

**AN EXPLORATION OF THE INFLUENCES OF  
SUPERVISORS OF MIDWIVES IN THE CONTEXT OF THE  
LIFELONG LEARNING (CONTINUING PROFESSIONAL  
DEVELOPMENT) OF PRACTISING MIDWIVES**

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## **ABSTRACT**

This study aimed to explore the influences of Supervisors of Midwives in the context of Lifelong Learning (continuing professional development) (CPD) of practising midwives.

This study was designed using a mixed method approach incorporating both qualitative and quantitative approaches to data collection to enable validation of results and to gain a variety of information to illuminate the experiences of participants in this area of study. Questionnaires and focus groups were utilised in order to obtain the data.

The participants in this study comprised:

- the total population of midwives and Supervisors of Midwives in three NHS Trusts
- the total population of LSA Midwifery Officers in England
- the total population of Lead Midwives for Education in England.

This study has provided a variety of evidence specifically on the developmental role of the Supervisor of Midwives which has not been explored previously. There is an increasing emphasis on informal learning to meet CPD and these need to be given a higher priority for achievement within the work environment and supervisory framework. Collaboration between supervisors, managers and educationalists requires review to ensure midwives are afforded the opportunities to meet their needs. The process of education contracting between NHS service providers and education providers is not understood by supervisors unless they hold the dual role of manager and this needs addressing if midwives are to have equal opportunity in accessing resources. The dual role of manager and supervisor also needs further research as an emergence of the 'policing' role has been raised by some midwives in this study.

Conclusions - Supervisors of Midwives are in a unique position to influence midwives CPD but the lack of a coherent approach with managers and educationalists prevents this being effective. Supervisors of Midwives need to have more influence in enabling midwives to access the available resources to achieve their CPD needs. Informal learning opportunities need to be valued and developed to facilitate midwives lifelong learning to improve practice and good outcomes for women and their families.

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# Chapter 1:

## Introduction to the study

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The midwifery profession is unique in having a statutory system of supervision, the main purpose of which is to protect the public from malpractice by actively promoting a high standard of care (LSA 2001, LSA 2009). Supervision of Midwives is one aspect of the regulatory process of the profession of midwifery which ensures minimum standards of education, practice and conduct and calls midwives to account if their practice falls below an acceptable standard as designated by the regulatory body.

The role of the Supervisor of Midwives includes helping midwives to evaluate their practice, identify areas for continuing professional development (CPD) and agreeing how these needs may be met (NMC 2006). This developmental role was formalised by the Midwives Act 1936 when CPD for midwives became statutory and so this too has differentiated the midwifery profession from nursing and health visiting.

The need for further studies in midwifery on the issue of CPD was advocated during the 1990's but very few have been undertaken specifically on this profession since then. The vast amount of research available on CPD is in relation to nursing and it is not always clear within these studies if midwifery is included as the term 'nursing' is often used to embrace all fields of nursing, midwifery and health visiting and is often



referred to in this way even in government documents. However, the findings from research on CPD undertaken in nursing are still relevant to midwifery and needs consideration for future policy and practice to meet the needs of a dynamic maternity service.

The literature on the supervision of midwives explores the history of supervision, midwives' perceptions of the role of the supervisor (McDaid and Stewart-Moore 2006), midwives understanding of the role (Hughes and Richards 2002), support mechanisms (Duerden 1996a, Duerden 1996b, Deery 2005, Gnash 2009) and leadership (Wells 2002) but none have specifically explored the developmental aspect of the role. Although in a few studies the developmental role does emerge to a minor extent it is not overtly analysed as it is not the main remit of the research (Duerden 1995, Stapleton, Duerden and Kirkham 1998, Jackson 2002, Mason 2002).

The Nursing and Midwifery Council (NMC) Standards (NMC, 2006) have, according to McKenzie (2009) put an increased focus on the developmental role of the supervisor, however, the literature only tends to state the developmental role in terms of reiterating the role and its importance, others link to small local innovations introduced to support midwives practice development (Oakey 2002, Jackson 2002, Lucas 2002).

Historically, midwives were required to undertake statutory refresher courses in order to continue to practice, which up until 1987 took the form of a 5 day residential course every 5 years. Since this time other formal options became available; these being either 7 days accumulated over a 5 year period or a 2 week planned period of clinical practice with theoretical

input (Robinson 1994). Since the introduction of the PREP requirements, which must be met, the requirements for registered practitioners is that they undertake 35 hours of learning activities every 3 years to retain their eligibility for re-registration (NMC 2004a). The PREP handbook (NMC 2010a) and the Midwives Rules (NMC 2004b, NMC 2010c) do not specify what learning activities midwives should undertake but rather require the midwife as an autonomous practitioner to identify their own learning needs and take the necessary steps to achieve these. The NMC do specify that PREP does not need to cost any money, that there is no such thing as approved PREP activity, there is no need for practitioners to collect points or certificates of attendance, however, the learning activity must be relevant to the work the practitioner is doing and must help to meet the highest possible standards of practice and care. This therefore leaves the learning activity up to the individual midwife to identify which may be via informal or formal learning methods although there is a requirement that these activities are evidenced by the midwife within a professional profile (NMC 2010a) which must comply with any request from the NMC for audit.

The statutory framework, established by the NMC, for CPD and compulsory refreshment of midwifery knowledge requires midwives to undertake lifelong learning throughout their careers. Munro (2008) argues that the nature and type of CPD undertaken is influenced by both the midwife and the employing organisation which creates tensions as both parties hold different perceptions of need. The midwife is concerned with individual needs whereas the manager is concerned with service developments and provision.

In addition to this scenario, the developmental role of the Supervisor of Midwives requires consideration as the NMC identify that supervisors must meet with midwives and discuss their CPD needs, plan and also agree the means by which their learning needs may be met. The role and influence of a Supervisor of Midwives on midwives accessing CPD activities is not known and this requires exploration. The known ways in which a supervisor can influence the CPD of midwives is through developmental and supervised practice programmes implemented following clinical incidents where a midwife's practice is brought into question. The NMC (2007) specify criteria for a developmental or supervised practice programme as it is a formal process with academic and practice learning outcomes to assist a midwife to improve knowledge and skills to demonstrate competence in practice and fitness to remain on the NMC register. This situation may be viewed as being reactive to incidents rather than being proactive at an earlier stage within the supervisory framework.

It is argued that CPD links satisfy the goals of both the organisation and the individual midwife although Lester (1999) and Jordan (2000) note a lack of evidence that CPD does in fact improve practice. According to Clark, Draper and Sparrow (2008) there is in fact little evidence of a direct impact of continuing professional development on improvements in health care as benefits tend to be assumed or implied rather than evidenced by service users.

The lack of evidence on the impact of CPD on professional practice has not deterred the Department of Health (DH) in strengthening the need for CPD and lifelong learning in the NHS and reports over the years have sought to

actively implement this approach (DH 2001a, DH 2002, DH 2004a, DH 2004b). In parallel to this implementation the general public have become increasingly litigious as people are more informed of their rights and will actively complain in the event of any failures in care provision (DH 2001b, DH 2006a), which then highlights the need for CPD as a key component of clinical governance which attempts to restore public confidence in the competence of practitioners in the NHS.

The statutory supervision of midwives is viewed as an important component of the clinical governance frameworks which aims to strengthen systems for quality control, based on standards, evidence based practice and learning from poor performance. Supervisors of Midwives are able to meet these standards through audit, identifying good practice and sharing this through the supervisors network (Duerden 2002). For example, all untoward incidents involving midwives are recorded, investigated and monitored by Supervisors of Midwives. The Local Supervising Authorities (LSA's) then compile this data into a report for their local Trust Boards and the NMC which according to the Kings Fund (2008) identifies the statutory supervision of midwives as a good learning resource at national and local levels. Critical incident analysis is therefore an important aspect of the supervisor's role ensuring problems are investigated and lessons are learnt.

This supportive system through supervision reflects the aim of clinical governance which is to enable quality care to be delivered achieved partly through the developmental needs of midwives being identified and continuing professional development programmes being implemented.

However, from a critical perspective this may also be considered to be a reactive approach to addressing midwives CPD needs rather than being proactive for example at the annual supervision review meeting ensuring a realistic and achievable CPD plan is able to be implemented thereby preventing incidents in the first place. The main aim of the supervision of midwives remains clearly focuses on public safety and protection from incompetent practitioners with the resultant requirement of these programmes being implemented if CPD is not evidenced in practice.

Although the literature suggests that supervision has been transformed from a punitive, controlling system (Stapleton et al 1998), to a more enabling and supporting framework for midwives (Duerden 2002) tensions are still believed to continue today and can to some extent be evidenced from the findings from the NMC analysis of the LSA annual audit reports. These reports demonstrate an increasing number of midwives being recommended to undertake periods of supervised practice programmes each year. It is also interesting to note that nationally in the period 2008 - 2009 (NMC 2010b) only four complaints and one appeal issued by midwives were reported regarding the discharge of the supervisory function whereas in the period 2009 – 2010 (NMC 2011) this has increased to twelve complaints. These complaints related to impartiality (NMC 2010b, NMC 2011) and to consistency in approach (NMC 2011).

The increase in the use of supervised practice programmes is reported to be variable across the UK but for some LSAs there has been an increase on previous years (NMC 2010b), this has been identified as an area that requires further analysis to ensure midwives are being fairly treated. In

addition the increasing number of investigations undertaken by supervisors is also an area that requires further analysis other than just being reported as being undertaken due to greater confidence and skills of the supervisors as this should also be viewed from a midwife's perspective as professional practice is being assessed with a recommended outcome to be implemented. It is worth noting that in addition to a supervisory investigation a management investigation takes place at the same time so the midwife's practice is being scrutinised more so than any other professional (Gould 2009). This issue and that of appealing against a supervisor's decision has not been included within this research but is an area that would benefit from further research as it is not clear if midwives are aware that there is an appeal process within the statutory supervision framework although a midwife cannot appeal against a supervisor's findings or recommendations. If there are an increasing number of midwives requiring individualised programmes of this nature then it must be questioned why their learning needs had not been recognised earlier and a plan for CPD created.

A few small studies have been undertaken in midwifery to enhance reflective practice (Jackson 2002, Yearly 2003, Ralston 2005) and strengthening CPD support through a personal trainer concept (Mason 2002). In practice an annual supervisory review meeting should occur at least once per year (NMC 2010c), providing the opportunity for midwives to discuss their professional development needs with their Supervisor of Midwives through reflection on practice with the aims of determining specific knowledge gaps and the assessment of their standard of midwifery practice. The NMC Standards (NMC 2006) have placed the focus for CPD within the developmental role of the supervisor which according to

McKenzie (2009) has resulted in midwives being more comfortable in approaching their supervisor for advice on professional development. The professional development needs arising from the discussion at the annual review meeting should be addressed by the midwife undertaking appropriate educational activities to meet these needs as the responsibility for keeping up-to-date ultimately rests with the individual midwife (NMC 2004b, NMC 2010c). The actual discussion that takes place at the annual review is worthy of exploration in order to ascertain midwives and supervisors experiences in this area as there is no evidence readily available.

The actual day to day enforcement of supervision of midwives is the responsibility of the NMC through the Local Supervising Authorities (LSA's) in which an LSA Midwifery Officer (LSAMO) is appointed to achieve these responsibilities in practice. The LSA's historically appointed a midwifery inspector to supervise the registered midwives in their area and were initially allowed almost unlimited scope by the regulating body to investigate a midwife's practice. The inspection of midwives has been viewed as being punitive with the disciplinary procedures heavily weighted against the midwife and performed in a manner of 'policing' (Kirkham 1995, Heagerty 1996). This term policing continued to be used throughout the century and according to Stapleton et al (1998) is still considered to be a style adopted by some supervisors, particularly those in dual managerial positions. The functions of supervision and management have been difficult to separate due to the dual role and this still has the potential to be problematic as management hierarchies in the NHS and the pre-occupation with risk management have developed.

Mayes (2002) describes an authoritarian culture which pervades the health services with the performance of staff being appraised against job descriptions and the objectives of the organisation which has resulted in supervision being seen as part of the management of midwives with no clear division between the dual roles of supervisor and manager. The dual role creates tensions between aiming to organise a workforce, protecting the public and assisting a midwife to develop professional practice (Lansdell 1989; Magill-Cuerden 1994; Royle 1994). Research undertaken by McDowell (1993) also suggested that some Supervisors of Midwives still have difficulty in differentiating between managerial and supervisory aspects of their role. Indeed, Mayes (2002) argued that the research highlighted that midwives knowledge of supervision was poor and that inconsistencies between supervisors in some cases had caused damage through inappropriate disciplinary actions (Shennan 1996, Williams and Hunt 1996, Stapleton, Duerden and Kirkham 1998, Halksworth, Bale and James 2000). Therefore the experiences of midwives and Supervisors of Midwives in the current climate of the NHS need revisiting in order to understand the complexities surrounding CPD.

NHS Employers today advocate and provide mandatory training that will meet the clinical governance agenda by evidencing attendance of staff at these CPD events to maintain standards of competence and contribute to the hours of learning activity required for PREP but it does little to promote CPD and lifelong learning which is central to healthcare development. A concern highlighted through this process relates to the cancellation of mandatory training and updating in Trusts due to increased clinical activities (NMC 2010b) and practitioners CPD needs and service needs



competing for limited resources. This adds to the existing tension between meeting mandatory learning activities for the organisation and meeting CPD through identified individual practitioner learning requirements. These tensions need to be explored to determine the reality of practitioner's experiences and the challenges they face in trying to achieve their CPD needs.

The context of supervision described raises questions in relation to how the Supervisors of Midwives achieve their role in enabling midwives to meet their CPD need. Cunningham and Lewis (1997) argue that for a supervisor to be able to facilitate midwives CPD they need access to educational services and programmes as well as to be able to work with their midwife educator colleagues. There is no evidence in the literature relating to the influence Supervisors of Midwives have in enabling midwives to access CPD activities other than through developmental or supervised programmes following clinical incidents.

To enable evaluation of the developmental role of the Supervisor of Midwives this aspect of their role requires further research. Although the NMC and Local Supervising Authorities (LSA's) have systems in place to monitor the activities of the supervisors and through local audit of supervision some aspects of the role are explored, very little evidence is available on the influence supervisors have in their organisation on what learning takes place. This is particularly so in relation to the 'means by which' midwives expertise can be maintained and developed. There is no current evidence available within the literature in this area and therefore this study aims to illuminate the experiences of midwives and supervisors.

The literature also suggests that supervisors are increasingly undertaking investigations following incidents in practice and as a result more midwives are being required to undertake supervised periods of practice. Although this specifically is not a feature of this study it does raise questions of whether the CPD needs of midwives are being correctly identified as unless this is achieved deficits cannot be acknowledged and may lead to poor clinical outcomes. The method of identifying CPD needs will be explored in this study.

In the current economic climate where resources are limited then supervisors need to be able to argue for these resources to support the maintenance and development of a midwives practice. It may be argued that supervisors should be able to influence not only the midwives they supervise but also the managers in an organisation regarding the learning needs of midwives if a safe service is to be achieved and maintained. This tension is compounded by the fact that many supervisors hold the dual role of manager with the manager role providing the authority and power in decision making as they have the control over the available resources to invest in staff. The tensions created between these two roles in terms of organisation and management of the process, the influencing of learning that takes place and how midwives achieve CPD is worthy of exploration.

One further dimension in this study relates to the collaboration between Supervisors of Midwives and education providers in the process of organising and managing CPD. The move of midwifery education from the NHS to Universities in the 1990's has created a formal system of contracting for CPD opportunities. The system for contracting has changed

a number of times during the past decade and is management led with opportunities for collaboration between NHS service providers and midwifery education providers being variable. The experiences and influences of Supervisors of Midwives in this system are not known and therefore will also be explored within this study.

Midwives clearly do meet registration requirements in achieving their PREP requirements and are able to continue to practice as autonomous accountable practitioners. The learning that midwives specifically undertake and the challenges they face in achieving their PREP requirements needs exploration and is of relevance to both managers, supervisors and educationalists as this will certainly influence future CPD provision.

In conclusion, this study aims to explore the influences of Supervisors of Midwives in the context of the Lifelong Learning (CPD) of practising midwives. The research questions focused upon are:

- How do Supervisors of Midwives identify and influence midwives learning to meet CPD requirements?
- What actual learning activities are undertaken by midwives to meet their identified CPD requirements?

The structure of this study will be as follows;

Continuing professional development (CPD) will be further explored through the literature review presented within Chapter 2. The term CPD will be used throughout this thesis and will encompass continuing Professional Education (CPE), the formal learning and informal learning activities within or outside of the workplace with the aim of continuing development of knowledge and skills and the maintenance of competence to practice. It includes formal learning in terms of activities purchased through NHS Trusts, funded by the Strategic Health Authority and self funding by individual healthcare practitioners. Both CPE and CPD are essential and complementary as either can be used to legitimately meet PREP requirements although these views may differ between managers and practitioners.

Chapter 3 will focus on the research methodology utilised within this study and highlights methodologies of previous research studies in this area and within nursing and midwifery generally. The choice of mixed methods will be justified in recognition of wider social science trends. The experiences of the researcher in the process will be reflected including decision making and ethical issues as required by research governance processes.

The findings and analysis of the data through discussion will be presented in chapter 4 to prevent any repetition and to clearly highlight the key findings of significance in this study. The areas specifically discussed will relate to the purpose of supervision, the organisation and management of CPD and identification of what learning actually takes place.

Chapter 5 will finalise the study by detailing the conclusions and implications for policy and practice arising from the study and the need for further research studies. This chapter will also reflect on the limitations of the study and the methods for dissemination of the findings to best effect.

# Chapter 2:

## Literature Review

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### **2.1 Reviewing the literature**

In this study the literature review was undertaken prior to data collection to initially explore the work in this area and has since been ongoing throughout the period of research activity as themes emerged and their relationship to previous research analysed. The usual protocol of searching the databases both electronically and by other relevant methods has been employed and specific authors contacted to request copies of unpublished work. Studies from other countries have been of little use other than to provide background to the study as the system of supervision in midwifery is specific to the UK.

The literature specifically relating to the supervision of midwives, their statutory framework and their role within CPD has been identified within the introduction chapter to this study and affirms that there is a lack of research in this specific area.

Therefore the literature search for this chapter has focused on CPD and concluded that research and publications on this subject area in nursing and midwifery tended to be very prolific during the late 1980's and 1990's possibly due to changes in nursing and midwifery education nationally over this period of time. It also is evident that the majority of this literature relates to 'nursing' a term that is often used to include all spheres of nursing, midwifery and health visiting so specific professional groups are not always clearly recognised. The need for further studies in midwifery on the issue of CPD was advocated during the 1990's but very few have been

undertaken specifically on this profession since then. However, the findings from this literature and from research in nursing are still relevant to midwifery and needs consideration for future policy and practice to meet the needs of a dynamic maternity service.

To provide an outline theoretical perspective to the study the social context of learning specifically related to continuing professional development will be initially explored.

## **2.2 The Social Context of continuing professional development.**

In the literature learning and education is often discussed based on the assumption that there is a beginning and an end, that it is as a result of teaching and it is best to separate learning from other activities (Wenger 1998). However, more recent attention has been given to the social context of learning in particular the role that activities and experiences have on development of skills and knowledge (Field 2004, Hall 2006). Social theory suggests that people learn from observing other people and that these observations take place in a social setting.

Learning is perceived to take place in this framework of social participation rather than just within the confines of the individual mind (Lave and Wenger 1991). As a result they introduced three key concepts which included situated learning, legitimate peripheral participation and communities of practice. Lave and Wenger (1991) refer to learning in the context of peoples' day to day activities as they become involved and engaged in work. They propose that learning becomes part of a person's working life so that their every day practice is the context for their learning

and is termed by Lave and Wenger (1991) as situated learning. The process through which learning is acquired is termed legitimate peripheral participation according to Lave and Wenger (1991). This is a process where people interact in their day to day activities. The legitimacy of participation relates to the belonging to the field of practice as well as the learning and implies that the collaboration itself provides the learning context. This view of learning as a social process where identity, membership and collaboration are of significance resonated well with the field of midwifery.

Lave and Wenger furthermore defined communities of practice as groups of people who share a common interest or passion for what they do and improve their learning as a result of regular interaction. Wenger (1998) intended that a community of practice meant more than just the process of a structured team within an organisation working together but rather members crossing structural boundaries of defined teams and creating a working culture. Andrew, Tolson and Ferguson (2008) further define these communities of practice as a model of situational learning based on knowledge rather than tasks where individuals collaborate and work to a common purpose.

In order for these communities of practice to exist a shared domain of interest is required and this shared competence distinguishes members from other people (Lave and Wenger 1991), which implies a sense of identity and belonging. These members pursue their interest and interact, build relationships and share information that enables them to learn from each other. In addition, the members are specifically identified as practitioners who develop a shared experience and repertoire of resources which develop over time as a result of social participation, community



engagement and collaboration (Andrew and Wilkie 2007). Andrew et al (2008) also suggests that these communities develop their practice through methods for example, problem solving, discussing developments, visiting other members and seeking the experiences of others members. Therefore, within a community of practice situated learning enables practitioners to use complex situational understanding developed as a result of their practice experiences.

The NHS may be considered to be a learning organisation which is defined as an organisation that facilitates the learning of its members through structures and processes and in doing so transforms itself. Indeed, students undertaking professional programmes are supported in practice by experienced practitioners who enable their development of knowledge and skills and assess their ability and competency to practise to enter the professional register and thereby belong to that community. This approach is built on the apprenticeship model which links to training and development in organisations. Newly qualified staff are also linked to preceptors in practice to enable their transition from student to qualified accountable practitioner or as described by Benner (1984) progressing from novice to expert and to fulfil their sense of belonging to the community recognising the hierarchy of need. Both of these examples encompass processes of active participation in the practices of the community and as a result construct their identity with the community. This identity is a holistic view of learning rather than just internalisation of learning as individuals learn how to communicate using terminology used by the community, how to behave and practice within the accepted ways of the community.

Learning from practice experiences requires individuals to reflect on the experience in order to learn (Jarvis 2004, Fowler 2008). This is termed in the literature experiential learning and became a popular term used in education during the 1980's (Mezirow 1998, Kolb 1984). Fowler (2008) defines experiential learning as learning resulting from experience of a certain quality with meaningful reflection. If the experience is of a limited quality and the reflection also limited then learning is also limited.

Burnard (1991) suggests learning by doing also involves reflection which is an active learning process although a common definition is not agreed within the literature. Burnard (1996) later supported by Jarvis (2004) argued that it is the facilitation of learning that will enhance the individuals learning, this facilitation may be the deliberate or random intervention by either the practitioner or a third person. This intervention is believed to act as a motivator to learning in that the individual is internally driven to reflect on the experience, the patient questioning the practitioner, the supervisor encouraging the reflection or in the practitioner producing a written account of the event.

A study by Hughes (2005) identified that practitioners found it difficult to reflect on practice which according to Tennant and Field (2004) is an integral process within CPD. The clinical environment can be considered to be a barrier to experiential learning due to the competing demands being made which limits the experience and the reflection being brought together. This may be the result of a busy ward, a lack of internal energy on behalf of the practitioner or active resistance by the practitioner related to their personal beliefs (Fowler 2008). It is proposed by Fowler (2008) that the barriers arising in practice can be broken down by a 'coach' which in relation to the practice of midwives could be considered to be the

Supervisor of Midwives. The supervisor would in the role of 'coach' actively seek to motivate midwives and break down barriers to learning through informal activities enabling the bringing together of experiences and reflection to enhance learning. However, Dewar and Walker (1999) previously pointed out that the ability of a supervisor to facilitate experiential learning depends on the extent to which they understand the process.

Boud, Keogh and Walker (1985) consider reflection to be an active process that enables experience to be turned into learning. Reflective learning challenges practitioners to examine their practice and is a way of accounting for actions undertaken and offers to inform future actions through changes in perspectives. Reflective learning also has the opportunity to offer valuable informal CPD opportunities through the national supervisory framework a view also supported by Kirkham (2000). Jones (2000) also at this time outlined how the Supervisor of Midwives could assist midwives in developing reflective skills to fulfil PREP requirements and at the same time increase confidence and competency.

However, the value of reflection is, according to Dalley (2009), subjective in terms of the purpose and context of the reflection and in the context of learning the benefits need to be measured against the time taken to reflect and the importance of the outcome as perceived by the practitioner or others. Ghaye (2007) argues that there is a personal risk of disclosure through reflection that may be weighed against any benefit reflection may bring particularly if this is being measured against professional standards by supervisors. Indeed, Burns and Bulman (2000) earlier suggested that the process of reflection forces practitioners to face often uncomfortable

facts about their practice, the organisation in which they work and themselves.

The NMC (2004c, NMC 2010c) specifically identify self assessment through reflection on practice as a prerequisite for all practitioners, with many attempts to integrate this further into clinical practice since the 1990's. However, earlier studies by Schumacher and Severson (1996) and Wallace (1999) argued that critical thinking skills are needed in order to develop reflective ability. This supports the view previously proposed by Mezirow (1991) who identified reflection as a skill requiring higher order thinking and reasoning. Reflection is to be considered more than just thinking and reasoning and rather as an active process that should result in learning, changing behaviours and practice.

The reflective process as previously described by Mezirow (1981) involves perspective transformation whereby a practitioner becomes aware of how traditional thinking and acting limit understanding and actions of themselves or others. It is further described by Nakielski (2005) as a result of a sudden insight into one's own perceptions or assumptions. Therefore, reflection is essential for professional practice and needs to be undertaken in a structured way through the use of a model of reflection. Many models exist in the literature and individuals need to select a model from those available or develop one according to their personal preference. Through the model midwives should be able to answer the questions of who, what, why, where and when focusing on their professional practice (Nakielski 2005).

Taylor (2006) highly regards reflection as a skill that specifically enables practitioners to become self aware and therefore empowered to improve

care. The concept of clinical supervision in nursing and statutory supervision in midwifery is underpinned by reflection in and on practice to improve performance and increase the quality of care.

According to Schon (1991), a practitioner's expertise may be enhanced by reflection on practice which aids the internalisation of learning opportunities which in turn will enable the development of expert knowledge. Chesney (1996) and Miller (1999) later described reflection as a valuable learning resource that practitioners need to utilise if they are to gain maximum benefit from their professional experiences. More recently Nakielski (2005) adds that reflection serves as a foundation for both personal and professional growth and development.

My interest in midwives continuing professional development and the influence of Supervisors of Midwives concerns the everyday professional lives of these practitioners and the learning that takes place in the workplace. The social context of learning and particularly the situated learning as defined by Lave and Wenger (1991), reflection in and on practice (Boud, Keogh and Walker 1985, Mezirow 1991, Schon 1991) all closely reflects the issues relevant for this professional group in relation to both informal and formal learning.

The review of the literature on CPD revealed a range of terms used to describe the activities in which professionals engage to achieve their continuing professional development. The terms identified will be explored specifically to provide some context to the development of CPD for health professionals.

### **2.3 The Concept of Lifelong Learning**

Lifelong learning is a concept that, according to Gopee (2001a), has only been used in the field of education since the 1970's and embeds both formal and informal methods of education. However, Tight (1998) suggests it can be traced back to the early 20<sup>th</sup> Century. An early advocate of lifelong learning, Dave (1976), defined the concept as a process of accomplishing personal, social, and professional development throughout the lifespan of an individual to enhance the quality of life for both the individual and their groups. According to NIACE (2004a, NIACE 2004b), people's attitudes to lifelong learning have changed as a result of government initiatives (DfEE 1998, DfEE 1997a, DfEE 1997b), with an increasing number of workers participating in lifelong learning. However, although the numbers of workers participating in lifelong learning have increased the numbers in society generally has fallen (Aldridge and Tuckett 2003).

The concept of investment in human capital relates to spending on education to improve the knowledge and skills of the worker and their productive capacity. People are therefore invested in for the maintenance and improvement in the knowledge and skills they possess enabling them to perform in new ways (Coleman 2001). Indeed, OECD (1998 p9) highlights that people are especially important in a knowledge and competency based economy. Therefore, to accurately identify and measure the many different components that make up human capital requires the consideration of what it is that individuals bring to work and economic activity, their attitudes, enthusiasm, and motivation as well as their cognitive ability. For example, not all learning is job related and acquisition of a new language may bring benefits and motivation to further develop through lifelong learning.

In the literature the term lifelong learning is often used interchangeably with related terms such as adult education, recurrent education and continuing education which have been derived from different developing theories over the years. Lifelong learning is defined by the UK government for the DH in terms of outcomes as a process of continuing development for all individuals and teams to meet the needs of patients and deliver the health care outcomes and priorities of the NHS, and which also enables professionals to expand and fulfil their potential (DH 1998a, DH 2000d, DH 2008). Earlier, the English National Board (ENB) (ENB 1994) had also stated that lifelong learning goes beyond CPD by suggesting that it also required a different culture, a different approach and attitude.

Acknowledging these definitions in that lifelong learning goes beyond CPD it is suggested that professionals should aim to achieve a 'life plan' of development.

The importance of professionals maintaining and improving competency in health care first began to be recognised in the 1980's and has become increasingly recognised as important for all professionals as a means to continually develop their knowledge and competence. It may be argued that lifelong learners have their own distinctive style of learning influenced in part by their background, their character and their environment but also due to changing attitudes to learning as personal circumstances change. Every individual has characteristics related to their previous experiences (Daines, Daines and Graham 2002) and attempting to understand these characteristics enables educators to provide effective teaching and learning experiences.

The English National Board (ENB 1994) described the characteristics of a lifelong learner as being, innovative, challenging and creative in practice,

flexible and resourceful, adaptable and able to work as change agents, self-reliant and responsible and accountable for their own practice. Burnard, Chapman and Smallman (2005), added to this list their thoughts regarding the characteristics of a lifelong learner and described these as one who appreciates the changing nature of knowledge, is highly pragmatic, with a strong desire to acquire knowledge and become competent in its application to practice.

It is argued in the literature that lifelong learning is both conscious and unconscious learning which is part of a professional's life and is more than just simply keeping up-to-date. However, Knapper and Cropley (2000) argue that lifelong education refers to deliberate learning rather than spontaneous everyday learning and that there are clear characteristics evidenced which are; that learning is intentional as learners are aware that they are learning; that there are specific goals and these are the reason that learning is undertaken; and finally that the learner intends to retain and use what has been learnt. In their debate on lifelong education they suggest that lifelong education is the system whereas lifelong learning is the content, the goal and the outcome. In this definition they propose that lifelong education can be seen as complementary to lifelong learning.

The process of lifelong learning within nursing, midwifery and health visiting became formalised with the introduction of the PREP framework although since the Midwives Act 1936, statute has required midwives to attend refresher courses to ensure their knowledge and skills remain up-to-date. The PREP framework requires practitioners to identify their educational needs and provide mandatory evidence of continuing professional development as a prerequisite for maintaining professional registration (ENB 1990, NMC 2010a). The Government supports the view



that lifelong learning should meet service needs as well as individual needs and aspirations and advocates for developing both lifelong learning and continuing professional development (DH 1998a, DH 1998b, H 1999a, DH 1999b, DH 2000a, DH 2000b, DH 2000c, DH 2000d, DH 2001a, DH 2003a, DH 2003b, DH 2008).

Therefore within the concept of lifelong learning the term continuing professional development emerges as an element of lifelong learning which is now well integrated into the culture of the NHS in order to keep pace with the advances in technology, research and the complex needs of patients in our diverse society.

## **2.4 The Concept of Continuing Professional Development**

Friedman and Phillips (2001) highlight that the term CPD used in the UK is not universal as other terms for example, continuing medical education, continuing vocational education and continuing education, in-service training and on the job learning are terms found in the literature and used by other professionals. These terms do not always mean the same but are generally considered to be inclusive within the umbrella of CPD as described by the standing committee on postgraduate medical and dental education (SCOPME 1999). There is ambiguity in the literature as to the kinds of activities that 'count' as CPD however, it is generally accepted that CPD encompasses all formal and informal learning within healthcare practice, including for example, in-house training, professional discussions, reflection with colleagues, mandatory training, clinical supervision, and accessing the literature.

According to DeSilets (2006) and Jarvis (2005), the term CPD is further differentiated from continuing professional education (CPE) as the former encompasses formal and informal learning, learning within or outside of the workplace, whereas CPE is seen as formal learning activities undertaken after initial registration and occurring outside of the workplace. Clark, Draper and Sparrow (2008) agree that the term CPD also applies to taught or formal courses but add that this also includes assessment of learning and the expectation of subsequent application of this learning to practice.

Quinn (2000) argues that the terms identified are used interchangeably and as a consequence complement each other a stance also supported by Gould, Kelly, White and Glen (2004) but they acknowledge that there is a lack of agreement within the literature concerning their definition.

Similarities between the terms have also been noted by Friedman and Phillips (2004) who define continuing professional development in terms of being the systematic maintenance, improvement and a broadening of knowledge and skills. This is similar to that previously recommended by Friedman and Phillips (2001) in support of the generally accepted definition of CPD within professions as defined by the Construction Industry Council (1986, p3),

'CPD is the systematic maintenance, improvement and broadening of knowledge and skill and the development of personal qualities necessary for the execution of professional and technical duties throughout the practitioner's working life'

This definition clearly includes personal as well as professional qualities and the scope of broadening not just maintaining knowledge.

