

## University of Southampton Research Repository ePrints Soton

Copyright © and Moral Rights for this thesis are retained by the author and/or other copyright owners. A copy can be downloaded for personal non-commercial research or study, without prior permission or charge. This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder/s. The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given e.g.

AUTHOR (year of submission) "Full thesis title", University of Southampton, name of the University School or Department, PhD Thesis, pagination

**UNIVERSITY OF SOUTHAMPTON**

Faculty of Health Sciences

**The Role of Consultant Midwife: An exploration of the expectations, experiences and intricacies**

Ann Robinson

Thesis for the degree of Doctor of Philosophy

December 2012



UNIVERSITY OF SOUTHAMPTON

## **ABSTRACT**

FACULTY OF HEALTH SCIENCES

Doctor of Philosophy

### **The Role of Consultant Midwife: An exploration of the expectations, experiences and intricacies.**

**Ann Robinson**

Consultant nurse and midwife roles, with the expectations of significantly moving forward the professions in relation to practice development, effective leadership and quality care provision, have been a major UK policy initiative since 2000. Whilst consultant nurses have received much attention, consultant midwives have been relatively little researched.

This study aimed to explore the intricacies of the consultant midwife role. Using an in-depth qualitative case study design, the roles of eight consultant midwives across eight NHS Trusts in England were studied. Data were collected via in-depth interviews with consultant midwives, their heads of maternity services and consultant obstetricians; additionally, the consultant midwives were observed in practice and documentary evidence (their job descriptions) were examined. Data were analysed thematically and aggregated, revealing three dominant themes related to clinical wisdom, taking control and shaping the future.

Findings showed that the consultant midwife is in a position of power, built on a foundation of clinically acquired wisdom, transformational leadership skills and a belief in woman centred care, essential to a profession fit for the future. Individually and collectively, the consultant midwives conveyed a passion for their role, whilst aware of the demands of their position. Their impact lay in relation to the way they used their experience, skills and understanding, to undertake complex roles in practice, juggling responsibilities to effect change and improve services for childbearing women and their families. Their strength was born out of acquired knowledge and expertise, as leaders and as role models, influencing not only practice but the midwives of the future.

This thesis provides the first in-depth exploration of the consultant midwife role and as such greatly strengthens the hitherto limited evidence base. As well as focusing on the particular aspects of day-to-day consultant midwifery it also gives detailed recommendations for further development of the role organisationally.



## Table of Contents

ABSTRACT .....	i
Table of Contents .....	iii
Table of Tables.....	vii
Table of Figures .....	ix
Academic Thesis: Declaration of Authorship .....	xi
Acknowledgments .....	xv
Abbreviations .....	xvii
<b>1 Introduction .....</b>	<b>1</b>
1.1 Introduction.....	1
1.2 Rationale for the Study .....	1
1.3 Consultant Midwifery Practice: Context and Role Establishment .....	3
1.3.1 A Time of Transition and Modernisation .....	4
1.3.2 Numbers of Consultant Midwives in Practice .....	5
1.4 Consultant Midwives and a Reorganizing NHS .....	5
1.5 Improving Maternity Services .....	6
1.6 A Brief Overview of the Research Design.....	7
1.7 Midwives and Obstetricians in Practice: Terms and Definitions Used .....	8
1.8 Presentation of the Thesis .....	8
1.9 Summary of Introductory Chapter.....	10
<b>2 Review of Literature .....</b>	<b>11</b>
2.1 Introduction.....	11
2.2 Rationale for Review of Literature and Research Evidence.....	12
2.3 Identification of Eligible Literature and Research Studies.....	12
2.4 Selected Evidence .....	14
2.4.1 Early Initiatives Taken to Define Consultant Practice .....	14
2.4.2 The Impact and Effectiveness of Nurse, Midwife and Health Visitor Consultants.....	15
2.4.3 The Consultant Nurse Role: Preparation, Characteristics and Achievements .....	21
2.4.4 The Consultant Midwife Role: Preparation, Characteristics and Achievements .....	30
2.5 Summary of Literature Review .....	41
<b>3 Research Design.....</b>	<b>45</b>
3.1 Introduction.....	45
3.2 The Research Questions .....	45
3.3 The Aim and Objectives of the Study .....	45
3.4 Constructivism and Qualitative Methodology.....	46
3.5 Case Study Design .....	48
3.5.1 Defining Case Study.....	48

3.5.2	Identifying the Case .....	49
3.6	Recruitment of Participants.....	50
3.6.1	Inclusion Criteria for Participants .....	52
3.6.2	Exclusion Criteria for Participants.....	52
3.7	Methods of Data Collection.....	53
3.7.1	Consultant Midwives.....	53
3.7.2	Heads of Maternity Services.....	53
3.7.3	Medical Practitioners (Consultant Obstetricians) .....	53
3.7.4	Interviews .....	54
3.7.5	Observation .....	55
3.7.6	Documentary Evidence (Job Descriptions).....	56
3.7.7	Reflexivity .....	57
3.8	Data Analysis.....	59
3.8.1	Thematic Analysis of Interview Transcripts.....	59
3.8.2	Organisation of the Interview Data .....	60
3.8.3	Identification of Descriptors and Emerging Themes .....	61
3.8.4	Analysis and Integration of the Observational Data and Documentary Evidence .....	63
3.9	Ethical Considerations .....	64
3.9.1	Beneficence.....	65
3.9.2	The Right to Human Dignity.....	66
3.9.3	Justice .....	67
3.9.4	Ethical Approval.....	68
3.10	Trustworthiness .....	69
3.11	Summary of Research Design.....	73
<b>4</b>	<b>Findings .....</b>	<b>75</b>
4.1	Introduction.....	75
4.2	Theme 1 Having Clinical Wisdom .....	75
4.2.1	Being Clinically Competent.....	77
4.2.2	Being a Role Model .....	81
4.2.3	Understanding the Meaning of Practice.....	87
4.2.4	Having Clinical Wisdom: An integration of the Three Sources of Data 93	
4.3	Theme Summary .....	94
4.4	Theme 2 Taking Control .....	96
4.4.1	Influence without Power .....	96
4.4.2	Providing Strong Midwifery Leadership .....	102
4.4.3	Coping with Frustrations.....	106
4.4.4	Taking Control: An Integration of the Three Sources of Data .....	112
4.5	Theme Summary .....	113
4.6	Theme 3 Shaping the Future .....	114
4.6.1	Role Sustainability .....	117
4.6.2	Senior Practitioners within Midwifery Hierarchy.....	121
4.6.3	A Maternity Service for the Future .....	125
4.6.4	Shaping the Future: An Integration of the Three Sources of Data .	128
4.7	Theme Summary .....	129
<b>5</b>	<b>Discussion.....</b>	<b>131</b>
5.1	Introduction.....	131
5.2	The Role of the Consultant Midwife .....	134
5.2.1	Clinical Wisdom .....	136

5.2.2 Taking Control .....	145
5.2.3 Shaping the Future .....	150
5.3 Summary of Discussion .....	152
<b>6 Conclusions and Recommendations .....</b>	<b>153</b>
6.1 Introduction.....	153
6.2 Design Strengths and Limitations including Obstacles Encountered ....	154
6.3 Specific Implications for Midwifery Policy and Practice.....	159
6.4 Implications for Future Research.....	164
6.5 Summary of Conclusions and Recommendations .....	165
 Appendices .....	 167
Appendix 1 Research Guide.....	169
Appendix 2 Ethics Committee Approval Letter.....	177
Appendix 3 Participant Letters.....	181
Appendix 4 Participant Information.....	189
Appendix 5 Participant Consent Form .....	197
Appendix 6 Consultant Midwife Demographics.....	201
Appendix 7 Interview Guides .....	205
Appendix 8 Template for Recording Observational Notes .....	213
Appendix 9 Client Information Sheet and Consent Form .....	221
Appendix 10 Anonymised Job Description .....	227
Appendix 11 Consultant Midwife Biographies.....	237
Appendix 12 An Example of Observational Notes Taken .....	243
References.....	253



## Table of Tables

Table 1	Inclusion and Exclusion Criteria of Evidence included in Literature Review .....	14
Table 2	The Application of Preliminary Descriptors to an Extract of Data.....	61
Table 3	An Example of How Preliminary Descriptors across Interview Transcripts were Colour Coded and Categorized .....	62
Table 4	An Example of How Comparable Preliminary Descriptors Became Broader Descriptors .....	63
Table 5	An Example of How Broader Descriptors Finally Became Encapsulated Into A Theme .....	63
Table 6	Sections of Observational Data to illustrate the Themes which arose following Thematic Analysis of the Interview Data .....	64
Table 7	Sections from Job Descriptions used to illustrate Themes.....	64
Table 8	A Summary of Participants' Rights in relation to the Consultant Midwife Study.....	68
Table 9	A Flexible Design Approach.....	69
Table 10	Models of Trustworthiness .....	72



## Table of Figures

Figure 1	Ethical Principles for Protecting Research Participants .....	66
Figure 2	Theme 1 Having Clinical Wisdom .....	76
Figure 3	Having Clinical Wisdom: An Integration of the Three Sources of Data .	94
Figure 4	Theme 2 Taking Control .....	97
Figure 5	Taking Control - An Integration of the Three Sources of Data .....	112
Figure 6	Theme 3 Shaping the Future .....	115
Figure 7	Shaping the Future: An Integration of the three sources of data.....	129



## **Academic Thesis: Declaration of Authorship**

I, Ann Robinson

declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Title:

**The Role of Consultant Midwife: An exploration of the expectations, experiences and intricacies.**

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. Either none of this work has been published before submission, or parts of this work have been published as: [please list references below]:

Signed:

Date:



This PhD Thesis is dedicated to my much loved brother Robert, whom I know would have been immensely proud and would have shared in my achievement.

**Robert John Williams**  
**1964 - 1994**



## Acknowledgments

This PhD thesis would not have been completed without the enduring support and guidance I received from colleagues, family and friends. Some deserve individual acknowledgement for their unfaltering encouragement.

Firstly, I wish to express my gratitude to Professor Judith Lathlean whose wisdom, guidance and encouragement has been constant. Apart from sharing her knowledge and expertise, Judith gave me the confidence to realise my potential, she has been inspiring and dedicated. I would also like to thank two other research supervisors, Dr Jane Rogers and Professor Andrée Le May. Dr Rogers I thank for her guidance in the early days and in particular in identifying possible research participants. To Professor Andrée Le May I say a special thank you for all the support and encouragement given to me in the final stages of my PhD studies.

I would particularly like to extend my appreciation to those who enthusiastically gave their time to participate in this research study, by describing their experiences and perspectives on the consultant midwife role. This thesis would not have been written without them; I have taken care to represent their perspectives and I hope that in some way this study will help sustain the role of consultant midwife, by identifying the significance of the role in relation to the future of the midwifery profession.

To my midwifery and nursing friends within the Faculty of Health and Medical Sciences, University of Surrey, I thank you for your continuing support, advice and patience.

Finally, an enormous thank you to my parents Kenneth and Shirley Williams and to my husband David. To Mum and Dad I thank you for your endless support and on-going belief in me to succeed; to David a special thank you for being there and for your enduring patience and encouragement.



## Abbreviations

AHP	Allied Health Professional
CINAHL	Cumulative Index to Nursing & Allied Health Literature
CMW	Consultant Midwife
CO	Consultant Obstetrician
COREC	Central Office for Research Ethics Committees
DH	Department of Health
DFeS	Department for Education and Skills
EMBASE	The Excerpta Medica database
HOMS	Heads of Maternity Services
HSC	Health Service Circular
ICM	International Confederation of Midwives
ICN	International Council of Nurses
IRAS	Integrated Research Application System
MRC	Medical Research Council
MIDIRS	Midwifery Information & Resource Service
MREC	Multiple Research Ethical Committee
MW	Midwife
NHS	National Health Service
NMC	Nursing and Midwifery Council
NRES	National Research Ethics Service
OPSI	Office of Public Sector Information
R&D	Research and Development
RCM	Royal College of Midwives
RCN	Royal College of Nursing
REC	Research Ethics Committee
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing Midwifery and Health Visiting
VBAC	Vaginal Birth after Caesarean Section
WMA	World Medical Association



# 1 Introduction

## 1.1 Introduction

Innovation in health policy led to the recruitment of consultant midwives in maternity units across the United Kingdom (UK) from early in the twenty first century. These experienced clinicians have had a critical role to play in moving the midwifery profession forward in relation to practice development, effective leadership and quality care provision (Department of Health (DH) 2007; DH 2008; DH 2009). This introductory chapter provides a rationale for this in-depth midwifery study which focused on exploring the practice of consultant midwives within the National Health Service (NHS) in England and in so doing gaining perspectives as to the intricacies of the role. A brief overview of the research design is provided, key terms referred to within the document are defined and the presentation of the thesis is explained.

## 1.2 Rationale for the Study

Part of my rationale for undertaking this research study on consultant midwifery practice ultimately stemmed from an interest in following the transition of practitioners within new roles. In particular, my motivation came from a curiosity to observe the development of senior clinical roles in relation to leadership skills and collaborative and inter-professional working. Inspiration for the study also emanated from those who had previously studied specialist and advanced practice roles (e.g. Manley 1997 and Wilson-Barnett et al 2000) as well as the lecturer practitioner role (Lathlean 1992, 1997; Elcock 1998) which, like the consultant midwife (mw) is complex and multi-faceted, combining different aspects of clinical practice and education.

As a midwife it is fascinating to observe midwifery practice evolving in response to the changing needs of childbearing women and their families accessing the maternity services. Recommendations instigated through primary research and initiatives generated by the Department of Health, The Nursing and Midwifery Council and The Royal College of Midwives (RCM) are designed to lead the way to a modern and responsive maternity service (O'Neill 2008). The aim of midwifery, as expressed in policy documentation e.g. DH (2009) and as articulated by commentators such as Walsh and Downe (2010), is to increase excellence in practice through broadening of the midwife's role, visibly leading practice development, working collaboratively and continually responding to the needs of childbearing women especially in relation to keeping pregnancy and delivery normal (DH 2009; Walsh and Downe 2010). At the beginning of this research journey and up to the present day, considerable demands continue to be seen being placed on practice, these relate to meeting the challenges of a rising birth rate, health inequalities and women's

more complex needs e.g. the older mother (DH 2007, Lewis 2011). Simultaneously, developments in midwifery practice continue to be impeded through reduced funding, difficulties recruiting and retaining staff and the effect of junior doctors' hours having been reduced.

The introduction of new and different roles to cope with changing demands, reduced resources and to provide 'solutions' to increase efficiency and raise standards in the NHS is commonplace. Within midwifery this has resulted in posts such as modern matrons, maternity support workers and consultant midwives. The consultant role was particularly intriguing to me because of its potential complexity and the claims that were made for it, for example that it would

“...help to provide better outcomes for patients by improving services and quality, to strengthen leadership and to provide a new career opportunity to help retain experienced and expert nurses, midwives and health visitors in practice” (NHS Executive, HSC1999/217).

Although it was possible to trace the development of the consultant midwife through professional and Government literature (e.g. DH 1989; Manley 2000 a and b; Hayes and Harrison 2004; Graham and Wallace 2005), and research studies had been undertaken on the first generation of consultant nurses, midwives and health visitors (notably Guest et al 2001 and 2004) nursing consultants had been the predominate focus. Substantial, research based studies had not been published which focused solely on the consultant midwife role, experience and achievement. The available literature comprised mainly of discussions relating to experiences, rather than primary research (see for example, (Shuldham 2004; Brett 2005; Ambler 2006).

There was justification therefore to look at the roles separately, since although nurses and midwives are both regulated by the NMC and both are providers of healthcare and are accountable for their actions, there are fundamental differences, with midwives practising much more autonomously than the majority of nurses (NMC 2004). Professional similarities relate to developing practice, supporting policy development and initiating change, via effective leadership and inspired role modelling. Whilst initiatives taken by consultant nurses were seen as valuable and informative for providing insights into this new kind of 'consultant role', it was felt important to study consultant midwifery practice especially in relation to the influences the midwives were having on midwifery care provision, but also in relation to their experiences and the operational and strategic influence consultant midwives were having on developing the midwifery profession.

The purpose of this study was therefore to explore exclusively the intricacies of the consultant midwife role. Using a case study approach, the study was designed to focus on the role and experiences of consultant midwives working in eight NHS Trusts in England. Heads of maternity services and consultant obstetricians, all of whom worked closely with the consultant midwives, provided perspectives as to the consultant midwife role. To this end the title for this study was *The Role of Consultant Midwife: An exploration of the expectations, experiences and intricacies*.

### **1.3 Consultant Midwifery Practice: Context and Role Establishment**

Nurse, Midwife and Health Visiting Consultant roles came to fruition in the latter part of the last decade and early twenty first century (NHS Executive, HSC1998/045; NHS Executive, HSC1998/161; NHS Executive, HSC1999/217) but had been planned for some time, as different ways of working were considered (DH 1989; DH 1991; DH 1997a; DH 1997b; DH 1999a; DH 1999b; United Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1999). Nurses, midwives and health visitors were not alone; allied health professions (AHP's) also introduced consultant positions to enhance quality and modernise practice. By 2004, consultant allied health professionals were newly in post. They were called "therapist consultants" to differentiate AHP's from nursing and medical consultants...." (DH 2000, 5.10); the vision however was the same, that is to strengthen patient services, improve quality and leadership and modernise and enhance practice, thus the outcomes for patients. This somewhat 'national' revelation has since expanded further; with non-medical consultants slowly infiltrating practice on an international scale e.g. Canada, Australia.

In Britain, preliminary consultation focused on limitations of the career structure for nurses, midwives, health visitors as well as allied health professionals e.g. physiotherapists, radiographers, pharmacists, speech therapists. There had been concern as to the numbers of experienced staff leaving the NHS to achieve career and salary advancement. A new strategy was sought which reflected a more flexible, innovative and collaborative workforce, where senior practitioners were given authority to develop practice and strengthen their leadership (NHS Executive, HSC1998/045), leading to improved career opportunities, role retention and improvements in care for childbearing women and their babies (NHS Executive, HSC1999/217). Detailed proposals were discussed in the document 'Making a Difference': Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare (DH 1999a), The NHS Plan (DH 2000) and Meeting the challenge: A Strategy for the Allied Health Professions (DH 2000). Operational plans were circulated via the Health Service Circular (HSC) (NHS Executive, HSC1999/217).

### **1.3.1 A Time of Transition and Modernisation**

The four fundamental features of the consultant role were documented as being expert practice; professional leadership and consultancy; education, training and development; and practice and service development, research and evaluation (NHS Executive, HSC1999/217). It was envisaged that these practitioners would be practice based and “that partnerships between the NHS and local universities would be set up to enhance education and research functions” (Redfern et al 2003:154).

As emphasised, this enterprise came at a time of transition and rejuvenation (DH 1997a; DH 1999a), at a time when people’s expectations in healthcare provision was ambitious. Sociological changes, medical and technological advancement and political inquisitiveness meant that healthcare provision had to change in readiness for the escalating demands that a new century would no doubt entail (Graham and Wallace 2005). Government and professional policy makers were encouraging change and improvements in patient care, delivery and outcomes. The new NHS was “committed to giving the people of this country the best system of healthcare in the world” (DH 1997a, p4). To this end, a ten year health strategy for England namely, ‘Saving Lives: Our Healthier Nation’ (DH 1999b, p1), aimed to “improve the health of everyone”, to improve length and quality of life and to reduce health inequalities. The document called for “professional staff to apply their skills and knowledge (and) to play a part in securing the aims set out...” (DH 1999b, 11.9).

A more reactive and well-informed workforce, able to multitask and contribute to strategic healthcare development was sought. The NHS Plan had, amongst its core principles, a promise to “reward and invest in individuals and organizations, providing opportunities for individual staff to progress in their education, training and personal development” (DH 2000, p4).

The Government’s healthcare strategy had therefore been defined and it was clear from the start that nurses, midwives, health visitors and allied health professionals would be influential in shaping the health services of the future (Redfern et al 2003). Skills in leadership, education and advanced practice needed a keen focus and practitioners with experience and initiative i.e. the new consultant practitioners, were to be remunerated for practicing “at the highest level in a new practice career framework” (NHS Executive, HSC1999/217). At the heart of the role would be practice and improving patient care provision through leadership and strategic advancement.

### 1.3.2 Numbers of Consultant Midwives in Practice

The number of consultant nurse posts greatly outweighs that of midwives and the expansion has been exponential. Thus, since the establishment of the consultant role in 2000, the Government's workforce statistics have shown a growth in the number of consultant nurses in post. In 2001, 139 consultant nurses were in post and by 2008 this number had escalated to 859 (NHS Information Centre 2009). There are no corresponding workforce statistics for consultant midwives, however the numbers of consultant midwives in practice have over time fluctuated, with some midwives moving into midwifery management positions or leaving the profession (Stephens 2006). In order to accurately identify the number of consultant midwives in practice in England, individual Strategic Health Authorities were contacted, and they estimated that as of November 2009, only forty eight consultant midwives were in post in England.

### 1.4 Consultant Midwives and a Reorganizing NHS

Since the inception of consultant midwives in the year 2000, health reform has continued to dominate professional debate and discussion. The emphasis today is on promoting wellbeing, reducing health inequalities and providing excellent quality care (DH, 2004a; DH, 2006; DH 2007; Department of Health, Social Services & Public Safety et al 2010; DH 2012). Maternity care providers have long had an agenda which seeks to uphold the government's commitment of providing a high quality, safe and accessible maternity service. Collaborative working and the integration of services, form the basis of contemporary midwifery care. Strengthening clinical leadership in midwifery is crucial (RCM 2009; RCM 2012) if services are to be developed and patient outcomes improved.

Consultant midwives continue to be seen as being in a prime position to act as facilitators for any changes envisaged. Whilst recent history has witnessed senior practitioners moving away from practice into education and management in order to advance in the midwifery career structure (Finlayson et al 2002; RCM,2009), consultant midwives have the opportunity to remain 'in practice' (NHS Executive, HSC 1999/217). In fact, guidelines relating to the role of the consultant midwife emphasise 50% of time being made available to practice, enabling practitioners to maintain their professional competences and clinical credibility. This guidance emphasises "sustaining the authority of professional expertise" (NHS Executive, HSC 1999/217:6).

Being 'in practice', providing 'hands on' care and being 'with woman', thus remaining clinically competent, is important for midwives at all levels and an improved career structure for experienced practitioners was long awaited (RCM 2009). The arrival of consultant practice was intended to represent all that equates to being 'in practice' and leading practice development as a result of professional and academic advancement. The

Anglo-Saxon translation of 'midwife' is to be 'with woman' (mid – 'with' & 'wyf' – woman) whilst the Italian 'comare' means 'with – mother' and the French 'sage-femme' translates as 'wise woman' (Donnison 1988). These translations emphasise clinical practice and experience; both are key features of the consultant midwife role. This study was therefore designed to focus on role development and how consultant midwives are leading services at a time when concerns about the ways in which NHS maternity care is advancing (DH 2004a; DH 2007; RCM 2009).

### **1.5 Improving Maternity Services**

Consultant midwives are expected to be fully engaged in improving care for all users of the maternity service (DH 2004a; DH 2007). Ensuring safety in practice and providing excellent care in the shape of evidence based practice has become a key aspect of the consultant role (Rogers et al 2008). Midwifery practice in Britain is one of self-regulation which via The Nursing and Midwifery Council (NMC) adheres to rules, standards and guidelines (NMC 2004; 2008) aiming to protect the public from poor practice, ensuring the wellbeing of childbearing women and their babies. Midwifery self-regulation depends on midwives from the point of registration being competent and accountable for their actions and practising in accordance with Midwifery Supervision. Midwifery Supervision distinguishes midwives from other health professionals (Butler et al 2006) and is characteristic of the midwifery profession in the United Kingdom. Midwifery education is heavily regulated by the NMC (2004, 2009), Universities and The International Confederation of Midwives (ICM) (ICM 2008) with students being required to achieve the competencies set out, before they are entered onto the NMC midwifery register.

Initiatives to protect the public and improve health services have long received public, professional and political attention. Improving NHS patient care was given renewed energy in the last Government by Lord Darzi, in a report of a national NHS review, entitled 'High Quality Care for All' (DH 2008). This review involved consultations and discussions undertaken both nationally in England and at Strategic Health Authority level. An NHS fit for the future was called for, with client information, choice, partnership and quality care at the heart of the discussion. For this to become common place, effective leadership, integrated services and collaborative working was seen as needing renewed energy so as to improve the quality of care given to all (DH,2008).

Specific to the maternity services, a King's Fund report, written at the same time and entitled Safe Birth: Everybody's Business (O'Neill 2008), was an independent inquiry into the safety of maternity services in England; it made several recommendations relating to safe practice and contemporary ways of working. This report concluded that although the majority of births in England are safe, staff needed to work on improving effective team

working. As with Lord Darzi's (DH 2008) recommendations, problems identified included poor interprofessional relationships, leadership difficulties and communication breakdown. Improved organisation, leadership, management and skill-mix were seen as essential for collaborative working to be effective.

The provision of safe, contemporary midwifery practice continues to be important to the profession and to every midwife (RCM 2012a). Equity and excellence: Liberating the NHS (DH 2010) and the Health and Social Care Bill (United Kingdom Parliament Bills 2012) resumed where Darzi (DH 2008) finished. Although concerns now relate to commissioning and strategic reorganisation, thought is still being given in practice to collaborative working, motivating leadership, role modelling and expert practice (RCM 2012b). As will be revealed, this study was able to demonstrate these as being key features of the consultant role and key to a modern day health service, where "leadership will be the key to achieving *High Quality Care for All*" (Nicholson 2009:1).

### **1.6 A Brief Overview of the Research Design**

A case study approach was used to analyse the role of eight consultant midwives in eight NHS Trusts in England. Empirical literature and theoretical findings were used to impart meaning and historical significance to the aim of the study and to the relevance that the consultant midwifery role has on its own professional history. Data were collected via in-depth interviews of the consultant midwives as well as heads of maternity services and consultant obstetricians. In addition, the consultant midwives were observed in practice and documentary evidence, in the form of job descriptions was collected to further illustrate intricacies of the consultant midwife role.

Case study was considered appropriate, due to it being holistic, explorative and systematic in nature (Robson 2000; Stake 2000; Appleton 2002). The consultant midwife role was very much an unknown phenomena; case study provided the means by which multiple methods of data collection facilitated an in-depth exploration of the complexities and intricacies surrounding the consultant midwife role. All practitioners were asked questions to elicit an understanding of the consultant midwife role in relation to the four fundamental aspects of the consultant role (NHS Executive, 1999/217). In addition observation was used as a tool by which the consultant midwives were observed 'in practice'. The term 'in practice' was interpreted by the individual consultant midwives. Documentary evidence was in the form of job descriptions, these were useful in understanding the Trusts' perspectives on the consultant midwife role. Following transcription, data were analysed thematically (Robson 2002) and three themes emerged relating to the consultants' experiences, influence on practice development and in relation to future role development.

### **1.7 Midwives and Obstetricians in Practice: Terms and Definitions Used**

The definition of 'consultant' and 'practice' potentially cause debate and differing interpretation amongst practitioners from differing professions. Understanding of such terminology differs from profession to profession as well as within one profession. The word 'consultant', originates from the 17<sup>th</sup> century and may be seen as someone in an advisory capacity or relating to an individual (from any discipline) with a specific expertise (Soanes and Stevenson 2005). In health care it has traditionally been interpreted as an experienced and specialised medical practitioner who accepts total responsibility for the patients in his or her care. The use of the word 'consultant' in relation to nursing and midwifery is relatively new (DH 2000).

In midwifery the term 'in practice' usually relates to a midwife providing direct care to a woman or baby. The NMC's (2008) definition of 'practising' is broader and includes administrative, supervisory, teaching, research and managerial roles as well as direct care. The Government's vision was for a consultant nurse or midwife to have an expert practice function (NHS Executive, HSC1999/217) and for 50 per cent of time to be practice based. This 'practice function' remained undefined and it was anticipated that this lack of clarity would lead consultant practitioners to interpret 'practice' in a number of different ways.

Women and their families receiving care during pregnancy and childbirth are attended to 'predominantly' by midwives and / or obstetricians. Midwives are trained to care for the normal or low risk mother and baby, (NMC 2008) whilst obstetricians, being medically trained, manage cases that become high risk or where there are major complications. The two professions collaborate to provide safe outcomes for the childbearing woman and her family (CMACE 2011). Traditionally in nursing and midwifery, the powerbase rested with medical consultants; today midwives welcome a more shared approach to woman centred care where collaborative working is encouraged.

This study focuses not on medically trained consultant obstetricians, but specifically on the skills, knowledge and expertise of the consultant midwife. Due to the nature of the study and the role of consultant midwives, team work or collaborative working i.e. midwives working in partnership with obstetricians has been explored.

### **1.8 Presentation of the Thesis**

Considerable thought was given to the presentation of this thesis. The intention from the outset was to guide the reader from inception of the project, through the various design and data collection stages to final completion and discovery. It was crucial to unravel a

systematic research design based on exploring methodology and the research approach. The final chapters relating to discussion of the findings and implications for practice and future research were designed to culminate the research journey by concisely revealing the intricacies of the consultant midwife.

This thesis is presented in six chapters; as seen the first is an introductory chapter, focusing on some of the professional developments that have resulted in the recruitment of consultant midwives across the United Kingdom. It presents the consultant midwife role as being embedded in practice and in providing strong midwifery leadership and “quality midwifery care and service delivery” (RCM 2009 p2). It provides the rationale for the study, and defines the research question and research design. Issues relating to definitions of key terms used in the document are considered and the presentation of the thesis explained.

Chapter two reviews literature on the consultant practitioner role and experience. Analysis of the evidence commenced prior to obtaining ethical approval and continued throughout the study. Much of the literature on the consultant practitioner focuses predominantly on consultant nurses and although crucial to our understanding, did provide justification for analysing the consultant midwife role separately. Non research - based accounts, written by consultant midwives describing their experiences were included, since they provide insight into the everyday working lives of consultant midwives. Within this chapter, search criteria have been documented indicating inclusion criteria for the selected evidence. Finally, emphasis is made as to how the research evidence informed the research design.

Chapter three, the research design, provides justification for the research study and provides a rationale for the chosen methodology, that of qualitative research as well as the approach taken, that of case study design. It explores theoretical and philosophical issues acting as a foundation for the research design. In addition, it explores trustworthiness and the systematic route of enquiry taken to ensure validity and reliability; issues relating to sampling, data collection and handling are explored as are issues relating to access, consent and ethical considerations.

Chapter four presents the findings. Thematic analysis was used to analyse the interview transcripts from all three groups of participants. In addition, the observational notes were examined to provide evidence and clarity as to the role of the consultant midwife. Similarly, documentary evidence in the form of job descriptions were examined. Finally, all findings were integrated to exemplify the consultant midwife role.

The findings are presented in relation to three themes:

1. Having Clinical Wisdom;
2. Taking Control;
3. Shaping the Future.

These are clearly presented; diagrams have been used to assist understanding in relation to the process by which the themes emerged and the integration of all data streams.

Chapters five and six discuss the findings and present a conclusion to the thesis. Their aim being to ensure that the research questions, documented in chapter three, have been answered and clearly articulated and that implications for midwifery practice and the consultant midwife role have been clearly documented. Research evidence and this study's research findings are used to emphasise the consultant midwife role. Effort has been taken to describe how consultant midwives have interpreted their role. Illustrations are provided as to how consultant midwives are developing and influencing midwifery practice. In addition, the study's strengths and limitations are considered, implications for practice emphasised and future research recommendations made.

### **1.9 Summary of Introductory Chapter**

This preliminary chapter has focused on some of the developments in health policy that led to the recruitment of consultant midwives across the United Kingdom. It has presented consultant midwifery as being embedded in practice and focused on developing safe care for women and their families, whilst moving the midwifery profession forward by providing strong leadership and quality care (DH 2007; DH 2008; DH 2009).

The title for the research study has been delineated and a rationale for undertaking the study presented. It has shown how inspiration for the study came from those studying previous advanced practice roles (Lathlean, 1992; 2007). Justification for the study has been emphasised, in relation to there being little research evidence that has focused specifically on the consultant midwife role. The research was therefore embarked upon to provide a comprehensive exploration of the role of the consultant midwife and to document how these midwives are practising and developing midwifery practice. A brief overview of the research design has been provided demonstrating how a case study approach has been used as a framework by which the role of eight consultant midwives in eight NHS Trusts in England was analysed. Finally in this introductory chapter, key terms referred to have been defined and the presentation of the thesis explained. An analysis of the literature follows, putting into context what is already known about the consultant role.

## 2 Review of Literature

### 2.1 Introduction

As seen, the consultant midwife role materialized as a result of on-going NHS policy development in part due to concerns over retention of senior staff at the start of the 21<sup>st</sup> century (DH 1997a and b; DH 1999a and b; NHS Executive, HSC1998/045). The NHS Plan had set out the Government's modernization agenda for the NHS and had pledged commitment to investing in new clinical leaders (DH 2000). The four key functions of the consultant role were linked to expert practice, leadership, education and service development (NHS Executive, HSC1999/217).

A review of the literature commenced prior to obtaining ethical approval (October 2004) for this study and has continued to the present day. As explained in the introductory chapter, although small numbers of midwives had participated in research focusing on consultant activities, much of the primary evidence focusing on the consultant role had been undertaken by non-midwives. Non-research evidence written by consultant midwives describing their experiences was included since it provided insight into the everyday working lives of consultant midwives. Search criteria have been documented indicating inclusion criteria for the selected literature and research studies. Finally, emphasis has been made as to how the research evidence informed the overall research design.

Emerging trends relating to the consultant nurse and midwife role emphasise the significant effect consultant practitioners have on client care and delivery. Developments in practice have been categorised under primary and experiential evidence and focus predominantly on the four original key role categories (NHS Executive, HSC1999/217). Strengths and limitations of the role have been highlighted with concerns relating to role overload, lack of organisational support (Woodward et al 2006; Stephens 2006; McSherry et al 2007) and a generalised feeling of being under prepared for the role (Macrory 2003; Charters et al 2005).

Background characteristics relating to previous experience and academic ability have been explored (Guest et al 2004; Woodward et al 2005; Booth et al 2006). Effecting cultural change and skills in transformational leadership appear well within the remit of consultant practitioners (Manley 2000a and b).

Findings suggest considerable initiatives demonstrating expert practice and practice development (Redwood et al 2005; Rogers and Cunningham 2007; Dawson and Coombs 2008). What is clear however is that time spent carrying out each feature of the

consultant role varies between individuals and professions (Guest et al 2004; Redwood et al 2005; Humphries et al 2007). It is quite difficult to extrapolate findings specifically in relation to one professional group. It is due to this that a midwifery specific research study focusing on the experiences of consultant midwives was undertaken.

## **2.2 Rationale for Review of Literature and Research Evidence**

There are different definitions of a literature review with most describing an interpretation and analysis of primary evidence (Merriam 1988). The aim of this literature review was to:

- Provide justification for the research study, putting into perspective what was already understood about the consultant role and thus forming a starting point for this research study (Parahoo 2006);
- Consider how the literature enabled an understanding of the consultant role and to identify limitations and discrepancies in the evidence available (Polit and Beck 2006);
- Trace literature and research evidence that has focused on the role of the consultant practitioner and to consider how an understanding of the literature can contribute to the overall design of the study, in particular to data collection and analysis;
- Identify issues affecting consultant practitioners which could inform the questions asked at interview.

## **2.3 Identification of Eligible Literature and Research Studies**

An initial literature search was performed to identify appropriate literature and primary research evidence (Parahoo 2006). A comprehensive search in English using the terms 'consultant nurse', 'consultant midwife' and 'consultant health visitor' was carried out. Although other consultant practitioners within and allied to medicine are in practice (e.g. radiographers, physiotherapists and speech therapists) and have published research relating to the consultant role, these articles were not included due to differences in the nature of their professions. Today, the use of the word 'consultant' in relation to nursing, midwifery and those allied to medicine is relatively new (DH 2000) however in this study, specific reference is made to the consultant midwife.

Literature analysed as part of this consultant midwife study 'predominantly' therefore focuses upon nurses, midwives and health visitors. Some of the research analysed however does include both nurses and 'allied health professionals', as an exception, these have been included but not directly sought.

Data bases used included The Cumulative Index to Nursing and Allied Health Literature (CINAHL), The Excerpta Medica database (EMBASE), The British Nursing Index and the Midwifery Information & Resource Service (MIDIRS). Contemporary primary research

evidence was sought predominantly between 1993 and the present day. Although the majority of consultant practitioners did not take up post until 2000 some older literature was seen as important as it focused on early initiatives and the development of government policy e.g. Manley (1997).

Although this research study focuses on the practice of consultant midwives in England, it was appropriate to incorporate evidence written and published by consultant nurses in Scotland, since these provide an additional perspective on experience and role interpretation. In addition, parallels could be drawn in relation to some of the research approaches taken. Consultant posts were introduced to Scotland in early 2000 and as in England are senior clinical roles (Booth et al 2006).

As explained earlier, non research evidence written by consultant midwives was included. The articles included were published in professional literature and were viewed as being particularly valuable in identifying consultant midwife experience. Activities in relation to collaborative working whilst changing attitude and culture and empowering midwives are clearly documented. Literature written by consultant midwives describe initiatives taken to identify gaps in service provision and in providing an integrated service based on research evidence. Limitations of the role as well as the strengths were clearly articulated by the midwives and relate to role isolation, role overload and conflict between leadership and management. By including these experiential accounts, it was then possible to explore primary research evidence written by nurses and in so doing compare and contrast nurse consultant experience with that of midwives.

Due to the large volume of literature written by consultant midwives, articles were selected according to the following:

- Those focusing specifically on the nature of the consultant midwife role;
- Those relating to specific accomplishments since taking up the post as a consultant midwife.

The selected articles identify consultant midwives experiences and perspectives and in so doing, the roles strengths and limitations. This evidence was seen to be representative of the many initiatives being undertaken by consultant midwives to promote and develop midwifery practice and in addition focused on a vision for the future. In relation to both the primary evidence and non-research evidence, inclusion and exclusion criteria of evidence may be seen below in Table 1 on page 14.

**Table 1 Inclusion and Exclusion Criteria of Evidence included in Literature Review**

Inclusion Criteria	Exclusion Criteria
Primary Sources * (*experiential accounts written by consultant midwives included)	Non primary sources
Publications between 1993 and 2012	Publications prior to 1993
Publications written in English.	Publications not written in English.
Evidence focusing on Consultant Nurses, Midwives, Health Visitors or those allied to medicine	Evidence not focusing on Consultant Nurses, Midwives, Health Visitors or those allied to medicine

## 2.4 Selected Evidence

Once appropriate evidence had been identified (please refer to Appendix 1), notes were taken and the evidence organised into themes. By focusing specifically on the nature of the literature or the research undertaken (including the title of the research or research question), four themes were identified as demonstrated below:

- Early Initiatives Taken to Define Consultant Practice
- The Impact and Effectiveness of Nurse, Midwife and Health Visitor Consultants
- The Consultant Nurse Role: Preparation, Characteristics and Achievements
- The Consultant Midwife Role: Preparation, Characteristics and Achievements

### 2.4.1 Early Initiatives Taken to Define Consultant Practice

Work by Manley (1997; 2000a and 2000b) focused on the justification for and the development of the consultant role. Manley motivated by her work in teaching, as a lecturer at the RCN Institute in London, and confident that being a transformational leader was essential to being a successful consultant nurse, influenced the government's strategic planning in relation to the establishment of consultant practitioners. Manley (1997) presented a preliminary conceptual model for advanced practice / consultant practice whilst undertaking data analysis following a 3 year action research study focusing on the consultant nurse role. On completion, this theoretical model based on shared qualities and objectives was multi-faceted and included:

- "The integrated roles of the advanced practitioner / consultant nurse;
- A set of skills and processes;
- The contextual pre-requisites;
- Practice Outcomes" (Manley 1997 pp179-190).

Blended roles (identified by Hamric 1989) involved being an expert practitioner, educator, researcher and consultant. Skills involved being a transformational leader, having foresight, being influential in facilitating change and being a role model. In order for this to

be achieved, certain stipulations were required such as having “shared values and beliefs, an open non hierarchical management and organizational authority attributed to the post” (Manley 1997 p183).

As will be seen from more recent work, combined roles help to improve well-being in practice by developing and empowering staff thus developing a transformational environment. Manley’s three year action research study resulted in the development of a facilitative, organisational culture (Manley 2000a and b), which needed to be promoted if consultant practitioners were to practice freely and to the extent of their professional ability. Organisational culture stems from anthropology and sociology and provides a structure for combining a range of ideas, theories and practices, with most of the research being undertaken in industry.

“Organisational culture is a system of shared values and beliefs about what are important, what behaviours are appropriate and about feelings and relationships internally and externally. Values and cultures need to be unique to the organisation, widely shared and reflected in daily practice and relevant to the company purpose and strategy. But there is no single best culture” (CIPD 2010 online).

From reading Manley’s work (2000a and b) on organisational culture, it would appear that organisational culture is imperative since it effects how we interpret our responsibilities. In relation to the consultant practitioner role, it may be interpreted that achieving organisational change and developing and extending practice, stems from effective leadership and the art of skilled communication. These skills combined with those of the expert practitioner, formulate the way in which consultant practitioners influence practice.

#### **2.4.2 The Impact and Effectiveness of Nurse, Midwife and Health Visitor Consultants**

In relation to the number of participants involved and the extent of research findings the most significant research contribution to date relating to the consultant practitioner role is that of Guest et al (2001; 2004). A team of experienced researchers from Kings College, London and Birkbeck College, London evaluated the impact of nurse, midwife and health visitor consultants (Guest et al 2004).

Prior to evaluating the impact of nurse, midwife and health visitor consultants, Guest and his researchers had been awarded a preliminary grant to evaluate the effect this new role was having on service delivery and patient care. The team reported in 2001 following telephone interviews, observation and a survey. In relation to this preliminary study’s

findings, multiple issues were identified focusing on academic experience, length of service, preparation and some of the problems experienced by consultant practitioners (Guest et al 2001). The results of this preliminary study were published not only by Guest and his team in 2001 but separately by a member of the team, Sally Redfern, in a book entitled 'Leading health care organizations' edited by Dopson and Mark (2003).

In relation to this preliminary study, this group of consultant practitioners were experienced and very well qualified. Thirty two consultants (4 midwives) were interviewed via the telephone so as to ascertain an initial understanding of the role. Questions related to experiences and role difficulties. Data was also collected by undertaking ten case studies of consultants in practice (2 midwives) this included interviews, observation and documentary analysis. "The aim was to understand perceptions of the new role among network members and any implications for members' own roles and for the effectiveness of the unit" (Redfern et al 2003 p159). Lastly, 158 questionnaires (all consultants in post in February 2001) were sent, concentrating on role and experience ("autonomy, complexity, workload; conflicts"). A total of 153 questionnaires were completed and returned, this accounted for a 95 per cent response rate. Amongst the 153 were questionnaires from midwives accounting for seven per cent.

In relation to the four core functions of the consultant role (NHS Executive, HSC1999/217), multiple roles had originally been proposed by the Department of Health. Guest et al (2001) presented their findings in relation to each Department of Health category; differences were noted in relation to expert practice. Significantly more midwives were occupied in expert practice compared with other groups and also considerably more involved in research and development. Overall, midwives reported greater participation in all key areas than any other group (Guest et al 2001; Redfern et al 2003).

In summarising the findings of this preliminary study, Guest et al (2004 p11) highlighted that "eighty per cent of participants reported high levels of autonomy and 40 per cent said the job was high in terms of demands and complexity". There was disproportion in what equated as practice; for 44% of the consultant practitioners, time meant being in practice. Many consultants reported discord in practice e.g. role uncertainty, excessive responsibilities and a lack of support and resources. The consultants did however report achievements and the development of relationships, practice and confidence. Half of those participating reported that the role met their expectations; 70 per cent felt that the role would help retain senior staff and a very large percentage were satisfied with the role (Guest et al 2001).

Following completion of the preliminary report due to the continuing growth in the number of consultant practitioners, a second report commenced, predominantly to explore how the role was developing and to assess its impact in relation to Government policy.

Researchers again collected data via multiple methods. Interviews (including telephone interviews); focus groups; questionnaires and longitudinal panel telephone interviews were used as means of collecting the data. Consultant practitioners formed the majority of the participants with only a small sample of stakeholders participating. In order to obtain a wider perspective as to the impact consultant practitioners were having on the provision of care, it would have been useful to increase the participation of stakeholders. It appeared, however, that time was an issue due to problems met in achieving ethical approval.

The researchers concentrated on what the consultant practitioners were doing predominantly in relation to leading and managing. Their influence was a focal point as was "role crafting" and motivation. The major aims of the study centred on:

- "The impact of the consultant role on patient care;
- The leadership role of consultants;
- Crafting of the role;
- Predictors of attitudes, behaviour and performance;
- Supply and retention of consultants in practice" (Guest et al 2004 pp17-18).

The questionnaire sample (528) was a result of figures received from the Department of Health in August 2003. Returned questionnaires accounted for 419 consultant practitioners, i.e. a 79 per cent response rate. The majority were from consultant nurses (92.4 per cent); 7.4 per cent were from midwives and one was from a health visitor consultant. In addition to the questionnaires, 22 participants agreed to take part in focus groups and 32 had an interview (Guest et al 2004).

The results of the study have been summarised as follows. In relation to the four main aspects of the role as defined by the Department of Health (NHS Executive, HSC1999/217) 'leadership' took up most of the consultant's time; 86 per cent were involved in leadership. "Despite an expectation that consultants would act as leaders but not managers" (Guest et al 2004 p9), eleven per cent were heavily involved in management; none of these were in midwifery. Many consultants experienced difficulties in relation to not having managerial responsibility e.g. no power and a lack of support and resources.

An average of 43 per cent of time was spent in practice; this figure camouflaged wide variations. Assessment of overall influence on care was a key aim of this study. The

researchers emphasised frustration in that the results were based on consultant opinion alone and not stakeholders' and that accurately identifying impact was difficult. Some stakeholders were able to add an additional focus to the study by cross-checking responses following interview. In relation to the consultant midwives, criteria relating to impact were seen as being an increased incidence of normal births, less medicalisation and increased breastfeeding. In relation to perceived impact, consultant midwives reported "a higher impact on process items" (Guest et al 2004 p31) and considerably more midwives reported success in improving clients use of services, than other consultants.

Excessive work was an issue; 56 per cent cited it as being a major difficulty. The researchers commented that for some, time and experience helped with consultants becoming more able to define their role and manage their workload. Linked to an excessive workload, 28 per cent reported high levels of stress; it was lower amongst those where the role had met expectations and where consultants had more experience or academic preparation.

For many, consultant practice was not seen as the ultimate in career advancement, although most intended to stay in the role. There was considerable support for the role amongst consultants, since they perceived it was having a positive impact on improving patient outcomes. Eighty per cent, however, said that the role had been poorly organised; this was seen as being the responsibility of managers and extra support was needed.

In summary, the main aim of Guest et al's (2004) study was to evaluate the impact of the nurse, midwife and health visitor consultant. As predicted, assessing impact was complex, since access to clients is usually viewed as being ethically inappropriate and opinion sought from practitioners may be subjective. Midwives did participate in the study but the numbers were small. Overall, results were particular to the whole population of participants rather than being specific to the different professional groups; averages were given which obscured differences. The generic nature of the study made it difficult to assess accurately consultant midwife experience. Some comments exemplified strengths of the consultant midwife role as being linked to improving care for women, level of autonomy and leadership responsibilities. Although stakeholder opinion was sought, participation was minimal. A stronger contribution by stakeholders may have provided more objectivity. Despite this, a range of data collection methods were used which increased the credibility of the study.

In relation to research design, both studies emphasised that:

- there remained a need to evaluate the impact of the consultant midwife role;
- consultant midwives needed to be the specific focus of a research study where the primary aim was to analyse role experience;
- a range of data collection methods had been seen to facilitate in-depth exploration of the role of consultant (Guest et al 2001 and 2004); it was anticipated that similar methods could be used as a means by which the consultant midwife role is analysed;
- there remained a need to explore how consultant midwives plan their workload and whether they feel they are supported in practice;
- further research needed to be undertaken to corroborate the team's findings now that consultants have been in practice for longer.

Based on Ward's (1997 p4) feedback process, "the systematic collection and feedback of performance data on an individual or group, derived from a number of stakeholders" Redwood et al (2005) evaluated local impact of the consultant nurse role. Participating consultant nurses selected colleagues able to give a perspective of the consultant role and who would be members of an evaluation committee. Although invited participants could be viewed as being somewhat subjective, this adaptable method of data collection led to multiple perspectives and experiences informing the study's findings. Once all the interviews for one of the consultant nurses had been undertaken thematic content analysis was carried out. An individual draft case report was then shared with the consultant nurse prior to the team evaluation. Then the consultant nurse was able to participate in formulating the final report (Redwood et al 2005); key themes emerged from the data across all the cases, resulting in the following four categories:

- "Evolution;
- About the Person;
- The Work;
- Resolving Issues" (p49-54).

The results provided an interpretation as to how government policy has been locally implemented and how practitioners working with the consultant nurses perceived the role. Consultant nurse activities were varied; however, these were seen to be more limited in relation to leadership and research, where advances still need to be made and support and training given (Guest et al 2004). Although the consultant nurses highlighted the many services they had been instrumental in, they also emphasised the work being undertaken outside the Trusts in which they worked "to develop communications and processes between agendas or service sectors" (pg 50). One familiar frustration was that although the role was a powerful one, when it came to everyday working practice,

consultant nurses were sometimes powerless when it came to some leadership and financial issues.

In relation to prerequisites for the role of consultant nurse, key informants took the nurse's skills and expertise for granted. Critical to consultant practice was the ability to lead and develop practice, "references to their energy, motivation, enthusiasm and passion were frequent" (pg 51). As in Guest et al's study (2004) difficulties encountered in practice were viewed as not being in relation to a nurse's inability to cope but due to organizational limitations e.g. a very heavy workload. Recognition was seen to be slowly taking place that collaborative initiatives across professions was more successful if services and patient outcome were to improve.

Many of the findings that emerged from this study were raised by others evaluating the nurse consultant role (Guest et al 2001; 2004). The evaluation of experiences, challenges and achievements were seen to need observation if succession planning and role advancement was to be a success.

Two years later, Humphreys et al (2007) undertook a systematic review and meta-synthesis evaluating the effectiveness of nurse, midwife and allied health consultants. Inclusion criteria concentrated specifically on literature where an aspect of the consultant's role had been evaluated or where a consultant practitioner had carried out the research. In total, 107 studies met the inclusion criteria and of these 14 were included and analysed. Out of these research studies some involved measurement (e.g. Manley 2000 a and b; Guest et al 2004) whilst others provided either a literature review or were more descriptive in nature. Role confusion by consultants and stakeholders (Guest et al 2004) was seen as being a problem. Suggestions were made that this role confusion and the associated uncertainties could be due to how consultants describe themselves (Humphreys et al 2007); however this was not seen as a problem in midwifery.

In relation to the four main aspects of a consultant practitioner's role (NHS Executive 1999/217), Humphreys et al's (2007) selected literature revealed examples as to consultant activities. Evidence of expert practice included examples of role modelling, teaching, policy and guideline development and the acquisition of new skills.

Humphreys et al (2007) viewed developing services as an example of leadership responsibility but questioned as to whether there was evidence to support consultant practitioner leadership at a strategic level. They suggested the evaluation of service development and expert practice by "using a cost/benefit consequence analysis model"

(pg 1806), which could enhance understanding of role impact. Literature analysed provided evidence that consultants were engaged in education and that research activities fell into three categories namely audit or research by an individual (e.g. Manley 2000 a and b); team research involving a consultant and research on the consultant role that may not include a consultant in the research activity (e.g. Guest et al 2004). Humphreys et al (2007 p1806) were critical of studies that “claimed to evaluate the impact of the consultant role” e.g. Guest et al (2004) but failed to include a measurement of impact. They didn’t comment on the difficulties associated with accurately measuring impact.

### **2.4.3 The Consultant Nurse Role: Preparation, Characteristics and Achievements**

In 2005, Woodward et al published an article focusing on two themes that had arisen from her PhD study on nursing research strategies in five NHS organizations. The themes focused upon in this first article were ‘Nurse Consultants: their characteristics and achievements’.

Characteristics of a consultant nurse, namely qualities and incentive were identified. The research design was a cross-sectional design; ten consultant nurses from a variety of settings participated. No explanation was given for the participants selected. Transcribed data from tape recorded interviews were analysed and four themes were identified, two of which were focused upon in this article. The findings showed that academic ability and clinical experience prior to taking up the post were very important and impacted on the extent by which the practitioner engaged in practice, developed and improved service delivery. Those consultant nurses able to cope with the demands of the role tended to be more experienced, some had previously been specialist nurses and some had teaching and / or research experience. Having a higher degree was seen as being useful. Even the inexperienced were experts in their field and leadership was seen to develop over time. The nurses saw empowering others as being “one of their main missions” (pg849). Some consultants lacked self-confidence; this was seen to be due to an anxiety that they were not achieving all aspects of the role. As seen in the Guest et al’s (2004) study careful implementation of the role from an operational perspective was seen as critical and continuing role support was viewed as being important to prevent and observe for work overload.

In relation to the findings, Woodward et al (2005) concluded that for applicants to be selected for the post of consultant nurse they should have studied to a higher level; be confident and self-motivated as well as having a proven track record of operational leadership. The team emphasised the importance of on-going role evaluation.

The findings of this study emphasised accountability and made reference to the fact that consultant nurses “should not be expected to be line managers for other staff, as this creates role conflict” (pg. 853). As previously identified, role understanding and interpretation was varied; Woodward et al (2005) recommended a national debate to agree the nurse consultant’s sphere of activity. Although the title of the article promises to focus on ‘role achievement’ it is clear that measuring consultant practitioner effect on patient outcomes is difficult and little is provided in relation to specific initiatives. The achievements the nurses highlight are in relation to role development and not patient outcome.

In 2006, Woodward et al reported again in relation to her PhD research study, this time on organisational support systems affecting consultant nurses; two themes were identified following thematic analysis. These were ‘System Supports’ and ‘NHS Influences’.

A successful appointment was viewed by the researchers as one where developments had been made in education, leadership and research and where the consultant was adaptable and that their role was clearly evolving over time; for these practitioners organized support was valuable to their practice. Those who were not so happy with their levels of support requested more managerial support. For consultants newly appointed, effective managerial support was recognised as being essential to prevent them from becoming inundated by the role (Guest 2004). Support for consultants in practice came in many guises and could be viewed as a major contributing factor for role success or failure (Woodward et al 2006; Guest et al 2001). Booth et al (2006), in a study focusing on Scottish consultant nurses, and Guest et al (2001; 2004) both commented on distress caused by a lack of administrative support. Being able to prioritize time was seen as being important to Woodward et al’s (2006) participants also.

Direct and indirect influences affecting the consultant nurse role were found by Woodward et al (2006) to be largely linked to procedural and educational expectations. Developing practice and implementing national policy was seen as being a key focus for consultants; some worked more strategically than others and all had educational responsibilities; however, only one nurse had a joint contract with a University, all the rest had honorary contracts. The NHS power-base was seen by participants as a “hindrance” (Woodward et al 2006 p278) and one which was still motivated by medical consultants with many reluctant to collaborate or share responsibilities with the consultant nurses.

On completing their study Woodward et al (2006) again made recommendations in keeping with the findings of others. Two she reiterated from her 2005 article, namely the

need for a “national debate and agreed policy by nurses on exactly what is the remit of consultant nurses in the NHS” (pg 279) as well as the need for consultants to be seen as experts in informing local and national policy at the highest level. In addition it was felt that measurable outcomes related to all four features of the consultant role, not just related to clinical activities, should be visible.

