an impact on the racial mix of midwives caring for women in MCoCer models and be detrimental to the recruitment and retention of MCoCer models. Hardeman, Medina and KozhimAnnieil (2016) [36] discuss that care for black women in America is preferable from a black midwife to prevent structural racism. This study suggests that there is a need to encourage engagement with black and minority ethnic midwives to consider working in MCoCer models. Recruitment in your own image is more likely (Agarwal 2020) [37], and therefore having MCoCer midwives who are white recruiting for the model may skew the cultural diversity of the midwifery pool available. This study did not focus on this issue specifically, and any conclusions drawn are only tentative and require further exploration in research adopting, for example, explicit cultural standpoint theory and using more discursive methodologies (Whitehead 2017; Smith 2012) [38,39].

Transformative leadership enabling the assimilation of alternative frameworks of care: Required skill set

Within the wider managerial and leadership context it has been suggested that when supporting the implementation of change the leader is a key player in whether the change is successful (West et al 2017) [29]. Transformational management is a theory that resonates with the identification of the skill set of the participants. Transformational leadership is widely advocated within health and social care settings, Holly and Igwee (2011) [40] identify specific

identifying factors within transformational management skills: providing inspirational motivation, stimulating creativity, transmitting optimism and significance for tasks in hand, providing a sense of direction in attaining organisational goals, providing role models and examples of performance and instilling pride and motivation. The participants identified with the importance of these qualities and they all exhibited the skills identified as necessary to build a successful relationship with the midwives to encourage a positive culture that enabled a transformation to occur. The participants all suggested that the education for future midwifery leaders should include the necessary skill set required when implementing and sustaining MCoCer models.

The findings suggest that it is vital to provide service commissioners and policy makers with evidence around the importance of the skill set required by midwifery managers in relation to the implementing and sustaining of MCoCer within the NHS. Arguably not having the necessary leadership skills may challenge the implementation and sustainability of the model. Moreover, consideration of these skills needs to occur at the planning stage.

Having a transformational style of management motivated the participants as individuals to have the courage to stand up for midwifery through the challenging times. This motivation enabled them to thrive in their position as managers in both the implementation and the sustainability aspects of the model.

Promotion and protection of values-based midwifery and a woman centred culture: Required attributes

Consistent with Hewitt, Priddis and Dahlen's (2019) [12] work, this study confirms that managers of midwives who are working in a MCoCer model are required to clearly demonstrate a belief in the model. Hewitt, Priddis and Dahlen (2019) [12] describe it as 'Holding the ground for midwifery, for women' where the midwifery managers need to protect, guard, promote and safeguard the service. If we interpret safeguarding as actions that allow something, in this case, relational continuity of midwife carer, to continue over time in the

current NHS organisation, then the imperative to protect such a model involves a myriad of strategies to sustain such change including resolute, well attuned transformational leadership. Yet, it is worth considering that there are a small number of midwifery leaders with the experience of managing MCoCer models.

Participants required a thorough and intimate knowledge of MCoCer models and an ability to promote and defend the model within the current NHS organisational culture through these skills and attributes. During implementation a skilled manager needs to facilitate development of their staff so they can navigate and practice what is perceived as a non-mainstream service.

Mastery of high quality, safe midwifery continuity of carer models: Required behaviors

Participants related the importance of being willing to safeguard MCoCer, a non-mainstream service, within mainstream maternity services and having to recognise the vulnerability of having a model of care that may not be supported by other members of staff or could be and was resisted by some staff. The importance of the culture within the unit was a vital part of recognising how to integrate MCoCer into the service. This study suggests that in order to have a positive integration of MCoCer, the managers of the service must recognise the culture as something to influence and they must role model their expectations in order to form a positive, supportive environment to work in. To manage the changes, participants influenced the organisation's cultural behaviours by having an open and honest respectful relationship with the midwives. Likewise, development of positive relationships with the members of the hospital board to influence change and garner financial support for the MCoCer transition to practice is imperative.

This is consistent with the finding of McCourt et al's (2018) [41] ethnographic study on alongside midwifery units which suggested that establishing a trusting relationship within the unit's staff when leading change was important for the sustainability of the model. Furthermore, the intra-professional tensions that have been reported within the NHS maternity culture by the Francis report (2013) [42] were highlighted within this study in terms

of there being a need for collective working and collaboration when change in service is planned. Consequently, the building of relationships is repeatedly mentioned by participants as a key component of managing, leading, planning, implementing and sustaining the MCoCer model. McInnes et al (2020) [20] agree with this finding that developing trusting relationships at all levels is key to service transformation towards MCoCer.