The term CPD as defined by the professional body, the English National Board (1990), referred to post basic education (post initial qualification), updating existing skills, improving quality care, retaining currency to practice and continuing effectiveness as a health professional which was supported by the Department of Health (2001a), Cervero (2001) and Friedman and Phillips (2002). Ferguson (1994) also included that CPD offers many benefits to patient care, either directly through improving knowledge and skills or indirectly through the motivation of staff, improving recruitment and retention and reducing burnout. Indeed, many professions require evidence of CPD for the continuing registration of practitioners and for many practitioners there is a statutory requirement for continuing recognition as being fit to practice and for continuing registration on professional registers. The underpinning belief of the United Kingdom Central Council (UKCC) was that pre-registration nursing and midwifery education was regarded as insufficient for continued competent practice after initial qualification and this reaffirmed that CPD was a necessity.

CPD therefore contributes to evidencing competence and for renewal of registration for nurses and midwives with the Nursing and Midwifery Council (NMC). The NMC (2010a) require registered practitioners to undertake 35 hours of PREP activities every 3 years to retain their eligibility for re-registration. However, for a Supervisor of Midwives the requirement is 35 hours plus an additional 18 hours of CPD in relation to the specific role of supervision of midwives.

In addition to the professional body placing emphasis on CPD, the Department of Health (DH 1998a, DH 1998b, DH 2000a, DH 2000b, DH 2000d, DH 2000e, DH 1999a, DH 1999b) also identifies CPD as integral to

clinical governance explicitly linked to enhancing evidence based health care, public protection and professional self regulation. Swage (2004) argues that training and development of staff are the two main areas for supporting clinical governance in ensuring quality health care and accurate information based on clinical decision making, performance and outcomes. Swage also adds that the main aim of CPD is to respond to service developments, patient expectations and personal ambitions and as a result forms the basis for accountability. Each of these key aspects of clinical governance are not new to midwifery as they have been included in midwifery rules and codes of practice since the Midwives Acts in 1902, 1915 and 1918 through the role of the Supervisor of Midwives (Pulzer 1999, Duerden 2002).

## **2.5 Continuing Professional Development and the National Health Service (NHS).**

A number of key developments in policies within the NHS have driven the CPD agenda in for example, health reforms, changes in pre-registration education and the formalization of the Post Registration Education and Practice Project (PREP). These changes alongside the increasing demands for health care, new technologies, ethical challenges and demographic changes require a constantly developing health care workforce. Modernisation of the NHS with the emergence of new roles and working hour changes particularly for medical staff has also increased the necessity for CPD (DH 2008, DH 2001a, DH 2000a, Council of the European Union 1998). A further driver is the increasing litigious society of today where people are more aware of their rights and better informed not only regarding care and treatments but also failures within the NHS as previously mentioned. CPD is also specifically highlighted within the King's

Fund Report 'Safe Births: Everybody's Business (O'Neill 2008) in relation to the identification of the training needs of maternity care professionals in order for these professionals to be able to deal with more complex maternal health requirements. Ultimately, the overall purpose of CPD must be to build upon a practitioner's education and experiences thereby maintaining and enhancing professional knowledge and skills in order to improve the health of the public. The aim of CPD is therefore essential for both advancing professional knowledge and skills and also for preventing incompetence.

The Department of Health (DH 2002) consider that every aspect of healthcare delivery and strategies for health depend on the education and skills of individual staff. They went on to argue that investment in learning and personal development was, in a real sense, spending on patients and essential to the future quality of the health service. Although lifelong learning has been embraced by the NHS and supported by policy documents, in the current financial climate there is the fear that this may not be sustainable and more informal learning activities will become the norm. However, the maintenance of competency and fitness to practice has become a major concern of both the public and the government during the past decade and the need for CPD is now even stronger (DH 2006a, DH 2006b).

Steele (2009) advocates that planned learning should form part of a personal and professional development plan (PDP) which should then be able to determine the level of funding and learning time made available to meet the plan especially if aligned to the strategic plan for service improvement. Research undertaken by McLean (1980) surveyed midwives views of the importance, their experiences and uptake of CPD in Wales and

obtained an 88% (n=147) response rate. The recommendations from this study may be considered to be ahead of their time as McLean stated that all midwives should have a planned professional development profile and that newly qualified midwives should have a supported first year of regular study, these ideas today being framed within Agenda for Change (DH 1999c, DH 2003a, DH 2003b, DH 2004c).

The system for PDPs is underpinned by the Knowledge and Skills Framework within the Agenda for Change (DH 2003b) and is contained within management performance appraisal systems and culminates from the discussion between a manager and an individual practitioner. There has been a strong support for all staff not just health professionals to have PDP's designed to enhance the skills of interpreting and applying knowledge based on research and development. However, the Audit Commission (2001) questioned the value of these plans and found that not all staff actually had a plan even though the Department of Health (DH 2002) advocated that all practitioners had PDPs.

The level of investment in CPD from local employers particularly relates to pay reforms introduced through Agenda for Change (DH 1999c), encouraging greater flexibility of roles underpinned by lifelong learning. The reforms have linked pay and progression to the practitioner's ability to demonstrate advancements in clinical expertise and knowledge (2003a, DH 2003b) firmly embedding CPD practices as part of the professionals' role. This system for linking pay to skills and abilities rather than grade recognised that dissatisfaction with pay and career advancement was a common reason for attrition from health care roles.

The report *Working Together, Securing a Quality Workforce for the NHS* (DH 1998b), confirmed the government's intention that all NHS employers should have in place training and development plans. This report was consistent with the government's strategy for lifelong learning as set out in *The Learning Age* (DfEE 1998) as CPD was seen as having a significant role in supporting this strategy. The government also recognised in these reports the need for an increasingly competitive labour market that attracted, motivated and retained high calibre professionals, managers and other health care staff was essential. A longitudinal study by Robinson (1994) identified that there was a distinct lack of evidence to suggest that there is a link between CPD and retention of staff. The importance of CPD for encouraging retention in midwifery was identified in this study although the actual degree to which opportunities for CPD is related to retention was described as difficult to determine. Obtaining post-registration qualifications, attending in-service courses and combining part-time study with work had been experienced by a small number of midwives but overall 70% of participants in this study wanted a greater provision of in-service courses relevant to their work. It must be noted at this point in time that the in-service courses were provided by the Schools of Midwifery attached to the district health authorities in which midwife teachers were employed by the NHS.

Effective health care delivery depends on the ability of service providers to employ sufficient numbers of appropriately trained staff therefore recruitment and retention of staff to meet service needs is central to the modernisation of the NHS (DH 2000b, DH 2008). According to Aitken and Patrician (2000) hospitals employing a higher proportion of well qualified staff generate better patient outcomes. West, Borrill, Dawson, Scully, Carter, Anelay, Patterson and Waring (2002) further argue that a well

developed appraisal system for staff supported by a comprehensive programme of continuing professional development has been strongly associated with reduced mortality rates as well as better patient outcomes. However, Jordan (2000) later supported by Attree (2006) argue that significant investment in CPD by the government lacks any empirical evidence as to its effectiveness.

## **2.6 The Organisation and Management of CPD in the NHS**

This situation of employer and employee working together is a theme running through the literature but little attention is paid to the contribution an educationalist may make in this process. It was suggested by Ellis (2000) that a triangulated approach between managers, employees and education providers may lead to a greater impact of CPD on practice, also reflected by the English National Board for Nursing, Midwifery and Health Visiting (2001) as part of the mandatory re-registration requirement. However, this is not evidenced in later literature on this topic. Larcombe and Maggs (1991) also reported a decade earlier that where the employer and employee worked in partnership to identify CPD needs the effectiveness of service delivery was enhanced, a view also endorsed by Orme (1992).

In the UK there has been increasing evidence of the need to link CPD with organisational goals (Hemmington 1999). However, Kennie and Enemark (1998) writing earlier suggests that this still needs to happen as CPD is given a low priority and is fragmented. The fragmentation may arise where there are disagreements between the individual practitioner and their manager in relation to priorities. In addition, Scholes and Endacott (2003) and Campbell (2004) argue that if different definitions of CPD are



used by different stakeholders then the opinions of managers may be inappropriate due to their corporate agenda which is only one aspect of CPD. Indeed, Nolan, Owen, Curran and Venables (2000) previously drew attention to the tensions created in the dialogue between employer and practitioner where short term skill development is prioritised against lifelong learning. Whereas, Hemmington (1999) has an opposing view that in fact CPD links well into organisational views and can be seen to satisfy the goals of both parties although Lester (1999) and Jordan (2000) notes a lack of evidence that CPD does in fact improve practice.

The extent to which an individual is supported by their manager was examined by Larcombe and Maggs (1991) who found that managers were unsupportive or had a negative attitude towards CPD. Allen (2000) had previously detailed that even when midwives were given time and funding to attend they still cited lack of support as a factor affecting attendance. The different perspectives held by managers and the midwives may contribute to the lack of support as managers need to consider the service as a whole whilst midwives would be concerned with their own needs. This brings into question the role of the Supervisor of Midwives in identifying midwives CPD needs, planning and agreeing appropriate CPD activities and the collaboration with managers.

The selection of practitioners for CPD courses rests with the manager who is required to agree a place on a course with both the education provider and the practitioner. This situation has not changed and requires managers who may also hold the dual role of Supervisor of Midwives to identify appropriate courses for their staff and appropriate practitioners to attend these courses. It is not known what influence the Supervisor of Midwives has on the selection and access to CPD activities as the authority

rests with the manager. In reality staff may request attendance at courses but this is not always supported by managers unless there is a specific organisational need for example, preparation of mentors.

Perry (1995) questioned whether CPD was a luxury or a necessity and highlighted the mismatch between the needs of the individual and those of the service. In a large organisation like the NHS there is likely to be tensions between the training needs of an individual and those of the wider organisation and this may, as Perry (1995) suggests, result in a mismatch of needs as later pointed out by Lawton and Wimpenny (2003) and Draper and Clark (2007). In 2001, the Bristol enquiry (Kennedy 2001) and the Shipman enquiry (DH 2001b) both highlighted that CPD is an essential requirement for professionals in order to provide effective and quality care for patients. It is therefore not surprising that Working Together, Learning Together (DH 2001a) allies' professional development to clinical effectiveness and prioritises this within the NHS and makes explicit links to education, training, career development and reward systems. As a result the NHS knowledge and skills framework (KSF) forms one of three pathways aimed at improving staff performance and retention and represents a great commitment to training and development in the NHS.

Allen and Meyer (1997) have linked CPD to the commitment practitioners have to their employing organisation. This organisational commitment, according to Cohen (1993), has received a lot of attention in research studies with a range of health care professionals as it is considered to have a link to staff retention and turnover a view previously proposed by Wagner (1989). Shields and Ward (2001) add that the intention to stay with an employer is related to CPD opportunities and is also associated with job satisfaction and this links to what Drey, Gould and Allan (2009) describe as

professional commitment although they concluded that there was no evidence of any relationship between professional and organisational commitment to undertaking CPD.

In a study undertaken by Cervero (1988), individuals are categorised in terms of being '*middle majority*' or '*laggards*'. This classification of individuals describes four types of practitioners; innovators who seek to improve practice, study independently and enjoy education; pace-setters who are strongly committed to education; middle majority the main group of practitioners who vary in attitude to education ranging from enthusiastic to apathy; finally the laggards who resist new ideas and do the minimum necessary. Carpenito (1991) suggests that approximately 25 – 35% of professionals are '*laggards*' although recognises that individuals will move between categories depending on their situation at different times during their professional lives.

Furze and Pearcey (1999) have identified that individual motivation is a significant factor contributing towards participation in CPD activities. Indeed, Dowswell, Hewison and Millar (1998) had previously acknowledged that career progression was a motivational factor in CPD. Motivation to participate in CPD may also operate from an external force exerted by the employer where funding is provided which encourages the individual practitioners internal motivation to access CPD (Munro 2008). The Agenda for Change (DH 1999c, DH 2003a, DH 2004b, DH 2004c) framework provides an extrinsic or external motivation for individual staff. If they were able to demonstrate their attainments matched to the Knowledge and Skills Framework at their annual appraisal, and then they would stand to personally benefit from a financial reward.

If a practitioner is found to be non compliant with CPD through the process of monitoring, this would lead to ineligibility to re-register with the NMC (NMC 2008b) or ultimately removal from the register due to incompetency. This penalty, a sanctions model, does increase public protection and emphasises both the content and process of learning. In relation to the supervision of midwives, the focus is on public safety and protection from incompetent practitioners and may also be considered to as a sanctions model of monitoring with the resultant developmental or supervised practice programme being implemented if CPD is not evidenced in practice. Hughes (2005) investigated nurses' perceptions of continuing professional development using a method of sequential triangulation involving the use of questionnaires and then interviews to follow up lines of enquiry raised by the responses to the questionnaire. This study did illustrate that nurses were disassociating PREP from lifelong learning and were selecting study activities to meet PREP requirements rather than to improve their practice. This raises the question of whether nurses understand the aim of CPD or just focus on it in terms of meeting the quantitative target of PREP. If this is the case then, as Hughes (2005) argues, nurses and indeed midwives are not getting the most from the ethos of CPD.

It is argued that pre-registration education fosters an intrinsic desire to undertake CPD to enable personal growth and career progression. Quinn (2000) believes that where individuals are intrinsically motivated due to perceived individual needs self directed study will be undertaken. This would appear to support the theory proposed by Mezirow (1991) that adults identify their needs in a way that children cannot and recognise their need to know which he terms transformational learning. In practice newly qualified midwives actively seek opportunities to participate in CPD in order to progress in the salary grade banding which is underpinned by achieving

specified competencies. However, experienced midwives who have already progressed in their careers may be more passive in their learning as according to Sparling (2001) they may not have been exposed to the more informal learning methods such as self directed learning. Maslin-Prothero (1997) and De-Marco et al (2002) argue that it is important for educators to develop students into active learners for their professional and personal lives, a view supported by Hughes (2005) who advocates that professionals need to be self-directed learners able to identify their own educational needs and pursue lifelong learning as a method of CPD if client care is to be improved.

It may be argued that clinical expertise cannot be developed in isolation from formal educational programmes as it is not sufficient to learn skills without the knowledge to apply this in practice. Indeed, Apgar (2001) states that to develop an enquiring mind and challenge practice educational programmes within academic institutions are required. Apgar (2001) further states that prevention of obsolescence, broadening of the depth and breadth of information to deal with change and innovation as well as career maintenance and development are attributed to CPD. Formal education through CPD enables practitioners to pursue identified learning needs and is less prescriptive than pre-registration education in that it enables new roles to develop, provides specialist updating and development of a self directed practitioner (Cervero 2001).

As previously analysed continuing professional development is a fundamental component within the continuum of lifelong learning. The type of CPD activity depends on an individual's needs as well as those of the organisation. Motivation to undertake CPD is driven internally and externally at any stage and age within the lifetime of the practitioner.

Sadler-Smith and Smith (2004) take this view a stage further and suggest that CPD has three functions of importance to the practitioner: the *maintenance role* that fosters the notion of lifelong learning, the *survival role* that requires practitioners to demonstrate ongoing competence, and the *mobility role* that aims to increase the practitioners' employability. The maintenance and survival roles would appear to link with the NMC requirements to maintain knowledge and skills to enable re-registration and the ability to practise. The mobility role due to CPD requirements enables practitioners to develop their personal professional profile which then can be used to seek future employment and career progression a view previously supported by Nolan et al (2000), Gould et al (2004) Gould, Drey and Berridge (2007) and Munro (2008). Indeed, Davey and Robinson (2002) earlier found that around a third of nurses with degrees had used these to change their jobs to other areas of health care and a third had described these as enabling careers outside of nursing.

In terms of career development the concept of investment in human capital is recognised as a controversial issue. Critics argue that education does not increase the productive capacity of an individual but rather acts as a screening device that enables employers to identify individuals with innate ability or potential that makes them more productive (Woodhall 2001). Screening implies that employers use educational attainment as a means of narrowing down the number of applicants for a job as educational attainment implies 'trainability' so that these individuals are more likely to acquire the skills required for the future which will influence the provision of services (Killeen, Turton, Diamond, Dosnon and Wach 1999). It may be argued that employers are using educational attainment to exclude certain categories of applicants and in recognising qualifications assumptions are being made about the characteristics of the individual to which education

does not necessarily contribute. As more individuals are able to achieve a given level of educational attainment then the level of screening will inevitably rise. This situation has driven the basic education and training of a midwife to be raised from Diploma status to an all honours degree level profession. Therefore to embark on a career in midwifery entrants now need to demonstrate higher academic achievement at A level standard or above.

It may be argued that the acquisition of qualifications assumes permanent gains. However, obsolescence is an important issue as drawing information from initial education as a professional may not be a true reflection on the individuals' ability. However, Woodhall (2001) argues that employers still prefer educated workers with qualifications as they believe that education affects attitudes, motivation and other personal characteristics, as well as providing knowledge and skills. Ultimately the way forward would be to promote lifelong learning in order to maintain and further develop this human capital.

Investment in human capital is different from investment in physical capital due to the mobility of the worker. If an employer does invest in an employee's education there can be no guarantee that the employee will stay with that employer or will indeed acquire the additional knowledge and skills. However, as there are only a minority of midwives in private practice with the NHS employing the majority of midwives then mobility is less of an issue as the NHS will still benefit from the investment in continuing professional development but the actual investing Trust may not. Therefore mobility is an issue that may determine whether an employer is willing to invest in an individual.

Typically professionals that have undertaken more education progress to higher positions and earn a higher salary than those who have done less education as the average gains from completing educational programmes are large but to complete specialised programmes the gains would need to be even greater. Perri (2003) refers to the comparisons between students undertaking Masters courses and students taking Doctoral courses, highlighting that those students who would have gone for an advanced degree now chose to take a Masters course instead as the rewards are greater and quicker.

An earlier study by Clarke and Rees (1989) surveyed 178 midwives in South Glamorgan to ascertain their experiences of CPD and to obtain views of which subjects would be the most useful. Although a low response rate was achieved (56%) the participants in this study supported compulsory attendance to CPD rather than voluntary attendance. This is an interesting finding as CPD for midwives was at this time, and still is compulsory for practice so attending courses for CPD must have been viewed as different to attending refresher courses. Parnaby (1987) explored the views of midwives on the content of refresher courses as Mander (1986) had questioned the usefulness of these statutory courses. Findings from respondents (n=141 midwife teachers, and n=117 midwives) showed that the topics wanted were; recent changes in midwifery practice (90%); new policies/ rules of statutory bodies (83%); new government legislation on reports in midwifery practice (83%); choice in sessions at refresher courses (88%). Recommendations from this study in terms of allowing midwives to choose separate courses according to their CPD needs is now a reality for midwives although it was initially offered as an alternative to a refresher course for those who did not wish to attend a course of 5 consecutive days.



This association between CPD and career progression highlights the importance of selecting the most relevant education. This links to the cost for the individual in terms of both finance and time. Employers according to Ellis (2000) have no legal obligation to provide or finance CPD whether mandated or otherwise. However, it may be argued that the most equitable solution would be for both employer and employee to share the responsibility.

A large number of studies suggest that CPD increases the confidence of practitioners and enables them to be more questioning and challenging in practice (Stanley 2003, Hardwick and Jordan 2002, Audit Commission 2001, Platzer, Blake and Ashford 2000a, Jordan and Hughes 1998). Davey and Robinson (2002) conclude that patients also benefit as a result of the increased confidence, a view supported by Nolan et al (2000). Platzer, Blake and Ashford (2000b) undertook semi-structured interviews and reflective discussion groups with part time students in their second year of post-registration studies (n=30) and found these students reported an increased confidence, assertiveness, able to challenge others and feel more empowered to improve care.

The literature also identifies that nurses' study for personal reasons such as: having friends or peers who are studying; to increase confidence; to increase motivation and morale; for job satisfaction; to improve career prospects (Gopee 2003, Stanley 2003, Hardwick and Jordan 2002, Smith and Topping 2001). Other studies suggest that CPD is undertaken to primarily maintain and develop competency, knowledge and skills (Ryan 2003, Apgar 2001, Beatty 2001). The benefits to undertaking post-registration studies was investigated by Johnson and Copnall (2002) and reported the benefits to be: increased employment opportunities;

experiences gained during the course; self confidence; achieving a qualification; promotion opportunities; recognition from other professions and gaining overseas registration.

## **2.7 Barriers to CPD**

Johnson and Copnall (2002) identified barriers to CPD as: reduction in hours and loss of salary (90%); course fees (89%); lack of remuneration (70%); inability to retain position held prior to the course(36%); lack of opportunities for career advancement (25%); travelling to class (18%); distance from university (14%); family commitments (2%); course workload (1%). The Audit Commission (2001) also found that these different factors were common in different Trusts with an indication that local culture may influence access to university education. Although travelling to access CPD features in a number of studies this issue was not found to be statistically significant and tended to relate to nurses working in rural areas (Johnson and Copnell 2002, Penz et al 2007).

Studies by Sugerman (1988), McCrea (1989), and Clarke and Rees (1989) are all small scale but each focus on in-service education for midwives within single health districts. Sugerman (1988) utilised questionnaires and the findings revealed that staff was prevented from attending due to shortages of staff. McCrea (1989) found that only 13% had attended courses other than refresher courses. Both McCrea and Sugerman identified family responsibilities and staffing levels influenced course attendance in addition to lack of support from managers as well as lack of motivation of some midwives.

The English National Board in 1996, commissioned a study to identify the changing educational needs of midwives in developing new dimensions of care in a variety of settings which was undertaken by Pope, Cooney, Graham and Holliday and this was reported in 1998. This study used postal questionnaires and in depth interviews for data collection and found that both midwives (83%) and Supervisors of Midwives (92%) acknowledged the importance of identifying and addressing midwives needs in planning CPD programmes particularly integrating theory and practice. In addition findings related to part-time midwives in that they had particular problems in finding time or resources to study.

The literature suggests that individuals are resentful at the perceived lack of financial support available for CPD (Dowswell et al 1998), with a high proportion of staff self funding their CPD (Alejandro 2001, Audit Commission 2001). This situation has change since the early part of the century as most education is now funded by the Strategic Health Authority (SHA) and therefore fewer professionals should need to self fund post-registration education (DH 1999d). It is not yet clear from the literature whether this funding has increased practitioners' motivations to access formal CPD but the implication is that more should be able to access studies. The situation for funding is made more complex by the need for managers to agree access to funding through the SHA's as there is no facility to 'back fill' staff which makes being released from work to attend courses more difficult if there is a shortage of staff (Gopee 2003, Audit Commission 2001). Anecdotally, this may be a reason why some courses are not viable as places remain unfilled due to organisational constraints rather than a lack of motivation to engage in CPD studies.

Long, Kneafsey, Ryan and Berry (2002) identify the difficulties in accessing suitable CPD courses locally by specialist nurses. It is suggested by Gould et al (2007) that these difficulties can be overcome by identifying gaps in training provision across Trusts and then commissioning education events with one university will be more cost effective rather than each education provider competing with neighbouring universities for limited numbers of students. Collaboration between education providers and Trusts will reduce the need for Strategic Health Authorities to tender for post-registration education as is the current system. Shields (2002) and Gould, Kelly, White and Glen (2004) corroborate the findings in their studies highlighting the lack of a quick response time to meet service changes or individual needs and better CPD activities could be provided either in-house or by charities. The lecturers who participated in these studies identified lack of influence in commissioning as they were not directly involved and senior Trust staff was perceived to be out of touch with practitioner needs thereby failing to commission appropriate courses. If universities do not engage more closely with NHS Trusts and responsively provide education to meet CPD needs then the danger is that Trusts will develop their own events which may limit the educational and learning experiences of staff and decrease the educational opportunities offered by the Universities.

The demand for post qualifying education will reflect the expected rewards in future years from present expenditure and effort. Therefore demand for education may be made by the practitioner privately investing as a means of improving job prospects and increasing earnings, or investments by employers through government funding with the expectation of improving health care. If human capital is to be analysed input indicators, the quality of the investment and output indicators, the actual outcomes of investment need to be considered. The input indicators tend to be the total

resources devoted by a government and or individuals to all education and training. The important indicators relate to the outcomes of the education that will provide information on sustainability and improvements. An example of an outcome measure reflecting the inadequacy of human capital formation in a country would be skill shortages leading to migration flows. This is an issue that has been experienced by the midwifery profession as midwives select to work abroad in an attempt to experience a better personal and family life. This results in increased shortages of midwives in the UK, a position which even with increased commissions has still not been fully addressed.

A health professional considering continuing professional development will estimate the reward they may gain as a result of investing time, money and effort in such activities. For a midwife the probability of obtaining a more senior or specialist role or for continuation of the current employment contract as well as ongoing re-registration with the statutory body must be considered. If opportunities for promotion are limited or nonexistent then investment may seem unattractive. The timing of the investment may also need consideration as professionals nearing the end of their career, those with family commitments and part time workers may choose not to invest as they may not have the resources to do so or that the investment will bring additional pressures.

Ayer and Smith (1998) found that the time, pace and place available for study were also influential factors determining participation in CPD activities. Time constraints particularly impact on study and affect the home life work balance which prevents some practitioners from participating in courses (Gopee 2003, Stanley 2003, Ryan 2003, Alejandro 2001, Reid 2000). Dowswell et al (1998) demonstrates the impact of study

on home life and reports how 20 practitioners describe the changes to their home lives with changes to their role of parent or spouse resulting in tensions at home. If individuals experience pressure at home as a result of study then family and spouses attitudes to study can positively or negatively affect their experiences (Gopee 2003, Ellis and Nolan 2005).

Within the available literature domestic responsibilities and child care have been identified as barriers or inhibiting factors. Indeed, midwives in a study undertaken by Pope et al (1998) found that it was particularly challenging to try to combine study and paid work especially if they had to study in their own time. Dowswell, Bradshaw and Hewison (2000) argue that social role theory provides insight into this issue and suggests that existing social roles influence the opportunities that individuals believe are open to them and their responses to those opportunities. Therefore a perceived opportunity for one role may not be a practical opportunity for another role if it results in damage to the other role. If the opportunity to study can result in a poorer performance as a parent then the opportunity to study will not be taken.

Home commitments and child care issues may create a bigger barrier to accessing education much more than the issue of funding as there is a presumption that women are more liable to family pressures that will discourage accessing CPD (Stanley 2003, Schuller 2000). Gopee (2002) considers that partners may be able to provide social capital through moral support and childcare but if they are not also studying then personal relationships may be negatively affected due to the differences in interests and the feelings of inadequacy. It is from this stance that Gopee (2002) further states that some nurses will not take the risk of damaging personal relationships and therefore choose not to access CPD. In relation to single

parents Gopee (2002) argues insufficient child care may prevent uptake of formal study. This view is endorsed by a study undertaken in Canada by Penz, D'Arcy, Stewart, Kosteniuk, Morgan and Smith (2007) who also found that for single, divorced or widowed nurses there were greater barriers to participating in CPD. This study also found that barriers were further increased where there were dependent children or relatives. Similarly, a study conducted by Hegney, Tuckett, Parker and Robert (2010) also identified family commitments as being a principal barrier to undertaking CPD. The issue of family life is also highlighted by Hughes (2005) who reports that participants in her study viewed family life as a barrier to CPD voicing the opinions at interview that day's off and family life were considered to be precious as shift work caused tiredness and reduced motivation.

In a study by Dowswell, Bradshaw and Hewison (2000), interviews were conducted with participants on a range of courses and included nurses, midwives and allied professionals (excluding audiology and radiography). The study also focuses on the impact of child care responsibilities on the decision to participate in continuing professional development activities and on participant's experiences of combining study with the role of parent. The sample comprised 81 women and 9 men aged between 24 and 59 years. The number of households representing children under the age of 16 years was 45, these participants reported: guilt associated with their role as parent or guilt associated with asking 'favours' from friends or relatives in terms of child care provision; more than two thirds reported that the course had affected their home care activities describing a deterioration in home care and catering standards; that the course was a strain and that the course was having serious detrimental effects. The study did not take into account the caring responsibilities for older relatives for some

participants, the social networks that might increase the opportunity to access CPD courses or the individuals' economic circumstances. The limitations of this study relate also to the sample as this comprised students participating in selected courses and this selection may not be generalised to other groups.

Gender differences are also to be found in the literature as Davey and Robinson (2002) found that more men than women were degree minded although only 6% of respondents in this study were men. Their longitudinal study distributed 1265 questionnaires to a purposive sample of nurses at qualification, at 6 months, 12 months, 2, 4, and 8 years to ascertain the effects of having a degree and reasons for not planning to obtain a degree. The questionnaire construction in this study is of multiple choice questions and this may limit the responses or lead participants to particular responses and so in effect limits the study findings. The barrier to undertaking a degree for females in this study was combining work with study and child care. The men in the study cited a lack of remuneration and the belief that a degree would not enhance their skills as reasons for not studying. Interestingly, nurses reported that there would be problems obtaining study leave and funding whereas those who were actually studying had study leave (75%) and funding (73%).

The shortages in the healthcare workforce, with particular reference to nurses and midwives, are of an international concern (WHO 2006) and this increases the demand for the retention of older practitioners. Ball and Pike (2005) found that the age of a nurse at the point of qualifying is 29 years. The RCM (2006) identified that the average age of student entering midwifery training is 34 years. Both studies reflect the changing age profile of the workforce for which may present a barrier in accessing CPD. Wray,



Aspland, Gibson, Stimpson and Watson (2009) in a postal survey of nurses and midwives working in the NHS found that 73% of these professionals aged 50 years and over had undertaken fewer CPD activities than those under 50 (27%). The differences between older and younger staff accessing CPD may reflect discrimination against the older practitioner and put them at a disadvantage when opportunities are available. The findings from this study support those of Watson, Manthorpe and Andrews (2003) and Meadows (2002) who also found that older nurses and midwives find it more difficult to access training and CPD than younger colleagues. However, it may be argued that older nurses and midwives may access less CPD activities by choice rather than discrimination considering their wealth of experience. An important challenge for employers will be to respond to the CPD needs of the older practitioners within the workforce as a lengthening of the working lifespan allows workers to continue beyond the normal retirement age and safe, competent practice must be maintained.

In early studies (Ferguson 1994, Barriball, While and Norman 1992) the literature reveals inequity of access to CPD for part time or permanent night staff in the NHS compared to full time or day staff. Some researchers argue that this is still evident (Audit Commission 2001, Scott 2003). Part-time staff involved in a survey carried out by Nolan et al (2000) was perceived as being disadvantaged and this was proven to be statistically significant. It was also found that the lower grades of staff were also significantly disadvantaged in accessing university courses.

Even though the literature highlights the barriers to undertake CPD it fails to identify the reasons why nurses and midwives do achieve CPD despite these obstacles.

## **2.8 Clinical Practice and CPD**

There is very little evidence in the literature regarding the impact of CPD on practice despite mandatory professional body requirements and the lifelong learning principles of government policies (Beesley 2004, DH 2004a, DH 2004b, DH 2000a, DH 2000d, DH 2000e, NMC 2003, Nolan et al 1995). According to Clark, Draper and Sparrow (2008) there is little evidence of a direct impact of continuing professional development on improvements in health care as benefits tend to be assumed or implied rather than evidenced by service users. They further add that studies to evaluate programmes of professional development tend to focus on the learner experience or teaching strategies rather than on any direct impact on practice. The view that CPD has an impact on practice is stressed in many document but few studies have really examined this assertion. A study by Murphy-Black (1991) examined the effects that a course had on participants' antenatal education teaching styles and teaching methods. The response rate from the questionnaires pre course 94% and post-course 78% showed a high degree of satisfaction with the course and most respondents stating they had learnt about teaching and communicating with women. Evaluation studies comprising process measures are useful to ascertain satisfaction or strengths and weaknesses of a course but do not necessarily mean there will be a subsequent change in practice. Murphy-Black also argued that outcome studies were needed to assess changes in practice.

An aim of CPD, implied in its definitions, is to improve both patient care and service provision (Waddell 1992) but debate on the theory practice gap indicates that learning and new knowledge is not always implemented in practice. It is argued by Jordan (2000) that a significant investment in CPD has been made in health care despite the lack of empirical evidence of its

effectiveness and as a result proposes that public money should therefore be redirected towards clinical roles. This view is endorsed by Campbell (2004) adding that CPD should be patient focused. Jordan (2000) in this stance considers that CPD has no effect on improving patient care whereas Smith and Topping (2001) and Tenant and Field (2004) feel the evidence is inconclusive.

Smith and Topping (2001) used a mixed methodology of case study, questionnaires and semi-structured interviews to assess whether a specific course had led to an impact on patient care. A purposive sample of 14 nurses who undertook the course participated in this study and although participants believed their increased knowledge would enhance practice the researchers concluded that it was inconclusive as to whether it would impact on care. Cervero (2001) argues that a professional's performance can improve as a result of CPD but successful completion of a course does not always necessarily lead to improved practice or practice changes. Other studies by Gopee (2003), Stanley (2003), Hicks and Hennesy (2001) conclude that CPD does improve patient care although others identify limitations to the extent it impacts on this care (Ellis and Nolan 2005).

The perception of nurses, highlighted by Wood (1998), Waddell (1991) and Shepherd (1995), is that care is improved following CPD. Indeed, Waddell (1992) in a meta-analysis supported the hypothesis that CPD impacts positively on patient care despite almost a third of the studies included in the analysis failing to report on the reliability or validity of the data collection methods. Jordan and Hughes (1998) utilised a grounded theory framework to investigate nurses' perceptions regarding the implementation of skills learnt from a physiology module. Triangulation using self reporting

diaries, pre and post course questionnaires and semi-structured interviews enabled a conclusion that enhanced knowledge led to a greater insight into patient care and even modified decision making.