In 2007, McSherry et al performed a descriptive, qualitative study based on three nurse consultants working in the north east of England. Again using a 360 degree semi structured interview framework the team evaluated “the perceived role of the nurse consultant through the lived experience of healthcare professionals” (pg 2066). The use of the framework was imaginative and far reaching with data received from colleagues, managers, users and the consultants themselves. Stakeholders were thus a major part of this study with up to ten per cent of consultant nurses detailing information relating to the consultant role (McSherry et al 2007). The 360 degree framework facilitated this collaboration since it took into account varying views and perspectives. By involving stakeholders from the beginning conflicts in relation to organisational issues (Manley 2000a; Guest et al (2004) were discussed early on and legitimate recommendations made.

Thirty semi-structured interviews were undertaken and thematically analysed. Findings related to how the role could be improved by further involving staff and by “developing a phased approach to implementing and evaluating the role” (McSherry et al, 2007); findings such as these corroborate the work of others (Guest et al 2001; 2004).

In 2008, Dawson and Coombs undertook a review of the role and function of consultant nurses in critical care; their aim was to provide a contemporary synopsis of the consultant nurse role and to emphasise developments to the role between 2003 and 2006. Having gained ethical approval and using a previously validated survey tool (Dawson and McEwan 2005) an email survey was sent to all known critical care nurse consultants in England, Northern Ireland and Wales (66 in total) in order to focus on the four main aspects of the consultant role (DH 1999a); the return rate was 73% ( $n=47$ ). Participants used a five-point Likert scale to denote role contribution. The participants were also asked to provide detail relating to demographic, biographic and scholarly activities. The data were analysed using a computer (SPSS version 11.5). Results were compared to an almost identical survey carried out in 2003 (Dawson and McEwan 2005). As has been seen in midwifery, data collected revealed that the consultant nurses participating were predominantly female and had stayed in post since the original survey in 2003, thus gaining in experience.

The survey (Dawson and Coombs 2008) was designed to focus on the following four key features of the critical care consultant nurse role; an average overall involvement score for each aspect of the consultant role was calculated:

- Practice and service development;
- Education, training and development;
- Leadership and consultancy;
- Expert practice (NHS Executive, HSJ 1999/217).

As expected, the critical care consultant nurses spent most of their time undertaking practice and service development activities. As seen in midwifery being 'in practice' did not always relate to 'hands on' client contact (Guest et al 2004). The practice and service development activities were divided into 11 activities none of which directly involved client care. Activities such as developing clinical audit; developing clinical guidelines and protocols; evaluating local services were listed and a mean involvement score calculated.

Education, training and development accounted for "the next highest overall involvement function" (Dawson and Coombs 2008:190). Focusing on updating individuals and developing programmes to educate a wider audience were key components of the role. Leadership and consultancy responsibilities linked to strategic development accrued a high mean involvement score.

Expert practice was predominantly linked to receiving referrals or referring patients, this had a lower score. As in the Guest et al study (2001), Dawson and Coombs (2008) reported that, "compared to the 2003 survey, expert practice received a lower mean involvement score". Qualitative analysis demonstrated that being the only nurse consultant in a Trust is not unusual and that the weight of responsibilities expected to be undertaken by consultants either reduce time spent 'in practice' or their own area of expertise. Concerns regarding the future of the consultant role were raised in relation to *numbers of practitioners* remaining static set against a background of a more complex and multifaceted role. *Organisational support* appeared to be lacking in most areas (Guest et al 2004; Woodward 2005). Expert practice was a core function of the consultant role (NHS Executive, HSC1999/217) with 50% of time anticipated to be undertaken in an expert capacity. Examples of indirect expert practice influence were noteworthy; however, consultant practitioners were spending less than 50% of time clinically (Guest et al 2004; Dawson and Coombs 2008).

For nurses, midwives and health visitors the consultant role is seen as the summit or ultimate in career progression. A statement from the Department of Health (2003) led

practitioners to believe that consultant numbers would increase; analysis revealed that this does not appear to have been the case. Although practitioners are largely staying in post, numbers need to increase progressively, in relation to succession planning requirements.

In relation to personal academic development, in 2003 71% of critical care consultants held a higher degree compared with 94% in 2006 (Dawson and Coombs 2008). In comparison, Guest et al (2004) revealed that in their cohort of participants 65% had a higher degree. The recognition that a higher degree is needed by these advanced practitioners is supported by others (Woodward et al 2005; Manley 1997). Audit and research activities are frequently undertaken by consultant practitioners (Dawson and Coombs 2008; Guest et al 2004). Joint and honorary contracts for consultant practitioners with associated Universities are not common place; this surely is the way forward for consultants in relation to increasing research participation, facilitating research funding as well as realising individual academic potential. In addition, parity with medical consultants is not a reality, with doctors continuing to be paid above and beyond that of consultant nurses and midwives. Practising at a higher academic level also does not give rise to financial reward.

Dawson and Coombs' (2008) email survey of critical care consultant nurses focused on the core components of the consultant role (DH 1999a). It was well managed by experienced researchers and although some deficiencies were realised in relation to the survey tool (potential bias, subjectivity and incorrect interpretation of terminology) it provided a contemporary focus on the evolving role with potential concerns and recommendations for future role development. Comparisons were also possible with results from previous research namely Guest et al (2004); Woodward et al (2005).

McIntosh and Tolson (2008) undertook a small scale qualitative study that focused on the first four consultant nurses in Scotland. The aim of the study was to assess how consultant nurses fulfilled the requirements of their posts, which focused on the four features of the role (NHS Executive, HSC1999/217). Interestingly, consultant nurse and stakeholder opinion was sought (the importance of stakeholder opinion was emphasised by Guest et al (2005) and Redwood et al 2005). The four consultant nurses were interviewed twice, whilst the Directors of Nursing Services (3), the Senior Nurse Manager, and the Director of Nurse Education were interviewed once. In addition five stakeholders for each consultant nurse were invited for interview. In the event, 18 stakeholders agreed to be interviewed. In total 31 in-depth interviews were undertaken.

Following thematic analysis, the findings revealed the considerable expertise needed to manage the role of nurse consultant including skills in transformational leadership (Manley 1997), change management, critical and strategic thinking and problem solving.

Obstacles were also (identified in relation to some of the difficulties experienced. Specific barriers were not alluded to, however, signifying opposition to the role, reference is made to the fact that “developments in practice that involve significant change are...not universally welcomed by practitioners” (McIntosh and Tolson 2008 p225).

Stakeholder opinion was positive, the consultant role was observed to be a significant success, whilst the nurses were seen to be effective role models and leaders “developing nurses’ skills, building confidence, raising awareness of professional issues and providing vision” (McIntosh and Tolson 2008 p225).

Acknowledgement was given to the fact that this study focused on nurses with minimal experience of the consultant role. Extra effort had been taken to sample both practitioners and stakeholders. It would be interesting however, to repeat the study when the nurses had experienced more time in the consultant role. Findings may then be more representative of the strengths and limitations of the role.

Similar to Woodward et al (2005), Booth et al (2006 p85) devised a postal survey, which aimed to “describe the background characteristics and career pathways of consultant nurses and midwives in Scotland and identify the post-holders’ views on key factors in role initiation, development and progression to inform future development and appointment of nurse / midwife consultants in NHS Scotland”. A 26 question questionnaire was designed by four consultant nurses and reviewed by three other consultant nurses. All 16 consultant nurses and midwives in Scotland at the time were sent the questionnaire. Thirteen out of the 16 questionnaires were returned, giving an 81% return rate. In order to gather a range of information relating to the consultant role open and closed questions were included.

Background information was sought i.e. career profile; educational preparation for the role; terms and conditions and formal support offered. Secondly, participant interpretation of the role was sought especially in relation to the four core functions of the role, limitations and role obstacles were also sought as were views on the future of the consultant role.

As with several of the recent small scale studies focusing on consultant experiences, consultants took part in the process of data analysis (Redwood et al 2005). This gives

rise to the feeling that the findings are somewhat subjective since consultant practitioners are obviously keen to be viewed in a good light. In this case, data analysis involved the use of descriptive statistics as well as content analysis; this was predominantly undertaken by a consultant nurse and an academic (formerly a consultant nurse).

This research study by Booth et al (2006) focusing on consultant nurses and midwives, provides insight into the consultant role and makes suggestions for future role development. What is clear from Booth et al's study (2006) is that role interpretation varies greatly between managers and organisations and that there is a need for effective planning for role development, implementation and service integration. Results from this study identified variations in terms and conditions which within a relatively small group of practitioners can lead to anxiety. Participants were asked to estimate the amount of time spent undertaking each of the core functions of the consultant role. As in the McIntosh and Tolson study of 2008, since aspects of the consultant role overlap, being specific was not possible, however for purposes of the study, estimates were given, giving rise to concern over accuracy. The highest concentration of time was attributed to expert practice (the average being 32.5%); this was in contrast to Dawson and Coombs' (2008) findings and gives rise to queries relating to the interpretation of 'expert practice'. In relation to direct patient care, 2/3rds of participants provided 'hands on' care whilst 1/3<sup>rd</sup> did not. Confusion exists as to what is meant by being in practice for 50% of time and whether this equates to direct patient care.

Participants were asked to comment on the following:

- "What they found helpful in developing their role since taking up post;
- What barriers they had experienced;
- Where the gaps in support were;
- What they thought would be useful for the future to enable consultant posts to develop" (Booth et al 2006 p87).

In relation to what was found to be helpful, consultant practitioners stated that it was very important to have a clear job description. Formal support in relation to clinical supervision and appraisal was also seen as key, but this was not available for all. "A further positive influence was the perceived autonomy associated with the role" (Booth et al 2006 p87), enabling innovative practice and collaborative working. Barriers to efficient working included issues relating to role confusion, experienced either by the consultants themselves or by others. Negative perceptions from managers and other colleagues seeing the consultant role as no different from their own were also obstacles to overcome. Work overload and role isolation were also cited. A lack of appropriate reporting

mechanisms, inadequate office provision and a lack of administrative support / IT equipment were all cited as being problematic.

As previously seen, designing a future for consultant practitioners is essential for further development of the service and succession planning. In relation to the future Booth et al (2006) emphasised the need for organizational support, which would need to include an effective infrastructure, adequate remuneration and improved role clarity. In relation to future consultant practitioners, suggestions were made to develop a "recognized career pathway for aspiring CN/M's" (Booth et al 2006 p88). This small scale study has added to the emerging body of knowledge on consultant practice and illuminates the experiences of practitioners whilst providing clarity as to the way forward. What is clear from this study and many others is that there are many different interpretations of consultant practice and role clarity and effective organizational planning is important for practitioners to work efficiently, flexibly and innovatively. Role autonomy was evident and was seen as important, comparisons were made to advanced practitioners who like consultant practitioners have achieved academically and have a broad professional focus. Although consultant midwives were included in this study, differences in relation to a midwife's autonomy and a nurse's autonomy were not compared.

At approximately the time that Booth et al (2006) were carrying out this study Masterson (2004) had been asked by the Scottish Government to consider the circumstances necessary for the development of new nursing roles in Scotland and in so doing consider how clinical leadership can be augmented. As in England, a need to develop a more collaborative, innovative and flexible approach to health care provision was recognised by the Scottish Government. Some of the issues highlighted by Booth et al (2006) had been pre-empted by Masterson (2004) such as the need to engage stakeholders and others prior to appointment of new practitioners and for clear role descriptors to have been carefully considered. She pointed out that practitioners lacking in support from managers or their colleagues are unlikely to succeed and may well resign due to lack of support.

From a different perspective, Charters et al (2005) undertook a survey of consultant nurses in emergency care. Nurse registrars produced a questionnaire which focused on how prepared consultant nurses were for the role and this was sent to 44 consultant nurses with 25 responding, a response rate of 58%. The main aim of the study was to consider preparation for the role. Three quarters of participants had no specific preparation for the role; a small percentage had received a short induction. Participants felt that preparation needed to echo the four key features of the role (NHS Executive HSC1999/217) and that in terms of standardising the role a national consultant

practitioner preparation programme at Masters Level would be useful. Role Standardisation and clarity is important but for current consultant practitioners, most of whom are already equipped with a higher degree (Gerrish et al 2008), this may come too late. In relation to succession planning practitioners moving up the career ladder may find such a programme helpful.

Charters et al (2005) argued that since for some (24%) this was their second consultant post, lack of role clarity and lack of organizational preparation (Guest et al 2004; Woodward et al 2005) could account for consultants not staying in post. In relation to leadership those feeling unprepared cited lack of knowledge in managing projects and securing funds. The authors focused on hierarchy in healthcare and the need for consultants to be supported if they are to exert their authority and become influential.

In relation to education the majority of participants reported having a Masters degree which is known to be the norm across consultant practitioners (Guest et al 2004). Initiatives taken to develop junior colleagues and thus improve patient care were documented.

Armed with experience of focusing on and operationalizing the consultant role (Manley 1997; 2000a; 2000b), Manley et al (2008) undertook a 6 month study to help modernise services for the care of the elderly and focused on the leadership strategies of consultant nurses working in elderly care. Although research has concentrated on improving the care of the elderly (Costello 2001) scope to improve services further was recognised. Manley et al (2008) saw this as an opportunity to consider the strategic, operational and practice responsibilities of consultant nurses in elderly care. A type of action research was used called the co-operative inquiry approach where the participants i.e. the consultant nurses were also researchers. The research question was "What are the leadership strategies that we use as consultant nurses in older people nursing" (Manley et al 2008 p149). In brief, each of the 4 consultant nurse participants wrote a story identifying their leadership role. The stories were then shared, critiqued and developed with the tacit knowledge underpinning practice brought to the forefront. Five questions facilitated this process, namely:

- "What made you decide to take the approach you did?"
- What were you trying to achieve?
- Why did you respond in the way you did?
- How did you come to this judgement?
- How did you achieve what you set out to do? (Manley 2008 p150).

Appropriately, data analysis focused on the phenomenon, that of leadership and the consultant experience by using interpretative phenomenological analysis. Inductively categories and themes arose out of two of the stories. The resulting themes were arranged into “an organising framework of characteristics, enabling factors and consequences” (Manley et al 2008 p150). The other two stories were also analysed inductively and then deductively; emerging categories were then linked to the themes and framework. Two main themes became apparent, that of complexity and pathway thus enabling carers to see the complexity of client needs and help develop an individualised pathway of care.

Familiar to consultant practitioners from all disciplines, Manley et al's (2008) study provided a framework that focused on enabling factors “that precede the use of leadership strategies at the clinical and organizational level and its associated outcomes” (pg157) and the findings support other contemporary research undertaken focusing on leadership styles.

#### **2.4.4 The Consultant Midwife Role: Preparation, Characteristics and Achievements**

Consultant midwifery practice is about engaging in collaborative working and “changing attitude and culture in an attempt to improve maternity services for women” (Stephens, 2006 p279). Having commenced a qualitative study focusing on the consultant midwife role Stephens (2006) provided interim findings and questioned whether the role is promoting normality and creating a career framework for midwives. Stephens (2006) felt that little research has been undertaken focusing specifically on the midwifery consultant role and verbalised concern that where consultant midwives are in post, their impact can be diminished, by an overtly medicalised and hierarchical structure.

Stephens (2006) interim findings were bleak, emphasising that consultant midwives have experienced difficulties in establishing their roles and have raised concerns regarding support and role expectation. From the exploratory phase of the study Stephens (2006) emphasised that midwives with a remit for normality, were generally optimistic in the beginning, but early concerns were raised regarding intense medicalisation. Feelings of isolation and hostility were articulated and in relation to research activity “all respondents reported little or no research activity” pg 279. Stephens (2006 p279) concluded rather pessimistically by equating the consultant midwife role with “the struggle for normal birth”.

In order to deliver quality care Holmes (2004) and Ambler (2006) both agreed that consultant midwifery practice was about negotiation and the empowerment of midwives.

Holmes' (2004) appraisal of the midwifery consultant role was positive and she considered herself fortunate "to have one of the best jobs in midwifery" (pg 444). Her practice objective was substantial, aiming to reduce inequalities in health and to improve the health of mothers and babies in Glasgow. In relation to expert practice Holmes' (2004) role was community based and involved leading a multiprofessional health promotion team in a deprived area. This major undertaking would demand skills in communication and negotiation, research, design and education. The challenges appeared to be immense since the role involved operating at an overtly strategic level. Like Stephens (2006), Holmes (2004) emphasises difficulties managing people's expectations of the consultant role. She highlighted the importance of working clinically and the need to maintain clinical credibility.

Ambler (2006), a consultant midwife at the Whittington Hospital NHS Trust, focused on this concept of clinical credibility and questioned whether it was unrealistic to maintain clinical competence whilst undertaking the breadth of responsibilities expected of a consultant midwife. She questioned what constitutes clinical credibility and drew parallels between consultant midwives and midwifery lecturers, who have long been criticized for not having time to maintain their clinical currency. Ambler (2006) was knowledgeable as to the clinical pursuits of her fellow consultant midwives, but took a differing perspective. She argued whether being clinically competent really mattered and believed that midwives perspectives on the subject varied considerably. Ambler (2006) saw strong leadership and a noteworthy record of practice expertise to be important. Experience had shown her that the consultant role was not so much about maintaining clinical skills but in supporting, influencing and facilitating others. What was of interest was that Ambler (2006) had what could be considered the ideal balance, a part time consultant role and a separate contract in a different Trust where she was able to practice clinically one day a week.

Like Ambler (2006), Price (2006) believed a large part of the consultant midwives role related to facilitating educational opportunities and identifying gaps in service provision. She believed this worked well so long as midwives have a clear vision as to what their focus is (Price 2006). Price (2006) a consultant midwife practising in Bristol, spoke with passion and saw herself as fortunate to have such a "dynamic and challenging role" (pg 28), whilst being supported by the organisations she worked in. Her remit was public health and she felt well placed to fulfil the four key features of the role through working in partnership with education and practice. Price (2006) recognised the need not only to practice at the highest level but to educate and support midwives in practice, so as to maintain a highly trained workforce. She enjoyed working with midwives to identify gaps in service provision and to make necessary improvements. It was unsurprising that Price

(2006) defined her role as being chiefly one of professional leadership. It was clear from this article that as a transformational leader, “transparency, accessibility and approachability” (pg 29) were essential attributes of her role, as was empowerment i.e. the giving of support and guidance.

Price (2006) interpreted the uniqueness of the consultant role to be its strength and although her journey appeared largely positive there were concerns. At the time of writing Price was the only consultant midwife practising in the south west, she like others (Sullivan 2004) spoke of role isolation and welcomed the possibility of increased peer support.

Sullivan (2004) whilst a consultant midwife at Nottingham City NHS Trust, articulated that she felt consultant midwifery to be about supporting a philosophy that was essential to the midwifery profession, due to the integration of practice, research and service development. In 2004, Sullivan published an article in ‘Midwives’ which focused on a survey carried out the year before, on consultant midwife experiences. Whilst introducing her findings, she highlighted the differences in role interpretation and emphasised that success would depend on consultant midwives “achieving tangible benefits for mothers and babies” (pg 354). To collect the views of consultant midwives, Sullivan (2004) had sent a survey via email to an unknown number of consultant midwives; the questions were based on discussions the midwives had had at the RCM consultant midwives forum and also in relation to Guest et al’s (2001) on-going research evaluation of the consultant role.

The results of the survey were not generalisable to other consultant midwives, due to the small number of responses received. Sullivan (2004) presented an early draft to the RCM forum in September 2003. Her article was aimed at highlighting issues that had been raised by the responding consultant midwives. She focused on three areas, role implementation, midwifery leadership and impact on clinical care; strengths and limitations were presented equally. In relation to role implementation the responding midwives were agreed that they supported the underpinning philosophy behind the role. Tensions appeared to exist with regard to preparation for the role and there appears to be significant unease with regard to where consultant midwives sit in the management hierarchy and the degree to which they are supported to practice autonomously. It would appear from Sullivan’s (2004) presentation that changes to an organisations infrastructure, prior to and following appointment, were essential if role development and support was to be encouraged. It was clear from the survey that one relationship that needed nurturing was clearly that of the consultant midwife and head of maternity

services; Sullivan (2004) concluded by saying “Heads of Maternity Services have a well-established power base to facilitate or prevent successful role development” (pg 355).

In relation to providing strong clinical leadership, Sullivan (2004) articulated professional advantages, but also identified that for many new in post, leadership skills need developing and in some cases training was required. It would appear that although consultant midwives were clearly experienced clinicians, at the point of selection this did not automatically mean to say that they had advanced leadership skills.

As in the case of Holmes (2004) and Ambler (2006), Sullivan (2004) raised the issue of clinical credibility identifying that this can “increase the consultant’s sphere of influence” (pg 354). It would appear that being influential was not always straightforward and midwives had voiced feeling intimidated and blocked by hierarchical management structures and negative and obstructive managers and obstetricians. For some the experience was positive with colleagues being more inclusive; however the reader was left feeling saddened by a final quotation which made reference to bullying, intimidation, and critical frustrations.

Sullivan (2004) cited other challenges facing consultant midwives to include isolation, role overload, budgetary constraints and little administrative support. Positive aspects of the role generally appeared to connect with taking practice forward following strategic discussions and improving services which supported both midwives and childbearing women and their families.

Sullivan’s (2004) survey provided much needed insight into the experiences of consultant midwives; the reader was left feeling confident that for the profession, the role of consultant midwife and its underpinning principles was highly valued and is a mechanism for practice and professional development. It was hoped that with time, multi-professional support would be more forthcoming and that there would be recognition amongst midwifery managers that the role was not to be seen as hostile or threatening. Hopefully consultant midwives are here to stay and for them to be effective, partnerships clearly need to be nurtured and support given.

In looking to the future Byrom et al (2009) put into context some of the changes that have taken place to the profession since consultant midwives were first in post (DH 2004a; DH 2007). They explored how consultant midwives were contributing to the public health and normality agendas. Multiple projects and achievements were cited and like Sullivan (2004) comment was made as to the importance of forming an effective working

relationship with the head of maternity services if developments were to be realised. Multi-agency and multi-professional partnerships across primary and acute sectors were identified and where consultant midwives were actively engaged in research or education Byrom et al (2009) emphasised the importance of this collaboration in reducing the theory practice divide. The role according to Byrom et al (2009) was about identifying what worked well and initiating change when it did not.

From this literature, it was possible to see that influencing and challenging practice development at a strategic level demanded vision, and excellent skills in communication. Byrom et al (2009) like others spoke of working clinically and 'being visible'; they felt strongly that support from midwives was essential and reiterated the nature of the role, identifying that visibility may not always be possible. In order for the consultants to be effective in influencing practice development, they emphasised that behind the scenes work was almost inevitable. In addition, they recommended vigorous succession planning and course development, to prepare potential consultant midwives for the role ahead.

Succession planning was seen as crucial in order to identify potential consultant midwives for future practice. An academic mentorship programme in England for prospective consultant midwives had already been set up in Southampton (RCM 2009) and was credited with having been a success (Byrom et al 2009). The catalyst for this new initiative was Jane Rogers, a consultant midwife from Hampshire. Prior to the establishment of this scheme, Annette Weavers, a midwife from Berkshire benefited from having one-to-one consultant midwife mentorship support. Rogers and Weavers (2005) documented the nature of the year long support given and an article was published in 'Midwives' in 2005. The two midwives had collaborated; Rogers had orchestrated initiatives which would benefit practice, as well as acting as a framework by which leadership skills necessary for the consultant role could be taught. From analysing this particular article it appeared that objectives to raise the profile and skills of future consultant midwives had been achieved. In this instance it had provided the soon to be consultant midwife with skills necessary for strong leadership, dealing with conflict and participating in strategic development. Minimal evidence was provided as to the benefits and shortfalls of the initiative.

Some consultant midwives were employed to focus specifically on the public health agenda. These midwives focused on developing their own areas of expertise whilst providing care to vulnerable groups of women who were often socially excluded. In so doing these consultant midwives provided valuable clinical midwifery leadership. Their work was multifaceted and involved reducing health inequalities. It included caring for

pregnant women who may have been teenagers, or financially or educationally disadvantaged. Some may have been suffering from some form of addiction whilst others victims of domestic violence. Some consultant midwives worked on Sure Start projects aiming to improve outcomes for pregnant women who were disadvantaged in some way.

Articles by two consultant midwives, working in inner cities, identified consultant midwifery accomplishments and collaborative working in relation to the public health agenda. Penny Brett (2005), a consultant midwife in Lewisham, documented her involvement in developing a teenage pregnancy service. The government's teenage pregnancy strategy (Social Exclusion Unit, 1999) had clearly been articulated and concern had been raised as to the severity of the problem both nationally and locally. Brett (2005) had focused on literature so as to be clear as to what needed targeting. The literature emphasised had not been critiqued but provided evidence as to the need for teenagers to access the maternity services early in pregnancy, smoking cessation and increasing the numbers of teenagers' successfully breastfeeding. Stakeholder opinion had been obtained which emphasised how important it was for a midwifery team to be central to multi agency working. Collaborative working involved participation from social services, education, Connexions and Sure Start Plus. Impressively, teenagers were involved in focus group discussions about developing this service. The team listened to and put into action ideas from teenagers, relating to where the service should be run from, to suggestions regarding the type of midwives involved in providing the service.

The service was successfully implemented in 2003 and Brett (2005) clearly explained early antenatal and postnatal initiatives, all of which had been recommended by teenagers. It was clear that having launched this new initiative, the team did not stand still; they responded to an audit carried by Mookherjee (2004). Two groups of particularly vulnerable teenagers were identified as requiring additional support, those having just left 'care' and those who were refugees or asylum seekers with little financial security. Again Brett (2005) accessed relevant literature focusing on situations which increase the chances of becoming pregnant whilst a teenager. As a result of Mookherjee's audit (2004) initiatives were actioned which focused on early identification of mental health issues as well as the importance of working collaboratively with those working with refugees.

Brett (2005) documented the achievements of this new service against its original targets. Targets relating to early access, reducing smoking and increasing birth weight had all

been achieved. Breastfeeding rates were unchanged; as a result care was reviewed and initiatives put in place e.g. antenatal breastfeeding workshops.

Clearly this initiative was a great success and work continued to improve the service in line with on-going evaluation. Messages were given with regards to consultant practice. One was that clinical leadership and innovation could only be effective through collaborative working, improved communication and effective use of available resources such as stakeholder and client opinion as well as research evidence. Secondly, consultant practice often centres on the development of an individual's own area of expertise or speciality.

Like Brett (2005), Fay Macrory (2003) wrote about her role as a consultant midwife addressing the public health agenda, whilst leading a specialist midwifery service in drugs, alcohol and HIV in Manchester. Again, multi-agency working was central to the role. In this case collaboration between community and acute sector services enabled initiation and funding for the post. The aim of the post was to improve health outcomes to particularly vulnerable groups within the local population. Macrory (2003) identified the complexities involved and the importance of collaborative working across multiple agencies. As a consultant midwife, Macrory (2003) focused her attention on managing and developing the service as well as leading a specialist team of midwives. The service provided care not only to midwifery units, but to community drug, sexual health and detoxification units, as well as to other services caring for vulnerable groups in the local population. Education and support was provided to a wider audience, locally, nationally and internationally.

Macrory (2003) not only emphasised the aims and objectives of the service but also focused on managing the consultant midwife role. The objectives were clear and included reducing prejudice, making sure that the needs of the vulnerable were heard and that new partnerships were forged to improve healthcare provision. In relation to being a consultant midwife, Macrory (2003) accepted that the role went far beyond the conventional image of a midwife, but felt strongly that multi-agency working was valuable and that "midwifery truly means being 'with women' at other vulnerable times in their lives" (pg423).

For Macrory (2003), practising as a consultant midwife involved delegation, supervision clinical practice as well as education. She emphasised that the recommended 50% in practice needed interpretation on an individual basis and also emphasised the importance of support both locally via consultant midwife meetings and nationally through the Royal College of Midwives Consultant Midwives Group; managerial support and good clinical

supervision was seen as valuable. Macrory's role as a consultant midwife appeared overwhelming due to its diversity and complexities. What was clear from this article was that successful management results from being not only a clinical specialist but an effective leader, communicator, negotiator and educator (NHS Executive, HSC1999/217).

Like Brett (2005) and Macrory (2003), Jewell (2005), a consultant midwife specialising in working with women from minority ethnic communities, felt strongly that addressing the public health needs of women and families was best achieved by working in partnership with other health care professionals. Whilst caring for vulnerable women, Jewell (2005) emphasise the need for midwives to be accessible and to work collaboratively with those specialising in services supporting drug and domestic abuse, asylum seekers and minority ethnic groups. Initiating the integration of community services, securing funding and working collaboratively was demanding but at the same time fulfilling, in that integrated services improved access to services and resulted in increased self esteem (Jewell 2005).

Some consultant midwives working to improve health outcomes for vulnerable families were and had been involved in Sure Start and Sure Start Plus initiatives (Stringer 2004; Cooke 2004). The development of children's centres to serve disadvantaged families, provided collaborative care, education and support. Although service provision was provided largely by educational services, there was provision for health care to run from or be coordinated by children's centres (Stringer 2004). The Department of Health's (2004c) review into midwives and health visitors' contribution to vulnerable children and young people had identified the important contribution midwives make in improving the health of vulnerable children. To name a few, this review recommended the integration of community midwifery services with children's centres; on-going support for families following birth and the increase in new midwifery roles such as consultant midwives specialising in public health (Stringer 2004).

Pauline Cooke (2005) a consultant midwife in Paddington had been responsible for leading caseload midwifery in deprived areas of north London. The areas were supported by Sure Start schemes and had Sure Start midwives working within them. On-going clinical audits provided evidence of a reduction in the Caesarean Section rate. Like Cooke (2005), Byrom and Edwards (2005), two consultant midwives in public health, had joint academic appointments and shared a passion for consultant practice and improving maternal and child health and wellbeing. As consultant midwives they worked to implement and develop practice locally and strategically. Midwifery practice had involved them establishing one to one midwifery practice and community midwifery – led care centres, developing teenage pregnancy and Sure Start projects, and in the development

of care pathways to meet individual needs (Byrom and Edwards (2005). These three practitioners exemplified the consultant midwife role by specialising in the development and initiation of practice, by focusing on educating others and by working collaboratively.

By taking into consideration the work of the above consultant midwives specialising in public health, it is clear that working in partnership to improve care for disadvantaged women is of great importance. There is evidence to show that consultant midwives involved in delivering the public health agenda are aware of the benefits of multi-agency working. Negotiation skills which help in overcoming organisational barriers have been demonstrated as have skills in securing financial support. The public health agenda demands innovative working and midwifery influence at the highest level; consultant midwives have demonstrated that they possess these advanced skills.

It is clear from the above that public health has received much attention from consultant midwives, with service development focusing on the vulnerable and socially excluded. Whatever the specific focus, consultant midwives have been seen to be involved in strategic thinking and practice development; initiating healthier outcomes for varying populations of childbearing women and their families.

Some NHS Trusts employed consultant midwives not to be specialists in public health but to focus on promoting normality in midwifery practice. Increased medicalisation in childbirth had reduced choice for women, impacted on midwifery skill acquisition and development, as well as the provision of midwifery led care to women experiencing uncomplicated pregnancies, labours and deliveries. Midwives have long recognised the need to readdress the balance and initiatives were being supported locally and nationally. The National Service Framework for Children, Young People and The Maternity Services (DH 2004a) and more recently Maternity Matters (DH 2007) both reinforced the need to treat women individually and to offer informed choice. Initiatives taken to increase home birth, develop birthing centres and to address care issues with regards to low risk women in acute settings were proliferating and challenging health care providers and commissioners.

Three articles published in professional journals illustrated the practice and clinical achievements of consultant midwives employed to focus specifically on increasing normality for childbearing women. Rogers and Littlehales (2006) described an on-going strategy aimed at developing midwifery led services for women accessing Barnet and Chase Farm NHS Hospital's Trust. This article emphasised the importance of working in partnership to achieved shared goals; Rogers was a consultant midwife whilst Littlehales

a head of maternity services. The rationale was to strengthen practice leadership, a key feature of the consultant role (NHS Executive, HSC1999/217) and initial work was undertaken to identify priorities and to engage in an open discussion with stakeholders. Rogers and Littlehales (2006) described the importance of working collaboratively which ultimately led to changes in practice via a strategic midwifery forum. Mechanisms were put in place to overcome potential barriers and initial objectives focused on providing evidence based guidelines and altering the route by which low risk women accessed midwifery care.

It was clear from reading this article, that expertise in change management, dealing with complications and effective stakeholder negotiation meant that many initiatives were successfully put into action. Change action was supported by educational support and development and like Munro and Spiby (2000) guidelines for midwifery led care were developed (Rogers and Littlehales 2006). The achievements had been far reaching and the consultant midwife and head of service partnership was clearly critical in realising a vision for change in service provision. Their roles were both complimentary whilst being different and resulted in success through collaboration. In conclusion Rogers and Littlehales (2006 p243) emphasised that “the consultant midwife by establishing a culture where all staff grow in their knowledge and skills and are facilitated to influence the direction of services, is ideally placed to meet these challenges”.

Jamie Richardson a consultant midwife at Whipps Cross University Hospital specialised in promoting normality. Like many, Richardson (2005) questioned why there needed to be such a focus when midwives are trained to provide normal midwifery care. The need was clearly linked to reducing medicalisation and offering maternal choice. By working clinically with midwives and women largely on labour ward, key issues became apparent. Richardson’s (2005) initiatives were simple but effective; women categorised as being low risk were written in green identifying to medical staff that these women were midwifery led cases. In collaboration with the delivery manager, two labour rooms were identified as being for midwifery led cases only. The challenge in this instance related to maintaining the rooms specifically for low risk women. In addition Richardson (2005) led discussion forums focusing on intrapartum care.

It was clear that, Richardson’s (2005) passion for providing midwifery led care to women experiencing normality was far reaching and culminated in forging links with higher education, specifically with regard to designing and leading a midwifery module focusing on normal birth. In addition, Richardson (2005) exerted his creative expertise and skills in collaborative working to successfully open a birth centre at the Trust. As a consultant

midwife Richardson (2005) demonstrated how effective midwifery leadership and educational ambition can champion normal midwifery practice.

More recently, Rogers and Cunningham (2007) both consultant midwives with a remit to promote woman-centred care, provided the background to a consultant midwives' clinic established to provide additional support to women in pregnancy. Some of the circumstances by which women were referred included those seeking additional support and guidance in relation to mode of delivery; women suffering from a fear of childbirth and those suffering from physical or sexual abuse (Rogers and Cunningham 2007). Their care philosophy was based on the best available evidence and involved providing women with individualised care and the confidence to make decisions. From reading this article it seemed that collaborative working was encouraged whereby practitioners were encouraged to gain insight into the nature of women's concerns and involved in documenting a birth plan. An audit of the service was undertaken between September 2004 and September 2005 and focused on birth outcomes, the quality of communication between those making referrals and the consultant midwives and finally women's opinions. Case scenarios were carefully incorporated which provided invaluable insight into the needs and concerns of women accessing the service and initiatives taken to increase the chances of a successful birth outcome. Staff views were largely positive, 110 audit forms were circulated to midwives and doctors making the referrals; the response rate was good, sixty seven per cent. In addition, 97 per cent of respondents felt that communication with the consultant midwife was either good or very good and 96 per cent felt the input was either helpful or very helpful (Rogers and Cunningham 2007).

In seeking women's views, questionnaires were sent to 115 women post delivery, with a return rate of 50%. The responses were largely positive to questions asked in relation to information provided and with regard to needs being met. Comments received from both staff and women were coded and presented qualitatively. From a readers perspective these accounts created an illusion of transparency, whereby it was possible to assess the diversity of issues concerning childbearing women and the holistic nature of evidence based care provided following lengthy discussions.

In this instance two consultant midwives had formed a partnership to develop and successfully lead a service provided for women with special childbearing needs. Their continued success would depend on future collaborative working, to encourage effective communication and flexible working and to use research evidence to facilitate individualised care.

Like Rogers and Littlehales (2006), Richardson (2005) and Rogers and Cunningham (2007) other consultant midwives with a remit to develop midwifery led care and to promote normality had been successful in orchestrating changes in practice. As a final example, Clarke (2005) took a multi-disciplinary team approach to reduce the Caesarean section rate by leading and developing an ECV (External Cephalic Version) service. In relation to the consultant role, Clarke (2005) highlighted that this initiative fitted with the four defining features of the role (NHS Executive, HSC1999/217) as well as providing “some credibility among midwives and consultant obstetricians” (pg128). Skills were needed in guideline development, educating maternity care workers and auditing the process. Clarke (2005) identified how as a consultant midwife she identified a need in practice and successfully delivered change. Audit findings were favourable (41% of the women receiving ECV experienced success and 57% of these women went on to have normal deliveries).

In relation to the above focus on initiatives taken to promote normality, the struggle for normality in childbirth continues and challenging medicalisation and promoting normality in childbirth have occupied many consultant midwives since the role became established. As a result, the establishment of midwifery led services have facilitated increased choice for childbearing women (Rogers and Littlehales, 2006; Richardson, 2005; Rogers and Cunningham, 2007; Clarke 2005).

## **2.5 Summary of Literature Review**

This literature review has predominantly focused on the first generation of consultant nurses, midwives and health visitors. Primary literature and personal accounts on role experiences and achievements have shown that consultant experience is varied, that differing interpretations of the role are evident and that consultant practitioners are impacting on the development of practice and in leading a modern day workforce. Research has demonstrated that the consultant role requires considerable commitment, skill and expertise and for many is the ultimate in career advancement. Due to the complexity of the role, clinical and educational experience as well as organizational support has been recognised as being needed for the post-holder to maximise role potential (Guest et al 2005; Charters et al 2005; Woodward et al 2005).

Support from managers and colleagues', including medical practitioners has been seen as being essential, as is the overall development of a supportive workplace. A carefully planned induction linked to the four main features of the role was recognised as being important (Charters et al 2005); support in relation to the development of leadership skills was also seen as being valuable (Redwood et al 2005; Rogers and Weavers, 2005). The role was identified as being dynamic, complex and changing; emerging issues included

the need for role clarity, a reduction in role overload due to unrealistic demands being made on consultants by managers, as well as by consultants' own self demands (Guest et al 2001 and 2004).

Historically, nurses and midwives have not always led the way in relation to managing change within practice; the research analysed within this literature review has shown the importance of valuing senior non-medical staff experience if their skills are to be recognised. Research has also demonstrated that there is a need for support, especially in relation to consultant practitioners developing leadership and research skills (Rogers and Weaver 2005). Consultant midwives have emphasised that consultant midwifery is about engaging in collaborative working and "changing attitude and culture in an attempt to improve maternity services for women" (Stephens 2006: 279). Consultant midwifery practice has been shown to be about negotiation and the empowerment of midwives to deliver quality care and in so doing practise effectively (Holmes 2004; Price 2006; Ambler 2006). The role has been described as facilitating educational opportunities and recognizing deficiencies and inequality in service provision (Price 2006). The literature identified that consultant midwives support a philosophy that is essential to the profession, the integration of practice, research and service development (Sullivan 2004); however they need a clearer perspective as to what their focus is (Price 2006).

Collectively, consultant midwives have presented a powerful image of the consultant midwife role; they have illuminated some of their experiences, achievements, obstacles and challenges. Future objectives have been outlined in relation to initiatives and succession planning. Having critiqued this body of evidence it was clear however that the role of consultant midwife needed specific observation and interpretation. The above accounts and research studies made reference to developments orchestrated in practice by consultant practitioners from a variety of disciplines and it was clear that various role interpretations existed (Guest et al 2004; Redwood et al 2005; Rogers and Cunningham 2007; Humphries et al 2007). Role ambiguity, isolation, work overload and a lack of preparedness for the role especially in relation to leadership ability had been emphasised by many (Woodward et al 2006; Stephens 2006; McSherry et al 2007 and Charters et al 2005).

Evidence therefore clearly supported the need for an in-depth, robustly designed qualitative research study using a multi-method approach to data collection. Such a study would be able to focus specifically on consultant midwives; exploring expectations, experiences and intricacies of the consultant midwife role. New knowledge which clearly documents the consultant midwife's position within the hierarchy of the midwifery

profession was required, so as to recognize the ways in which these midwives work, as well as their contribution to the care of women and their families, at a time of healthcare reform. Having analysed literature relating to the consultant role, questions remain unanswered in relation to the consultant midwife's knowledge, expertise, ways of working and the feasibility of the role in a modern NHS. Evidence relating to the role of consultant midwife needed to be sourced from others working closely with the practitioners (Guest et al 2004; Woodward et al 2006), so as to identify collaborations and support networks. A gap in the literature has clearly been shown to exist in relation to influence and the implications for midwifery practice as a direct result of the consultant midwife role.



## **3 Research Design**

### **3.1 Introduction**

This chapter provides justification for the research study and presents a rationale for the chosen methodology, that of qualitative research as well as the approach taken, case study design. It explores theoretical and philosophical issues acting as a foundation for the research design. A synopsis of case study design is given including the design initiatives taken to analyse the role of consultant midwife in order to gain knowledge and understanding. In addition, it considers trustworthiness and the systematic route of enquiry taken to ensure rigour. Sampling, data collection and handling are explored as are issues relating to access, consent and ethical considerations.

### **3.2 The Research Questions**

Having carefully considered the rationale for the study, the following research questions became clear:

- 1 What is the role of the consultant midwife in contemporary midwifery practice?
- 2 What are the perspectives of consultant midwives, heads of maternity services and consultant obstetricians on the role of the consultant midwife?

In posing these two questions, the intention was to witness at first hand consultant midwife practice and what consultant midwives understand their role to be. Initial role expectations and the reality of the role, (workload, challenges and frustrations) were important to understand. Secondly, it was critical to observe how these practitioners fitted into a modern day maternity service, including its management structure and how they contributed to midwifery care provision alongside other midwives. As part of this investigation, projects initiated by the consultant midwives, were scrutinised and perspectives sought from heads of maternity services and consultant obstetricians as to the ways in which they were developing practice.

### **3.3 The Aim and Objectives of the Study**

The aim of this study was therefore to understand and analyse the role of the consultant midwife by observing and questioning a number of consultant midwives practising in NHS Trusts across England. In addition, perspectives of the role were obtained from heads of midwifery as well as consultant obstetricians practising alongside the consultant midwives, in the same NHS Trusts.

To achieve this aim, three objectives were identified:

- To establish consultant midwife participants' expectations and understanding of their role as a consultant midwife;
- To place the consultant midwife role in its political and professional context during a period of on-going professional change;
- To examine how consultant midwives have influenced midwifery practice, as viewed by the consultant midwives and members of the multi-professional team.

### **3.4 Constructivism and Qualitative Methodology**

Whilst considering the research questions and possible overall research design, philosophical research concepts were focused upon since they provide justification for, and an underpinning of, the research design. It was relatively clear from the beginning that a qualitative methodology "based on a belief in investigating phenomena in their natural setting" (Streubert Speziale and Rinaldi Carpenter 2007, p459) would need to be taken to answer the research questions. Since numerical data in the form of a survey or questionnaire would not provide sufficient depth by which the phenomena could be explored, paradigms such as Positivism and Post-positivism were naturally excluded. A qualitative paradigm was sought which related to interpretation, a holistic vision and a need to understand (Denzin and Lincoln 2000). The Feminist paradigms were briefly considered since the research did focus predominantly on women, however this study wasn't a study about women or the way in which women are viewed or treated in society. Therefore, following careful consideration of the primary aim of the research and two research questions, constructivism was identified as being the paradigm best suited to access knowledge in relation to the phenomenon being studied.

Constructivism is based on a belief that knowledge is constructed out of experience and "that reality is socially constructed, i.e. that the phenomena of the social and cultural world and their meanings are created in human social interaction" (Robson 2002, p552; Creswell and Piano Clark 2011). Here learning relates to dialogue and the understanding or making sense of someone else's natural environment. Meaning rather than the development of theory is anticipated assisted by the use of qualitative data collection tools. In this respect, the goal of research "is to rely as much as possible on the participants' views of the situation being studied" (Creswell and Piano Clark 2011, p 8).

In describing constructivism in relation to social research, Creswell and Piano Clark (2011, p8) make reference to the work of Crotty (1998) who suggested the following:

"1 Meanings are constructed by human beings..... (with) researchers tending to use open-ended questions so that the participants can share their views.

2 .....researchers seek to understand the context or setting of the participants through visiting this context and gathering information personally.

3 The generation of meaning is always social arising in and out of interaction....”

By taking such perspectives therefore, relevance was placed on not being able to separate oneself from the social world, but working with people i.e. participants, so as to understand them, their lives and their actions. By understanding this concept it became possible to demonstrate core principles and beliefs relating to the identification of meaning; this became visible in the methods used to collect data and the influence on the whole research process.

Constructivism is ‘naturalistic’ and ‘interpretive’ and relates to a researcher “collecting naturally occurring data” (Robson 2002, p549; Lincoln and Guba 2000), focusing on the subjective and non-quantifiable and seeking interpretation grounded in participants’ experiences (Polit and Beck 2006). In this instance, constructivism permitted in-depth understanding as to the role of the consultant midwife. The phenomenon was viewed as a whole (Lincoln and Guba 2000) and the research became more than data gathering, demanding social skills, sensitivity and a trusting relationship to be established between researcher and participants. The knowledge acquired was inductive; this was because by using constructivism the approach taken was not intent on proving or disproving a theory, but one where reasoning permitted the data to be heard and for understanding to emerge from the data (O’Reilly 2005; Polit and Beck 2006).

A research design, in line with this philosophical perspective developed. To achieve an in-depth understanding of the role of the consultant midwife and to analyse the ways in which these practitioners were working and influencing the development of midwifery practice, direct contact with the midwives was seen as being important. Data were therefore collected by means of observing the midwives in practice and by semi-structured interviews. Additionally, in order to examine views and experiences of the multi-professional team, it was decided that staff members who worked closely with the consultant midwives would be interviewed. A qualitative methodological research approach was therefore seen as appropriate where actions, interactions, attitudes, beliefs and experiences could be observed and questions asked (Robson 2002). Using qualitative methodology it became possible to analyse and understand the role of the consultant midwife and the influence these practitioners are having on midwifery practice.

This process of identifying a philosophical perspective simultaneous to a research design enabled the “creative and rigorous structuring of ideas that projected a tentative, purposeful, and systematic view of the phenomena” (Chinn and Kramer 2004, p91).

### 3.5 Case Study Design

Case study design was considered as being an appropriate research approach to take, since it facilitated the collection of information by using varied data collection methods so as to fully understand an otherwise unknown or poorly explained phenomena.

Although not anthropological in background, similarities were seen to exist between case study and ethnography in relation to the means by which a particular culture or population is best studied i.e. in its natural environment and the tools used to collect data. To aid methodological understanding, with regards to the research approach taken in this instance, the following ethnographic attributes were ‘not’ viewed as being appropriate in this study of the consultant midwife:

- 1 A single location. Multiple locations existed.
- 2 Multiple and lengthy episodes of observation. The study involved participants in various locations of the UK, where due to logistics it was not possible to spend lengthy periods of time collecting data;
- 3 Informal or free discussion. So as to increase objectivity, field work was restricted to semi structured interviews (interview schedules were used) (Madden, 2010).
- 4 The analysis of actions “and how these are implicated in local, and perhaps also wider contexts” (Madden 2010, p3). The analysis of data was thematic; all the different data strands were used to answer the specific research questions and to describe role intricacies.

#### 3.5.1 Defining Case Study

Case study is a commonly used research approach but definitions of case study vary considerably (Yin 2003; Zucker 2001; Appleton 2002; Stake 2000) and a clear interpretation was needed from the start.

According to Stake (2000 p435) “the case study is not a methodological choice, but a choice of what is to be studied”. Both Stake (2000) and Yin (2003) are renowned as experts in relation to case study research. Both offer different perspectives; Stake takes a holistic perspective whilst Yin (1993; 2003) is more orientated to a positivist paradigm. Stake (2000 p436) explains that a case may either be simple or complex and his definitions focus on an integrated system “a functioning specific...with working parts”. He describes three types of case study namely intrinsic, instrumental and collective. Yin (1993 p10) however defines a case as “a unit of analysis”; he describes a case as being

either single (holistic or embedded) or multiple. There are multiple differences in relation to the way in which Stake and Yin interpret case study. In relation to the generation of theory, Yin (1993, 2003) focuses on theoretical guidance and the generation of theories whilst Stake (2000) suggests that although theories may emerge, they may not always.

### **3.5.2 Identifying the Case**

In case study it is necessary to define the actual case (Robson 2000; Stake 2000; Appleton 2002; Yin 2003). There are multiple interpretations; a case may be an individual, a group of people, an event, even an organisation. Polit and Beck (2006 p242) consider that “case studies are in-depth investigations of a single entity or a small number of entities”. Similarly, Bowling (1997p 286) stated that case study “focuses on the circumstances, dynamics and complexity of a single case, or a small number of cases”.

Having analysed the multiple interpretations of ‘a case’, like Appleton (2002) questions were asked as to whether it was imperative to adhere to a particular researchers definition or whether the case identified need only be specific to this study, so long as it was carefully defined. More recently, Moule and Goodman (2009) encapsulated the definition of case study as being “a research design that focuses on specific groups or populations, often one, and collects data using a number of methods. The case is defined and unlimited”. This definition focused thought on a single case consisting of a group of individuals. The work of Stake (2000 p437) was then returned to, in particular his “intrinsic case study” used when a researcher seeks in-depth understanding.

The ‘case’ in this research was a single intrinsic case of consultant midwives. The midwives were the focal point of the study and emphasis was focused on understanding this little known phenomena. What was crucial was “understanding the case in itself” (Hammersley and Gomm 2000:4). By taking a holistic view of the case, rather than just focusing on specific aspects (Weerd-Nederhof 2001) it became possible to fully answer the two research questions.

To summarise, a single case study best described the research objectives since:

- It facilitated systematic inquiry, whereby a particular unexplained phenomena was comprehensively described (Stake, 2000; Zucker 2001);
- It enabled data to come from varied sources e.g. archival records, interviews, observation (Yin, 2003);
- Questions were central to the method and to the phenomena under scrutiny (Yin, 2003).

According to Zucker (2001, p1) “the key features of a ‘case study’ are its scientific credentials and its evidence base for professional applications”. This single case study was a process of learning and the product of that learning (Stake 2000). The ‘phenomenon’ or ‘case’ was real, tangible and specific; the objective being to develop as full an understanding as possible.

### **3.6 Recruitment of Participants**

Since the aim of the study was to formulate an understanding of the consultant midwife role, consultant midwives were the main focus and were observed in practice and interviewed. Secondly, staff members (Heads of Maternity Services and Obstetricians) working closely with the midwives, were interviewed so as to gain their views of the consultant role. All three groups of participants were selected specifically in relation to their role, experience and knowledge. This type of sampling is called ‘purposive sampling’ which involves making an evaluation of the sample since appropriate individuals need to be approached i.e. “the principle of selection in purposive sampling is the researcher’s judgement as to typicality or interest” (Robson 2002 p265). In this instance, purposive sampling involved the selection of practitioners whose qualities and experiences permitted an understanding of the consultant midwife role.

Prior to recruiting the consultant midwife participants, a group of consultant midwives was identified and a short presentation on the proposed research study was delivered at the RCM Consultant Midwife Forum. The purpose was to elicit interest in the proposed study and to explain the purpose of the research, chosen methodology and the participation requested. Following the presentation approximately twenty consultant midwives showed interest in participating in the study and provided contact details and information as to how long they had been employed as a consultant midwife.

Initially, it was planned that ten consultant midwives from ten different NHS Trusts in England would be selected and recruited, along with ten heads of maternity services and ten medical practitioners (consultant obstetricians). This it was felt would provide a good distribution of consultant midwives across Trusts and in varying types of post i.e. consultant midwife for normal birth or consultant midwife in public health. The medical practitioners were all to be identified by the consultant midwives. The midwives were asked to select medical practitioners who understood the role of the consultant midwife and had worked closely with them in practice for two or more years.

Following Multiple Research Ethical Committee Approval (MREC) (see Appendix 2), letters and information sheets (Appendices 3 and 4) were sent to the consultant midwives,

who had shown interest in participating in the study and in accordance with set inclusion and exclusion criteria (see Sections 3.5). Their respective heads of maternity services' were also sent an information sheet and letter explaining the proposed research study and requesting their participation (see Appendices 3 and 4). Information was provided explaining the study, the background to the study, why they were chosen and the benefits of participating. It was made clear in the documentation that participation was entirely voluntary. One of the difficulties experienced in recruiting the consultant midwives was that since the first meeting at the RCM, some were no longer consultant midwives; a few had moved into management positions, whilst others had taken a break in service. Fortunately, the number of consultant midwives that had originally shown an interest in participating in the study was high and eventually it was possible to recruit eight midwives in accordance with the inclusion criteria (see Section 3.5).

Once eight consultant midwives and their heads of midwifery services in different NHS Trusts had agreed to participate, local Research and Development departments were contacted and their approval sought and received.

On meeting the consultant midwives and heads of maternity services participation was again explained, any questions answered and informed consent requested and received. The participant consent document was signed by the participant and researcher and a copy was retained by both (see Appendix 5). Most consultant midwives asked to be met at their place of work i.e. their participating NHS Trusts (on the maternity unit).

The consultant midwives were asked to identify one medical practitioner most familiar with their practice and the role of consultant midwife. In all cases the practitioners were consultant obstetricians. Information sheets and letters were sent to the identified medical practitioners (see Appendices 3 and 4). Participation was again entirely voluntary and informed consent was received.

The consultant midwives' demographic details at point of first interview are presented within the appendices. Information incorporated includes age, length of service as a midwife and a consultant midwife, highest academic qualifications, previous consultant role, hours worked, registered teaching qualification and funding of role by higher education. In addition, brief biographies of these consultant midwives recruited are also presented in the appendices.

### 3.6.1 Inclusion Criteria for Participants

**Consultant Midwives** - The consultant midwives were at the heart of this case study. Eight consultant midwives were recruited. It was important to recruit consultant midwives with experience since the aim of the study was to understand the role and it was felt that those with experience would be more able to articulate not only their initial expectations of the role, but their experiences and perspectives of the role over time. The consultant midwives therefore needed to have been in post for two or more years, working in the same midwifery unit in England. Demographic information relating to the consultant midwives was compiled focusing on amongst others midwifery experience, length in years as a consultant midwife, highest academic qualification, whether full time or part time and whether their role as a consultant role was part funded by higher education (please see Appendix 6).

**Heads of Maternity Services** – Once the consultant midwives had agreed to participate in the study their Heads of Maternity Services were contacted and ultimately recruited. As with the consultant midwives, each Head of Maternity Services required experience of working with their consultant midwife so as to be able to articulate their perspective on the role. In all cases the Heads of Maternity Services had worked with their consultant midwives for 2 or more years.

**Medical Practitioners<sup>1</sup>** - The participating consultant midwives identified medical practitioners who they worked with closely; who understood their role and who they thought would be willing to participate in the study. These medical practitioners were consultant obstetricians and all were sent a letter and information sheet requesting participation (see Appendices 3 and 4).

### 3.6.2 Exclusion Criteria for Participants

**Consultant Midwives** - Consultant midwives in post for less than 2 years, at the start of data collection or having had less than 2 years employment at the participating NHS Trust were not invited to participate in the study.

---

<sup>1</sup> Eight Consultant Obstetricians were invited to participate in the study but only seven were able to be interviewed at the time arranged.

**Heads of Maternity Services** - Heads of Maternity Services having had less than 2 years working with a consultant midwife in their maternity unit in England were not invited to participate in the study.

**Medical Practitioners** - Medical practitioners having had less than 2 years experience of having worked with the consultant midwife at the start of data collection were also not invited to participate in the study.

### **3.7 Methods of Data Collection**

Data were collected via semi-structured interviews and observation. Additionally, documentary evidence in the form of job descriptions was collected. This was analysed so as to gain the Trusts perspective on the consultant midwife role. This documentation detailed the Trusts expectations of the consultant midwife and emphasised essential and non-essential criteria.