Previous writers have emphasized the impact on quality care provision through cultural change when choice and control are able to be exerted by midwives over their working life (Patterson, Hollins Martin and Katazias 2019) [15]. As stated previously, self-determination and autonomy are essential in successful MCoCer models of care (Homer et al 2019) [43]. This is not described by the participants as an easy task to initiate or maintain, moreover it is described as an essential one, it is a prerequisite to sustain the change in practice to MCoCer within the whole maternity service. With the ongoing endemic culture in contemporary NHS maternity services being described as bullying and negative (RCM 2016) [44] the impact of cultural change from individualistic to collaborative, and transactional to relational, requires a hierarchical managerial system to behave in a non-hierarchical way. This calls for transformative and meaningful leadership with a clearly articulated vision.

Leading meaningful midiwfery: Midwifery managers' voices and vision

The participants use their communication skills to advocate for autonomous midwifery. They recognise a need to use their position as managers to change practice and enable MCoCer models to support midwives and women in the service. They stand by their vision and use their midwifery voice to transition the services to benefit those with less power to enact change. By utilising their managerial position within a hierarchical organisation, participants are able to action a vision that they care about in order to benefit midwives and women who require a voice. Participants demonstrate a passion and care for midwifery and woman-centred services and are motivated to create an impact on service delivery in their organisations for the benefit of women and their families. Their midwifery mindset of relational care and a passion

for developing relationships and caring for women in a compassionate way determines and strengthens their voice. Having this clear strong leadership voice is essential. The need for a voice resonates with the work of Leap and Hunter (2013) [45] where acknowledgement of a hierarchical structure and the positions of power that are afforded to those within the NHS are more likely to be male and medical. The gender roles of female midwifery managers giving voice at board level negotiating structures on behalf of a female workforce to care for birthing women is a role that needs preparation and support (Homer et al 2019) [43]. The participants in this study all sought support from colleagues and others in positions of status to advance their navigation through the bureaucratic structure.

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

Sustaining the model through mastery

Participants were all dedicated to the managerial role and the provision of MCoCer models – this requires energy and commitment and is demanding on a personal level. This dedication is in correlation with their aim for the women in the service to be cared for compassionately in relational models of care. This can be perceived as a seeping of power from midwifery managers to midwives to enable autonomous practice within a hierarchical institution. By delivering the outcomes that mattered to themselves they were able to sustain a level of fortitude and energy to maintain the model.

It appears from this study that having midwifery managers who have personal direct experience of working in a MCoCer model enhances their ability to understand what the supportive role of a midwifery manager for MCoCer entails. They understand how the life of a MCoCer midwife differs from those working in the traditional models of care. By describing the midwives who chose to work in this model as different or 'other' there is an implication that the participants in this study may also identify with being 'other' as they were once those

midwives working in such ways. This appears to be both stimulating in how the managerial style of those individuals translated into practice by being non-hierarchical, but also challenging in their innate understanding of the relational model and its difficulty in fitting into the individualistic and highly structured culture of the NHS. For participants the personal passion and drive for relational care is collaborative and they want to make a difference, but they also find it draining in terms of the personal energy that it requires. The juxtaposition of requiring collaboration of philosophies in order to provide individualised care alongside the individualistic nature of leading a transformative change programme is a constant challenge. Participants identify that being 'other' was a vulnerability, therefore they live in a vulnerable place as midwifery managers. It is however in their nature to develop relationships; this enables authentic understanding and choice in a culture where unconventionality is supported.

This unconventional behaviour is discussed by participants in relation to supporting women with their choices. It can also be seen in the participants supporting the midwives in unconventional models that do not conform to system 'traditions' despite being condoned by evidence and policy. There was a need to control the parameters of the working environment so that the participants could function in their role whilst preserving the choice for midwives to work autonomously in MCoCer models, this took time and effort. This finding concurs with Menke et al (2014) [46] who recognised that large institutions such as the NHS, require rule bound compliance to provide accountability. Usually, a command-and-control style of leadership will be adopted in pressurised situations (Edmondson 2016) [47]. This can lead to a blame culture with hostility and scapegoating of outliers such as those midwives working within a MCoCer model. Therefore, the participants gained mastery by developing their skills and repeatedly being courageous in their defence of autonomous midwifery models within the NHS.