A study by Adriaansen, van Achterberg and Borm (2005) was also unable to conclude that university studies enhance patient care. They studied the effects of a post-qualifying course in palliative care using a pre and post-test quasi-experimental design with two experimental groups and two control groups based in two localities. Data collection tools were developed by the researchers and analysed indicated increased knowledge, insight and self-efficacy but was not statistically significant compared to the control groups. The researchers in this study had developed the course and worked closely with the groups which may have led to subjective interpretation of data. The focus in this study appeared to be the evaluation of the development of knowledge rather than the impact of knowledge on practice which is in common with the study by Smith and Topping (2001).

Lawton and Wimpenny (2003) and the Audit Commission (2001) acknowledge the difficulties in measuring the impact of CPD on practice as this is problematic in terms of quantification. Evaluation tools developed by researchers tend to focus on process, content and outcome of programmes of education rather than the effectiveness of the CPD programme on practice. Ryan, Campbell and Brigham (1999) advocated that further research is necessary in relation to the research tools used to collect data on behavioural change following CPD activities as the reliability and validity of the tools is questionable.

Hicks and Hennessy (2001) assessed the changes practice nurses made to patient care following course attendance, with participants self reporting on 30 competency statements before and after the course to determine the impact on practice. The results demonstrated no statistical significance in participant's competency although statistical tests indicated performance in some tasks had decreased training needs. This was a small study of just 15 participants and generalisability is limited due to the small sample size and lack of control group. It can also be argued that one would expect that competency over a period of time in the same job would increase so this brings into question the validity of the study although data was collected from the employers of some of the nurses which corroborated the nurses responses providing some degree of reliability and validity to the evaluation.

In being able to determine the impact formal course have on practice multiple variables must be acknowledged the extent to which these influence application of knowledge and skills to practice. It may be argued that any study undertaken by an individual must be at the right time in that professionals career to ensure new learning is building upon existing knowledge and skills (Kolb 1993). In addition, the educational programme, the environment in which the professional works and the motivation to learn must all be present to enable learning that will impact on practice.

Ellis and Nolan (2005) consider the practice environment to be the most influential determinant in enabling change. They used a short course in an illuminative evaluation model where data was collected through documentary analysis and in-depth semi-structured interviews with students, managers and educators prior to, immediately afterwards and at 6 and 12 month intervals after the course. This study also highlights

factors such as selection of staff for courses, their disposition, motives for study, quality of the education and practice issues as all influencing a practitioners' perception of CPD outcomes, a view previously proposed by Cervero (1985). Whilst motivation and manager support are also identified as important the practice environment is still considered the most significant determinant of change although these studies did not explore the actual participant's responses in any depth.

The Audit Commission (2001) found that a practitioners commitment to learning and study was significant in terms of those with little interest in CPD were unlikely to alter their practice. A view supported by Nolan et al (2000) and Ellis and Nolan (2005). Gopee (2003) also added that not all practitioners appreciate being propelled into lifelong learning nor are motivated to develop professionally. A number of researchers believe that if an individual is motivated to study rather than coerced and envisages the relevance to practice then this leads to improved care (Elis and Nolan 2005, Gopee 2002, Ellis 2000, Jordan et al 1999).

In the practice environment peers and other professional may view those having undertaken CPD as threatening which can create a resistance to change (Nolan et al 2000). Stanley (2003) states that instigating change in practice is stressful and requires support which is something that is lacking within the NHS as professional jealousy, tension and conflict are reported (Jordan and Hughes 1998, Scholes and Endacott 2003). Jordan and Hughes (1998) found that senior nurses felt threatened, despite their senior position and experience, without academic qualifications. Indeed, Nolan et al (1995) found nurses in higher grades to be more threatened by junior staff who had undertaken courses and it was these senior staff that created the barriers to implementing new skills. Williams (2000) asserts

that a practitioner's determination and motivation for change can overcome the barriers within the practice environment but Ellis (2000) and Nolan et al (1995) dispute this and suggest individuals become disenchanted and implementation of skills therefore, will not happen. Hughes (2005) also found that nurses unable to alter practices as a result of new learning were drawn into a cycle of frustration and disillusionment leaving them feeling disempowered to the point of wanting to leave the profession. This frustration was identified by nurses of all grades who attempted to make changes in practice but were unable to leading to apathy.

As the literature suggests implementing new skills in practice to improve care will not occur if the practitioner is not supported and these will then ultimately be lost in a culture of traditional practice with resistance to change. In a study by Hughes (2005 p 47) participants identified a lack of support from managers in implementing change as well as how managers' leadership styles played a part in the 'no change culture'. Hughes suggests that managers' leadership styles can affect nurse's feelings about their environment and this, she argues, is linked to the experience of the manager in fostering an environment of change which can have a dramatic effect on motivation to change practice as a result of CPD.

Ryan (2003) argues that the characteristics of a practitioner need also to be considered in terms of implementing skills. The age of the practitioner was considered by Waddell (1991) who concluded that there was no relationship between experience and age and behavioural change whereas Franke et al (1995) found that younger nurses were more likely to change than older nurses as they were not as set in their ways. Aoki and Davies (2002) also found in their survey of nurses experiences of CPD within nursing homes that some nurses feared they were too old to study and

13% did not feel the need to undertake any further training. Gopee (2003), Furze and Pearcey (1999) also suggest age may prevent older nurses from accessing CPD as many older nurses perceive themselves ineligible to undertake formal CPD as a result of integration to higher education. It is interesting to note that in a study undertaken by Hardwick and Jordan (2002) some nurses do not disclose their academic achievements to peers or colleagues due to the fear of negative reactions.

## **2.9 Summary of the literature review chapter**

The social context of learning is believed to influence continuing professional development in particular the role that activities and experiences have on development of skills and knowledge (Field 2004, Hall 2006). Learning is perceived to take place in a framework of social participation rather than just within the confines of the individual mind and according to Lave and Wenger (1991) include the concepts of communities of practice, situated learning and legitimate peripheral participation. The NHS may be considered to be a learning organisation which is defined as an organisation that facilitates the learning of its members through structures and processes and in doing so transforms itself.

The literature highlights the concept of experiential learning that became popular in education during the 1980's (Mezirow 1998, Kolb 1984). Learning from experiences requires individuals to reflect on the experience in order to learn (Jarvis 2004, Fowler 2008). Reflection is considered to be an active process that enables experience to be turned into learning (Boud, Keogh and Walker 1985). Reflective learning challenges practitioners to examine their practice and is a way of accounting for actions undertaken and offers to inform future actions through changes in perspectives.



Nakielski (2005) further adds that reflection serves as a basis for both personal and professional growth and development.

The concept of ownership of professional development and individually tailored learning is considered to be more positive on personal and professional development (Ellis and Nolan 2005, Ellis 2000, Quinn 2000). Indeed, Ellis (2000) argues that a personal development plan increases effectiveness of CPD and enables practitioners to focus their own development. This is particularly important as Cervero (2001) and Tobias (2003) describe how professionals need direction in CPD otherwise an ad hoc system of development exists which is not congruent with the needs of the different stakeholders in health care. If direction is not focused then the outcomes will have little difference on patient care or the practitioners own practice. Tobias (2003) describes this as 'travelling' but without a guide to help them find a destination. Stanley (2003) also describes students as 'travellers' who are motivated to study in order to increase confidence. She goes on to state that guides within travellers journeys were friends, family, managers and tutors who were all influential in enabling them to cope with the stresses of study.

Learning needs to be identified correctly as unless this is achieved deficits cannot be acknowledged (Audit Commission 2001). Whilst Cervero (2001) asserts that nurses can identify their learning needs Jordan (2000) argued that professionals are not always aware of these. This may be particularly so when an incident in practice occurs and as a result a midwife is required to undertake a period of supported practice. Jones (2000) outlines how the Supervisor of Midwives can assist midwives in developing reflective skills to fulfil PREP requirements and increase confidence and competency, a view also supported by Kirkham (2000). The actual identification of midwives

CPD needs requires review in order to demonstrate the experiences of both midwives and supervisors in this process.

Even when suitable programmes of CPD are available the barriers that influence attendance (Gould, Berridge and Kelly 2007) including as previously discussed within this chapter for example, the locality of the course, travel, costs and release from practice still prevail. One solution to the backfill debate comes from Gould et al (2007) who argue that the NHS knowledge and skills framework (KSF) may improve the situation by identifying the skills of practitioners on a database to enable cover needs when staff attends CPD courses.

The KSF developed as part of the NHS Agenda for Change (DH 2004c) was designed to promote fair opportunities for CPD, pay and career progression. This framework is linked to annual appraisal or annual development reviews which represents the learning cycle (Kolb 1993). The stages of this cycle are: the training needs analysis; planning educational events to meet identified training needs; implementation of training; and evaluation to inform the next training cycle. The development review involves assessment, planning, implementation and evaluation of learning needs and in order to function effectively the KSF and developmental review require partnership between the staff member and the manager. As the manager and staff member jointly agree learning needs then the appropriate CPD package should be made available thus supporting career planning and contributing to progressive practice. It may also be argued that in identifying training needs for people at different career points applying the KSF should assist managers in identifying gaps in knowledge and skills for teams across a service using standard job profiles.

The Department of Health (2007) document 'Trust, Assurance and Safety – The regulation of Health Professionals in the 21<sup>st</sup> Century' examines how fitness to practice may be revalidated in the future and it is suggested that employers will provide information to regulators regarding this issue. The information provided emerging from the KSF review. However, this is only one method of evaluating an individual's practice and it is interesting to note that the annual supervisory review undertaken by a Supervisor of Midwives is not utilised by managers in some way at the KSF review. The evidence contained within the annual review could inform the PDP and link training needs more accurately to service needs and meeting the competencies of the post held by the individual. This area needs further exploration in relation to supervisors, managers and midwives sharing information to enable accurate CPD needs to be identified.

Although continuing professional development is compulsory for midwives and other health care professionals (DH 2000a, DH 2000d, DH 2000e) and its importance widely recognised the system of commissioning focuses on pre-registration education at the expense of post-registration provision although this was believed to be due to the inadequacy of training needs analysis on the part of Trusts (Shields 2002).

The impact of CPD on practice in the literature does not enable a definite correlation to be made between CPD and improved practice. Some studies provide evidence of the benefits to the individual practitioner, others highlight the many variables that affect practice and as a result do not always allow for CPD to impact on practice. There is no agreement in the literature reviewed to suggest that by attending university courses or formal study that this in fact does improve practice or patient care.

The literature provides evidence of the main areas frequently associated with practitioners and CPD in terms of factors enabling or barriers preventing development. In addition the role of the manager in CPD is considered for nursing. The impact of CPD on practice is an area that requires further research.

From a midwifery perspective the role of the supervisor is unique and therefore their influences in enabling midwives to achieve CPD requires research to be undertaken specifically on this group. The literature from the NMC professional body does relate to the role of the supervisor in CPD but evidence to support this activity is lacking.

The interface between the Supervisor of Midwives and the midwives themselves also need exploration to determine their actual role and influences on midwives achieving CPD. This also applies to the role of the manager as supervisors are often in a dual role of manager and supervisor therefore this brings potential conflicts and tensions that require analysis.

The provision of formal education provided by approved educational institutions also requires consideration in terms of how communication, collaboration and providing educational provision relevant for the CPD of midwives is achieved.

The aim of this study is therefore to explore the influences of Supervisors of Midwives in the context of the lifelong learning (CPD) of practising midwives. The literature reviewed as summarised above identified a lack of research in relation to continuing professional development in midwifery

and the role of the Supervisor of Midwives in enabling professional development of the midwife. The transferability of the literature related to nursing and other professional groups is limited as the system for supervision is not the same. The importance of roles and contexts is also important so the need for further research in this area is justified.

The methodology for this study will be presented in chapter 3 and takes into account the research methods utilised in the studies located within the literature search thereby informing the direction taken for this study.

# Chapter 3:

## Research Design

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### 3.1 Introduction

This Chapter will focus on the research methodology utilised within this study and highlight methodologies of previous research studies discussed within the literature review presented in chapter 2. The choice of mixed methodologies will be justified in recognition of social science trends and the experiences of the researcher in the process will be reflected including decision making and ethical issues as required by research governance processes.

Research undertaken on CPD by midwifery researchers relates to the survey method (McLean 1980, Parnaby 1987, Sugerman 1988, Clarke and Rees 1989, McCrea 1989, Clarke and Rees 1989, Murphy-Black 1991, Larcombe and Maggs 1991, Robinson 1994, ENB 1996, Mitchell 1997) and mainly comprised the use of questionnaires and interviews for data collection. The survey is one of the most frequently used methods in social sciences research according to Parahoo (2006) and according to Rees (1997) is a way of gathering large quantities of data. In health care, clinicians are bombarded with surveys and according to Parahoo (2006), are frequently dismissed without being read. This therefore, brings a challenge for the researcher in terms of achieving a reasonable response rate.

Studies from an entirely naturalistic perspective are few in number but do provide rich data including quotes from participants which although increases the trustworthiness and credibility are subject to methodological weaknesses (Ellis and Nolan 2005; Gopee 2003; Stanley 2003). In analysing the work of Gopee (2003) he utilises triangulation to validate his findings suggesting a partly positivist perspective on data collection and analysis.

Some studies include the use of questionnaires which increases credibility and reliability of findings but a low response rate was noted in some of these which reduces the ability to generalise (Beatty 2001; Nolan et al 2000). Jordan (2000) argues that observations to validate questionnaires and interviews should be used to reduce bias and whilst some studies used observational techniques behaviours may alter during the observation phase (Oakley 2000) which then questions the validity of this method.

Other studies used interviews as the method for data collection but some studies did not state where these took place or how many took place (Stanley 2003, Hogston 1995). Some studies used documentary analysis to support interviews and questionnaires (Ellis and Nolan 2005, Gopee 2003, Ellis 2000, Daley 2001) to corroborate practitioner responses but this is considered irrelevant as it is unlikely to indicate changes in patient outcomes but is more likely to demonstrate nurses' efforts to meet assessed course outcomes. Stanley (2003) and Daley (2001) argue that by returning transcripts to participants prior to analysis increases the credibility and dependability of studies when participants recognise these as their own experiences.

The quantitative studies reviewed (Adriaanson, van Acherberg and Born 2005; Lawton and Wimpenny 2003; Beatty 2001; Nolan, Owens, Curren and Venables 2000, Wood 1998) attempt to identify variables which have an impact on practice but do not achieve this as this is particularly difficult to measure as some aspects of practice are unquantifiable. Practitioners' experiences of practice and their developmental needs lead to different interpretations about undertaking CPD whether it be for example, from an access point of view, barriers preventing participation, motivation or decision making to study. Therefore positivist methodologies may be inappropriate as these issues are not really measurable (Smith and Topping 2001; Jordan, Coleman, Hardy and Hughes 1999).

It can be seen that a range of methodological approaches have been utilised as presented above although most studies provide readers with definitions of terms it is not clear whether participants are always provided with these definitions. The use of the terms CPD, CPE and Lifelong Learning makes it difficult to make comparisons due to the formal and informal activities under the umbrella of the major term CPD. The methodology selected for this study is justified following the literature review and critique of the methods employed in the research found on this subject area. The use of questionnaires enables a large number of practitioners to be targeted for inclusion within this study and the focus groups allows for the data to be taken a stage further to gain further insights into a subject that still appears to lack clarity in terms of definitions and activities. The study will also add to the limited research available on CPD and the supervision of midwives.



Although this is a small study it utilises both the quantitative and qualitative research approaches. Crabtree and Miller (1999) and Steen and Roberts (2011) support this mixed method approach as they consider the benefits are likely to assist in identifying, describing and therefore leading to an explanation of the phenomenon under investigation. Indeed, qualitative research, in this case using focus groups as the source for data collection, offers the researcher the opportunity to focus on how individuals and groups perceive and understand their world and create meaning out of their experiences (Baker 2006), thereby generating rich, detailed and valid data that although may not be generalizable in a quantitative sense are often considered transferable as findings may resonate with the experiences of other practitioners and so have the potential to change practice.

In the social sciences qualitative research is particularly well established and it is only more recently that qualitative research studies have been widely accepted as being of clinical relevance in the field of maternal and child health and as a consequence scientific review processes now require knowledge of both quantitative and qualitative research approaches in ethical review. The qualitative approaches utilised in these disciplines progress through thorough systematic exploration and offer the opportunity to yield a depth of understanding, whereas quantitative approaches progress through systematic testing and controlling with the outcome of simply quantifying a definition or response. Disciplines such as nursing, midwifery and education according to Crabtree and Miller (1999), have utilised these roots for their studies and the development of a research body of evidence have resulted mainly from the interpretive paradigm based on the inseparability of the individual from their

environment. It is acknowledged that there is a divide in the literature between qualitative and quantitative research compounded by the promotion of hierarchies of evidence but it is increasingly recognised that both approaches can complement each other and aid understanding of behaviour in health care organisations and how the organisation impacts on individuals rather than just focusing on verifying facts and causal relationships through quantitative approaches.

The emergence of the clinical governance agenda in health care has also had a positive impact on the status of qualitative research as it is recognised that these methods of enquiry are the only way to understand the perspectives of health processes and outcomes from the user's perspective. The users in this case are not just the general public using health care but also the care givers working in the health care services.

In order to explore the ways in which Supervisors of Midwives work with Midwives and Universities to influence the provision, uptake and the activities of CPD for practising midwives a triangulation of approaches using quantitative and qualitative methods was considered appropriate. This approach enabled the researcher to obtain a more valid picture of the experiences of participants in an area not previously researched to enable a shared understanding of the complexities for midwives in achieving CPD. This use of a questionnaire for data collection, indicating in part a survey approach, enabled a large number of midwife practitioners to be targeted and analysis using descriptive statistics. The undertaking of focus groups in this study was to enable thematic analysis of the qualitative data

collected to provide further depth to understanding the phenomenon studied.

Research that is relevant to clinical practice generated the researcher's initial interest in conducting this study. As an educationalist and a supervisor of midwives my interest has focused around enabling midwives to develop both personally and professionally to benefit women, babies and their families. In a dynamic health service practitioners are busy trying to meet service demands on a daily basis which is unpredictable in midwifery and this leaves little time left for their professional development. However, with the expansion of roles and the relevance to clinical grades, professional development becomes essential in the achievement of clinical expertise and furthering career opportunities.

The health service being in a constant state of ongoing change with staff stretched to the limit also leaves researchers with the problem of how best to capture the imagination of, in this study midwives, and to promote their participation in the stages of the research. Undertaking research involves a considerable commitment from both the researcher and the participants if the results are to be meaningful and inform policy and or practice.

According to Altheide and Johnson (1994) qualitative research begins and ends with the reflexivity process. Throughout the whole research process it is important for the researcher to recognise their own personal biases and experiences and the effect these may have on the study. Kingdon (2005) refers to this as reflexivity, an acknowledgment by the researcher

of their own viewpoint or theoretical perspective. In addition, Burns and Grove (2011) view reflexivity as a process that also requires an awareness of self requiring the researcher to explore personal thoughts and experiences and to integrate these into the research. Similarly, the researcher must be aware of the influences they have on participants and how their own beliefs and value systems may affect the research study.

### **3.2 Being known to some of the participants**

The researcher was known to some of the midwives and supervisors of midwives in some of the Trusts included in this study. It is difficult to determine whether being known to some of the participants made a difference to the information provided during this study. It is not possible to determine if participants also responded any differently than they would have if the researcher had not been known to them. The process of reflexivity highlights this issue and the potential as a researcher to influence the process. Reflexivity is essential to qualitative research and it is argued that it is important for researchers to continue to return to the data and check and recheck their interpretations (Pyett 2003). By doing this the researcher must consider how they may have influenced the analysis. Also, as argued by Finlay and Gough (2003), the behaviour of the researcher may affect the responses of the participants and as a result influence the findings. Therefore, if the researcher influences the research from the outset reflexivity is a necessity for the research to be viewed as valid.

### **3.3 Study Design**

This study was designed using a mixed method approach incorporating both qualitative and quantitative approaches to data collection to enable validation of results and to gain a variety of information to illuminate the experiences of participants in this area of study. A sequential strategy was adopted creating two stages to the study:

**Stage 1** - of the study was designed using the questionnaire as the tool for data collection as the researcher aimed to target a large number of participants and so the quantitative approach was selected to gather demographic data of participants and to be able to quantify some of the available evidence on CPD activities. According to Polgar and Thomas (1991) selection of key themes and concepts identified whilst critically reviewing the literature provides a useful guide on which to base further research in a particular area. In addition the researchers experience may contribute to the compilation of the research questions. The questionnaire was formulated from this premise.

**Stage 2** - of the study was designed from a qualitative perspective designed to explore the feelings and perceptions of practitioners with the central focus on the lived experiences of the individuals in everyday practice which could not be captured by using only a quantitative method. According to Munhall (1989) and Smith, Flowers and Larkin (2009) individual practitioners have varying perceptions of any given situation and this influences the way they interact with the environment, interpret it and ultimately make decisions. This is described as the naturalistic paradigm

which is concerned with describing the situation including beliefs, feelings and generalities.

In designing the study it was envisaged that the data from each method would enable triangulation to confirm the findings generated at stage 1 with the findings obtained at stage 2. This approach aims to complement each other and to strengthen the validity of the data collected (Mitchell 1986, Steen and Roberts 2011). The challenge for the researcher would then be to interweave the data from these methods at relevant points in the presentation of findings and in discussion to create relationships between the data in demonstrating the influence of supervisors of midwives in the CPD activities of midwives.

### **3.4 Participants**

The participants in this study comprised:

#### **i. Qualified Midwives**

The names of the qualified midwives working within three local NHS Trusts was obtained with the consent from the Heads of Midwifery via the mentor database held at each Trust. The detail provided related to midwife's initial and surname and department in which they worked i.e. community team, hospital ward. The information provided did not give any other detail or information regarding leave that may be occurring. Therefore questionnaires were sent to all the named midwives and hand delivered to the departments in which they worked. The researcher was informed by ward leaders/ clinical leads when delivering the questionnaires which midwives were not available to take part in the study due to extended sick

leave and maternity leave. The total population of the midwives at each Trust were included.

## **ii. Supervisors of Midwives**

The names of the Supervisors of midwives working within three local NHS Trusts were provided by the relevant contact supervisors of midwives. The names of the local supervisors of midwives are publically available from the LSAMO, within each Strategic Health Authority, who is required to publish a list of current supervisors of midwives. A discussion with the local LSAMO was also held prior to the study commencing and an offer of assistance was made if the need arose. All of the supervisors of midwives were included within the study due to the small numbers of these post holders in each Trust.

## **iii. Local Supervising Authority Midwifery Officers**

A Local Supervising Authority (LSA) Midwifery Officer from each of the Strategic Health Authorities in England. The Local Supervising Midwifery Officer from each of the Strategic Health Authorities in England participated in stage 1 of the research study only. The name of the LSA Midwifery Officers was obtained from the National LSA website. The LSA Midwifery Officers were included in this study to ascertain their expectations of how Supervisors of Midwives could influence the continuing professional development of midwives. LSA Midwifery Officers (Birmingham City University 2010) are specifically required to:

- i. offer advice and guidance to supervisors of midwives in relation to local supervisory and practice issues

- ii. Provide guidance to ensure optimal participation of midwives and confidentiality within the supervisory relationship
- iii. Operate a system for ensuring that each midwife meets the statutory requirements for practice
- iv. Demonstrate evidence of engagement with higher education institutions in relation to supervisory input into midwifery education.

#### **iv. Lead Midwives for Education**

A Lead Midwife for Education (LME) from each University in England. The Lead Midwife for Education (LME) at each of the Universities in England where midwifery education programmes are provided participated in stage 1 of the research study only. The names of the LME's were obtained from the NMC database. The LME's were included within this study to provide some context to the influences on continuing professional development of midwives from an educational perspective. This background would include issues such as; collaboration between Supervisors of midwives within the Trusts and Education staff; development of appropriate education provision for midwives; provision of CPD advice to enable career development; contracting arrangements with NHS Healthcare Workforce Development Deaneries.

The Heads of Midwifery had been approached by the researcher for approval of the study and letters of agreement were forwarded to the Trusts Research and Development Departments. This took place before approval of the study was granted by the Research Ethics Committee and the Trust Research and Development Departments.



### **3.5 Methods of data collection**

In order to explore this subject area meaningfully two phases of data collection were designed. Hunter (2004) suggests that stages to studies are commonly used in research and are justified in terms of triangulation of data generated which is considered to add robustness and reliability to a study. The rationale for the two stages in this study was to generate initial data that would then form a basis for further exploration to provide a greater depth of understanding of the perceptions and experiences of midwives and supervisors of midwives in relation to continuing professional development.

#### **Stage 1 – Questionnaires.**

A total of four questionnaires were designed for the participants in this study and covered the following areas:

- background information on the participants
- A series of questions about CPD practice within their respective organisation.

**Questionnaire 1** - was targeted at individual midwives to gain an insight into their perception of the role of the supervisor of midwives in relation to identifying CPD needs of the midwives. The inclusion of midwives as consumers of education is required to be able to gain a perspective of accessibility to education activities and relevance of courses to their CPD needs (see appendix 1).

**Questionnaire 2** - was targeted at the Supervisors of Midwives to ascertain their method of identifying CPD needs of their supervisees and to

determine how they disseminate these needs in order to enable midwives to access educational activities (see appendix 2).

**Questionnaire 3** - was sent to the Midwifery Responsible Officers for the Local Supervising Authorities to elicit information of their expectations of supervisors of midwives in terms of fulfilling their developmental role in relation to identification and advice on the CPD needs of midwives (see appendix 3).

**Questionnaire 4** - was sent to The University Lead Midwife Educators. The LME role is a statutory requirement within higher education and the most senior midwife educator is appointed by the Nursing and Midwifery Council (NMC 2009). This questionnaire aimed to ascertain their perceptions of the collaboration between supervisors of midwives and educationalists and determine whether the LME's consider supervisors of midwives played an influential role in determining the provision and uptake of education activities by midwives (see appendix 4).

Questionnaires are a means of gathering large quantities of data by directly questioning respondents for information (Rees 1997), however, in health care, clinicians are bombarded with surveys and according to Parahoo (2006) these are frequently dismissed without being read. This therefore, brings a challenge for the researcher in terms of achieving a reasonable response rate.

The basic principles of questionnaire design were considered following Bell (1991), Polit and Hungler (1995) and Polgar and Thomas (1991). The

questionnaire consisted of open and closed questions to provide the respondents with a variety of opportunities and to maintain interest.

The questionnaires were hand delivered to the workplace of prospective participants with a covering letter introducing the researcher as a Midwife Educator and a Supervisor of Midwives and the reason for undertaking the study along with a personal invitation to take part in the study (see appendix 5). An information sheet further detailing the purpose and duration of the study was also included (see appendix 6). The potential participants were then given a period of 4 weeks in which to complete the questionnaire and return this to the researcher in the prepaid stamped addressed envelopes.

The questionnaire was designed with both open and closed questions with space left for comments if respondents felt that none of the fixed responses were suitable. This form of questioning ensures ease of analysis and allows some freedom for expression on behalf of the respondent (Oppenheim 2005) and in some way addresses the concern of Parahoo (2006) who considers that questionnaire use make it difficult to assess perceptions and attitudes. The option to add additional text was to enable participants to include their personal experiences and views/beliefs. The wording of questions succinctly and unambiguously is also a difficult task but this was to be tested out at the pilot stage of the research process and amended as necessary.

## **Stage 2 – Focus Groups**

Focus groups were held with the following participants:

- **Midwives**

The midwives will be invited to attend a focus group to further explore the findings elicited from the questionnaires

- **Supervisors of Midwives**

The Supervisors of midwives will be invited to attend a focus group to further explore the findings elicited from the questionnaires

The focus groups contributed to obtaining the qualitative data and were tape recorded and transcribed in full. Focus group, according to Polit and Hungler (1995), offers the researcher some flexibility in gathering information from the research subjects. It was anticipated that the focus groups would elicit participants' views of working within their organisation and the contracting process and identification of specific themes (Polgar and Thomas 1991). The emphasis of the focus groups would be to allow interviewees to respond reflecting their own experiences and personal views rather than being guided towards possible interviewer bias. The transcripts from the focus groups were to be analysed using a qualitative software computer package for example, NVivo. The focus group would also be the main source for the qualitative data collection aimed at obtaining greater depth and richness of data from participants' interactions.

It is reported within the literature that there are three approaches to focus group design which include the exploratory, clinical and phenomenological approaches to qualitative research. In relation to this study the

phenomenological approach is used to understand the everyday experiences of participants in this case for cross validating data from the questionnaires as a means of triangulation and providing insights into the meaning and interpretation of results.

A focus group is according to Holloway and Wheeler (2000) characterised by using the interactions between the participants to discover how individuals think and feel about particular issues. The participants stimulate each other to think more deeply about topics and one person's comment can trigger ideas from other group members. This approach although not better than other forms of enquiry does not just rely on the ideas of the researcher and one participant as in an interview situation but instead, the members of the group generate ideas and possibly new questions building on answers from others in the group.

Litosseliti (2003) argues that focus groups provide a more natural environment than that for individual interviews and are more likely to stimulate a variety of views which invites reflection and reactions from participants enabling sharing of understandings and differences. This approach is also considered to allow for the collection of more data in the same space of time thus making them quicker and cheaper than individual interviews. Williams, Lavender, Richmond and Tincello (2005) also believes that a focus group can provide a forum where participants feel more comfortable discussing sensitive issues within a group rather than with a researcher in a one to one interview alone. This issue was raised in the feedback from the Local research Ethics Committee questioning how the researcher in this study would deal with any participant becoming upset during a focus group meeting. It was therefore planned that participants would be reminded that they could withdraw at any point of

the focus group and that a supervisor of midwives would be available to offer support in the area. The focus groups were set up with this arrangement at each local NHS Trust.

The facilitation of a focus group according to Litosseliti (2003) requires skilled moderation and details the qualities requires for this to be effective. In particular the researcher acting as moderator must display respect for the participants, an in-depth knowledge of the subject area under examination and the ability to detach their own opinions and assumptions. The moderator must, according to Kreuger and Casey (2000), be aware of their own biases and the potential for influencing participant responses.

Prior to conducting the focus group participants were asked for their consent to tape recording the meeting. Participants were also given another copy of the information sheet and asked to sign the consent form to take part in the study. The participants were then given a number alongside their name to enable clarification of issues arising to be linked to each participant but then to de-identify them at the transcribing stage.

At the start of the focus group the researcher provided some background information about the study and the aims of the meeting. Participants were also reminded that they could withdraw from the group at any time, an important requirement within the research ethics framework (van Teijlingen and Cheyne 2004). The issue of confidentiality and anonymity were also reiterated. The researcher also encouraged the participants to express both positive and negative views and that there was no right or

wrong answer. An issue not mentioned at the start of the focus group was for one individual to be allowed to speak at any time which not only would have enabled transcription but also respect for each other's opinions. Midwives and supervisors of midwives did at times talk over each other rather than to the group as a whole. The agreeing and use of ground rules was considered an issue that the researcher would revisit for future research activities.

Another limitation of the conduct of the focus groups was the lack of note taking by the researcher as facilitating the discussion made the taking of notes very difficult and the behaviours of participants could, therefore, not always be captured. Again for future research a note taker or assistant working with the researcher would be considered to be of benefit as described by Krueger and Casey (2000).

Participants were invited to comment on questions posed by the researcher as well as those raised through discussion. A guide sheet of questions prepared before the focus group meeting was used to prompt the group to encourage a wider and deeper discussion of relevant points to be used as necessary. As a novice researcher and inexperienced in facilitating focus groups the researcher utilised the skills developed through teaching experiences along with non verbal communication skills.

Initially the participants in a couple of the focus groups were reluctant to begin to participate and the researcher found that questions had to be posed as responses were not very forthcoming. This may have been due

to the fact that all members knew each other and revealing experiences was initially difficult. This situation is discussed in the literature by van Teijlingen and Pitchforth (2006) who suggest that in focus groups people who do know each other may or may not speak openly about issues and be active within the discussion generated. Participants within focus groups may also feel pressure towards a consensus and unanimity especially as they work together and are expected to adhere to a common professional standard and code of ethics. In this study, the focus area being specifically in relation to supervision of midwives is not, in the researchers' opinion, a topic that midwives generally discuss openly with each other and this may have influenced the discussions within the focus groups with the midwives.

Once further reassurances were given regarding confidentiality and anonymity the discussion did develop, but this was still somewhat limited compared to the facilitation of other focus groups with the supervisors of midwives. One midwife did mention the presence of the tape recorder as a barrier to expressing views.

The focus group interaction with the supervisors of midwives varied as in a couple of the groups loud and opinionated individuals tended initially to dominate the discussion with others being reluctant to speak although as the discussion developed most members did make a contribution to the discussion. The dynamic nature of focus group discussions means they can be unpredictable and researchers are sometimes left with the feeling that certain aspects could have been improved (van Teijlingen and Pitchforth 2006). This was felt following some of the focus groups in this study and rough notes were made after these events. Delament (2004) argues that



these reflections following focus groups should be incorporated into the analysis of the study otherwise there is no point in making these reflections.

Through the group interviews it was possible to discover the perceptions and attitudes of midwives in relation to the research topic. The members of the focus group responded not only to the researcher but also to each other eliciting their experiences of supervision of midwives. Interestingly not all the participants shared the same views or experiences within individual NHS Trusts.

The numbers within each focus group varied as follows:

**Midwives:**

- Midwives – focus group 1 consisted of 4 participants
- Midwives – focus group 2 consisted of 3 participants
- Midwives – focus group 3 consisted of 4 participants.

The numbers participating in the midwife focus groups was disappointing as a lot of interest had been generated at the questionnaire stage with respondents agreeing to participate in the second stage of the study. The respondents completed a separate form indicating their agreement to be contacted to take part in the second stage of the study. The poor attendance at the focus group may have related to the practicalities of being released from the work environment even though the focus groups were held within the proximity of the clinical areas enabling midwives to be called back to the work environment if required. The groups were also held

at the point where handover of staff had occurred providing a window of opportunity for participants to attend as more staff were available to cover service needs at this time.