Data collection in each of the eight NHS Trusts differed in relation to the order of events. This depended on the participants work load / schedules. What was important was that uninterrupted time needed to be allocated whilst the data were being collected.

#### **3.7.1 Consultant Midwives**

Each consultant midwife participated in one in-depth taped interview, lasting approximately one hour, at a time and location that was convenient to them. This was either in their office or a quiet location at their place of work. Additionally, the consultant midwives were observed in practice on two occasions. The consultant midwives were asked to identify aspects of their role which best depicted the consultant midwife role and which were suitable to be observed. Examples included the observation of practice (e.g. VBAC clinics); department meetings chaired by a consultant midwife and meetings with individual Trust employees to discuss a concept or policy document).

#### **3.7.2 Heads of Maternity Services**

Similarly, data were collected from the consultant midwives' head of maternity services via one in-depth taped interview, lasting approximately forty five minutes, at a time and location that was convenient.

#### **3.7.3 Medical Practitioners (Consultant Obstetricians)**

Once the consultant midwives had identified potential medical practitioners (consultant obstetricians) and once they had agreed to participate, each took part in a taped interview lasting approximately thirty minutes, held in a convenient location.

### 3.7.4 Interviews

An interview schedule, which acted as a guide, was created for each group of participants (see Appendix 7). These were devised following analysis of the evidence, in particular the literature written by consultant midwives relating to their experiences. It was planned that at each Trust the consultant midwife would be interviewed first, followed by the head of maternity services and finally the consultant obstetrician. Due to conflicting commitments, this order did alter considerably and on one occasion, due to unforeseen circumstances, a separate visit needed to be arranged to interview a consultant obstetrician.

The rationale for interviewing the consultant midwife first was to enable time to be given to thinking about the midwife's responses, views and experiences, prior to the observational episodes and the interviews with the head of maternity service and consultant obstetrician. When this did happen, brief notes were made in a field diary during the interview, as to issues needing to be followed up, i.e. questions needing to be asked of the head of maternity services or consultant obstetrician, or observed during the observational episodes that followed. In contrast, an advantage of observing the midwives prior to interviewing them was that any queries relating to the observation could be followed up at interview.

Semi-structured interviews, with open-ended questions, were used to obtain focused information and provided an opportunity to resolve any ambiguities as the interviews progressed (Duffy et al 2004). By using semi-structured interviews the participants were provided with an opportunity to speak freely. Often the interview guide acted only as a prompt. Most of the participants spoke with ease, quite naturally. They talked in detail about the consultant midwife role, often answering the questions on the interview guide before they had even been asked.

All interviews were face-to-face, conducted without interruption, in the participants' offices or a quiet place within their area of work. Each interview was recorded. Interviews at Trust 1 were used to pilot the interview schedule. This provided an opportunity to test the questions in the interview guides (see Appendix 7). In addition, the procedures required to arrange observational sessions and select a suitable medical practitioner were experienced for the first time. This 'piloting' worked well, with only minor changes needing to be made to the interview guides in order to remove repetitive questions and improve clarity.

Whilst interviewing, a determined effort had to be made to remain focused on the research process and not become distracted by the desire to ask misleading questions (Allen

2004). It was important not to influence the discussions by offering clinical and professional opinion, which at times would have been very easy to do (Marchant and Kenney 2000). The interviews of all three groups of participants were unstructured and more like episodes of conversation. Participants were not inhibited; they were relaxed and naturally volunteered information relevant to the consultant midwife role.

### **3.7.5 Observation**

The observational episodes were undertaken to provide evidence as to how the consultant midwives were practising, communicating and developing midwifery knowledge.

A field diary was also used during the episodes of observation. This recorded thoughts and feelings relating to the observations made. A form for observational notes was created (see Appendix 8) with headings relating to the “dimensions of descriptive observation” (Robson 2002 p320). These included ‘the environment’; ‘the participants’; ‘activities observed’ and ‘interactions between the consultant midwife and clients / others present’.

The extent to which an observer participates whilst observing has been considered by many researchers. According to Streubert Speziale and Rinaldi Carpenter (2011) there are four ways in which observation can be used in research activities - complete observation; observer as participant; participant as observer and complete participant. Complete observation was seen as unrealistic, since as a midwife myself, there were bound to be instances where interaction was unavoidable. The role of ‘observer as participant’ was seen as being the most appropriate description, since the intention was to observe the midwives without undue intrusion into their practice or interactions.

In the event, researcher participation was kept strictly to a minimum, so not to distract the midwife or in some cases the client. Consent was gained from all clients (see Appendix 9) and it was possible to observe quite unobtrusively, taking into account the behaviours and interactions between client and midwife.

In advance of the episodes of observation the consultant midwives were asked to identify activities that they felt emphasised their role as a consultant midwife and were appropriate to be observed. To avoid intruding on clients being cared for by a consultant midwife, it was envisaged that suggested opportunities might include meetings, discussion forums and teaching opportunities. In the event, several clinical activities were suggested by the consultant midwives and these were observed. Where opportunities existed for observation

to take place whilst the consultants were caring for a client, client written consent was obtained, in keeping with ethical committee guidance (see Appendix 9). Each consultant midwife was observed on two separate occasions. The length of time spent observing the consultant midwives in practice spanned either a one or two day period.

One advantage of observing consultant midwife activity was that it provided opportunities to observe professional interactions, communication styles and the transfer of information between client and midwife. Being an observer however, did feel awkward at times and I questioned the extent to which being observed affected the dialogue between midwife and client. The observer's effect or Hawthorne effect "are terms used to describe changes in the participants 'usual' or 'normal behaviour' as a reaction to being observed" (Parahoo 2006 p470). Robson (2002 p311) also asks "how do we know what the behaviour would have been like if it hadn't been observed". Having considered this, the answer is unknown; however whilst being observed the consultant midwives appeared to act completely naturally.

Having undertaken previous qualitative research, I was aware of the importance of not making assumptions or coming to premature conclusions. The need for objectivity was important; I needed to describe and not interpret observations. Another consideration was the time consuming nature of observation. I was aware that I needed to observe with precision, from the start to the finish; attention was therefore paid to not losing focus and not being distracted. Maintaining field notes assisted in remaining focused and remaining alert. Actions and behaviour sometimes needed to be observed simultaneously; it was therefore important to position myself in order to facilitate a clear view without being too obtrusive.

To summarise, the trustworthiness of the observations made depended on me remaining unobtrusive, alert and consistent in maintaining accurate field notes. Although the observational episodes were time consuming, their strength lay in providing information relating to the role of the consultant midwife that would otherwise not have been collected; the episodes of observation provided evidence, and gave meaning and clarity to the role of consultant midwife.

### **3.7.6 Documentary Evidence (Job Descriptions)**

In addition to the data collected via interviews and episodes of observation, documentary evidence in the form of job descriptions (see appendix 10 for an example) proved invaluable in determining the role of each consultant midwife. Job descriptions were common to all; they were the manifestation of the Trusts' expectations of the role of

consultant midwife. There was no other documentation e.g. Strategic Trust documents, that focused so specifically on their role or aspects of it. Once the interview data had been analysed, extracts from the job descriptions were integrated, as a means by which the role of the midwife could be exemplified.

The individual consultant midwives were asked to provide their original job description, these were analysed so as to gain the Trusts' perspectives on the consultant midwife role. This documentation detailed the Trusts' expectations of a consultant midwife and emphasised essential and non-essential criteria. Each Trust comprehensively interpreted the four key elements of the role, as initially documented (NHS Executive, HSC1999/217). It was interesting to contrast what had been envisaged prior to recruitment and how the role of consultant midwife had developed over time.

### **3.7.7 Reflexivity**

The consultant midwife study emphasised how demanding reflexivity is in relation to remaining true to the phenomena being observed and to remaining self-aware at all times. Self-awareness in relation to responses made or actions taken, as well as an understanding "of the researcher's relationship to the research topic and the participants" (Dowling 2006 p 8). In this case, reflexivity demanded total concentration in an effort to remain focused and almost invisible, so as to maintain objectivity, thereby not negatively impacting on the overall research process.

In keeping with publications relating to reflexivity (Fleming, 1998; Carolan, 2003; Kingdon, 2005) and by adhering to Ahern's (1999 p408-10) plan (cited in Robson (2002 p173), the following points (in italics) were reflected upon during the research process so as to ensure reflexivity.

*Self-Awareness.* As a midwifery lecturer, enthusiasm had developed from having the opportunity to witness consultant midwifery practice in eight maternity units across England. Maintaining clinical competence and credibility is a challenge when much of your time is spent in a classroom and not a practice area. I was therefore particularly interested to see how the consultant midwives were managing their time and the type of practice they were undertaking. I was however overtly aware of this enthusiasm and of the need to remain focused, so as not to stray away from the purpose or process of the research.

*Areas of conflict.* It was anticipated that certain participants, well known to me from a professional perspective e.g. those in a senior or well-known position within the

profession, would increase my anxiety during interviewing. It was therefore important for me in advance to consider how I would approach them; I also rehearsed taking time between questions and ensured that I dealt with each participant in the same way, so as not to bias the findings.

In addition, I was particularly conscious that being so close to the consultant midwives whilst undertaking observation may have a negative effect. I was concerned that although being in practice with the consultant midwives provided me with the opportunity to observe them in their natural environment; it might make it difficult for me to remain detached. I realised that just by being there, I could affect the research in some way (Streubert Speziale and Rinaldi Carpenter 2011). I therefore made a conscious effort to focus on the mother / midwife relationship and to reflect after each event.

Similarities between reflection and reflexivity are well known. Reflection enabled issues arising out of the process of research to be given thought and consideration. This reflective process was on-going, assisted by discussions with research supervisors and others.

*Impartiality.* As a lecturer engaged in educating students to use research evidence in practice, I also wanted to explore how consultant midwives were developing evidence-based midwifery care. I was keen to observe how advanced knowledge and multi-professional collaborative working was influencing service delivery. Even though many of the consultant midwives had educational backgrounds I was careful not to focus too heavily on educational initiatives. It was important for each midwife to be asked similar questions to ensure parity. In addition, due to my clinical background being in intrapartum care, I knew I would be naturally interested in contemporary advances affecting labour and delivery. I knew therefore that I would need to make a considered effort to remain focused on what I was there to do and not to explore unrelated issues.

*Documentation.* Making sure that the views of all participants were reflected was important. It was essential to ensure that the perspectives of all three groups of participants had been heard and that one had not been quoted more than another (Parahoo 2006).

*Evidence used in analysis of the findings.* It was important to ensure that the findings were supported by contemporary evidence and not lost in unrelated dialogue. Answering the research questions was crucial and time needed to be taken to ensure clarity.

To conclude, recent literature focusing on reflexivity emphasises that the above approach was in fact a valid one (Neill (2006); Dowling (2006); Freshwater (2010); Arber (2010); Carr (2010). In addition to the researchers mentioned, Lambert et al (2010) undertook a literature search so as to determine articles focusing specifically on “reflexivity and maternity care and reflexivity and midwifery” (Lambert et al 2010 p322). Three themes emerged from the literature, these related to “knowledge, intuition and education; self-awareness and the impact of personal situational influences on research and midwife-client relationships” (Lambert et al 2010 p322). Although Lambert et al’s (2010) research was not published whilst designing the consultant midwife study and during the process of data collection and analysis, on reflection much of what the authors revealed resonate with actions taken.

In this consultant midwife study, much thought had been given in relation to the process of the research. It had been important to deliberate on the effect I might have, either consciously or unconsciously on the different stages of the research process (Kingdon 2005; Freshwater 2005; Lambert et al 2010). Lambert et al (2010) emphasise the source of knowledge, gained through study as well as a result of intuition gained through experience. They acknowledge the importance of recognition and of knowing one’s ‘self’ so as to legitimize a study and ultimately a study’s findings. In reality, knowing the source of our knowledge or understanding does not occur simultaneously to an action, but only after periods of contemplation or reflection. Remaining focused so as to remain objective or true to one’s self, demanded concentration so as to ensure as far as possible an unbiased perspective (Finlay 2003; Arber 2006). The identification of personal feelings that might negatively affect objectivity, therefore needed to be acknowledged throughout the research cycle (Horsburgh 2003).

### **3.8 Data Analysis**

This section presents the approach taken to analyse the interview transcripts (from the consultant midwives, heads of maternity services and consultant obstetricians). It also describes the process by which the observational data and documentary evidence were examined and the findings integrated to provide evidence and clarity as to the role of the consultant midwife.

#### **3.8.1 Thematic Analysis of Interview Transcripts**

The aim was to make sense of large amounts of narrative material and “to organise, provide structure to, and elicit meaning” (Polit and Beck 2006, p397). By revisiting and analysing the transcribed interview data, the findings became based on a coming together

of all three perspectives, the consultant midwives, heads of maternity services and obstetricians.

A transparent process was necessary in order to visualise how the different strands of data could be integrated to provide a description of the consultant midwife experience and their influence on midwifery care provision. The chosen method of analysis for the interview data needed to identify themes and patterns; this appeared appropriate from an early stage of data collection, due to the identification of recurring experiences and opinions voiced by participants in all groups. Thematic analysis was selected as it is “an accessible and theoretically flexible approach to analysing qualitative data” (Braun and Clarke 2006, p77). It is widely used in midwifery and by other health scientists; Gibb and Hundley 2007). Interview data were systematically coded, classified, indexed and analysed for emerging patterns and themes. The process of thematic analysis was divided into the following phases:

- Organisation of the data;
- Identification of descriptors, categories and emerging themes.

### **3.8.2 Organisation of the Interview Data**

The aim of this case study research approach was to describe accurately and completely the phenomenon being studied (Zucker 2001). With this in mind, early investigation into the coding mechanism used as a means of thematic analysis was essential due to the amount of data anticipated. Data needed to remain manageable and this became apparent early on once data collection had commenced. Some researchers recommend creating a preliminary list of codes prior to fieldwork thus linking theoretical ideas to the data. In this case, although the literature did drive questions asked at interview and the observations made in practice, descriptors were not created until the fieldwork was completed and data analysis started in full, suggesting the identification of more empirically driven coding.

There is not a single accepted method by which qualitative data should be handled and coded; many approaches have been well documented and it was important to select the most appropriate approach in order that the full meaning of the data could be revealed (Robson 2002). To assist in the identification of meaningful data an ‘editing’ style of analysis was selected where codes were “based on interpretation of the meanings or patterns in the texts” (Robson 2002 p458). Although data analysis computer software packages e.g. Nud\*ist; ETHNO are frequently used to assist in data organisation, on this occasion manual handling of data was thought to be more appropriate, primarily due to

the closeness it permits. Being thoroughly immersed in the data, for considerable amounts of time, provided multiple opportunities on which to reflect on the process of data collection and more importantly the individuals and environments visited.

Where possible, episodes of simultaneous data collection and preliminary analysis ensured emerging issues were considered (Endacott 2005) i.e. letting each interview inform the next one. All recordings were transcribed verbatim by the researcher. Prior to transcription data from the recorded interviews and field notes were read or played repeatedly as a reminder of the event and to elicit meaning (Easton et al 2000; Lapadat 2000). Listening repeatedly to the recordings facilitated closeness with the data, as time spent collecting the data was reflected upon. Time was spent paying attention to aspects of non-verbal communication such as laughter, hesitations, tone of voice since this further facilitated interpretation. Listening to the data recordings and typing took place concurrently and was a very lengthy process. This process, however, is more likely to result in accuracy (MacLean et al 2004), since inaudible sections of the recordings or colloquialisms can be played time and again to check for understanding. Once transcription was complete the document was read repeatedly so as to understand what each participant was saying in relation to the role of consultant midwife.

### 3.8.3 Identification of Descriptors and Emerging Themes

The Consultant Midwives were central to the study and as such it was helpful prior to commencing data analysis to reflect on each individual and document a brief bibliography. With care taken to maintain anonymity, accounts of each consultant midwife were written (please see Appendix 11). Writing these descriptions assisted in the process of reflection and acted as a useful mechanism by which immersion in the data became a reality. To commence this analytical process, the interview transcripts were read individually and repeatedly allowing consistencies to surface and for relationships and patterns to appear. Each line within a paragraph was analyzed and an identifying number was attributed to individual sections of the data; a preliminary descriptor was then applied; an example of this is presented in Table 2 below.

**Table 2 The Application of Preliminary Descriptors to an Extract of Data**

Part. No	ID No.	Data Extract	Preliminary Descriptor
8	2	You do need to be a competent midwife, to be credible in the eyes of your clinical colleagues. To have academic achievement and to be credible is a real achievement. As an individual you need to be self-motivated, you have to organise yourself.	Competency Credibility  Academic Achievement  Self-Motivation

The preliminary descriptors were drawn from the data. Some of the descriptors were very familiar due to the periods of reflection that naturally followed each interview. These preliminary descriptors were the exact words used by the participants themselves; this has been referred to as 'in vivo coding' by Glaser and Strauss (1967, p107) the advantages of which relate to providing a clear and accurate description based directly on the participants words or phrases.

Once preliminary descriptors had been drawn out of all the data a list of approximately 70 preliminary descriptors was formulated. Now that a list of preliminary descriptors existed further reading took place to identify recurrences.

As presented in Table 3 below, extracts of data from all transcripts were highlighted using different colours, linking preliminary descriptors to similar sections in other transcripts that covered comparable issues. This involved reading and rereading sections of data so as to check understanding, making sure correct preliminary descriptors had been applied.

**Table 3 An Example of How Preliminary Descriptors across Interview Transcripts were Colour Coded and Categorized**

Part. No	ID No.	Data Extract	Preliminary Descriptor
2cm	2	I think it's vital if the consultant midwife has a considerable amount of practical experience, to have credibility as a clinical practitioner.	Practice Experience Clinical Credibility
8cm	2	You do need to be a competent midwife, to be credible in the eyes of your clinical colleagues. To have academic achievement and to be credible is a real achievement.	Competency Clinical Credibility Academic Achievement
3hom	21	Well I think it is important that they have enough clinical involvement to retain their clinical credibility and to hold their heads up amongst others saying 'I am out there and am doing it'....	Clinical Involvement Clinical Credibility

A more detailed coding system then followed by formulating the preliminary descriptors into broader descriptors i.e. by breaking the data down further once clear meaning had been ascertained. An example is provided in Table 4 on page 63. This resulted in a further list being generated consisting of broader descriptors or categories; in total 40 categories now existed.

**Table 4 An Example of How Comparable Preliminary Descriptors Became Broader Descriptors**

<b>Preliminary Descriptors</b>	<b>→</b>	<b>Broader Descriptor</b>
An example of comparable preliminary descriptors e.g.  1 Having Clinical Credibility 2 Having Good Clinical Judgement 3 Providing Expert Practice	Sections of data relating to these preliminary descriptors were then read repeatedly to ascertain meaning →  A broader descriptor was then formulated to encapsulate all preliminary descriptors.	<b>Being Clinically Competent</b>

Finally, further reading of data extractions, lists of descriptors (preliminary and broad) was undertaken. The broader descriptors were then encapsulated into groups and given a title or theme emphasising an all-encompassing description. Table 5 below exemplifies how broader descriptors finally become encapsulated into a theme.

**Table 5 An Example of How Broader Descriptors Finally Became Encapsulated Into A Theme**

<b>Broader Descriptors</b>	<b>→</b>	<b>Theme</b>
1 Being Clinically Competent 2 Being a Role Model 3 Understanding the Meaning of Practice	Sections of data relating to broader descriptors were then read repeatedly to again check meaning →  These broader descriptors finally became encapsulated into a theme or final descriptor.	<b>Having Clinical Wisdom</b>

### **3.8.4 Analysis and Integration of the Observational Data and Documentary Evidence**

Following thematic analysis of the transcribed interview data, each set of observational field notes were read repeatedly (for an example of observational notes taken, please see Appendix 12). Sections of text were highlighted, which provided evidence to the broad descriptors and themes that had emerged following thematic analysis of the interview data; this is demonstrated in Table 6 on page 64.

**Table 6 Sections of Observational Data to illustrate the Themes which arose following Thematic Analysis of the Interview Data**

Theme	Sections of Observational Data illustrating Themes
<b>Having Clinical Wisdom (Theme 1)</b>	One of the ways the midwives expertise was observed was in relation to the use of national guidelines <i>“this information is based on national guidance” (Trust 1, Observation1)</i> and also in relation to the interpretation of nationally recognised statistics e.g. <i>“the risk of having a second caesarean section is low, seventy to eighty per cent of vaginal births will be successful” (Trust 2, Observation 1).</i>
<b>Taking Control (Theme 2)</b>	<i>“The consultant midwife spoke with authority referring to research findings and clearly engaged the practitioners in attendance, who asked questions and sought support and guidance...” (Trust 7, Observation 1).</i>

Analysis of the consultant midwife’s job descriptions was undertaken in the same way. Each job description was read carefully and again sections of text were identified as evidence, to support the themes that had arisen following analysis of the interview data. Examples are provided in Table 7 below.

**Table 7 Sections from Job Descriptions used to illustrate Themes**

Theme	Sections from Job Descriptions used to illustrate Themes
<b>Having Clinical Wisdom (Theme 1)</b>	<i>All job descriptions focused on the successful applicants “being clinically competent.... Expert practice, role modelling and team working” were emphasised.</i>  <i>“...holding a caseload; developing guidelines and promoting autonomous practice”.</i>

Following rigorous analysis of the observational notes and job descriptions the highlighted extracts were used as supporting evidence and integrated with the interview findings, to provide a full description of the consultant midwife’s role. This is illustrated in Chapter 4.

### 3.9 Ethical Considerations

Ethical considerations were taken into account at each stage of the research process.

Ethics in research relates to “a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal, and social obligations to the study participants” (Polit and Beck 2006, p499; Rees 2003).

Health professionals must follow ethical principles set down by Government and Professional regulators e.g. The International Council of Nurses (ICN) (2006); The Research Governance Framework (DH 2005); The Medical Research Council (MRC) (2005); and The World Medical Association (WMA) (2000) to ensure the safety and respect of those in their care. The MRC (2005, p3) records that “good research practice is essentially an attitude of mind that becomes an attitude of work”. Taking into consideration all of the above, this research study was conducted by following the ethical principles set down above and in Figure 1 on page 66.

### **3.9.1 Beneficence**

Beneficence is a fundamental ethical principle “that seeks to prevent harm and exploitation of, and maximize benefits for, study participants” (Polit and Beck, 2006, p496). In relation to beneficence, only participants who volunteered to participate were recruited. The Oxford Dictionary of English (Pearsall and Hanks 2005) documents that beneficence relates to ‘doing good’, which emphasizes the importance of conducting research which benefits participants and those associated. In this instance, the research design had been carefully planned; from research evidence it was clear that such a study was required and it was anticipated that the consultant midwives would welcome the study, since it provided a mechanism by which their experiences and achievements could be documented.

**Figure 1 Ethical Principles for Protecting Research Participants  
(International Council of Nurses (ICN) (2006))**



Much that is observed during qualitative enquiry requires participants to expose their vulnerability and may touch upon emotional periods of their lives. To prevent psychological damage being inflicted on participants in this study, every effort was taken to phrase questions sensitively and non-intrusively, making every effort not to embarrass. Questions demanded of the practitioners, an articulation of their experiences and perspectives on the consultant midwife role and how it related to the future of midwifery practice (see Appendix 7).

### 3.9.2 The Right to Human Dignity

This principle focuses on independence and the right to be informed i.e. informed consent (Polit and Beck 2008). With regard to freedom from exploitation, clear and concise information was given to participants at all stages of the research process. A participants' information leaflet was produced which formed the basis for informed consent. It contained details as to the participants' rights and benefits of participating in the study and gave details as to how to contact the researcher. Informed consent was seen as essential, demonstrating that the participant's decision to partake was optional (Streubert Speziale and Rinaldi Carpenter 2011) following receipt of accurate, clear and detailed information. Participation was therefore entirely voluntary; the participants were not coerced into participating and were able to withdraw from the study at any time without giving a reason.

Written informed consent was received from all participants. Participants were asked that:

- They confirm their understanding as to what is involved by their participation and that they have had time to ask questions;
- They understand that participation is entirely voluntary and may discontinue participating at any time;
- They understand that the researcher is the only person to have access to observational material, interview material and transcripts.

Each participant was given a copy of the informed consent form signed by both parties.

### **3.9.3 Justice**

This refers to the provision of fair treatment and privacy (Polit and Beck, 2006). All participants were treated fairly, from the research design stage through to participant selection, data collection and finally the handling of data. All participants were given privacy; they chose where to be interviewed and were not disturbed during the interviews. The right to privacy includes the right to participant and NHS Trust confidentiality and anonymity. Since qualitative enquiry often touches the senses most personal to an individual, guarantees must be made that ensure that all data are maintained securely (Parahoo, 2006). Personal identity must be protected at all times.

In this research study, participant confidentiality and anonymity was seen as essential, the researcher and the supervising team being the only people to have access to the observational material, data and transcripts. All data were maintained confidentially and encrypted. The lists of encryptions were kept locked away, separate to any other documentation. All recordings, research notes and transcripts were also stored securely (Office of Public Sector Information (OPSI), 1998).

In summary, participant and NHS Trust confidentiality was maintained via the following means:

- The names of all participants were known only by the researcher;
- All data and research notes did not include the names of the participants or their employing NHS Trusts;
- All data and research notes were encrypted so as not to identify the participants; The list of encryptions were maintained confidentially and locked away, separate from the data (OPSI, 1998);
- Any publications resulting from this study will not disclose or identify the participants or employing NHS Trusts.

**Table 8 A Summary of Participants' Rights in relation to the Consultant Midwife Study (Parahoo 2006; International Council of Nurses (ICN) (2006))**

Right to Beneficence - Protection from physical and psychological damage	There was no physical contact (harm);  Every effort was taken to phrase questions sensitively and non-intrusively.
Right to Human Dignity - Self-determination and full disclosure	A detailed participant information booklet was provided for all participants, providing information on all aspects of the study;  Every effort was taken to answer participant's questions on an on-going basis;  Participation was entirely voluntary;  Informed consent was given by participants;  All participants were aware that they could withdraw from participating at any time.
Right to Justice – Fair treatment and privacy	Ethical approval and Research Development approval sought and awarded;  Participants interviewed in a place of their choice. All interviews were conducted privately;  Participants considered in accordance with research governance (DH 2006) and professional regulations relating to behaviour (NMC 2008).
Right to Veracity – The establishment of a trusting relationship	Trust was seen as important and was sought from the very beginning i.e. when meeting participants for the first time.
Right to anonymity and confidentiality.	All data is held under the data protection act (OPSI 1998) i.e. anonymised and not traceable to individuals; Anonymity was awarded to all participants.

### 3.9.4 Ethical Approval

Research planning culminated in the acquisition of ethical approval. As seen, ethics in research can be considered to be the degree to which the research conforms to moral standards, including issues related to professional, legal and social accountability. Any participant involved in research is entitled to confidentiality, voluntary participation, informed consent and protection against physical or emotional harm (Parahoo 2006; Robson 2002).

Ethical approval was the culmination of precise preparation and explanation as to the proposed research study. Ethical committees necessitate the provision of detailed participant information and informed consent before data collection (Robson 2002), emphasizing that participants have the right to choose not to participate and may terminate their participation at any point. Ethical approval was sought via the former Central Office for Research Ethics Committees (COREC 2004), now the National Research Ethics Service (NRES). Following this application process, multiple research

ethical committee approval (MREC) was received from the Kent and Medway Strategic Health Authority, Multiple Research Ethical Committee.

As well as gaining MREC approval, NHS Research and Development (R&D) approval was applied for and obtained from each of the eight NHS Trusts, prior to data collection.

Research and Development committees within NHS Trusts adhere to the Research Governance Framework (RGF) (DH 2005). Obtaining R&D approval from eight NHS trusts was both lengthy and convoluted, with application processes and requirements different for every NHS Trust.

### 3.10 Trustworthiness

This section demonstrates the processes undertaken in this research study to systematically ensure rigour and trustworthiness. Trustworthiness, a term used in qualitative research, reflects coherent and meticulous research design and data handling, where careful research planning results in credible data, which are close to the truth (Greenhalgh 2006). Denzin and Lincoln (2000, p393) emphasize that trustworthiness “is about description and explanation and whether the explanation fits the description”. Robson (2002) believes that there are situations that make demonstration of trustworthiness possible, i.e. a flexible research design. The design of this study was flexible and adhered to some of the characteristics of flexibility (Polit and Beck 2006; Robson 2002; Creswell 1998). Table 9 below demonstrates the study’s flexible design and strategies taken to demonstrate trustworthiness.

**Table 9 A Flexible Design Approach  
(Polit and Beck 2006; Robson 2002; Creswell 1998)**

<ul style="list-style-type: none"><li>▪ The study was holistic in design;</li><li>▪ Two methods of data collection were used;</li><li>▪ The means by which the data were collected have been clearly documented;</li><li>▪ The research design was ‘emergent’ i.e. on-going design issues were considered in relation to what needed to be learnt;</li><li>▪ There were periods of intense involvement whilst data were collected;</li><li>▪ The design required the researcher to become the research tool (observation);</li><li>▪ On-going data analysis was undertaken to refine the interview strategy;</li><li>▪ Comparisons and recurrences occurred as data were collected;</li><li>▪ Rigorous data analysis was undertaken with verification of accuracy by researcher;</li><li>▪ The findings are accurate and reflect the research title.</li></ul>
--

Trustworthiness emphasizes that findings reflect the reality of the experience and that accurate and honest handling of the data is essential (Robson, 2002). Different models of trustworthiness exist; Guba (1981) proposes four criteria – truth value, applicability,

consistency and neutrality. Terms such as 'dependability'; 'transferability' and 'credibility' (Guba & Lincoln 1994; Denzin & Lincoln 2000) are also common place. Table 10 on page 72 highlights some of the criteria used to measure trustworthiness in qualitative research, and provides interpretation and application within this consultant midwife study.

Truth refers to credibility (Guba 1981; Guba and Lincoln 1994; Miles and Huberman 1994); and the believability of findings. It was important to represent the study in such a way as to confirm integrity. The design pathway was transparent and ensured accuracy of planning and honest data collection and handling. Robson (2002) emphasizes that a credible qualitative researcher should denote a credible result; previous experience made data handling easier. As seen in Table 10 on page 72 several initiatives were taken in this study to emphasize 'credibility'. Member checking or peer review can be appropriate in some cases (Creswell 2003). In this research study however, a 'counselling' approach to data collection was used instead, as recommended by Benner (1994). This involved the use of repetition and reflection ('is that what you mean?'). This acted as an on-going process by which each participant's understanding was checked on an on-going basis, as well as on completion of an interview (Benner 1994). The first and only account of the given phenomenon was therefore obtained and participant confidentiality maintained.

Involving participants in the quest for trustworthiness was not seen as appropriate and participants were not asked to authenticate the transcripts or findings. A disadvantage of returning to participants once data has been collected is that it can confuse issues. Some participants may say 'yes', that's exactly how I feel, others may offer an alternative perspective by introducing new thoughts and feelings on the subject.

The use of triangulation via more than one method of data collection increased the study's credibility (Robson 2002). Supporters of triangulation believe that by using this approach trustworthiness can be improved, since the strength of one method may "help to compensate for the weakness of another" (Streubert Speziale and Rinaldi Carpenter 2007, p380). In this case, triangulation was demonstrated through the use of interviews, observation and documentary evidence where appropriate.

As has been explained, reflexivity helped to ensure researcher objectivity i.e. impartiality and detachment (McGloin 2008). In this study, reflexivity was viewed as a deliberate action due to the nature of the study and the closeness between the researcher and participants. As indicated in section 3.6.7 actions and values were considered reflectively (Robson 2002), this played a key part in achieving the study's credibility.

Dependability “is a criterion met once researchers have demonstrated the credibility of the findings” (Streubert Speziale and Rinaldi Carpenter 2011 p49). It denotes ‘consistency’; and in this study an ‘audit trail’ (Denzin and Lincoln 2000), made explicit each step of the research process. Rigorous preparation, sampling, data collection and analysis were seen as critical. Consistency in approach and clearly documented evidence meant that ‘dependability’ resulted from meticulous research design, planning and implementation. Team analysis (Denzin and Lincoln 2000), an approach by which another researcher can travel the same methodological pathway, resulting in similar findings (McGloin 2008), was considered but was not undertaken in this study, since it would have involved multiple data translation by individuals not closely involved with the participants, the research process, or indeed the phenomenon being studied.

Transferability refers to ‘generalizability’ i.e. whether the findings of a study can be applied to other settings that are similar (Streubert Speziale and Rinaldi Carpenter 2011). For that reason, consideration was given to providing sufficient detail for others to make connections and to compare findings to their own set of circumstances. The findings of the consultant midwife study were therefore seen as being transferable to the wider consultant midwife population. In addition and of importance, they contribute to the evidence base on consultant midwife practice.

A study that has demonstrated its credibility, transferability and dependability can be said to be ‘confirmable’ (Lincoln & Guba 2000). In this case confirmability was seen as relating to transparency and in summary was ensured by:

- The clear visualisation of a methodological audit trail;
- The application of findings to practitioners practising in similar settings;
- The use of three methods of data collection to gain a more holistic perspective.

**Table 10 Models of Trustworthiness**  
 (Streubert Speziale and Rinaldi Carpenter 2011; Guba 1981; Guba and Lincoln 1994; Miles and Huberman 1994)

Criteria	Interpretation	Application in consultant midwife study
<b>Truth Value</b> (Guba 1981).	Relating to 'true' research findings; Measures <b>Credibility</b> _(Guba and Lincoln 1994; Miles and Huberman 1994).	Findings were rich and meaningful and grounded in the data; The accounts were convincing to the researcher (Miles and Huberman 1994); Prolonged engagement with subject matter had been undertaken (Streubert Speziale and Rinaldi Carpenter 2011); Observation was undertaken in participants' natural environment; Reflexivity was unavoidable but was used positively and objectively through reflection (McGloin 2008) to identify the possibility of researcher bias (Robson 2002); The use of triangulation (interviews, observation, analysis of associated documentation) was undertaken to increase rigour (Robson 2002); The data are representative of existing theory reviewed in review of literature.
<b>Dependability</b> (Guba and Lincoln, 1994) <b>Consistency</b> (Guba 1981).	Met once credibility of findings demonstrated (Streubert Speziale and Rinaldi Carpenter 2011); Linked to 'Confirmability'.	Audit trail easily visualized (Guba and Lincoln 1994); Clear research questions asked; Researchers role explicit; Coding checks undertaken; Theoretical framework clearly documented (Miles and Huberman 1994).
<b>Applicability</b> (Guba 1981).	The degree to which the findings may be applied to other groups; Measures <b>Transferability</b> ; <b>Generalizability</b>	Findings transferable to a wider audience of health professionals. Sometimes described as 'fittingness' (Streubert Speziale and Rinaldi Carpenter 2011).
<b>Neutrality</b> (Guba 1981).	This relates to the overall trustworthiness of the data.	The findings are true and have not been influenced by external factors or biases; Assisted by - Triangulation of research methods; Reflexivity; In-depth nature of study (Yin 2003).

### **3.11 Summary of Research Design**

This chapter has identified two research questions focusing on the role and experience of the consultant midwife. Justification for selecting qualitative methodology and a case study approach has been presented. Attention to detail has emphasised appropriateness of methodological choice and an exploration of philosophical issues acting as a foundation for the research design.

Clarity has been provided with regard to how the participants were identified and recruited. The participants were selected specifically for their knowledge and experience and included consultant midwives as well as heads of maternity services and obstetricians, who had worked with the consultant midwives over a set period of time. Three methods of data collection have been justified and explored in relation to their use (interviews, observation documentary analysis). Detail has been presented as to the mechanism for analysing and presenting the transcribed data and integrating the three strands of data.

Ethical considerations relating to beneficence, confidentiality and trust have received detailed attention demonstrating how the participants were respected and cared for in accordance with these approved values. Finally, the processes involved to ensure trustworthiness have systematically been identified and justified.



## 4 Findings

### 4.1 Introduction

This chapter presents the study's findings. Three themes emerged from the data; these were Having Clinical Wisdom; Taking Control and Shaping the Future. The themes are presented below; extracts from the interview data transcripts have been used to illustrate meaning. In addition, illustrative extracts resulting from documentary and observational analysis have been used as supporting evidence and integrated, to provide a full description of the consultant midwife's role. The final description is based on a coming together of the three different methods of data collection.

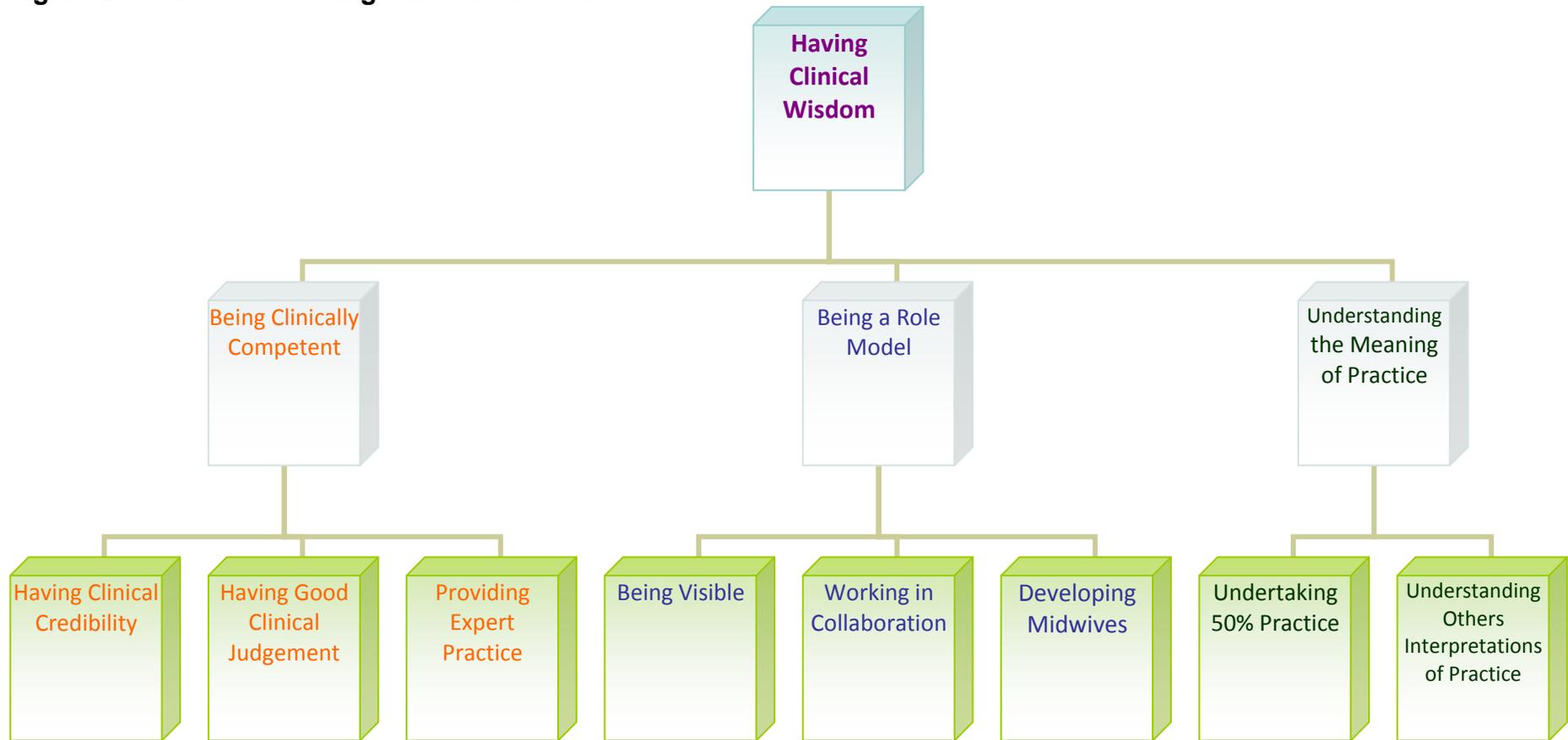
### 4.2 Theme 1 Having Clinical Wisdom

This theme is all about clinical practice. The consultant midwives were passionate about midwifery, their clinical credibility and competence. Being visible in practice and using their skills and experience to make valid clinical decisions and judgements was fundamental to them as consultant midwives. They became role models and were seen to work collaboratively with a range of practitioners; one of their primary aims being to develop midwives, their skills and their attitudes.

The consultant midwives interpreted 'practice' in different ways; few interpreted it in relation to the actual percentage of time spent 'in practice' i.e. in relation to the fifty per cent envisaged when the role was first established. Some felt that there was a degree of flexibility; generally they felt that 'being in practice' meant far more than practising clinically.

The phrase 'Having Clinical Wisdom' encapsulated consultant midwifery practice; 'clinical' in relation to undertaking clinical skills and 'wisdom' in the shape of cognitive thinking in order to make safe clinical judgements and make changes. 'Having Clinical Wisdom' exemplified what the midwives and other participants identified; in relation to the need for visibility, competency, and expert practice where the consultant midwife is very much 'in practice'. As well as a full description of the theme, diagrammatic representations of the theme are presented in Figure 2 on page 76 identifying firstly the preliminary descriptors, broad descriptors and emerging theme and secondly the coming together of the three strands or sources of data.

Figure 2 Theme 1 Having Clinical Wisdom



### 4.2.1 Being Clinically Competent

*[Having clinical credibility, good clinical judgement and providing expert practice].*

All job descriptions alluded to the successful applicants being **clinically competent**. Some highlighted the holding of a midwifery caseload; others spoke of clinical input, whilst others were less specific using terms such as developing and promoting practice.

All the participants clearly emphasised the importance of **clinical competency and credibility**. The consultant midwives were expected to be competent practitioners, able to make clinical judgements and to practice proficiently. Being seen to be competent in practice gave the practitioner and the role of consultant midwife a degree of credibility. The role of consultant midwife was clearly seen as being a clinical role and a senior position within practice; as such, a considerable amount of clinical practice experience was seen as being mandatory.

Clinical competency was seen as being necessary due to the strategic level at which consultant midwives need to function and make decisions. The consultant midwives felt a need to effectively communicate; they needed the freedom to act; being clinically competent provided them with the confidence and experience to do so. The following data extracts illustrate how consultant midwives valued being clinically competent and credible. Being a clinical practitioner with experience and being seen to be credible by colleagues was important to the consultant midwives. It was implied that respect came from 'being seen to be competent'. Consultant midwives enjoyed practice, originally seeking the position of consultant midwife so as to remain in practice. They gained satisfaction from emphasising their skills and experience and developing the same in others.

*"I think it's vital if the consultant midwife has a considerable amount of practical experience, to have credibility as a clinical practitioner". Consultant Midwife (CMW) 2:2.*

*"You do need to be a competent midwife, to be credible in the eyes of your clinical colleagues.....I have always been treated with respect and seen as being competent, as being someone with knowledge". CMW8:2 and 25*

*"I really enjoy hands on practice that is why I actively sought a role like this, I wanted people to know I had these skills and was competent, I wanted time to do it". CMW6:32*

One way of demonstrating clinical competence and clinical credibility, was by working additional 'bank shifts'. This worked well for a part-time consultant midwife; apart from being able to demonstrate her competence as a practitioner, it provided time for the midwife to see what was happening in the practice setting without the added

responsibilities of being a consultant practitioner. She concluded by saying *'people like it'*, indicating the importance of being seen to be credible.

*"Also I do additional shifts. I do on calls for the Birth Centre too. If you do bank shifts you keep in touch with what is really happening. People like it."* CMW8:16

Being a credible and experienced practitioner, was also seen as being an essential feature of the consultant midwife by heads of maternity services and consultant obstetricians. Heads of maternity services used adjectives such as 'credible', 'competent' and 'skilled' to emphasise current proficiency. One viewed competency as 'being able to provide a full range of care'. 'Still practising' and 'delivering' and being 'active' were words used to describe consultant midwives.

*"She obviously has to be credible as a practitioner"*. HOM2:5

*..."she should be a competent midwife and an experienced midwife, a midwife to be able to provide a full range of care..."*HOM 3:18

*"She is a highly experienced midwife, she still practices and delivers she is still an active midwife in her own right and has continued to be so throughout her career..."* CO6:22

Consultant obstetricians (CO's) were concerned regarding the loss of competent senior midwives from clinical practice to management or education and were complementary of the consultant midwife role since experience and skill were being seen to remain in practice.

*"There are a lot of problems with the midwifery structure. What I usually see is fantastic clinical midwives wishing to progress in their careers having to go into management or education, rather than staying as jobbing midwives, which is actually what they would like to do...."* CO3: 14

*"With regard to introducing the consultant midwife, I think the idea is excellent, there is also the issue around not losing excellent senior clinically skilled midwives"* CO4:42

Being clinically competent not only related to credibility and an ability to make sound judgements; it encapsulated what has been described as **providing 'expert practice'**. In discussing 'expert practice', one of the core features of the consultant midwife role (NHS Executive, HSC1999/217), with all three groups of participants, definitions varied. For some, 'expert practice' was translated literally whilst others translated the term more broadly seeing it as encapsulating a range of skills and competencies. One of the ways the midwives expertise was observed was in relation to the use of national guidelines *"this information is based on national guidance"* (Trust 1, Observation1) and also in relation to

the interpretation of nationally recognised statistics e.g. *“the risk of having a second caesarean section is low, seventy to eighty per cent of vaginal births will be successful”* (Trust 2, Observation 1).

Expertise came from a depth of knowledge and confidence as a practitioner and this was emphasised in relation to the questions asked by clients and the relaxed way in which the consultant midwives answered questions emphasising up-to-date facts and figures. Observational field notes alluded to competent practice e.g. *“an exemplary performance, research based...clients content and equipped with the evidence required to make decisions”* (Trust 2, Observation 1).

In relation to job descriptions, ‘expert practice’ was first on the list relating to duties and responsibilities. Terms used to interpret ‘expert practice’ included being an expert practitioner; being a role model; supporting and developing practice and developing confidence and skills in others. Some of the job descriptions included holding a caseload; developing guidelines to support practice; promoting autonomous practice and leading on change to improve care for childbearing women.

From a literal perspective midwives interpreted ‘expert practice’ to mean being an expert resource in the sense of providing evidence.

*“I think I define it as woman focused with evidence informing options – a confident, advocate style”* CMW 1:14.

*“I see it as meaning an expert resource”* CMW7:6.

From a more complex perspective having a ‘particular’ expertise was seen as essential. ‘Expertise’ related to expert contemporary knowledge, practice and skill.

*“This implies that they (consultant midwives) have good skills, they are expert midwives, they have a particular expertise and knowledge and understanding and drive and experience in midwifery”* HOM6:16.

*“It’s about that level of expertise and knowledge. If you don’t have expert knowledge it’s hard to fulfil the role, because it’s that that enables you to comment and analyze. If you don’t have that core expertise it would make it very difficult”* CMW5:19.

*“Expert’ accounts for experience, skill and being highly up to date”.* CO6:22

Being convincing, listening to people and ‘acknowledging’ differing perspectives was essential too. The term ‘having credible authoritative knowledge’ was used to emphasise meaning.

*“It’s about having the expertise and knowledge to put arguments forward in such a way that is convincing, acknowledging peoples needs”..... “Expert practice is about having experience and common sense. It’s about having credible authoritative knowledge.” CMW2:20*

Not everyone felt comfortable with the word ‘expert’. It was seen as being a matter of perception; one could be an ‘expert’ without being an ‘expert’ in everything. Some saw true ‘experts’ as being the senior midwives providing direct care every day. One midwife indicated that midwives often credit expertise as being able to manage a busy high risk labour ward. She felt the opposite to be true, in that being alone in the community, and managing a case competently, demonstrated far more ‘expertise’.

*“I don’t like people who say they are ‘experts’, they are setting themselves up to fail really. I look back and think I have expertise in home birth and in setting up caseloads, I think I have authority in practice, I can make decisions well, it’s whether or not you use the term ‘expert’ – the title doesn’t sit comfortably with me” CMW4:42..*

*“I think I am, but I think what people consider to be expert isn’t how I would define it. As a practitioner I work as an expert – I support, I have clinical understanding, communication skills and I have the support of midwives. However, If you put me on a busy labour ward today I would be slower not so slick. If you ask me about being an expert I think I have the knowledge and skills but I may do them in a different way – that’s what makes me an expert” CMW8:22.*

*“...people like our group practitioners are the real experts. I think pretending we are better than them is ridiculous. On the other hand, I am an experienced midwife so I suppose for people who are newly qualified or who have worked in heavily medicalised units, I have something to offer them... Sometimes you have to be prepared to be accountable when you are pushing the boundaries e.g. the long second stages, the VBAC in the pool, the breeches. Then I am an expert” CMW 3.25.*

‘Expert Practice’ was also associated with leadership and the need for confidence in order to challenge practice.

*“I suppose it’s about having the courage of your convictions. You need confidence to challenge. I am told I am a leader; it’s interesting because I get dozens of emails requesting information and I often think that if I made it up, they would believe me, because people attribute things to you as a leader”CMW7:16*

Heads of maternity services generally associated ‘expert practice’ with consultant midwifery practice. Key differences however were identified between being a specialist or advanced practitioner and a consultant midwife, where energy and focus needed to be directed towards supporting a service rather than individuals. Being able to function at a higher level and having strategic vision was associated with ‘expert practice’.

*“I see that an ‘expert’ is someone who has the practice experience and the knowledge base to support it. The consultant midwives have a wealth of experience and yes they are expert practitioners” HOM8*

*“For me expert practice is about experience and taking practice to a higher level. It’s not what is expected from a normal registered midwife, they don’t have that strategic vision; I would expect an ‘expert’ to be well read - it’s a combination of advanced skills, academic success and managerial experience...a consultant midwife needs to bring that expertise into the mainstream.” HOM7:14*

*“For me the consultant midwife’s expertise is more in her ability to support a service than to support individual women, she should be a competent midwife and an experienced midwife, a midwife able to provide a full range of care. For me the expert practitioner is more like a specialist midwife than a consultant midwife” HOM3:18.*

Consultant obstetricians generally felt that the consultant midwives did provide ‘expert practice’, but that the reason for their expertise could vary. One obstetrician however struggled with the concept of ‘expert practice’ and could not see a difference in the work undertaken by the consultant midwife and other senior midwives whilst another was very critical of the role and was unable to see the relation with clinical practice.

*“... ‘expert’ accounts for experience, skill and being highly up to date. She is very on top of the evidence base for all aspects of midwifery care and obstetric care...I think she is a genuine ‘expert’ because she fulfils what I see as all the criteria. I think the point about that is she is widely respected in the unit by the obstetric body because she is experienced and very well informed” CO6:22*

*“Some consultant midwives are very wise, very skilled and very expert, but also expert in making relationships with patients and generally handling people. Some are expert practitioners because of years and years of experience” CO4:20.*

*“There is no doubt that she is an expert at what she does although she isn’t any different to some of the other senior midwives in that respect. Some senior midwives provide leadership and have that degree of expertise in a similar way” CO2:10.*

*“No as I told you they are not ‘clinical’. That is my problem. You wouldn’t call me a consultant obstetrician if I wasn’t delivering an Obstetric service, would you?” CO8:12.*

#### **4.2.2 Being a Role Model**

***[Being visible; working in collaboration and developing midwives].***

Reflecting back on the observational episodes and whilst analysing observational field notes, realisation struck that on more than one occasion the consultant midwife as ‘role model’ had been observed in relation to undertaking specialist practice.

*“the consultant midwife was seen almost as an independent practitioner, taking on the character of a doctor in terms of confidence and posture, appearance and demeanour, but keen that patients knew she was a midwife – very professional an excellent role model” (Trust 3, Observation 2).*

Extending career opportunities for experienced midwives was a major reason as to why the role of consultant midwife was originally developed. It was noted that Trusts needed to retain the experienced practitioner by offering career progression.

*“We had a lot of vacancies in the Trust and it was something that we recognised wasn’t being accounted for. We thought it would have a very good effect on the way the service was developed, that was why it came about”.* HOM1:1

Now that consultant midwives have been in practice for several years role models have been created and junior staff inspired. Not all consultant midwives spoke of being a role model, although it was implicit in the manner in which they described their role. A thought was given to future consultant midwives, in relation to the advantages of having an experienced consultant midwife as a role model.

*“In a sense you act as a role model for midwives, directing and supporting and pointing the way in relation to their own potential. I often have midwives approaching me with career issues. Maybe I am the one that has the time to do that”* CMW5:19

*“I do think you need to be assertive but I think a commitment to developing others, working alongside people”.* CMW 6:3

*“If we appointed again now the new appointee would have a role model. That person may say ‘I’m not doing it like that’ but there is something there, whereas when I was promoted I thought well what am I to do, there is no one to tell you exactly.”*CMW8:3

Heads of maternity services easily made the connection between consultant midwife and role model. Discussions centred on career pathways, effective leadership and changing and modernising practice.

*“Well I think we are nicely placed, we now have a role model to engage with. There is a career pathway from maternity care assistant to consultant midwife. You can see people being inspired”* HOM1:28

*“She is an excellent role model and leader for younger less experienced midwives. Her clinical teaching skills are excellent and she has been seen to make a real difference in practice”* HOM 6: 21

*“She’s an inspiration, a dedicated role model in relation to changing and modernising practice”* HOM 4: 25

Consultant obstetricians spoke of the effect a role model can have on collaborative working and the need for practitioners to be able to aspire to be better. A warning was given in relation to the support required for role models in order to prevent isolation.

*“...but it is also raising the profile of midwifery by having someone who is well informed, communicates well and is a role model for joint working between Midwives and Obstetricians”. CO6:27*

*“...midwives lack good role models. It is vital to any profession; people have to have others that they aspire to be like” CO1:21*

*“...sometimes being a role model can be very isolating – we must be mindful of that...some midwives are natural role models and leaders. It is our duty to provide an environment where they can practice and inspire others”. CO4:26/29*

Being a role model necessitated **visibility**. The consultant midwives spoke of how difficult it was to create visibility. Judgements were made as to how frequently they worked on labour ward and for some being centrally located i.e. on labour ward meant that they were utilised effectively and valued. Frustrations were felt in relation to being the only consultant midwife and not being able to be everywhere.

*“...”you are often judged by how often you are seen caring for someone in labour”  
CMW1:13*

*“They say ‘they don’t know what she does’, I do find that difficult - trying to get the message out about what you are doing, for everyone to know that I am a resource for all is important. I know there are rumblings around on delivery suite that I haven’t been there. I haven’t for the last eighteen months, I can’t be everywhere”CMW2:15*

Heads of maternity services also spoke of a need for visibility and the need to be central to the service. Visibility was linked to clinical practice and the gaining of respect due to their clinical presence. Feelings were more intense when there was only one consultant midwife in post. Practicalities relating to being the only consultant midwife were not focused upon.

*“She has gained a lot of respect from midwives and obstetricians by being so visible in practice. Consultant midwives must be seen to practice and to devote much of that time to their area of expertise, in this case normal birth”. HOM6: 21*

*“A consultant midwife needs to be visible and central to the core of the midwifery service”. ...she is our only consultant midwife and we need the post to be central to the service” HOM7: 5*

*“Perhaps it may be a role with more flexibility introduced into it, dedicated clinical sessions visibility more apparent”. HOM1:27*

Consultant obstetricians also acknowledged how valuable it was for a consultant midwife to be visible in relation to a central location. Visibility tended to relate to the provision of direct clinical care (usually on labour ward); non-direct clinical activities were for some unwelcome.

*“She is central to labour ward, I have been very fortunate as we do ward rounds together and that has been very valuable”*CO6:15

*“I see a consultant midwife as a clinical person looking at the patients, looking at the mothers, assisting with the process of delivery. I don’t see a midwife sitting somewhere in the corner formulating guidelines... I don’t see that is what a ‘consultant’ is meant to be”* CO 8:7

**Collaborative working** was usually overt but was also implicit in the way the consultant midwives conducted their clinical activities. They worked autonomously, yet mindful of the support, skills and practices available from medical colleagues. Clinical care appeared seamless; trust and authority for the making of clinical decisions had been awarded to consultant midwives by their medical colleagues.