Making meaning from leading

Contributing to the greater good is a deep and fundamental human need (Rogers 2004) [48]. By offering a clear path and a vision these exceptional leaders are able to create a more positive future for all. They do this by using their skills in leadership to support MCoCer models through challenges by planning and integrating the models into the NHS system of maternity care. This is the result of working and believing in the care provided through relational continuity. They tackle poor behaviour and model a compassionate approach towards the staff by listening to staff and being available for them modelling an open and honest culture. They positively recruit to the values of the MCoCer model and encourage healthy work environments for midwives to choose where they work. Having this as a basis became apparent in their approach to implementing and sustaining the MCoCer model. They understand the need to make work matter to others in a meaningful way.

Cummings et al (2018) [49] systematic review of nursing working environments confirmed that relational and transformational leadership is required by leaders within the health services to create job satisfaction in the workplace. Having a belief in people and relationships is essential in changing the culture, which is necessary within the NHS, therefore thinking differently is essential. Without a belief in the primacy of relationships, MCoCer will fail to develop the relational aspect of the midwifery role that is considered protective in the model. Considering human factors and concern for employees as people has been shown to be an essential attribute for leaders to maintain recruitment and retention in healthcare (Cummings et al 2018) [49].

Carr et al (2019) [50] also concur that inclusion in the workplace is necessary for team working. By enabling an outlying group of midwives to work within the NHS and provide good quality relational care, MCoCer leadership can encourage team focus and meaningful inclusion at work by preventing exclusion of this cohort of midwives. By being seen to openly support this cohort of midwives, participants create a safe culture where there is encouragement to learn and develop together.

It can be construed that overall; this study has found that midwifery managers who have compassion and drive to implement MCoCer will encourage autonomous development of midwifery. By earning respect from the midwives and maternity stakeholders, participants have the courage to take the road less travelled. This supports and encourages MCoCer services to be implemented and sustained. This meaningful environment is a sustainable way to provide MCoCer models in the NHS. Although this study demonstrates that this leadership requires considerable effort it also comes with its own dividends. The style of leadership exhibited in this study has been shown to lead to intellectual stimulation and the ability to become an exemplary leader (Kouzes and Posner 2017) [51]. These are motivating and meaningful outcomes for all midwifery leaders who aim to make a difference.

Strengths and Limitations

This study was focused on the creation of a theoretical framework grounded in the views and experiences of experienced UK midwifery managers in MCoCer models that could then be employed by midwifery managers who have little to no MCoCer management experience in their own services. The purpose was to produce a pragmatic and practical framework in order to improve future service provision.

The constructivist grounded theory approach was an ideal methodological choice and provided a robust process for this to be achieved; whilst acknowledging that the framework now needs to be fully evaluated in future work. This study recruited five participants that may be construed as too few to reach theoretical saturation, however, MCoCer models within the UK NHS organisation has a complex and challenging history and this is reflected in the limited population of potential participants. The challenge in having a breadth of experience across borders and health boards is due to the nature of the models where implementation has been sparse, and experience limited to the few rather than the many as identified by Homer et al (2017) [4]. There could have been an homogenising effect of experienced MCoCer managers creating an environment that is based on similar experiences to each other in this study. It

could be suggested that those who have sought out specific experiences as leaders is due to their preference for autonomous midwifery practice and that they consequently identified or even colluded with similar impressions and experiences as each other limiting the extent of the theoretical framework and therefore only reflect the perceptions of those involved who are committed to the model and thus may not be generalisable. Conversely, this study suggests that in order to successfully support autonomous midwifery practice within a MCoCer model, a midwifery manager needs to be grounded in the belief that MCoCer model is of value.

Conclusion

MCoCer models are sustainable within the NHS when support and leadership is from midwifery managers who have the necessary aptitude, attitudes, skills and behaviours. Midwifery managers who implement and sustain MCoCer successfully are highly motivated, driven, practice-based midwifery leaders who care passionately about supporting autonomous midwifery. They have a clear woman centred philosophy and desire to enact this philosophy through sharing their vision and promoting relational care with women. The overarching purpose of their leadership is creation of positive, inclusive, evidence focused compassionate working environments for midwives to flourish in MCoCer models even within more traditonal maternity settings. The desire to lead maternity services towards a cultural shift that changes how midwifery practice occurs and alters the way women are cared for is essential. Midwifery managers who impliment and sustain MCoCer find meaning professionally and personally with relational continuity. Sustainable implementation and succession of MCoCer leadership will be achieved through development of a values-based recruitment and retention policy and leadership development of midwives with previous experience in MCoCer. Although providing the appropriate support for MCoCer is time consuming and personally demanding for midwifery managers and leaders, implementing and sustaining MCoCer is shown to be rewarding and meaningful.