### **Supervisors of Midwives:**

- Supervisors of Midwives – focus group 1 consisted of 5 participants.
- Supervisors of Midwives – focus group 2 consisted of 7 participants
- Supervisors of Midwives – focus group 3 consisted of 7 participants

There is some debate within the literature regarding the ideal focus group size although generally, it is considered that between three and twelve people would make the group large enough (Ritchie 2003, Holloway and Wheeler 2000). The optimum number is however stated as being between six and ten as this is seen to be large enough to allow for a variety of ideas and perspectives but small enough to be manageable (van Teijlingen and Pitchforth 2006).

Each of the sessions lasted between 45 minutes to one hour as the pace and length of time are determined to some extent by the participants of the focus group. However, it is acknowledged that the timing of the focus groups is also under the scrutiny of the Research Ethics Committees who requires researchers to state the length of time to be allowed for these groups.

The participants were contacted, well in advance of the focus group and again just a few days before the meeting, by email or telephone according to the details they had provided. However, when contacting these

individuals some gave work commitments as reasons for not being able to attend, or initially agreed then on the day sent apologies. The difficulties experienced in arranging the focus groups endorses the view of Krueger and Casey (2000) who suggests that individual interviews are easier to organise than those for focus groups.

The rooms where the focus group was conducted were near to the practice areas so easily accessible. The focus groups with midwives were more difficult to organise as this relied on the midwives being on the premises to make the venue accessible and the timing to fit around the different shift patterns worked. Some midwives did come to the focus group on their day off which was much appreciated by the researcher and made the group viable to continue.

Prior to commencing the data collection, informal 'small talk' was entered into with participants encouraging them to relax in the presence of the researcher and the tape recorder and to confirm their consent in the study (Polit and Beck 2004, Morse and Field 1996). They were also informed that there were no right or wrong answers but that the researcher was looking for their views, opinions and experiences to illustrate and inform the study.

The questions posed were formulated from the responses to the questionnaire and current issues surrounding continuing professional development and the supervision of midwives. The questions were posed where not intended to lead the discussion but to enable continuation of conversation and refocusing on the subject area as required, so these were

asked in no fixed order and not all questions were raised within each focus group due to the path taken by the focus group participants.

### **Distribution of the questionnaires**

The distribution and return rate are considered by Henderson and Shields (2008) as the two factors which impact on numbers of responses. They suggest that the personal touch provides an opportunity for the researcher to engage with potential research subjects and encourage participation. With this in mind during the development of the research proposal the researcher discussed the topic area with supervisors of midwives at the various NHS Trusts and with midwives at study events and in practice. Once the research study had been approved the distribution of the questionnaires was undertaken by hand, issuing the questionnaires and related information to the midwives and supervisors of midwives in the clinical areas of their own NHS Trust. This was not a strategy that was achievable in respect of the Lead Midwives for Education or the Local Supervising Officers as the whole of England was targeted for these populations.

### **3.6 Ethical Considerations**

Midwives work under the statutory Nursing and Midwifery Council Rules (2010c) and as autonomous, accountable practitioners are required to comply with this code of behaviour as well as the ethical rules and principles governing research activities. Ethics are principles of conduct governing research activities and are reflected in the way researcher's value and show concern for participants in a study. Therefore ethics relate to both the researcher, who should know their obligations and responsibilities and the participant who should be protected.

At all stages of the research process it is necessary to adhere to research ethics governance guidelines (DH 2005), the Data Protection Act 1998 in addition to professional guidance from the NMC as a regulating body. A number of ethical considerations are required when conducting research these include consent, confidentiality and right to privacy. Ethical consideration also extends to my role in this research as I am known to some of the research participants.

Qualitative research involving close personal contact, for example focus groups, where personal feelings and experiences are explored may highlight sensitive issues and consideration must be given to safeguarding the wellbeing of participants. The researcher must know how to refer participants to key individuals for support, debriefing and possible counselling following the focus group. In addition, the availability of a colleague to offer this support to any participant who becomes distressed during the focus group must be considered. This issue was raised by the Research Ethics Committee during the approval process and a statement of how the situation would be handled was required by this Committee.

### **University Research Ethics Committee.**

As a student undertaking research as part of the Doctorate In Education (Lifelong learning), ethics approval was required by the university in addition to approval from the NHS Research Ethics Committee. The School of Education has adopted the British Educational Research Association's revised Ethical Guidelines for Educational Research (2011). A Statement of

Research Ethics form was required to be completed and submitted to the School for approval prior to the research commencing (see appendix 7). The principles underpinning the guidelines require all educational research to be conducted with an ethic of respect for the person; knowledge; democratic values; the quality of educational research and academic freedom. The issues of the responsibilities to participants, sponsors of research and to the community of educational researchers are contained within these guidelines. The discussion within this section on research ethics serves to consider the ethical principles required of the researcher in this study.

The approval from the School ethics committee was achieved in April 2008 but required the researcher to strengthen the ability of prospective participants to give or decline their informed consent by stating the perceptions of the possible benefits and costs of participation. In addition, the information letter for midwives needed minor modification in relation to contacts for further information on this study. The chair of this committee also commented on the feedback/approval form, as a reminder to the researcher that,

‘Professional development and learning doesn’t  
just come about via CPD activities’.

## **Ethics Committees**

In health services there are two types of ethics committees, these are, clinical ethics committees that deal with ethical dilemmas that arise in practice; and human research ethics committees that are considered to be the ‘watchdog’ for ethical conduct of research. Local Research Ethics

Committees were set up to consider research projects at a planning stage to ensure that the researchers conformed to national ethical guidelines (DH 2005). The Department of Health established Local Research Ethics Committees (LREC) in an attempt to standardize the availability and functioning of ethics committees, their role being to consider the ethics of proposed research which involves human subjects and apply their research governance guidelines to both staff and patients. Access to staff within the NHS and Universities will be required hence Research Ethics Committee approval and Research and Development permission is needed (see appendix 8).

### **Feedback from the Local Research Ethics Committee**

Following the application for ethical approval feedback was provided with a time limit for responding. Generally the feedback can fall into one of three outcomes which are:

1. The application is approved
2. The application is rejected
3. The application needs clarifying or amending in some way before approval is granted.

This study met outcome three with minor changes required as follows:

- Written consent is not required for completion of the questionnaire, its return is consent. They request that the consent form is not sent separately out with the questionnaire. A tear off slip returned separately to the questionnaire and/ or email /telephone contact details should be used for the participant to indicate interest in the focus group and written informed

consent should be taken prior to the focus group. This would ensure the questionnaire is anonymous.

- The committee requested clarification of how many focus groups would be held in total
- The Committee request clarification of how you will select participants for the focus groups if more than the required numbers express an interest. A mechanism for selection and to notify those not chosen should be in place. If a letter will be sent to those not selected then a copy must be submitted.
- A statement should be added to the focus group consent form confirming that participants understand that the discussion is confidential and identifiable information should not be disclosed outside of the group.
- The Committee request clarification of how you will manage it if a focus group participant requests to withdraw after the focus group has taken place. They suggested that a statement should be included in the information sheet explaining that if the participant withdraws then no direct quotes will be used in any study reports but data from the focus group will still be used.
- Clarification of how long the focus groups will last is requested. The focus group was listed as taking 30 minutes to an hour in question A10-1 and in question A13 of the application form and the information sheet just 30 minutes.
- The Committee request clarification of what you will do if a supervisor is consistently reported, by participants, to bully or harass staff.
- The Committee were concerned that the demographic information requested in the supervisor's questionnaire could identify a member of



staff. Reassurance is sought that this information will be analysed in a way which cannot identify individuals, preferably separately to the feedback data.

A four month period was given for the reply and a period of 60 days for a response to be made by the LREC following this resubmission of documentation. The researcher responded to these questions and returned the amended documents as requested by mid-July 2008 (two weeks after the conditions were received).

Final approval of the study was granted at the end of July 2008. The conditions of approval were that management approval must be obtained from each host site organisation prior to the start of the study at the site concerned. This required the R&D departments to give approval of the study at each NHS Trust before the study could start.

### **NHS Trust Research and Development Approval**

All research projects taking place in or having links with individual NHS Trusts are required to have approval prior to the commencement of the research study. An application for approval was made to the individual NHS Trusts within this study during March 2008. Details of Peer Review were required to accompany this application to each NHS Trust (appendix 9). Peer review was undertaken by a midwife educator colleague with experience as a supervisor of midwives and as a member of a Local Research Ethics Committee. All documentation sent to the main Research Ethics Committee (REC) was sent to each NHS Trust. All letters regarding the study received from the REC with amended documentation was also

sent to the NHS Trust R&D department to keep them up-to-date with the process of approval of the study.

The Lead R&D department was to be NHS Trust 1. The approval for the study to commence was received from NHS Trusts 2 in August 2008 and from NHS Trust 3 at the end of September 2008. NHS Trust 1 did not approve the study until the end of November 2008 despite frequent contacts from the researcher. The letter granting approval was not received until late December and so this delayed the start of the study until January 2009 as all NHS Trusts had to give this approval prior to commencing the data collection (see appendix 10). The R&D Departments at each of the NHS Trusts were updated with a report as requested as the study developed.

The researcher also sought permission from the heads of Midwifery at each of the NHS Trusts before engaging in the research process.

## **Consent**

Respects for human dignity is concerned with ensuring participants are given the right to make a choice of whether they take part in research activities without being penalised or criticised for their decisions (Cluett and Bluff 2000). Participants were given voluntary and informed choice about their participation in this study. This principle was observed at each point of the research where stakeholders were invited to participate. Information was provided by the researcher in the form of an information sheet and letters.

Consent is a key issue within research ethics and this was sought from participants using a written participant information sheet which detailed the title and purpose of the study, participation, advantages and disadvantages of participation, collection of the data, dissemination of the findings, funding issues and review by the research Ethics Committee. Potential participants were also invited to make further enquiries about this research from their local Research and Development Department at their Local NHS Trust. Participants were also provided with contact numbers and email addresses of the researcher and the academic supervisor if further discussion was required.

In addition to the participant information sheet a participant consent form was created which required participants to initial each statement and sign on completion of the form to agree to take part in the study and to ensure they understood the purpose of the study (see appendices 11 and 12). Both of these forms were included with the questionnaire sent to prospective participants.

Another consent form was also created and sent to participants who stated they were willing to take part in the focus group which acted as a reminder of the purpose of the study and also that the focus group would be audio-taped. The participant information sheet was again forwarded to prospective participants prior to the focus group meetings with the focus group consent form.

Careful consideration is needed regarding the process of obtaining informed consent in qualitative research as according to Baker (2006) written consent potentially risks the individual being identifiable as opposed to verbal consent. Therefore, consent was obtained prior to collection of the data. Completion of the questionnaire and return of the same implied consent, although all participants returned the consent form in a separate envelope to the questionnaire as two envelopes were provided by the researcher for this purpose.

Cohen, Manion and Morrison (2000) suggest that consent has four dimensions: it must be voluntary, full information must be provided to participants, participants must be competent and able to comprehend the consent. These dimensions were all considered when developing the information sheet and the consent forms. This information was also discussed prior to each focus group to ensure comprehension.

### **Confidentiality, anonymity and right to privacy**

Confidentiality is considered to be a fundamental ethical concept which provides research subjects with a guarantee that any information the subject provides will not be publicly reported or made accessible to anyone other than those involved in the research. However, in qualitative studies confidentiality may only be assured by maintaining anonymity as stating that information will not be seen by others is not the case as research requires dissemination. The 'raw' data however is not accessible to anyone other than the research team and anonymity is achieved through editing of this data for publication. Murphy et al (1998) argues that generally in qualitative research where there are fewer participants there is a greater

potential for each to be identified therefore greater care is required especially when verbatim excerpts are used.

To ensure confidentiality the questionnaires were anonymous. The questionnaires were coded as each participant was given a code according to the Trust in which they worked and according to their role, these being:

Trust coding:

- Trust 1 – T1
- Trust 2 – T2
- Trust 3 – T3

Role coding:

- MW – midwife
- SoM – Supervisor of Midwives

An example of a comment from a midwife from the questionnaire would therefore be T1MW1\* and for a focus group midwife T1MW1. An example of a comment from a supervisor of Midwives questionnaire would therefore be T2SoM1\* and from a focus group T2SoM1. The questionnaires coded for the remaining participants were by role and number sent out, for example;

- LME – Lead Midwife for Education, LME1, LME2 etc.
- LSA – Local Supervising Authority Midwifery Officer, LSA1, LSA2 etc.

The questionnaires were then placed in an envelope and sealed. The address labels were added following this so that the codes could not be linked to any individual thereby ensuring anonymity.

Participants were also asked to provide their name and contact details prior to the focus groups so that a convenient date and time could be arranged for the meeting to take place. I assured participants that their personal details would remain confidential and that these contact details would not be passed onto any other party. Participants were reminded that they could withdraw from the research at any point if they wished. I asked the participant to detach their personal details form and return this information separately to the questionnaire in an envelope provided for this purpose.

An important consideration in respect for confidentiality is the Data Protection Act and the researcher must conform to these regulations. This involves information being kept on a computer, the right of individuals to see the information that is kept on them and their right not to have the information passed on to another party. In addition, the Data Protection Act requires consideration regarding the storage of information on computer and safe storage of data for a specified period beyond completion of the study depending upon R&D requirements.

The audio-taped focus groups were transcribed without identifying individuals by name. This data was accessed by the researcher and the academic supervisor. On completion of the research study the data collected will be stored for seven years as per the University Code of research conduct requirements.

## **Validity**

The term validity within qualitative research is concerned with discerning whether the findings from the research are trustworthy (Guba and Lincoln 2005). Validity also refers to the degree to which a procedure measures what it is proposed to measure and this mainly relates to quantitative research (Bryman 2008).

Trustworthiness in research is, according to Guba and Lincoln (2005), concerned with the degree to which we can trust the adequacy of the research process. Polit and Hungler (1995) suggest there are four criteria to assist researchers to establish trustworthiness in their research these are, credibility, dependability, confirmability and transferability. In qualitative research supporters claim the intense involvement between researchers and subject and the probe for the most truthful responses yields a more in depth analysis of data than other methods. Therefore, qualitative researchers are advised to utilise strategies of honesty, openness and reflexivity according to Pyett (2003). Inevitably in qualitative research the researcher will influence the collection, selection and interpretation of data so openness and honesty is important.

Finlay and Gough (2003) argues that reflexivity is a tool to enable the researcher to engage in an explicit, self awareness in analysis of the research process as well as continual evaluation of subjective responses and inter-subjective dynamics. Reflexivity may be confused with reflection and indeed within the literature these terms are used interchangeably. At one end of the scale reflection can be considered to be the "thinking about"

whereas reflexivity at the other end of the scale is a more immediate, continuing, dynamic and subjective self awareness.

From a personal perspective the researcher in this study, from the formulation of the idea for the study, reflected on the topic and their own relationship with the topic examining personal motivations, assumptions and interest as a means of identifying how the research might develop in any particular direction. These assumptions can lead a researcher to interpret the nature of the phenomenon before it is researched. It is therefore important to acknowledge that as a supervisor of midwives and a midwife educator I was at both an advantage and disadvantage in relation to the research focus chosen. Therefore throughout the research process it has been valuable to try to unravel the instances in which the participants and I shared understandings and ones where we diverged. This has enabled me to consider at each point of the research process the impact my position and perspectives could have as researcher.

### **Reliability**

Reliability in relation to quantitative research rests with the assumption that replication of testing procedures is possible and that another researcher can clearly follow the analysis pattern used by the researcher in the study i.e. that it can be audited. An audit trail allows dependability and confirmability to be endorsed as the process can be retraced and examined. The experience of the researcher in this study is captured within the relevant chapters in an attempt to demonstrate the research process followed and acknowledging the limitations of a novice researcher.



## **Transferability**

The extent to which the findings or research process may be transferred to other contexts is termed transferability. It is therefore important for researchers to provide detailed and accurate accounts of the research so that future researchers and other stakeholders can make judgements about the applicability of the findings to other settings. The researcher in this study has provided details of the setting, context and approach to the research to facilitate transferability.

## **Credibility**

The term credibility in relation to research refers to the degree of confidence in the data collected and the outcomes of the research, by guarding the research process from being influenced by the researcher's personal bias (Polit and Hungler 1995). Credibility is believed to be strengthened when descriptions or interpretations of an experience are recognised by people who have had the experience, this is termed confirmability.

In qualitative research supporters claim the intense involvement between researchers and subject yields a more in depth analysis of data than other methods and is strengthened by the period of engagement in processing the data collected so that an in-depth understanding is achieved. The length of time undertaken to achieve this study has enabled the researcher to become immersed in the study and gain an in-depth understanding of the issues emerging.

Polit and Hungler (1995) also suggest that triangulation enhances credibility in research the data collection tools used and the diversity of the people involved in this study provide a valuable insight into the area studied.

In addition, to achieve credibility peer debriefing is considered to provide an external validation of the research enquiry and provides further scrutiny in the process. The academic supervisor reviewed the research throughout the study period enabling clarification and interpretation of issues to be discussed and further reviewed.

### **Costs**

All associated costs in relation to the questionnaires, focus groups, postage, stationery, travel and copying were borne by the researcher in relation to this study.

### **3.7 Pilot Study**

A pilot study was undertaken before commencing the main study to ensure the questionnaires represented a valid and reliable tool for data collection. The midwife questionnaire was distributed to three midwives, one from each NHS Trust. These pilot questionnaires were given to midwives by a midwife teacher located at each of the NHS Trusts and so were not known to the researcher. The same process was employed for the Supervisors of Midwives in the piloting the questionnaires at each of the NHS Trusts. The Lead Midwife for Education was approached by the researcher at one University for completion of the pilot questionnaire. The Local Supervisory

Authority Midwifery Officer within one Strategic Health Authority was also approached to complete the LSAMO pilot questionnaire.

The feedback from all of these individuals was positive in terms of time estimated to complete the forms was appropriate, no amendments were necessary apart from the removal of the word 'responsible' from the title on the LSA Midwifery Officers questionnaires. Previously the title of the role had been 'LSA midwifery responsible officers' whereas the title now required the word 'responsible' to be removed in order to be totally up-to-date with the role within the literature.

## **Population**

The term population refers to all those people whom have a characteristic which is of interest to the researcher and about which a researcher intends to make statements. In this study the whole population of midwives were targeted at stage one of this study involving the completion of a questionnaire. It may be argued that it is impossible to collect information from a defined population as there are always some individuals that cannot be contacted for various reasons. In this study the whole population of midwives at each NHS Trust were targeted with the exception of those midwives on sick leave or maternity leave. Therefore all midwives eligible to work during the data collection period were included within the study.

The individuals within the organisations selected are included because of their relevance for the purpose of this study (purposive sampling). These

individuals are also the most appropriate to best inform the research according to the requirements of this study. This is recognised by Mapp (2008) as an important principle that guides qualitative sampling.

The sample for this study will comprise the whole population of:

- All Midwives within the selected NHS Trusts:
  - Trust 1 – approx 218
  - Trust 2 – approx 269
  - Trust 3 – approx 129
  
- All Supervisors of Midwives within the selected Trusts
  - Trust 1 – approx 22
  - Trust 2 – approx 25
  - Trust 3 – approx 12
  
- All LSA Midwife Responsible Officers in England - total of 10
  
- Lead Midwife Educators for England – total of 48

The rationale for selecting the three Trusts relates to their provision of an integrated maternity service within each of these localities thereby targeting midwives and Supervisors of midwives working in similar ways.

## **3.8 Management of the Data**

### **The questionnaires**

The quantitative data collected from the questionnaires were analysed using descriptive statistics and the SPSS statistical package. The qualitative data was collected by hand and incorporated into the discussion section of the thesis alongside the transcript data relating to the relevant themes identified.

### **Focus Groups**

Data management begins with transcription of data collected at the focus groups and according to Bird (2005) is integral to its interpretation. The transcriptions were undertaken by the researcher which was considerably time consuming but allowed for the reading and re-reading of the data collected to capture the issues which arose and assist with interpretation. Analysis of the data aimed to compare data collected and identify overlapping areas or themes between focus groups. Transcription of data was undertaken immediately after the focus groups to document the contextual situation and limited observations noted during the meeting and whilst voices were able to be linked to individuals to enable coding of comments. It also assisted in enabling inaudible words to be documented as some of the tapes were of a poor quality due to background noise making conversation with quietly spoken participants more difficult to hear.

According to Polit and Beck (2004) transcription errors are inevitable and the importance of checking and re-listening to the tapes is advocated which is again very time consuming. This self transcription allowed the researcher

to become immersed in the data and enhanced familiarity with that data. This enabled the participant's voices to be re-heard and the focus group reconstructed due to the researchers closeness with the data (Watson 2006) and the tapes transcribed in entirety including pauses, laughter and other utterances.

The original intention was to use a computer aided qualitative package to aid data analysis, NVivo, however, as the amount of data generated at the focus group stage was not as lengthy as first envisaged a paper based method of data analysis was utilised. The identification of themes emerging from the data enables understanding of the issues discussed by participants it also enables quotes to be used to illustrate the different themes (Forrest Keenan, van Teijlingen and Pitchforth 2005). The participants were informed that any quotes used would be anonymised in the study.

Polit and Beck (2004) argue that data collection and data analysis occur at the same time and as the data is collected the researcher subconsciously begins to analyse the information. Richards (2005) also supports this view and asserts that analysis is an ongoing process which starts with the literature search, preparing the research data collection tools and leads to a deeper understanding of the subject. In this study data analysis began with the researchers own experiences in the subject area, the literature search and formulation of the questionnaires and questions for inclusion within the focus groups. This analysis continued throughout the data collection with collating the responses from the questionnaires and the arrangement of the data from the transcripts into thematic areas. The

reading and re-reading of the transcripts and listening to the tapes of the focus groups; the revisiting of the original questionnaires to check details on the collated versions enabled more familiarity with the data. This led to the categorising of data rather than actual coding of data as the themes were moved to enable a better flow of analysis creating more coherence of issues rather than being too rigidly separated. Richards (2005) suggests that coding data does not prevent creating a cluster of codes or a smaller number of categories to be developed as codes may in some way relate to an underlying concept or overarching category that allows these to be re-sorted and brought together. Similarly categories in this study were grouped together later in the analysis phase to allow a bigger picture to emerge from the data.

Descriptive statistics were used to present the quantitative data obtained from the questionnaires.

Thematic analysis was also used to process the qualitative data generated from both the questionnaire and the focus groups. Thematic analysis involves looking for patterns or recurrent issues that can be categorised into a theme involving common threads. It enables the organisation of information and presentation of this data so that it may be compared to the statistical data and be categorised. Pre-existing knowledge, relevant to the topic being researched, can assist in thematic analysis as it helps the researcher to recognise information that is meaningful. However, this may also present limitations as personal bias or preconceived beliefs must be acknowledged.

### **3.9 Data Analysis**

The questionnaire was designed to enable nominal and ordinal levels of measurement to be utilised in analysis of the quantitative data generated and enabled production of descriptive statistics. Qualitative data from the questionnaire was analysed separately for descriptions and recurrent features. The focus groups recordings were transcribed and coded so that specific categories or themes could be identified through analysis.

Sandelowski (2008) suggests that interpretation of data occurs in various ways and as a result is dependent on subjective interpretation that exists between researchers, experts and participants which becomes questionable. In qualitative research such as this study, data from focus groups requires understanding and co-operation between the researcher and the participants so that the data obtained can be interpreted based on mutual understanding and in the context of participants experiences. This is an important issue when discussing trustworthiness of qualitative research analysis. Creating categories is a central feature of qualitative data analysis that enables content that shares commonalities to be grouped together. However, the personal experiences of participant's means that data cannot always be assigned to a single category due to the interwoven nature of human interactions. In order to manage the data the creation of themes within categories allows for linking of experiences and interpretation of the data.

As data collected involves multiple meaning once again the researcher must be aware of their own personal beliefs and experiences which is difficult as the data is collected and analysed by the researcher. According



to Patton (1990) this brings into question the researchers qualifications, training and experience so that there is a fine balancing act between presenting all perspectives of the data gathered and enabling the data to 'tell the story' and for the researcher to avoid implying meaning or to omit any data.

### **3.10 Benefits of the study**

The study will not only benefit the Academic Division of Midwifery within the University of Nottingham but also the Supervisors of Midwives locally and Nationally in terms of developing effective systems for identifying, collaborating and the development of relevant CPD learning opportunities for midwives provided by Universities in addition to other activities to enable professional development.

The following Chapter (4) presents the data generated from this study. The findings and analysis of the data through discussion will be presented together to prevent any repetition and to clearly highlight the key findings of significance in this study.

# Chapter 4:

## Presentation of Findings and Discussion

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### 4.1 Introduction

This chapter aims to present the findings from the study alongside a critical discussion of the three themes arising from the data. The three themes relate to the overall focus of the study and describe the experiences of the midwives, Supervisor of Midwives, LSA midwifery officers and the lead midwives for education in the context of continuing professional development of practising midwives.

The quantitative data relating to the response rates and the demographic data of each participating group will be discussed initially to provide some context and background to this study.

The remaining quantitative and qualitative data will be interwoven throughout this chapter to demonstrate the factual evidence and the views of the practitioners in relation to the following three themes formulated from the aims and objectives of this study:

- (i) The purpose of supervision of midwives building upon the statutory framework of supervision of midwives and focusing on the

protection of the public through the perspectives of enabling professional development, risk management and performance management.

(ii) The management and organisation of professional development

(iii) The actual learning activities that take place within this context.

## **4.2 Response rates for each cohort of participants**

Recruitment to research studies is an ongoing subject of interest to qualitative researchers and views in the literature differ on what constitutes an adequate response rate. The literature is rich in providing guidance on recommended response rates but there is very little advice for researchers on the challenges of implementing any recruitment plan. A range of between 35 – 54% has been stated as the lower response range for research in the social sciences although many qualitative research studies do not actually state a response rate. Reporting on methods of recruiting and influences on response rates are more useful to researchers as this can assist in attempting to address the challenges of conducting their studies.

### **i. Midwife Response Rate**

The total number of questionnaires sent to midwives was 453 an overall response rate of 32% (n=144) being achieved although the individual response rate in Trust 3 was slightly better than the other Trusts. The actual response rate per Trust is presented in Table 1. These response rates and certainly the overall response rate was less than expected however, by utilising more than one research tool it was considered that the experiences of respondents could still be analysed in depth. A reason for this low return may be the timing of the research as this was conducted over a winter period, a time where winter pressures are greater in the health services and where annual leave and other activities following the Christmas period may have impacted on the participation in the study. In addition, this study coincided with other studies being conducted in the hospital setting and therefore staff may have been less willing to

participate even though the questionnaires had been hand distributed by the researcher.

	<b>Trust 1</b>	<b>Trust 2</b>	<b>Trust 3</b>
<b>No. of questionnaires distributed to Midwives</b>	176	180	97
<b>No. of responses</b>	57	50	39
<b>Response rate</b>	32%	27%	39%

**ii. Supervisors of Midwives Response Rate**

The total number of questionnaires sent out to the Supervisors of Midwives was 46 and a response rate of 72% (n=33) was achieved. This is an acceptable response rate overall and although the individual response rate in each Trust varied, as shown in Table 2, each is in line with what would be expected in such a study. The topic of research in this study should be of particular interest to this population of practitioners and the researcher would therefore have expected a good level of response rate from these participants.

	<b>Trust 1</b>	<b>Trust 2</b>	<b>Trust 3</b>
<b>No. of questionnaires distributed to Supervisors of Midwives</b>	17	19	10
<b>No. of responses</b>	12	15	6
<b>Response rate</b>	71%	79%	60%

### **iii. Local Supervising Authority Midwifery Officers Response Rate**

The total number of questionnaires sent out to the Local Supervising Authority Midwifery Officers in England (LSAMOs) was 10 and this achieved a response rate of 50% (n=5). This was a disappointing response rate as the expectation of the researcher was that the topic being researched would be of interest to this population especially as little research has been done in this area. The NMC standards expected of Supervisors of Midwives (NMC 2006) have not been subject to evidencing compliance other than through annual audit of supervisory activities which currently does not include all aspects of the role.

### **iv. Lead Midwife Educators (LME) Response Rate**

The total number of questionnaires sent out to the Lead Midwife Educators (LMEs) population was 47 which achieved a response rate of 47% (n=22). Again this was a disappointing response rate especially as research in this area is for midwifery particularly is almost non-existent. The timing of this research may not have been opportune as over the past year the number of LMEs has varied due to retirements and the reorganisations of education provision.

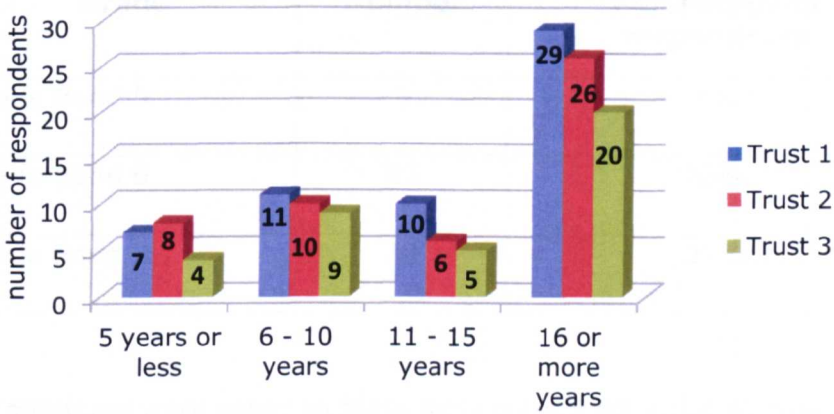
## **4.3 Demographic data on the respondents.**

### **i. Midwife Respondents**

The midwives were invited to state the length of time they had been qualified as a midwife. The majority of respondents, 52% (n=75), had been qualified as a midwife for more than 16 years; 13% had been qualified for 5 years or less; 21% for 6-10 years; 14% for 11-15 years.

Figure 1 displays the responses from midwives at each trust and shows a similar pattern of response from all three trusts.

**Figure 1: Number of years qualified as a midwife.**



The majority of respondents stated that they worked part time, 54% (n=79), 46% (n=66) of respondents worked full time.

The majority of respondents, 65% (n=93), stated that they were within Grade Band 6. 2% (n=3) of respondents did not state their grade band.

The grade bands relate to the NHS Knowledge and Skills Framework (DH 2004c) launched as part of the Agenda for Change and is an objective developmental package designed to help the development of the individual practitioner and the NHS services. Practitioners are expected to meet the knowledge and skills that correspond to the subset outlines within the grading bands and progress via gateways through each band. The key benefits of Agenda for Change therefore, include the recognition and reward for the knowledge and skills staff acquire throughout their careers.

Only 27% (n=39) of midwife respondents had progressed to pay grade band 7. A minority 6% (n=9) were still on pay grade band 5, five of these midwives had been qualified for 5 years or less, four had been qualified for

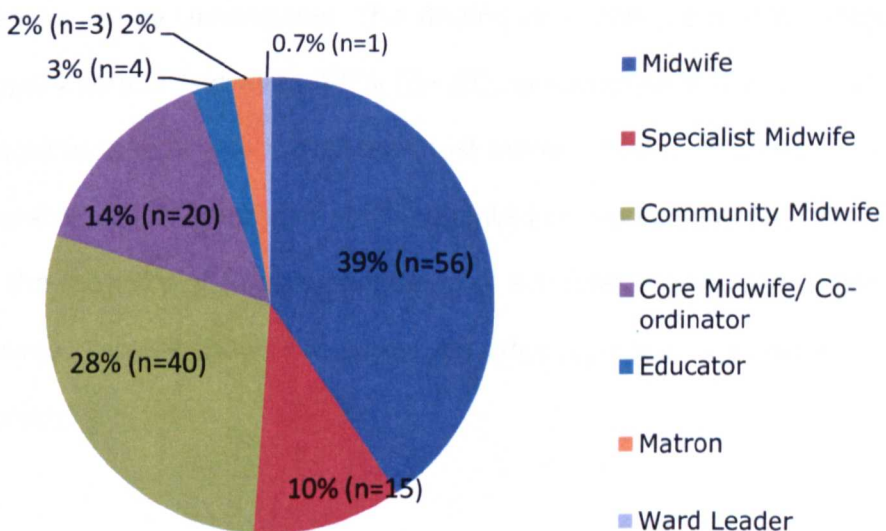
11 years or more. It is not clear why midwives qualified for more than 5 years were still on this grade banding and this would need further exploration.

**Table 3: Grade Bands of respondents.**

Grade	Number	Percentage of respondents
Grade Band 5	9	6%
Grade Band 6	93	65%
Grade Band 7	39	27%

The midwives were asked to state their current job titles to provide some context to the study in terms of their experiences and position in the organisation. The majority of respondents were hospital, community (primary care) midwives or a combined role of both, 67% (n=96), and fewer respondents as would be expected occupied leader, managerial or educator roles 30% (n=43). However, overall 96% (n=139) of respondents completed this question. The job titles of the midwives are demonstrated in Figure 2.

**Figure 2: Job Titles of Midwives**





## **ii. Supervisors of Midwives Respondents**

A third, (33%; n=11), of the Supervisors had been qualified for 5 years or less, and 67% (n=22) of Supervisors had been qualified for 6 years or more. None of the Supervisors of Midwives had been qualified for 16 years or more. This is an interesting finding as the majority of midwives in this study had been qualified over 16 years yet there were no equivalents in terms of Supervisors of Midwives. Supervisors have to have at least 3 years experience as a midwife before becoming a supervisor and therefore it would be expected that some would have been qualified 16 years or longer.