*“an excellent example of individualised care given to a high risk client with limited understanding as to her condition. The midwife spoke with confidence as to future care arrangements and the advice that would be given by the consultant obstetrician at her next appointment....”* (Trust 4, Observation 1).

Some of the participating consultant midwives did speak of effective collaborative working and the formation of partnerships aimed at improving care and services for childbearing women. Challenges were noted; however effective working relationships were identified in the context of consultant midwives being agents for change and role models. Obstetricians were challenging to work with; working with them was easier than attempting to change the way in which they worked.

*“Working with obstetricians is always a challenge; there is lots of evidence to show that where you have good relationships the standard of care is so much better.”* CMW8:34

*“...after a couple of years I had an ‘ahha’ moment when I realised I couldn’t control what obstetricians were doing but I could control what midwives were doing”* CMW3: 11

*“I love working alongside people, I love developing people and I love team working. I have worked hard at that and have gained respect of medical colleagues and there is joint referral both ways.... I am proud of the relationships I have developed with midwives, obstetricians, neonatologists and anaesthetists”* CMW 6: 33

Multiple Initiatives had been undertaken by the participating consultant midwives working in partnership with medical colleagues.

*“The home birth rate has gone from 2% to 5%. It is not me alone, that is one of the things about consultant midwives, you have to be the member of a team, you can not achieve alone.”*CMW8:17

*“My focus is to increase the percentage of normal births and work with the obstetricians to begin to decrease the caesarean section rate” CMW1:1*

*“What has grown out of that is a clinic I do with a consultant doctor...a new venture here, we set that up together” CMW3:10*

*“Opportunities were taken to influence collaboratively both current practice and current delivery of care and how it is organized....” CMW5:12*

Collaborative working not only involved doctors, midwives participated too.

*“...we set this group to write guidelines for normal birth. I still edited them but in the main they were written by newly qualified midwives because they have all the papers at their finger tips”CMW3:28*

Heads of maternity services spoke of excellent midwife / obstetrician working relationships; being located centrally was seen as important in relation to generating effective relationships. Some of the consultant obstetricians had worked in partnership with consultant midwives and provided examples of joint working.

*“There has always been an excellent relationship here between Obstetricians and Midwives” HOM 6:12*

*“She has worked with various groups here to do just that, not just with midwives, she is also working with her obstetric colleagues to develop more complex care pathways” HOM 2: 20*

*“...previously there was good access, there were good working relationships, now that the post has changed and become external there appears to be less transparency and collaborative working from an obstetric / midwifery perspective” HOM 7: 7*

*“...This has been in collaboration with the consultant midwife; she has been the most productive of the team (the multidisciplinary team). We asked her to look at our induction process / our induction rate and to do something positive and she has achieved that” CO 6:10*

*“We’ve collaborated on a lot, often in an informal way, just in the same way I work with a lot of consultant colleagues- pushing things forward on labour ward or the fetal medicine unit...just making changes, we work in the same way”. CO 3:8*

Collaborative in-direct clinical care did not always involve medical practitioners.

Consultant midwives and consultant nurses were also seen to work in partnership on specific projects, where appropriate. It was interesting to observe them in partnership and to note parallels linking the two roles.

*“Very knowledgeable practitioners, clearly enjoying this collaborative exercise. Their confidence, presence and experience emphasised equal status, parallels were identified....they both welcomed the opportunity to present the document to staff jointly” (Trust 8, Observation 1).*

New projects often necessitate new facilitates. Collaborative working, with a difference, was observed on two separate occasions. In these instances the consultant midwives were observed stepping outside the clinical arena and were seen to think laterally and with experience. They were seen to take on new responsibilities and in so doing communicated their knowledge to a wider audience.

*“I felt anxious due to my lack of business experience and was clearly out of depth in terms of strategies and language. I felt in ore of the consultant midwife’s newly found confidence and skills and realised there is always potential for self development” (Trust 5, Observation 1).*

Consultant midwives generally felt that where possible their skills were more effectively used in a support capacity, **developing the skills of midwives**, rather than in providing direct one to one care. Influencing practice, helping midwives reflect on their practice, and being seen as a resource was a major part of their role.

*My role is in influencing or making midwives think how they practice..... Making midwives think about what they are doing and how they are doing it. What attitudes they hold and how these influence how they practice. That’s how I see my role.”CMW2:23*

*“Eventually after a few months even if I wasn’t working clinically midwives would come and get me, if they were struggling –‘Can I just run this by you?’ or ‘Will you come and have a look at this woman?’, I think that is what the consultant midwife is about rather than doing shift after shift”. CMW3:7*

*“I did normality sessions for all the staff ...At that time many primigravid women were not encouraged to have a home birth, so the midwives needed support”. CMW8:11*

Most heads of maternity services listened to the feedback from staff and valued the consultant midwives educational input. Consultant obstetricians too were positive from a multi-professional perspective; both midwives and obstetricians benefited from the professional guidance given.

*“Our consultant midwife takes the view that ‘I have done this, I don’t know all the answers but my role is to develop those skills in others’. This she has done very successfully”. HOM2: 27*

*“I pay much more attention to what the midwives say and how much they value her. I just know the midwives in this unit have found the support of our Consultant midwives immeasurably helpful, as I have. They have just been brilliant”. HOM3: 19*

*“I think it has been very valuable in relation to the support our consultant midwife has given to the individual midwives, if there are problems she is a resource for support, she has been a tremendous support to the community midwives and to*

*the midwifery led teams. She has been very good for the trainee obstetricians too because she has that degree of authority which means they have to think twice about what they say and do on ward rounds and things like that. She has been a very good check and balance for potentially uperty Specialist Registrars and that's been good"*CO6:14

### 4.2.3 Understanding the Meaning of Practice

*[Fifty per cent Practice; Others Interpretation of Practice].*

For most consultant midwives, the meaning of practice was firmly linked to how the consultant midwife was practising for **fifty per cent of her time** (NHS Executive, HSC1999/217). Some felt that 50:50 was unrealistic and there needed to be flexibility in relation to interpretation.

*"In terms of the 50% we have to use that wisely. It's how you interpret practice".* CMW1:13

*"I have never had demarcations in my diary – I did do a bit of that in the beginning but it never works like that because the days you select to be clinical are bound to be quiet, then I would be trying to teach, and when its quiet midwives want to catch up with their friends, it would be very artificial."*CMW3:24

*"If there is more than one of you, you can maintain a fairly substantial clinical role. I am not sure that 50:50 is realistic. A lot depends on the environment in which you are working. Some of the consultancy posts don't have any clinical practice in them at all but they are perfectly valid in terms of leadership; the leadership aspect can be so important."* CMW5:18

The challenge increased if there was only one consultant midwife employed in a Trust. Consultant midwives also emphasised concern as to how their clinical effectiveness was perceived by other midwives. Criticism was heard when practice didn't involve being overtly visible i.e. working on labour ward.

*"If there is more than one of you, you can maintain a fairly substantial clinical role. I am not sure that 50:50 is realistic. A lot depends on the environment in which you are working."* CMW5:18

*"I still work clinically and the clinic you observed, is me working directly with women - some midwives might argue 'what is the point of that, we are not getting you where we want you on the labour ward because you are unseen' but actually I needed to develop that expertise myself to know how the service needed changing – then it is possible to see how you can deliver it in a bigger way across the Trust"*CMW8:6

*"Midwives often view it as 'how often do I see you care for someone in labour'. What they don't see is the clinic I do every 2 weeks, the extra women I fit in because they know I'm there, a lot of midwives don't see that".* CMW1:13

## Chapter 4 Findings

Since most of the consultant midwives participating in the study were specialists of normal birth, practice descriptors focused heavily on skills necessary to support and develop normal childbirth. Only one of the job descriptions mentioned time i.e. fifty per cent of time being engaged 'in practice'. Direct 'hands on' care was alluded to but there was clearly freedom of interpretation.

Observational episodes provided evidence that the consultant midwives participating in the study were involved in both direct hands on clinical care and indirect clinical care. Direct care involved observing the midwives running hospital based clinics for childbearing women.

Some midwives held caseloads others did not, due to place of work and interpretation of their role. Heads of maternity services were supportive of the concept.

*"All the women I see antenatally are a case; I will see them again". CMW5:18*

*"The other part of my hands-on-practice is my personal caseload. I take on about 20 women a year and I'll follow them through from booking to transfer to the Health Visitor". CMW6:13*

*"I think it is appropriate for some consultant midwives to caseload but my job is for labour ward, I do take on one or two women, often members of staff who have asked me. No one would really benefit expect me, for having a nice little normal caseload. It wouldn't benefit my colleagues and the whole idea of the consultant job is that you influence inexperienced people and you wouldn't be able to do that if you were working in isolation. It is more appropriate for my colleague who works with vulnerable women to take on a caseload." CMW3:23*

*"Yes I do think caseloading is realistic. I am not sure we have quite done that here in that our consultant midwife in the community had a client group, she didn't necessarily deliver all those women, she delivered some, so whether it is true case loading, but it would certainly be possible to do that" HOM3:20*

*"Yes I think so, they would have to identify what is reasonable and what they were expected to participate in. It would be limited numbers and they would need back up by the community midwives" HOM5:21*

Indirect clinical care was also observed; some of the participating consultant midwives chaired multi-professional clinical meetings, often involving a range of professionals. These observational episodes provided opportunities to observe the relationship between the consultant midwife and senior midwifery and medical staff. They also provided an opportunity whereby the consultant midwife's grasp of what is important to midwives, neonatal staff and medical practitioners could be considered.

*“Throughout the meeting the consultant midwife was articulate; her knowledge across a range of clinical activities was emphasised. The depth of discussion facilitated by the consultant midwife was impressive; she demonstrated that she could hold her own when challenging medical initiatives or supporting new ideas to help women during pregnancy and childbirth” (Trust 3, Observation 2).*

In relation to undertaking clinical practice, the heads of maternity services saw flexibility in interpretation, in keeping with the philosophy of the consultant midwife role, as being important. Defining what constitutes fifty per cent, was not seen as clear.

*“I feel confident that the consultant midwife is engaged in clinical aspects of the role, although not necessarily delivering care 50% of the time”<sup>HOM1:18</sup>*

*“Its fluid & I firmly believe that a practitioner of seniority and expertise can manage that. She has a ring fenced day for practice each week and the rest of her practice she fits in around other commitments, that works well for her”<sup>HOM2:19</sup>*

*“Well I think it is important that they have enough clinical involvement to retain credibility and to hold their heads up amongst other Consultants to say ‘I am out there and am doing it’. Whether that works out as 50:50 I am not sure and the question is ‘how do you define the 50% clinical?’. You could say you have to work on the labour ward 2.5 days a week, face to face with women. I am not sure that would necessarily be achieving my objectives because the woman would gain good support but I would really rather that the clinical involvement was about working with midwives, flexible in that respect”<sup>HOM3:20</sup>*

*“Well actually when you look at the consultant midwife and her working timetable she does do 50%. The other 50% would be education, she has got a big teaching brief and she does audit too...”<sup>HOM4:23</sup>*

All the consultant obstetricians participating in the study were labour ward consultants. To them, consultant midwife practice was largely witnessed on labour ward or during episodes of collaborative working.

*“Our consultant midwife focuses on practice in its true and wider sense”<sup>CO6:24</sup>*

*“We’ve collaborated on a lot, often in an informal way, just in the same way I work with a lot of consultant colleagues- pushing things forward on labour ward, just making changes, we work in the same way”<sup>CO3:36</sup>*

In relation to really **understanding their role**, a phrase repeated time and again amongst the consultant midwives was ‘having a passion’. This was said in relation to improving services for women and their families and in relation to providing a positive childbirth experience. Many of the participants within this study focused on increasing normal birth and their ‘passion’ helped provide the energy and drive needed to initiate clinical change and improve services.

*“You need to have a real passion for midwifery - that is what drives everything. I know quite a few consultant midwives and those that are successful have a real passion for midwifery and for the wellbeing of women and their families. You can spot that easily”. HOM6: 8*

*“It would be very hard to be a consultant midwife without being passionate, if you don't you will fail, because you are not going to influence anybody. You have to have the passion for the job and to really want to improve things and to see it from the women's perspective - and for the midwives too because you have to work through the midwives, that is the way you achieve.”CMW8:5*

*“I believe (her passion for normality) has certainly changed the skill mix of our midwives. She has changed the mindset of many midwives, it has also helped many of the Consultant Obstetricians to be mindful of a normal labour and delivery, even for those who are high-risk, e.g. women with previous Caesareans, women with twins, for those who don't want to follow the protocol CO5:3*

It took a while for the original consultant midwives to really understand their own role; they were the first and although broad guidelines had been set they had not been put into practice. Although this could have been viewed as a disadvantage it did provide a sense of freedom and a free hand at interpretation. It wasn't only the consultant midwives that needed to understand, others had difficulties too.

*“With those first jobs no one had much of an idea what it was about; it was all a bit vague then. No one could say ‘this is what this job looks like. That was one of the difficulties which in a way was an advantage because you could have made anything out of it”. CMW3:2*

*“The consultant obstetricians couldn't see the point at all...I think the proof has been in the pudding. It was difficult in the beginning...” HOM8: 4*

*“We were certainly challenged by our Consultant Obstetricians who couldn't understand the rationale or the purpose of the post at all” HOM2:4*

*“Consultant obstetricians were ambivalent, equivocal at best” CO1:4*

As time advanced, interpretation became easier but there were still difficulties. In some cases, a practitioner's understanding depended on the consultant midwife first clearly comprehending the role herself and then being able to articulate and defend it. Being certain as to what the role entails appears imperative, if time is to be apportioned appropriately.

*“...a consultant midwife needs to be very organized – they could otherwise find themselves drawn into lots of different things; I think they need to be certain as to what their role is” HOM6: 8*

*“Sometimes I wonder whether the consultant midwives do actually know what their role is because when they're often faced with somebody saying to them, ‘you're just a glorified Band 7' there appears to be a poor response. It's about re-educating everybody else about what the role is.” HOM4: 35*

*“When people realise that you’re here everything comes flooding at you and sometimes you have to say ‘no’ and that really upsets people. It’s not because you don’t want to do it but it’s because this is not the right role to be doing it in...”* CMW1:9

*“Although I am happy to support them when it is short staffed, I don’t want my name on the off duty and be just one of the numbers, then I wouldn’t be free to do what needed to be done”* CMW3:6

Not all staff were sceptical as to the role of consultant midwife; there were positives too. Time passed and benefits of the role have been observed by midwives, heads of maternity services and consultant obstetricians.

*“Eventually after a few months even if I wasn’t working clinically, people would come and get me, if they were struggling –‘Can I just run this by you?’ or ‘Will you come and have a look at this woman?’”*CMW4:7

*“Now I think I can honestly say the consultant midwives are on a par with the consultant obstetricians. I think it has raised the profile of midwifery a lot really. In the beginning every one was uncertain but now there is a real healthy respect for that role and nothing would be introduced in midwifery without consulting us”*CMW3:17

*“The really positive bit is that this role is here and is viewed as championing”*CMW1:7

*“the post we created has been so successful, particularly with the staff here, the medical and midwifery staff; this has created a real partnership”* HOM6:2

*“I think it has been a tremendous success. I think it has been very valuable in relation to the support our consultant midwife has given to the individual midwives, if there are problems she is a resource for support, she has been a tremendous support to the community midwives and to the midwifery led teams. She has been very good for the trainee obstetricians* CO6:13

In relation to the consultant midwife role, some practitioners did question whether there were any differences between senior midwives and consultant midwives.

Consultant midwives themselves were keen not to take on the work of senior midwives and could clearly see role demarcations.

*“Initially, there was a lot of discussion as to how different this role would be from senior midwives & so forth. Initially there were concerns across the profession as to the relevance of having consultant midwives”* HOM 1:4

*“It’s a very difficult balance between moving things on and knowing there’s a manager in each area and that’s their responsibility. You don’t want to take that from them; equally if they don’t use those skills effectively, sometimes you need to say that’s your responsibility”.* CMW1:8

*“I don’t see huge differences.... clinical competence be it in a manager or consultant midwife is all important and you have to have the respect of the staff;. Well thought through job descriptions and targets are so important”*CO4:22

*"I think it is an unnecessary distinction between a senior midwife who can guide the team – we have those people around"* CO8:5

Although flexibility was welcomed, keeping in mind the philosophy of the organisation was seen as being important to heads of maternity services and obstetricians.

*"The work undertaken by consultant midwives needs to be in the Trusts interest."* CO4:28

*"In deciding on new ideas, the Trusts interests and units philosophy need adhering to"* CO3:23

*"I suppose my position on this is how ever autonomous and self-directing they are they do need to be agreeing their objectives with the person holding the purse strings. They can't just assume that because they are consultant midwives they can major on this or that. In the same with an obstetrician who can't do whatever they fancy, it's got to be in line with the service strategy".* HOM3: 29

*"I think being more rooted within the Trust that they are working within. When I say rooted I mean taking on more of that Trust ethos as a responsibility, because existing in an independent role as a consultant midwife won't do any good whatsoever. I think a lot of consultant midwives do that because they are so busy delivering the brief they forget a little bit about the organisation. It's vital to understand the philosophy of the organisation".* HOM4: 9

Being the only consultant midwife in a Trust or being part time was difficult and for some totally unrealistic. If the consultant midwife was based on labour ward, relationships with other staff appeared easier, since labour ward was viewed as being central and core to the service.

*"I have difficulty with there not being enough time or enough of me e.g. I know there are rumblings around on delivery suite that I haven't been there...I can't be everywhere"* CMW2: 15

*"Sometimes it is hard to achieve only by influence. Also time, I only have 2.5 days to be a consultant midwife on different sites, its hard to create visibility and a presence, I'm sure there are midwives who don't know who I am"* CMW8:23

*"Not everyone is as positive / keen on the concept of a consultant midwife. Sometimes it is quite difficult to understand what the role of the consultant midwife is. It depends on the consultant midwife. There hasn't been a problem with our labour ward consultant midwife; she has always had a clear and definite role, she's been very active. People could see what she did"* CO3:6

*"...there is only one of her and to run a unit like this, with the numbers of deliveries we have, with one Consultant Midwife and with what she has to do and the amount of work she could potentially take on, is more than one person can do. Having just one Consultant Midwife feels like a token appointment".* CO2: 3

Consultant obstetricians varied with regard to their understanding of the role, the effort taken to understand the role and their general level of support.

*“I think the obstetricians here were quite unique anyway and good advocates for the midwife role. Their workload is huge, they don't want to do stuff that they don't have to do and they want midwives to be midwives. They all get on with what they need to do. They view the Consultant midwife role as a way of giving some things that they don't necessarily have to do, into the hands of senior midwives”*  
HOM4:6

*“...not at all positive because basically a lot of people didn't know what a consultant midwife did and still don't. The role is all muddled; the term 'consultant' refers to someone who has an independent practice, an advisory training role. Some people see it is just an unnecessary middle layer, middle management”*  
CO8:5

*“I think it has been a fantastic success; I have to say, I think a lot of that comes down to the personality of the person who was appointed. I think it has been very valuable in relation to the support our consultant midwife has given....”*CO6:12

Whilst engaged in observing the consultant midwives in practice, it was interesting to observe the way in which staff responded to them. On all occasions the consultant midwives appeared 'in authority', confident and knowledgeable; practitioners responded accepting their guidance and leadership.

*“The consultant midwife maintained the formality of the meeting throughout. The midwives in attendance appeared comfortable with the style of leadership and accepting of the consultant practitioner being in a lead position” (Trust 2, Observation 2).*

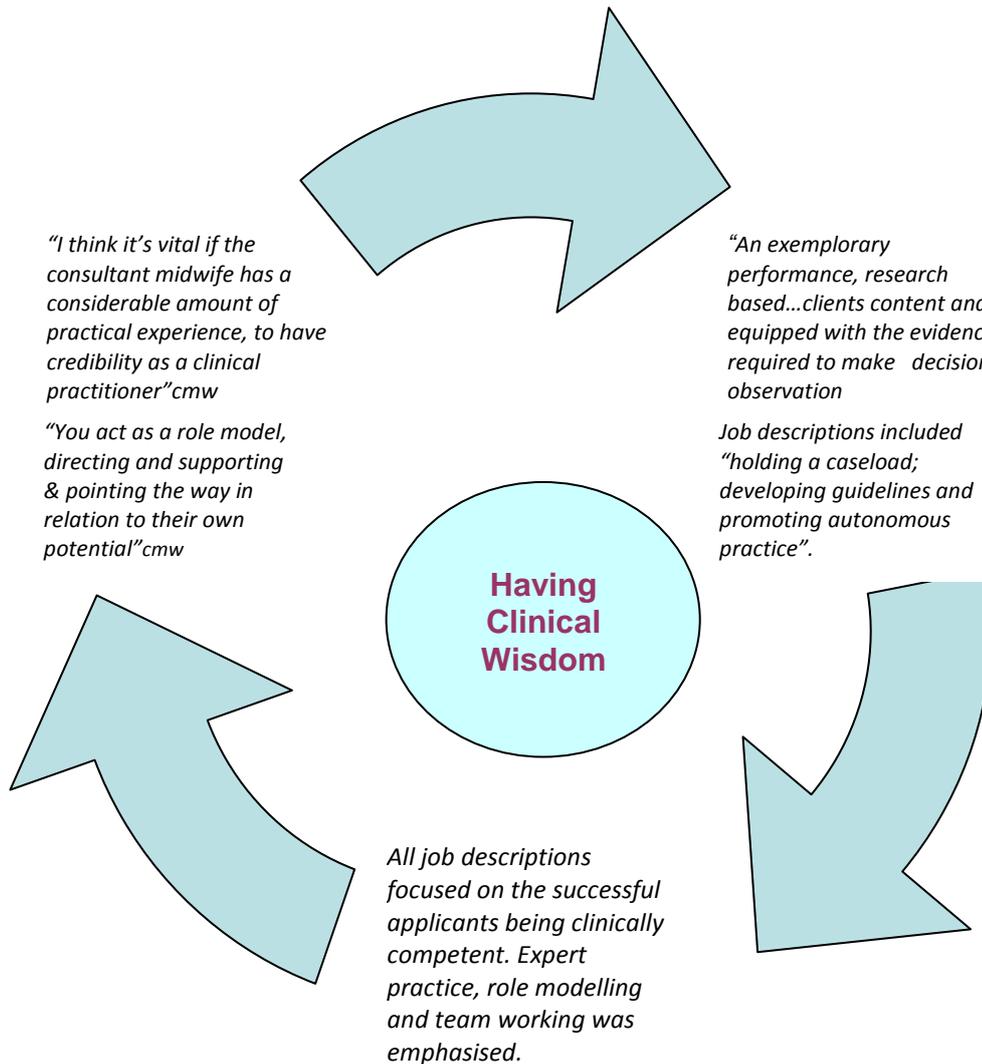
*“The consultant midwife spoke with authority referring to research findings and clearly engaged the practitioners in attendance, who were keen to ask questions and seek support and guidance...” (Trust 7, Observation 1).*

*“The consultant midwife responded knowledgably and knowingly....she held eye contact with those responding and medical colleagues sought her opinion at various times” (Trust 4, Observation 2)*

#### **4.2.4 Having Clinical Wisdom: An integration of the Three Sources of Data**

To emphasise clarity, Figure 3 on page 94 depicts Theme one 'Having Clinical Wisdom'. Surrounding this theme are examples from the three strands of data (interviews, observation and documentary analysis) which illustrate it.

**Figure 3 Having Clinical Wisdom: An Integration of the Three Sources of Data**



### 4.3 Theme Summary

In summary, all participants emphasised and demonstrated the importance of clinical competency. Being clinically competent was viewed as being a pre-requisite for consultant midwives and midwives rightly look to consultant practitioners as being proficient and credible in practice. For many consultant midwives, being seen to be competent in practice equated to credibility and increased confidence. The role of consultant midwife was seen as being a clinical role and as such a considerable amount of clinical practice experience and expertise was seen as being mandatory.

Clinical competency equated to being able to articulate at a strategic level; there was also a relationship between clinical competency and practitioner respect, this was important to some. Working in practice not only increased competency and professional respect from

colleagues, it also meant that consultant midwives could see what was really happening in practice.

Expert practice, a key feature of consultant practice, was not so easy to interpret but was easy to observe for in practice. Definitions ranged from being 'evidence based' and knowledgeable, to demonstrating a specific clinical expertise. There was pretty much a consensus in relation to the fact that no one could be an 'expert' in everything. Heads of service interpreted expert practice broadly, seeing that it related to the role of consultant midwife in its entirety and not just clinical practice experience or competency. Obstetricians interpreted the term in relation to clinical skills and the delivery of care.

The participating consultant midwives had demonstrated their expertise. Combined with an ability to make clinical judgements and decisions, these midwives exemplified expert practice and were seen as role models, by themselves and the wider midwifery / medical community.

The 'meaning of practice' was interpreted in relation to the percentage of time consultant midwives spent 'in practice', compared to the fifty per cent envisaged when the role of consultant was first established. Some felt that there was a degree of flexibility, some did not and some felt that 'being in practice' meant far more than practising clinically. Time spent in practice very much depended on the number of consultant midwives employed in a Trust, although surprisingly, some lone consultant midwives exceeded all expectations. It had taken time for the first set of consultant midwives to fully understand their role. The same applied to those in an observational capacity; some were critical, most applauded their expertise, skills and support.

Consultant midwives participating in this study had demonstrated their 'Clinical Wisdom' in relation to clinical competency and credibility amongst practitioners. Expert practice skills included being able to make skilled clinical judgements and these had been observed. Being visible in practice and central to practice was seen as critical. Collaborative working had been witnessed and it was clear that the multi-professional team benefited from the consultant midwives support and guidance.

#### **4.4 Theme 2 Taking Control**

The theme 'Taking Control' is all about providing strong midwifery leadership and being in a position to influence the development of clinical practice without having direct managerial responsibility. Not having managerial responsibility was seen by consultant midwives as both a strength and a limitation. For some, not having managerial responsibility was liberating allowing time to be spent more freely. For others it equated to not having authority, which meant that self motivation and determination became crucial if changes and developments were to be realised.

The consultant midwives were united in providing visible and effective midwifery leadership both at a ward level as well as at a strategic level. Whilst working with midwives and childbearing women, being a visible and accessible presence mattered, there was a strong feeling that in order to have an impact they were 'needed to be seen'. At a strategic level these midwives were in a position where their professional experience counted and where they were able to push boundaries and impact on change development.

Frustrations were associated with the role of consultant midwife, the most significant relating to managing the enormous workload, managing conflict and for some coping with role isolation.

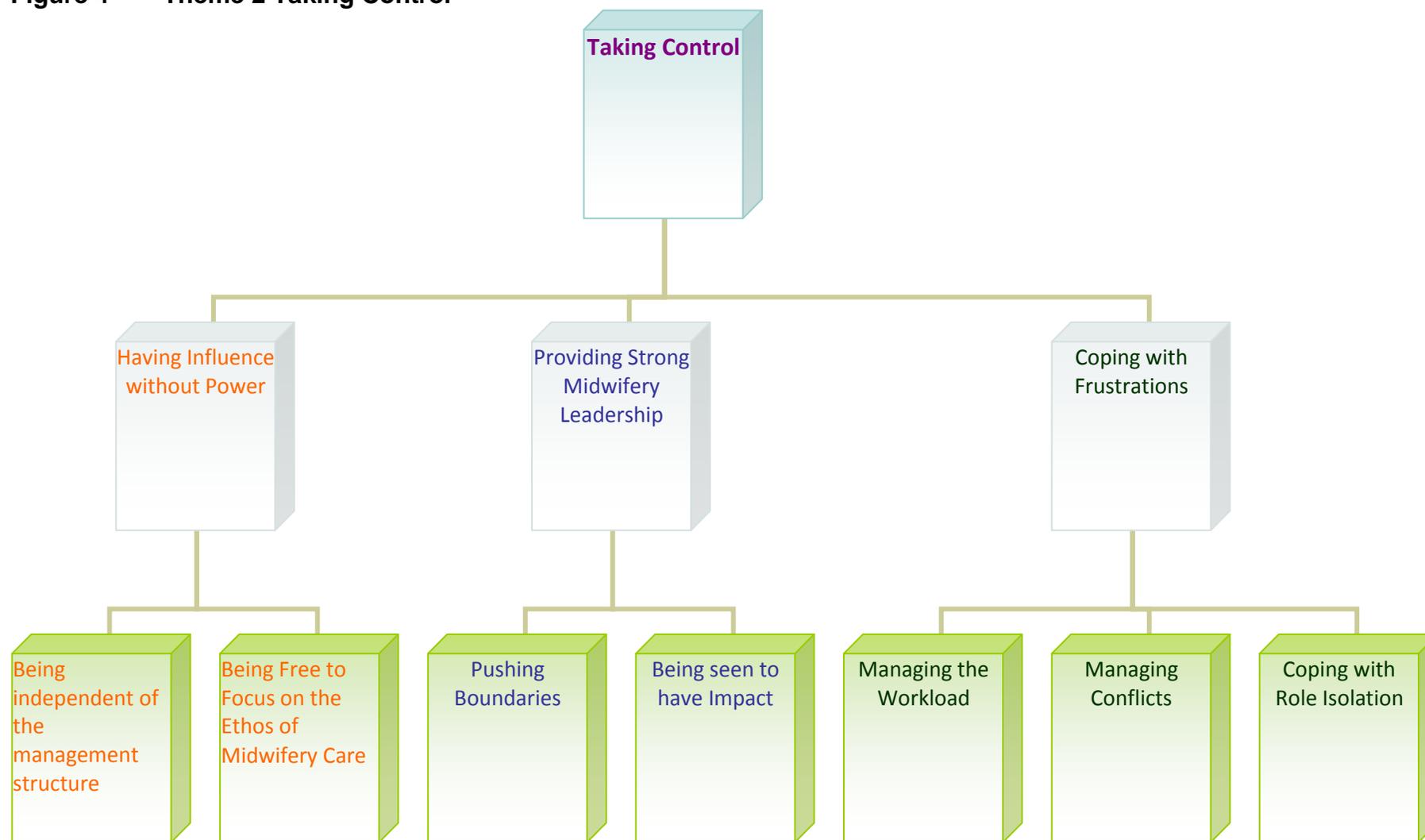
As well as a full description of the theme, a diagrammatic representation of the theme is presented in Figure 4 on page 97 identifying firstly the preliminary descriptors, broad descriptors and emerging theme and secondly the coming together of the three strands or sources of data.

##### **4.4.1 Influence without Power**

*[Being independent of the management structure; Being free to focus on the ethos of midwifery care].*

In keeping with the four core functions of the consultant role (DH 1999/2000), all of the job descriptions analysed focused on having leadership skills i.e. "to provide inspirational leadership" (Trust 8). Some trusts specifying leadership experience had amalgamated leadership with consultancy, expert practice or service development. Focusing on leadership specifically, phrases such as 'to change' and 'to develop' were used repeatedly. Being an agent for change involved developing evidence-based guidelines, the sharing of information (Trusts 1, 2), contributing to policy / strategic issues (Trust 3) and leading and supporting services and new initiatives (Trust 6).

Figure 4 Theme 2 Taking Control



In exercising professional leadership the post holder was expected to inspire, improve, innovate, actively advise and develop. Specific trust responsibilities linked to leadership, included being a lead in clinical audit / risk management, leading specific fora or committees and leading clearly defined clinical areas / providing specific specialised care advice.

Although the job descriptions focused heavily on 'taking the lead' and 'being the lead for clinical practice' no explicit references were made to 'having management responsibility'. The inference was that the consultant midwives would 'work with' and have many key working relationships; they were professionally accountable to the head of maternity services, the director of midwifery or the director of nursing.

Consultant midwives saw that there were both advantages and disadvantages to not having managerial responsibility. Having no power base meant that self motivation was essential if influence in practice were to be a reality. Not having management responsibilities was liberating permitting creativity, but this also meant that having the authority to make decisions was absent. Management in its entirety was not yearned for it was having the authority to help realise change and development.

*"I don't think consultant midwives want management it's the authority to make decisions. It's not clinical decisions, its management authority". CMW6: 25*

*"The difficulty with the consultant midwife's role is that it is non managerial, so you haven't got the authority to release people. You always have to go to a manager, and then it depends on whether she is short staffed. It's all about collaboration. If times are tough the answer is no. Having no budget and no managerial authority is the downside to the consultant midwife's job. It is also an upside because you are not wrapped up in all of that". CMW3:39*

Since consultant practice was seen to lack a traditional power base, being influential and not waiting to be invested with power was seen as essential. Not being invested with power was not seen as a disadvantage. Being driven, taking power and defining objectives was an essential part of the consultant role.

*"I am seen as a source of knowledge and information and support, that's what gives me the clout. Someone once said to me - 'You don't have to be invested with power, you take power' and I thought that was a very insightful thing to say, if you wait for someone to give permission you will wait forever and it is the same with the consultant midwife role a bit, you have to define what you see as your remit, and go for it, you don't have to wait to be asked". CMW8: 25*

*"You have to create where you sit, there is no power base, and it's all about influence, so you have to be self motivated and passionate about midwifery, wanting to deliver and improve the service"CMW8:4*

*“It has its downside in so much as you don’t have power; this doesn’t mean that just because you don’t have management authority, you don’t have influence.”*CMW2:12

Not being involved in managerial issues facilitated practice development and creativity. Having space and time to think was seen as essential if opportunities were to be identified and realised. Having management responsibilities equated to being constrained by politics and budgets.

*“There are more opportunities for midwifery if you don’t involve yourself in managerial issues.”*CMW3:19

*“I love doing all of it. I think being able to work on promoting practice without having the constraints of budget and politics is wonderfully enabling and freeing.”*CMW4:11

*“In a way not having any managerial responsibility frees you and gives you the scope to think. The best industrial organizations have thinkers in them as well as managers. I think part of the problem with the health service is that there has always been an emphasis on the activity that has to be achieved; we have always been bad at giving people the opportunity to think outside the box. I saw not having managerial responsibility being given the option to do that. I have settled for a drip drip influence rather than a big bang approach.”*CMW5:5

Heads of maternity services were generally unanimous in that consultant midwifery practice should not be constrained by being categorized as a management position. It was recognised that a strong authoritative voice was needed within practice and that development of the role of consultant midwife related to giving the role strength outside of the management arena. A close working environment was sought, where effective midwifery management and dynamic consultant midwifery leadership worked as one.

*“...it is a lack of imagination in midwifery management if you think a consultant post can’t work without being in a managerial role. I think people who are able to provide you with a well argued case based on evidence and who has respect because of their clinical competence can play an incredibly strong role in moving services forward. The role of management is to listen and put in place ideas assuming they are well thought out and positive. Equally the role of any consultant is to be sensitive to the constraints on management and not to expect to drive through stuff without thought. For me it should be serendipity where the two support each other. I think it would be an incredible loss to midwifery if it was thought that to be effective consultant midwives need to be managers. Clearly one of the things that is happening is that consultant midwives are going into midwifery management because of a lack of management in the leadership side of midwifery”.* HOM3: 11

*“The consultant midwife has been able to go into situations and open up dialogue and discuss and progress things without that kind of incumbency”.* HOM2: 3

A contrary perspective was however given, emphasising a need to reduce the division between midwifery management and consultant practice. In relation to the close working relationship of both practitioners, the feasibility of being employed on equal terms was raised.

*“...they need to involve themselves in staffing issues and budgeting and management, this would reduce that dichotomy that exists, not here, but in other Trusts, between managers, or heads of midwifery and consultant midwives. I do think the consultant midwives need to integrate themselves a little bit more into management, not necessarily to be managers but to have an understanding, an appreciation of budgets and management issues”* HOM4: 10

*“Consultant midwives should be on an absolute par with the heads of midwifery and I tried to challenge it here and haven’t had a lot of success but I am going to rechallenge it”* CMW6:5

*“Managerial responsibility may not be the answer, being on equal footing with the head of midwifery may be the way of the future, after all the two roles can’t function without each other”* HOM6: 13

Having management expertise was seen as being totally different and was not seen to be a disadvantage. A consultant midwife with previous management experience emphasised how previous experience, with a realisation of what people management involves, helped in the role of consultant midwife.

*“Personally I think it helps if you have been in management, it gives you a sense of what it is like to be responsible for a large group of staff, to deal with the day to day issues that come with running a service. Everyone comes into the role from a different route, but it certainly helped me.”*CMW5:2

With regard to the consultant obstetricians, there was agreement that consultant midwives needed to be independent of the management structure. Remaining free from management constraints and ensuring the role of consultant midwife remains ‘in practice’ was essential.

*“The good thing about the consultant midwife being independent of the managerial structure is that she essentially maintains and practices her skills as a midwife”.* C06:23

*“I mean in a sense seniority brings management responsibilities and they can creep up on you. We are inundated with midwifery managers and I think the consultants’ role should be totally clinical”.* C05:10

*“Consultant midwives should not be part of the management hierarchy. What I always see are fantastic clinical midwives wishing to progress in their careers having to go into management or education, rather than staying as jobbing midwives”* C03:14

Having a clear vision and being able to articulate that vision was vital in order for the midwives to take control, however establishing the role was not straightforward. Focusing on the maternity unit's philosophy and how the consultant role fitted into an already constructed hierarchy was important. What was clear was that the role of consultant midwife did not always easily divide and often time was needed to be taken to establish purpose and place.

*"My role has been influenced by where the maternity services were and what was needed - leadership and moving practice forward were the focus" CMW1:6*

*"Having a clear vision, knowing what you want in midwifery. Being able to articulate a vision for midwifery and what you see as important for midwifery. Having an opinion and not being frightened to say, that's what you're employed for – giving the same messages out repeatedly, being able to articulate a future, this is where we're going and being able to take it forward on behalf of the Trust" CMW2:4*

*"After a couple of years I had an 'ahha' moment when I realised I couldn't control what obstetricians were doing but I could control what midwives were doing. Then I abandoned the meetings and began talking to midwives about normal birth and normal labour" CMW3:12.*

*"Obviously everyone's role doesn't neatly carve up – I think what is very clear is that consultant practitioners must be in practice for 50% and it is how you define that. The way I manage it is I do a day a week on Labour Ward and my role there is to think about normality" CMW6:12*

Heads of maternity services emphasised that usually the consultant midwives focus was quite clear; they too emphasised that setting joint objectives was essential. There was a feeling that however autonomous a consultant midwife is, objectives needed to be set in line with service strategy.

*"It has improved client care because the post we defined focuses on normality since we were stuck in a very medicalised model....It's been immensely successful in changing the mind sets" HOM1:3*

*"It would really depend on how they had set their objectives with the head of midwifery, I suppose my position on this is how ever autonomous and self-directing they are they do need to be agreeing their objectives with the person holding the purse strings. They can't just assume that because they are consultant midwives they can major on this or that. In the same with an obstetrician who can't do whatever they fancy, it's got to be in line with the service strategy" HOM3:29*

Consultant obstetricians observed how the consultant midwives had taken control of their role. All were positive apart from one who had difficulty in interpreting the nature of the role.

*“The phrase used quite a lot was ‘promoting normal birth’ – the primary brief was for the post holder to promote normal birth and to work closely with the Labour Ward Lead Obstetrician so we would have both sides of the coin, approaching the management of labour and the philosophy of the unit as a joint post. That’s exactly what happened” C06:5*

*“A lot of what she is doing is trying to improve guidelines to keep us on the right track with regard to community care.. I hope that this will help us to get a birthing centre here. She does a lot of clinical work too, antenatal work” C02:7*

*“I see a midwife per se as a clinical person looking at the patients, looking at the mothers, assisting with the process of delivery, of antenatal care, somebody educating other people on site. I don’t see a midwife sitting somewhere in the corner formulating guidelines, honestly. I don’t see what a ‘consultant midwife’ is meant to be”C08:7*

#### **4.4.2 Providing Strong Midwifery Leadership**

***[Pushing boundaries; Being seen to have impact].***

Although the verb ‘to lead’ was used repeatedly in job descriptions, so were phrases such as ‘to work closely with’, emphasising trust unity and the need for mutual objectives.

Trust 6 emphasised the need “for a thorough understanding of local and national objectives” emphasising again the need for a shared vision.

Also emphasised is the need for evidence in relation to leadership ability (Trust 7).

Supporting evidence included having undertaken leadership training; the demonstration of diplomacy and negotiation skills and overall excellent communication skills.

Observational episodes provided evidence of the fact that the consultant midwives participating in the study were actively taking control and leading in a multiplicity of ways. In relation to clinical leadership, some of the midwives were observed leading specialist midwifery clinics (Trusts 1, 2, 3, 4, 8). All of the clinics observed had been initiated by the consultant midwives themselves when newly in post. Collectively they were seen to take a lead; and in the main demonstrated clinical dexterity and advanced knowledge.

*“The midwife was not at all shaken and used the client’s concerns and anxieties to further emphasise her sensitivity, knowledge and clinical experience” (Trust 3 Observation 1).*

The following data extracts illustrate how consultant midwives interpret leadership in relation to their role. Having a voice, **pushing boundaries** and leading by engaging with midwives was essential; engagement related to being visible and standing firm on issues

that mattered to midwives. Leadership related to change management, taking a clinical lead as well as being at the forefront of the profession from a national perspective.

*“The leadership I have is having a voice and making that voice heard and taking people with me. Supporting individual women involves leadership; managing tricky practice issues shows leadership.”* CMW8:28

*“You have to be seen to lead, to actually make a stand and say this is what we want e.g. when I came here there was not a hint of a birth centre. Now it’s on the strategic agenda, it will happen. It’s being able to stand your ground, to lead, to be someone others will recognise as someone they can go to get a positive feedback.”* CMW2:21

*“People will look to you for answers even the head of Midwifery will because you are supposed to be the clinical expert; you will be asked for your opinion. Leadership responsibilities come with the job”* CMW3:26

*“The other part of my work is all the outside work, I chair an RCM sub group.... there is also all the conferencing speaking”.* CMW6:24

Part of being ‘an agent for change’ involved the development of evidence-based guidelines and the sharing of information. One observational episode provided an opportunity to observe a consultant midwife in a preliminary discussion with the lead labour ward obstetrician and specialist registrar regarding a forthcoming national guideline.

*“The meeting was led by the consultant midwife...all three showed respect for each other and the differences in professions became blurred”* (Trust 6 Observation 2).

With regard to ‘leading on new initiatives’ and pushing boundaries, consultant midwives were observed exhibiting excellent communication skills in relation to diplomacy and negotiation. Consultant midwives were observed whilst chairing steering groups for new specialist services and whilst discussing joint initiatives with members of the multi-professional team.

*“the consultant midwife had demonstrated skills in the face of a new challenge... a very informative meeting capably chaired by the consultant midwife who demonstrated excellent skills in leadership and organisation”* (Trust 6 Observation1)

*“Both practitioners were keen to discuss the work they were leading on in their own specialist areas...excellent communication skills observed, the two practitioners worked in harmony and appeared to appreciate each others experience and background”* (Trust 8 Observation 1).

The heads of maternity services generally referred to leadership in relation to taking a clinical lead. Most of the participating consultant midwives were leading on 'normality' and two of the examples below relate to increasing normal birth experiences for women and midwives. Consultant midwives were spontaneous in relation to knowing and acting upon what could be done to improve outcomes for women. From a Trust perspective, taking a lead in a multi-professional forum enhanced their status in relation to leading midwifery.

*"Our consultant midwife took it upon herself to look at normal birth rates and increasing them. She audited practice; all women were having an admission CTG regardless of risk status, so we set up a programme for midwives and the number of admission CTG's came down. That was a tangible effect of her role – the same with decreasing episiotomy rates, rupturing membranes. Changes to practice as a result of educating / updating midwives lead to tangible outcomes". HOM6: 17*

*"...She's taken fairly new and inexperienced midwives out into the community and given them that support and expertise. They have a high home birth rate, in a 'Sure Start' area, so some are quite deprived. They have one to one care, low caesarean section rates. That is one of her greatest achievements". HOM6:19*

*"The meetings are multi-disciplinary, there is a user rep and they are quite powerful groups. Representing midwifery gives the consultant midwives a status to lead and control" HOM4: 11*

Consultant obstetricians generally saw the consultant midwife in a position of leadership; seeing the bigger picture and working collaboratively was seen as being important if practice developments were to be realised. The need for effective leaders was acknowledged.

*"Staff need to be lead and this can't be underestimated." CO4:18*

*"I think a consultant midwife should be one of the most knowledgeable midwifery practitioners in a unit and I would expect her to be a 'beacon' to which other midwives can aspire to. It is a leadership role in my opinion" CO1:7*

*"A consultant midwife is only going to be able to lead effectively if there is someone who is working with them on the obstetric side. If you put a consultant midwife into a unit that is antagonistic, they would have a very difficult time doing their job" CO6:4*

*"...what the consultant midwife has is all about the bigger picture, so where she may deliver a baby today or help a student to suture, her work is for the whole department, a much more corporate view...". CO3:15*

In exercising professional leadership, the consultant midwives were observed improving care options and generally innovating practice and practitioners. On several occasions consultant midwives were observed leading specific fora and committees aimed at evaluating services and generating new ideas.

*“The consultant midwife maintained the formality of the meeting throughout. The attending midwives appeared comfortable with the style of leadership and accepting of the consultant midwife being in a lead position”. (Trust 2 Observation 2).*

*“A very informative meeting capably chaired by the consultant midwife, who demonstrated excellent skills in leadership and organisation” (Trust 6, Observation 1).*

*“A proficient leader, able to generate enthusiasm and new ideas, in relation to intrapartum care, from a multi-professional team” (Trust 4, Observation 2).*

The consultant midwives spoke of **the need to be seen to have impact** and how difficult it was to be seen to influence and take control. Being seen to have impact, helped them to become more influential; their actions needed to be seen so as to be acknowledged by others.

*“Sometimes it is hard to achieve only by influence....it is hard to create visibility and a presence, I’m sure there are midwives who don’t know who I am”. CMW8:23*

*“You need to be visible and central. You need to be seen to have an impact”  
CMW6:36*

*“Sometimes it is hard to achieve only by influence....it is hard to create visibility and a presence, I’m sure there are midwives who don’t know who I am”. CMW8:23*

Heads of maternity services also spoke of a need for their impact to be seen and the need for consultant midwives to be central to the service. This was linked to taking a lead and the making of decisions to improve outcomes for women and their families. Feelings were more intense when there was only one consultant midwife in post. Practicalities relating to being the only consultant midwife were not focused upon.

*“She has gained a lot of respect from midwives and obstetricians by being so visible in practice. HOM6: 21*

*“A consultant midwife needs to be visible and central to the core of the midwifery service”. ...she is our only consultant midwife and we need the post to be central to the service” HOM7: 5*

Consultant obstetricians also acknowledged how valuable it was for a consultant midwife to be centrally located, although this tended to relate to the provision of direct clinical care rather than to impact and influence. Non-direct clinical activities were for some unwelcome activities.

*“She needs to be able to lead the service and to work clinically and for this she needs to be located centrally within the department, ideally on labour ward” CO 3:8*

*“I see a consultant midwife as a clinical person looking at the patients, looking at the mothers, assisting with the process of delivery. I don’t see a midwife sitting somewhere in the corner formulating guidelines... I don’t see that is what a ‘consultant’ is meant to be” CO 8:7*

### 4.4.3 Coping with Frustrations

*[Managing the workload; Managing conflicts and Role Isolation].*

**Managing the volume of work** was the overriding concern voiced by the consultant midwives. The enormity of the role was often overwhelming, made worse if there was only one consultant midwife employed in a Trust and especially for those working part time. Being focused, having a vision and feeling confident with the boundaries set was seen as essential. Being able to say ‘no’ was crucial; however whether the consultant midwife worked alone or as part of a team of consultant midwives their workload ‘on paper’ was multifaceted, complex and potentially overwhelming.

Being seen to be effective and creating visibility and a presence was a real problem if you were the only one and especially if the maternity unit was across multiple sites.

*“I find it is very hard to have a healthy balance between home and work because of the volume of work.”CMW7:3*

*“The negative aspects of the role are related to the enormity of the role. I am no good at saying ‘no’, I love challenges. You have to decide what you are going to focus on, a bit more than I did” CMW5:13*

*“It is very difficult not to get involved because everything overlaps” CMW7:19*

*“I have difficulty with there not being enough time or enough of me e.g. I know there are rumblings around on delivery suite that I haven’t been there. I haven’t for the last 18/12, I can’t be everywhere. If I’m doing the PCT stuff I can’t be on delivery suite.”CMW2:15*

*“I only have 2.5 days to be a consultant midwife on 4 different sites, its hard to create visibility and a presence, I’m sure there are midwives who don’t know who I am. To be fair I might feel the same if I was full time, it is one of those jobs that is never ending” CMW8:23*

Consultant midwives voiced internal tensions about prioritising work, facing enormous expectations and coping with conflict. Being able to see the bigger picture in relation to Trust or unit priorities was important but just as crucial was the smaller picture and the every day reality of managing workload. The role was seen as being realistic but being too idealistic was not advocated.

*“There will always be an internal tension. A consultant midwife will always want to achieve more than they can. I think it can be realistic and manageable but it’s always at the expense of your idealistic enthusiasm”* CMW 1:22

*“Sometimes you get given jobs that are not strictly speaking in the consultants role”*CMW3:18

*“Not knowing sometimes what is the most important project to focus on, at any given time and not having anybody else to talk it through. I do feel the weight of responsibility that goes with it, it can be daunting – The expectations of what you need to achieve can be daunting”* CMW 2:16

*“Sometimes it’s just the sheer complexity of the role, when you don’t feel you ever finish a task”* CMW6:37

Not overloading the consultant midwives was articulated by some heads of maternity services. There was awareness that volume of work was a real problem and a facilitative working environment where consultant midwives could organise and discuss their workload was recommended. Being the only consultant midwife in a Trust was again seen as limiting.

*“I think we have to be very careful not to overload the role for the post holders...”*  
HOM2:30

*“It is all about being clear with the organisation you are working in about what they want you to do and what you are expected to achieve and what you are not going to be able to achieve. I know I have been guilty in saying ‘oh yes the consultant midwife could do that’ – I’ve seen it become impossible. It’s about having the structures in place that allow the consultant midwife to say ‘I can’t do it all”* HOM3:32

*“When there is strength in numbers you feel more powerful and more daring, more challenging to push the boundaries”* HOM4:16

*“My advice to any consultant midwife would be ‘be careful not to take on too much in the early days’ you just have to balance the give and take”*HOM3:30

*“You need the right person to say I can do this much, this will be my focus and actually I can lead that or do that but I can’t do that as well. They have to be realistic and organised in what they can and can not achieve. Every job could be impossible if you piled too much into it, you just have to be sensible about what you think can be achieved”* HOM6:29

The consultant obstetricians were also able to identify the potential for work overload.

*“There is only one of her and to run a unit like this, with the numbers of deliveries we have, with one consultant midwife and with what she has to do and the amount of work she could potentially take on, is more than one person can do* CO2:3

*“We have to be careful; with junior doctors hours being cut we have to agree that consultant midwives don’t take on what they shouldn’t be”*CO4:23

Being able to **manage conflicts** was more necessary for some than others. It was clear from the consultant midwives that the formation of good relationships with the multi-professional team was important if effective working interactions were to be formed. What was clear from all consultant midwives was that the relationship between consultant midwife and the head of maternity services was absolutely critical if a successful and supportive working relationship were to be created.

*“The relationship you have with the Head of Service is critical – if you don’t have a good relationship with your head of service; if you don’t share the same philosophy; if you don’t have a working relationship with the managers you will achieve nothing.”*CMW5:4

*“You have to have a good relationship with the Head of Maternity Services and the midwifery team. It’s important to get on with the obstetric consultants too, they are people with huge influence and power and you have to be able to influence them.”*CMW2:8

*“I do recognise that if you have difficulties with the head of maternity services you are sunk.”*CMW8:25

Relationship conflicts often materialised between the head of maternity services and the consultant midwife. Due to the close overlapping nature of the two roles, tensions were commonplace.

*“I know that many of my consultant midwife colleagues have conflict with their heads of midwifery due to rivalry. You overlap a lot but your core function is slightly different. I can see that there is tension between the two roles”* CMW8:8

*“...there is the emphasis on what you don’t do rather than what you do do. A lot of other people feel that. It’s the small things that can get you at times; the volume of work, cancelling meetings. It’s the corporate presentation – I can see the bigger picture and the smaller picture. It can be about dealing with conflict”*CMW7:12

*“At the RCM Consultant Midwives Forums a lot of the time there is in discussion about the relationship between the consultant midwife and head of maternity services and there have certainly been issues.”* CMW7:21

*“I know other people have difficult relationships with individuals. When I go to The Consultant Midwives Forum that’s what I hear, about the difficult relationship with the HOM, people like that. I have not had those difficult relationships here. I have always had good working relationships here, frustrating sometimes.”*CMW2:14

For some, very supportive relationships, formed out of mutual respect, had been created.

*“The head of maternity services has a very facilitative style; she is the same with everyone. She is supportive, so there is no conflict. I don’t think she knew what a consultant midwife did but she is willing to listen, she is sympathetic, very ease to work with – she gives you a free reign”*CMW4:8

*"...the post we created has been so successful, particularly with the staff here, the medical and midwifery staff; this has created a real partnership. I came into a climate where there was already a mutual respect for each others professions, I thought this would be the icing on the cake, and it has been". HOM6:2*

Rivalry could also be a problem; some consultant midwives felt that consultant midwives and heads of maternity services were or should be on the same level.

*"I know that many of my consultant midwife colleagues have conflict with their Head of Maternity Services due to rivalry. You overlap a lot but your core function is slightly different. I can see that there is tension between the two roles". CMW8:8*

*"Consultant midwives should be on an absolute par with the Heads of Midwifery - I tried to challenge it here and haven't had a lot of success but I am going to rechallenge it."CMW6:5*

*"I think it (accountability) needs to be someone higher than the head of midwifery because the consultants and head of midwifery are pretty much on the same level". CMW3:3*

*"in terms of where you are seen in the structure you need to be seen as equal"  
CMW4:10*

Some heads of maternity services alluded to hostility but there was no real consensus of opinion in relation to being on equal status. The consultant obstetricians did not comment

*"The role could be strengthened if only there was a relaxation and less hostility"  
HOM7:21*

*"there was never really a problem here.... In other organisations I knew there was anxiety about the person accountable to and it was my reading of the situation that there was as much hostility from heads of midwifery as consultant obstetricians"HOM3:5*

*"The buck needs to sit with one person. I don't believe that consultant midwives have that level of responsibility at all. The posts should complement each other but there can only be one Head of Maternity Services". HOM7: 20*

*"...being on equal footing with the head of Midwifery may be the way of the future, after all the two roles can't function without each other". HOM6:13*

*"I would love their job. Look at my role we are paid the same but I would say that my responsibilities 24 hour responsibility, budget responsibility and people responsibility is vast compared to what they do. Equally they would say back that I do have the power to influence and control. They can be full of the best ideas and want to move things forward but don't have the oomph behind it. Do they want the control? No not from what I can see, no" HOM8:27*

Coping with **role isolation** was for some demanding. Being a consultant midwife could be isolating especially if there was only one; power in numbers did count especially when it came down to influencing change and pushing boundaries.

*“You are very very isolated; you are on your own.... I am particularly isolated, there is no one else around - It would help having someone alongside you working in a similar role...I think isolation makes you wonder if you are getting it right, whether you have got the right focus. If questioned whether you have got it right, are you doing the right thing, you have nothing to measure yourself against.”* CMW2:16

*“It’s good to have a few. One person would become isolated in a big organisation... When you have two or three and when the going gets tough you support each other. When there is strength in numbers you feel more powerful and more daring, more challenging to push the boundaries”.* HOM4: 16

Support came from a multiple of sources, other consultant midwives, nurses, senior managers.