Recommendations

When developing policy concerning MCoCer within organisational change, the skill set of the midwifery managerial oversight should be considered and recruited for to enable implementation of change. The theoretical framework developed in this study could be used in recruitment of midwives at all levels to encourage engaging the workforce of the NHS in supporting and protecting MCoCer until it becomes more mainstream. Including non-hierarchical and transformational management educational packages and encouraging Universities within the UK to recruit staff and students through a values-based recruitment model to include philosophical drivers and attitudes of candidates towards MCoCer models, succession planning and long-term sustainability of leadership of this model could be improved. Furthermore, the theoretical framework of this study requires further evaluation to validate and help generalisability. This evaluation work needs to be done in conjunction with further studies examining the structural issues within the NHS that create barriers and facilitators to implementation and sustainability of MCoCer.

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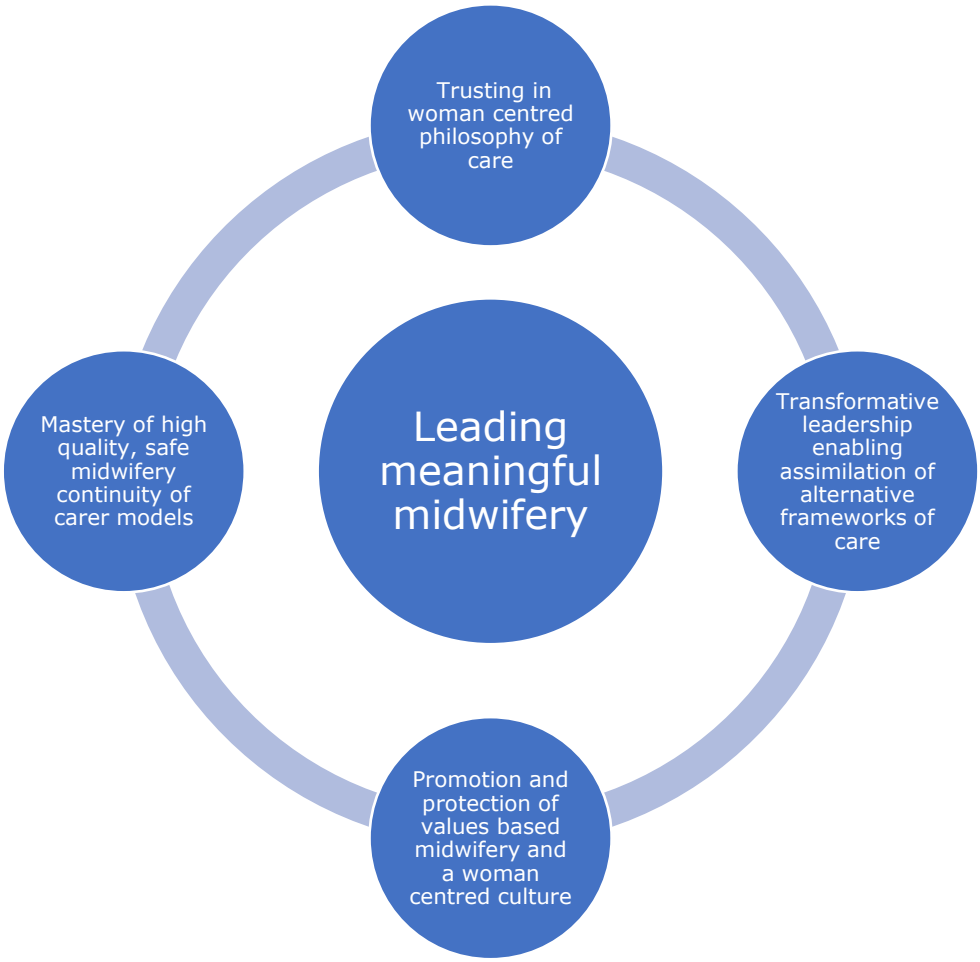
Figure 1 :Theoretical model of Leading meaningful midwifery



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