The majority, 79% (n=26), of Supervisors of Midwives reported to work full time and the minority, 21% (n=7), worked part time. This finding was common to each Trust in this study.

15% (n=5) of Supervisor of Midwives respondents were graded within the lower band 6; the majority (55%; n=18) were within the grade band 7; and the remaining 18% (n=6) were graded within the higher band 8. The Supervisors of Midwives employed as educators are not included within this finding as they are not graded according to the NHS agenda for change and are employed by Universities. This finding does indicate that the majority of Supervisors of Midwives, 85% (n=28), are employed in a leadership/ managerial type of role rather than just being a clinical midwife. This demonstrates a hierarchy of staff appointed to the supervision role rather than the majority of Supervisors being of a similar level to the majority of midwives. Table 4 shows the actual job titles reported by Supervisors in this study.

<b>Table 4: Job Titles of Supervisors of Midwives</b>	
<b>Job Title</b>	<b>No. Of respondents</b>
Midwife	2
Community midwife	3
Lead Midwife/ area coordinator	8
Risk Co-ordinator/ midwife	4
Core midwife	3
Clinical Specialist	3
Head of Midwifery	2
Senior Midwife	2
Educator	2
Senior Community Midwife	1
Matron	1
Senior Matron	1
Area Manager	1

**iii. LSA Midwifery Officers (LSAMO) Respondents**

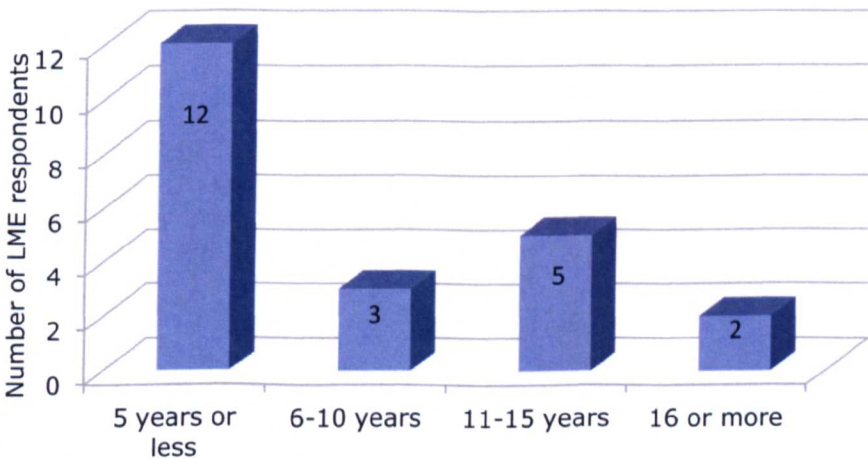
The LSAMO participants were asked how many years they had been a Local Supervising Authority Midwifery Officer. Table 5 demonstrates the responses.

<b>Table 5: Years as LSA Midwifery Officer</b>	<b>Frequency</b>	<b>Percent</b>
5 years or less	2	40
6-10 years	2	40
11-15 years	1	20
Total	5	100

**iv. Lead Midwives for Education (LME) Respondents**

These participants were also asked how many years they had been the lead midwife for education and findings identified that the majority, 55% (n=12) had been in post for 5 years or less as Figure 3 demonstrates. This means a significant number in post have limited experience in this role.

**Figure 3: Years as a Lead Midwife for Education**



The LMEs were also asked to state their job title to determine their position in their educational institution. The LMEs with 5 years or less experience in

this role had a range of titles for example; Midwifery Lecturer, Senior Lecturer, Principal Lecturer, Award Lead. Only a few (14%; n=3) reported their title to be Professor of Midwifery, Associate Head of School and Director of Midwifery which would relate to more senior positions in the University.

The LMEs with more than 6 years experience (45%; n=10) tended to have the role of Professor of Midwifery, Head of Midwifery or Associate Dean. A couple of respondents (9%; n=2) reported the title of Team leader and Principal Lecturer.

#### **4.4 The Purpose of Supervision of Midwives**

Statutory supervision of midwives was established in England with the introduction of the Midwives Act of 1902. The British midwifery system of supervision denotes the direct exercise of power by the state over midwives via Supervisors of Midwives exercising caseload supervision and reinforced by Local Supervising Authorities by statute. During the past century supervision of midwives has developed and become recognised as an effective framework for the regulation of midwives and the NMC since 2002 has delegated and monitored this role.

The main purpose of supervision of midwives is to ensure public safety by supporting and enabling individual midwives to maintain and develop the competencies set by the Nursing and Midwifery Council (NMC) and by promoting practice environments which best meet the needs of mothers and babies (NMC 2002, NMC 2006). Statutory supervision therefore provides the means by which the NMC's standards and rules are monitored and maintained.

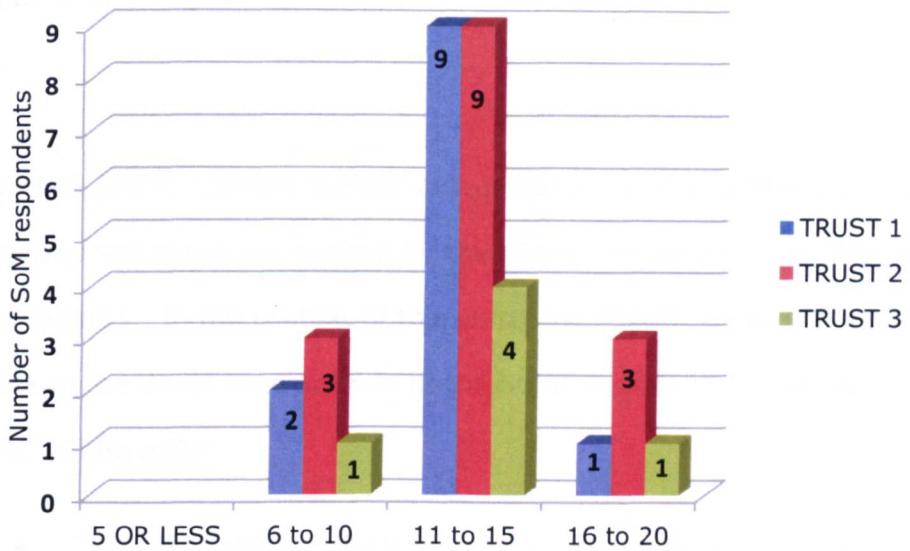
This is particularly important as midwives can practice without referring to a doctor from the point of qualification and are therefore accountable in a different way from nurses for their practice. Midwives are authorised to take full responsibility for women and their babies throughout each sphere of childbirth unless there is a deviation from the norm in which case they are required to refer to a doctor or other registered practitioner (NMC 2004b, NMC 2010c). The Supervisor of Midwives is required to ensure that midwives are fit to practice to this level of autonomy and that they

maintain and develop their knowledge and skills and when practice is impaired initiate appropriate actions. Supervisors therefore play an important role in ensuring high quality delivery of maternity services and that midwives maintain their competence to practise and remain fit to practise.

As supervision is enshrined within legislation all practising midwives must have access to a named Supervisor of Midwives. This is evidenced from the findings of this study as the majority of midwives (99% n=143) stated that they had a named Supervisor of Midwives. 1 midwife did not complete this question.

The numbers of midwives supported by a Supervisor of Midwives is referred to as the 'case load'. It is recommended by the NMC (2010c) that a supervisor should have no more than 15 midwives in a case load. This is further demonstrated as a LSA Standard which is audited each year by the LSA Midwifery Officer in each locality. Figure 4 shows the findings.

**Figure 4: Case load numbers held by supervisors**



It was noted that 15% (n=5) Supervisors had case loads in excess of the maximum recommended number by the NMC. Of these 60% (n=3) were in full time employment and 40% (n=2) were part time. The supervisor to midwife ratio are highlighted in the NMC analysis report of LSA annual reports and indicates that the numbers of Supervisors has increased over the past 3 years (NMC 2011). However, this has had little effect on ensuring the ratio of supervisor to midwives reflects the NMC recommendation of 1:15. This is due to the numbers of Supervisors who have retired or resigned from the role and the increasing numbers of midwives selecting to work part-time. The highest ratio of Supervisors to midwives is reported to be 1:18 in an LSA area but this does not truly reflect the actual numbers supported by individual Supervisors within the Trusts or Boards. In considering the actual number of midwives supported by a supervisor the ratio increases to 1:39 in one Trust (NMC 2011). This high ratio is a concern and is considered to influence the effectiveness of supervision as differences within Trusts still exist regarding the time Supervisors are granted to undertake the role resulting in some cases

where Supervisors undertake the role in their own time with no financial support for doing so.

The NMC (2006) identify specific outcomes for the role of the Supervisor of Midwives and these are audited by the LSAMO on behalf of the NMC on an annual basis. In the context of this study the specific outcomes explored relate to the developmental role of the Supervisor of Midwives particularly (NMC 2008d p10):

- 'Being available for midwives to discuss issues relating to their practice and provide appropriate support'
- 'Arrange regular meetings with individual midwives, at least once per year, to help them to evaluate their practice and identify areas for development'

Historically, the ENB (1996 p13) included within the standards the additional statement:

- 'and to agree the means by which their midwifery expertise can be maintained and developed'.

This statement is still included in the Supervisors of Midwives Resource Pack (Birmingham City University 2010 p11) based on the Learning Pack provided with the Preparation of Supervisors of Midwives Course (NMC 2002). Prior to this publication the additional statement does not appear in the standards and consequently the role of the Supervisor of Midwives in terms of being able to influence the means by which CPD activity can be achieved is unknown.



The forum for discussion regarding the CPD needs of midwives was agreed by 97% (n=140) midwives and all Supervisors as the annual supervisory review meeting and this was clearly evidenced from the findings within this study. This aspect of the NMC outcomes is therefore achieved through dialogue with the midwife at the annual review meeting enabling the individual midwife to identify their own professional development needs in relation to maintaining and improving their practice. This aims to ensure that the midwife fulfils her role as an autonomous, accountable midwife practitioner.

The majority of midwives (88% n=127) and all Supervisors of Midwives (100% n=33) confirmed that they discussed both practice issues and continuing professional development (CPD) needs with their supervisor and that this discussion took place at the annual supervisory review meeting. 12% (n=17) of midwives stated that they did not discuss practice issues with their supervisor.

The data from the midwives specifically identified that this discussion tended to focus on three main areas these being:

1. review of practice issues,
2. enabling reflection and
3. discussion of clinical incidents.

It may be argued that discussion is an important element of the annual review meeting between the supervisor and the midwife but as the meeting takes place annually descriptions of events occurring in practice may become inaccurate and lead to misinterpretation due to the degradation of memory over time. This view is supported by Newell (1992) who suggests

that not only does memory become faulty but the teller, in this case the midwife, may recount events differently according to place and time in order to be seen in the best possible light and to prevent damage to self esteem. It therefore becomes difficult for the supervisor to ascertain what learning has taken place following the event or indeed what learning is needed for personal practice to change as a result of the event.

Some midwives, on both the questionnaire and in the focus groups, identified that rather than just wait until their annual review meeting to discuss any issues with their supervisor they would actively seek support and advice when needed. These midwives commented positively about the availability of Supervisors other than just for the annual review meeting suggesting that Supervisors were approachable, helped with debriefing, provided reassurance and built their confidence. These findings suggest that the supervision framework would appear to offer a valuable opportunity for midwives to discuss practice and develop reflective skills in order to increase confidence and competence as well as fulfil PREP requirements, a view also supported by Jones (2000) and Kirkham (2000).

#### **4.4.1 The annual supervisory review meeting**

The NMC (2004b, NMC 2010c) require midwives to proactively seek the support of their supervisor and arrange for this meeting, they are also required to record the date of the meeting on the Midwife's Intention to Practice Form which is completed each year. The NMC expected standard for Supervisors of Midwives and midwives to meet is a minimum of once per year.

98% (n=141) of midwives stated that they met with their named supervisor once per year. Only one midwife responded 'No' to this question and commented that she did not meet due to:

poor planning and time constraints (T1MW6\*).

One midwife did not answer this question and another midwife stated she had not formally met with her named supervisor yet but did not make any further comment. It is presumed this latter midwife may have been new to the Trust.

This agreed with the findings from Supervisors of Midwives as 97% (n=32) stated that they met with their supervisees once each year for an annual review. Three of these Supervisors of Midwives made further comments on the questionnaire,

apart from sickness, maternity leave (T2SoM4\*)

usually yes, meetings are requested by Supervisors but not always taken up by the midwife (T2SoM7\*).

except for circumstances such as long term sickness (T1SoM10\*)

3% (n=1) Supervisor of Midwives did not meet with her supervisees at least once per year due to working constraints (T2SoM3). This supervisor was experienced, having worked for 6-10 years as a supervisor and worked full time with a case load of 15 midwives. Even though there is an NMC expectation, stated within the Midwives Rules (NMC 2004b, NMC 2010c),

regarding a minimum requirement for this meeting there is no evidence to suggest any sanction is made if this is not achieved.

The date of the annual review meeting being recorded on the notification of Intention to Practice Form which midwives are required to complete on an annual basis (NMC 2010c) and submit to their Supervisor of Midwives links to the maintenance and eligibility for re-registration. Supervisors are required to identify opportunities for midwives to update themselves concerning statutory requirements particularly the PREP requirements. The PREP requirements for midwives are that they undertake a minimum of 35 hours of continuing professional development in each three year registration period (NMC 2008b), in addition to 450 hours of practice and maintenance of a professional portfolio. A supervisor signing the Intention to Practise form confirms that the midwife has met these PREP standards for maintaining registration as a midwife.

The majority of respondents in this study (97% n=140) also agreed that CPD was discussed at the annual supervisory review meeting and midwives made the following comments:

we discuss what I need to complete i.e. learning packages etc to achieve goals (T2MW9\*)

we discuss CPD together, I usually propose/ come up with a plan, sometimes further suggestions are made by my Supervisor (T1MW40\*)

Advise on courses, suggests routes to reach planned goals (T3MW28\*)

The Supervisors of Midwives also agreed (100% n=33) that the annual review meeting was the starting point for discussions on CPD needs, commenting on the difficulties and limitations of this meeting:

It's quite difficult isn't it because you know, when you think of an annual review which is probably the main event for all of us, I mean how long does it take, they take a long time don't they and if they haven't thought about what they want to do, there's not a lot of time left is there to devote to that. I just don't think that are many opportunities really. I personally feel it's difficult to empower the midwives to take ownership of their own learning, I find that really difficult because they just don't seem to want to. It's difficult to get them to come to an annual review (T1SoM2)

On your annual (review) update as well, you ask them to identify their learning needs, so they might have been on the ward for a while and they are nervous about going back down on the labour suite so they might identify things that they are apprehensive about. So before they go there you might sort of send them off in different directions to seek help, go and see (named manager). So they are the sort of things that aren't covered on the mandatory days but are their own personal professional needs (T3SoM6).

Although the midwives state that there is discussion on CPD needs with Supervisors at the annual meeting it would appear that for some Supervisors they generate the discussion rather than the midwife having given any prior thought to their professional development needs before the meeting. This would appear to support the view of Cervero (1988) who described these individuals as being '*middle majority*' or '*laggards*' in relation to CPD who vary in attitude to education ranging from enthusiastic to apathy with the laggards who resist new ideas and do the minimum necessary as reflected in the following comments,

There isn't much impetus for them to go beyond what they are doing for their compulsory (mandatory) days is there, let's be honest, there's no pressure. So long as they fulfil their PREP requirements, the pressures off really (T1SOM1).

This is the difficulty if you have got people that just tick along, that are OK with just doing the bare bones and the basics, what happens when they do get faced by a challenging situation, have they got the ability to draw on other information that they know is stored at the back of their brains somewhere, that's what concerns me (T1SOM3)

I think a lot of midwives see CPD as being a modular course and there are midwives who don't want to do that, I think this puts an enormous pressure on individuals who don't want to put in for more academic study and they sort of leave places more for other people. And I think we need to recognise that, I think there is that emphasis on "Oh what course are we going to get next" and I don't think that is fair on people who are at the level they want to be but still want to maintain their statutory (mandatory) updates (T2SoM1).

At Trust 3 the Supervisors commented that a lot of midwives considered that attending mandatory days at the Trust met their professional development although some would seek further CPD activities as the following comments reflect,

It's because we have a mandatory day that we change on an annual basis to meet continuing professional development needs (T3SoM2).

I don't think I have ever had any of mine not just wanting to do their mandatory days they've always, usually got something else that, I'm not saying they definitely achieve it, but that they are hoping or that they are planning to go off and do (T3SoM5)

If professionals demonstrate these attitudes to CPD then their experiences must be taken into account to determine the underlying reasons for this

response. This attitude demonstrated by professionals may be one reason why organisations have developed mandatory schemes to ensure that less active practitioners undertake some CPD. Alternatively, it may also be considered to be a response to the increasing sense of accountability demanded by the general public today. In this way employers are seen to be implementing some form of training as a means of public protection but, according to Gopee (2003), practitioners perceive these mandatory CPD schemes as ineffective and which only pays lip service to their actual development needs and instead only just maintains competence.

The Supervisor of Midwives is also responsible for agreeing how midwifery expertise can be maintained and developed (NMC 2006). This is partly achieved through dialogue with the midwife at the annual review meeting which enables the individual midwife to identify professional development needs in relation to maintaining and improving clinical practice and thereby ensuring the midwife fulfils her role as an autonomous, accountable midwife practitioner. However, barriers exist that prevent or limit the ability of the Supervisor of Midwives to agree the actual mechanism for achieving the CPD needs for example, time or funding to attend formal study events. These barriers to achieving CPD will be analysed later within this discussion chapter.

The LSAMO respondents (80% n=4) also agreed that the annual review meeting was the forum where CPD should be discussed. In addition to the annual review meeting two LSAMOs suggested discussions on CPD should occur as demonstrated by the following comment,

following incidents, Supervisors of Midwives should ensure that midwives realise their own responsibilities in relation to CPD (LSAMO5)

All Supervisors of Midwives responded 'Yes' to the question regarding practice issues being discussed at the annual review meeting (100% n=33). The majority of midwives (88%; n=127) also agreed, however 12% (n=17) stated No to practice issues being discussed at the annual review meeting. The following comments reflect the experiences at the annual review meeting of the midwives,

Discuss incidents and what can be learnt from these (T1MW32).

If I have had stressful cases to deal with I can contact her if I feel the desire to. (T2MW2\*)

Discuss situations that have occurred and outcomes (T2MW10\*)

#### **4.4.2 Personal profiles**

In this study 96% (n=138) of midwife respondents stated that they had a personal profile for recording CPD activity but in the majority of cases this was not reviewed by their Supervisor of Midwives. Only 1 midwife further commented that she did have a personal profile but that it was not up-to-date. A minority, 4% (n=6) of midwives, did not have a personal profile.

The Supervisors of Midwives were asked if they reviewed a midwife's CPD activity records each year. 94% (n=31) Supervisors responded with a 'Yes' to this question. However, 6% (n=2) of Supervisors stated 'No' they did not review their midwives CPD record of activity.



The Supervisors of Midwives provided further comments on the questionnaire and 21% (n=7) identified discussion using the annual review documentation as the main means of reviewing a midwife's continuing professional development. However, 6% (n=2) of the Supervisor of Midwives respondents reviewed attendance certificates and 9% (n=3) of these respondents identified the PREP folder which can be considered to be aspects of a professional portfolio/ profile. Other methods of reviewing a midwife's CPD records tended to reflect the reliance on management tools for some Supervisors of Midwives with the following being cited as examples; personal file, application for promotion, completion of study leave or learning activity forms, mandatory study day attendance, completion of Trust learning packages or liaison with the midwife's manager. These methods of review may well relate to the dual role the participants held in the Trust as a manager and Supervisor of Midwives as many, it could be argued, reflect management processes.

The majority, 80% (n=4) of LSAMO respondents stated that the Supervisor of Midwives should encourage the midwife to record CPD activities in a personal portfolio. Although PREP (NMC 2010a) requires midwives to maintain a personal professional profile of learning activity which may be audited at any time by the NMC. There is no formal requirement for a Supervisor of Midwives to review this portfolio however she must verify that the midwife has achieved PREP requirements on the Intention to Practise form as previously stated. The NMC also require practitioners, as part of self regulation, to declare that they have complied with the PREP standard on their Notification of Practice form which is completed every 3 years when professional registration is renewed.

Just under half (48%; n=16) of the Supervisors stated that they did not have access to a database demonstrating the qualifications of their case load midwives. However, 52% (n=17) did have access to such a database. The LSAMOs, 60% (n=3) of respondents, stated that the LSA database should be used to record midwives CPD activities however, as only Supervisors of Midwives have access to this database it makes it impossible for midwives to record these activities and therefore entries on this database rely on the record keeping of the supervisor. The NMC (2004b, 2010c), Rule 12, requires Supervisors to maintain records for all supervisory activities although the actual type of documentation is left to the discretion of the individual supervisor or on guidance from the Local LSAMO.

As demonstrated by the findings there is duplication in record keeping for the midwife in completing a portfolio for PREP and an annual review document prior to meeting with their supervisor each year. The value of the portfolio is not being given a high enough profile to be valued by Supervisors or midwives as other means of evidence is reviewed by some Supervisors. There needs to be a review to simplify the system so that midwives can record their CPD activity in one place which can be accessed by the midwife, the supervisor, the LSA midwifery officer and possibly even the NMC. One possible solution would be to enable midwives to access part of the LSA database to record their CPD activities in much the same way as Supervisors do currently. This would mean that Supervisors have instant access to these records and that they could be audited annually by the NMC and LSA.

#### **4.4.3 Provision of CPD advice**

The supervisor's of midwives role in enabling professional development of the midwife suggests that Supervisors should be able to 'identify' areas in which a midwife needs to update their knowledge and skills or preparation to take on new roles.

Participants were asked if advice on CPD was provided at the annual review meeting. Overall, 90% (n=129) of midwife respondents stated Yes to this question, although 10% (n=14) stated No. All of the Supervisors of Midwives (100% n=33) stated that they did provide advice on CPD.

#### **4.4.4 Preparation for the role of providing CPD advice**

All of the Supervisors of Midwives responding to the questionnaire (100% n=33) felt that they were prepared and able to provide CPD advice to midwives agreeing that they all should be able to do this. This question was followed up at the focus group meetings and the majority of Supervisors in all Trusts felt that they had learnt to do this as they had 'gone along' rather than having been prepared to undertake this aspect of the role.

Typical comments are reflected,

I picked it up as I went along, for me. After I qualified as a supervisor, I did go in with other Supervisors just too sort of view how they did their annual review but I think you pick it up as you go along, isn't it? Taking advice, from other colleagues and then at Supervisors meetings (T3SoM7)

My preparation as a supervisor (pause), I didn't get any mentorship so I just literally just picked everything up as I have gone along and when I look at how it's moved from where I was five

years ago to how it is now, and the fact that newly qualified Supervisors go through a very structured process, a full interview and CPD is pushed to the forefront then I think that's brilliant but I personally have just picked it up as I've gone along (T1SoM3).

One supervisor commented that although the course may not have included this preparation in the past she 'felt' that more recently qualified Supervisors were probably more prepared. This was supported by other Supervisors who believed that although CPD is pushed to the forefront more now Supervisors still had to pick it up as they developed in their role. The discussion at the focus groups tended to reflect that Supervisors learned from each other through either discussion or in shadowing each other when advising midwives on how they may achieve their CPD.

One supervisor commented that although she felt prepared to discuss CPD needs she felt she was,

very limited as to being able to facilitate (T2SoM7).

This view was supported by other Supervisors at the focus group meetings at Trust 2.

Further comments from Supervisors related to the 'type' of midwives that they supported and suggested that if the supervisee was a manager then a clinical grade supervisor may find it difficult to discuss CPD needs.

Whereas, an 'average' clinical midwife would be easier to advise. The following comment was supported by Supervisors,

as a clinical practising midwife I would have to say No, if many of my supervisees were not clinical e.g. managers etc, but usually managers chose others in a similar role as their Supervisor (T1SoM10\*).

Some Supervisors in senior roles, staff development roles, practice development roles and teachers who were also qualified as Supervisors found it easier to provide advice on CPD and related this to their main job role commenting,

no preparation for this in the role of supervisor but due to my full time role as a midwife teacher I am prepared (T2SoM15\*).

clear links with my main job role and role of supervisor (T1SoM12\*).

All of the LSAMOs (100% n=5) however, considered that the preparation of Supervisors of Midwives course did prepare Supervisors to be able to provide CPD advice to midwives. These respondents also stated that if the supervisor did not feel prepared then they should seek support from their own LSAMO. This was suggested by some Supervisors of Midwives, in the focus groups, that more guidance was needed to assist them in advising midwives on CP. This was an issue they planned to raise with their LSA midwifery officer as it was a CPD need this study had identified specifically for Supervisors. Supervisors indicated that they wanted to update in this area to ensure they were all doing the same and that the advice they gave was consistent.

The LMEs generally considered that midwife teachers had a better overview of the education provision available, and that it would assist midwives in accessing good development information. 63% (n=12) of the 19 LME

respondents, felt that Supervisors were not appropriately prepared to enable them to give CPD advice, only 16% (n=3) felt Supervisors were appropriately prepared for this role. The LMEs also considered that:

this is a useful area to research as it is relatively unknown and assumptions exist regarding the Supervisors of Midwives knowledge of available CPD for their case load of midwives (LME12).

The LMEs considered that some Supervisors of Midwives were able to give advice but not all and that it would vary between individuals. Some thought advice given by Supervisors of Midwives would:

depend on their own background and experience and philosophy of supervision. Also if they worked closely with midwife teachers this would assist (LME22).

they are prepared but need to develop this skill in their everyday practice (LME 13)

not aware of much CPD advice in the preparation of Supervisors of Midwives programme. Students on Supervisors of Midwives preparation programmes report variable experiences of their role as Supervisors of Midwives in giving (CPD) advice (LME 21).

Four LMEs % (n=4), felt the personality and position of the supervisor and the environment in which the supervisor worked had a large effect on CPD.

This was further stated as:

many Supervisors of Midwives who also tend to be senior people in their organisations become very focused on balancing their budgets and on managing their service. They tend to perhaps see CPD as a secondary aspect of their job and delegate it to someone else. It becomes an issue of concern to them only when an individual midwife is found to be deficient in professional practice and problems arise. I think CPD and how it can improve care for mothers and babies should be given more prominence (LME16).

Only one LME believed that Supervisors of Midwives should be knowledgeable about such matters and been themselves updated although then added that midwife teachers are always happy to advise and lend support in these matters. Other comments from LMEs supported the view that:

a tripartite system with a Supervisor of Midwives and a midwife teacher would be an effective way of addressing CPD needs (LME9).

This view has also been suggested by Ellis (2000) as it is believed that a triangulated approach between managers, employees and education providers may lead to a greater impact of CPD on practice as educationalists have a greater knowledge of the education opportunities available for practitioners. In a cost conscious NHS Ellis believes this tripartite method of CPD to be effective but does not identify how it is effective.

Although the links with education were positive the LMEs (n=4) felt that more formal processes were needed.

In this study the midwives were also asked if they felt their Supervisors were adequately prepared to provide CPD advice. The midwives responses to this were typically as follows:

Discuss the practice element of my CPD the theory element is through IPR (T3MW34\*)

My supervisor advises me in ways to access particular courses, training I am interested in (T2MW7\*)

I feel my supervisor supports me to achieve CPD not necessarily advise as I work in such a specialist area (T1MW42\*).

The findings here are interesting as midwives had a perception that from a clinical or practice perspective, Supervisors would discuss and give advice on CPD. However, the theory or being able to access study events would be through the manager at individual performance review. In addition, specialist midwives were of the opinion that CPD advice for them from Supervisors was not provided as the nature of their work was an area where Supervisors lacked knowledge. The availability of courses for specialist practitioners is acknowledged by Long, Kneafsey, Ryan and Berry (2002) who identified the difficulties in accessing suitable CPD courses within their locality or courses not being available due to the small numbers needing access.

The Audit Commission (2001) also highlighted that learning needs to be identified correctly as unless this is achieved deficits cannot be acknowledged. There is also a debate within the literature of whether professionals can identify their learning needs and Cervero (2001) believes practitioners are able to do this as opposed to Jordan (2000) who argues that practitioners are not always aware of their needs. This latter view tends to be supported for example following an incident in practice where learning needs become identified as a result of a poor clinical outcome.

Overall, Supervisors commented in discussion that the Preparation of Supervisors of Midwives course content may now include details of how to advise midwives on identifying and achieving their CPD but the data from



this study suggests that many do not really feel prepared. This therefore demonstrates a CPD need for Supervisors of Midwives.

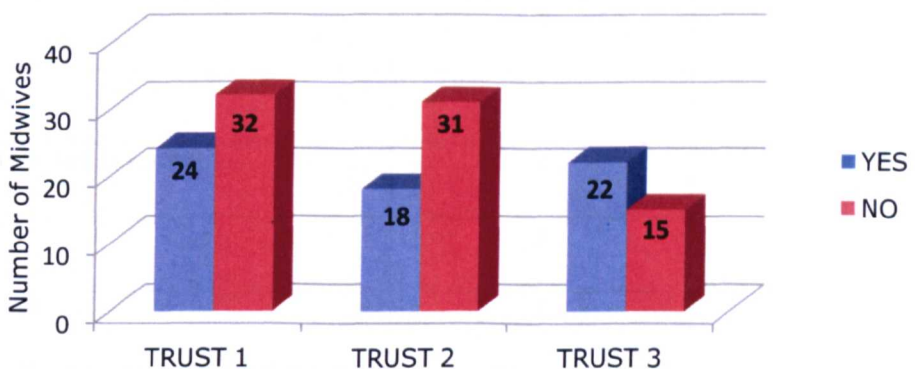
#### 4.4.5 Supervisors are aware of educational events to meet midwives CPD needs

The majority of midwives 83% (n=119) considered that their Supervisor of Midwives was aware of educational events to meet their CPD needs. The majority (91%; n=30) of Supervisors also responded that they were aware of educational events designed to help midwives achieve their CPD needs. However, 9% (n=3) Supervisors did not agree.

#### 4.4.6 Provision of CPD advice from others.

The midwife respondents were asked if advice was sought from people other than Supervisors in relation to CPD. Less than half of the midwives, 44% (n=64) did seek advice from others whereas 54% (n=78) did not seek additional advice from others. Two midwives did not answer this question. The results for each Trust are shown in figure5.

**Figure 5: Advise is sought from others regarding CPD**



The researcher continued to ascertain the opinions of all midwife participants about others who could provide advice to midwives in relation to achieving CPD needs. In a previous study by Mitchell (1997) the strategy used to obtain advice from others on CPD was predominantly through discussion with peers/ colleagues and the strategy used least often was discussion with managers. It is surprising that advice was not sought from Supervisors and midwife educators. The findings for this study are demonstrated in Table 6:

<b>Table 6: Personnel from which midwives sought or are referred to for CPD advice.</b>		
<b>Source of Advice</b>	<b>Number of Midwife respondents</b>	<b>Number of Supervisor respondents</b>
Midwife Manager	25	4
Colleagues/ Peers	14	0
Senior midwives	0	1
School of Midwifery/ Midwife educationalists	6	17
Other Supervisors	3	3
From articles/ Journals	3	0
Practice/ professional development midwife/ specialist midwives	2	3
Consultants	1	0
RCM	1	1
NMC	1	0
Institute for Learning	1	0
Library	1	0
Internet	1	1

As demonstrated in Table 6 the situation today is one where the majority of midwives chose only to seek CPD advice from their Supervisor of Midwives (53% n=78) a direct contrast to the findings of Mitchell (1997). The remainder of midwives (44% n=64) did seek advice and chose to obtain this advice predominantly from their managers. This finding would support the comments made previously regarding the midwives viewing the theory component of CPD to be identified and agreed through performance review with their managers. It may also be considered that some midwives view CPD as formal educational events.

The Supervisors of Midwives (76% n=25) mainly encouraged midwives to seek further advice from educationalists and to a lesser extent (13% n=4) to managers so this demonstrates a degree of influence exerted by Supervisors.

The LSAMOs, 100% (n=5), considered that Supervisors should refer midwives to others where appropriate and that this referral would be to either educationalists or to other Supervisors of Midwives. The latter were described as consultant midwives and specialist midwives who also held the dual role of supervisor. However, 100% (n=5) of the LSAMO respondents considered that Supervisors should be aware of educational events on offer locally that would meet midwives needs. The LSAMOs also stated that they would be prepared to circulate flyers and further information to Supervisors regarding National CPD opportunities.

The LMEs were of the opinion that Supervisors should refer midwives to midwife teachers with 95% (n=21) agreeing this strategy as this was

considered to be more structured and demonstrated a partnership between service and HEI's. One LME additionally stated,

I think referring midwives to midwife teachers in a HEI is absolutely necessary as I do not think generally Supervisors of Midwives have this information and would not be able to advise on a study pathway (LME5).

The LMEs also generally considered that midwife teachers had a better overview of the CPD provision available and that it would assist midwives in accessing good development information. However, this view implies that CPD advice relates mainly to formal education activities of which educationalists would have a better knowledge of in terms of provision and matching learning outcomes to learning needs.

Practitioners need ownership of their own professional development and an individually tailored learning plan is considered to have a more positive effect on personal and professional development (Ellis and Nolan 2005, Ellis 2000, Quinn 2000). This is particularly important as professionals need direction in CPD otherwise an ad hoc system of development will result which is not congruent with the needs of the different stakeholders in health care and will as a result make little difference on patient care or the practitioners own practice, a view supported by Cervero (2001) and Tobias (2003).