*“From the other consultant midwife here, I can talk freely to her about the difficulties of the role and she to me”*CMW8:26

*“As a team of consultant midwives and nurses and a physiotherapist, we are about seven in number. We are about to go out to advert for two more. They are very valuable to the relationship since some of the problems that we face are similar, not actually speciality specific at all, they are people specific.”* CMW1:4

*“The Senior Management team, then I do support most of what they are doing.”*CMW2:17

Some consultant obstetricians voiced concern regarding isolation or the potential for isolation.

*“I feel someone could become isolated because they could become not part of the midwifery seniority structure and their peers, they are senior to the more junior midwives and they may be isolated by the obstetricians. Potentially it could be an isolating role”*CO6:25

*“I suspect in certain circumstances they could feel isolated. It shouldn’t have to happen. It depends on the communication within the department and the consultant midwife, its all about defining your role and the people you work with”* CO3:17

*“...sometimes being a role model can be very isolating – we must be mindful of that. Modern practice is all about multidisciplinary practice and we need to welcome that and support it.”* CO4:26

Other more minor frustrations existed such as a lack of administrative support and location of office. As emphasised already, being visible impacted on the way in which the consultant midwives were viewed.

*“More administrative support, it is very limited” CMW3:20*

*“We have had terrible secretarial support. We have only had a bit of their time and often my computer skills are better than theirs. In the end you say ‘what is the point’, I need to be able to say ‘do this’ and they will do it.”CMW8:32*

*“One negative aspect is not having secretarial support. I spend a lot of time typing up minutes and they take a lot of time. I am not here to be paid as a secretary. I liaise with GP’s and health visitors, when I see women there are notes to be typed – it would be so lovely to have help” CMW6:35*

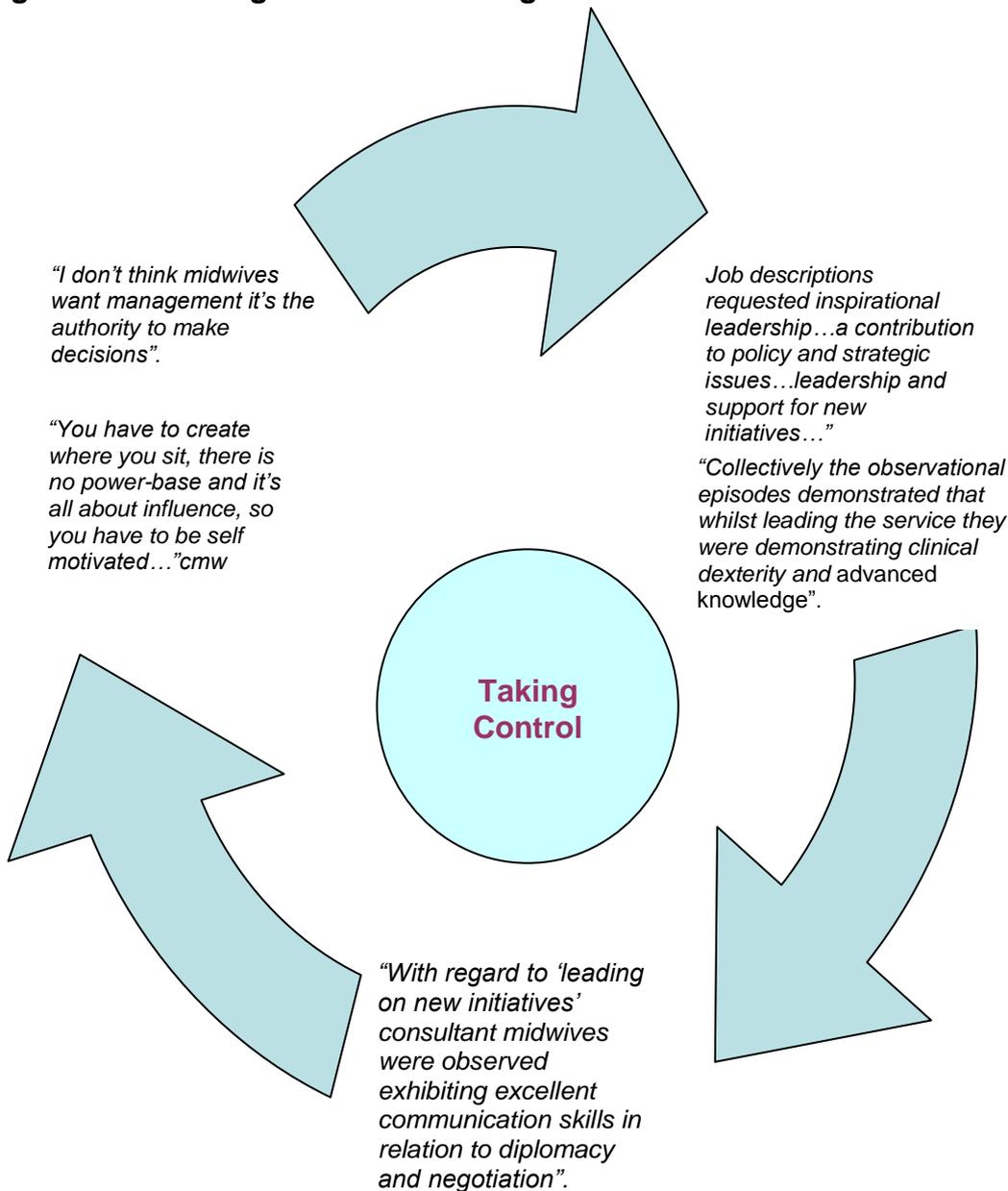
*“Another big gripe was where my office used to be based – I was in the basement hidden away. If you are not seen people don’t think you are working – You need to be visible and central. You need to be seen to have an impact” CMW6:36*

*“My office has either been on Labour Ward or just around the corner so they can always come and get me. I think that is the way it ought to be”CMW3*

#### 4.4.4 Taking Control: An Integration of the Three Sources of Data

To emphasise clarity, Figure 5 below depicts Theme two 'Taking Control'. Surrounding the theme are examples from the three strands of data (interviews, observation and documentary analysis) which illustrate it.

**Figure 5 Taking Control - An Integration of the Three Sources of Data**



#### **4.5 Theme Summary**

In summary, the theme 'Taking Control' focused on consultant midwives being in a crucial position to influence the development of clinical practice without having direct managerial responsibility. It focused on the strengths and limitations associated with where in the midwifery hierarchy consultant midwives are positioned and emphasised some of the complexities associated with the role and their relationship with management. Self motivation was seen as being important. Since the consultant midwives were not charged with having the authority to make decisions, an ability to take power and influence others was seen as being essential.

Consultant midwives articulated how they had taken control of their role as consultant midwives. Having a clear vision and being able to articulate that vision, making change a reality, was fundamental to the role. The enormity of the role was indeed emphasised by all participating groups; frustrations and internal tensions about prioritising work, facing expectations and coping with conflict and isolation were discussed.

What was clear from all consultant midwives was that the relationship between consultant midwife and the head of maternity services was absolutely critical if a successful and supportive working relationship were to be created. Some supportive relationships, born out of mutual respect were spoken of. Rivalry was seen as a problem by some; suggestions were made that consultant midwives and heads of maternity services were or should be on the same level; there was no real consensus of opinion in relation to being on equal status.

Being a solitary consultant midwife was seen as isolating; power in numbers did appear to count especially when it came down to influencing change and pushing boundaries. Mechanisms for support were articulated; some consultant obstetricians voiced concern regarding isolation or the potential for isolation.

#### **4.6 Theme 3 Shaping the Future**

Theme three focuses on role sustainability and the future of the maternity service.

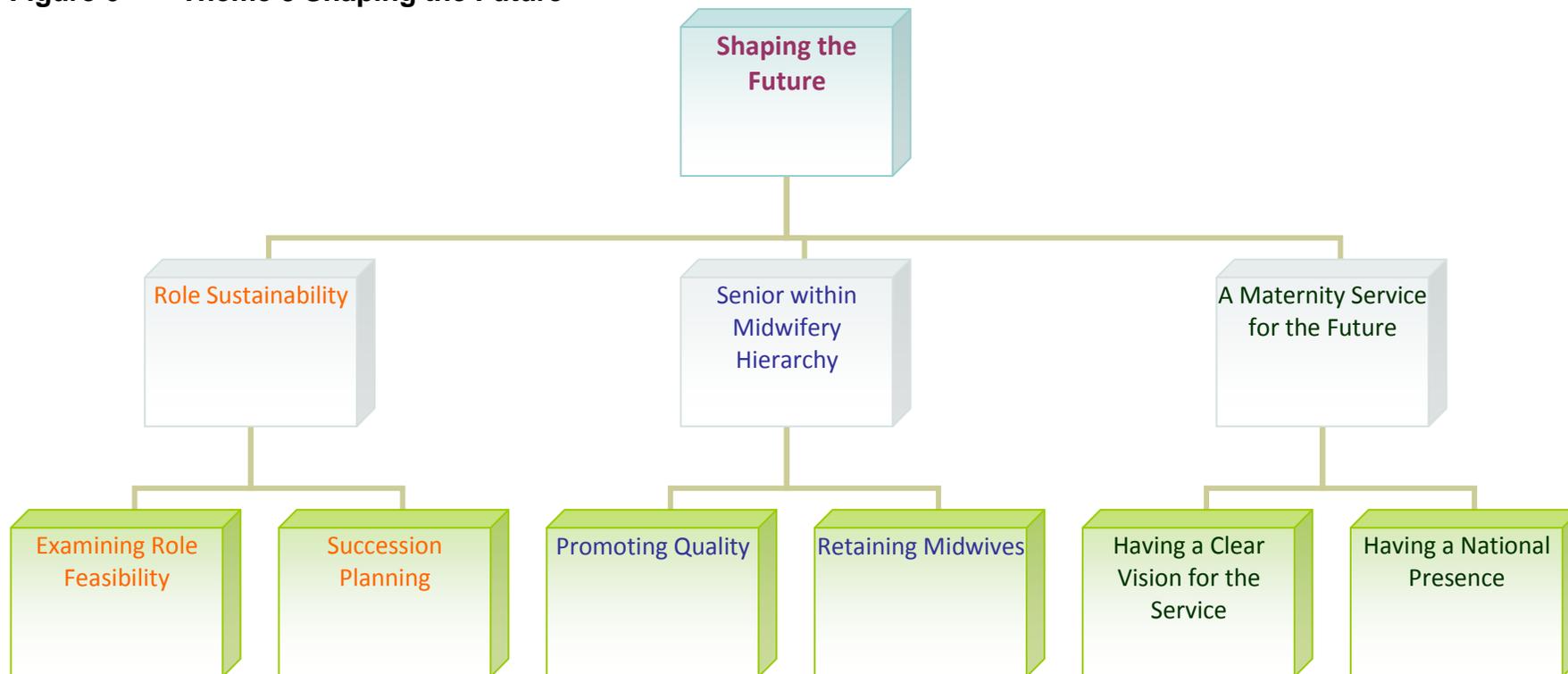
Concerns relating to contemporary changes being taken to modernise the NHS and the effect these are having on the maternity services were articulated. The consultant midwife was viewed as a senior practitioner within the midwifery profession and aspects of the role relating to quality assurance and the retention of midwives were explored.

Role feasibility and limitations of the role were considered in relation to role interpretation, personal choices taken and objectivity from within an organisation. Issues relating to role evaluation and succession planning were also explored.

Being senior and experienced practitioners, consultant midwives identified skills involved in promoting quality. In the main, clinical governance equated to the overseeing of safeguarding procedures, such as the development and interpretation of clinical guidelines and the processes involved in dealing with complaints. Being senior within the profession also demanded from the consultant midwife an ability to practise at a higher academic level and in so doing support and develop midwives in clinical practice.

As well as a full description of the theme, diagrammatic representations of the theme are presented in Figure 6 on page 115, identifying firstly the preliminary descriptors, broad descriptors and emerging theme and secondly the coming together of the three strands or sources of data.

Figure 6 Theme 3 Shaping the Future





### 4.6.1 Role Sustainability

#### *[Role Feasibility; Succession Planning].*

From talking to the consultant midwives and observing them in practice it appeared clear that in terms of **role feasibility and sustainability**, the role of consultant midwife was limitless yet at the same time needed taming. Success came down to the individual, in relation to personal expectations, time management and support; realistic objectivity from within the organisation was crucial.

*“I think it’s realistic if the person in it is being realistic and the person perceiving it is realistic. There will always be an internal tension. A consultant midwife will always want to achieve more than they can. I think it can be realistic and manageable but it’s always at the expense of your idealistic enthusiasm. At the end of the day you are an employee and care of women must come first. We have to make the role manageable because if we don’t it won’t exist.”* CMW1:22

*“It’s a huge undertaking. You have to work out what your focus is. My focus 2 years ago is different from what it is now and I think you grow into the role and then see the areas for development.”*CMW6:47

*“...the only way I end up achieving is by putting in those extra hours. I remember the day I got my job, I went to a conference and another consultant midwife was speaking and I remember feeling ‘where do I start’. She said she was working 50-60 hrs a week and that’s what I do. Last week I worked everyday, it’s hard, I’m told to claim it back but if I did the head of maternity services would be horrified by the amount. All the people that are very passionate and committed have to do that – There is enough work here for two full time posts”.* CMW8:32

*“The output of work has been phenomenal. The negative aspects of the role are therefore related to the enormity of the role. I am no good at saying ‘no’, I love challenges. You have to decide what you are going to focus on, a bit more than I did”*CMW5:13

In the main, heads of maternity services appeared to be realistic and conscious of the need not to overload their consultant midwives.

*“I think we have to be very careful not to overload the role for the post holders and so we discuss whenever she is invited to do things nationally, locally or regionally, a) is it relevant, b) can we fit it in and if so we try to weigh its importance from the service point of view and the professional development perspective”.*HOM2:30

*“My advice to any Consultant Midwife would be ‘be careful not to take on too much in the early days’ you just have to balance the give and take...”.* HOM3:30

Focussing on experiences within their own trusts, some consultant obstetricians were firm advocates of the role...

*“I think that such a role is significant to the whole ethos and working of a maternity unit if it is right. I think you could argue that every maternity unit of a significant size should have at least one, certainly if the unit is involved in teaching midwives and obstetricians. I am a firm advocate for the role and any unit without one is poorer for it.”* CO6:28

*"I think it is sustainable and will carry on. I say that because midwives lack good role models. It is vital to any profession; people have to have others that they aspire to be like"*CO1:21

Although credible, some voiced concerns as to isolation and an overly ambitious work load if there was only one consultant midwife within an organisation...

*"I Think that what she is expected to do is more than anyone could achieve. I think the role is credible; we just need more people doing it."*CO2:17

*"I just wish there were more of them. If there were more it would solve issues of isolation and make consultant midwives more effective"*CO3:18

One consultant obstetrician was generally positive but had reservations in relation to the need for continuing to review objectives and in ensuring the trusts interests were being maintained. Another consultant obstetrician appeared to have poor understanding of the role and was very much opposed...

*"Yes, having said that it needs managing. The work undertaken by consultant midwives needs to be in the trusts interest. Depending on need, the focus will change with time."* CO4:28

*"I don't know what is envisaged for the role; I wish we knew exactly what 'consultant' means. I don't know, I really wish I knew what they are supposed to do. We have Modern Matrons, we understand what they do. A modern matron is far more useful....They are on site, managing a service. You have one consultant midwife for the entire Trust, for 500 midwives, where is the role, the clinical role....They are invisible"*CO8:16

In relation to analysing the true feasibility of the role, evaluation was viewed by some as a valuable tool, especially from the Department of Health, the originators of the role.

*"The roles have to imbed since they are still new and with the current climate they are being seen as the jobs which may be disposable. I think that because they are so new, people have a sense that we could do without them. It's hard to say what the consensus view is within a Trust...The Department of Health has a responsibility to say these people have made a difference."*CMW5:21

*"The direct feedback from midwives relates to 'why should some people get special treatment?' and 'are you suggesting we are not competent?' Midwives are very proud of their skills"*CMW4:8

*"The university evaluates student feedback and I get a copy (always positive)".* CMW2:28

Realistic job descriptions and role review in relation to changing expectations was seen as crucial to consultant midwives and heads of maternity services.

*“I think ‘if’ the role is well described in the job description then it’s manageable. I often get sent job descriptions for review. If normality and public health are seen as one role I say ‘it’s impossible – these 2 posts can not go together’. I think there should be a minimum of 2 and possibly a third. The job descriptions mustn’t be too vague or too big. Some may say that’s good you can define your own role, but others could say you haven’t fulfilled your role” CMW5:21*

*“Some times practitioners find themselves split in some many directions that their skills are not able to be used effectively. Well thought through job descriptions and targets are so important.” CO4:22*

*“It’s about having the structures in place that allow the consultant midwife to say ‘I can’t do it all’. I equally think they need to have what I call flexible job descriptions, it’s like the consultant doctor, you do his job plan every year, things may drop off and things may go in. I think that is the issue, you need a broad role description then you agree the key purpose for this year and then it might be different next year. Potentially it is perfectly doable.” HOM3:32*

*“You need the right person to say I can do this much, this will be my focus and actually I can lead that or do that but I can’t do that as well. Job descriptions have to be realistic and organised. Every job could be impossible if you piled too much into it, you just have to be sensible about what you think can be achieved.” HOM6:29*

The observational episodes provided evidence of the fact that the consultant midwives participating in the study were exhibiting a high level of intellectual expertise; were heavily involved in the monitoring of quality mechanisms to maintain safe practice; were spending time supporting and developing midwives and did have, to a greater or lesser degree, a national profile. The consultant midwives were observed leading on innovation and developing the workforce in readiness for future professional demands.

Intellectual expertise was demonstrated as new services were developed and introduced to staff. On such occasions it became clear as to the consultants involvement; they demonstrated being at the forefront of professional development.

*“as chair the consultant midwife was in control and it was clear that staff acknowledged her authority and that she was responsible for the initiation and development of this new service” (Trust 6, Observation 1).*

*“this was clearly a business discussion; the midwife had no trouble understanding and articulating managerial / business issues and language” (Trust 5, Observation 1).*

Most consultant midwives felt that **succession planning** was valuable and sub-consciously had identified potential candidates for the role.

*“When you do appraisals and supervisor reviews you kind of know who would aspire to be a consultant midwife and you know who has the educational know how to do it. I have one in mind who has the capacity to do the job” CMW3:38*

*“Some I would like to encourage have a little more to do. Certainly I can think of at least 3 people who would be suitable” CMW5:22*

*“The next stage is growing another, succession planning is important. We appointed a caseload midwife a while ago and she has the skills” CMW6:46*

*“Succession planning is needed.” CMW7:22*

Some heads of maternity services acknowledged the importance of nurturing the potential in others.

*“Early on in people’s careers you get a feel as to whether these people will go down a clinical development path or are looking at leadership roles. Without being conscious of what I’m doing I would be able to say ‘Yes this person could develop into such a role” HOM2:31*

*“We are certainly talking to people in the organisation about getting MSc’s because we see them as potential consultants. Yes we are focusing on the next person, they are probably the same people who would have gone into midwifery education, I don’t know how midwifery education will cope with that. They are also potential heads of midwifery; it’s the same pool of talent we are talking about” HOM3:33*

*“I think we need to have some succession planning and to have trainee consultant midwives. We need to encourage and to commit to giving them one day a week when they can shadow or take on some of that brief, so its succession planning” HOM4:34*

*“There are midwives who you can see have this potential and can see their passion for promoting midwifery.”HOM6:30*

*“I could name two easily and they are studying with that in mind” HOM8:28*

Consultant obstetricians generally felt it was for midwives to succession plan but were keen to participate in the process of selection so as to identify the right person. Some saw the potential in midwives and did comment.

*“...what I would hope would happen would be that the senior midwives and university and consultant midwives would discuss what they saw from the role and then share that with the obstetricians and accept advice.” CO6:31*

*“It would be good to have another. Sometimes you see a midwife who does have potential for a specific role and I do occasionally say something” CO1:22*

*“Just as midwives may identify medical staff for promotion, doctors see the potential in midwives”. CO2:18*

*“I think we see individuals all the time that have potential, but it’s up to the midwives, it’s all to do with career and life choices; I might however identify someone or encourage them.”CO3:19*

*“In working together we are able to spot and encourage. The profession is changing in that women are getting older, with more medical complications – we need a work force that is responsive and is able to provide midwives with contemporary skills. Some midwives are natural role models and leaders. It is our duty to provide an environment where they can practice and inspire others” CO4:29*

#### **4.6.2 Senior Practitioners within Midwifery Hierarchy**

##### ***[Promoting Quality; Retaining Midwives].***

Implicit in the job descriptions analysed is a sense that consultant midwives are senior practitioners in relation to midwifery hierarchy. Evidence for this is found documented within the lists of key responsibilities and overall role summaries. Phrases such as “to provide leadership to midwives and facilitate changes in midwifery practice” (Trust 2) and “the key purpose of this role is to ensure a high level of intellectual and practice expertise...” (Trust 3) allude to the nature and scope of the undertaking. It is this intellectual acumen that equips these midwives with the readiness to prepare for the future, to move with the times and to anticipate a climate that is fast changing. Associated skills relate to having good judgement, clinical expertise and insight (all trusts).

Being a senior member within the midwifery profession necessitates best practice and professional leadership, through which strategic planning may result in new initiatives, significant local development (Trust 6) and “innovative care structures” (Trust 5), whilst at the same time maintaining a level of consciousness in relation to the “strategic direction of the directorate (or trust)” (Trust 5). Senior practitioners need to be role models acting as windows to the profession where “standards of behaviour and professionalism” (Trust 7) may be observed and where “a standard of conduct (will) sustain public confidence and trust” (Trust 8).

As experienced practitioners, consultant midwives act as change agents “introducing and implementing evidence based practice” (Trust 8). A significant aspect to the role involves the monitoring of quality mechanisms to maintain safe, contemporary practice whilst “supporting and developing staff” (Trust 6). On a daily basis, this involves “developing evidence-based guidelines for midwifery practice that promote midwives autonomy and confident decision making” (Trust 2).

In keeping with maintaining rigorous quality mechanisms aimed at protecting women and their families, most trusts emphasise that a requirement of the consultant role is for the post holder to “formulate appropriate contributions to policy documents” (Trust 3) and be a member of various committees where updated information is disseminated to staff (all trusts).

As senior practitioners, the participating consultant midwives identified their role in **promoting quality**, by implementing outcomes of clinical governance processes that highlight where things are not as good as they might be. In the main, clinical governance equated to overseeing CNST processes, developing midwifery guidelines and dealing with complaints. Consultant midwives spent a considerable amount of time updating guidelines and presenting changes to staff. The midwives focused on work that had been undertaken both locally and nationally i.e. the NSF, NICE, CEMACE.

*"I have done a lot of antenatal, intrapartum and postnatal guideline work. Probably the NSF was the most important, that was a large undertaking. I was involved in shaping the guidelines for all three areas."*CMW5:9

*"I play a big part in the development of labour ward guidelines here, writing and editing. We have guideline meetings every month which I see as a priority, just to make sure the woman doesn't get forgotten."*CMW3:28

*"CNST is a big thing, although it gives you lots to do and sometimes moves you away from the role; it can be a good lever"*CMW1:10

The monitoring of quality mechanisms to maintain safe, contemporary practice took considerable time and involved collaborative working in order to update and respond to new initiatives.

*"the consultant midwife took responsibility for leading the discussion with two senior obstetricians regarding the unit's implementation of the new guidelines". (Trust 6, Observation 2).*

Heads of maternity services and consultant obstetricians were instrumental in identifying consultant midwives as being ideally placed to address quality monitoring issues.

*"...she has a strong role in promoting quality and being proactive about promoting a quality service. I would expect the consultant midwife to be abreast of guidelines and developments and to be feeding them in and saying 'look we are miles behind; I have also used the consultant midwife in supporting women who are unhappy with their care, either women who are unhappy during the course of their care or are unhappy subsequently. Consultant Midwives can do a lot in unravelling complaints and helping women to the point of resolution and I would put that under clinical governance"*HOM3:22

*"We asked her to look at our induction process and to do something positive and she has achieved that...she looked at our figures and the way we practiced...She gave us figures and it's worked well. The word collaboration to us is rather flattering to us, this was her work, I don't think we entirely helped, we perhaps hindered to some extent!"*CO1:10

Consultant midwives believed that being senior within the profession also translated to developing and **retaining midwives** within the service. Extending career opportunities for experienced midwives was a major reason as to why the role of consultant midwife was originally developed. It was identified that trusts needed to retain the experienced practitioner by offering career progression.

*“We had a lot of vacancies in the trust and it was something that we recognised wasn’t being accounted for. We thought it would have a very good effect on the midwives, on midwifery retention and the way the service was developed, that was why it came about”. HOM1:1*

As senior practitioners within the midwifery hierarchy there was a general acceptance that having a higher degree helped in relation to the vast range of scholarly activities needing to be undertaken as part of the consultant midwife role. These ranged from thinking strategically and writing for publication and speaking at conferences, to helping develop midwives knowledge and skills and being role models. Skills in analysis and synthesis gained by undertaking a higher degree appeared to provide a sense of authority.

*“I think they need to be at MSc level and I don’t think it matters what the degree is in – They have to be able to think at that level, to reflect at that level and be able to synthesize and understand the information, to be able to take it forward”. HOM8: 5*

*“An MSc because of the breadth of knowledge that is required and the writing you have to do. A consultant midwife writes prolifically – papers produced at the drop of a hat. Also putting together documents; getting involved in national procedures”CMW5:1*

*“ I do believe that although a midwife can have a lot of experience she may not be able to demonstrate that unless she has been through research themselves and all that goes with being able to think analytically, so I would say an MSc is essential. I do think it gives you certain gravitas in terms of discussing research, putting your point of view across, helping debate”. HOM6: 6*

*“A first degree or MSc is important; they need to articulate at a high level; a higher degree helps you to achieve this.” CO2:3*

Retaining senior midwives within clinical practice was viewed as crucial to the future development of the service. Six of the consultant midwives participating in the study had achieved a registered teaching qualification prior to becoming a consultant midwife. There was a strong feeling that this was particularly helpful in light of the scholarly activities within the university and at trust level. Heads of maternity services were unanimous in emphasising the parallels involved; consultant midwives with teaching experience were seen as valuable commodities to both education and practice.

*"My background in teaching is good preparation." CMW1:24*

*"Midwives look to me for support and advice and teaching. I really like that because I was in education before and I do like teaching. The thing I don't like about education is that there is limited opportunity to work clinically and I think there should be." CMW3:27*

*"I teach sessions on normality; home birth – I love it! Consultant midwives do benefit from an educational background, giving confidence and teaching ability. I think we should have an education and research link" CMW6:45*

*"...the role would not be viable without this relationship. Education needs clinically sound input for their learners and practice demands the analytical understanding educationalists bring. The consultant role is a marriage between the two". HOM5: 29*

*"...it is totally appropriate for a consultant midwife to have a teaching role just as it for an obstetrician; I would expect to let them to have time for that". HOM3: 27*

*"She enjoys teaching and does a lot of training; she forges links between education and practice and spends a lot of time speaking nationally" HOM7:18*

*"She had sound teaching qualifications; I was excited about that and I thought it was most likely that it would be beneficial to the unit" CO6:1*

In working efficiently as a senior practitioner and in acting as a role model to junior midwives, being articulate and having effective communication skills was seen as of paramount importance by all three participating groups.

*"Being able to articulate a vision for midwifery and what you see as important for midwifery. Having an opinion and not being frightened to say, that's what you're employed for – giving the same messages out repeatedly, being able to articulate a future, this is where we're going and being able to take it forward on behalf of the Trust." CMW2:4*

*"You have to be articulate and to be able to communicate at all levels." CMW5:*

Heads of maternity services and consultant obstetricians tended to agree that effective communication related to being articulate at all levels as well as being proficient in relation to the use of evidence and raising the profile of the unit.

*"In terms of personal qualifications you have to be a very skilful communicator at all levels, you need to be able to communicate at the right level, at the right time, with the right people. You can't be too bombastic or you will put people off" HOM6: 7*

*"You have to be able to clearly articulate what is good evidence and she uses that very effectively to improve care for women and babies" HOM 4:23*

*"...for me it's more to do with capability and thought processes, verbal and written communication rather than knowledge" HOM 3:6*

*“She sits on a number of committees and groups on a wider basis and I think raising the profile of the unit is very helpful but it is also raising the profile of midwifery by having someone who is well informed and communicates...” CO 6: 27*

### 4.6.3 A Maternity Service for the Future

*[Having a Clear Vision for the Service; Having a National Presence].*

Consultant midwives have a significant part to play in ensuring that **the midwifery profession is fit for the future**. This is where having a high level of intellectual insight helps; the importance being that knowledge and foresight is disseminated (Trust 3) and that education and research is integrated with practice development (Trust 2).

If midwives are to be retained in practice to facilitate the needs of future childbearing women, they need clinical and academic development. Consultant midwives are in a key position to support, encourage and develop midwives. All job descriptions emphasise “working with midwives”, identifying learning or development needs, inspiring and initiating confidence and self belief. Phrases such as “provide clinical supervision” and “ensure the clinical environment is conducive to learning” (Trust 7) proliferate. Most of the job descriptions emphasise that a master’s degree or equivalent is required to ensure appropriate academic readiness. In addition, consultant midwives are expected to work in partnership with higher education (Trust 6; Trust 5).

Many of the consultant midwives participating in the study did have a **clear vision for the future for the maternity services**; predictions and objectives however varied, some focused on current topical issues such as caring for vulnerable groups....

*“The opportunities from the Government are all about vulnerability so it is about being in there, putting your proposals in a timely way to capitalise on that bit of funding. That’s where the developments will be and I think we have to be on the ball.” CMW3:40*

*“Midwives do display a passion for working with inequalities or with specific groups, you can sometimes see that” HOM5:34*

Other consultant midwives looked at the changing face of the maternity service and the need to maintain skills and midwifery led care. Specific concerns centred on the fact that acute units are continuing to grow in size dominating services and diminishing community care provision.

*“I have major concerns about what is happening to the maternity services. One is the amalgamation of units to create units responsible for 7-10,000 births a year. I*

*think that is deathly for midwifery practice. Midwives hate working in them and they become so deskilled in decision making... My fear is that as these massive units get bigger and bigger and busier and busier and because acute services are the main employers of all midwives, what we are seeing around the country is the big units are drawing from the community. .” CMW5:23*

In facing the future and associated change, staying true to the role of a midwife was seen as stabilising. Focusing on normality and individualised care was viewed as being crucial to maintaining a midwifery identity. Increasing the home birth rate by working more flexibly, was seen as a way of reducing the caesarean section rate.

*“I think it is on-going development of the midwifery role. Midwives need to be clear of what they are focusing on. We are here to be midwives, the focus has to be on normality and that has to be the key focus – It’s about being very clear about what a midwife is. We have to support one to one support during labour – that is fundamental”. CMW6:48*

*“In hospital, we do need to be providing better midwifery care for the type of women we are caring for – high risk women, older women with medical disorders. I don’t think we are doing that very well” CMW8:33*

*“I think there is still work to do on the rising caesarean section rate. Our way to deal with that is to increase the home birth rate and change the way we work so we are supporting women much more e.g. assessing women at home, not bringing them in. We need to capitalise on opportunities there for women and just being more flexible. One of the challenges of doing that is that not all midwives want to; there are some who because of their own commitments can’t.” CMW3:40*

Directly in relation to the consultant midwife role, practitioners participating in the study identified a time when the focus ceases to be about maintaining ‘normality’; it was felt that new objectives would be identified and championed by consultant midwives.

*.”There will become a time when the consultant midwife doesn’t need to focus on normality and the role will evolve into different aspects of care. That may be due to the person changing or because it needs to move in a different direction. Hopefully, the work they are doing will become so embedded that you won’t need to have a champion because every one is a champion of it”. HOM1:27*

*“It’s difficult to say where we go from here. Our consultant midwife has been with us for 5 years now. We’ve certainly benefited from and seen a difference that the role has made to our service. These roles are absolutely critical to services with all the changes going on”HOM2:29*

*“Well I think it would be great if there were more. It would be great to have a consultant midwife for postnatal care & breastfeeding.”CMW3:36*

Many of the consultant midwives participating in this study appeared to be conscious of their responsibility to develop the profession and to create a better service for women and their families. Opportunities were sought to influence current practice, its organisation and

the future of the service by **creating a national presence**. Some were influential in an advisory capacity at trust level but also in relation to professional issues at the RCM and Department of Health. The consultant midwives and heads of maternity services spoke of their skills and the opportunities available as part of the consultant role.

*“My passion is about strategic planning and modernization – taking the profession forward and trying to influence the future in whatever way”<sup>CMW5:3</sup>*

*“You need to have experience, a depth of knowledge and be able to work at a strategic level.”<sup>CMW1:1</sup>*

*“It’s a freedom to move between organisations without constraints, the ability to function at a national level and have access to that national agenda, listening to what is happening and bringing that here to influence the local agenda, without constraints.”<sup>CMW2:13</sup>*

*“I suppose my view is if you don’t let the Consultant Midwives have a voice around the right tables and to the right people, I don’t know why you have them in post”.<sup>HOM3:15</sup>*

*“...just having somebody in a senior position that is able to take on more of a strategic approach to midwifery care. Midwives are advocates for women but I think there needs to be a bigger picture and I think that’s where the consultant midwife comes in, to really take on that strategic role, on behalf of the profession and all women”<sup>HOM4:2</sup>*

*“The consultant midwife also sits on the Trust Nursing and Midwifery Committee, which is a high level committee for very senior people”<sup>HOM5:10</sup>*

As senior practitioners within the midwifery profession, maintaining a national presence is indeed advantageous. One of the core functions of the consultant role (DH 1999/2000) involves consultancy. This is achieved through “vigorous and inspirational leadership” (Trust 6) and “participation in the national consultant midwife network” (Trust 5). In relation to the future, consultant midwives are expected to “act in a consultancy capacity...taking a lead in shaping the future, in accordance with the NHS Plan and Department of Health” (Trust 7).

For some of the participants the demands associated with being a consultant midwife did stretch far beyond their immediate practice area. Having a national presence meant being engaged in writing for publication, speaking at national conferences, being on editorial and advisory boards, participating in research and generally engaged in raising the profile of midwifery at the highest level. *In order to maintain the consultant midwives anonymity specific examples below are kept to a minimum.*

*“It’s a freedom to move between organisations without constraints, the ability to function at a national level and have access to that national agenda, listening to*

*what is happening and bringing that here to influence the local agenda, without constraints".*CMW4:13

*"I sit on the editorial board for..... and I sit on a midwifery committee... I have been asked to be a critical appraiser for NICE too."*CMW2:27

*"Outside the Trust its about building bridges...knowing how to influence change in practice"* CMW2:9

*"They asked me to be an Honorary Research Fellow. I have been involved in international research projects. Currently I am involved in a multi-centre project"*CMW7:20

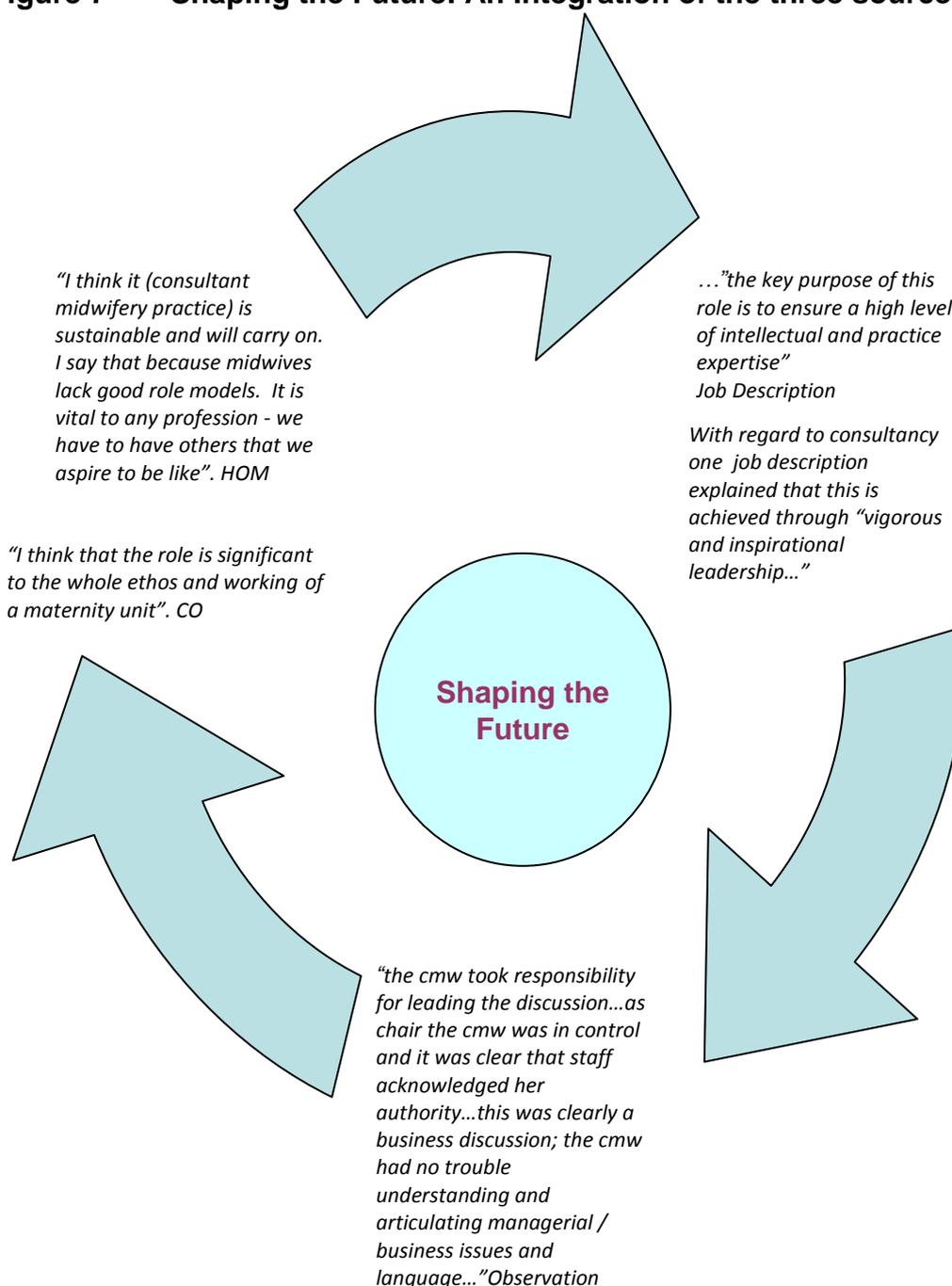
Additional documents provided as evidence by the consultant midwives emphasised their extended role and national profile. Confirmation was provided as to their involvement in professional and government committees, conference speaking and writing for publication. This evidence combined with what had been seen and heard during the episodes of data collection, emphasised the consultant midwives intellectual capacity and presence with regard to being at the forefront of professional development.

#### **4.6.4 Shaping the Future: An Integration of the Three Sources of Data**

To emphasise clarity, Figure 7 on page 129 depicts Theme three 'Shaping the Future'.

Surrounding the theme are examples from the three strands of data (interviews, observation and documentary analysis) which illustrate it.

**Figure 7 Shaping the Future: An Integration of the three sources of data**



#### 4.7 Theme Summary

Theme three 'Shaping the Future', focuses on consultant midwives as senior practitioners in relation to midwifery hierarchy and leaders within the profession. Leadership skills and intellectual and practice expertise made reference to the nature and scope of the role. Intellectual shrewdness was seen to equip these midwives with the readiness to prepare for the future.

## Chapter 4 Findings

When asked about the future for the maternity services predictions and objectives varied, some focused on current topical issues whilst others looked at the changing face of the maternity service and the need to maintain skills and midwifery led care. Stabilisation was seen as crucial as was being true to a midwife's sense of identity.

It was abundantly clear that the role of consultant midwife was limitless; it appeared to come down to the individual in relation to personal expectations, time management and support and realistic objectivity from within the organisation. In the main, heads of maternity services and obstetricians were conscious of the need not to overload their consultant midwives.

Strengths and limitations of the consultant midwife role were cited by all three participating groups. Role evaluation was seen as important and it was intimated that an evaluation from the Department of Health would be welcomed. In the short term, realistic job descriptions and on-going role review was recommended.

With regard to role sustainability in the current economic climate, time will tell if consultant midwives continue to be recruited. All job descriptions justifiably emphasise salaries in excess of what is considered normal for a registered midwife. Role sustainability does not however only relate to salary; role feasibility needs evaluating. Most of the job descriptions analysed were extremely detailed emphasising every aspect of the role. At first sight they appear unrealistic and it is anticipated that now consultant midwives have been in practice for more than a decade, newly revised job descriptions will emphasise individual negotiation, in line with the post holders experience and unit philosophy.

Most practitioners felt that succession planning was very valuable and sub-consciously had identified potential candidates for the role; nurturing the potential in others was seen as important. Staff development was a major focus; consultants were observed demonstrating sensitivity and awareness of individual needs and developmental requirements.

## 5 Discussion

### 5.1 Introduction

At the outset, the principal aim of this qualitative case study was to understand the role being undertaken by consultant midwives in English NHS Trusts. Following analysis of the literature and professional and Government policy documentation two research questions emerged:

- What is the role of the consultant midwife in contemporary midwifery practice?
- What are the perspectives of consultant midwives, heads of maternity services and consultant obstetricians on the role of the consultant midwife?

This penultimate chapter therefore centres on these two research questions and the themes which emerged following in-depth analysis and integration of data. It demonstrates how the findings from this study provide a credible explanation as to how consultant midwives are coping with the demands of modern day practice and how they are effecting practice development and moving the midwifery profession forward (Cooke 2005; Ambler 2006; Rogers 2010) at a time when practice development and effective leadership continues to undergo change and development (DH 2000; 2003; 2004; 2007; 2010; 2012).

As part of this discussion chapter, research focusing on the consultant midwife, published following the initial literature search (please refer to Chapter 2) was analysed. This was to compare the findings of more recent literature with those from this consultant midwife study. As has been explored, early research had focused not specifically on the consultant midwife role but on the combined experiences and challenges of consultant nurses, midwives and allied health practitioners. In relation to the number of participants involved and the breadth of research findings, the most significant early contributor was that of Guest et al (2001; 2004). Guest et al's preliminary study (2001) using a multi-method approach focused on the strengths of the role but also on limitations such as role confusion, lack of support and an excessive work load. The teams second study (Guest et al 2004), again a multi-method study, aimed to explore how the consultant role was developing and to assess impact on care provision in relation to Government policy. The team focused on what the consultant practitioners were doing largely in relation to leadership and management. Since 2004, significant further research contributions were made for example by Woodward et al (2005 and 2006); Redwood et al (2005); Humphreys et al (2007); Hardy and Snaith (2007); McSherry et al (2007).

Since 2007, literature continued to focus on evaluating the non - medical consultant role, achieving a consultant position and the role of the consultant with regard to enhancing research being undertaken in the practice setting (Mullen and Gavin-Daley (2010); Chiarella et al (2008); Mitchell et al (2010); Chummun and Tiran (2008); Barnes et al (2010); Rogers (2010). In 2010, NHS North West (Mullen and Gavin-Daley, 2010) published the results of an evaluation focusing on non-medical consultants practising within their Trust. Their objective was to calculate how many non-medical consultant practitioners there actually were and to understand their role and impact on practice. The research design was of mixed methodology with data collected from a large purposive sample of consultant practitioners and some stakeholders via focus groups and questionnaires. As with earlier work (Guest et al 2004) and the results of this consultant midwife study, the authors found that the non-medical consultants were practising in relation to the four original core competencies “albeit to different levels of complexity” (pg 5).

Although not focusing specifically on the consultant midwife role, the findings did resonate with those of this consultant midwife study, in relation to contribution to service quality and development, education and research involvement. Recommendations relating to organisational preparation prior to role uptake (Woodward 2005) and having realistic expectations also resonated. As with this consultant midwife study and others e.g. (Guest 2004), strategic leadership was found to be a major role component and was linked to clinical credibility and expertise. Similarly, excellent accounts of how non-medical practitioners were working in collaboration with others were provided, as were findings emphasising expert practice, innovation, service development and education and training.

In 2008, Chiarella et al reported on a review of Australian Clinical Nurse / Midwife Consultant roles using a questionnaire as a method of data collection. This was a convoluted study since its aim was to focus not only on nurse / midwife consultants but also on nurse / midwife practitioners. Questions also related to the validity of the tool used to collect data; this had been “developed by the Irish National Council for the Professional Development of Nursing and Midwifery and modified” (pg7). Commonalities between this consultant midwife study and the work of Chiarella et al (2008) related to service enthusiasm, multi-professional sharing, workforce planning, (organisational preparation, resources, support, succession planning) and collaborations with higher education.

As with the work of almost all researchers focusing on the consultant role, Mitchell et al’s (2010) objective was to demonstrate role complexity, identifying differences in relation to

other advanced practice roles. This study (interestingly classified as audit not research so as not to seek ethical approval) used written accounts to emphasise the nature of their roles and differences between the consultant role and other advanced or specialist roles. Four themes were identified “Entrepreneurial activity and innovation; Clinical autonomy and role dynamism; Influential national and international research conduct; Consultancy and education across discipline boundaries” (Mitchell et al 2010 p483). These wonderfully creative descriptors appear to have collectively emerged due to the innovative practice ventures experienced and documented by the participants. Comparisons with other advanced roles led to four key observations. Namely, that the complexity of the consultant role is not evident in literature; that the consultant nurse role is strategic and encompasses many skills and that consultant nurses have a good understanding of the nursing agenda. The consultant midwife study can easily identify with three of these interpretations. It may be argued however that the complexity of the role is actually clearly evident in the literature, by focusing on the many role interpretations in existence (Dawson and Coombs 2008; Charters et al (2005); Manley et al (2008).

Taking a different approach Chummun and Tiran (2008) focused on the application of research in clinical practice with twenty five articles selected and examined. The research emphasised a lack of research application and “research leadership” (pg 327) in practice largely due to time limitation. Engaging in research was one of the original DH features of the consultant role and evidence has shown different levels of research involvement across professional groups (Guest et al 2004). Advice is given as to the benefits of practising in a “research friendly organisation” (pg 331) and consultant nurses were urged to consider these benefits in relation to improved recruitment and retention rates and the provision of a “facilitating culture” (pg 331) where boundaries could be seen to be pushed. An organisational shift was urged and practice was encouraged to take on board the ethos of encouraging research activity. Research groups were suggested as vehicles by which consultant nurses could lead clinical research. The findings suggest that although practice is becoming more research friendly there is still a way to go in relation to breaking down barriers and reenergising staff. Certainly from the results of the consultant midwife study, active research involvement was limited, mainly due to time constraints rather than interest or academic ability. Consultant midwives were seen to be more likely to engage in short term audit activities where changes in practice could become more immediate. Due to current financial constraints resulting in a shortage of midwives, now may not be the time to engage clinicians further in research activities. Practice development however suggests that audit and research activities are not totally dormant and clearly indicates the need for on-going consultant practitioner involvement.

Taking another perspective in relation to recently published literature, findings from this consultant midwife study suggest that with regard to succession planning, midwives demonstrating potential are often easily identifiable, and in some locations were seen to be encouraged and offered opportunities to shadow consultant midwives already in post. As discussed previously, part of workforce planning focuses on succession planning, this is a way forward in identifying potential consultant midwives for the future (Mullen and Gavin-Daley 2010). An academic mentorship programme in England for potential consultant midwives, was set up in Southampton in 2008 (RCM 2009) and was credited early on with being a success (Byrom et al 2009). The catalyst for this new initiative and programme was led by a consultant midwife from Hampshire. Detail regarding this training programme was published by Rogers in 2010, including a full description of the programme with insights from the trainee consultant midwives. Clearly a steep learning curve with regard to the acquisition of leadership skills and engaging with service development projects, the training programme was seen as being a success particularly in relation to the support provided and the opportunities gained, by being carefully directed to connect with leaders of the profession and development initiatives. Also in 2010, the trainee consultant midwives published for themselves an article relating to their experiences of the consultant midwife training programme (Barnes et al 2010) highlighting their experiences at the beginning of the programme and their achievements and learning in relation to the four features of the consultant role. A major advantage of Rogers (2010) training programme relates to preparation. In contrast to this, many of the consultant midwives in this consultant midwife study, reported a lack of forethought and the need to “try things out” since limited guidance was available (Woodward et al 2005 and 2006). Finding suitable, experienced practitioners is essential if posts are to be filled by appropriate staff (Hardy and Snaith (2007). Whether it’s a training programme or an in-house period of acclimatisation, what is clear is that for the role of consultant midwife to remain sustainable, succession planning is key to successful appointment.

## **5.2 The Role of the Consultant Midwife**

As seen, threads link much of the literature already published on the non-medical practitioner. Commonalities linking previous research and this midwifery focused study are also visible. As a result of this research study new knowledge now firmly exists which places the consultant midwife in a position of power built on a foundation of clinically acquired wisdom, transformational leadership skills and a belief in woman centred care, required by a profession fit for the future. Three emerging themes represent this new understanding, these were entitled:

Having Clinical Wisdom

Taking Control

Shaping the Future

Through a process of observation and exploration, consultant midwives became the focus of an in-depth research study which provided insight into what the consultant midwife role was within modern day practice. The aim throughout was to make sense of the consultant midwife role and to focus on its intricacies. Previous research had alluded to the immeasurability of the role and the multiplicity of facets to it. In reality however, consultant midwives do not set out to compartmentalise their role, instead the role becomes an ever changing fusion of responsibilities as service demands become more convoluted. By undertaking this study it became possible to observe first hand what this fusion represented, by being invited 'in', to listen and to observe. The various pieces of the consultant midwife role needed to be seen as separate entities, as well as being assembled to build a complete picture. Consultant midwives, heads of maternity services and consultant obstetricians told the story aided by documentary analysis in the form of job descriptions.

Fortunately the eight consultant midwives participating in this study were keen to show what their work entailed and what the end results meant for themselves and for others. Commonalities observed included an overwhelming pride in their accomplishments, as well as a tangible sense of duty and an overt pride in the team of midwives in which they shared a passion for taking midwifery practice forward. Their responsibilities were observed as being considerable, but to the midwives participating, responsibility meant more than a contractual obligation, they were clearly captivated by a passion to succeed at the highest level and to take others with them. Participants identified that it would be hard to be a consultant midwife without being passionate; their enthusiasm for the role was captivating. One midwife reported (cmw 8.5 pg 90) that without passion a consultant midwife would fail since she would not be able to influence anyone. On this occasion, passion related to wanting to improve care for women

This is not to say that the midwives were not in any way unrealistic or unaffected by the demands of their position, or impeded by protocol, budgetary constraints or time. Like most senior employees working in large public sector organisations, they were used to being hindered by the every day obstructions, officialdom, formalities and slow pace of life that can constrain progress. What united them however was a visible confidence and self-belief, clearly grounded by the fact that their experience and expertise had been rewarded, in that they had secured a revered midwifery position rooted in practice, education and research. It was however unclear as to whether the midwives were genuinely aware as to just how effective they were at projecting this inner confidence. Recognition of their status, expertise and contributions made to practice was evident

through the ways in which the consultant midwives were received or sought by others and how they engaged seamlessly with staff across professions.

### **5.2.1 Clinical Wisdom**

The consultant midwives were observed demonstrating an overt clinical wisdom, reinforced by insightfulness and responsiveness. This was seen to be encapsulated within their practice and emphasised their clinical knowledge and reasoning gained involuntarily over years of professional practice. At times their practice was seen to be judicious yet perceptive, for example, they appeared intuitively aware of the salient issues constraining or affecting care provision and the need for progress or improvement through collaborative means. They projected a maturity in the way in which they managed themselves and in the developments they were inspired to embark upon. The consultant midwives clearly experienced professional pride by advancing practice, not in relation to increasing their own personal kudos but out of a genuine desire to orchestrate change through the advancement of others and sharing in multidimensional debate. In relation to the various observational episodes undertaken as part of this study, the consultant midwives were seen to be focused, rarely distracted and always fully absorbed in their activities. On reflection, the midwives were cognitively aware of the significance or consequences of their actions and the desired outcomes. In this case, clinical wisdom encompassed clinical ability, the enablement of others and role understanding; the midwives were acutely aware of the expectations placed upon them to facilitate change and development. The midwives interpreted 'practice' in relation to the percentage of they spent 'in practice', compared to the fifty per cent envisaged when the role of consultant was first established. Some felt that there was a degree of flexibility, some did not and some felt that 'being in practice' meant far more than practising clinically.

The midwives demonstrated wisdom in the way in which they conducted themselves. Literature acquaints wisdom with intellect, as well as knowledge, understanding and perception developed over time through personal experience (Haggerty and Grace 2007). The consultant midwives emphasised this cognitive awareness as a result of years of professional practice. The terms clinical wisdom and practice wisdom appear interchangeable and a fitting contemporary definition of practice wisdom is provided by Titchen and Higgs (2001 p275) as being "the possession of practice experience and knowledge together with the ability to use them critically, intuitively and practically..."

Through their observed actions and interactions, and in discussion with other participants (HOM 6:16 pg 76), the consultant midwives participating in this study were able to demonstrate that clinical wisdom develops out of actual and tacit experience and is multi-

faceted; often the coming together of a knowledgeable and clinically competent practitioner, skilled in the art of decision making, prioritizing and often the effective management of intellectually challenging situations. Through their actions they confirmed that clinical wisdom does come out of experience (Kunzman and Bates 2003) and that the ability to make quick and accurate clinical judgements follows years of professional practice and theoretical and experiential learning (Eraut 2000; Benner et al 1999).

Consultant midwifery practice encapsulated the art of clinical wisdom by verifying that even at the highest level, knowledge is not sufficient in isolation. “Emotional and intellectual sensitivity” (Haggerty and Grace 2008 p 239) as well as intuitive understanding (Banning 2008) form the additional necessary links. As with Trust 3, Observation 1 (pg 102), the consultant midwives capably demonstrated the art of knowing allied with intellectual sensitivity, influenced by years of practice experience, education and culture (Carr 2005). It also became clear from listening to all the participants that the acquisition and demonstration of knowledge is “continuously (being) created and recreated, (it remains) not just as an independent entity to be acquired and transmitted” (Kolb 1984 p38). Reflecting upon this traditional perspective, knowledge clearly needs exposure and the consultant midwives were able to experientially demonstrate and articulate this on an on-going basis. The consultant midwives shared their wisdom so that others could learn; they shared experiences and helped others make sense of new knowledge and its application (Carr 2005). The midwives knowledge and acquired skills were in a sense contagious; a snowballing effect meant that the less experienced developed in relation to their understanding, skills and confidence.

In relation to the acquisition of knowledge, the consultants participating in this study demonstrated that midwifery is both a science and an art and by its very nature demands skills in decision-making and in making judgements based on experience and knowledge. Clinical decision-making underpinned the work of the consultant midwife, with decisions made seen to effect clinical outcome and client and learner experience. For some of the participants the demands associated with being a consultant midwife did stretch far beyond their immediate practice area (cmw4:13, pg 127). Having a national presence meant understanding the national agenda and moving seamlessly between organisations so as to influence a wider audience. Like most practitioners, the consultant midwives appeared primarily to rely on their experience as a resource to aid decision-making. Thompson (2003 p231) questions “whether (such) experience is a sufficient basis for reliable clinical decision making”. Research evidence clearly demonstrates that clinical decision-making is affected by various factors not solely the level of experience (RCN 2010). In practice decisions taken by consultant midwives were observed to be made not in a solitary fashion with little more than experience to base judgements upon, but with

knowledge handed down by colleagues, through collaborative discussion and the use of research evidence in the form of guidelines and protocols. The use of research evidence was seen to combat biases which could have resulted from “uninformed decision making” (Thompson (2003 p231). It was also seen to reduce subjectivity by preventing unsupported predictions and by keeping hold of anxieties or over self-confidence.

Decision-making is a complex mechanism; whilst observing the midwives ‘in action’, it was clear that several intertwining processes were used in their decision making. Whilst listening attentively to some of their collaborative discussions, it was clear that conscious reasoning was clearly being applied, probably supported by instinctive tacit-knowledge and interpretation, likely to be as a result of years of professional expertise and clinical hands-on experience (Higgs and Titchen 2001; Gabbay and Le May 2011). According to Greenhalgh (2002) the often unclear processes by which decisions are made, are sometimes used by skilled practitioners where decisions are based on intuition which is hard to articulate. It became clear from observing and listening to the consultant midwives that the processes by which they made decisions would indeed require explanation to those with little professional knowledge. Most did make an effort to articulate a rationale for their actions, whether it were to clients or other staff members. One of the ways the midwives achieved this was through reference to national guidelines (please refer to page 78) and also in relation to the interpretation of nationally recognised statistics (please refer to page 79).

The consultant midwives reminded me as to how powerful a tool tacit knowledge is. Often likened to intuition or non-formal learning (Eraut 2000), it is distinctly personal to an individual and like a finger print relates to actual and emotional experiences (Benner 1999; Herbig et al 2001; Gabbay and le May 2011). A unique feature of tacit knowledge is that individuals often do not perceive learning to have taken place (Eraut 2000) or it to have guided their actions (Dienes and Berry 1997); however it is well known that intuitive actions often result in significant decisions being made. This was certainly the case in this study; the actions taken by the consultant midwives were profound, born out of experience, which was traceable and through reflection recognisable by the midwives themselves. Theorists are able to articulate where clinical knowledge and understanding comes from and are able to demonstrate that clinical decisions are based not only on acquired knowledge but on intuition which is personal, a result of intense professional experience (Herbig et al 2001; Benner et al 2009; Gabbay and le May 2004, 2011). Insight, perception, recognition and interpretation are often the words used to help describe tacit knowledge. In the earliest of the above, Herbig et al’s (2001) objective was to demystify tacit knowledge in nursing. The research team developed two research

questions; the first asked “do nurses who successfully deal with a critical nursing situation differ in their tacit knowledge from nurses who less successfully deal with the same situation”. The second asked, “what kind of differences between these two groups can be found and how do they relate to experience-guided working” (pg690). The research team simulated critical situations and although there were problems associated with data collection, results identified that successful nurses used ‘feelings’ effectively whilst the unsuccessful nurses felt that ‘feelings’ were disruptive and annoying. The research team inferred that tacit feelings “are a crucial aspect of the competence to deal with critical situations” (pg694).

More recently Gabbay and le May (2004) undertook an in-depth ethnographic study focusing on how practitioners in general practice make decisions, so as to understand the constituents of their knowledge and the basis of their decision making. The findings of the study again emphasise the power of tacit knowledge, born out of experience and a result of networking and multiple collaborations, not only with colleagues but directly and indirectly with everyone around them. This type of knowledge they encapsulated in the term “mindfulness” and the findings of the study are clearly transferable to other populations.

Herbig et al (2001) and Gabbay and le May (2004) both emphasise the importance of enabling individuals to reflect on interactions, collaborations and previous experiences, bringing tacit knowledge into the consciousness to assist decision-making (Eraut 2000). Like the practitioners in Gabbay and le May’s study (2004) consultant midwives demonstrated a fusion of experiences, interactions and collaborations all of which resulted in their ability to communicate and make critical judgements. Collaborative working (p85) was usually overt but was also implicit in the way the consultant midwives conducted their clinical activities. They worked autonomously, yet were mindful of the skills and practices of medical colleagues.

The exploration of story telling and narratives has been shown to uncover a wealth of rich intuitive and experience based knowledge able to inform clinical practice (Higgs and Titchen 2001; Hardy et al 2002). The consultant midwives participating in this study exuded enthusiasm for their stories to be told. The stories told were rich in detail based on years of experience, intuitive understanding and personal interpretation. By listening to the midwives reflecting upon their experiences as consultant practitioners, insight was revealed in relation to professional relationships formed and the potential of contemporary midwifery practice. In 2002, Hardy et al presented extracts of data from four nurses participating in the Royal College of Nursing Institute’s Expertise in Practice (pilot) Project.

The purpose of the project was for supervised practice and assisted reflection to explore what is meant by expertise in practice. The team revealed that “exploring a discourse of nursing expertise exposes the tacit nature of professional practice” (pg196). Although discourse analysis was not undertaken with the consultant midwives parallels may still be drawn. By listening to and analysing data obtained from interviewing the consultant midwives and listening to them whilst observing them in practice, it became clear that expertise manifests itself from various types of knowledge. It is this fusion of acquired and tacit knowledge that is so powerful resulting in practitioners being fit for the future but very aware of where they have come from and the importance of reflection in relation to relationships formed, the effect of organisational structures and hierarchy and political and clinical traditions affecting professional practice.

In 2005, Manley et al published the findings of the Royal College of Nursing (RCN) Expertise in Practice Project with the title, “Changing patients’ worlds through nursing practice expertise” emphasising the importance of understanding what constitutes practice expertise. They explained how the research team had worked beside six cohorts of nurses (between 1999 and 2002) in the United Kingdom and their “critical companions” (Wright and Titchen 2003). Data were collected via observation, action learning, 360° feedback and reflection and amalgamated into a portfolio of evidence. Critical companionships (Wright and Titchen 2003) in this case were practitioners selected by the participants themselves to help them develop, understand and verbalise their expertise in practice (Manley et al 2005). Three main research questions were developed based on action learning methodology, “How do we develop a recognition process for expertise; What is the nature of expertise in UK nursing and its different specialisms; How do we go about demonstrating impact of expertise”. Expertise as defined by Manley et al (2005 p25) was seen as being “the professional artistry and practice wisdom inherent in professional practice”.

In this consultant midwife study, expertise was identified as being central to the core of what constitutes clinical wisdom and was perceived as being a dominating factor through which the consultant midwives were seen to succeed in effecting change. Although identified but not defined by the Department of Health (NHS Executive, HSC1999/217) it has become one of the characteristic features of consultant practice (Guest 2001, 2004). As emphasised, parallels may be drawn between Manley and McCormack’s (1997) analysis of practice expertise and Manley et al’s Expertise in Practice Project (2005) with this consultant midwives study. The consultant midwives participating in this study demonstrated their wisdom through a display of their midwifery competence and credibility; their ability to make sound judgements; the forging of professional relationships

and successful collaborative working with women, their families and professional colleagues. The midwives confirmed that they were able to effectively utilise differing types of knowledge (tacit and taught) to guide their practice, make changes in practice and effect the outcome and experience for clients accessing midwifery services. They demonstrated a deep-rooted ability to respond to overt and hidden cues, recognising the needs of peers, colleagues, mothers and their families. Promoting and enabling accountability and the decision-making ability of others and recognising expertise in others was observed as being congruent to the consultant role. The consultant midwives performed professionally and by interpreting and putting into action their own clinical wisdom and expertise confirmed an understanding of the role of consultant midwife which is to enable others through professional change and development.

The consultant midwives demonstrated expertise and in part, their 'wisdom' lay in the way they were viewed in relation to competence and clinical credibility (cmw 8.2, pg 77). The consultant midwives felt pressurised to retain their competency, their ability to make clinical judgements and to practice proficiently. Being seen by others, to be competent in practice, gave the practitioner and the role of consultant midwife a degree of 'credibility'. The role of consultant midwife was clearly seen as being a clinical role and a senior position within practice; as such, a considerable amount of clinical practice experience was seen as being mandatory. The Department of Health's original definition of the consultant role did not implicitly specify clinical competence; it was however inferred through phrases such as 'expert practice', 'professional leadership' and 'practice development' (NHS Executive, HSC1999/217). Similar to the every day pressures placed on a range of healthcare practitioners, consultant midwives have to cope with conflicting responsibilities reducing time spent in practice and the maintenance of clinical skills and competencies. For consultant midwives remaining in their own Trust and entering the world of consultant practice via a clinical midwifery route, maintaining clinical credibility was easier; but as stated by Fisher (2005 p22) "clinical currency" does not last indefinitely and skills need to be practised.

Criticisms have long been associated with practitioners who have become far removed from practice and conversely practitioners based in practice, unable to link theoretical learning to practice. According to Goorapah (1997) and Fisher (2005 p22) the terms clinical competence and clinical credibility "are often ill defined and often used interchangeably in the literature". Goorapah (1997) investigated teachers' perceptions of clinical competence and clinical credibility identifying poor interpretation and specifically an imprecision when defining credibility. Baillie (1994) documents that clinical credibility is demonstrated through clinical ability; whilst dictionary definitions refer to credibility as

relating to 'authority', 'standing', 'influence' and 'aptitude'. The use of such defining words facilitates understanding as to why the consultant midwives in this study felt somewhat pressurised to maintain their clinical competencies thus ensuring that their 'clinical currency' is kept up-to-date.

Parallels can be drawn between the complex and multi-dimensional roles of the nurse or midwife teacher, the lecturer practitioner and the consultant midwife. Much of the work focusing on clinical competence and clinical credibility has to-date focused on the nurse teacher (e.g. Cave 2005; Williams and Taylor 2008; Ousey and Gallagher, 2010). Prior to such literature, Benner (1984) is well renowned for debating clinical competency in relation to level of experience and the progression from novice to expert. Focusing on the theory practice gap from an educational perspective, Cave (2005) questioned whether nurse teachers in higher education have a future if they are unable to demonstrate clinical competence. Evidence focusing on the lecturer practitioner, emphasises conflicts relating to time management and prioritisation of responsibilities and accountability (Lathlean 1992; 1997; Leigh et al 2005; Carnwell et al 2007), however in addition it does emphasise how students value this clinical resource, especially since they see lecturer practitioners as being central to practice and having realistic expectations based on contemporary clinical knowledge (Noonan et al 2009). Due to the multi-dimensional nature of the consultant midwife's role, it was therefore understandable as to why the midwives in the consultant midwife study were so keen to reflect their competency and retain their clinical currency or credibility.

In keeping with this important aspect to the role of consultant midwife, a three phase qualitative study undertaken in Wales explored managerial perceptions of mentor, lecturer practitioner and link tutor roles (Carnwell et al 2007). Using three NHS Trusts and two Higher Education Institutions participants were interviewed via focus groups and the transcribed data were analysed thematically. Although the study can't be generalized due to the small sample of participants, the findings are significant since they focused in part on the clinical competences of practitioners undertaking complex roles. The managers articulated that although the lecturer practitioners should have had a strong clinical presence, at the end of a secondment they were being "forced into an educational career because they were deskilled in clinical practice"pg27. A suggestion was made that in a supernumerary capacity they should be working clinically with students thus enabling themselves to remain updated and be 'seen' in practice thus "retain(ing) their clinical credibility"pg930.

Carnwell et al's (2007) findings resonate differently from those of a study undertaken a year earlier. The focus of Brown's (2006) qualitative study was to describe the lived experience of teaching for five lecturer practitioners practising in the south of England. Here the lecturer practitioners were portrayed as being at the core of clinical practice; they worked in practice "were visible to practitioners and patients...working in partnership with practitioners to enable change" pg 605.

Again focusing on the nurse teacher role and using focus groups to identify and discuss eleven nurse teacher's perceptions and experiences of undertaking clinical practice, Williams and Taylor (2008 p903-904) demonstrated that the views and experiences of individuals can vary considerably. Some of the participants in their study saw clinical practice as a time "for direct involvement in care giving", whilst others expressed different objectives emphasising "a lack of clarity in relation to what was expected from clinical practice". Interestingly, just as in the case of the consultant midwives, participants in Williams and Taylor's (2008) study spoke of the positives of undertaking clinical practice in relation to "maintaining clinical competence and clinical credibility" pg 904. As with the consultant midwives, barriers to working clinically included conflicts in relation to work load and institutional priorities. In an article entitled 'Clinical Credibility?' Ambler (2006) (a consultant midwife), questioned whether consultant midwives are able to maintain their clinical skills and credibility whilst undertaking the multi-faceted demands of the consultant role. She too commented on the paucity of literature focusing on clinical credibility. She like others worked part time as a consultant midwife managing to practice her clinical skills by maintaining a separate clinical contract "this fulfils my basic and personal need to work with women and their families, which may be why I do not feel my clinical skills and credibility are under threat" (pg145).

Ramage (2004) whilst concentrating on negotiating multiple roles, supports the views of consultant midwives, highlighting that clinical credibility can not be assumed or automatically be part of a role (cmw 1:13, pg83). It has to be earned or awarded and can contribute to considerable stress and tension in the workplace for those attempting to juggle multiple responsibilities. As seen in this consultant midwife study, managing multiple roles takes a phenomenal effort, it's a balancing act and negotiation on several levels is required if such roles are to be sustainable (Ramage, 2004; Noonan, 2009).

In assessing whether clinical competency relates to clinical wisdom and is an essential component of complex nursing and midwifery roles, individual roles need focusing upon in isolation, a collective opinion is unhelpful. For nursing and midwifery lecturers, maintaining clinical competency is not an integral part of their every day role and

responsibility (Ousey and Gallagher 2010); consultant midwives however are usually employed either fully or in part by practice and by definition are required to spend 50% of their time in practice (NHS Executive, HSC1999/217). Common sense however needs to prevail; where a role is as diverse as in the case of consultant midwives, individual manager / practitioner negotiations need to be practical and variance in what constitutes 'practice' accepted. All practitioners working 'in practice' emphasise their competencies in different ways and what equates to competence must be open to individual negotiation interpretation and tolerance. The consultant midwives passion for midwifery practice and their efforts to maintain 'clinical currency' was seen to be considerable.

The demonstration of clinical wisdom was also visible in the way in which the consultant midwives collaborated and acted as effective role models (CMW5:19, pg82). Extending career opportunities for experienced midwives was a major reason as to why the role of consultant midwife was originally developed (NHS Executive, HSC1998/045). Today, consultant midwives are acting as role models, inspiring those that follow and possibly being instrumental in maintaining a career pathway for experienced practitioners. Not all consultant midwives participating in this study spoke directly of acting as a role model for junior staff; it was however implicit in the manner in which they described their role and were observed undertaking their role. Most practitioners recognise that they have become the practitioners they are by observing the practice and practises of others. Role theory supports this view, in that practitioners perceive their identity as being shaped by those around them, by those who inspire them, and who in some way have affected their performance (Green 1988). Role modelling has been defined by generations in relation to the acquisition of common skills and attributes. In the nineteen sixties Bandura (1965) explored the fact that people generally do mimic exemplary behaviour whilst Kemper (1968 p33) described a role model as having acquired "skills and displays techniques that the individual lacks and from whom, by observation and comparison with their own performance, the individual can learn".

More recently others have focused clinically on the ability to transform and develop others in the clinical situation Donaldson and Carter 2005; Perry 2009). Using grounded theory Donaldson and Carter (2005) demonstrated the importance of role modelling in relation to the teaching and learning of adult nursing students. In total 42 student nurses participated; interviews and focus groups were used at different stages of the students training. Using constant comparative analysis the findings demonstrated that all students had been able to identify 'good' and 'bad' role models and that they had expected to identify practitioners whom they would be able to emulate "she [role model] was everything I was looking to become..." (a quotation from Donaldson and Carter's study

(2005)). Although on a relatively small scale and within a specific geographical location, this study does demonstrate the importance of having 'good' role models in the clinical setting, enhancing a student's learning and being instrumental in shaping learners for future practice.

Perry (2009) in a phenomenological study focused on role modeling excellence in clinical nursing practice. Like Guest et al (2004), Perry (2009) was interested in how craft knowledge is taught; 'craft' being that "which happens when nurses combine practice observations, clinical experience, knowledge and skill, to a specific patient centred purpose" (Price and Walker 2007 p49). This time Perry (2009) did not focus directly on students; instead qualified practitioners were interviewed in order to assess the ways in which they practised. The way in which they were recruited was unusual and possibly somewhat subjective or prone to bias in that the participants were identified by their colleagues. Nurses were asked "if you were ill, which of your nurse colleagues would you want to have care for you?" The hope was that exemplary nurses would be identified by their colleagues; this possibly could not be relied upon. Data were collected via interviews, conversations and observation. As in the case of the consultant midwives, Perry (2009) identified that the participants as well as being 'exemplary' nurses were also identified as "outstanding role models...they attended to the little things, making connections, actively role modeling, and affirming others" (Perry 2009 p39).

In conclusion, by examining clinical wisdom, this initial theme has been shown to epitomize the role of the consultant midwife in relation to their insightfulness and responsiveness, made visible through their clinical competency, role modelling and effective role interpretation. The participating consultant midwives had demonstrated an overt 'wisdom', an ability to make clinical judgements and formulate decisions. This was based on a readiness to emphasise expert practice whilst engaging with those around them.

### **5.2.2 Taking Control**

So far within this discussion of the study's findings, clinical wisdom has been explored in relation to consultant midwifery practice and threads have been drawn identifying the consultant midwives clinical competence, role modelling ability and practice interpretation. Another dominant theme running through the findings of this study related to leadership ability and how consultant midwives were seen to take control and act as 'transformational' leaders and change initiators within professional practice. One midwife described leadership as being part of the role (cmw3:26, pg 103). As with clinical expertise, leadership is another of the original core features of the consultant role

identified by the NHS Executive (HSC1999/217) and many of the attributes of clinical expertise pertain to leadership (Hardy and Snaith 2007).

Taking control however was not always so easy to achieve, due to the fact that the consultant midwives had no management responsibility and a host of organisational frustrations. One midwife explained that role negativity related to the enormity of the undertaking (CMW5:13, pg 106). The enormity of the role as described here was often overwhelming and being seen to be effective, thus creating visibility and a presence could be a problem. The role of consultant midwife was seen as complex yet isolating (cmw2:16, pg 110), support was essential, especially from the Head of Maternity Services, whom the consultant midwives worked so closely with.

In exercising professional leadership, consultant midwife job descriptions were seen to focus heavily on 'taking the lead' and 'being the lead for clinical practice', however no explicit references were made to 'having management responsibility'. Consultant midwives saw that there were both advantages and disadvantages to this, with one stating that she felt consultant midwives didn't necessarily crave management responsibility just the 'authority' to make things happen (cmw 6:25, pg 98). Having no power base meant that self-motivation was essential if influence in practice were to be a reality. Not having management responsibilities was however liberating permitting creativity, but this also meant that having the authority to make decisions was absent. Management in its entirety was not yearned for it was having the authority to lead so as to realise change and development.

Professional and policy related documents have long emphasised the need to develop leadership within the NHS, stressing links between improving quality and clinical outcome, use of resources and client and professional satisfaction (DH 1999, 2000, 2008a, 2008b 2009; Kings Fund 2007, DH 2012). In recent years the uptake for professional training in leadership has increased amongst many groups of practitioners and in relation to midwifery, examples of effective leadership can be seen relating not only to consultant practice but other senior midwifery positions as well e.g. Supervisors of Midwives. In recent DH publications (2008a, 2008b) focusing on nurses and midwives contribution to improving quality care, acknowledgment is given to prioritising and developing the leadership capabilities of midwives at differing organisational levels. The leadership aspect within the role of consultant midwife was seen as crucial by all groups of practitioners taking part in this study, in relation to supporting midwives in practice, instigating change and in relation to taking control whilst working collaboratively.

Effective leadership in midwifery is largely linked to increasing excellence in practice, upholding clinical governance and importantly facilitating choice for users of the maternity services (DH 2007). According to four aspiring consultant midwives, consultant practice is all about providing leadership “that influences and contributes to the strategic and operational planning of services” (Barnes et al 2010). Heads of maternity services participating in this consultant midwife study spoke of consultant midwives abilities aimed at empowering others and developing clinical skills whilst acting as role models and initiators of change. Links were made to change management, strategic innovation and importantly in relation to creating a culture able to promote and sustain individual development inspiring improvements in the delivery of midwifery care. Consultant midwives themselves spoke of the need to influence and to grasp leadership opportunities, often made more challenging by not having power based on managerial responsibility (cmw 8:4, pg 98).

The consultant midwives were observed being inspirational in the way by which they took control. An inspirational style does not come as part of a role or set of responsibilities, but tends to be developed within an individual over time by observing differing leadership styles within an organisation and is a coming together of inherent and learned behaviours (Hardy and Snaith 2007 p268). Theoretical concepts and ideas relating to leadership styles have been the subject of considerable discussion for many years amongst groups of researchers, educators and clinical specialists (Sadler 2003) and herald from disciplines relating to sociology and psychology. Whilst focusing on leadership in health care settings, Barr and Dowding (2008 p55) compartmentalised leaders into three different groups depending on their leadership behaviour “autocratic, democratic (and) laissez-faire”. The autocratic leader was by name controlling favouring hierarchy; the democratic leader was all encompassing and democratic involving others in decision-making, whilst the laissez-faire leader was “conscientiously makes the decision to pass the focus of power on to subordinate members” (pg55).

By nature traditional leaders do tend to be autocratic and hierarchical, whilst contemporary leadership models such as the Vroom-Jago Contingency model (1988) favour group participation, competence and commitment (Barr and Dowding 2008). Whilst observing the consultant midwives in practice and listening to the perspectives of team members and the consultant midwives themselves regarding the role of consultant midwife, it became clear that what was central to the role was not so much the individual midwife but a precise understanding and execution of what the organisation required. All groups of participants emphasised the need for collective working, shared values, intellectual and individualised stimulation i.e. a focused, transformational style of

leadership which centred on motivating others. One midwife in particular spoke of motivating others and the need to be inclusive (cmw8:28, pg 103).

Facilitating a single style of leadership is possibly unsustainable due to the complex nature of activities involved and the fact that people become shaped by all that is around them e.g. unit policy, management hierarchy (McIntosh and Tolson (2008). Whilst undertaking this consultant midwife study however, the traditional transactional style of leadership was not observed in practice. This created a sense of relief, since it is likely that this would not have been welcome by staff, students and clients. According to Avery (2004) the attributes of a transactional leader are traditional in relation to valuing organisational hierarchy and not so facilitating in times of change. The transactional leader uses incentives and sometimes coercion in relation to getting a project completed, opinions tend to be sought but the leader makes the ultimate decision. The midwives observed did demonstrate the need for control, but in a more supportive and facilitating way, wholly reminiscent of a transformational style of leadership.

Focusing on the practice setting, Gopee and Galloway (2009 p59) defined some of the qualities of a transactional leader (in italics below). These attributes were 'not' seen to be suited to consultant practice or the demands of contemporary midwifery practice, for example,

*"Aims to maintain equilibrium and status quo"* (generally, the consultant midwives participating in this study were observed verbalising and demonstrating an appreciation for a stable working environment by practising in accordance with the philosophy of the maternity unit; they were however skilled at identifying the need for change and not being afraid to instigate change);

*"Is task-centred and orderly"* (the consultant midwives were inspired, lateral thinkers, inclusive and practised at sharing a new vision with the team);

*"Performs tasks strictly according to policies and procedures"* (consultant midwives were imaginative and inventive with a vision for the future of midwifery, keen to inspire other midwives and the wider collaborative team);

*"Has a short or medium term focus"* (the consultant midwives could see the long term; some of the initiatives instigated and managed were far reaching aimed at changing traditional thinking and improving services and outcomes for childbearing women);

*"Coaches and fosters sheltered learning"* (the consultant midwives were seen to seek out midwives with specific learning requirements as well as instigating more major unit updates as well as conference speaking on a national perspective);

*“High self-interest”* (the consultant midwives were not overtly spurred on by self-interest, they all demonstrated a passion for what they were doing and their enthusiasm was contagious far reaching and did make a difference;

*“Sees home and work as separate entities”* (the role of consultant midwife was seen to be overwhelming at times; working extra hours appeared to be ‘part of the job’). (Gopee and Galloway 2009 p59)

A transformational style of leadership (motivation, encouragement and long term vision) was clearly observed and was seen as being more suited to taking the midwifery profession forward (Hinchliffe 2010, Ralston 2005). The attributes of a transformational approach including charisma, intellect, inspiration, vision, commitment, dedicated participation and the art of collaborative decision-making (Avery 2004) became recognisable. What was clear was that a transformational leaders’ power comes from others (Ralston 2005); staff, students and clients were treated with respect and as equal contributors in facilitating change.

Research focusing on leadership and the consultant role was largely initiated by Manley (2000a, 2000b) who recognised the attributes of a transformational style of leadership within consultant practice. Recently, McIntosh and Tolson (2008) undertook an evaluation of consultant nursing in Scotland; a research paper followed focusing specifically on leadership as part of the consultant role. Data was collected using semi-structured interviews over a period of nine months; consultant nurses and stakeholders participated to reveal a clear understanding of leadership processes in consultant nurse practice. As in England the leadership element of the consultant nurse role was noteworthy. As with this study and the findings of others (Guest et al 2001, 2004) leadership was linked to working at a “strategic level, undertaking practice and service development (and) giving an educational contribution (McIntosh and Tolson 2008). As with the consultant midwife study echoes of transformational leadership were evident and likewise the nurses did not have a totally free reign, having to negotiate with managers at a senior level, emphasising the challenges that can arise when dealing with hierarchy and the importance of forging positive working relationships. Also in accordance with McIntosh and Tolson (2008) the consultant midwife study reflected the enormous effort being taken by midwives, in relation to cognitive effort and interpersonal skills to effect change and development through transformational leadership.

Recent research has also focused on the effects transformational leadership has on followers’ work and well-being (Murphy 2005; Nielsen et al 2008, 2009; O’ Brien et al 2008). Although the consultant midwife study did not specifically set out to concentrate on

the midwives style of leadership and its effect on other midwives and colleagues, observations were made with regard to how infectious enthusiasm for change and development can be, inspiring creativity, participation and a shared vision. This observation is supported by a longitudinal questionnaire study focusing on whether there is a relationship between leadership style and well-being (Nielsen et al (2008)). Although the research team highlight some reservations in relation to the length of questionnaire; the research population and the use of uni-dimensional scales of transformational leadership, implications for practice are noteworthy in relation to the study's findings. The results primarily emphasise how important it is for managers to be aware of the degree to which they are able to influence employees' wellbeing and ability to implement organisational change.

In summary, what transpired from observing the consultant midwives and hearing of their challenges was that being an effective leader and being able to take control, comes from within and is supportive and facilitating. Managerial responsibility wasn't seen to be mandatory, what was required was an ability to take hold of an initiative and with confidence influence others thereby facilitating change. The consultant midwives did not abdicate responsibility, they were proof to the fact that midwives can and should grasp opportunities to instigate change, making a difference for women and their families as well as the working environment for themselves and others.

### **5.2.3 Shaping the Future**

The third dominant theme emerging from this study of consultant midwives related to role sustainability and the future of the service. At a time of financial austerity and NHS reform it could be argued that consultant practice is an extravagance that the health service can no longer afford; this study has shown however that consultant midwifery practice is very much at the core of midwifery's future (please refer to pages 117 and 118). Retaining these highly experienced, knowledgeable and clinically competent professionals is essential, not only on an organisational level but due to the fact that consultant practice equates to and even defines midwifery practice in relation to taking the profession forward, capitalising on creativity and preparing for future organisational needs.

All three groups of participants in this study provided multiple examples by which consultant midwife practice had improved outcomes for women, their families and for the professionals providing the care. Although advocates for the consultant midwife role, comments from all groups of participants emphasised the enormity of the role and the need to manage objectives, so as not to overload. For a role to be successful it needs to be sustainable; the consultant midwives emphasised how, in an ever changing work

environment, they had a responsibility to pass practice knowledge on not only to those around them but to the next generation of midwives (please refer to pages 119 and 120). Likewise, in British Columbia, Clauson et al (2010 p1) recently demonstrated this by initiating a project namely the 'legacy mentor project'. Likewise, the Canadian team held a view that with an on-going cascade of changes affecting healthcare practice it is essential to "capture and build upon the insight and knowledge of senior practitioners". Establishment of this project also followed recognition of the fact that the knowledge and experience accrued by nurses over time, was valuable to the profession and in particular to junior staff. The focus of this project was to disseminate older practitioners "wisdom" (pg1) and retain their employment for longer. Not only were senior nurses in Canada retained in practice, but as with the consultant midwives in this study, by acting as 'mentors' their skills and experiences were seen to palpably improve practitioner's capacity to act and make the judgements as well as increasing multi-professional collaboration.

Role sustainability involves the identification of suitably equipped personnel to take on roles when vacancies become available; as seen from the consultant midwife study "it is a process that allows retention of intellectual and knowledge capital by identifying and preparing potential successors to assume new roles, thus encouraging individual advancement" (Carriere et al 2009). Garman and Glawe (2004) emphasise the importance of not only identifying the right person or people, but tracing their developmental needs and supporting them from an organizational resource perspective. These sentiments are echoed not only in this consultant midwife study but also through the research of Guest et al (2004); Woodward et al (2006). Many of the participants interviewed in this consultant midwife study felt that succession planning was essential and either consciously or sub-consciously had identified potential candidates for the role (pages 119 and 120). In addition, the participants had articulated concern relating to midwife shortages and retention issues due to poorly developed career pathways, issues seen to exacerbate the need for succession planning initiatives.

Implicit in the job descriptions analysed, was a sense that consultant midwives are senior practitioners in relation to midwifery hierarchy. The role was seen to represent intellectual and practice expertise, a corner stone to a profession fit for the future. Being a senior member necessitated best practice and professional leadership, through which strategic planning resulted in new initiatives and significant local development. As senior practitioners the consultant midwives were viewed as role models in relation to maintaining standards, behaviour and professionalism, so as to sustain public confidence and trust.

The consultant midwives acted as change agents implementing evidence based practice whilst monitoring quality mechanisms to maintain safe, contemporary practice. Many of the consultant midwives participating in the study did have a clear vision for the future for the maternity services, with many identifying inequality and caring for vulnerable individuals as key issues to be focused upon (cmw 3:40; HOM 5:34).

### **5.3 Summary of Discussion**

This penultimate chapter has centred on defining some of the intricacies of the consultant midwife role, as a result of this in-depth case study. The study's two research questions and the themes which emerged following analysis and integration of the three streams of data collected have been the primary focus for discussion. Central to the role of the consultant midwife is clinical wisdom which when analysed equates to much more than the role ever set out to achieve. It encapsulates the complexities of what constitutes professional knowledge and the passion and drive needed to inspire change and lead others to a new future, whilst contending with on-going organisational difficulties. The challenge of leadership in the absence of managerial responsibility became a debating point. Being able to influence change and development without power was for some a major frustration. Although obstacles were seen to stand in the way of progress and role fulfilment, the consultant midwives' enthusiasm for the role, in which they strove to achieve excellence in, was invigorating. Observing them and hearing of their initiatives and future objectives provided a sense of security for the future of the profession. The coming together of perspectives, from all three groups of practitioners participating in the study, provided testimony to the fact that the consultant midwife role has delivered and does have a secure place within a new NHS.

## **6 Conclusions and Recommendations**

### **6.1 Introduction**

This research study centring on the consultant midwife was undertaken due to there being limited research evidence focusing on the consultant role, specifically from a midwifery perspective. Its intention was to answer two research questions, namely what is the role of the consultant midwife in contemporary midwifery practice and what are the perspectives of consultant midwives, heads of maternity services and consultant obstetricians on the role of the consultant midwife?

Consultant nurse, midwife and allied health roles had been conceived in the nineteen nineties (NHS Executive, HSC1998/045; NHS Executive, HSC1998/161; NHS Executive, HSC1999/217), as different ways of managing health care were analysed (DH 1991; DH 1997a; DH 1997b; DH 1999a; DH 1999b; UKCC 1999). A new approach had been sought due to concerns over recruitment and retention of senior staff, which reflected a more adaptable, creative and mutual workforce, where senior practitioners were given the ability to develop practice and strengthen their leadership (NHS Executive, HSC1998/045). It was envisaged that this would lead to an improved career structure, retention of staff and improvements in outcomes for service users (NHS Executive, HSC1999/217). At the time, it was seen that these experienced practitioners would play a valuable part in moving health care forward and the NHS Plan had encapsulated the Government's modernization plan for the NHS, emphasising a commitment to investing in new practice leaders (DH 2000). The four key functions of the consultant role had been defined and were linked to expert practice; leadership; education and service development (NHS Executive, HSC1999/217).

Midwifery continues to evolve in response to the changing needs of childbearing women and their families (DH 2007), at the time it was anticipated that by gaining multiple perspectives of the consultant midwife role, a clear understanding would be obtained as to the influence these midwives are having on the development and provision of midwifery care. A review of the literature commenced in tandem with research design and the application for ethical approval. Much of the primary literature focusing on the consultant role had previously been undertaken by non-midwives (Guest 2001, 2004) and naturally concentrated not only on midwives but on nurses, health visitors and allied health care professionals acting in a consultant capacity.

Narratives written by consultant midwives proved invaluable and insightful. Such literature emphasised the significant effect consultant practitioners were having on client care and delivery. Strengths and limitations of the role were highlighted with concerns relating to

role overload, lack of organisational support (Woodward et al 2006, Stephens 2006, McSherry et al 2007) and a generalised feeling of being under prepared for the role (Macrory 2003, Charters et al 2005).

Primary evidence suggested activity around expert practice and practice development (Redwood et al 2005; Rogers and Cunningham 2007; Dawson and Coombs 2008). Background characteristics relating to previous experience and academic ability (e.g. a Masters degree) had been explored (Guest et al 2004; Woodward et al 2005; Booth et al 2006) and transformational leadership appeared well within the remit of consultant practitioners (Manley 2000a and b). It was quite difficult however, to extrapolate findings specific to an individual professional group e.g. midwifery. It was due to this that a midwifery specific research study focusing on the experiences of consultant midwives was undertaken.

Having provided a brief synopsis as to why this research study was designed and undertaken, this chapter now focuses on summarising the study's strengths and limitations as well as some of the obstacles encountered. Having answered the study's research questions, this final chapter emphasises implications for midwifery policy and future research as a result of the study's findings.

## **6.2 Design Strengths and Limitations including Obstacles Encountered**

The purpose of this study was to analyse the role of the consultant midwife by observing a number of consultant midwives in practice and by gaining perspectives of the role from consultant midwives themselves as well as heads of midwifery and consultant obstetricians practising in NHS Trusts across parts of England. A major strength of this study lies in the fact that to date no other research study has concentrated solely on midwifery consultants; this study paved the way in providing a clearer understanding of the role, by observing practice and by gaining multiple points of view.

It was clear from the start that a systematic approach to research design would help support the study's trustworthiness. On reflecting on the process of research design and its application it was evident that considerable effort had been taken to ensure consistency and accuracy, through from the proposal stage, to analysis of findings. Having considered justification for the study, a significant amount of time had been taken to ensure that the research title accurately illustrated the study's objectives and more importantly the research questions relating to the consultant midwife role and the perspectives sought from consultant midwives, heads of maternity services and consultant obstetricians. In posing the two research questions, the intention was to witness at first

hand consultant midwife practice and what consultant midwives and others understood the role to be.

Having concluded this project it was clear that the qualitative methodology used had ensured interpretation, a holistic perspective and a clear understanding (Denzin and Lincoln 2000). This qualitative methodology had ensured that actions, interactions, attitudes, beliefs and experiences were observed and questioned (Robson, 2002). By using this methodology it had been possible to analyse and understand the role of the consultant midwife from a range of perspectives.

To achieve a true understanding of the consultant midwife role it had been important to consider the correlation between personal theoretical views and the methodology chosen (Crotty 2003). Constructivism had been identified as the way to access this knowledge or understanding of the consultant midwife role and having defined constructivism, it was seen that the knowledge sought would ultimately be constructed from experience and social contact or communication (Robson 2002). Objective data collection and data analysis did result but only once reflexivity had been considered and personal behaviour patterns questioned, i.e. the need to remain conscious of one's personal actions and how they might unwittingly inhibit participant participation or interaction (Kingdon 2005). This process of identifying a philosophical perspective concurrent with research design did enable the "creative and rigorous structuring of ideas that projected a tentative, purposeful, and systematic view of the phenomena" (Chinn and Kramer 2004 p91).

Another of this study's strengths related to the chosen research approach that of case study. Case study was an asset in that it facilitated the collection of information by using varied data collection methods (Yin, 2003; Zucker 2001; Appleton, 2002; Stake 2000) thus increasing the study's objectivity and generalisability. It was however, one of the most complex aspects of the study's design, due to definition of the actual case. There appeared to be multiple interpretations (Robson 2000; Stake 2000; Appleton 2002; Yin 2003) and conflicting ideas relating to case study and much time was taken firstly in understanding traditional interpretations, before one's own perspective could be illustrated and relied upon.

Amidst these multiple interpretations of 'a case', it became possible to enquire whether it was vital to follow traditional definitions and pathways strictly (Appleton 2002). After hours of reading and consideration, Moule and Goodman's (2009) definition, resembling Stake's "Intrinsic Case Study" (2000, 437), appeared to encapsulate the definition of case study that had been envisaged; a single case incorporating a number of individuals where a

number of methods are used to collect data. Thus, the 'case' had finally been identified resulting in the consultant midwives becoming the focal point of the study (Parahoo, 2006; Creswell 1998). Data was successfully collected emphasising understanding as to this little known phenomenon. This interpretation of case study enabled data to be collected from different sources and for social contact to result in understanding and description (Robson 2002).

A major obstacle encountered was the time taken to secure ethical approval, specifically Research and Development (R&D) approval from the multiple NHS Trusts participating in the study. An on-line application via The Central Office for Research Ethics Committees (COREC) for Multiple Research Ethical Committee Approval (MREC) had been made. Although a complicated system especially for the novice, the process was relatively straight forward and approval was given with only minor changes requested i.e. an information sheet and informed consent form specifically for clients (in the event that observation involved the consultant midwife performing clinically). Naïve to the fact that R&D approval takes a considerable amount of time following MREC approval (with application forms or on-line application processes varying in type and degrees of complexity with each Trust) time was wasted waiting for approval before data collection could start. On reflection and in relation to time management, this was a useful lesson learned. Fortunately COREC has now been superseded by a more efficient and integrated on-line research ethics application service (IRAS).

Although a painstakingly long time had been endured in designing the study and in obtaining ethical and R&D approval, satisfaction resulted from the fact that ethical considerations were visible at each stage of the research process. It was important to demonstrate values such as respect, trust and confidentiality, put in place to protect participants and present an honest portrayal of the consultant midwife role. Although securing ethical approval was essential for the research to begin, it became more than an example of how key ethical principles had been enacted upon during the research process. It was used as a framework or jigsaw by which the study was designed and implemented.

It could be argued that a limitation of the study relates to generalizability, due to the small numbers of consultant midwives participating. The purpose of this study however was not just to focus on consultant midwife experience but to formulate an understanding of their role from a wider view point. Consultant midwives were obviously the main focus, but views and experiences from staff members were extremely valuable, providing a fuller picture. Overall the amount of data collected and analysed was significant; a larger

sample of consultant midwives could have been recruited but this would have made the study unmanageable, especially with regard to the manual transcription and analysis of data which had been planned. Selection and recruitment of participants was not however without its problems. All three groups of participants were selected specifically in relation to their role, experience and knowledge. The selection process began unhindered; prior to recruiting participants, a group of consultant midwives had been identified and a short presentation on the proposed research study delivered. The purpose was to elicit interest in the study and to explain the purpose of the research, chosen methodology and the participation required. Following the presentation, twenty consultant midwives showed interest in participating in the study and provided contact details and information as to how long they had been employed as a consultant midwife. Confidence was high and initially it appeared that recruiting ten experienced consultant midwives from ten different NHS Trusts in England would be fairly straightforward, due to the interest generated as a result of the presentation. Unaware that following MREC approval, a time delay would be incurred whilst waiting for Research and Development approval, several consultant midwives identified as possible participants, had either changed their role within the Trust or temporarily left the service. The consultant midwives experience mattered and although there were newly appointed midwives in post, only midwives with a minimum of two years experience as a consultant midwife were to be recruited. Adhering to this inclusion clause and obtaining R & D approval from what became unnecessary Trusts; eight consultant midwives were finally recruited. Fortunately, in all but one case, the recruitment of obstetricians and heads of midwifery was fairly straightforward. All that was asked was for the consultant midwives to select medical practitioners who understood the role of the consultant midwife and had worked closely with them in practice for two or more years; the heads of maternity services were all in post and were keen to participate in the study. One minor obstacle involved timing the periods of observation and interviews, in most cases these were timetabled for one day, others stretched over a few days due to diary obligations.

Although an inordinate amount of time had been spent preparing for data collection, collecting data from different sources did ultimately result in a clear understanding and description (Robson, 2002) of the consultant midwife role. Time taken to undertake the pilot study was also worth while; this ultimately involved testing the interview guides and observation tool (Polit and Beck, 2006), resulting in minor changes to be made to the interview guides, by removing repetitive questions and improving clarity. Interviewing the consultant midwives first was as planned a sensible approach. It provided the necessary time to think about their responses, views and experiences, prior to the observational episodes and the remaining two interviews. Quiet reflection whilst waiting for the next interview or episode of observation, resulted in notes being read or made and thoughts

being given as to any change in approach or additional questions to be asked. In contrast, an advantage of observing the midwives prior to observing them did mean that any queries relating to the observation were able to be followed up at interview.

Remaining detached and objective throughout the various episodes of data collection was challenging, but knowing the effect that minimizing one's influence (Streubert Speziale and Rinaldi Carpenter 2011) has on increasing objectivity and the quality of data collected, every effort was taken to remain focused. Although a form for observational notes was created, with headings relating to the "dimensions of (the) descriptive observation" (Robson 2002, p320), documenting all the interactions observed was difficult. The observational notes taken provided an excellent record of the witnessed episodes and were used to exemplify and support data received at interview, however not every word or gesture could be recorded for analysis post the event. On reflection, recording the communications or using film would have created a fuller more permanent picture, which could have been analysed in more detail post the event. This however, would have been more intrusive for the clients and midwives involved, both may have felt inhibited and the clients may even have refused consent. Although the recording of observational evidence could be criticized, these experiences or insights into the role of the consultant midwife proved invaluable. Fortunately, a decision had been made to ask the consultant midwives to identify for themselves activities that they felt epitomised their role as a consultant midwife and were appropriate to be observed. Unknowingly, this had been a brilliant idea; the midwives knew what needed capturing to illustrate the uniqueness of their role. By observing a range of activities it was possible to observe various clinical interactions, communication styles and the transfer of information between professionals.

Another strong point to this study lay in the approach taken to analyse the research data. The aim was to make sense of (the) large amounts of narrative material and "to organise, provide structure to, and elicit meaning" (Polit and Beck, 2006:397). Where possible, episodes of simultaneous data collection and preliminary analysis had ensured emerging issues were considered (Endacott 2005), letting each interview inform the next one. All recordings were transcribed verbatim and the process of thematic analysis was undertaken manually so as to ensure accuracy and to help with data familiarity. Due to the amount of data needing to be analysed, the mechanism by which data was coded needed careful thought. The process needed to be logical and easily traced; creating preliminary and broader codes resulting in themes helped provide transparency, this was further assisted with the help of diagrams. Following thematic analysis of the transcribed data, the observational notes and job descriptions were analysed and extracts were used as supporting evidence, integrated with the interview findings, to provide a full description

of the consultant midwife's role. This process worked well and the result was a clear identification of the consultant midwife role from multiple perspectives.

In relation to rigour it was important to project objectivity providing assurance in relation to trustworthiness. In relation to this, a coherent and meticulous research design has been reflected. Strength lies with the fact that the study design was flexible and adhered to the characteristics of flexibility (Polit and Beck, 2006; Robson, 2002; Creswell, 1998) e.g. the study was holistic in design; more than two methods of data collection were used; the means by which the data were collected was clearly documented; the research design was 'emergent' i.e. on-going design issues were considered in relation to what needed to be established and rigorous data analysis was undertaken with verification of accuracy by the researcher.

The study's integrity or credibility was emphasized by its transparency and accuracy of planning and honest data collection. The use of triangulation via three methods of data collection increased the study's credibility as did a reflexive approach to data collection and overall study design. Dependability was made explicit to the reader by ensuring that each step of the research process could be traced. Consistency in approach was thus seen as being crucial. A limitation of the study could be argued in relation to the fact that team analysis of data (Denzin and Lincoln 2000) had not been undertaken to help prevent bias. There were sound methodological and ethical reasons for not using team analysis as discussed in chapter three.

Transferability, the final piece in the jigsaw denoting a study's confirmability (Lincoln and Guba 2000), refers to consideration being given to provide sufficient detail for others to make connections and compare findings to other circumstances. Concern related to the fact that by focusing on a single case, the findings may not easily be generalisable (Corcoran, 2004). This was not the case in this instance; the findings of the consultant midwife study were transferable to the wider consultant midwife population and did contribute to the evidence base on consultant midwife practice.

### **6.3 Specific Implications for Midwifery Policy and Practice**

Over time, the midwifery profession has experienced considerable pressure and disruption as a result of changed political opinion and public expectation. Today the challenges we face as midwives are no less extraordinary, caused largely by the austere financial circumstances that force a stranglehold on Britain and the resulting cuts and reduced resources made available to the NHS. To emphasise the scale of the problem, following a review of the NHS, spending efficiencies need to be made to prevent an

escalation in health spending from £104 billion in 2010-11 to £114 billion in 2014-15 (Centre for Workforce Intelligence) (Dunkley and Haider 2011 p4). Parallel to this, concerns escalate as to the uncertainties relating to NHS commissioning and the commissioning of maternity services and planned Strategic Health Authority cuts affecting student midwife numbers (Editor of Midwives 2011). More than ever, high standards, that improve the lives of mothers and babies (Lewis 2011), need protecting and united midwifery voices need to resonate strategically at both a national and local level. As numbers of midwives diminish or are not replenished and services become more vulnerable (RCM 2010) leaving advances in midwifery to become curtailed, support for midwives is now more crucial than ever. As the birth rate increased (“a 2.4% increase in live births in the last year alone” (ONS 2011; Guardian 2011) and whilst voicing concern as to the Government reneging on its promise to increase midwife numbers, Cathy Warwick calculated that 4700 more midwives were needed to maintain safe services for women (Editor of Midwives 2011). Keeping the vision of a sustainable safe maternity service alive, shared practice and collaborative working with influential leaders investing in people, it is hoped that it may still be possible to realise targets, standards and expectations.

According to the House of Commons Health Select Committee (2007) almost three quarters of NHS spending is on staffing. With this in mind and whilst focusing on the current savings required by the Department of Health, it is right for us to be concerned as to the future of more highly paid NHS practitioners. In midwifery, as resources become threatened concerns echo regarding the sustainability of the consultant midwife. The argument however for maintaining the consultant midwife centres on the strong leadership and wisdom they provide. Consultant midwives have been seen to have a significant impact on service provision, outcomes for women and support for midwives. The findings of this study resonate the work of others (Guest et al 2001, 2004) who have demonstrated, also through a variety of approaches that leadership and expert practice are central to the consultant role. As challenges within the profession multiply, midwifery experience shows that strong leaders are a vital commodity one which needs to be nurtured, educated and supported (Johnson and Dale 2011). Conversely, concerns regarding staff attrition are also focused upon more keenly at a time of reorganisation, allied with concerns relating to an aging workforce of experienced practitioners, the consultant needs to be focused upon as an opportunity for Trusts to retain their senior staff, promoting knowledge and leadership ability (Department of Health 2011). Reflecting on the “under - supply of midwives”, Dunkley and Haider, from The Centre for Workforce Intelligence (2011:44) focused on initiatives to retain staff and agree that skill-mix is all important, with maternity support workers, midwives and consultant midwives working

together. Utilising staff appropriately, thus making efficiency savings and working collaboratively (a key feature of the consultant role), is according to the Kings Fund and others, essential if services are to be managed appropriately (Price 2011) and lives saved (Lewis 2011).

Lead by Professor Steve Field, The NHS Future Forum (Field 2011) recently led on listening and recommending on changes to Andrew Lansley's controversial White Paper *Equity and Excellence: Liberating the NHS* (DH 2011) regarding our future NHS including highly controversial changes to NHS commissioning. "The four core themes of this NHS listening exercise (related to) choice and competition; public accountability and patient involvement; clinical advice and leadership and education and training" (Field 2011 p3). Core features of the consultant midwife role were immediately recognisable within the document e.g. the importance of effective leadership, collaborative working, patient choice and support for clinicians. This study has shown the consultant midwife to be heavily involved in "focused leadership" (pg 13) and "multi-professional involvement and leadership" (pg 28), both key recommendations for a significantly improved service. The forum also emphasised the importance of supporting staff, engaging in continuing professional development, taking on of new roles and responsibilities, using research effectively and promoting innovation; all are key features of the consultant role, surely making the role sustainable and a key element of the newly structured NHS.

In response to the NHS Future Forum (Field 2011) the RCM (2011) added additional recommendations from a midwifery perspective. Apart from making recommendations relating to the commissioning of maternity services, the RCM (2011; RCM 2012) emphasised the importance of networking, a visible midwifery presence and advocating choice of care (not just provider). As has been seen from practice, the consultant midwife epitomises the experience and knowledge needed to respond and make recommendations on behalf of the profession at such a strategic level.

With regard to championing normal birth, this study has depicted consultant midwives making progress in increasing home birth numbers, establishing birth centres, reducing caesarean section rates through VBAC initiatives and overall promoting normality and midwife led care. Playing to the strength of consultant midwives, recommendations have been made to increase midwifery models of care for low risk women (Sandall et al 2011), but as services are put under stress by a reduction in staff numbers and other available resources, initiatives naturally become strained and the fight to retain and develop services and initiatives becomes more onerous. Recent concerns may be cited e.g. a reduction in the home birth rate in England and Wales, down from 2.9% in 2008 to 2.7% in

2009 (ONS 2010). Overall there is concern as to how an increasing birth rate and a population of more complex cases (Bonar 2010) can be cared for effectively.

As midwives we practise at a time when reducing risk and medical negligence is central to our working lives (Doherty 2010). Complex cases, an increase in birth rate, staff shortages and reduced resources go hand in hand with maintaining targets and providing a safe service, whilst at the same time navigating a culture of blame through the reporting of incidents. More than ever support for midwives working in stressful and demanding environments is needed. Support can be variable and varied, with a multiplicity of midwives (managers, supervisors of midwives, practice liaison midwives) all contributing to a greater or lesser extent. This study has shown that an advantage of the consultant midwife role is that by being supernumerary, consultant midwives are more available to identify midwives and practice areas needing support, updating or auditing. Support is vital to a safe and efficient service, with time needing to be spent for “inspiration, reflection and to refresh our professional vision” (Warwick 2010 p05). A huge part of the consultant midwife’s role has been seen to be in averting clinical negligence; by ensuring that national research based guidelines are interpreted locally, put into action and care audited. Consultant midwives have been seen to be a major resource in helping to ensure that other midwives and the wider multi-professional community reach their potential and practise in a safe environment.

As seen from this study, the support required by midwives working in stressful environments should not be underestimated. Approximately sixty percent of midwives practice in excess of their contracted hours (RCM 2010), due to insufficient midwife availability. In addition, midwifery cases are now more complex than previously, due to changing medical and social care reasons, thus requiring more midwifery time and expertise. With this combined with issues relating to limited salary increases, it is easy to see why a significant number of midwives leave the profession within the first five years following registration (Midwifery 2020 Delivering Expectations 2010). Consultant midwives have been seen to be a stabilizing influence within the practice environment, supporting staff and providing clear leadership and vision. With the average age of practising midwives being forty four and since 40-45% of midwives in practice will reach retirement in the next ten years (Dunkley and Haider 2011) now is not the time to confound the stability of service provision further by limiting the number of consultant midwives in practice.

Consultant midwives have been seen to be major advocates for the midwifery profession, visible at local and national level, published and contributors to strategic discussion and

the implementation of services. They have been seen contributing to the overall skill-mix within a maternity unit and have been seen to be overt in supporting staff at all levels. Considerable work has been witnessed centring on supporting the maternity support worker and developing the role, liaising with higher education, contributing to innovative discussions relating to workforce provision and being a core collaborator between medical and midwifery staff.

As a result of this consultant midwife study, new knowledge now firmly exists identifying the contributions made by consultant midwives to practice and woman-centred care. As well as being clinically competent and having visible clinical credibility, they have been observed working as excellent role models and have been seen working collaboratively to develop practice and improve outcomes for women and their families. Significantly, this study has revealed a clinical wisdom in the way in which the midwives use the knowledge they have acquired overtly and implicitly. Wisdom in the way they make clinical decisions and judgements and wisdom in relation to expert practice and their ability to liaise and collaborate to extend normality in childbirth.

These midwives are leaders of their profession, their articulate vision being observed at a strategic, national and local level. They do not however work alone, due to the multi-faceted nature of their role, they collaborate and reflect on and with, all that is around them. Consultant midwives have been seen to make a huge commitment to initiating and developing midwifery models of care. They also have a large part to play in reducing clinical risk by engaging in quality mechanisms to ensure safe, evidence based practice.

Consultant midwives are involved in education and research activities, both locally and within higher education and are to a greater or lesser degree outside the management structure, still however seen to push boundaries and be influential without having management responsibility. Having undertaken this research, opinion is united that the consultant midwife role is feasible and sustainable and has a major part to play in shaping service provision. There is a strong view however, that for the role to remain fit for purpose and practice, succession planning is vital in order to retain this sustainability.

Consultant midwives do however have to cope with massive often unrealistic workloads, role conflict and role isolation. Organisations have been seen to be ill prepared for consultant midwives in relation to role expectations and the effect their presence has on managerial hierarchy. Heads of Maternity Services need to embrace the consultant role and in developing shared objectives, use consultant practitioners to their full potential. Heads of Maternity Services need to ensure clear and appropriate accountability as well

as on-going clinical support. In order to reduce role isolation, managers also need to consider the value of securing funding for more than one consultant midwife in a Trust, whilst at the same time considering potential role conflicts thereby developing realistic objectives prior to recruitment.

At a time of on-going debate regarding the future of the maternity services, opportunities are being considered to improve skill-mix and models of care. As has been seen from this study and the work of others (Guest 2001, Guest 2004) the role of consultant midwife is strategic, able to “reflect the changing needs of health and maternity care” (DH et al 2010, p20), with the wisdom and expertise, leadership capabilities and vision to sustain a secure service.

With support and investment from government, the profession and locally, this role will continue to be a major factor in the provision of midwifery led care; it is viable and sustainable, part of the nation’s future maternity service.

#### **6.4 Implications for Future Research**

Important outcomes have been identified as a result of this study. Consultant midwives have been observed in relation to their clinical credibility and competence and in relation to their engagement in collaborative working to develop practice and improve outcomes for women and their families. They have been identified as having clinical wisdom and have demonstrated expert practice and an ability to make sound clinical judgements based on strong leadership ability. They are to a greater or lesser degree outside the management structure, but have been observed pushing boundaries and being influential. Opinion is united that the consultant midwife role is feasible and sustainable and has a major part to play in shaping service provision for the future. Role limitations have been observed in relation to unrealistic work loads, role conflict and role isolation. In addition, organisations have been seen to be ill prepared for consultant midwives in relation to role expectations.

This study has given rise to recommendations for future research, relating to future strategies taken to facilitate a sustainable midwifery workforce, following a restructured NHS and the effect of change to the commissioning of maternity services. Specifically in relation to consultant practice, The Department of Health needs to formerly evaluate the role of non-medical consultants. In relation to the key findings from this consultant midwife study, clinical wisdom clearly demands specific focus, in relation to the way in which knowledge is utilised not only by consultant midwives but across the profession. This study has emphasised tensions relating to midwifery leadership and the importance of effective working relationships between consultant midwives and heads of service; there is therefore scope to examine where leadership is being emanated from within the

maternity service and whether changes to a traditional midwifery hierarchy are recommended.

### **6.5 Summary of Conclusions and Recommendations**

This final chapter has provided a synopsis as to why this research study was designed and undertaken, it has focused on summarising the study's strengths and limitations as well as some of the obstacles encountered. It has answered the study's research questions by painting a full picture of the role of the consultant midwife, especially in relation to wisdom, leadership qualities and role sustainability. Implications for midwifery practice and future research, as a result of the study's findings have also been clearly documented. Having been privileged to observe consultant midwives in practice and by listening to them and others it is clear that although currently in uncertain times, consultant midwives do have a future role to play in making a difference to women, midwives and the wider profession. For the role to flourish, stakeholders and sponsors need to realise the full potential of the role and how it positively impacts on quality and innovation initiatives.