In this context it would appear to be important for midwives to be referred to others for advice in order to support and enable professional

development and the 'travelling' towards a coherent and recognised destination to benefit the practitioner and the needs of the organisation in which they practice, a view presented by Tobias (2003). The guides in this scenario related to midwives would include Supervisors, managers and educationalists.

#### **4.4.7 Protecting the public – Supervisors of Midwives and risk management**

In addition, to practice issues being discussed critical incident analysis was also cited by a number of midwives as being an area they discussed at this meeting. A critical incident or event in practice often leads to a reflective discussion between the midwife and her Supervisor of Midwives and/or the midwife and her peers. Church and Raynor (2000) suggest that critical incidents are useful tools in enabling midwives to develop self awareness in order to practice more effectively. However, the longer the interval between the incident and the reflection may affect recall according to Morgan (2000).

The issue of clinical incidents was raised by both midwives and Supervisors of Midwives in this study with some midwives citing the annual review meeting as a forum for discussion of incidents as well as other practice issues. The incidents highlighted by midwives and Supervisors tended to be those where a poor outcome for the woman or baby had resulted rather than a positive aspect or where good practice could be evidenced. A typical comment was as follows:

Reviewing documentation, notes, also when I was involved with a neonatal death she helped me through it (T3MW10\*)

The NMC require Supervisors to investigate critical incidents and to identify the action required, whilst seeking to achieve a positive learning experience for the midwives involved and in liaising with the LSA as appropriate. Indeed, the standards for supervision of midwives (NMC, 2007) set out that following an incident, a Supervisor of Midwives should undertake a full supervisory investigation including where necessary a risk analysis or root cause analysis. The NMC (2008a) provides further guidance for Supervisors of Midwives in relation to facilitating midwives' reflection on critical incidents.

The reporting of adverse events is central to the risk management process as the aim is to improve the quality of the service whilst reducing the cost of litigation. As supervision of midwives aims to protect the public by maintaining and improving the quality of care it is viewed as an integral aspect of the process of risk management (Wilson and Symon 2002) and clinical governance (Pulzer 1999). It is further argued by Swage (2004) that training and development of staff are the two main areas for supporting clinical governance to ensure quality health care and accurate information based on clinical decision making, performance and outcomes. Swage (2004) also adds that the main aim of CPD is to respond to service developments, patient expectations and personal ambitions and as a result forms the basis for accountability.

If a midwife discloses poor practice which requires remedial action this puts the supervisor in a dilemma as confidentiality is one of the basic requirements within the supervision relationship and information disclosed may in part or full be confidential depending on the situation. However, the overriding principle of supervision is to protect the public and disclosure of information is essential to support the midwife as well as protect the public. There is a danger that if a supervisor views the issues disclosed by a midwife as a one off event, there is a risk that no action will be taken and that this may then compromise public safety. The concept of information silos has been known to result in tragic outcomes as in for example in the Lord Laming Report (2003) and so the sharing of information is important. Therefore, disclosure should be on a need to know basis which offers Supervisors the opportunity to share information in support of the public protection.

Where an adverse critical incident occurs the supervisor's role is vital to support and guide the midwife especially if deficiencies in practice have been identified (Stewart 2002). Specific learning outcomes would need to be prepared for the midwife and through either developmental support or a more formal programme of a supervised practice period (NMC 2007) which would be implemented depending on the outcome of the investigation. Supervised practice is implemented where there is a serious concern about a midwife's attitude or practice and in this case the supervised period of practice would involve the LSAMO, the investigating supervisor, the midwife who would be supernumerary, a midwife teacher and the named supervisor would oversee the process and offer support. The midwife would be directly supervised by a sign-off mentor in practice. This framework for support is clearly recognised and acknowledged through NMC and LSA

guidance and implemented as the need arises for these support programmes.

Educators, managers and Supervisors need to work together to enable continuous quality improvements in maternity services and to enable CPD and lifelong learning, a view also supported by Lucas (2002). Therefore, it must be argued that if a tripartite arrangement is effective in meeting midwives learning needs following an issue in practice then surely it would be worth being proactive and adopting this tripartite arrangement for identifying midwives learning needs in the first place rather than just reacting to incidents as they arise which clearly does compromise public safety. A comment agreed by midwives was as follows,

It would be lovely to see a proactive approach that would be of benefit rather than having to experience a reaction to events because then it would be educationally driven rather than catching up with problems (T1MW3).

In this study the midwives commented about managers reacting to clinical incidents and that a mandatory session would be created for all midwives following these incidents to rectify an identified need. One midwife commented on the system stating:



There's a knee jerk reaction often, something happens, there will be a critical incident (Midwives agree) or serious untoward incident and suddenly all staff have got to be trained in that particular topic, like (topic stated) for example. Myself and three colleagues have been on the (topic stated) working party as volunteers for five years, more, five to six years, and we have written a guideline, produced a referral pathway, we have done voluntary training, done workshops, and on the mandatory study days because sometimes we weren't able to be released from practice, just for that hour, hour and a half, we would make sure that that was our day off so that we could come in and actually do that teaching in our own time, but then suddenly there's an incident and every member of staff has to go on a whole day of (topic stated), which is a fabulous training, don't get me wrong, a fabulous speaker, but that's what we had been asking for five years (T1MW1).

The role of the supervisor in relation to incidents was not mentioned by the midwives in this study but rather the role of the manager in terms of influencing educational activities as a result of a clinical incident. This may be due to in part by the dual roles undertaken by managers and Supervisors of Midwives that causes some confusion and lack of clarity for midwives as described by Kirkham (1995). The literature also highlights many examples where managers fail to distinguish between supervision and management (Seaman 1995, Johnson 1996). However, to some degree all Supervisors of Midwives have several concurrent roles as supervision is carried out in conjunction with another midwifery post. Kirkham and Stapleton (2000) argue that the different requirements of each role are potentially conflicting, both for the supervisor and the midwife. An example to support this view is the differentiation of the time spent on supervision activities demonstrated in a study by Mead and Kirby (2006).

The Supervisors of Midwives in this study did consider their role in relation to creating educational activities in response to clinical incidents and the following comments reflects their view,

at supervision meetings, we pick up training needs generally as a group, if we are talking about incidents that midwives have been involved in and things like that, that will influence what goes on our midwifery update days or on our emergency skills training. (T3SoM5).

Supervisors of Midwives described their experiences of supporting midwives through incidents and those identified through risk management and commented on how they would influence organising educational events to meet identified professional development needs:

Certainly if there has been a critical incident then I would look at that and see what the development needs are, whether it's serious or not, but I would need to look at the development needs around that (T1SoM2).

We also get it through problems that develop that are investigated through risk management might identify that a particular midwife needs some further development or training in certain subjects so that also be another trigger to organise some more development (T3SoM3)

It is widely recognised that medical litigation in obstetrics is the highest contributor in terms of financial costs (Johnston, 2003). Cooper and Jolliffe (2003), argue that to reduce these costs clinical risk management in maternity care is to be promoted as the key to improving care. The supportive and proactive role of the Supervisor of Midwives is commended by Wilson & Symon (2002) within clinical risk management as they acknowledge that midwives are faced with competing demands brought about by the complexities of professional practice, clinical protocols, government agendas and statutory regulation. More recently, the King's Fund (2008) also identified in their report that the statutory system of

supervision of midwives is potentially a rich source of learning at both national and local level, since local supervising authorities report trends in incidents to both NHS Trust Boards and to the Nursing and Midwifery Council.

It may be argued that the NMC operates a sanctions model in relation to CPD where penalties for non compliance with CPD if found through their process of monitoring, would lead to ineligibility to re-register (NMC 2008c), or removal from the register due to incompetency. This sanctions model aims to increase public protection and emphasises both the content and process of learning. In relation to the supervision of midwives, the focus is on public safety and protection from incompetent practitioners and may be considered to be a sanctions model of monitoring with the resultant requirement for a midwife to undertake a developmental or supervised practice programme supported by supervision if CPD is not evidenced in practice. If improved professional practice, at a level of initial registration cannot be evidenced through these supportive mechanisms then removal from the register would be recommended.

#### **4.5 The organisation and management of CPD.**

Supervision of midwives is claimed to be a quality strategy (Winship 1996) contributing to quality service provision. However, as managers are often also Supervisors of Midwives it has been argued that this leads to some midwives viewing supervision as an imposition on their practice and a policing mechanism (ARM 1995, Stapleton et al 1998). The surveillance and inspection overtones that this creates in terms of penalising midwives appears to be more of a motivational factor than professional development through the supervision of midwives and this may be considered to be similar to the pedagogical approach rather than one of an androgical approach (Knowles 1990). Equally this demonstrates the shift in balance of power between managers and the professionals so rather than fostering independence in line with adult learning the emphasis is on the product. Gilbert (2001) argues that supervision provides a channel for subtle surveillance and distant control of professional activity thereby suggesting it can be used as a performance monitoring tool by managers.

All professionals are subject to surveillance in different forms and in the case of managers this is achieved through job appraisal whereas for supervision it is achieved through reflective practice. In the case of supervision, surveillance is made more ethical through reflective practice as it is more explicit than implicit. However, Gilbert (2001) argues that both reflective practice and supervision exert control over health professionals with the assumption that reflective learning improves practice. Supervision therefore still exerts some control over midwives as it ensures professional standards are maintained which according to Jarvis (1983) is inherent within socialisation in the professions. This surveillance

is further considered by Gilbert (2001) to mould the professional identity of practitioners to produce self managing individuals. The endorsement of reflective practice linked to supervision is firmly placed within the clinical governance agenda and can be viewed as a 'top down' initiative. It is from this perspective that supervision of midwives can be seen to fulfil both professional development and professional regulation which is argued combines some managerial responsibility with that of enhancing practice.

In this study, 82% (n=27) of Supervisors were employed in grade band 7 or above. According to the descriptors for the grade bands within Agenda for Change, grade band 7 describes the roles of midwife team leaders, specialist midwives and higher practice midwives which would include managers. The Supervisors themselves reported their job titles (shown in table 4) and this demonstrated that only 24% (n=8) were clinical midwives, 21% (n=7) were in specialist roles, the majority 49% (n=16) were in management posts and 6% (n=2) held educator roles. These findings highlighted that almost half of the respondents held management related roles which actually limits the choice for midwives in selecting Supervisors who are not managers. As most of the Supervisors in this study were also managers this poses the potential to conflict in the different roles.

Some Supervisors alluded to the conflicts arising from the needs of the organisation and the needs of the individual and the following comments reflect their opinions,

... obviously within the Unit, the Trust, we have a professional development midwife so it is very linked to with what is agreed through management and then we try to link it in with supervision and it sometimes can pose a few difficulties with the conflict between the two..(T2SoM1)

It all comes down to communication as well then, because it can't be done in isolation to the needs of the service and the managerial side of things as well, because obviously it's all right you sitting there as a supervisor saying "Go away and do X, Y and Z" because if there is no money in the pot, if the service doesn't need it, you are stumped really. They go to their manager and say "my supervisor says..." but that's as far as it goes (T1SoM3).

From a historical perspective, it has been common practice to appoint senior midwifery managers as Supervisors of Midwives and this has taken place since 1974 (Kirkham 1995). The appropriateness of this combination has been greatly debated in relation to the advantages and disadvantages of joining these roles (Lansdell 1989; Magill-Cuerden 1994; Royle 1994). This dual role can be argued to create tensions between aiming to organise a workforce, protecting the public and assisting a midwife to develop professional practice. Research undertaken by McDowell (1993) suggested at this time that some Supervisors of Midwives still had difficulty in differentiating between managerial and supervisory aspects of their role.

Supervision is a means to bring together midwives and skilled Supervisors together to reflect upon practice with the aim of identifying problems, improving practice and increasing understanding of professional issues. It was not meant to be either a management control system nor be hierarchical in nature as it had been in the past. Also as many managers

are Supervisors and who also manage the other Supervisors in a team it may pose some difficulty in terms of not formally recognising their loss of authority and hierarchy within the supervision forum.

The midwifery manager aims to ensure a high standard of service is delivered to women and their families an aim which is also consistent with the role of the Supervisor of Midwives as one dual role supervisor/ manager commented,

Yes, I think as a supervisor you have to think of the implications of supporting that piece of development and the implications on the rest of the service, don't you? Because you know it's about fundamentally it's about keeping the service safe, isn't it? And as a supervisor you could say to all people you supervise, "Yeh, that's great " (others agree) and actually you scupper the service ....So whether that's the supervisor keeping the service safe or the manager keeping the service safe, we have all got that same duty of care, haven't we? (T3SoM4)

The role of Supervisor of Midwives is often identified as an essential or desirable role combined with that of manager in a job description. In practice Supervisors commented that this means that the post holder can undertake both roles in terms of during work time whereas the supervisor holding a clinical post will have more of a time management issue to undertake the supervision role. This may mean that the manager does not differentiate between the two roles. As one supervisor manager commented,

I think it very much depends on the group of Supervisors, doesn't it, and who makes up that group and the group that you manage, and I think that sometimes, that can confuse that. Do you need to have two conversations or will one do? (T3SoM4).

This comment generated a lot of laughter from the Supervisors present at the focus group but they all mainly agreed with the comment.

Some of the midwives in this study voiced similar concerns regarding Supervisors of Midwives who held management posts and were particularly concerned that the roles could not be differentiated between and had the potential to conflict. Midwives particularly in Trust 1 commented on their selection of supervisor as the following quote demonstrates,

I have seen tensions in the past between management and supervision but not my particular Supervisor because I have chosen a supervisor who isn't a manager because I had scenarios where I have found that difficult with a person in the past when they have been both, and I think that it is very difficult to switch heads and you can have a conversation with someone with a supervision head on but then they will come back to you with their management head on at a later date about that issue, and I find it conflicting and it's something I'm not comfortable with so I deliberately chose a supervisor that isn't a manager or certainly not my manager (T1MW2).

This comment suggests that managers/ Supervisors in dual roles may have more influence than non-manager Supervisors as their position within the managerial hierarchy provides the power and authority in decision making in the Trust. Therefore, being both a manager and a supervisor does have advantages as it places the dual role supervisor in a position to influence others and initiate change. According to Kirkham (1996) a supervisor has



to be a leader and a valued role model but if she has the position and power of a manager in the organisation to influence midwifery then her role as counsellor and friend within the context of supervision may be diminished especially in the minds of the midwives themselves.

Although there has been a flattening of management structures in the NHS which has led to a diminished hierarchy, now with clinical governance there are significant pressures from management to meet the Clinical Negligence Scheme for Trust (CNST) standards (NHSLA 2011) and this tends to dominate decision making even in supervision forums. Indeed, the NHS inquiries into clinical incidents often point to deficits in management practices and has as a result driven this issue through supervision of midwives from a top down perspective. However, the literature on supervision of midwives does not clearly differentiate between supervision and managerial supervision although the former is statutory and has been since the early 1900's. If a supervisor is not clear about her role or is very controlling then supervision will return to being more of a management policing and inspecting role as was the situation in the 1990's (Duerden 2002). It may be that it is more difficult for managers to reflect on issues in practice as they are more distant to practice than the more clinically based Supervisors on bands 6 or 7, a position which, according to Walton (1995) makes supervision more of a peer review system. Friedman and Phillips (2001) support this view and argue that examination of capability and competence is difficult to gauge and suggest it must involve both peer review and direct observation therefore clinically based Supervisors are in an ideal position to achieve this.

The organisation of work in the NHS means that midwives work in a medically dominated culture in which clear hierarchical divisions still persist between all levels of staff (Kirkham 1999). This according to Kirkham (2003) is similar to an industrial model of childbirth where practices are routine and task oriented which gives the manager more power and control and the view that the organisation is more important than the workers. The manager therefore blocks the workers from developing to their full potential due to the demands of the organisational setting and in this process effectively acts as gatekeeper to CPD opportunities and block involvement in any educational development. However, those midwives already in senior positions for example, specialist practitioners or coordinators of clinical areas, do not identify many of the constraints or barriers to CPD as experienced by those lower in the grading hierarchy, a view supported by Currie, Tolston and Booth (2007).

Most Supervisors in this study were also managers and this poses the potential for conflict in the different roles. The supervisor is concerned with safe practice and clinical competency whereas the manager has broader organisational aims for example the quality of the service and the effective use of resources. It may be argued that the people in an organisation are the most valuable assets and one way to ensure high quality services is to encourage the professional development of staff. The manager therefore should be interested in both the long term and short term gains as a means to improve performance and efficiency by matching skills and knowledge to the developmental plans of the service. As one supervisor/manager commented on the dilemma,

Well, it can be, but as a supervisor I have a slightly different advice line to a supervisee than I would if I was their manager in that ...their personal development was not exactly the same as the Trust development and that's where you get the dilemma..'(T3SOM8)

This comment highlights the CPD dilemma in terms of the manager's agenda in opposition to that of the supervisor and the consequence for tensions in practice. In this scenario the manager is focusing on the professional development needs for service development rather than the individual needs of a midwife thereby creating a two tier aspect for agreeing access and funding for CPD. Therefore a CPD need of an individual compared to a service need is viewed as less important in terms of agreeing the use of resources to meet the need. This may be why midwives in this study 39% (n=25) sought advice from managers regarding their CPD needs rather than obtain advice from an educationalist or a Supervisor as managers would be seen to have more power and influence to support access to CPD activities. The line manager is therefore seen as an important resource to access for CPD purposes as this person would have control over the available resources. Interestingly, midwives who had been qualified for 16 years or more were the main group who accessed their managers to discuss CPD and were the least likely to self fund these activities.

The relationship with the manager influences the level of empowerment experienced by midwives and additionally Currie et al (2007) found that the direction and control by others may impede development of others. This is a view previously proposed by Wood (1998) in the concept of 'organisational governance' as key stakeholders in an organisation, such as

managers and possibly even Supervisors seek to control the development of others. The control over the work and development of individual practitioners by managers who are described as powerful controlling agents within an organisation has also been debated by Attree (2006). Therefore the balance of power between manager and individual practitioner influences the direction and potential for progression in their role. This was alluded to by one supervisor who felt there was an advantage for midwives to be supervised by a manager, a view also supported by some Supervisors at the other Trusts,

Sometimes midwives will not always agree but they have just got to try and think that there is an advantage to a supervisor being the manager (T3SoM5)

Managers might block individuals developing because they themselves may feel threatened by staff increasing their knowledge and so respond by inhibiting their development. The managers own educational level also seemed to influence their responsiveness to midwives wanting to pursue CPD activities as reflected in the following comment,

It depends where that supervisor is at in terms of their own continuing professional development, I suppose. If they have been very proactive in terms of doing a degree course and things or not as the case may be, it just depends upon the individual supervisor. I've had three different Supervisors and they were all slightly different (T3MW3).

The LMEs were of the opinion that the educational level of the manager would influence the support given to their staff to undertake CPD especially if they themselves had undertaken further study. Otherwise the LMEs believed that Supervisors should make managers aware of their

supervisee's profiles and thereby influence manager's investment of resources.

The manager will undertake performance review with individual midwives in the form of management appraisal to identify staff development needs which ideally should integrate the development needs of the individual with the needs of the developing organisation. The management appraisal is different to the annual supervision review and may cause tensions and it is important that these tensions are acknowledged as the aims of the manager, those of the supervisor and the individual may at times not be cohesive but rather pull in different directions.

However, it is in the achievement of the aims that brings the conflict as managers achieve the aim through job descriptions and individual performance reviews/ appraisals and other employment issues. The manager will support midwives through providing the appropriate equipment, the environment, administration and support systems, policies, procedures, protocols and appropriate skill mixes (Walton 1995). The manager may also discipline a midwife if poor performance is identified being matched to the job description. In addition, if the midwife reveals inadequacies in her role the manager may consider that the midwife should be downgraded to a more appropriate grade.

The supervisor will however, monitor performance from a different aspect this being through annual review (NMC 2004b, 2010c), and if the midwife reveals inadequacies then although this may not actually be evident in

midwifery practice the supervisor will identify a professional development need to rectify the deficit.

This issue was a particular concern for midwives at Trust 1 and the following comments reflects their opinions,

I've actually chosen a supervisor that isn't a line manager to me. And for me, I think that's really important because I think maybe some managers who are Supervisors are brilliant at sub-dividing themselves, but for me, I'd like, I want to go to talk to my supervisor who is not a line manager in my line.(T1mw1)

This comment reinforces the issue of midwives being able to choose their named supervisor in order to enable a meaningful relationship to develop integral to the whole process of supervision. It also serves as confirmation that midwives do have choice in selecting their named Supervisor of Midwives and some will no doubt select a supervisor who is also a manager. However, as the majority of Supervisors hold a dual role with management then this limits the choice for midwives who select not to have a manager in this role. This would also be influenced by the ratio requirement (NMC 2010c) of Supervisors normally having no more than 15 midwives on their caseload.

These midwives wanted a supervisor for support and with whom they could discuss in confidence certain issues they would not raise with their managers. The non manager supervisor was seen as being able to maintain confidentiality compared to the manager supervisor. However, according to Kirkham (2000) non manager Supervisors have less 'clout'

than manager Supervisors as the latter carries the most power in the organisation as previously mentioned.

It is interesting to note that the Supervisors of Midwives did not feel there was an issue in Supervisors of Midwives also being managers within the Trust. This was supported by Supervisors of Midwives who agreed with the comment:

I think the relationship has always been there and we have always had a very close working relationship with managers. But whether that is the first line manager on the ward, I certainly don't feel that that has ever been an issue (T2SoM2).

The comments tended to relate to the relationships between Supervisors and managers rather than between managers who were Supervisors and their relationship with midwives. This supervisor suggested that working with line managers may not be a problem but did not comment on managers higher in the hierarchy within the Trust or in different clinical areas of midwifery. The supervisor may require support from peers if she is of a clinical grade and feels she may have to challenge more senior staff than herself within the hierarchy to attempt to rectify the situation in relation to access to CPD. An example provided by Supervisors at Trust 3 related to access to Child Protection (Safeguarding) training as some staff had not been able to achieve updates despite being put forward or nominated by Supervisors. The decision making was described as being made at managers meetings.

The Supervisors of Midwives who held a dual role of manager and supervisor commented on the dual role,

And I think that as a supervisor and a manager you have a responsibility to be aware of what are, either team members that we manage or our caseload of supervisees, both are planning around development so that when we are talking about training needs, that we have a fair awareness not just as a supervisor, I know that, but as a line manager (T3SoM3)

But equally, there's been the case hasn't there where people have used their supervisor, because that's the softer option, because they will support me and the manager will ask me for some results from that. It works both ways doesn't it? (T3SoM4)

These comments generated a lot of laughter from the Supervisors at this Trust.

The idea of the supervisor as being a 'softer option' to a manager raises questions regarding the undertaking of the role. An example supporting this view may be seen from a managers perspective of learning benefitting the service as Supervisors in the dual role of manager/ supervisor commented on the need for individual midwives to 'pay back' their learning into the organisation:

But I don't think ....(named) that there is enough feedback to the Trust, so that if you learn something new you actually implement that into practice, it's all very you know "I've learned this and it was really good" but how do you help the service? (T1SoM4).



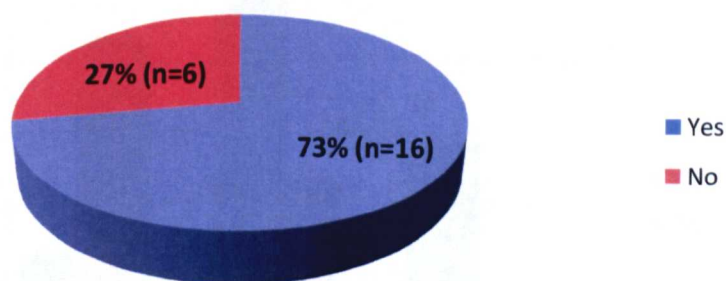
When I try and fund people to go on (named study day) for example, you equally ask them "what are you going to help give the service back", and you send people on these sessions and they don't want to do anything to give that additional support, they just look at it in a very narrow way (T1SoM2).

This issue was thought to be particularly relevant to midwives completing a dissertation as part of their degree pathway following qualification especially as these midwives were supported by funding from the Trust through the NHS Workforce development monies. It was felt by the Supervisors that these midwives should disseminate their research findings in a forum for midwives locally but that forum needed to be identified with a co-ordinated approach to potentially move the service forward. This was an issue for Supervisors at Trust 1 which they felt they should be able to influence as a result of raising this in the focus groups in this study.

Butterworth and Faugier (1992) argue that clinical supervision offers a supportive relationship between equals that promotes personal and professional development and therefore differentiates supervision of midwives from supervision by management. Kargar (1993) also argued that line management and supervision should be clearly separated due to the difficulties in wearing two hats. The ENB (1997) encouraged midwives to change their supervisor if they were not happy with the arrangements but following research by Kirkham (2000) who highlighted that midwives should be able to select their own supervisor many units started to move towards choice in supervision. Indeed, it is now advocated by the NMC that supervisees can and should choose their Supervisors and for some midwives they will in fact still opt for their line manager to be their supervisor.

In addition to managers undertaking the role of Supervisor of Midwives a number of midwife lecturers are qualified to undertake the role. The majority of the education establishments (73%; n=16) had midwife teachers who were also qualified as Supervisors on midwives and worked within their local NHS Trust as demonstrated in Figure 6.

**Figure 6: Number of Approved Education Institutions with Midwife Lecturers Qualified as Supervisors of Midwives**



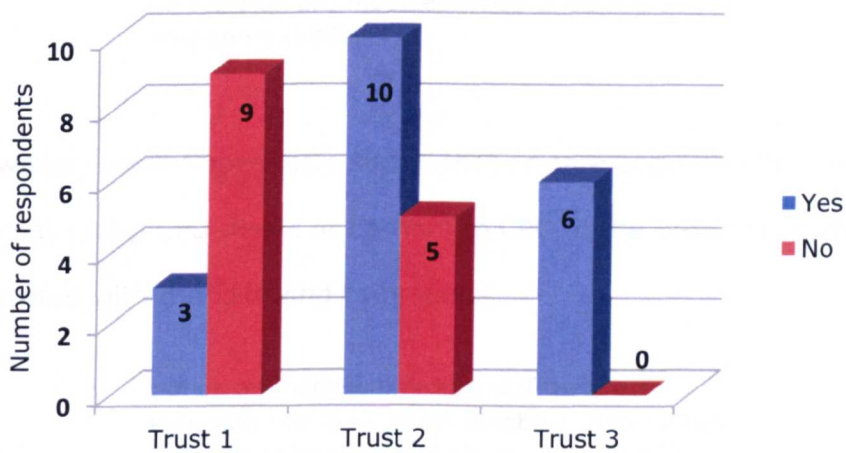
The numbers of lecturers qualified as Supervisors within each approved education institution ranged from 1-5 and is demonstrated in Table 7.

<b>Table 7: Number of midwife lecturers qualified as Supervisors of Midwives in each approved education institution.</b>	
<b>Number of approved education institutions</b>	<b>Number of midwife lecturers who are qualified Supervisors of Midwives</b>
18% (n=4)	5
9% (n=2)	4
14% (n=3)	3
9% (n=2)	2
23% (n=5)	1
27% (n=6)	0

#### 4.5.1 Decision making in the management of CPD

The questionnaire completed by Supervisors of Midwives revealed that only 58% (n=19) agreed that CPD was discussed at Supervisor of Midwives meetings. Figure 7 demonstrates the finding by Trust.

**Figure 7: Midwives CPD needs are discussed with the team of Supervisors**



However, the comments made at focus groups did not entirely reflect this position although the Trust mandatory days was a common item on the Supervisors agenda within each Trust and this would be what was discussed in this forum. The discussion may be due to the fact that some Supervisors are also managers who make decisions regarding content to meet Trust requirements. Alternatively, it may be aspects of practice that are identified by Supervisors in relation to risk management and safety that allows some influence over the mandatory Trust training to meet the most basic PREP requirements as well as CNST requirements.

In Trust 1 and Trust 2 Supervisors commented that there was a lack of opportunities to discuss CPD needs of midwives and that the Supervisors meetings were not usually used as a forum for these discussions. The Supervisors commented on the lack of opportunities to discuss the CPD needs of their supervisees as a collective group. A common view is depicted as being:

no apparent forum for this (T1SoM12)

(discussion on) modules tends to be with managers (T2SoM5)

However, some Supervisors stated that on rare occasions they were able to discuss group CPD needs or barriers to CPD at the Supervisors meeting as indicated with the following comments:

not on an individual basis but if there are recurring needs on a few numbers of midwives then would raise this as an issue (T2SoM13).

We try to engage, don't we, about what we do for the more formal courses, but I think ... we discuss it around lots of things like in supervision, like newborn - are we at saturation of what we need as a service over and above what people want to do for their development, so it's that sort of debate we have round bigger areas, isn't it? (T3SoM4).

The issue of confidentiality was also felt to be a barrier to discussion with other Supervisors regarding the needs of supervisees,

And we do all talk together, so you know if we have a problem keeping the midwife's confidentiality I think if they want to develop in a particular way that was their desire then I could talk to colleagues who could probably say well have you thought about that and we would support each other (T2SoM3).

There was agreement from other Supervisors on this latter comment and the perceived confidentiality issue tended to mean that Supervisors did not share individual midwives needs in a group forum with other Supervisors but rather an individual supervisor may speak to a peer supervisor on a one to one basis for guidance and support. Duerden (2005) argues that the supervisory relation does require Supervisors to maintain confidentiality within the supervisory relationship at all times. However, if some learning deficiency is identified which requires developmental or supervised practice then confidentiality cannot be maintained. The code (NMC 2008a) also requires Supervisors to adhere to these standards in relation to confidentiality about midwives and underpins the mutual respect within the supervisory relationship. This would appear to make it difficult for Supervisors to share the identified learning needs of midwives with other Supervisors so the action of any CPD plan, formulated at the annual review meeting, is therefore left to the midwife.

The issue of confidentiality also raises concerns regarding the practice of Supervisors as an increasing number of complaints made to the NMC (2011) question the consistency between Supervisors in discharging their duties. This may be further compounded by the lack of transparency between Supervisors which could be improved through increased collaboration and communication within the supervisory team. This is a potential area for further research in this sphere of practice.

Midwives at Trust 1 were sceptical regarding the issue of confidentiality as they were under the impression that managers could access the annual

review documentation on line and therefore would already know what had been discussed by Supervisors of Midwives. The following comment reflects the midwives concerns,

They do it on line now anyway, it's all done electronically. I thought it was all kept in a file; the write up from your supervision is emailed to different people. I can't confirm definitely that its emailed to management, but all Supervisors have access to that, and if all the managers are Supervisors, then they have access to the people they are managing, so as far as I'm aware it's not confidential information, I don't mean what's discussed within the supervision, I mean the actual small write up that the supervisor then puts on the electronic database, that is accessible by all Supervisors, who also are your managers (T1MW2)

At Trust 2 the Supervisors commented on decision making regarding CPD being held by managers with limited influence being exerted by Supervisors as highlighted by the midwives in the following comment,

I have in the past needed to discuss CPD needs with managers rather than Supervisors. However, most managers are Supervisors but discussion takes place from a management capacity rather than Supervision (T2SoM8).

Supervisors mainly agreed with this comment and added that the communication method was being channelled through one individual only, at management level, and not through discussion with other Supervisors. Supervisors meetings at this Trust were generally viewed as sharing information about midwifery issues or sharing thoughts about issues that

had been raised by managers as the following comment at the focus group highlighted,

We use this forum to share things that what we have been told to do as in midwifery issues (T2SoM1)

Supervisors in Trust 1 did not appear to have a mechanism for discussion with managers but did state that issues would be taken to the head of the service,

Well, now that the annual review document's changed, if we look at the previous annual review document, we had a page at the end of it didn't we, that said, if you have got additional training needs, please complete this and it got submitted to Head of Midwifery (HoM) didn't it? (Midwives agree). But that's got out of the annual review document now, but that doesn't mean to say that I don't stop asking about that, and if there was an issue I would take it to (HoM named) (T1SoM2).

Table 8 demonstrates responses from the questionnaire regarding the methods used to communicate with managers.

<b>Table 8: Methods of communicating midwives CPD needs to managers.</b>	
<b>Method of Communication</b>	<b>Number of responses</b>
In person	11 (37%)
Email	10 (33%)
Advise midwife to speak to their manager	4 (13%)
Referral to professional development midwife	1 (3%)
Formal form completed and sent to	1 (3%)
In writing	3 (10%)

A common issue for discussion at the supervisor's team meeting in all of the Trusts was the provision of mandatory Trust training. The following comments were typical of those made in relation to these discussions on mandatory provision and meeting CNST requirements,

usually in relation to trust requirements to meet CNST (T1SoM11\*)

At supervision meetings, we pick up training needs generally as a group. If we are talking about incidents that midwives have been involved in and things like that, that will influence what goes on our midwifery mandatory update day or on our emergency skills training day and make sure that they are identified in those ways so we make sure that they are passed on and then the midwives will get that (T3SoM5).

#### **4.5.2 Management Appraisal**

The experiences of the midwives at Trust 1, in this study, in relation to annual review undertaken by Supervisors of Midwives and the annual



individual performance review (IPR/ management appraisal) undertaken by managers was that they considered each to be totally separate activities. This view was also endorsed by the Supervisors of Midwives at this Trust.

The Supervisors commented,

It's seen as a different process I think (T1SoM4)

But it isn't is it at the end of the day, it should overlap (T1SoM3)

I can't think of any people I've done an annual review on for supervision that have said, "This is what I've put forward for my PDP", that's never happened (T1SoM1).

Other Supervisors of Midwives agreed with the above comments.

Supervisors of Midwives also indicated how they communicated their supervisee's CPD needs to managers with most stating,

if there is a developmental need and they really need to do something I will write to the manager (T1SoM4).

Other Supervisors of Midwives all agree and believed that perhaps Supervisors of Midwives should ask supervisees to produce their personal development profile at the annual review to reduce any area of overlap in preparation for the meeting. This was generally agreed to be an area which could be taken forward.

At Trust 3 the Supervisors had a different view of the two processes and felt there was some bringing together of CPD needs already in place,

Certainly some of my supervisees do. Cos we make mention of the fact that there is, at some point there is an overlap, isn't there in terms of their professional development and also it could be a service need as well, so, it's part of that discussion about their continuing professional ... it should, shouldn't it? (T3SoM1)

The midwives at Trust 2 also thought there was some overlap between the annual supervisory review and the role appraisal but made no other comments.

Midwives argued that managers were more likely to influence access to CPD activities as opposed to their supervisor and the following comment reflects their discussion,

I got that (named course) through my appraisal but not with a supervisor and I've had more out of my appraisal whilst I have been here than I ever had out of my annual review (T2MW3).

This statement implies that managers are able to influence access to CPD activities more than the different Supervisors of Midwives she has experienced. It may be argued that because these Supervisors were not in the dual role of manager/ Supervisor of Midwives this may have limited their influencing ability.

The KSF, developed as part of the NHS Agenda For Change (DH 2004c) was designed to promote fair opportunities for CPD, pay and career progression and is linked to annual appraisal or individual performance development plans (PDP) which represents the learning cycle (Kolb 1993).

The stages of this cycle are: the training needs analysis; planning educational events to meet identified training needs; implementation of training; and evaluation to inform the next training cycle. The development review involves assessment, planning, implementation and evaluation of learning needs and in order to function effectively the KSF and developmental review require partnership between the staff member and the manager. As the manager and staff member jointly agree learning needs then the appropriate CPD package should be made available thus supporting career planning and contributing to progressive practice. It may also be argued that in identifying training needs for people at different career points applying the KSF should assist managers in identifying gaps in knowledge and skills for teams across a service using standard job profiles. Therefore by enabling Supervisors of Midwives to review this PDP may actually assist in influencing the achievement of the CPD plan. However, the midwives in this study at Trust 1 were sceptical about whether there would be any benefit in sharing this plan with their Supervisors or indeed sharing their supervisory review with their manager. On discussion of this issue there was a lot of laughter from the midwives,

Well I actually keep my own action plan, I do it in my own way and I go along to my supervisor with my own action plan and then I do adapt my action plan for my annual review and also for other meetings because she finds that helpful (T1MW3)

In my experience, it's separate and covered by both of them. So, I don't necessarily, I mean I take my portfolio with me, but I don't necessarily get out me supervision document and say "this is this and this" but as part of the other meeting, it's raised anyway (T1MW1).

Midwives from Trust 2 and Trust 3 did make further comments related to the two annual meetings suggesting that both activities were similar and for performance review particularly it was about ticking boxes as the following comments reflect,

From a point of view of somebody doing their KSF it does feel like there is a big overlap (*between appraisal and annual supervisory review*) and that you are repeating yourself because of the way documents are worded ( T3MW1).

It is a very personal thing. Some people may not be interested in doing that type of thing and more interested in doing a course and that may be ... so I think there is a mixture between the appraisal and annual review and I think that those things do overlap (T2MW2)

I suppose it depends as well on the person that is having the one to one with the supervisor. Because it's the sort of person who tries to get out of doing the mandatory stuff, then they are going to focus more in the first place I would have thought because it is mandatory and then sometimes that can give you a lead into that they want to do something else or I'll not consider you doing anything else until you've done your mandatory stuff (T3MW1)

Midwife lecturers mentioned the differences experienced with having a manager outside of the Trust and a supervisor from the Trust,

I think I'm very different because having a university manager and an NHS Supervisor of Midwives there are different procedures because a Supervisor of Midwives wants to know one thing whereas the university manager wants something very different so I see them as very different but complementary things, so it is different what I get out of supervision and what I get out of performance review (T3MW3).

Parish (2007) found that only 60% of NHS staff had an annual appraisal, and that 20 – 30% of practitioners are dissatisfied with the appraisal system as many did not get feedback on their development which left them feeling undervalued. The Care Quality Commission (CQC 2011) previously known as the Healthcare Commission, report on NHS staff surveys conducted each year and in the latest report identified that the number of staff receiving appraisals had increased from 69% in the 2009 survey to 77% in the 2010 survey. However, despite an increase in the number of staff experiencing an appraisal only a third felt the appraisal was well structured, set clear objectives and that their work was valued. In addition, only 67% of staff receiving an appraisal actually had an agreed PDP as part of this meeting. Participants in appraisal processes, according to Hamlin (2000), also reported that feedback was only provided where performance required improvement although this is not overtly stated in the CQC report.

Gopee (2003) argues that personal development plans are important in planning lifelong learning but practitioners are still able to study without a plan although difficulty in determining the most appropriate course to attend is experienced. Therefore, it is inevitable that there will be some incongruence between the practitioners own perceived needs, the needs of the service and the politically driven NHS agenda.

The management appraisal meeting is in part a performance review and as such learning opportunities for development can take place through discussion with managers as skills such as communication, information technology, management and leadership skills will be explored and

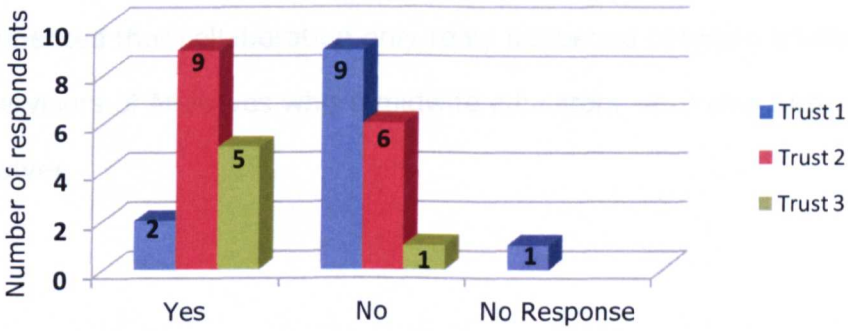
assessed in relation to their ongoing competence and employability through their CPD activities. The introduction of personal development plans through the Government's CPD strategy is seen as a method of ensuring learning is structured and reviewed on an ongoing basis and relevant to the individual as identifying where learning is achieved may be difficult as what is perceived as new learning for one practitioner may just be a repeat of learning for another.

If personal professional development plans and outcomes of discussion of the annual supervisory review meetings were shared between Supervisors of Midwives and managers by the midwife then this has the possibility of co-ordinating and promoting a culture of support for CPD activities in an organisation with the opportunity to develop both the individual and the service. The management appraisal system has always been kept separate from supervision in order to clarify the role of the supervisor as being different from management processes (Kirkham 1996). The sharing of PDP's could create a partnership arrangement which could be strengthened by approved education Institution involvement to develop and ensure CPD activities meet practitioners knowledge needs through the availability of both informal and formal learning.

### 4.5.3 Collaboration between Supervisors of Midwives and approved educational institutions

Overall, 48% (n=16) of Supervisors considered there was already sufficient collaboration between Supervisors and education providers. However, 48% (n=16), of Supervisors did not agree that this collaboration was effective, see figure 8.

**Figure 8: There is sufficient collaboration between Supervisors and Education providers.**



Supervisors at Trust 1 commented that they were not really aware of all the collaborative processes and that it felt quite management led. 4% (n=1) did not respond to this question although made the following comment,

years ago midwives received more information on courses/ study days available via email and post. Information on courses are available if enquiries are made but think many midwives have assumed courses have stopped since our Trust no longer has money available for study days etc. Also due to lack of midwives it is often only possible to attend funded courses in a midwife's own time now unless it benefits the Trust rather than it benefits the midwife (T1SoM10).

This supervisor did state that she knew the contracting process within her unit.

Supervisors at Trust 2 considered that there was good collaboration with educationalists however they also felt it was an area that could be improved. Some Supervisors also commented that where a midwife lecturer was a member of the supervision team this enabled communication. This view was supported by the LMEs who further commented that collaboration only really happened between educators and Supervisors of Midwives where midwife educators were also Supervisors of Midwives.

Trust 3 Supervisors perceived that collaboration was achieved through the LSA Officer and contact Supervisor of Midwives. At this Trust Supervisors also commented that there were regular meetings between midwife lecturers and the midwifery management team, who may also be Supervisors but not with the team of Supervisors. The Supervisors at Trust 3 felt that the funding issues had created a barrier to this collaboration.

At the focus groups it was generally felt by the majority of Supervisors at all of the Trusts that there was a need for more collaboration between education providers and Trusts. Supervisors made the following comments,

I think there could be more input from the University... I wouldn't know what is open to me education wise unless I went off and found out it is not sort of openly there (T2SoM7).



(Other Supervisors laughed at this comment).

I think there would be (*more collaboration*) if we asked, but I don't think it's sort of routinely flowing, certainly not in the circles I mix in. I would have no compunction in ringing one (midwife teacher) to say "is there anything for this" do you know what I mean? (T1SoM4).

The LSA Midwifery Officers, 40% (n=2), also considered that collaboration was insufficient between education providers and Supervisors of Midwives to ensure appropriate continuing professional development activities were available to meet the CPD needs of midwives and that this was an area that really needed to be enhanced. This view was supported by comments from the LMEs with 55% (n=12) agreeing collaboration needed improving.

20% (n=1) of LSAMO participants considered that collaboration was improving with the Lead Midwife for Education and the LSA officers working together. Only one of the LMEs (20% n=1) commented on having regular meetings with LSAMOs and with Supervisors of Midwives in the Trusts where students undertook clinical placements.

The LSAMOs also commented that collaboration was better where Supervisors of Midwives were members of workforce and education forums. However, the membership of such forums according to Supervisors depended on the dual role of supervisor and manager as it was senior managers who tended to be members of these forums. Some LMEs expressed concerns that although Heads of Midwifery and senior managers were also Supervisors of Midwives they felt that contracting was based on service needs. The view of the LMEs were similar in that there was no

official strategy for collaboration and that Supervisors were not specifically represented at appropriate meetings.

LSAMOs also commented that collaboration was insufficient due to the fact that HEI's could not, due to staffing, budget issues or that they were unwilling, to increase the boundaries of provision of CPD activities. The LSA officers also believed that Supervisors of Midwives have an opportunity to feed into Trust training needs plans and horizon scan for future requirements to help midwives. However, a concern of the LMEs was that some Supervisors of Midwives do not become involved with this process at all and may not be aware of courses currently on offer or have a vision of what is needed for the future development needs of midwives.

Two LME respondents (9%) made comments on the questionnaire but did not complete the yes or no boxes stating instead,

My knowledge is that this (collaboration) can be patchy and can always be improved (LME22).

difficult to answer yes/ no as Supervisors of Midwives attend our courses advisory meetings but this specific issue is not normally an agenda item. This question will now alter our agenda!(LME12).

This latter comment from LME 12 indicates an immediate change, as a result of this study, to the working arrangements between the Supervisors of Midwives and the university as CPD provision would now become an agenda item for discussion.

In HEIs where the Lead Midwife for Education was also a Supervisor of Midwives, or where some of the midwife teachers were Supervisors of Midwives collaboration was considered to be sufficient the following comment reflects the views of the LMEs,

we are very lucky having 4 Supervisors of Midwives within the team. However, there is no formal point for collaboration to discuss CPD needs (LME 14).

collaboration only really happens if some midwife educators are Supervisors of Midwives (LME21).

20% (n=1) LSAMO respondents considered collaboration to be sufficient. Others commented on LMEs and LSAMOs working more closely together enabling an improved collaboration. However, one LSAMO responded,

even if there is sufficient collaboration HEI's cannot meet Supervisors of Midwives suggestions because of limitations of their staff/ budget and the unwillingness of HEI's to increase the boundaries of provision (LSAMO4).

The reliance on LSAMOs and LMEs working closely together enabling collaboration is limited in terms of how this can achieve development of CPD activities specific to the local needs of midwives. This is due to the geographical area in which each LSAMO works as each may have a number of provider universities in their area. This is also dependent on whether local maternity services will support CPD activities at a distance to their service. The recommended action would be to improve local networking between universities and their local maternity service providers with the aim of improving educational opportunities for midwives.

Just over half of the LME participants (55%; n=12) agreed that there was insufficient collaboration between education providers and Supervisors on midwives to ensure appropriate continuing professional development activities for midwives. The comments from LMEs were as follows,

links with Trusts via appraisal and annual supervision meetings could be strengthened to link directly to CPD pathways for midwives (LME1)

there is no official strategy for collaboration (LME4)

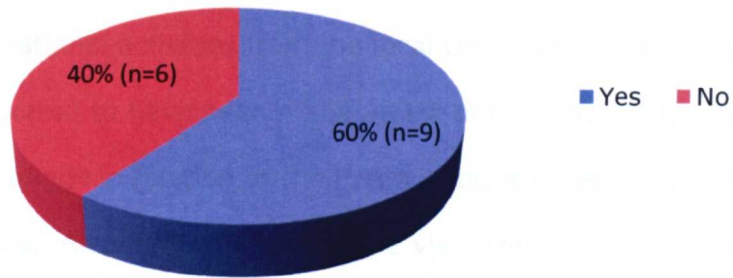
Supervisors of midwives do not appear to be personally represented at appropriate meetings (LME8)

Liaison between NHS Trusts in order to develop programmes/ modules and short courses to meet the needs of midwives following training needs analysis is ad hoc. This needs changing to be truly effective (LME18)

The LMEs believed it to be crucial to develop the relationships between education and service as in some areas this was lost in the move to HEI's and has since had an adverse effect on both service (clinical practice) and education.

The study participants were asked whether information was provided by lecturers/ Supervisors of Midwives to the universities regarding midwives CPD needs. Figure 9 shows the findings.

**Figure 9: Information is provided by lecturers/supervisor of midwives to universities regarding midwives CPD needs.**



From the 15 LMEs that answered this question, 60% (n=9) stated that the midwife lecturers/ teachers who were qualified as Supervisors provided feedback on the continuing professional development needs of the midwives from the local trust, to the University.

Four LMEs considered that feedback was through Trust mechanisms only and was not formally fed back to Universities via this route.

#### **4.5.4 Education contracting**

The Supervisors of Midwives were asked if they were aware of the educating contracting process within their Trusts. The findings were as follows:

85% (n=28) of Supervisors responded 'Yes' to this question.

15% (n=5) of Supervisors were not aware of the contracting process within their Unit.

The Supervisors agreed that the contracting system had changed over the years and this had led to a lack of understanding of the current system. Most Supervisors were aware that the NHS Workforce Deanery funded a contract of educational activities from the local Universities and these Supervisors reported to have been made aware of this through the contact Supervisors meetings in relation to the Preparation of Supervisors of Midwives courses. A comment reflecting the views of the majority of Supervisors was,

I was not aware that was how it operated, so we are not sort of party to that level of information, we just don't get involved in that particular area (T1SoM3).

Other comments from Supervisors suggested that although they were aware of the education contracting process they did not understand it and that it was,

known by managers rather than Supervisors (T1SoM11\*)

At the focus group meetings this question was further explored and Supervisors reported that they knew that funding was available via the SHA but did not know any detail regarding the process.

One LME reported that involvement in the contracting process was an NMC requirement in order to meet Standard 2 of the Standards for Pre-registration Midwifery Education. The NMC Standards for pre-registration midwifery education (NMC 2009, standard 2, p7) specify that involvement

with commissioning and purchasing agencies for midwifery education is a requirement of the LME role.

Of the LME respondents 81% (n=18) met this standard (NMC 2009) and were involved in contracting of education for midwives. 19% (n=4) of the LMEs reported their involvement with contracting was via discussion at meetings with the Strategic Health Authority and Directors of Services in joint educational forums. Others reported liaison with local NHS Trusts although this involvement was considered to revolve around pre-registration contracting rather than post-registration education which was reported as being somewhat 'hit and miss'.

Of the respondents who stated they were not involved in the contracting process (19%; n=4), it was stated that proposed commissioning numbers and types of modules were agreed with them before plans were submitted for contracting. 5% (n=1) LME reported that the involvement at their University was via a Lead member from a different part of their School.

Some LMEs expressed concern that although Heads of Midwifery were also Supervisors of Midwives they felt that contracting was managerially led and based on service needs. Two LMEs commented,

the CPD needs of midwives as identified through supervision is not very transparent (LME13).

the emphasis on development of midwives understanding and personal attributes is less of a focus for them ( Supervisors of Midwives) while it is more important to HEIs and LMEs (LME 9).

The majority of LMEs (81%; n=13) felt there was an expectation that educational activities would be influenced by the lecturers who were also Supervisors of Midwives. An opposing view was stated by one LME who believed that,

the influence the Supervisor of Midwives have is no different to the other lecturers via the link teacher role (LME2).

It was also suggested by the LMEs that the lecturers who were Supervisors of Midwives provided input to the Trust supervision course, CPD and to pre-registration programmes. A common view was that for some lecturers their University did not appear to appreciate the value of their role as a Supervision of Midwives at local level but within the Schools themselves Supervision of midwives advice and support was sought. An important comment from LSAMOs regarding the influence of the Supervisor of Midwives in terms of enabling midwives to achieve their CPD needs was reflected as,

Supervisors do not have financial responsibilities and therefore can only recommend rather than ensure a midwife's CPD needs are considered (LSAM05).



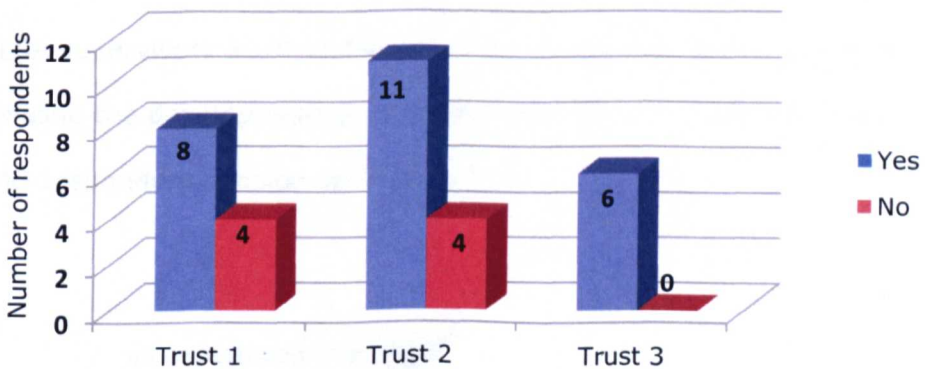
#### 4.5.6 Supervisors of Midwives influence the development of CPD opportunities.

Midwives considered that their Supervisors could influence the development of educational events to support midwives CPD with 53% (n=76) of respondents agreeing with this view. 30% (n=43) of midwives did not know whether Supervisors of Midwives influenced the development of educational events to support the CPD needs of midwives. 17% (n=25) of midwives did not view their supervisor as being able to influence development of CPD activities.

Nearly three quarters (73%; n=24) of Supervisors responded 'Yes' they could influence the development of CPD activities, see figure 10. A further 24% (n=8) of Supervisors did not consider that they were able to influence developments and 3% (n=1) did not complete the response box but commented,

Not sure, I know we fought to continue with the mandatory days (T1SoM8).

**Figure 10: Supervisors are able to influence development of CPD events.**



The 24% (n=8) of Supervisors in Trusts 1 and 2 commented on their inability to influence development of CPD events as,

The process is management led at present  
(T1SoM7).

Has more of a managerial influence in our unit  
(T2SoM8).

These Supervisors felt their role lacked the influence compared to some of their peer Supervisors who were also managers in the unit.

The LSAMO respondents stated that Supervisors of Midwives influenced in some areas but not all adding that most,

are involved in skills drills and mandatory  
training (LSAMO2)

This statement was also supported by the Supervisors of Midwives in all Trusts although their comments reflected that they were involved but did not necessarily influence the content of the mandatory training as this was also perceived to be management led with CNST being the greatest influence.

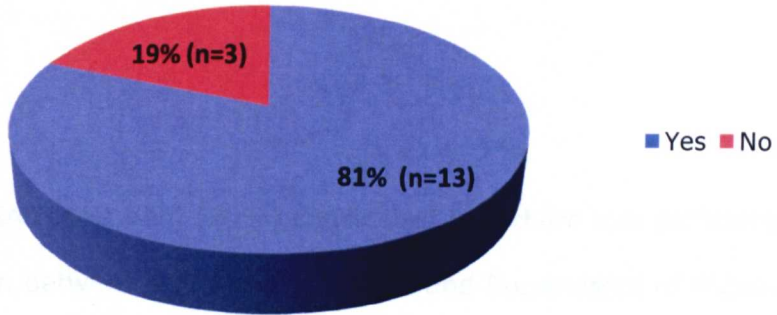
The LSA supervisory audit and supervisory report was stated as a means of influencing the development of education activities for midwives. One LSAMO respondent considered it to be,

an expectation that Supervisors of Midwives  
ensure they facilitate this awareness (LSAMO5).

The LME respondents were asked whether there was an expectation that midwife lecturers who were also Supervisors of Midwives would influence

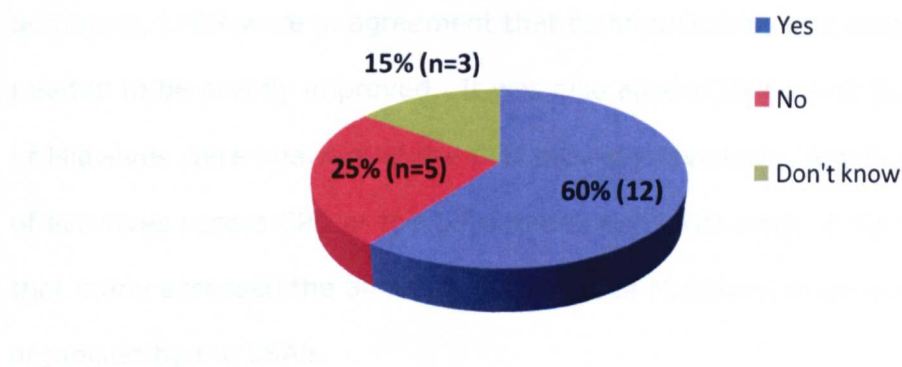
the provision of education activities provided by the University. The majority of LMEs (81%; n=13) felt there was an expectation that educational activities would be influenced by the lecturers who were also Supervisors of Midwives. See figure 11.

**Figure 11: Midwife lecturers/supervisors of midwives will influence CPD activities for midwives.**



60% (n=12) of the LMEs felt that in general Supervisors of Midwives influenced the development of educational events to support the continuing professional development of midwives. 25% (n=5) did not agree that Supervisors influenced the development of CPD activities. Two participants did not answer this question and 15% (n=3) did not know. Figure 15 displays the responses of the LMEs.

**Figure 12: Supervisors of midwives influence the development of education events**



Only one LSA respondent (20%) considered that there was sufficient collaboration between education providers and Supervisors of Midwives to ensure appropriate CPD activities are available for midwives. Two (40%) did not agree and stated that the situation was improving with the LSAMO and the LME working more closely together. The general feeling from LSAMOs was that collaboration needed to be enhanced. The issue of collaboration was also considered to be compounded by the fact that midwives and Supervisors of Midwives do not sit on workforce and education forums and that approved education institutions were perceived as being unwilling to increase the boundaries of provision of CPD.

The University perspective, from the 20 LME respondents, 60% (n=12) was that in general Supervisors of Midwives did influence the development of educational events to support the continuing professional development of midwives. Some LMEs reported that Supervisors of Midwives were members of developmental groups devising new programmes and that networking between Supervisors, LMEs and lecturers was good although there was a lot of inconsistency and no recognised coherent strategy. The

overall impression was that mechanisms varied between different Trusts and therefore a collective influence from Supervisors was not apparent. In summary, LMEs were in agreement that communication and collaboration needed to be greatly improved. It was also agreed that many Supervisors of Midwives were unaware of the CPD provision available, few Supervisors of Midwives access CPD at the Universities and most were of the opinion that many accessed the annual Supervisors of Midwives study days only organised by the LSA's.

The Supervisors of Midwives, 73% (n=24), stated that they felt they did influence the development of CPD opportunities for midwives and only 24% (n=8) did not agree and only 3% (n=1) who did not provide a response to this question. Some of the comments from Supervisors related to influencing 'in house' events such as the Trust mandatory days, the emergency drills days and specific midwifery updates that they had supported at a local level. However, some Supervisors felt that these events were more likely to be influenced by managers, incidents in practice and CNST requirements rather than by supervision. Supervisors in Trusts 1 and 2 concluded that CPD was influenced by managers although individual Supervisors had on some occasions spoken to midwife lecturers regarding midwives CPD needs.

Some Supervisors who responded in the No category commented that their influence was not as much as they would like to be as a supervisor and although some did try they were limited in success due to funding or lack of interest as CNST needs at the Trusts are always prioritised.

At Trust 3 the Supervisors felt there was a 'gap' in their supervision group as none of the Supervisors was from education although they all considered that liaison with education was effective at a local level mainly. It was also generally agreed that educational issues were 'taken' to educators in a timely manner but there was a need to be more proactive rather than waiting for something to become an issue. It was also argued at this Trust that senior midwives were on committees and attended forums with educationalists but were at these meetings as a senior midwife/manager rather than as a Supervisor of Midwives even though they may hold the dual role.

This situation was thought to be limiting for Supervisors as many at this Trust felt they had no influence in the hierarchy. One supervisor commented:

I know supervision is non hierarchical but you can't help but bide what your day job and the hierarchy that you go up into.... there are huge communication links and I don't sit there as a Supervisor of Midwives I sit there as (*manager role stated*) for this organisation but, you know what's that about, supervision talking to education. .... And whilst supervision isn't hierarchical, positions in organisations are, and the higher up you get into that there is, and I think that has been these big groups that influence midwifery, there are the people there but they might not be sat there with a badge of supervisor (T3SoM4)

The Supervisors stated their concerns with the situation and the fact that managers in senior positions were also Supervisors therefore when attending meetings the communication channels were viewed as managerial and supervision was not made explicit enough for them to influence. Some Supervisors commented on committees where both

managers and Supervisors were present which raised the profile of supervision and separated this from just the managerial role. The group also stated that they would need to rethink how Supervisors were represented in the Trust and in wider forums to be able to exert influence. A number of Supervisors at this Trust felt that the dual role of manager and supervisor was an advantage for them to be able to exert influence but again acknowledged that this influence would be perceived to be management led.

The largest influence for managers appeared to be the mandatory study days which were provided by all of the NHS Trusts within this study. The number of days varied between Trusts but each held at least one day for midwives with some Trusts having two or more mandatory days in total. The midwives considered that they were very lucky to have the days although some commented on the large number of topics that were included which made the depth of each very superficial. The range of topics included in the days at each Trust is demonstrated in Table 12 in section 4.5.

Midwives in Trust 1 regarded the provision of mandatory study days as being dependant on the risk management strategy and stated:

I think that CNST requirements play a large role in that if it is a CNST requirement then this is the mandatory training (T1MW2).

I feel that the Trust is more interested in education to reduce risk than in an individual's aspirations or in any collective attempt to achieve specific clinical outcomes within the Trust (T1MW1).

The Supervisors of Midwives collectively agreed with the midwives comments and linked the subjects within the mandatory day as being:

Because of the accreditation, you know, NHSLA requirements, there's all the very big push just coming up to level 3 assessments for instance, last year, you will do it, and there's no other option so if there is only a certain pot of money, that's where the money will be directed and I think that's quite an issue really (T1SOM4).

In addition, the Supervisors commented that this was a real issue and although the topics were reviewed each year the content was driven by management because of CNST and not driven by identified needs highlighted through the supervision of midwives.

#### **4.5.7 Attendance at CPD activities**

Midwives were asked if their Supervisor of Midwives could influence their attendance at educational events to meet their CPD needs. The majority of midwives from each trust (64%; n=93) responded Yes to this question. 19% (n=27) responded No, and 17% (n=24) did not know the answer to this question. The pattern of responses was similar for each Trust.

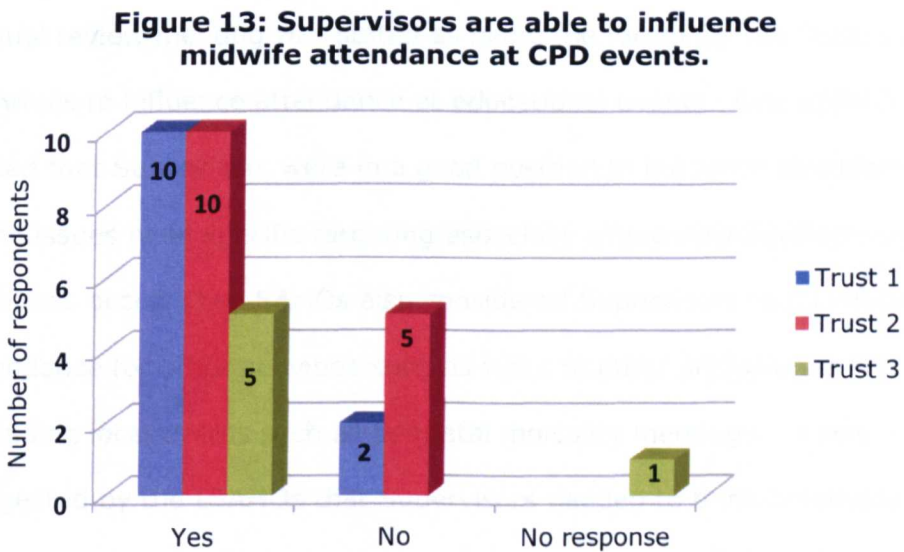
The Supervisors of Midwives were also asked this question with 76% (n=25) of the opinion that they could influence attendance at education events to meet midwives CPD needs. However, these Supervisors viewed their influence to be on the midwives they supervised and reinforced the importance of the annual review meeting. They considered that protected time for this meeting was available and that it provided the opportunity to reflect on individual needs. Some Supervisors commented that they felt



they would be able to influence attendance particularly if a safety issue arose related to practice otherwise their influence was very limited.

21% (n=7) Supervisors responded that they could not influence attendance. These Supervisors commented that they could only recommend attendance to midwives and then it was up to the individual to take this further. The general comments related to the fact that the budget controlled the access rather than being led by the practitioners needs.

Figure 13 shows the findings by Trust.



Supervisors at Trust 2 further commented on the processes in their Trust by commenting that it,

would be better if Supervisors could have a direct link to gaining places on courses/ study days after identifying midwives needs at annual review. Often gets "blocked" by (Named) Midwife (T2SoM3)

too often as a Supervisor it is frustrating to not meet the need due to a lack of commitment or finance from those in charge of in house education (T2SoM13).

Interestingly, Supervisors in dual roles did not perceive a problem and stated,

I feel that my role as Senior Midwife does enhance my role as a Supervisor and sadly I think a fair bit of influence over CPD of midwives is through my main role rather than as a Supervisor of Midwives (T3SoM4).

All LSAMO respondents agreed (100% n=5) that Supervisors of Midwives can influence attendance at educational events to meet CPD needs. The annual review meeting was stated as being the forum for the Supervisor of Midwives to influence attendance at educational events. One LSAMO stated that Supervisors were in a good position to influence attendance as some issues need specific targeting especially where new developments or problems occur. The LSAMOs also considered Supervisors could influence attendance for other activities such as visits to other areas/ units and attending local events such as perinatal mortality meetings. It was suggested by the LSAMOs that Supervisors needed to think creatively so midwives can use different opportunities to meet their CPD needs.

It is not clear from the comments made by the LSAMOs whether they were referring to the influencing of midwives or managers or both. In relation to the annual review CPD activities would be discussed but the individual resources of the midwife would ultimately influence achievement of any CPD plan for example funding and time. If part of the CPD plan required time out of practice and funding then the influence would need to be directed to the managers. Although it may be argued that it is the responsibility of the individual midwife to achieve CPD needs a variety of

factors may well become barriers to this achievement and Supervisors need to be able to influence sufficiently to be able break down some of these barriers.

The majority (77%; n=17) of the LME participants stated that Supervisors of Midwives can influence attendance at educational events. 14% (n=3) LMEs did not agree and 9% (n=2) did not know. One LME stated,

I'm sure that they can but not sure that they do (LME18).

One LME stated that Supervisors can influence attendance and were more likely to do so when,

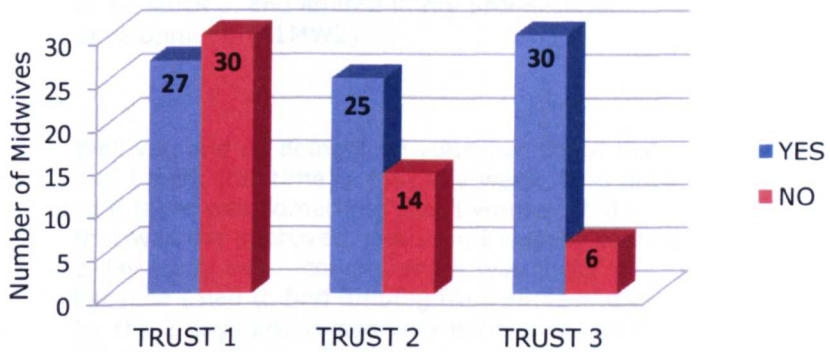
they themselves (the Supervisors) have pursued further academic study (LME10)

The LMEs also agreed with the LSAMOs that the forum for encouraging attendance at CPD events was the annual supervisor review meeting.