## **Appendices**



**Appendix 1**  
**Research Guide**



### Research Guide - Primary Evidence included in Literature Review

Study	Aim	Method	Findings	Strengths & Limitations
<p>Manley 1997 Journal of Clinical Nursing 6, 179-190</p> <p>A conceptual framework for advanced practice: an action research project operationalizing an advanced practitioner/consultant nurse role</p>	<p>To present a preliminary conceptual model for advanced practice / consultant practice thus reflecting the core features of the role.</p>	<p>The model was developed whilst analysing data from a 3 year action research project focusing on the operationalisation of an advanced practice/ consultant nurse role.</p>	<p>Thematic analysis of role activities; 7 themes – transformational leadership key, where all in practice can participate and develop.</p>	<p>Conceptual model clearly explained however the methodological underpinning is somewhat unclear.</p>
<p>Manley 2000a Nursing Standard 14 (36) 34-38</p> <p>Organizational culture and consultant nurse outcomes: Part 1 organizational culture</p>	<p>3 year study to operationalise the consultant nurse role.</p>	<p>Action research.  A review of organisational theory supporting the culture in which the consultant nurse develops practice.</p>	<p>The organisational culture in which the consultant nurse practised was key to developments made in practice;  Leadership is essential for cultural change.</p>	<p>Original / ground-breaking research focusing on organisational culture and change;  Detail regarding data collection and analysis not included.</p>
<p>Manley 2000b Nursing Standard 14 (37) 34-39</p> <p>Organizational culture and consultant nurse outcomes: Part 2 nurse outcomes</p>	<p>3 year study to operationalise the consultant nurse role.</p>	<p>Emancipatory Action Research;  Unstructured interviews.</p>	<p>All four core features of the role of consultant explored and seen as being essential for change.  It is the qualities leading to transformational leadership that facilitate change.</p>	<p>Limited detail regarding data analysis.  Reflexivity not mentioned / considered in relation to bias.</p>
<p>Guest et al 2001 Kings College London</p> <p>A preliminary evaluation of the establishment of nurse, midwife and health visitor consultants.</p>	<p>To preliminary evaluate the consultant nurse, midwife and health visitor role.</p>	<p>Thirty two consultants (4 midwives) were interviewed via the telephone; Ten case studies of consultants in practice (2 midwives) were undertaken involving interviews, observation and documentary analysis; 158 questionnaires (all consultants in post in February 2001) were sent, focusing on role and experience cent response rate. Among the 153 returned, seven per cent were midwives.</p>	<p>Guest et al (2001) presented their findings in relation to each core category.</p>	<p>Quite difficult to identify findings relating to different professions.</p>

Appendix 1 Research Guide

Study	Aim	Method	Findings	Strengths & Limitations
<p>Guest et al 2004 Kings College London</p> <p>An Evaluation of The Impact of Nurse, Midwife and Health Visitor Consultants</p>	<p>An evaluation of the impact of nurse, midwife and health visitor consultants</p>	<p>Quantitative and qualitative methodologies; Interviews – Telephone, face to face; Questionnaire; Focus groups.</p> <p>Statistical analysis; Content analysis.</p>	<p>Focused on the four core features of the role. Consultant practitioners were seen to be having a significant effect on patient / client care and delivery; Strengths and limitations of the role explored; Concerns related to role overload and lack of support; Time spent undertaking each feature of the role varied between disciplines.</p>	<p>Very thorough methodologically but again quite difficult to identify findings relating to different professions. Not able to view the impact of the role. Need for further stakeholder involvement.</p>
<p>Redwood et al 2005 Institute of Health and Community Studies Bournemouth University</p> <p>Perspectives on the Consultant Nurse Role</p>	<p>To provide descriptive accounts of these new roles and their impact on practice</p>	<p>A participatory research design - stakeholder involvement; - consultant nurses in mental health and pain management.</p> <p>A 360-degree evaluation approach;</p> <p>6 participating consultant nurses each with 6 key informants interviewed (face to face).</p>	<p>Thematic content analysis;</p> <p>Key themes and patterns identified and analysed across all 6 case studies;</p> <p>4 categories emerged from the data in relation to: Evolution About the person The work Resolving issues</p> <p>The findings suggest considerable activity around expert practice and practice development and education. Limited expertise identified in relation to leadership and research.</p>	<p>Users not invited to participate in the study – essential since the aim was to identify impact;</p> <p>Ethical concerns relating to selection of participants dealt with effectively;</p> <p>Good that there was equal gender participation;</p> <p>Unusual to give Interview schedule to participants prior to the interview – possibly affected the nature of the responses;</p> <p>Consultant nurses given the opportunity to negotiate the content of the final case report - Possibility of bias;</p> <p>Different researchers analysed the data (different findings possible).</p>

Study	Aim	Method	Findings	Strengths & Limitations
Woodward et al 2005 Journal of Clinical Nursing 14, 845-854  Nurse consultants: their characteristics and achievements	One aspect of a larger study focusing on nursing research strategies.	A cross-sectional design; A convenience sample; 10 nurse consultants from a variety of specialities interviewed (rationale for selection not provided);  Interview schedule not documented.	4 themes identified (first 2 presented in this paper) – It would have been useful to review all the findings in one complete document. Characteristics linked to attribute and motivation of post holder. Role achievement to role development and concerns of post holder.	Difficult to measure achievement;  The authors recommend that the consultant role should not include management responsibility –effective leaders need to be invested with management responsibility.
Charters et al 2005 Accident and Emergency Nursing 13, 186-193  Learning from the past to inform the future – A survey of consultant nurses in emergency care	To “elicit information regarding level of preparation for the consultant nurse role, the use of formal competency frameworks, current clinical scope of practice and perspectives on future preparation for the role”.	Survey of UK consultant nurses – A semi structured questionnaire emailed to consultant nurses in emergency care; 58% response rate	Eleven sections commented upon ranging from preparation – major achievements;  Preparation for the role was a concern, other than expert practice and clinical leadership the participants felt under prepared for the role.	Aim of study only documented in summary. Uncertain as to whether all objectives presented;  Survey distributed nationally? Concern as to whether all views ascertained;  Only 58% response rate – the views of those not responding could change overall results;  Questionnaire not included.
Woodward et al 2006 Journal of Clinical Nursing 15, 272-280  Nurse consultants: organizational influences on role achievement	One aspect of a larger study focusing on nursing research strategies.	A cross-sectional design; A convenience sample; 10 nurse consultants from a variety of specialities interviewed (rationale for selection not provided);  Interview schedule not documented.	4 themes identified (first 2 presented in previous paper);  Two themes presented in this paper – Support systems and NHS influences;  Support systems categorised as follows – networks, support, relationships;  NHS influences categorised as policy and power base of NHS research.	It would have been useful to review all the findings from the study in one complete document;  Aim of study unclear – different focus presented in abstract and under methods;  Uncertain as to why interviews held over such a long period;

Appendix 1 Research Guide

Study	Aim	Method	Findings	Strengths & Limitations
<p>Booth et al 2006 Journal of Nursing Management 14, 83-89</p> <p>New nursing roles: the experience of Scotland's consultant nurses / midwives</p>	<p>To describe career pathways of consultant nurses / midwives in Scotland in relation to role initiation, development and progression.</p>	<p>A postal survey of all consultant nurses and midwives in post (16);</p> <p>A 26 item questionnaire designed by 4 consultant nurses and reviewed by a further 3 CN's.</p>	<p>Descriptive statistics and content analysis;</p> <p>Findings in relation to: Background characteristics Terms of service Functions of the role Direct patient care Support Consultant Views.</p>	<p>Consultant midwife not involved in research design;</p> <p>? questionnaire completed by those involved in designing and reviewing the questionnaire – possibility for bias;</p> <p>Re findings - Differences not identified between consultant nurses and midwives;</p> <p>Backgrounds not provided;</p> <p>Survey not documented;</p> <p>Findings not compared to previous research e.g. Guest 2004</p>
<p>Humphreys et al 2007 Journal of Clinical Nursing 16, 1792-1808</p> <p>A systematic review and meta-synthesis: evaluating the effectiveness of nurse, midwife / allied health professional consultants</p>	<p>To identify and discuss studies that evaluated the nurse, midwife/allied health professional consultant role</p> <p>To review systematically and critically appraise the evidence for the impact and effectiveness of nurse/midwife and AHP consultants.</p>	<p>A systematic review and meta-synthesis: evaluating the effectiveness of nurse, midwife/allied health professional consultants.</p> <p>- Inclusion criteria focused on studies where an aspect of the role had been studied Or where the consultant carried out the research.</p> <p>14 studies were critically analysed and underwent thematic analysis</p>	<p>Meta-synthesis demonstrated role uncertainty; Although, midwives clearly known as consultant midwives;</p> <p>Consultants to a greater or lesser extent were seen to be functioning in relation to the 4 key features of role (pillars);</p> <p>Leadership was seen to be operational rather than strategic.</p>	<p>Clear summary of study's focusing on the consultant role;</p> <p>Few specifics given in relation to nurse or midwifery practice;</p> <p>Effectiveness of the role not able to be evaluated in relation to outcomes,</p>
<p>Mc Sherry et al 2007 Journal of Clinical Nursing 16 2066-2080</p> <p>Evaluating the perceived role of the nurse consultant through the lived experience of healthcare professionals</p>	<p>To evaluate the perceived impact of the nurse consultant through the lived experience of healthcare professionals.</p>	<p>A 360-degree evaluation approach;</p> <p>The sample included 3 consultant nurses;</p> <p>A collaborative purposive sampling approach was used – 10 participants per CN – A total of 30.</p> <p>Semi-structured interviews Thematic Analysis (Bowling 1997)</p>	<p>A series of themes emerged focusing on how the role can be improved in the future through staff involvement.</p>	<p>The researchers acknowledged the study's small scale;</p> <p>The use of the 360-degree evaluation ensured representation of a variety of views.</p> <p>Analysis carefully described;</p> <p>Although the researchers aimed to evaluate the impact of the role this was not specifically focused upon.</p> <p>Evaluated by Duke S (2008)</p>

Study	Aim	Method	Findings	Strengths & Limitations
<p>Rogers and Cunningham 2007 MIDIRS Midwifery Digest, 17 (2) 201-206</p> <p>A consultant midwives' clinic: a catalyst for cultural change?</p>	<p>An audit of staff and clients regarding a consultant midwife clinic.</p>	<p>An audit of the service was undertaken between September 2004 and September 2005 and focused on birth outcomes, the quality of communication between those making referrals and the consultant midwives and finally women's opinions.</p>	<p>Staff views were largely positive, 110 audit forms were circulated to midwives and doctors making the referrals- 67% response rate; 97 per cent of respondents felt that communication with the consultant midwife was either good or very good and 96 per cent felt the input was either helpful or very helpful; Questionnaires were sent to 115 women post delivery, with a return rate of 50%. The responses were largely positive to questions asked in relation to information provided and with regard to needs being met. Comments received from both staff and women were coded and presented qualitatively.</p>	<p>From a readers perspective these accounts create the vision of transparency, whereby it is possible to assess the diversity of issues concerning childbearing women and the holistic nature of evidence based care provided following lengthy discussions.</p>
<p>Dawson and Coombs 2008 Intensive and critical care nursing 24, 187-196</p> <p>The current role of the consultant nurse in critical care: Consolidation or consternation?</p>	<p>A follow up review of the role and function of critical care consultant nurses; Also to identify changes in the role from 2003-2006.</p>	<p>Using a survey tool previously used Dawson and McEwen 2003</p>	<p>A national email survey of all known critical care nurses, undertaken in October 2006;</p> <p>Return rate 73%;</p> <p>Results revealed in relation to the 4 core features of the consultant role;</p>	<p>Limitations addressed by researchers in relation to – Room for subjectivity in completing survey; Different interpretations could lead to incorrect responses.</p>

Study	Aim	Method	Findings	Strengths & Limitations
<p>McIntosh and Tolson 2008 Journal of Clinical Nursing 18, 219-227</p> <p>Leadership as part of the nurse consultant role: banging the drum for patient care</p>	<p>The main aim was to identify the extent to which the consultant nurses fulfilled their role in relation to the 4 core features</p>	<p>Documentary analysis Face to face interviews Focus group interviews;</p> <p>4 nurse consultants interviewed twice (at after being in post for 9 months and 5-6 months later);</p> <p>Stakeholder interviews (selected by CN's and research team);</p> <p>Focus group interview, post face to face interviews of CN's.</p>	<p>Thematic analysis; Varied leadership activities at local and strategic level;</p> <p>Attributes relating to transformational leadership identified.</p>	<p>The main aim of the study not represented in the title of the article although the authors do make it clear that professional leadership is the focus of this particular paper;</p> <p>The research team evaluated selection of stakeholders – room for bias;</p> <p>Findings in relation to documentary analysis reported elsewhere.</p>
<p>Manley et al 2008 Journal of Nursing Management 16, 147-158</p> <p>Leadership role of Consultant Nurses working with Older People: a co-operative study</p>	<p>The aim was to explore the leadership function of the CN role in relation to working with older people.</p> <p>Question – “What are the leadership strategies that we use as consultant nurses in older people nursing”.</p>	<p>A co-operative inquiry approach; 4 consultant nurse stories</p>	<p>Phenomenological analysis;</p> <p>3 consultant nurses wrote how leadership was integrated into their role; 1 consultant nurse illustrated leadership from an organizational perspective;</p> <p>2 key themes emerged relating to complexity and pathway.</p>	<p>Authors chose to investigate their own leadership practices / strategies;</p> <p>Their own values and beliefs were made explicit.</p>

**Appendix 2**  
**Ethics Committee Approval Letter**



**South East Multi-Centre Research Ethics Committee**

Kent and Medway Strategic Health Authority  
Preston Hall  
Aylesford  
Kent  
ME20 7NJ  
Tel: 01227 831 662 / 01622 713106  
Fax: 01227 831 662  
Email: jane-martin@stmrec.fsnet.co.uk

22 October 2004

Mrs Ann Robinson  
Midwifery Lecturer  
University of Surrey  
EIHMS  
Duke of Kent Building  
Guildford  
Surrey GU2 7TE

Dear Mrs Robinson,

**Full title of study: An investigation of the role of the consultant midwife and its impact on midwifery care**  
**REC reference number: 04/MRE01/35**  
**Protocol number: version 1**

Thank you for your letter of 18 October 2004, responding to the Committee's request for further information on the above research.

The further information has been considered on behalf of the Committee by the Chairman

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation.

**Conditions of approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

Document Type: Application  
Version:  
Dated: 17/06/2004  
Date Received: 23/06/2004

Document Type: Investigator CV  
Version: Anne Robinson version 1  
Dated: 01/06/2004

*The Central Office for Research Ethics Committees is responsible for the operational management of Multi-centre Research Ethics Committees*

Date Received: 23/06/2004

Document Type: Investigator CV Judith Ann Lathlean  
Version:  
Dated: 18/10/2004  
Date Received: 19/10/2004

Document Type: Protocol  
Version: version 1  
Dated: 17/06/2004  
Date Received: 23/06/2004

Document Type: Summary/Synopsis  
Version: version 2  
Dated: 18/10/2004  
Date Received: 19/10/2004

Document Type: Interview Schedules/Topic Guides  
Version: version 1  
Dated: 17/06/2004  
Date Received: 23/06/2004

Document Type: GP/Consultant Information Sheets  
Version: Head of Maternity letter vs 2  
Dated: 17/08/2004  
Date Received: 19/10/2004

Document Type: GP/Consultant Information Sheets  
Version: Consultant Midwife letter vs 2  
Dated: 18/10/2004  
Date Received: 19/10/2004

Document Type: GP/Consultant Information Sheets  
Version: Medical Prac. letter vs 2  
Dated: 18/10/2004  
Date Received: 19/10/2004

Document Type: Participant Information Sheet  
Version: 2  
Dated: 18/10/2004  
Date Received: 19/10/2004

Document Type: Participant Information Sheet Client  
Version: 2  
Dated: 18/10/2004  
Date Received: 19/10/2004

Document Type: Participant Consent Form Client  
Version: 2  
Dated: 18/10/2004  
Date Received: 19/10/2004

Document Type: Participant Consent Form  
Version: version 1  
Dated: 17/06/2004  
Date Received: 23/06/2004

Document Type: Response to Request for Further Information

Version:

Dated: 18/10/2004

Date Received: 19/10/2004

**Management approval**

You should arrange for all relevant host organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant host organisation before commencing any research procedures. Where a substantive contract is not held with the host organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

**Notification of other bodies**

We shall notify the research sponsor that the study has a favourable ethical opinion.

**Statement of compliance (from 1 May 2004)**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC reference number: 04/MRE01/35	Please quote this number on all correspondence
-----------------------------------	--

Yours sincerely,

**Appendix 3**  
**Participant Letters**



**Consultant Midwife**  
Maternity Unit  
Name of NHS Trust  
Address of NHS Trust  
Date

Dear Consultant Midwife,

**Re: An Investigation of the Role of the Consultant Midwife.**

Further to our previous conversations, I am now writing to request your participation in the above study. As you know, I am a Midwifery Lecturer at The University of Surrey and am undertaking MPhil / PhD studies at The University of Southampton.

My research study is a qualitative case study, focusing on the role of the Consultant Midwife. From a midwifery perspective the role of the consultant midwife needs to be observed in order to provide evidence of effective working. An in-depth qualitative study will contribute to our knowledge and understanding as to this complex role and hopefully will contribute to future policy development.

The South East Multi-Centre Research Ethics Committee has reviewed and approved the study.

Please find an information sheet relating to the study. As you will see I am hoping for participation from yourself, and your Head of Maternity Services. A medical practitioner will also be asked to participate.

As indicated in the information sheet, it is important to emphasise that should you decide not to participate or withdraw from the study at any stage it will not be detrimental to your future career.

I am now hoping to begin data collection. If you are happy to take part in this study please complete the attached form below and return to me in the enclosed stamped addressed envelope. I will contact you shortly to make arrangements. If you wish to contact me by phone or email with any queries, I may be contacted on 01483 686713 or at [a.robinson@surrey.ac.uk](mailto:a.robinson@surrey.ac.uk)

Following completion of the study I will be happy to provide you with a written report relating to the research process and its findings. I will also be happy to present my findings to The Consultant Midwife Forum at The RCM.

Yours faithfully,

Ann Robinson  
MPhil / PhD Student  
University of Southampton

Appendix 3 Participants Letters

Please **delete** as necessary:

- 1 **I am / am not** willing to take part in this study.
- 2 Name of Consultant Midwife.....
- 3 Please enter how long you have been employed as a Consultant Midwife in your current NHS Trust.

--	--

**Years      Months**

**Head of Maternity Services**

Maternity Unit

Name of NHS Trust

Address of NHS Trust

Date

Dear Head of Maternity Services,

**Re: An Investigation of the Role of the Consultant Midwife.**

I am a Midwifery Lecturer at The University of Surrey and am undertaking MPhil / PhD studies at The University of Southampton.

My research study is a qualitative case study, focusing on the role of the Consultant Midwife. From a midwifery perspective the role of the consultant midwife needs to be observed in order to provide evidence of effective working. An in-depth qualitative study will contribute to our knowledge and understanding as to this complex role and hopefully will contribute to future policy development.

Please find enclosed an information sheet relating to the study. As you will see along with yourself, I am hoping for participation from your consultant midwife, as well as a medical practitioner.

The South East Multi-Centre Research Ethics Committee has reviewed and approved the study. No information about the study needs to be submitted to your Local Research Ethics Committee however, I am writing to request your permission for your maternity unit's participation, including your own participation.

I am hoping to begin data collection as soon as possible. If you are happy to take part in this study please complete the attached form below and return to me in the enclosed stamped addressed envelope. I will then contact you shortly to make arrangements. If you wish to contact me by phone or email with any queries, I may be contacted on 01483 686713 or at [a.robinson@surrey.ac.uk](mailto:a.robinson@surrey.ac.uk)

As indicated in the information sheet, it is important to emphasise that should you decide not to participate or withdraw from the study at any stage it will not be detrimental to your future career.

Following completion of the study I will be happy to provide you with a written report relating to the research process and its findings.

I look forward to hearing from you.

Yours faithfully,

Ann Robinson  
MPhil / PhD Student  
University of Southampton

**Name of Head of Maternity Services**

.....  
**Name of Maternity Unit**

.....  
Please **delete** as necessary:

**1** I am / am not happy for my Maternity Unit to participate in this study.

**2** I am / am not willing to personally participate in this study.

**Medical Practitioner**

Maternity Unit

Name of NHS Trust

Address of NHS Trust

Date

Dear Medical Practitioner,

**Re: An Investigation of the Role of the Consultant Midwife.**

I am a Midwifery Lecturer at The University of Surrey and am undertaking MPhil / PhD studies at The University of Southampton.

My research study is a qualitative case study, focusing on the role of the Consultant Midwife. From a midwifery perspective the role of the consultant midwife needs to be observed in order to provide evidence of effective working. An in-depth qualitative study will contribute to our knowledge and understanding as to this complex role and hopefully will contribute to future policy development.

Please find enclosed an information sheet relating to the study. As you will see I am hoping for participation from yourself, this will involve interviewing you for approximately thirty minutes with regard to the concept of consultant midwifery and its noted impact on midwifery care.

The South East Multi-Centre Research Ethics Committee has reviewed and approved the study.

As indicated in the information sheet, it is important to emphasise that should you decide not to participate or withdraw from the study at any stage it will not be detrimental to your future career.

I am hoping to begin data collection as soon as is convenient. If you are happy to take part in this study please complete the attached form below and return to me in the enclosed stamped addressed envelope. I will contact you shortly to make arrangements. If you wish to contact me by phone or email with any queries, I may be contacted on 01483 686713 or at [a.robinson@surrey.ac.uk](mailto:a.robinson@surrey.ac.uk)

Following completion of the study I will be happy to provide your maternity unit with a written report relating to the research process and its findings.

Yours faithfully,

Ann Robinson  
MPhil / PhD Student  
University of Southampton

Appendix 3 Participants Letters

Please **delete** as necessary.

1 **I am / am not** willing to take part in this study.

2 Name of Medical Practitioner.....

3 Please enter how long you have worked with a Consultant Midwife in your current NHS Trust.

--	--

**Years Months**

**Appendix 4**  
**Participant Information**



## PARTICIPANT INFORMATION SHEET

### AN INVESTIGATION OF THE ROLE OF THE CONSULTANT MIDWIFE

You are being invited to participate in a midwifery research study. Before you decide to participate it is important for you to understand why the research is being undertaken and what it will involve. Please take time to read this information carefully and discuss it with your colleagues if you wish. If you require any further information or clarification please contact me on 01483 686713 or [a.robinson@surrey.ac.uk](mailto:a.robinson@surrey.ac.uk)

Thank you for taking time to read this.

#### **What is the purpose of the study?**

##### **The Objectives of this Study are:**

- To establish consultant midwife participants' expectations and understanding of their role as a consultant midwife;
- To place the consultant midwife role in its political and professional context during a period of on-going professional change;
- To examine how consultant midwives have influenced midwifery practice, as viewed by the consultant midwives and members of the multi-professional team.

#### **Background to the Study:**

- On the 18<sup>th</sup> January 2000 the then Secretary of State for Health Alan Milburn introduced the consultant practitioner role. It was seen that these new positions would “bring nursing, midwifery and health visiting into the 21<sup>st</sup> century, to provide faster, better and convenient services, and to improve the quality of care” (DH 2000).
- Recruitment has been steady and as of October 2002, thirty-five consultant midwives were in post in the UK (RCM 2002).
- Detail with regard to original role structure and its core functions is set out in a Health Service Circular (HSC 1999/217) and emphasize expert practice, professional leadership as well as educational and research capabilities.
- Employers are welcoming a renewed focus on normal midwifery practice as well as public health initiatives; increased professional collaboration and change developing from research evidence.
- To date little has been published as to the experiences and achievements of consultant midwives.
- Many have inquired as to the skills of a consultant midwife with many welcoming the concept of an “expert’ practitioner able to act as an interface between practice and education and in so doing raise the profile of the profession locally and nationally” (Elliot, 2000:266).

## Appendix 4 Participant Information

- From a midwifery perspective the role of the consultant midwife needs to be observed in order to provide evidence of effective working. An in-depth qualitative study will contribute to our knowledge and understanding as to this complex role and will contribute to future policy development.

### **Why have I been chosen?**

**You have been chosen to participate in this research study since you are either:**

- A consultant midwife of 2 or more years, *working in the same midwifery unit in the UK for the past 2 years*

OR

- A Head of Maternity Services *working in a midwifery unit in the UK that employs a consultant midwife.*

OR

- A Medical Practitioner *with experience of working with a Consultant Midwife over the past 2 years, in a midwifery unit in the UK.*

▪

Practitioners from ten midwifery units within ten Acute NHS Trusts within the United Kingdom have been invited to participate in this study.

### **Do I have to take part?**

No, participation is entirely voluntary. By participating you will not be asked any sensitive, embarrassing or upsetting questions. Your anonymity will be protected. This study will not cause you physical or emotional harm. The Chief Investigator will be the only person to have access to observational material, interview material and transcripts. If you decide to participate you will be asked to sign a consent form which emphasises that if you wish, you would be free to withdraw from the study at any time without giving a reason.

It is important to emphasise that should you decide not to participate or withdraw from the study at any stage it will not be detrimental to your future career.

### **What will happen if I take part?**

**If you are a consultant midwife** you will be:

- Interviewed by the researcher. This will be an in-depth interview lasting approximately one hour. The interview questions will have been developed following a review of current literature, and will be recorded.
- **Observed in practice.** Short episodes of observation will be negotiated with you.

**Suggested opportunities include:**

Meetings / discussion forums

Teaching sessions i.e. with student midwives

Classroom teaching

**In the main direct client contact will be avoided.** Where opportunities exist for observation to take place whilst you are caring for a client, client written consent will be obtained. Please see attached Client Information Sheet and Client Written Consent Form.

**Periods of observation:**

The length of time spent observing you in practice will not exceed one week. The time and observational opportunities will be decided upon following negotiation and in keeping with your roles and responsibilities.

**If you are a Head of Maternity Services** you will be:

- Interviewed by the researcher. This will be an in-depth interview lasting approximately 45 minutes. The interview will be recorded.

**If you are a Medical Practitioner** you will be:

- Interviewed by the researcher. This will be an in-depth interview lasting approximately 30 minutes. The interview will be recorded.

**What are the benefits of taking part?**

You will have the opportunity of participating in one of the initial in depth qualitative research studies focusing on the consultant midwife and their impact on midwifery care. You will have participated in primary research and experienced the development of a longitudinal case study.

**What will happen when the research study stops?**

Once the research study stops the researcher will transcribe the data and analyse it. A full report will be written and will be available for participants to read.

**Will my taking part in this study be kept confidential?**

All information collected will be maintained confidentially by the Chief Investigator. All documentation will be coded and will not bear your name. The lists of codes will be kept locked away, separate to any other documentation.

All recordings, research notes and transcripts will be stored securely within The Research Office of The School of Nursing and Midwifery at The University, for 15 years, following completion of the study.

All personal data relating to participants will be maintained in accordance with the Data Protection Act (1998).

### **What will happen to the results of the research study?**

On completion of the study, all participating maternity units will be provided with a full report. Articles may be written for peer reviewed journals. If requested, The Consultant Midwife Forum held at the Royal College of Midwives will receive a presentation. The thesis will be housed in Southampton University Library.

Due to the small number of Consultant Midwives taking part in this study every effort will be taken to ensure total participant confidentiality and anonymity.

- The names of all participants will be known only by the Chief Investigator;
- All data and research notes will not include the names of the participants or their employing NHS Trusts;
- All data and research notes will be coded. The list of codes will be kept confidentially and locked away;
- Any publications resulting from this study will not disclose your identity or employing NHS Trusts, again codes will be used;
- Any publications will be offered to the participants on request before publication;
- Again, all personal data relating to participants will be maintained in accordance with the Data Protection Act (1998).

### **Who is organising and funding the research?**

The study is self Funded.

### **Who has reviewed this research proposal?**

This research proposal has been approved by MREC.

It has been written under the guidance of two research supervisors:

Professor Judith Lathlean, University of Southampton (Research Sponsor).

Dr Jane Rogers, University of Southampton.

### **Contact for further information.**

You may contact me on 01483 686713 or [a.robinson@surrey.ac.uk](mailto:a.robinson@surrey.ac.uk) or at the following address:

Level 5, Duke of Kent Building, University of Surrey, Guildford, Surrey GU2 7TE

My research supervisors may be contacted via [J.Lathlean@soton.ac.uk](mailto:J.Lathlean@soton.ac.uk) or

[J.Rogers@soton.ac.uk](mailto:J.Rogers@soton.ac.uk)

Thank you for taking time to read this information. I do hope that you will consider participating in the study.

Ann Robinson



**Appendix 5**  
**Participant Consent Form**



**PARTICIPANT CONSENT FORM****AN INVESTIGATION OF THE ROLE OF THE CONSULTANT MIDWIFE****Name of Researcher: Ann Robinson****Please Initial boxes below:**

- 1 I confirm that I have read and understand the information sheet dated with regard to the above study and have had the opportunity to ask questions.

- 2 I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.

- 3 I understand that the only person with access to the observational data, interview recordings and transcripts will be the named researcher only.

- 4 I agree to take part in this study.

<b>Name of Practitioner</b>	
<b>Signature of Practitioner</b>	
<b>Date</b>	

<b>Name of Researcher</b>	<b>Ann Robinson</b>
<b>Signature of Researcher</b>	
<b>Date</b>	

**1 copy to be retained by participant**  
**1 copy to be retained by researcher**



**Appendix 6**  
**Consultant Midwife Demographics**



**Demographics - Consultant Midwives**

Age in Years Mean = 50 Years		Years as a Qualified Midwife		Length in Years as a Consultant Midwife		Highest Academic Qualifications		Undertaken Previous Consultant Role		Full Time or Part Time Hours		Registered Teaching Qualification		Role Partly Funded By Higher Education	
>30	1 midwife	10-15 yrs	1 midwife	> 2 Years	1	BSc	1 midwife	Yes	1 midwife	Part Time	2 midwives	PGCEA	6 midwives	NO	7 midwives
>40	2 midwives	15-25 yrs	5 midwives	>3 Years	0	MSc	6 midwives	No	7 midwives	Full Time	6 midwives	NO	2 midwives	YES	1 midwife
>50	4 midwives	>25 yrs	2 midwives	> 4 Years	0	MA	1 midwife								
>60	1 midwife			> 5 Years	3										
				>6 Years	3										
				>7 Years	1										



**Appendix 7**  
**Interview Guides**



## Interview Guides

A Consultant Midwife; B Head of Maternity Services;

C Consultant Obstetrician

### A Interview Guide – Consultant Midwife

The following acted as a guide at interview. Some or all of the questions were asked.

Demographics
Age
Educational & Professional Qualifications
Date of Midwifery Registration?
Previous Midwifery Roles in Current Trust?
Previous Midwifery Roles in Previous Trusts?
Date of Consultant Midwife Appointment?
Presentation Title at Interview?

Job Description
Job title
Full time or part time?
Essential qualifications?
Personal attributes of a consultant midwife?

3 Current Role
Accountability?
Role description?
Internal / external relationships at local and national level?
Positive aspects of role?
Negative aspects of role?
What would help you to become more effective?
Where do you gain most of your support?
Supervisor of Midwives?

4 Expert Practitioner / Leadership Responsibilities
Midwifery caseload?
50% of your time in clinical practice?
Definition of 'expert practice'?
Key 'leadership' responsibilities?
Clinical innovations initiated to date?
Role in the development and implementation of evidence based guidelines / protocols?
Consultancy functions?

5 Education and Training
--------------------------

Involvement in classroom teaching?
------------------------------------

Areas of expertise (teaching)?
--------------------------------

How do you support practice development in conjunction with the university?
---

Support for midwives undertaking research?
--

6 Strategic Vision
--------------------

How do you see your role developing?
--------------------------------------

Is the role manageable / realistic?
-------------------------------------

How do you identify and develop consultant midwives of the future?
--

What do you see are the main challenges for midwifery within the next 5 years?
--

## B Interview Guide – Head of Maternity Services

The following acted as a guide at interview. Some or all of the questions were asked.

<b>1 Rationale for Consultant Midwife Appointment</b>
What was the rationale for setting up such a post?
How did you perceive that such an appointment would improve client care?
Was the idea popular with your staff?
What are the essential educational / professional qualifications for a consultant midwife?
How did the consultant obstetricians respond to the appointment? Are you aware of their perspective now?

<b>2 Current Role</b>
Who is the consultant midwife accountable to?
Group membership?
What would help The consultant midwife to become more effective?
Have any strategies been suggested or set up to make the consultant midwife's output more effective?
Where do you perceive the consultant midwife gets most of her support?
Do you feel she ever suffers from role isolation?
Is the consultant midwife a Supervisor of Midwives? / Should she be?

<b>3 Expert Practitioner?</b>
Consultant midwives have been described as being 'expert practitioners': How do you define 'expert practice' and is that the case in your view?
How do you measure the consultant midwife's clinical impact?
What are her clinical innovations to date?
Is it realistic for her to hold a midwifery caseload?
Do you feel she spends 50% of her time in clinical practice?
What is her role in relation to the Clinical Governance Framework?

<b>4 Professional / Leadership Roles</b>
How would you describe your philosophy of midwifery care here?
How does the consultant midwife support / lead midwives in practice?

<b>5 Education and Training</b>
How does the consultant midwife implement evidence based care? Classroom Teaching? / Areas of expertise?
Do you perceive it to be important that the consultant midwife forges links between education and practice?
Does the consultant midwife support midwives undertaking research?

6 Practice and Service Development
------------------------------------

Does the consultant midwife organise the dissemination of local and national research initiatives / national and local policies.
--

Does the CM have a role with regard to public health initiatives?
---

7 Strategic Vision
--------------------

How do you see the consultant midwife role developing?
--

Is the role manageable / realistic?
-------------------------------------

How do you identify and develop consultant midwives of the future?
--

## C Interview Guide – Consultant Obstetricians

The following acted as a guide at interview. Some or all of the questions were asked.

<b>1 Rationale for Consultant Midwife Appointment</b>
How long have you worked at the Trust as a consultant obstetrician?
How long have you worked with the consultant midwife?
Is this the first time you have worked with a consultant midwife?
Were you or any of the other consultant obstetrician's involved in the setting up of the consultant midwife post i.e. job description?
What was the rationale for setting up such a post?
How did you perceive that such an appointment would improve client care?
How did the consultant obstetricians respond to the appointment?
<b>2 Current Role</b>
Having worked with the consultant midwife, how would you describe the role now?
How would you describe the view of the other obstetricians?
What collaborative work have you & the other obstetricians been involved in?
How do you measure the consultant midwife's clinical impact? Any clinical innovations to date?
Consultant midwives have been described as being 'expert practitioners': How do you define 'expert practice' and is that the case in your view?
What suggestions have you as to how the role of the consultant midwife could be extended or altered?
What do you see as the main differences between a consultant midwife & a senior midwife?
What would help The consultant midwife to become more effective?
Are you aware of any strategies that have been suggested or set up to make the consultant midwife's output more effective?
Where do you perceive the consultant midwife gets most of her support?
Do you feel she ever suffers from role isolation?
<b>3 Strategic Vision</b>
How do you see the consultant midwife role developing?
Is the role manageable / realistic?
Do obstetricians have a part to play in identifying and developing Consultant Midwives of the future?



**Appendix 8**  
**Template for Recording Observational Notes**



## Template for Recording Observational Notes

### Observational Setting

Date	
Trust Number	
Location within Trust	
Data Collected by	AR
Duration of Observation (total hrs/mins)	
Purpose of Activity e.g. to observe consultant midwife undergoing clinical activity.	

### The Environment

A Description of the setting e.g. Examination room in outpatient clinic in community hospital setting	
Appropriateness of venue for activity e.g. Appropriate - Spacious, light, modern environment	
Equipment / furniture in setting e.g. Desk, 3 chairs, examination couch; Seating arrangements.	
Additional Comments	

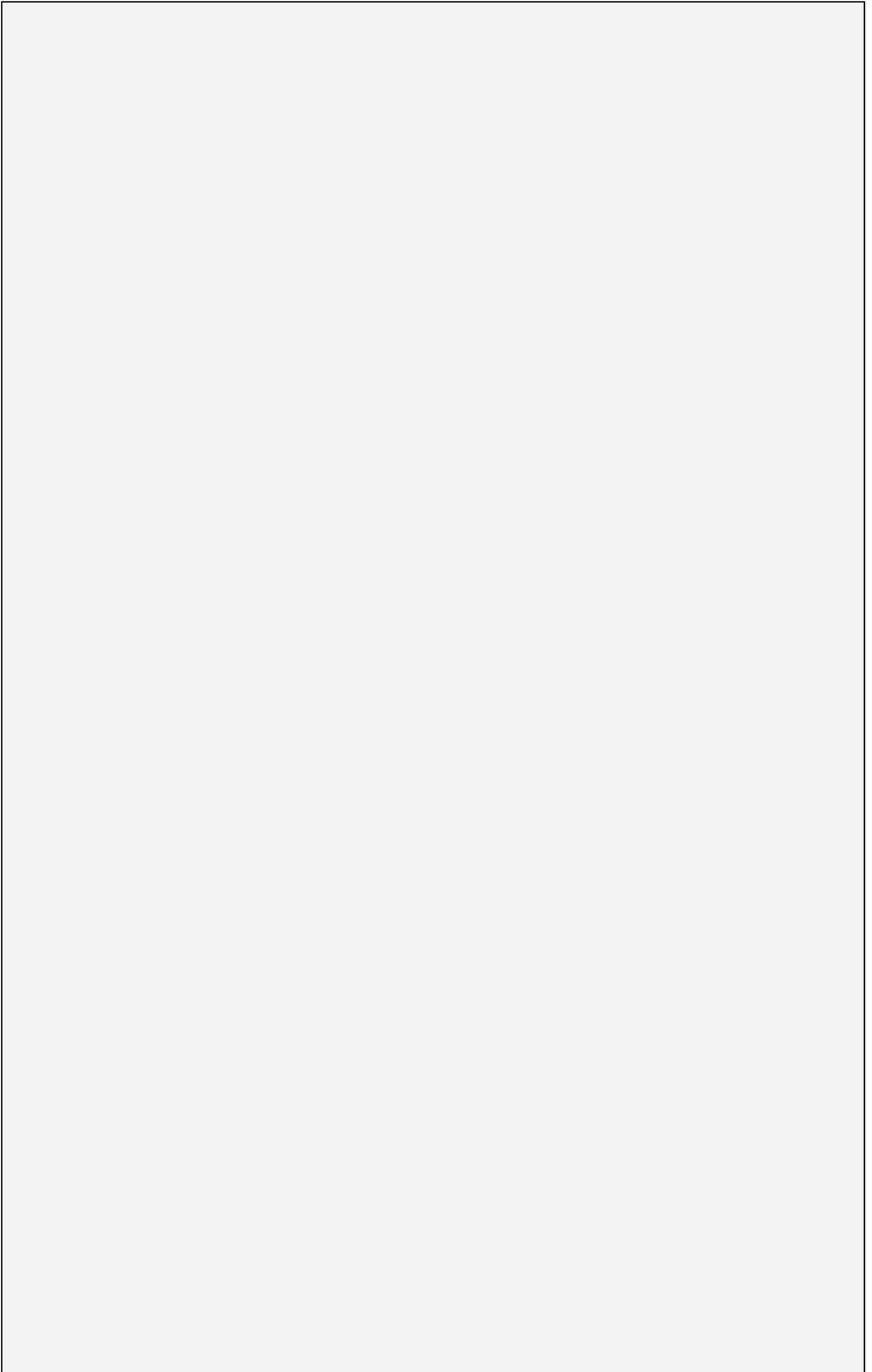
### The Participants

Those Present e.g. Consultant midwife, client; Extra people who enter observational setting.	
Informed consent e.g. If activity involves clients.	
Consultant Midwife e.g. Chairing meeting; Undertaking clinical activity; In uniform / No uniform.	
Additional Comments	

### Observation

#### Detail of Observation

--

A large, empty rectangular box with a thin black border, intended for recording observational notes. The box is centered on the page and occupies most of the vertical space below the header and above the footer.

**Observer Participation**

e.g. episodes of communication; examples of when participation or comments requested; any distractions.	
Additional Comments	

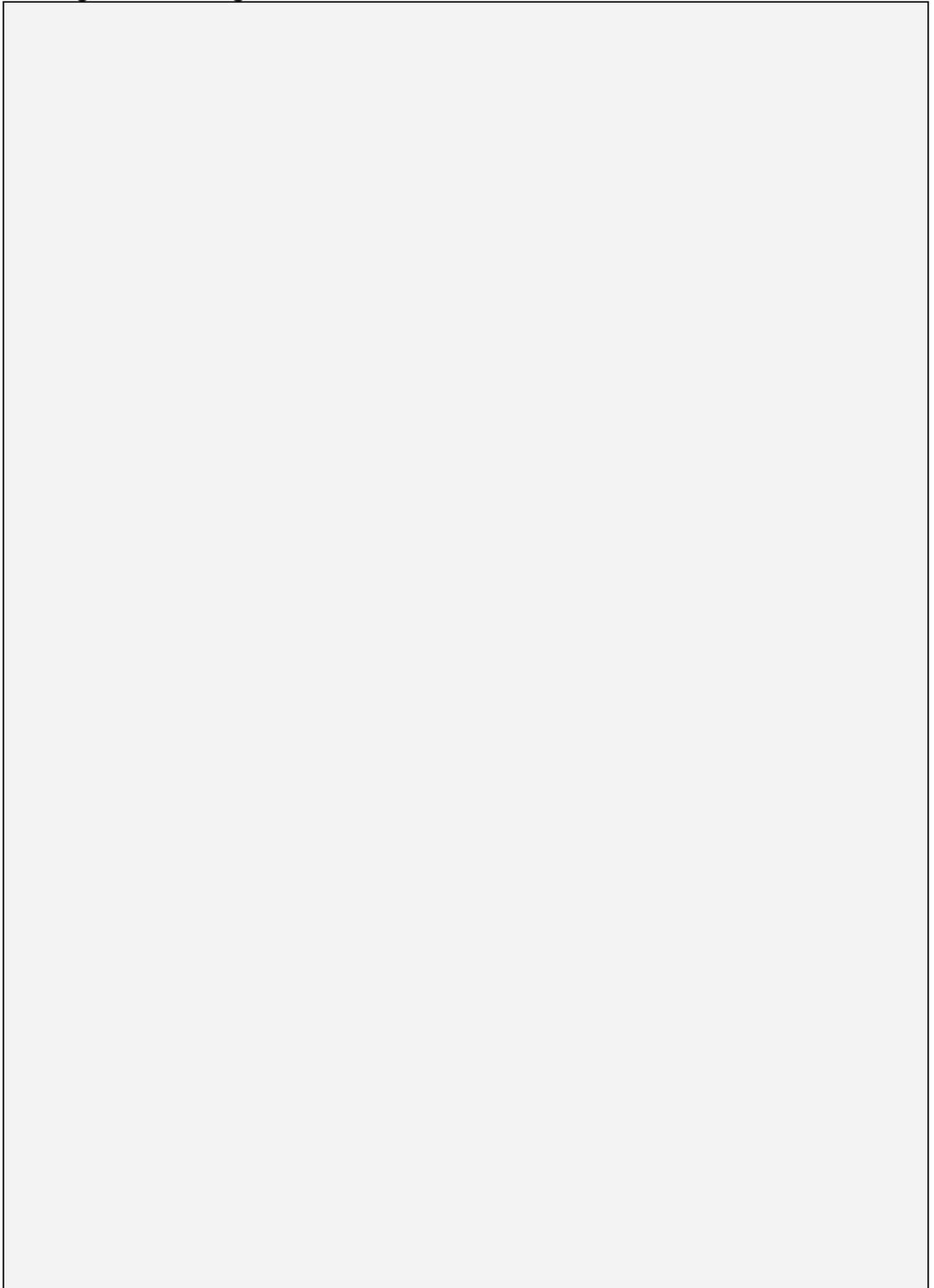
**Duration**

e.g. total time spent observing; or time broken down: Client 1 – Client 2 – Client 3 –	
--	--

**Outcome**

e.g. tasks accomplished; expertise of midwife assessed; midwifery competencies focused upon; communication skills observed; client responses acknowledged.	
Additional Comments	

**Thoughts & Feelings**

A large, empty rectangular box with a black border, intended for recording thoughts and feelings. The box is currently blank, providing space for the user to write their observations.



**Appendix 9**  
**Client Information Sheet and Consent Form**



## INFORMATION SHEET - FOR CLIENTS

### AN INVESTIGATION OF THE ROLE OF THE CONSULTANT MIDWIFE

#### Introduction.

My name is Ann Robinson (*hospital identification to be shown to client*).

I am a Midwifery Lecturer at the University of Surrey and am undertaking PhD studies at The University of Southampton.

Your Midwife is participating in my midwifery research study.

#### The Objectives of this Study are:

- To establish consultant midwife participants' expectations and understanding of their role as a consultant midwife;
- To place the consultant midwife role in its political and professional context during a period of on-going professional change;
- To examine how consultant midwives have influenced midwifery practice, as viewed by the consultant midwives and members of the multi-professional team.

Your written consent is sought to enable your Midwife to be observed by myself whilst she is caring for you on one occasion only. Your midwife will be my main focus; I will not be observing you only the interaction between yourself and your midwife. The care your midwife gives you will not be affected in any way.

#### Do I have to agree to my midwife being observed whilst she cares for me?

No, this is entirely voluntary. Do not feel pressurised in any way. By agreeing you will not be asked any questions and your anonymity will be protected. No physical or emotional harm will occur; your care will not be affected in any way. I will be the only person present and I will be the only person to have access to this observational material. I will take only notes, this episode of observation will not be tape recorded or filmed. All documentation resulting from this episode of observation will be maintained securely and totally confidentially – It will not bear your name. Your medical notes will not be accessed. If you decide to participate you will be asked to sign a consent form which emphasises that if you wish, you may change your mind at any time.

### **What are the benefits of taking part?**

You and your midwife will have had the opportunity of participating in one of the initial in depth qualitative research studies focusing on the consultant midwife and their impact on midwifery care.

### **What will happen when the research study stops?**

Once the research study stops I will analyze the findings. A full report will be written and will be available for the participating midwives to read. A copy may be sent to you on request.

### **Will my taking part in this study be kept confidential?**

All information collected will be maintained confidentially by only me. All documentation will be coded and will not bear any names only codes. The lists of codes will be kept locked away, separate to any other documentation.

All documentation will be stored securely within The Research Office of The School of Nursing and Midwifery at The University, for 15 years, following completion of the study. All personal data relating to this study will be maintained in accordance with the Data Protection Act (1998).

### **What will happen to the results of the research study?**

On completion of the study, all participating maternity units will be provided with a full report. Articles may be written for midwifery journals. My thesis will be housed in Southampton University Library. Due to the small number of practitioners taking part in this study every effort will be taken to ensure their confidentiality and anonymity. It will not be possible for you to identify the care that was observed, being given to you by your midwife, in any report or article written.

### **Who is organising and funding the research?**

The research study is self funded.

### **Who has reviewed the research proposal?**

This research proposal has been approved by MREC.

It has been written under the guidance of two research supervisors:

Professor Judith Lathlean, University of Southampton (Research Sponsor).

Dr Jane Rogers, University of Southampton.

**Contact for further information.**

I may be contacted on 01483 686713 or [a.robinson@surrey.ac.uk](mailto:a.robinson@surrey.ac.uk) or at the following address:

Level 5, Duke of Kent Building, University of Surrey, Guildford, Surrey GU2 7TE

My research supervisors may be contacted via [J.Lathlean@soton.ac.uk](mailto:J.Lathlean@soton.ac.uk) or [J.Rogers@soton.ac.uk](mailto:J.Rogers@soton.ac.uk)

Thank you for taking time to read this information.

Ann Robinson

Midwifery Lecturer / PhD Student

**CLIENT CONSENT FORM.**

**AN INVESTIGATION OF THE ROLE OF THE CONSULTANT MIDWIFE**

Name of Researcher: Ann Robinson, Midwifery Lecturer

**Please Initial boxes below:**

1. I confirm that I have read and understand the information sheet dated with regard to the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.

3. I understand that the only person with access to the observational data, interview recordings and transcripts will be the named researcher only.

4. I agree for my midwife to be observed by the above named midwifery researcher, whilst she provides me with midwifery care.

<b>Name of Client</b>	
<b>Signature of Client</b>	
<b>Date</b>	

<b>Name of Researcher</b>	<b>Ann Robinson</b>
<b>Signature of Researcher</b>	
<b>Date</b>	

**1 copy to be retained by client**  
**1 copy to be retained by researcher**

**Appendix 10**  
**Anonymised Job Description**



## Midwife Consultant (Labour Ward)

### Job Description

#### 1. Introduction

*(Section removed to preserve Trust anonymity).*

#### 2. Duties of the post

2.1 The midwife consultant post will be characterised by four principal role functions:

- an expert practice function
- a professional leadership and consultancy function
- an education, training and development function
- a practice and service development, research and evaluation function.

The balance of these functions may vary from time to time in consultation with the Director of Midwifery, the lead Clinician for the labour ward and the manager of the labour ward. However **at all times the postholder must maintain a fixed commitment of 50% of their time to practice and at all times the emphasis will be to supporting and developing normal midwifery practice.**

2.2 Final responsibility for determining the job plan of the midwife consultant will rest with the Director of Midwifery.

2.3 The initial objectives of the post are outlined in Appendix 2. It is expected that these will be relevant for the first 2-4 years of the post. They will however be reviewed with the postholder on a yearly basis.

#### 3. The Expert Practice Function

3.1 The postholder is expected to be an expert in the care of women in normal labour and will spend 50% of her time caring for women in labour. The focus of this allocation should be such as to enable the midwife consultant to have direct experience of the variety of conditions with which women arrive on the labour ward but it must be borne in mind at all times that the primary purpose of this post relates to the care of women in normal labour. The clinical practice component of the post should support the ability of the postholder to fulfil her other functions and it is therefore intended that she will normally spend her clinical time with women anticipated to have a normal labour.

3.2 The postholder will usually work with students (medical or midwifery) or with less experienced midwives who are newly allocated to the labour ward. However, when she is in clinical practice she takes overall responsibility for the care of the women allocated to her and is expected to be present at all times on the labour ward.

3.3 It is important to good labour ward practice to have clear managerial lines of responsibility and although whenever possible the postholder may negotiate the cases allocated to her to ensure she can fulfil other functions of her role, when she is fulfilling the expert practice function of her role, the allocation of her cases is ultimately the responsibility of the G grade midwife co-ordinator.

- 3.4 The postholder will make referrals to a minimum of SpR level if an abnormality is detected but if the postholder considers labour to be normal she will take full responsibility for all clinical decisions.

#### **4. Professional Leadership and Consultancy Function**

- 4.1 The postholder is expected to exercise leadership and inspire colleagues, to improve standards and quality and to develop professional practice.
- 4.2 The postholder is expected to be a Supervisor of Midwives.
- 4.3 The postholder will be a member of appropriate Committees to enable her to fulfil this function i.e. Labour Ward Management Group, Clinical Governance Committee, Supervisors of Midwives meeting, Senior Midwives management meeting, Risk Management meeting, Guidelines Committee, Maternity Services Liaison Committee.
- 4.4 Senior midwifery and obstetric staff will seek advice from the postholder when planning service developments and discussing the strategic direction of the service. The postholder will be expected to formulate appropriate contributions to policy/strategy documents.
- 4.5 The postholder will be expected to proactively offer advice to the appropriate parties on documents and knowledge emerging in her area of expertise. The postholder will be expected to provide written reports/evidence outlining for managers his/her recommendations for best practice.
- 4.6 The postholder will in particular advise the lead clinician for audit on appropriate topics for midwifery audit.
- 4.7 The postholder will be expected to provide an expert view on Notifiable Clinical Events relating to midwifery.

#### **5. The Education, Training and Development Function**

- 5.1 The postholder will be expected to ensure students experience an appropriate learning environment.
- 5.2 The postholder will also be expected to create a learning environment for qualified staff.
- 5.3 The postholder will be expected to identify the learning needs of midwives working in their area of special interest. In co-operation with the appropriate managers they will be expected to identify how these learning needs are to be met and (linking in with the risk management function) to ensure that appropriate processes are in place to record all learning taking place.
- 5.4 The postholder will partly fulfil the above function through role modelling and through mentoring and much of this will take place during the clinical practice component of the role. The postholder will be expected in particular to contribute to retention of midwives by ensuring appropriate support and supervision is available.
- 5.5 In ensuring staff receive appropriate education and support the postholder will at all times liaise with managers.

**NB** It remains a management responsibility to ensure all staff have a yearly performance appraisal and performance development plan, however there is no reason why the postholder may not take on a specific responsibility for a specific group of staff with special needs. At all times the postholder will exercise the education, training and development function in collaboration and co-operation with managers, lecturer practitioners, midwifery lecturers, specialist midwives.

## **6. The Practice and Service Development, Research and Evaluation Function.**

6.1 The postholder is responsible for promoting evidence based practice in their area.

6.2 This function may be exercised in a variety of ways e.g.

Role modelling

Guideline development

Influencing medical and midwifery curriculae

Encouraging reflective practice, journal clubs etc.

Dissemination of research articles

Undertaking audit and implementing change on the basis of the findings.

6.3 The postholder will be expected to advise managers on best practice at all times and to highlight areas where practice change is necessary.

6.4 The postholder will be expected to promote midwifery based research in the unit.

## **7. Secretarial Services**

The postholder will be provided with office space and a computer with all facilities including the Cochrane Database, Intranet, internal and external E-mail. All senior members of the Care Group are expected to support themselves using these facilities. However, the postholder will also be able to access the support of the Midwifery management team's secretarial pool.

## **8. Study Leave**

Study leave may be requested through application to the Director of Midwifery. It is expected that the postholder will have an MSc in midwifery or a related subject area. The postholder will be encouraged to work towards a Phd.

## **9. Leave**

To ensure the smooth and efficient running of the service the postholder will plan their leave in discussion with the Director of Midwifery and will take personal responsibility for ensuring arrangements are made to cover or cancel their clinical commitments.

## **10. Terms and Conditions of Service**

The post is covered by the terms and conditions of the General Whately Council and Trust Conditions and Service. Appointment is conditional upon a satisfactory medical assessment which may include an examination.

## **11. Other Facilities**

Full Library facilities are available at King's College Hospital in the Medical School. All medical and dental staff employed by the Trust automatically become associated members of the King's College Hospital School of Medicine and Dentistry and may therefore use the sports and social facilities available.

**The document is written using the female gender however the postholder could equally be male.**

**PERSON SPECIFICATION**

**MIDWIFE CONSULTANT (Labour Ward)**

1. Sound intellectual skills, evidenced by a professional training base supplemented by further academic qualification and appropriate clinical experience. A MSc is essential. A track record of research is desirable. Willingness to work towards a PhD is desirable.
2. A willingness to accept responsibility whilst providing high visibility leadership to a committed workforce.
3. An awareness of own strengths and weaknesses, coupled with the ability to deploy them to best effect within a senior clinical and management team.
4. A willingness to guide and advise colleagues in developing their service whilst acknowledging their individual responsibility for such matters within the Department.
5. Excellent interpersonal skills coupled with an ability to co-operate within a top senior clinical and managerial team.
6. A clear understanding of recent developments in their specialist area and the opportunities and challenges they present to a Maternity Unit.
7. Personal recognition within the midwifery profession with an existing network of professional contacts.
8. Qualification as a Supervisor of Midwives or willingness to acquire this qualification is essential.
9. Excellent leadership skills.

## **Midwife Consultant (Labour Ward)**

### **Summary Job Description and Key Objectives**

#### **1. Key purpose of post**

The key purpose of this post is to ensure a high level of intellectual and practice expertise is available within the senior maternity team. The postholder will be expected to contribute significantly to the ability of the Maternity Services to contribute to the Clinical Governance Agenda particularly through the provision of advice on best practice and the support and development of staff. In addition the postholder will advise on service development ensuring that this moves the service towards meeting the key objectives of national and local policy documents. The postholder will also contribute to midwifery based audit and research.

#### **2. Short to medium term objectives**

- to support the Maternity Services in meeting the recommendations of contemporary professional and Government documentation / guidelines
- to work with the labour ward management team and Director of Midwifery to develop and implement a strategy for coping with the expected reduction in junior doctor posts in obstetrics. In particular to recommend necessary changes in midwifery practice and the education support needed to implement such change.
- to take a lead on ensuring those CSNT standards related to midwifery care on the labour ward are met.
- to lead on providing internal midwifery advice in the case of midwifery related Notifiable Clinical Events.
- to recommend the way forward for the maternity services in relation to women's wish to have continuity of care/one-to-one support in labour and to undertake delegated aspects of any plan which is accepted by the labour ward management team/Director of Midwifery.
- to participate in a multidisciplinary audit of the rising Caesarean Section Rate.
- to review the labour ward as a learning environment for student doctors and midwives and recently qualified/newly appointed midwives and to create an action plan aimed at ensuring continued good recruitment and improving retention of midwives. To undertake any delegated work emerging from this plan.

#### **3. In addition to this the postholder is expected to advise as necessary on best practice/developing policy and to encourage midwifery research on the unit**

#### **NB**

- 1) This is a new post in which the postholder is expected to spend 50% of time in clinical practice. These objectives will need to be reviewed very regularly to

ensure the person in post has a manageable job and is working on those issues of highest priority.

- 2)** Regular review will also be necessary to ensure that the role of the postholder compliments the skills and expertise of the current senior midwifery team.



**Appendix 11**  
**Consultant Midwife Biographies**



## **CONSULTANT MIDWIFE BIOGRAPHIES**

Before analysis of all contributing data could begin brief biographies of the Consultant Midwives participating in the study were written to aid understanding of each midwife's background, job title and role within their organisation. In writing these, care was taken to maintain participant anonymity (NMC 2008).

### **Participant 1 – Consultant Midwife Normal Birth**

This Midwife came into the role of Consultant Midwife without having worked in the Trust before. She was an experienced midwife, had studied to masters Level and had worked comprehensively across the maternity services. Since qualifying as a midwife she had practised in an integrated care team and also as a case loading midwife, in addition she had practised within a traditional care model. She had gained management experience as a team leader and also had worked in higher education as a qualified midwifery lecturer.

Her role as Consultant Midwife was predominantly focused on normality, specifically to increase the percentage of normal births and to work with the Obstetricians to begin to decrease the Caesarean Section rate. The role description was broad and encompassed all aspects of care in order to achieve that. Although her focus was on normal birth she wasn't restricted to the Labour Ward.

### **Participant 2 – Consultant Midwife Normal Birth**

This experienced midwife had studied at Masters Level. She had practiced as a midwife in the community for several years, had considerable neonatal experience as well as more recently research and management experience. She had no previous experience within the Trust she was currently employed by, having come straight into the role of Consultant Midwife. The role originally had a remit for normal birth but over time this had become more public health focused.

From role experience she felt that it is vital for a Consultant Midwife to have a considerable amount of practical experience prior to taking up the post, most importantly she needs to have credibility as a clinical practitioner. She felt that studying to Masters Level was vital due to the need to be articulate at a high level; she felt that having a higher degree helps you to achieve this.

In relation to personal attributes of a Consultant Midwife, this midwife felt it important to be able to articulate your vision for midwifery; she felt that having an opinion and not being frightened to stand by that vision, is what you're employed for.

**Participant 3 – Consultant Midwife Labour Ward**

This experienced midwife had comprehensive midwifery experience and an expertise in labour and delivery. She had studied to Masters Level and had previous experience in midwifery education. Her first post in the Trust was as Consultant Midwife. In relation to essential Consultant Midwife experience she felt that primarily an ability to get on with people was vital. She felt it essential to be able to come in from the cold and immediately get on with people – She felt that a key role objective is “to make friends and influence people”.

From experience, she felt that to start with, few Consultant Midwives had much of an idea as to what the role was about. She remembered that no one could say ‘this is what this job looks like’. That was one of the difficulties, which in a way was “an advantage because you could make anything out of it”.

**Participant 4 – Consultant Midwife Home from Home Birth Centre**

Prior to taking up the post of Consultant Midwife this participant had worked in higher education as a midwifery lecturer. She had studied to Masters Level and had comprehensive midwifery practice experience. Her clinical expertise was broad; she had practised in all areas but with a focus on antenatal care, care during labour and delivery and midwifery supervision. She felt that having an educational background was essential for the role of Consultant Midwife since there was such a need to be articulate, to write, teach and research. She felt that other essential requirements of a Consultant Midwife included having good communication skills – “you want to be able to communicate with people at every level, at all different levels of the hierarchy”. Most importantly was the need to have clinical expertise – “we are there to guide and to lead on clinical practice”.

**Participant 5 - Consultant Midwifery Led Care**

This midwife had much experience in the role of Consultant Midwife, having been employed as one in a former Trust. In addition to this, and previously, this midwife had practised as a midwife in all areas both in the UK and abroad. She had extensive educational, managerial and project experience. Like most Consultant Midwives she was also a trained and practising Supervisor of Midwives. Academically, she had studied to Masters Level which she saw as key due to “the breadth of knowledge that is required and the writing you have to do”. She felt that this had helped her develop her depth of knowledge and to be able to work at a strategic level. She felt that her managerial experience helped her in her role as Consultant Midwife by giving her a sense of what it is like to be responsible for people and also because she had learnt to understand “the actual running of the service”. Her passion was clearly about strategic planning and modernization – taking the profession forward and trying to influence the future in whatever way.

**Participant 6 - Consultant Midwife Modernising Maternity Services (Normal Birth)**

This Consultant Midwife had considerable midwifery practice experience having trained in a large regional unit and having worked extensively within the community, hospital setting and abroad. She had studied to Masters Level and had multiple professional qualifications including an educational qualification. She came straight in as a Consultant Midwife and at the point of interview had been in post for approximately 5 years. She had been employed by her Trust prior to appointment as Consultant Midwife. She worked full time and had dedicated educational time.

This midwife felt it important for Consultant Midwives to have a Masters degree, due to the confidence studying at that level equips you with. She found that having an educational background was particularly beneficial to the role. She had a palpable confidence and love and passion for midwifery, she was committed to working interprofessionally and developing others.

**Participant 7 - Consultant Midwife – Public Health**

This participant like many others was one of the original Consultant Midwives following establishment of the role in 2000. She too had studied to Masters Level and had developed her specific expertise in midwifery by undertaking professional training. Prior to being appointed as a Consultant Midwife, this practitioner had practised as a midwife in the UK and abroad, she had been employed within her Trust prior to being appointed as a Consultant Midwife.

She described the role of Consultant as one which needed passion, commitment and excellent negotiating skills. Like many she spoke of the work life balance, difficulties associated with the role of Consultant Midwife due to the volume of work and felt strongly that a good relationship with whoever you are accountable to is vital.

**Participant 8 - Consultant Midwife Normal Birth**

This Consultant Midwife was particularly articulate and appeared to enjoy analysing and discussing her role. She too had studied to Masters Level had multiple professional qualifications and had trained as a midwife in a large regional unit.

This midwife was particularly familiar with her employing NHS Trust, having practised in multiple midwifery roles over many years. She too had educational experience. She believed that academic achievement and clinical credibility were key to becoming an effective and competent consultant midwife – “To have achieved academically and to be credible is a real achievement”. She described the role as being all about influence, motivation and passion – “You have to have passion for the job and to really want to improve things”. Other qualities she felt were key to being an effective Consultant Midwife

Appendix 11 Consultant Midwife Biographies

included being creative, a team player, leader and importantly and from a practical perspective “a completer finisher”.

## **Appendix 12**

### **An Example of Observational Notes Taken**



## **Observational Notes**

### **Observation Session 1**

<b>Date</b>	15 May 2006
<b>Site</b>	Trust 2 Community Hospital, ANC VBAC Clinic
<b>Data Collector</b>	Ann Robinson
<b>Duration</b>	1.5hrs Period of Observation – For first three clients attending clinic.
<b>Purpose</b>	Aim, to observe Consultant Midwife undergoing clinical activity.

### **The Environment**

The setting

Personal space

Examination Room in Outpatient Clinic in Community Hospital setting

Spacious, light, modern environment

Desk, 3 chairs

Examination couch (although not used)

### **The Participants**

Those present

Extra people who enter observational setting

3 clients seen

Informed Consent – All clients happy to participate

Consultant Midwife Present (Uniform not worn)

Researcher

### **Activities Being Observed**

The purpose of the exercise

### **Client 1**

P1

Previous LSCS for Failure to Progress

Now 20/40 gestation

**To discuss forthcoming labour and delivery in light of previous LSCS**

Birth Weight 3.5kg

Baby now aged 2

### **Client 2**

P1

Now 26/40 gestation

**To discuss forthcoming labour and delivery in light of previous LSCS**

Fetal distress during Labour

Birth Weight 3.2kg

Baby now 16/12 old

### **Client 3**

P1

Now 28/40

Previously Long labour, Failure to Progress → LSCS

**To discuss forthcoming labour and delivery in light of previous LSCS**

Birth Weight 4.1kg

Baby now 18/12

### **Interactions between Consultant Midwife and Clients**

What is said?

Who initiated interactions?

What is written?

### **Client 1**

A welcoming yet formal introduction. Consultant Midwife had collected client from waiting area and brought her to the examination room.

Client informed of purpose of visit and from the outset information given to client was detailed. Use of research statistics used confidently and accurately. Consultant Midwife knowledgeable / had made VBAC her area of expertise.

Issues discussed:

- Risk of a second Caesarean Section – “70-80% of vaginal births will be successful”;
- Risk of uterine rupture during the second labour. The Consultant Midwife said “If labour is not induced or augmented the risk of uterine rupture is less than 1 in 200. Most people work on a 0.5% chance”. She also explained that the chance of the scar line beginning to breakdown is low “1% chance”. To put things into context the Consultant Midwife confirmed that the likelihood of any client needing an emergency Caesarean Section for events other than uterine rupture is just fewer than 3%.

- The client asked if the baby would need to be continuously monitored or whether she would be able to walk about. The Consultant Midwife confirmed that “the advantage of continuous monitoring is that the relationship between fetal heart and contractions is seen more clearly”. Having said that she also confirmed that there are other ways of detecting a scar that is breaking down e.g. “increased maternal pulse rate”.

Apart from discussing the chances of having a normal vaginal birth, the client seemed intent on discussing her last labour and delivery. She was clearly distressed by her past experiences. The Consultant Midwife although appearing slightly rushed listened intently and said “The best thing to do is for me to get your old notes and see you at home to discuss them”.

Other issues discussed included explaining common misunderstandings in relation to VBAC and in so doing some physiology was clearly explained. The Consultant Midwife brought the appointment to a close on time saying “Your next appointment will be with your Obstetric Consultant to discuss mode of birth, this is because a birth following a Caesarean is outside normal midwifery practice, but I will see you at home first”. The client concluded “It’s been very helpful talking with you”.

## **Client 2**

The client was again collected from the waiting area and welcomed by the Consultant Midwife. The client was again interested in hearing about her chances of having a normal birth. The Consultant Midwife appeared more relaxed with this client and again provided a very thorough discussion of research based experience. “There is a 70-80% chance of you having a normal birth and a 20-30% chance of another C Section”. Health Outcomes were discussed “It’s better for you to have a vaginal birth but it’s safer for the baby to have an elective Caesarean Section – The risks to the baby are no greater than last time”. She again explained that “the risk of the scar rupturing was 0.5% or 1:200”.

The Consultant Midwife clearly had an order to the way information was delivered, a check list to follow. The provision of information was presented in an orderly, formal manner. The Midwife sat at the desk with the client facing her, a traditional medical appointment arrangement.

The client showed concern that her baby was now only 16/12 old “would this affect the chances of the scar rupturing”. The Consultant Midwife said “there is no evidence to show this is to be a problem”.

Again the midwife ended the appointment on time by saying “Do you have any further questions?” and explained that the next visit “would be at 36/40 gestation with the Consultant Obstetrician”.

### **Client 3**

Client 3 was clearly keen to make this a brief appointment. She appeared rushed and had a list of questions to ask. The Consultant Midwife carefully slowed everything down and despite the initial urgency the client relaxed into hearing about VBAC.

Information was delivered identically as in cases 1 & 2. The performance was again formal, the same statistics used to exemplify chances of having a normal birth.

The Consultant Midwife kept a distance between herself and the client (as before). The environment was formal and slightly pressured, the aim was clearly to impart this information and document so doing in the notes. The midwife did listen to questions presented by the client and always answered professionally and accurately. No humour, atmosphere not particularly relaxed.

Client questions related to pain relief in labour and what would happen if the pregnancy was “over due”. The Consultant Midwife explained that with “induction of labour comes a greater chance of the uterus rupturing”. She referred to a recent study – “the rate of uterine rupture with an induced trial of labour is higher than if labour is spontaneous, especially if Prostaglandins are used”. She explained that options would include “waiting, induction or an elective C Section”. She explained that in this case the client would see the Consultant Obstetrician at 41/40.

This time the Consultant Midwife recommended certain web sites for further information and again explained that the next appointment “would be at 36/40 gestation with the Consultant Obstetrician”.

The appointment ended on time.

### **Observer Participation**

Appeared not to be a distraction to clients.

No communication to clients expect during informed consent and good bye

### **Duration**

Client 1 – 30 minutes

Client 2 – 30 minutes

Client 3 – 30 minutes

## **Outcome**

Accomplished Tasks

Expertise of midwife assessed.

Midwifery competencies focused upon.

Communication skills observed.

Client responses acknowledged.

## **Thoughts & Feelings**

### **Emotions**

Good to have made mark as a Consultant Midwife by setting up a VBAC clinic.

Professional respect noted.

An exemplary performance, research based, identical for each client. Client individuality lost; there could have been a more informal / reassuring / caring aspect in relation to the delivery of care.

The clients did however appear content and were equipped with the evidence required to make personal decisions.

## Observation Session 2

<b>Date</b>	22 May 2006
<b>Site</b>	Trust 2
<b>Data Collector</b>	Researcher
<b>Duration</b>	2 hours
<b>Purpose</b>	Aim, To observe Consultant Midwife Chairing Divisional Midwives Board Meeting

### The Environment

The setting

Personal space

Large meeting room on Acute NHS Trust site.

Seating for approximately 25 around long rectangular table.

Good light, airy environment.

Relaxed but formal environment.

Agenda set and notes taken.

### The Participants

Those present

Extra people who enter observational setting

Good attendance.

Consultant Midwife Present (Uniform not worn) – Chair.

Head of Midwifery.

Hospital and Community Managers.

Community Midwives.

Senior Hospital based Midwives

Link Midwifery Lecturer from University.

Researcher.

All in attendance at start of meeting.

Meeting started on time.

### Activities Being Observed

The purpose of the exercise

To observe:

- The leadership skills of the Consultant Midwife chairing the meeting;
- The relationship between the Consultant Midwife and Senior Midwifery staff;
- The Consultant Midwife's grasp of what is important to Senior Midwifery staff.

## **Interactions between Consultant Midwife and other Midwives**

What is said?

Who initiated interactions?

What is written?

Sitting at the head of the table the Consultant Midwife opened the meeting and welcomed everyone in a formal manner. Consultant Midwife appeared relaxed in position as 'Chair' and conversant with formalities involved.

Notes of last meeting observed for accuracy and matters arising.

The first presentation commenced – *Audit on Women's Views*.

Slides presented relating to:

Birth environment;

Positions for Labour;

Skin to Skin contact;

Pain relief;

Mobility during labour;

Postnatal care in hospital;

Postnatal visits at home.

The Consultant Midwife maintained the formality of meeting throughout. The midwives in attendance appeared comfortable with this style of leadership and accepting of Consultant Practitioner being in lead position.

During the first presentation the Consultant Midwife leant forward, listening earnestly and at the end of the presentation asked "How are you going to cope with reduced resources in the postnatal clinics?" This gave rise to a major discussion relating to staffing levels, mothers needs, realistic expectations and Government initiatives and expectations. The Consultant Midwife appeared to have asked a very 'topical' question.

Some humour displayed but in the main the Consultant Midwife appeared focused on maintaining order and keeping to time. A very polished performance.

Other issues discussed:

- Masters Modules offered by educational provider discussed. Few midwives recruited. Consultant Midwife interjected suggesting eye catching posters in Trust.
- Practice Education Forum. Practice Educator Role explained by Consultant Midwife and strengths emphasised in relation to emergency skills workshops and enhancing relationship between University and Trust.

## Appendix 12 An Example of Observational Notes Taken

- Home Birth Leaflet – Consultant Midwife enquired as to whether it had been circulated to enough women and whether it provided a balance of information. “Was it evidence based”?
- Training Priorities – Consultant Midwife correctly interpreted needs of practising midwives:
  - 1 Supervision Module
  - 2 Examination of Newborn
  - 3 High Dependency Care

### **Observer Participation**

Appeared not to be a distraction to midwives / proceedings.

No communication by researcher during meeting.

### **Duration**

2 hours.

### **Outcome**

Accomplished Tasks

Leadership skills of Consultant Midwife assessed. Expertise of midwife as ‘Chair’ assessed.

Consultant Midwife’s grasp of key midwifery concerns noted.

Communication skills observed.

Senior Midwifery responses acknowledged.

### **Thoughts & Feelings**

#### **Emotions**

A very formal meeting capably chaired by Consultant Midwife who appeared to want to exhibit her leadership skills and for all to see the appropriateness of a Consultant Midwife leading such a meeting.

The Consultant Midwife clearly saw herself as senior, educated and influential. She showed that she could demand respect when speaking as a practitioner, researcher and educator.

On a more negative note the Consultant midwife did not appear to be approachable and one wondered how she would be viewed by junior staff.

## References

- Ahern, K.J. (1999) Ten tips for reflexive bracketing, *Qualitative Health Research*, 9, p 408-10.
- Allen, D. (2004) Ethnomethodological insights into insider-outsider relationships in nursing ethnographies of healthcare settings, *Nursing Inquiry*, 11 (1), pp14-24.
- Ambler, R. (2006) Clinical credibility? *Midwives*, 9 (4), pp144-145.
- Appleton, J.V. (2002) Critiquing approaches to case study design for a constructivist inquiry, *Qualitative Research Journal*, 2 (2), pp80-97.
- Arber, A. (2006) Reflexivity A challenge for the researcher as practitioner, *Journal of Research in Nursing*, 11 (2), pp147-157
- Avery, G.C. (2004) Understanding leadership paradigms and cases, London: Sage Publications Limited.
- Baillie, L. (1994) Nurse teachers' feelings about participating in clinical practice. An explanatory study. *Journal of Advanced Nursing*, 20, pp150-159.
- Bandura, A. (1965) Influence of models' reinforcement contingencies on the acquisition of imitative responses, *Journal of Personality and Social Psychology*, 1, pp589-595.
- Banning, M. (2008) Clinical reasoning and its application to nursing: Concepts and research studies, *Nurse Education in Practice*, 8, pp177-183.
- Barnes, H., Nash, K., Parr, C., Smith, L. (2010) The climb to the Top, *Midwives*, April/May, pp42-43.
- Barr, J. and Dowding, L. (2008) *Leadership in Health Care*. London: Sage Publications Ltd.
- Benner, P. (1994) *Interpretative Phenomenology – Embodiment Caring and Ethics in Health and Illness*, Newbury Park: Sage Publications.
- Benner, P., Hooper – Kyriakidis, P., Stannard, D. (1999) *Clinical Wisdom and Interventions in Critical Care*. Philadelphia: W.B. Saunders Company.
- Benner, P., Tanner, C., Chesla, C. (2009) *Expertise in Nursing Practice - Caring, Clinical Judgement, and Ethics*. Second Edition. New York: Springer Publishing Company.
- Benner, P., Hooper – Kyriakidis, P., Stannard, D. (2011) *Clinical Wisdom and Interventions in Acute and Critical Care*, Second Edition, New York, Springer Publishing Company.
- Bick, D. (2008) Editorial: Maternal mortality in the UK: The impact of the increasing complexity of women's lives, *Midwifery*, 24 pp 1-2.
- Bonar, S. (2010) In the Corridors of Power, *Midwives*, December, p 22.
- Bonar, S. (2011) NHS Reforms in England, *Midwives*, Issue 5, p 27.
- Booth, J., Hutchinson, C., Beech, C., Robertson K. (2006) New nursing roles: the experience of Scotland's consultant nurse/midwives, *Journal of Nursing Management*, 14 pp 83-89.

## References

- Bowling, A. (1997) *Research Methods in Health Investigating Health and Health Services*. Buckingham: Open University Press.
- Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology, *Qualitative Research in Psychology*, 3, pp77-101.
- Brett, P. (2005) Addressing teenage pregnancy in Lewisham. *Midwives*, 8(9), pp 390-391.
- Brown, S. (2006) The experiences of lecturer practitioners in clinical practice, *Nurse Education Today*, 26, pp601-608.
- Bryar, R.M. (2000) An examination of the case study, *Nurse Researcher*, 7(2), pp 61-79.
- Butler, M., Fraser, D.M., Murphy, R.J.L. (2008) What are the essential competencies required of a midwife at the point of registration? *Midwifery*, 24 (3), pp 260-269.
- Byrom, S., Edwards, G., Garrod, D. (2009) Consultant Midwives - 10 Years On! *MIDIRS Midwifery Digest*, 19 (1), pp 23-25.
- Byrom, S. and Edwards, G. (2005) Separated at birth – now joined at the hip! *Midwives*, 8 (12), pp 496-497.
- Carnwell, R., Baker, S-A., Bellis, M., Murray, R. (2007) Managerial perceptions of mentor, lecturer practitioner and link tutor roles, *Nurse Education Today*, 27, pp923-932.
- Carolan, M. (2003) Reflexivity: a personal journey during data collection, *Nurse Researcher*, 10 (3), pp7-14.
- Carr, E.C.J. (2010) Reflexivity A challenge for the researcher practitioner? *Journal of Research in Nursing*, 11 (2), pp158-159.
- Carr, S.M. (2005) Knowing nursing – the challenge of articulating knowing in nursing, *Nurse Education in Practice*, 5, pp333-339.
- Carriere, B. K., Muise, M., Cummings, G., Newburn-Cook, C. (2009) Healthcare Succession Planning, *The Journal of Nursing Administration*, 39 (12), pp 548-555.
- Cave, I. (2005) Nurse teachers in higher education – without clinical competence, do they have a future? *Nurse Education Today*, 25, pp646-651.
- Charters, S., Knight, S., Currie, J., Davies-Gray, M., Ainsworth-Smith, M., Smith, S., Crouch, R. (2005) Learning from the past to inform the future - A survey of consultant nurses in emergency care, *Accident and Emergency Nursing*, 13, pp186-193.
- Chiarella, M., Hardford, E., Lau, C. (2008) *Report on the Evaluation of Nurse / Midwife Practitioner and Clinical Nurse / Midwife Consultant Roles*, North Sydney, New South Wales : Department of Health.
- Chinn, P. L. and Kramer, M. K. (2004) *Integrated Knowledge Development in Nursing*. 6<sup>th</sup> Edition, St Louis, Mosby.
- Chummun, H. and Tiran, D. (2008) Increasing research evidence in practice: a possible role for the consultant nurse, *Journal of Nursing Management*, 16, pp 323-333.

- CIPD (2010) Organisational culture and values as a source of competitive advantage. Available at: <http://www.CIPD.co.uk/research/visionandvalues.htm>. (Accessed 10<sup>th</sup> February 2010).
- Clarke, P. (2005) Leading the development of an ECV service, *Midwives*, 8 (3), pp 128-129.
- Clauson, M., Wejr, P., Frost, L., McRae, C., Straight, H. (2010) Legacy Mentors: Translating the wisdom of our senior nurses, *Nurse Education in Practice*, pp1-6.
- Cooke, P. (2004) Promoting Partnerships in Paddington: a consultant midwife's role, *Midwives*, 7 (7), pp 310-311.
- Corcoran, P.B., Walker, K.E., Wals, A.E. (2004) Case studies, make-your-case studies and case stories: A critique of case-study methodology in sustainability in higher education, *Environmental Education Research*, 10 (1), pp 7-21.
- COREC (2004) *New Operational Procedures for NHS REC's: Guidance for applicants to Research Ethics Committees*. United Kingdom: NHS Central Office for Research Ethics Committees.
- Costello, J. (2001) Nursing older dying patients: findings from an ethnographic study of death and dying in elderly care wards, *Journal of Advanced Nursing*, 35 (1), pp 59-68.
- Coster, S., Redfern, S., Wilson-Barnett, J., Evans, A., Peccei, R., Guest, D. (2006) Impact of the role of nurse, midwife and health visitor consultant, *Journal of Advanced Nursing*, 55 (3), pp 352-363.
- Creswell, J.W. (1998) *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks: Sage Publications.
- Creswell, J.W., Piano Clark, V.L. (2011) *Designing and conducting mixed methods research* (2<sup>nd</sup> edn), Thousand Oaks, California : Sage Publications Ltd.
- Crotty, M. (1998) *The foundations of social research: Meaning and perspective in the research process*. London: Sage Publications.
- Crotty, M. (2003) *The Foundation of Social Research Meaning and Perspectives in the Research Process*. 2<sup>nd</sup> Edition, London: Sage.
- Currie, J. (2007) Keeping experience at the bedside: the emergency consultant nurse role, *British Journal of Nursing*, 16 (1), pp 18-21.
- Dawson, D. and McEwan, A. (2005) Critical care without walls: The role of the nurse consultant in critical care, *Intensive and Critical Care Nursing*, 21, pp 334-343.
- Dawson, D. and Coombs, M. (2008) The current role of the consultant nurse in critical care: Consolidation or consternation? *Intensive and Critical Care Nursing*, 24, pp 187-196.
- Denzin, N.K. and Lincoln, Y. (2000) *Handbook of Qualitative Research*. 2<sup>nd</sup> Edition. Thousand Oaks California: Sage Publications.
- Department for Education and Skills (DFeS) (2004) *Every Child Matters: Change for Children*. London: DFeS.
- Department of Health (DH) (1989) *A Strategy for Nursing*. London: HMSO.

## References

- Department of Health (DH). (1991) *The Patient's Charter: Raising the Standard*. London: HMSO.
- Department of Health (DH). (1997a) *The New NHS Modern and Dependable*. London: The Stationary Office.
- Department of Health (DH). (1997b) *Junior Doctors Hours: The New Deal*. London: NHS Executive.
- Department of Health (DH). (1999a) *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*. London: DH.
- Department of Health (DH). (1999b) *Saving Lives: Our Healthier Nation*. London: The Stationary Office.
- Department of Health (DH). (2000) *The NHS Plan*. Norwich: The Stationary Office.
- Department of Health (DH). (2000) *Meeting the Challenge: A Strategy for the Allied Health Professions*. London: DH.
- Department of Health (DH). (2003) *Choices in Maternity Services*. 9<sup>th</sup> Report of the Health Committee. London: HMSO.
- Department of Health (DH). (2004a) *National Service Framework for Children, Young People and the Maternity Services*. London: DH.
- Department of Health (2004b) *National Standards, Local Action* [online]. Department of Health, London. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4086057](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086057). (Accessed 6 March 2008).
- Department of Health (2004c) *The Chief Nursing Officer's review of the nursing, midwifery and health visiting contribution to vulnerable children and young people*. London: HMSO.
- Department of Health (2005) *Research Governance Framework for Health and Social Care* (2<sup>nd</sup> Edition.) [Online]. Department of Health, London. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4108962](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962) (Accessed 6 March 2008).
- Department of Health (DH). (2006) *Health Reforms in England: Updating and Commissioning Framework*. London: DH.
- Department of Health (DH). (2007) *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service*. London: DH.
- Department of Health (DH). (2008) *High Quality Care for All*, London: DH.
- Department of Health (DH). (2009) *Delivering High Quality Midwifery Care: the priorities opportunities and challenges for midwives*. London: DH.
- Department of Health (DH). (2011) *Equity and Excellence: Liberating the NHS*. London: DH.
- Department of Health, Social Services and Public Safety., Welsh Assembly Government., Department of Health., The Scottish Government. (2010) *Midwifery 2020 Delivering expectations*. Cambridge: Jill Rogers Associates.

- Dienes, Z. and Berry, D. (1997) Implicit Learning: Below the subjective Threshold, *Psychosomatic Bulletin and Review*, 4, pp3-23.
- Doherty, C. (2010) Learning to lessen risk, *Midwives*, December, pp 36-37.
- Donaldson, J.H. and carter, D. (2005) The value of role modelling: Perceptions of undergraduate and diploma nursing (adult) students, *Nurse education in Practice*, 5, pp353-359.
- Donnison, J. (1988) *Midwives and Medical Men*. London: Historical Publications Limited.
- Dopson, S. and Mark, A.L. (Editors). (2003) *Leading Health Care Organisations*, Basingstoke: Palgrave Macmillan.
- Dowling, M. (2006) Approaches to reflexivity in qualitative research, *Nurse Researcher*, 13 (3), pp7-21.
- Duffy, K., Ferguson, C., Watson, H. (2004) Data Collecting in Grounded Theory – some practical issues, *Nurse Researcher*, 11 (4), pp67-78.
- Dunkley, L. and Saider, S. (2011) *Nursing & Midwifery Workforce Risks and Opportunities*. United Kingdom: Centre for Workforce Intelligence.
- Easton, K.L., McCormish, J.F., Greenberg, R. (2000) Avoiding common pitfalls in qualitative data and transcription, *Qualitative Health Research*, 10 (5), pp 703-707.
- Editor of Midwives (RCM). (2011) Frontline - Essential news and information for midwives, *Midwives*, Issue 2, p 9.
- Elcock, K. (1998) Lecturer practitioner: a concept analysis, *Journal of Advanced Nursing*, 28 (5), pp1092-1098.
- Endacott, R. (2005) Clinical Research 4: Qualitative data collection and analysis, *Intensive Critical Care Nursing*, 21 (2), pp 123-127.
- Eraut, M. (2000) Non-formal learning and tacit knowledge in professional work, *British Journal of Educational Psychology*, 70, pp113-136.
- Fairley, D. and Closs, S.J. (2006) Evaluation of a nurse consultant's clinical activities and the search for patient outcomes in critical care, *Journal of Clinical Nursing*, 15, pp1106-1114.
- Field S (Chairman) (2011) *NHS Future Forum - Summary report on proposed changes to the NHS*. NHS Future Forum: London.
- Finlay, L. and Gough, B. (2003) *Reflexivity. A practical guide for researchers in health and social sciences*. Oxford: Blackwell.
- Finlayson, B., Dixon, J., Meadows, S., Blair, G. (2002) Mind the gap: the extent of the NHS nursing shortage, *BMJ*, 325, pp 538-541.
- Fisher, M.T. (2005) Exploring how lecturers maintain clinical credibility, *Nurse Education in Practice*, 5, pp21-29.
- Freshwater, D. (2005) Writing, rigour and reflexivity in nursing research, *Journal of Research in Nursing*, 10 (3) pp 311-315.

## References

- Gabbay, J. and Le May A. (2011) *Practice – Based Evidence for Healthcare Clinical Mindlines*, Abingdon: Routledge.
- Garman, A. and Glawe, J. (2004) Succession Planning, *Consulting Psychology Journal: Practice and Research*, 56 (2), pp 119-128.
- Gerrish, K., Ashworth, P., Lacey, A., Bailey, J. (2008) Developing evidence-based practice: experiences of senior and junior nurses. *Journal of Advanced Nursing*, 62, pp 62-73.
- Gibb, S. and Hundley, V. (2007) What psychosocial wellbeing in the postnatal period means to midwives, *Midwifery*, 23 (4), pp 413-424.
- Glaser, B.G. and Strauss, A.L. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine de Gruyter.
- Gopee, N. and Galloway, J. (2009) *Leadership and Management in Healthcare*. London: Sage publications Ltd.
- Goorapah, D. (1997) Clinical Supervision, *Journal of Clinical Nursing*, 6, pp173-178.
- Graham, I.W. and Wallace, S. (2005) Supporting the role of the nurse consultant – an exercise in leadership development via an interactive learning opportunity, *Nurse Education Today*, 25, pp 87-94.
- Green, G. (1988) Relationships between role models and role perceptions of new graduate nurses, *Nursing Research*, 37 (4), pp245-7.
- Greenhalgh, T. (2002) 'Intuition and evidence – uneasy bedfellows? *British Journal of General Practice*, 52, pp395-400.
- Greenhalgh, T. (Editor) (2006) How to read a paper. The basis of evidence based medicine. 3rd Edition. Oxford: Blackwell Science.
- Guardian (2011) Call for more midwives as birth rate reaches 40-year high, 13 July 2011, Guardian. Available at: [www.guardian.co.uk/society/2011/jul/13/more-midwives-birth-rate-40-year-high/print](http://www.guardian.co.uk/society/2011/jul/13/more-midwives-birth-rate-40-year-high/print). (Accessed 12<sup>th</sup> September 2011).
- Guba, E.G. (1981) Criteria for assessing the truthfulness of naturalistic enquiries, *Educational Resources Information Centre Annual Review*, 29 (2), pp 75-91.
- Guba, E.G. and Lincoln, Y.S. (1994) Competing paradigms in qualitative research. In N.K.Denzin and Y.S. Lincoln (Editors). *Handbook of Qualitative Research*. Thousand Oaks: Sage Publications.
- Guest, D.E., Redfern, S., Wilson-Barnett, J., Dewe, P., Peccei, R., Rosenthal, P., Evans, A., Young, C., Montgomery, J., Oakley, P. (2001) *A Preliminary Evaluation of the Establishment of Nurse, Midwife and Health Visitor Consultants*. London: King's College London.
- Guest, D.E., Peccei, R., Rosenthal, P., Redfern, S., Wilson-Barnett, J., Dewe, P., Coster, A., Evans, A., Sudbury, A. (2004) *An Evaluation of the Impact of Nurse, Midwife and Health Visitor Consultants*. London: King's College London.
- Haggerty, L A. and Grace P. (2007) Clinical Wisdom: The Essential Foundation of "Good" Nursing Care, *Journal of Professional Nursing*, 24 (4), pp 235-240.

- Hammersley, M. and Gomm, R (2000) Introduction, in Gomm, R., Hammersley, M., Foster, P. (Editors) (2000) *Case Study Method*. London: Sage Publications Inc., p4.
- Hampel, S., Procter, N., Deuter, K. (2010) A model of succession planning for mental health nurse practitioners, *International Journal of Mental Health Nursing*, 19, pp 278-286.
- Hamric, A. (1989) A Model for CNS Evaluation in The Clinical Nurse Specialist *in Theory and Practice*, Hamric, A., Spross, J. (Editors). 2<sup>nd</sup> Edition. Philadelphia: WB Saunders.
- Hardy, S., Garbett, R., Titchen, A., Manley K. (2002) Exploring nursing expertise: nurses talk nursing, *Nursing Inquiry*, 9 (3), pp 196-202.
- Hardy, M. and Snaith, B. (2007) How to achieve consultant practitioner status: A discussion paper, *Radiography*, 13, pp 265-270.
- Hawkins, J.W. and Fontenot, H. (2009) What do you mean you want to teach, do research, engage in service, and clinical practice? Views from the trenches: The novice, the expert, *Journal of the American Academy of Nurse Practitioners*, 21, pp 358-361.
- Hayes, J. and Harrison, A. (2004) Consultant nurses in mental health: a discussion of the historical and policy context of the role, *Journal of Psychiatric and Mental Health Nursing*, 11, pp185-188.
- Herbig, B., Bussing, A., Ewert, T. (2001) The role of tacit knowledge in the work context of nursing, *Journal of Advanced Nursing*, 34 (5), pp687-695.
- Hinchliffe, J. (2010) Leadership theories relevant to the role of the supervisor of midwives, *British Journal of Midwifery*, 18 (9), pp 588-593.
- Holmes, A. (2004) Changes and Challenges, *Midwives*, 7 (10), pp 444-445.
- Horsburgh, D (2003) *Evaluation of Qualitative Research*. 12 (2), pp 307-312.
- House of Commons Health Select Committee (2007). Available from: [www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/cmhealth.htm](http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/cmhealth.htm)  
Accessed on: 5 February 2011.
- Humphreys, A., Johnson, S., Richardson, J., Stenhouse, E., Watkins, M. (2007) A systematic review and meta-synthesis: evaluating the effectiveness of nurse, midwife/allied health professional consultants, *Journal of Clinical Nursing*, 16, pp 1792-1808.
- International Confederation of Midwives (ICM). (2005) *International Definition of a Midwife*. The Netherlands: ICM.
- International Confederation of Midwives (ICM). (2008) *Legislation to Govern Midwifery Practice*. The Netherlands: ICM.
- International Council of Nurses (ICN) (2006) *ICN Code of Ethics for Nurses* [Online] ICN, Geneva. Available at: <http://www.icn.ch/icncode.pdf> (Accessed 8th September 2009).
- Jewell, K. (2005) The public health divide, *Midwives*, 8 (7), pp 318-319.
- Johnson, G. and Dale, P. (2011) Leading the Way, *Midwives*, Issue 3, pp 40-41.

## References

- Kingdon, C. (2005) Reflexivity: Not just a qualitative methodological research tool, *British Journal of Midwifery*, 13 (10) pp622-627.
- Kolb, D.A. (1984) *Experiential Learning Experience as a Source of Learning and Development*. New Jersey: Prentice Hall.
- Kunzman, U. and Bates, P.B. (2003) Beyond the traditional scope of intelligence. Wisdom in Action in Sternberg, R.J., Lautrey, J., Lubart, T.I (Editors). *Models of Intelligence: International Perspectives*. Washington DC: American Psychological Association.
- Lambert, C., Jomeen, J., McSherry, W. (2010) Reflexivity: a review of the literature in the context of midwifery research, *British Journal of Midwifery*, 18 (5), pp321-326.
- Lapadat, J.C. (2000) Problemizing Transcription: purpose, paradigm and quality, *International Journal of Social Research Methodology*, 3 (3), pp 203-219.
- Lathlean, J. (1992) The contribution of lecturer practitioners to theory and practice, *Journal of Clinical Nursing*, 1 (5), pp 237-242.
- Lathlean, J. (1997) *Lecturer Practitioners in Action*. Oxford: Butterworth Heinemann.
- Lathlean, J. (2007) Researching implementation of pioneering roles in nursing and midwifery, *Journal of Research in Nursing*, 12 (1), pp 29-39.
- Leigh, J., Howarth, M., Devitt, P. (2005) The role of the lecturer practitioner: an exploration of the stakeholders and practitioners perspective, *Nurse Education in Practice*, 5, pp 258-265.
- Lewis, G (Editor). (2011) Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2006-2008. The eighth report of the Confidential Enquiries into Maternal Death in the United Kingdom. *BJOG: An International Journal of Obstetrics and Gynaecology*. 118 (Suppl 1):1- 206.
- Lincoln, Y.S. and Guba, E.G. (2000) Paradigmatic Controversies, Contradictions and Emerging Confluences in Denzin, N.K., Lincoln, Y.S (Editors). *Handbook of Qualitative Research*. Second Edition. Thousand Oaks: Sage Publications Inc.
- McGloin, S. (2008) The trustworthiness of case study methodology, *Nursing Researcher*, 16 (1), pp 45-55.
- McIntosh, J. and Tolson, D. (2008) Leadership as part of the nurse consultant role: banging the drum for patient care, *Journal of Clinical Nursing*, 18, pp 219-227.
- McSherry, R., Mudd, D., Campbell, S. (2007) Evaluating the perceived role of the nurse consultant through the lived experience of healthcare professionals, *Journal of Clinical Nursing*, 16, pp 2066-2080.
- MacLean, L.M., Meyer, M., Estable, A. (2004) Improving accuracy of transcripts in qualitative research, *Qualitative Health Research*, 14 (1) 113-123.
- Macrory, F. (2003) Sex and drugs and the role of a consultant midwife, *Midwives*, 6 (10), pp 422-424.
- Madden, R. (2010) *Being Ethnographic A guide to the theory and practice of ethnography*. London: Sage Publications Limited.

- Manley, K. (1997) A conceptual framework for advanced practice: an action research project operationalizing an advanced practitioner / consultant nurse role, *Journal of Clinical Nursing*, 6, pp 179-190.
- Manley, K. (2000a) Organisational culture and consultant nurse outcomes: Part 1 organisational culture, *Nursing Standard*, 14 (36), pp 34-38.
- Manley, K. (2000b) Organisational culture and consultant nurse outcomes: Part 2 nurse outcomes, *Nursing Standard*, 14 (37), pp 34-39.
- Manley, K. and McCormack, B. (1997) *Exploring expert practice*. London : Royal College of Nursing.
- Manley, K., Hardy, S., Titchen, A., Garbett, R., McCormack. (2005) *Changing patients' worlds through nursing practice expertise through emancipatory action research and fourth generation evaluation*, An RCN Research Report, 1998-2004, London: RCN.
- Manley, K., Hale, N., Minardi, H. (2008) Leadership Role of Consultant Nurses Working with Older People: a co-operative inquiry, *Journal of Nursing Management*, 16, pp147-158.
- Marchant, S. and Kenney, N. (2000) Conducting interviews with individuals and groups in Proctor, S. and Renfrew, M. (Editors). *Linking research and practice in midwifery: A guide to evidence-based practice*. London: Harcourt Press.
- Masterson, A. (2004) *New Nursing Roles: Deciding the Future for Scotland*, The Scottish Government. [Online] 13/7/2009, <http://www.scotland.gov.uk/Publications/2004/04/19201/35587> Accessed 7 March 2009.
- Maylor, M. (2005) Differentiating between a consultant nurse and a clinical nurse specialist, *British Journal of Nursing*, 14 (8), pp 463-467.
- Medical Research Council (MRC) (2005) *Good Research Practice* [Online]. MRC, London. Available from: <http://www.mrc.ac.uk/Utilities/Documentrecord/index.htm?d=MRC002415> [Accessed 8<sup>th</sup> September 2009].
- Merriam, S.B. (1988) *Case Study Research in Education: A Qualitative Approach*. San Francisco: Josey-Bass Publications.
- Miles, M.B. and Huberman, A.M. (1994) *Qualitative Data Analysis*. Second Edition. Thousand Oaks: Sage Publications.
- Mitchell, T., Butler-Williams, C., Easton, K., Ingledew, I., Parkin, D., Wade, S., Warner, R. (2010) The consultant nurse – expert practitioner and much more, *British Journal of Nursing*, 19, (8), pp 481-488.
- Mookherjee, J. (2004) *Their voices and our partners: qualitative lessons from the teenage pregnancy strategy in Lewisham*. London: Lewisham Primary Care Trust.
- Moule, P. and Goodman, M. (2009) *Nursing Research*. London: Sage Publications Limited.
- Mullen, C and Gavin-Daley, A. (2010) "Ten Years on – An Evaluation of the Non-Medical Consultant Role in the North West". NHS North West.
- Munro, J. and Spiby, H. (2000) *Guidelines for midwifery care in labour*. Sheffield: Sheffield Teaching Hospitals Trust.

## References

- Murphy, L. (2005) Transformational leadership: a cascading chain reaction, *Journal of Nursing Management*, 13, pp128-136.
- National Nursing Research Unit. (2007) Advanced nursing roles: survival of the fittest? *Policy+*, Issue 6, pp 1-2.
- Neill, S. (2006) Grounded Theory Sampling. The contribution of reflexivity, *Journal of Research in Nursing*, 11 (3), pp253-260.
- Nicholson, D., (2009) CNO Bulletin. London: Department of Health.
- NHS Executive. (1998) *Health Service Circular (HSC) 1998/045 Nursing, Midwifery and Health Visiting Strategy*. London: Department of Health (DH).
- NHS Executive. (1998) *Health Service Circular (HSC) 1998/161 Nurse Consultants*, London: DH.
- NHS Executive. (1999) *Health Service Circular (HSC) 1999/217 Nurse, Midwife, and Health Visitor Consultants: Establishing Posts and Making Appointments*. London: DH.
- NHS Information Centre, Workforce and Facilities Team (2009) *NHS Hospital and Community Health Services: Non – Medical Staff 1998-2008*. London: The NHS Information Centre.
- Nielsen, K., Randall, R., Yarker, J., Brenner, S-O. (2008) The effects of transformational leadership on followers' perceived work characteristics and psychological well-being: A longitudinal study, *Work and stress*, 22 (1), pp16-32.
- Nightingale, D. and Cromby, J. (Editors). (1999) *Social Constructionist Psychology*. Buckingham: Open University Press.
- Noonan, B.J., Hughes, M., Hayes, C.C., Hartigan, I., O'Connell, A., Fehin, P. (2009) The effectiveness of the lecturer practitioner role in clinical practice: an Irish perspective, *Nurse Education Today*, 29 (5) pp561-5.
- Nursing and Midwifery Council (NMC). (2004) *Midwives rules and standards*. London: NMC.
- Nursing and Midwifery Council (NMC). (2008) *The Code Standards of conduct, performance and ethics for nurses and midwives*. London: NMC.
- Nursing and Midwifery Council (NMC). (2009) *Standards for pre-registration midwifery education*. London: NMC.
- O'Brien, J.L., Martin, D.R., Heyworth, J., Meyer, N.R. (2008) Negotiating transformational leadership: A key to effective collaboration, *Nursing and Health Sciences*, 10, pp137-143.
- O'Neill, O. (2008) *Safe Births: Everybody's Business – An Independent Inquiry into the Safety of Maternity Services in England*, London, Kings Fund.
- O'Reilly, K. (2005) *Ethnographic Methods*. London: Routledge.
- Office of National Statistics (ONS) (2010) *Live Births in England and Wales by Characteristics of Birth*. Newport: ONS.

- Office of National Statistics (ONS) (2011) *Live Births in England and Wales by Characteristics of Birth*. Newport: ONS
- Office of Public Sector Information (OPSI) (1998) *Data Protection Act 1998* [Online]. OPSI, London. Available from: [http://www.opsi.gov.uk/acts/acts1998/ukpga\\_19980029\\_en\\_1](http://www.opsi.gov.uk/acts/acts1998/ukpga_19980029_en_1) [Accessed 8<sup>th</sup> September 2009].
- Ousey, K. and Gallagher P. (2010) The clinical credibility of nurse educators: Time the debate was put to rest, *Nurse Education Today*, 30, pp662-665.
- Parahoo, K. (2006) *Nursing Research Principles, Process and Issues*. 2<sup>nd</sup> Edition. Basingstoke: Palgrave Macmillan.
- Pearsall, J. and Hanks, P. (Editors) (2005) *Oxford Dictionary of English*. Oxford: Oxford University Press.
- Perry, R.N.B. (2009) Role modelling in clinical nursing practice, *Nurse Education in Practice*, 9, pp36-44.
- Polit, D.F. and Beck, C.T. (2006) *Essentials of Nursing Research, Methods, Appraisal and Utilization*. Philadelphia: Lippincott, Williams and Wilkins.
- Price, B. and Walker, C. (2007) Practice based assessment: strategies for mentors, *Nursing Standard*, 21 (36), pp49-58.
- Price, G. (2011) Like Minded Fellow, *Midwives*, Issue 4, pp 18-19.
- Price, S. (2006) Who wants to be a consultant midwife? *Midwives* 9 (1), pp 28-29.
- Ralston, R. (2005) Transformational leadership: leading the way for midwives in the 21<sup>st</sup> century, *Midwives*, 8 (1), pp34-37.
- Ramage, c. (2004) Negotiating multiple roles: link teachers in clinical practice, *Journal of Advanced Nursing*, 45(3), pp287-296.
- Redfern, L. (2003) Clinical Pinnacle, *Nursing Standard*, 17 (22), p 96.
- Redfern, S., Guest, D., Wilson-Barnett, J., Peccei, R., Rosenthal, P., Dewe, P., Evans, A. (2003) Role innovations in the NHS in *Leading Health Care Organizations*. Dopson, S., Mark, A.L. (Editors). Basingstoke: Palgrave Macmillan.
- Redwood, S., Carr. E., Graham, I. (2005) *Perspectives on the Consultant Nurse Role*. Bournemouth: Institute of Health and Community Studies, Bournemouth University.
- Rees, C. (2003) *Introduction to Research for Midwives*. London: Books for Midwives.
- Richardson, J. (2005) Are you normal? Implementing normality in the maternity unit, *Midwives*, 8 (11), pp 462-463.
- Robinson, A. (1995) *The Experiences of Mothers Breastfeeding Term Twins*, Unpublished Dissertation. Guildford: University of Surrey.
- Robinson, A. (2006) Phenomenology in *Principles and Practice of Research in Midwifery*, Cluett, E.R., Bluff, R. (Editors), Second Edition, Edinburgh, Baillière Tindall.
- Robson, C. (2002) *Real World Research*. 2<sup>nd</sup> Edition. Oxford: Blackwell Publishing.

## References

- Rogers, J. and Weavers A. (2005) Consultant Midwives: the next generation! *Midwives*, 8 (4), pp 172-173.
- Rogers, C. and Littlehales, C. (2006) Making choice a real option, *Midwives*, 9 (6), pp 242-243.
- Rogers, J. (2010) Aspiring consultant midwives: a trainee programme and its role in future practice leadership, *MIDIRS Midwifery Digest*, 20, (1), pp 20-23.
- Rogers, J. and Cunningham, S. (2007) A consultant midwives' clinic: a catalyst for cultural change? *MIDIRS Midwifery Digest*, 17 (2) pp 201-206.
- Rogers, C., Luck, S., Schiavone, N. (2008) Clinical Governance Framework and Quality Assurance in Relation to Midwifery Care in *Becoming a Midwife in the 21<sup>st</sup> Century*. Peate, I., Hamilton, C. (Editors). Chichester: John Wiley and Sons Limited.
- Royal College of Midwives (RCM). (2002) *Evidence to the Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine for 2003*. London: RCM.
- Royal College of Midwives (RCM). (2009) *Becoming a Consultant Midwife: building clinical leadership*. London: RCM.
- Royal College of Midwives. (2010) *RCM's Evidence to the NHS Pay Review Body 2010*. Available at: [www.rcm.org.uk/college/support-at-work/pay-pensions-tax/pay](http://www.rcm.org.uk/college/support-at-work/pay-pensions-tax/pay) (Accessed 11th September 2011).
- Royal College of Midwives. (2011) *Protect Maternity Services: In response to the NHS Future Forum*. Available at: [www.rcm.org.uk/college/campaigns-events/protect-maternity-services/future-forum/](http://www.rcm.org.uk/college/campaigns-events/protect-maternity-services/future-forum/) (Accessed 12th September 2011).
- Royal College of Midwives (RCM). (2012a) Another Questionable Procedure for maternity services. 15 (2), pp 42-43.
- Royal College of Midwives (RCM). (2012b) The Royal College of Midwives and the Health and Social Care Bill. London: RCM.
- Royal College of Nursing (RCN) (2010) *Advanced Nurse Practitioners / an RCN guide to the advanced nurse practitioner role, competencies and programme accreditation*. London: RCN.
- Sadler, P. (2003) *Leadership*. 2<sup>nd</sup> Edition. London: Kogan Page Limited.
- Sandall, J., Homer, C., Sadler, E., Rudisill, C., Bourgeault, I., Bewley, S., Nelson, P., Cowie, L., Cooper, C., Curry, N. (2011) *Staffing in Maternity Units Getting the right people in the right place at the right time*. London: The King's Fund.
- Savage, J. and Moore, L. (2004) *Interpreting accountability*. London: Royal College of Nursing (RCN).
- Shuldham, C. (2004) Consultant Nurse Roles: Experiences from an NHS Trust. *Nursing Management*, 10 (10), pp 14-17.
- Soanes C. and Stevenson A. (2005) *Oxford Dictionary of English*. Oxford: Oxford University Press.
- Social Exclusion Unit (1999) *Teenage Pregnancy*. London: HMSO.

- Stake, R.E. (2000) Case Studies in Denzin, N.K., Lincoln, Y.S (Editors) *Handbook of Qualitative Research*. Second Edition. Thousand Oaks: Sage Publications Inc.
- Stephens, L. (2006) Onwards and upwards: where now for consultant midwives? *Midwives*, 9 (7), pp 278-279.
- Stevens, P.M.J., Schade, A.L., Chalk, B., Slevin, O (1993) *Understanding Research*. Edinburgh: Campion Press.
- Streubert Specziale, H.J. and Rinaldi Carpenter, D. (2007) *Qualitative Research in Nursing Advancing the Humanistic Imperative*. 4<sup>th</sup> Edition. Philadelphia: Lippincott, Williams and Wilkins.
- Streubert Specziale, H.J. and Rinaldi Carpenter, D. (2011) *Qualitative Research in Nursing Advancing the Humanistic Imperative*. 5<sup>th</sup> Edition. Philadelphia: Lippincott, Williams and Wilkins.
- Stringer, E. (2004) Children's centres: the future. *Midwives*, 7 (12), pp 532-533.
- Sullivan, A. (2004) Heads above the parapet: consultant midwifery reviewed, *Midwives*, 7 (8), pp 354-355.
- Thompson, C. (2003) Clinical experience as evidence in evidence-based practice, *Journal of Advanced Nursing*, 43 (3), pp230-237.
- Titchen, A. and Higgs, J. (2007) Towards professional artistry and creativity in practice, In *Professional Practice in Health Education and the Creative Arts*. Higgs, J. and Titchen, A. (Editors). pp273-290.
- United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC). (1999) *A Higher Level of Practice*. London: UKCC.
- United Kingdom Parliament Bills (2012) Health and Social Care Bill. Available at: [www.publications.parliament.uk/pa/bills/cbill/2010-2012/](http://www.publications.parliament.uk/pa/bills/cbill/2010-2012/). (Accessed on 10<sup>th</sup> February 2012).
- Walsh, D. and Downe, S. (Editors). (2010) *essential midwifery practice - intrapartum care*. Chichester, West Sussex: Wiley-Blackwell.
- .Ward, P. (1997) *360 Degree Feedback*. London: Institute of Personnel and Development
- Warwick, C. (2010) Sharing support and inspiration, *Midwives*, October / November, p 05.
- Weerd-Nederhof. (2001) Qualitative Case Study Research *Management Decision* 39 (7), pp 513-538.
- Williams, A. and Taylor, C. (2008) An investigation of nurse educator's perceptions and experiences of undertaking clinical practice, *Nurse Education Today*, 28, pp899-908.
- Wilson-Barnett, J., Barriball, L., Reynolds, H., Jowett, S., Ryrie, I. (2000) 'Recognising Advancing Nursing Practice: Evidence from Two Observational Studies', *International Journal of Nursing Studies*, 37, pp 389-400.
- World Medical Association (WMA). (2000) *The Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects* [Online] Available at: <http://www.wma.net/e/policy/b3.htm>. (Accessed 17 May 2010).

## References

Woodward, V.A., Webb, C., Prowse, M. (2006) Nurse Consultants: organisational influences on role achievement, *Journal of Clinical Nursing*, 15, pp 272-280.

Woodward, V.A., Webb, C., Prowse, M. (2005) Nurse Consultants: their characteristics and achievements, *Journal of Clinical Nursing*, 14, pp 845-854.

Wright, J. and Titchen, A. (2003) Critical companionship. Part 2. *Nursing Standard*, 18 (10), pp 33-38.

Yin, R.K. (2003) *Case Study Research: Design and Methods*. Third Edition. Thousand Oaks California: Sage Publications.

Zucker, D. M. (2001) Using Case Study Methodology in Nursing Research *The Qualitative Report* 6 (2), pp1-9.