#### **4.5.8 Provision of Protected Time for CPD**

Just over half of the midwife respondents across the three trusts (57%; n=82) stated they had been given protected time to attend/ achieve CPD needs. 43% (n=50) of midwife respondents had not been granted protected time. The responses from midwives within each of the Trusts are shown in figure 14.

**Figure 14: Midwives get protected time for CPD**



The following comments reflect the statements made by these midwives,

I think it's a joint thing, because when I did my degree they gave me time off to do week sessions that I needed to do ... but other than that I didn't get time during the week and I funded it myself and I was quite happy to do that because it wasn't something run of the mill either. But I think you've got to be careful because courses are so expensive that at the end of the day there is only so much money in the pot so should we be funding midwives to go on one day course of several hundred pounds when all that money that could go towards another body on the floor and I still think it comes back to using sensible professional person and not expecting to be spoon fed every single thing, given time off, travelling, course fees. I don't think that's right (T3MW1).

I work full time and could still only get partial study time as protected time (T1MW14).

Some midwives respondents had not been granted protected time commented on adjusting their working hours to accommodate CPD activities reflected in the following statements,

Well, I actually reduced my clinical working hours so that I could have access to the course I wanted, because it was the only way I could do it, but I suppose that I was thinking about the long term, OK I was missing out on one day a week money but then I had to think of the long term that if didn't make this sacrifice I was going to be stuck ... and limited in my professional development' (T1MW2)

Well you end up doing it on your own day if like me, I work (full time) a four day week, long days, so if there was something that I wanted to do that was not approved, last time I wanted to do a 2 day study day - course, and it was tricky because I had to find funding from somewhere for the 2 days and it was very expensive and I did, fortunately the Trust let me go in their well, one day was in the Trust time and one was my day off, so it is limited as to what you can do but then I think it's going to be isn't it in this climate, but to take up a day off for something that you are going to put back into the Trust, but (pause) that was the only way I could do it and find funding from somewhere else' (T1MW1).

Four respondents stated that they undertook study days in their own time and one of these midwives added that,

allowance is made for me when requesting off-duty for me to be able to attend (T1MW40).

The majority (97%; n=32) of Supervisors of Midwives agreed that protected time should be granted to midwives to achieve their CPD requirements. Only 3% (n=1) supervisor disagreed with this. The comments made by Supervisors related to meeting Trust requirements as the following statement reflects,

I think they should (*get protected time*) but I think it should be pro rata. I think that the other difficulty is, I do think that the emphasis is on meeting the Trust requirements because there is so much pressure from the Trust (T1SOM4).

The LSAMOs (80% n=4) also agreed that midwives should get protected time although one respondent further stated,

good idea to get some protected time but not all professionals do so, why should midwives be different? (LSAMO3).

The Supervisors in Trust 1 and 2 were sympathetic towards the issue of providing protected time for midwives to meet CPD needs commenting,

too much is expected of midwives in their own time (T1SoM7).

Working full time and having a family leaves little time for study (T2SoM9)

The Supervisors in Trust 3 however commented that time should be protected in order to meet basic CPD needs and PREP. These Supervisors commented that other than meeting these basic needs midwives should utilise their own time to further their development and considered this to be fair for all staff members. This view conflicted with the issue of equity as Supervisors on the issue of funding did not feel there was any transparency or equity in how resources such as time and money were made available to midwives. Clarity regarding what amount of time midwives get for CPD was questioned by Supervisors as both attendance and then meeting course requirements needed to be considered,

Protected time again can be divided into two shoes though can't it around "Is this protected time to attend study days, or is this protected time to undertake the work that you need to around that, the preparation for assignments and the assignments and that needs to be looked at as well as to how many hours people work, what can they fit in over and above their normal working job. Is it that we will give you a day a week or just get the days they attend the study days and the rest is up to you? (T3SOM3).

This supervisor continued and stated,

I think there is still an issue around funding. Are we talking about paying for the place or are we talking about time to attend a formal study session and the time to attend sometimes gets forgotten or overlooked by supervisees. A conversation earlier about what is a free place, and yes, you know that might be free in cost but is not free in provision of time for people to attend (T3SOM3)

These comments were agreed by all the Supervisors present at the focus group.

Although 97% (n=32) Supervisors and 80% (n=4) LSAMOs stated midwives should get protected time further comments were made regarding the amount of time that should be available especially midwives working arrangements were taken into account. There was general agreement that time should be available pro rata to meet midwives needs.

The needs of the service were of concern to Supervisors and comments on the need to cover the service required consideration when agreeing protected time for midwives to attend CPD activities. Supervisors at Trust 2 stated,

due to ever increasing activity and current funded establishments it is a constant struggle to ensure time for CPD is protected (T2SoM4).

*(protected time)* would be ideal but staffing is such that it is not always possible (T2SoM5).

A supervisor from Trust 1 commented,

There have recently been problems with midwives having time to attend mandatory training. This will impact on service i.e. safety if it continues (T1Som1).

Some of the midwives in Trust One also reported their difficulties in accessing study days,

It is not always easy to attend study days, modules due to workload and shortages of staff (T1MW48\*).

I am finding it increasingly difficult to get funded study days. I have brought up the issue of child protection study day with my Supervisor of Midwives and manager for the last three years to no avail, despite not having had an update since 2000. This is particularly warring for me as child protection is an integral part of my role as a community midwife (T2MW25).

Although a few midwives did suggest that there were difficulties in accessing study days/ conferences the overall impression from the data reveals that the majority of midwives do attend these activities as a means to keeping up-to-date. The exact nature of attendance in relation to attending in own time or at personal expense was not able to be clarified and further research would be necessary as midwives reported both being given time and attending in their own time.



An interesting finding from the data was related to specialist practitioners. These midwives, employed in specialist roles, found the situation very different from an 'average' midwife and commented,

I'm very lucky in that my direct manager is (named) and she just lets me do what I want to do so if there is training from (named), I do not have to run it past her and she just lets me do it (T3MW1).

I have a little bit more flexibility in my specialist role now, but previously if there was a gap in my portfolio of something I felt that I needed to address, and I had actively sought to address that, but then the manager of the area was not able to facilitate that, and the following year I would come back and explain that, then what happens? The onus is still on the individual supervisee to just keep trying, and I have found that particularly difficult at the time (T1MW2)

These specialist midwives in each Trust were able to achieve protected time to achieve their CPD needs but this tended to reflect events that were needed to develop knowledge and for these to be implemented into the service. Specialist midwives also stated they provided input to mandatory days for midwives and in some cases this was done in their own time. Therefore the specialist midwives did not really consider access to be an issue as their position in the organisation allowed this to happen with managers readily enabling access. Although one comment was received from a specialist midwife in Trust 1 stating that some CPD was undertaken in her own time.

The midwives in Trust 2 and 3 commented that accessing study days was a very individual issue and not influenced by their Supervisors of Midwives,

I've been on study days, but that was nothing to do with my supervisor (T2MW2)

I've mainly accessed it (study days) off my own back, I've not really gone via supervision (T3MW3).

This was a similar situation in Trust 3 as Supervisors commented on the off duty allocation in terms of trying to accommodate those doing courses in their own time. One supervisor stated that midwives would be assisted in attending modules even if the need was not required by the Trust. This supervisor stated,

if they want to go in their own time, we'll try and facilitate it if (the off-duty rota) will allow' she further stated 'they are clear that we will give them flexibility within their work to try to help them achieve but because there is not a need that is necessary in an individual module, they are not going to get the time necessarily, they understand that, but it is still, we are supporting them to a degree aren't we (T3SoM7).

However, there are limitations in what midwives are prepared to undertake as many were frequently giving up personal time to attend CPD activities.

A common comment from midwives was,

*I wasn't able to be released from the area to actually go and because I was already doing so much in my own time, I didn't want to come in again in my own time' (T1mw2)*

Midwives commented on protected time depends on the budget holder and that time was less easily obtained than in previous years. In addition, work based packages and on-line packages had to be completed at home as there was no time allowed in the working day for these to be achieved.

Two midwives in Trust 1 stated that they also attend meetings, local

presentations, research days and some training in their own time. One other midwife further stated that she even attended her annual supervisory meeting in her own time.

The following comment sums up the midwives views from all of the Trusts that,

*'I think really that the way at the moment the way that CPD is provided for us, it tends to be the very self aware and proactive midwives will seek out courses...and really the way that it's currently organised provides a basic level that we would be looking at for CPD and the rest is your own time' (T1MW3).*

The majority, 99% (n=142), of midwife respondents stated that they were required to attend Trust mandatory events and this was generally in work time. At Trust 1 comments from midwives related to the difficulties in attending mandatory study days at the Trust due to staffing issues. At Trust 2 and Trust 3 midwives commented that they were required to attend two Trust mandatory days which included Trust mandatory issues (Health and safety) and the second day for midwifery emergencies/ issues. Midwives also commented on the superficial coverage of subjects on these days.

The midwives were also asked if their Supervisors were more likely to support attendance at Trust mandatory events to meet service needs rather than supporting meeting their individual CPD needs. There was a similar response across each trust, with 45% (n=65) of midwife

respondents stating Yes to this question, whereas 35% (n=50) did not agree. 20% (n=28) of midwives stated that they did not know.

The midwives in the focus group at Trust 1 considered that Supervisors of Midwives prioritised the Trust mandatory training as opposed to pursuing other activities. The following comment reflects the view stated by midwives,

'The mandatory training days and the professional days, obstetric emergency days, are all protected. And like we've said, they (the midwives) would have asked to go on so many other things, and it seems a bit odd that time is to be found to go on these, the domestic abuse, everybody had to go on and it's a full day, and there's conflict resolution, and there's this and there's that, child protection and you can go on those in work time but if there is something that particularly interests you and you are going to put it back to the Trust, it doesn't seem to be as well supported, shall we say'(T1MW2).

The midwives concurred that mandatory Trust requirements take a priority and that it has to be done, but when it came to continuing professional development there was a perception that this was seen as less of a priority by managers and Supervisors. They felt that the Supervisors put an emphasis on meeting the mandatory sessions as opposed to continuing professional development as the midwives highlighted,

I mean, they do talk to you about continuing professional development but I think that the focus is towards meeting the mandatory things for the Trust before meeting your own development needs (T1MW3).

Mine's (supervisor) always been very much "Have you got your CPR up to date, have you got this up to date, have you got that up to date." It is very much going back to tick the box on the list of what you've got to do (T2MW3).

The attendance at mandatory study days was perceived by midwives in all Trusts to be a priority area,

Mandatory sessions are protected in time (T1MW36).

This statement was endorsed by other midwives who further stated that protected time was only available if the service was covered. This view was also supported by the Supervisors who commented on the service needs being met before staff could be released. Both the midwives and Supervisors commented within the focus groups on covering the service and highlighted that midwives would be taken off the mandatory days depending on the staffing needs. Therefore even though the mandatory days are seen as a priority, attendance was still was not guaranteed as service needs would take priority

Just over half (58%; n=19) of Supervisors responded that they were not more likely to support Trust mandatory events as opposed to CPD needs of midwives. Many were of the opinion that,

Trusts mandatory days do fulfil what many midwives need and ask for e.g. obstetric emergencies (T1SoM10).

However, 42% (n=14) of Supervisors responded Yes to this question indicating that they were more likely to support Trust mandatory events.

The comments reflect this stance,

Only because it is easier to do this and anything in between is always made to do as 2<sup>nd</sup> place (T2SoM13).

Yes, Yes I think it is definitely (*prioritised*). It is what they (*the midwives*) are required for their Trust activities so the Trust has identified that as the priority and then that is what they are going to offer (T2SOM4).

The Supervisors also found it difficult to facilitate the different demands made on midwives as the following statement demonstrates,

(it is ) quite challenging because there are the compulsory (mandatory) days and then if they are on Grade Band 5 they have got to then progress to Grade Band 6 and that also tends to direct where they have got to spend all their time and energies – IV's, cannulation, administration of medicines, perineal repair, I have got some girls that have been qualified several years, and they are still chasing up all of those up (Midwives agree) so that takes up all their time plus the compulsory (mandatory) days (T1SOM1).

Compounding this progression was the way midwives were required to move around the different clinical areas within the unit,

The rotation doesn't help them as well, they are just about to be signed off their suturing and they find themselves back on the ward (named), inconveniently, and they don't complete (T1SOM4).

Supervisors also tended to comment that midwives needed to maintain competency and confidence to practice as a midwife. Some Supervisors were critical of midwives in the fact that they did not pursue any other CPD activity other than what the Trust provided or required for grade progression as the following comments demonstrate,

most of my supervisees attend mandatory study days and child protection and nothing else. I feel after 2 – 3 years these midwives are not learning anything new, just updating and their knowledge is static. Many midwives will not use their own time or money to further their knowledge (T1SoM4).

Services are just going up and up and up, what they get, like mandatory, its way, way over, you never really have to worry about a supervisee failing to meet PREP requirements that are employed here (T3SOM5)

There isn't much impetus for them to go beyond what they are doing for their compulsory day's is there, let's be honest, there's no pressure. So long as they fulfil their PREP requirements, the pressures off really (T1SOM1)

At one focus group the Supervisors commented that the mandatory study days in her Trust were very management orientated and that Supervisors could not influence the content of that day. Other Supervisors at this focus group added that consideration of where the maternity service was developing and service needs required planning in order to determine how midwives need to be developed made the days management led. However, this was not agreed by all of the Supervisors present and further comments were made regarding mandatory study and CPD in that they ran side by side because some of the content was mandatory and some for CPD. Therefore some Supervisors perceived the mandatory days as meeting in part midwives CPD needs.

Two LSAMO respondents agreed that they thought Supervisors of Midwives are more likely to support midwives to attend mandatory events to meet Trust requirements rather than the individual CPD needs of midwives. Two respondents stated in the comments section of this question both Yes and No (LSAMO3, LSAMO4) and therefore did not complete the response boxes but stated that they thought Supervisors did both. Where managers are also Supervisors of Midwives one LSAMO respondent believed this may be more likely. LSAMOs also responded,

If Supervisors of Midwives really understand the difference between fitness to practice versus purpose the answer should be NO (*not more likely to support mandatory events*) (LSAMO4)

Mandatory training is important for employment but CPD relates to registration (LSAMO1).

(Supervisors) can encourage the midwife to utilise mandatory training for **some** of their CPD (LSAMO3).

67% (n=21) of LME respondents stated that they considered that Supervisors were more likely to send midwives to activities that meet service developments rather than individual midwife CPD needs although they felt that service needs and individuals needs were interlinked. Further comments from LMEs related to their experiences with Supervisors in that many came with a strong service /management bias although this they felt was to some extent changing. Other views expressed related to the Supervisors position in the Trust stating that senior midwife posts would have more influence over budgets and spending and as a manager they would have to balance the tensions in this area. One LME made the following comment which reflects the views expressed by other LMEs,

many Supervisors of Midwives who also tend to be senior people in their organisations become very focused on balancing budgets and on managing their service. They tend to perhaps see CPD as a secondary aspect of their job and delegate it to someone else. It becomes an issue of concern to them only when an individual midwife is found to be deficient in professional practice and problems arise. I think CPD and how it can be improve care for mothers and babies should be given more prominence (LME16)

There was no consensus of opinion of Supervisors of Midwives at Trust 2 as to whether protected time was granted for midwives to pursue CPD activities. Some of the Supervisors in this Trust stated at the first focus group that midwives did not get any protected time whereas the second



focus group gave a different impression. The protected time issue was further defined by one supervisor who considered that protected time can be divided into two themes questioning whether the protected time was for attendance or to complete the assessment. This supervisor stated that both,

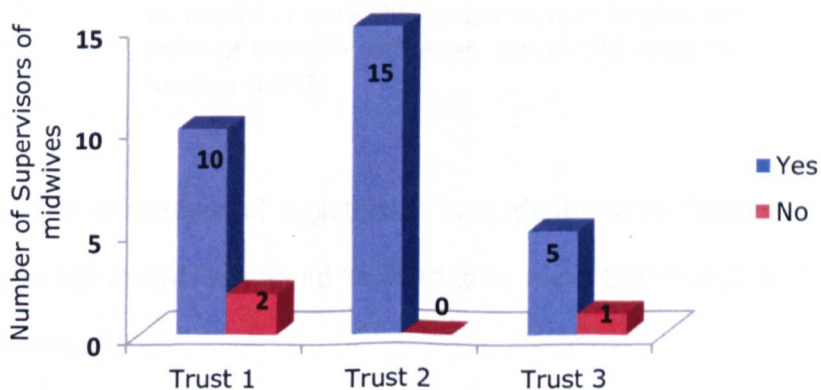
needed to be looked at as well as the hours people worked and what they can fit in over and above their normal job. Is it that we will give a day a week or just give the days to attend the study days and the rest is up to you (T3SoM4).

In all Trusts Supervisors were in consensus with midwives being given protected time to attend the mentor preparation module and in Trust 3 the examination of the newborn module.

#### 4.5.9 Funding CPD

Overall, 91% (n=30) Supervisors considered that CPD activities for midwives should be funded and only 9% (n=3) of Supervisors did not feel funding should be available. Figure 15 displays the responses

**Figure 15: Midwives CPD should be Funded**



The Supervisors generally commented,

(midwives) should be funded to do mandatory training to fulfil PREP requirements. Other study should be negotiated i.e. study time and/ or funding depending on the needs of service (T1SoM1).

In Trust 2 the Supervisors were mainly of the opinion that in an ideal world funding should be available but then agreed with the following comments,

In a realistic world I think it would be better value if we had adequate funding for midwives on the shop floor and good midwife numbers then we could release midwives more to do things (T2SoM1).

Only 9% (n=3) of Supervisors and 25% (n=1) of LSA officers did not feel funding should be available and commented that CPD,

should be discussed on an individual basis e.g. may be required to access CPD due to practice issues (T1SoM3).

takes a variety of formats, I do not think it should be funded. If the Trust requests specific CPD needs then this should be funded in time and cost (T1SoM9).

Although ticking the box that midwives should not be funded, I think they could be part funded for some of the CPD. However, not all CPD requires funding (LSA3)

The issue of renewal of registration was identified by Supervisors at Trust 3, who felt midwives should be funded to meet CPD needs and commented,

Yes, but not as a given, if you are talking about the difference between what is required for registration and what is required for service. If it's so that they can register as a midwife then it's their issue, but if it's for service, then it should be funded (T3SOM2).

Another supervisor disagreed on this point and stated,

But then, maintaining registration shouldn't be about money should it? Maintaining registration can be done in lots of different ways actually (T3SOM4).

LSA officers commented that ideally midwives should be funded but if funding was not available then the midwife has responsibility to ensure she is fit to practice but should be overseen by the Supervisor of Midwives.

Further comments were generated and Supervisors agreed service needs should be funded and so should improvements in quality that meet service needs. All Supervisors in all of the Trusts supported the need for funding for mentor preparation modules as a priority area for Trusts.

75% (n=3) LSAMOs agreed midwives should be funded to achieve CPD. The comments made by the LSAMOs reflected that it was mainly the midwife's responsibility to ensure she is fit to practice overseen by the Supervisor of Midwives but in addition the employer has a responsibility so there should be a joint arrangement for funding. Although it was felt that this would be an issue for self employed midwives.

A view supported by both Supervisors and LSAMOs was that they considered meeting CPD needs was a joint responsibility between the employer and the midwife.

The LSAMOs also referred to the limitations for Supervisors in relation to the financial considerations of CPD as the following comment demonstrates,

Supervisors do not have financial responsibilities and therefore can only recommend rather than ensure a midwife's CPD needs are considered (LSAM05).

The literature suggests that individuals perceived a lack of financial support available for CPD (Dowswell et al 1998), leading to a high proportion of staff self funding their CPD (Alejandro 2001, Audit Commission 2001). Historically funding has been a barrier to CPD (Davey and Robinson 2002, Furze and Pearcey 1999) and to some extent this barrier for some practitioners still exists. The overall impression from the data from this study is that the majority of midwives have received funding for CPD but also there were many who had self funded courses.

Just over half (53%; n=76) of midwife respondents stated that they had received funding to achieve their CPD needs. 47% (n= 68) of midwife respondents had not received any funding.

Respondents were also asked to state how funding had been obtained.

Table 9 indicates the sources of funding:

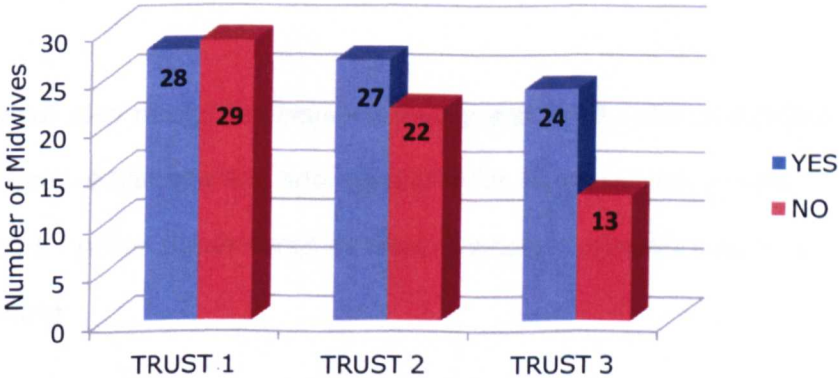
<b>Table 9: Sources of Funding for CPD.</b>		
<b>Sources of Funding for CPD.</b>	<b>Number of Respondents</b>	<b>Percentage of Respondents</b>
Trust funded	19	25%
Deanery funded	6	8%
Employer/ University	4	6%
Self funding	2	3%
Medical equipment company	2	3%
Personal Training allowance	1	0.7%
Scholarship	1	0.7%
Trust Fund for specialist training	1	0.7%
Pegasus	1	0.7%
National screening Committee	1	0.7%
Sure start funds	1	0.7%
RCM	1	0.7%

The majority of funding obtained by the midwives was cited as being received from the Trust 25% (n=19) and a further 8% (n=6) stated as being obtained via funding from the East Midlands Heath Care Workforce Deanery. Midwives were not asked about the contracting process in the questionnaire and therefore it cannot be clarified in relation to midwives understanding of how their CPD may be funded.

Self funding was reported by 55% (n=79) of midwife respondents who stated that they had self funded all of their CPD needs. Midwives who had self funded had accessed a range of courses including Degree and Masters Programmes, NALS and ALSO courses. A number of midwives from each Trust believed that all CPD was self funding and undertaken in their own time but gave no examples of what they had self funded. Clearly courses such as the NALS and ALSO are requirements of a quality service recognising the complexity of users of the service and as such should be funded by the Trusts. It is therefore not clear why these midwives would self fund these courses unless they had opted to obtain time instead of funding in order to attend. In addition, many midwives at each Trust stated either on the questionnaire or at the focus group that they had also paid for travel costs and in some cases accommodation to attend relevant study days.

The responses from midwives in each Trust are shown in figure 16.

**Figure 16: Midwives have self funded CPD activities**



The funding situation, since contracting through the Strategic Health Authority (SHA) was implemented, has meant that fewer professionals

should need to self fund post-registration education (DH 2002). In this study 53% (n=76) of the midwife respondents stated that they had received funding to achieve their CPD needs. Whereas, 47% (n= 68) of midwife respondents had been declined funding.

A typical comment from midwives who worked either full time or part time and had received funding was as follows,

I've not had protected time for the course that I'm on. It has been in my own time ... but the funding has been available so I don't think in a way that's a compromise, you can't have funding probably and protected time because of the cost issue (T3mw3).

It may be argued that there is a lack of transparency regarding funding arrangements at Trusts as some midwives commented that all CPD was self funded whereas others clearly obtained support to attend. This was highlighted by one midwife, who stated,

I am self funding a part time degree as the Trust would not support for me although they had for several others – there is inequity due to funding (T2mw28\*).

A supervisor also raised the issue of equity and believed that funding should be more transparent and equitable for all midwives, a view supported by other Supervisors in Trust 3 whose comments were similar to the following,

I'm for fairness and equity for everybody to have some degree of continuous professional development. At the moment, it's those that are highly motivated, keen to get on in the profession who are shouting out the loudest. I'll have a place, I'll have a place, and the others who are perhaps are not that way inclined or getting anything, but there is this thought throughout the unit that there is a free place, I might as well have it because its free but actually it's not because that money has been taken away and channelled into these modules, but it means that for everybody, everybody is not getting the opportunity to have their fair share, a fair slice of that money (T3SOM1).

The transparency of the process was further questioned by one supervisor stating that midwives argue between themselves regarding the fairness of the system whereas other Supervisors were of the opinion that,

they (the midwives) don't know what people are having and that's been their own contribution towards that and it's like (named person) stated sometimes a lot of courses take loads of additional placement funds and things like that and others don't so it's really individual (T3SoM3).

However, Supervisors overall agreed that equity was a real challenge and needed to be addressed.

A final comment regarding the lack of communication between Supervisors and managers was highlighted by one supervisor who had experienced frustration in not being able to influence attendance due to a lack of funding resulting in a comment supported by other Supervisors,

It all comes down to communication as well then, because it can't be done in isolation to the needs of the service and the managerial side of things as well, because obviously it's all right you sitting there as a supervisor saying "go away and do x, y and Z" because if there's no money in the pot, if the service doesn't need it you are stumped really. Because they will go to their manager and say "my Supervisors says...." but that's as far as it goes (T1SOM3)



It is not yet clear from the literature whether access to funding has increased practitioners' motivations to access formal CPD but the implication is that more should be able to access studies. However, the situation for funding is made more complex by the need for managers to agree access to funding even though there is no provision to 'back fill' staff which makes being released from work to attend courses more difficult especially if there is a shortage of staff (Gopee 2003, Audit Commission 2001).

## **4.6 Learning activities that take place**

The NMC approach to CPD requirements through the PREP system may be considered to be a formalised system of learning which is characterised by the emphasis of planning, recording and reflecting with the individual practitioner being the best judge of their learning needs (Friedman and Phillips 2001).

According to the literature reviewed CPD encompasses all formal and informal learning within healthcare practice, including for example, in-house training, professional discussions, reflection, mandatory training, supervision and accessing the literature. The provision of advice on CPD needs to be considered in relation to the methods that are acceptable for achieving PREP and in maintaining individual competency. Therefore both formal and informal methods of learning need to be equally valued.

Completion of formal education such as degrees and undertaking skills based study days or courses are sensible educational commitments for practitioners in line with current trends in the education of pre-registration health care students. In addition mandatory training supports practitioners to maintain their level of knowledge and skills but does not necessarily enable further development. However when pressured by individual or personal commitments, limitations of resources and increasing work pressures a commitment to formal CPD becomes less attractive. Therefore the option to undertake less formal educational activities such as reading and reflection on practice may be seen to be both more flexible and achievable options.

In this study the educational activities, to meet CPD requirements, undertaken by the midwives were attending Trust mandatory sessions (94% n=136), discussion with colleagues (92% n=133) and reading journals (90% n=129). Although the midwives reported on the barriers to attending formal education activities a high proportion (83% n=119) did also report to having attended professional study days or conferences.

The Supervisors of Midwives promoted equally (100% n=33) the attending of professional study days/ conferences, courses and/or modules and Trust mandatory sessions. This would appear to place these formal activities as being of as much value as attending mandatory study days, an informal method of achieving CPD.

It is interesting to note the findings from each of the participant groups (see Table 10) as the data collected would give the impression that midwife practitioners value the formal education provision, even though barriers exist that may prevent access to these activities, yet the majority undertake informal methods to achieve their CPD needs. As an educationalist the support for CPD in terms of formal attendance and completion of study days, modules and courses would be the preferred option as knowledge needs to underpin practice and this is comparable to the views of participants but, given the barriers to attendance and the current economic climate a realistic re-evaluation of these strategies is needed.

<b>ACTIVITY</b>	<b>Number of Midwife respondents</b>	<b>Percentage</b>	<b>Number of Supervisor of Midwife respondents</b>	<b>Percentage</b>
Attending professional study days/ conferences	119	83%	33	100%
Attending courses/ modules	84	58%	33	100%

#### **4.6.1 Formal educational activities**

The activities identified by Supervisors of Midwives which can be seen to be viewed as of equal importance and which they encouraged were for midwives to attend professional study days/ conferences 100% (n=33) and attending courses/ modules 100% (n=33). However this view did not correlate with the views of the midwives themselves who considered these activities as less popular although 83% (119) cited attending professional study days and 58% (n=84) cited attendance at courses/ modules. These findings are more favourable than those of a study by Sturrock and Lennie (2009) who found that only 41% of clinicians reported attending courses as a regular CPD activity.

The literature also suggests that over the past three decades midwives have had difficulties in attending courses/ modules influenced by a multitude of factors for example; lack of availability of courses (McLean 1980), shortages of staff (Sugerman 1988), unsupportive managers (Allen 2000), course fees (Johnson and Copnall 2002), domestic responsibilities

(Gopee 2003). However, it is recognised that even with these difficulties identified some midwives will still attend formal courses/ modules and their experiences of doing so are presented.

#### **4.6.2 Informal educational Activities**

The data revealed that midwives use and are encouraged by Supervisors of Midwives to use a variety of other informal educational strategies to meet their CPD needs, which interestingly still supports previous research, particularly that of Larcombe and Maggs (1991). Also in a study undertaken by Mitchell (1997) the main strategies used to achieve CPD by midwives were discussion with colleagues and accessing study days and it would appear from the data collected in this study that these strategies are still popular with midwives today.

The other learning activities being undertaken by the midwives in this study are demonstrated in table 11, alongside the activities advised by Supervisors of Midwives.

<b>Table 11: Informal CPD activities undertaken by the midwives.</b>		
<b>Learning Activity</b>	<b>Activities Advised by Supervisors of Midwives</b>	<b>Activities Identified and undertaken by Midwives.</b>
Attending mandatory days	100% (n=33)	94% (n=136)
Using guidelines/ guideline development	30% (n=10)	
Audit	9% (n=3)	
Shadowing colleagues/ working with other midwives/ visiting other areas	27% (n=9)	2% (n=3)
E-Learning (includes internet/literature searches, CD ROMs and computer packages, RCM and NMC websites, open university, distance learning	15% (n=5)	12% (n=17)
Discussion with colleagues	79% (n=26)	92% (n=133)
Discussions with Supervisors of Midwives (includes case study and incident discussions), discussions at team meetings	6% (n=2)	1% (n=2)
Reading articles/ text books		3% (n=5)
Mentoring students / teaching others		3% (n=5)
Reflection	3% (n=1)	3% (n=5)

To keep pace with the dynamic changes and the complexities of practice practitioners are required to take responsibility for their own learning. The data from this study demonstrates that informal learning takes place either within the workplace or organisation for example, mandatory days or through activities involving just the individual practitioner such as reading and literature searches. Midwife practitioners described utilising informal methods to share learning experiences for example, during regular interaction with peers at team meetings, visiting other areas and at annual supervision meetings.

Some of the informal activities cited by Supervisors in this study promote active participation by the midwife and will now be discussed.

#### **4.6.3 Mandatory Trust study days/training**

Midwives identified attendance at Trust mandatory sessions as being the main activity undertaken to meet CPD needs with 94% (n=136) undertaking this activity. This correlates with the findings from the Supervisors of Midwives as being one of the main activities they would encourage midwives to attend 100% (n=33). This would appear to be the most frequently undertaken activity by all midwives in this study.

Mandatory study days were provided at all Trusts within this study. The number of days varied between Trusts but each held at least one day for midwives with some Trusts having two or more mandatory days in total. The midwives commented that they felt very lucky to have the days although some commented on the large number of topics that were included which made the depth of each very superficial. This reaffirms the view of Gopee (2003) who highlighted in his study that practitioners perceive mandatory CPD as ineffective and that only pays lip service to their actual development needs.

When midwives were asked if they viewed Trust mandatory days to be different to meeting CPD requirements the majority of midwives agreed with the following statements,

I think it's all linked to the one umbrella really;  
the mandatory ones are non-negotiable and

some people will just do the bare minimum to keep themselves updated and like you said, not go off and do other things (T3MW3).

The views of midwives reflect the fact that mandatory training is compulsory and all midwives were required to attend and therefore non-compliance is rare although in the questionnaire 1% (n=2) midwives did state they were not required to attend mandatory training. In providing mandatory training, Trusts run the risk of providing practitioners who are most in need of updating their knowledge and skills with the minimum requirements to participate in CPD. Friedman and Phillips (2001) also argue that compulsory schemes for CPD encourage little motivation on behalf of the practitioner and indeed may lead to resentment at being compelled to take part.

A supervisor provided a distinction between mandatory provision and CPD stating,

The Trust mandatory training is very blanket topics they are not specific, they are not job specific, one of them are our sort of midwifery sort of mandatory training that we have but if you are looking at the Trust days in isolation, then sort of, there is a hospital wide day they are not particularly specific to midwifery practice, obviously our midwifery days are. But I think the CPD is about that individuals' needs as opposed to midwife (a) might have this, midwife (b) might have that, but looking at their particular needs rather than just a general overview (T2SoM 2).

From the questionnaires 94% (n=136) of midwives stated the main activity they undertook to achieve CPD requirements was attending Trust



mandatory days/ sessions which correlated with the findings from the Supervisors (100% n=33).

The distinction between mandatory CPD, intended to retain core skills and developmental CPD required for career development and the ability to undertake extended roles is not made apparent in the literature. Bahn (2007 p715) regards mandatory or in-house teaching to be 'a self-protection measure by the employer, not related to personal development and with no perceived benefit on client care'. This view was found to be supported by both the midwives and the Supervisors of Midwives within this study.

Mandatory training in the NHS may be defined as the training requirements specified by each NHS Trust and agreed at Trust Board level or by the Trust Education and Workforce Development Group or equivalent who usually report to the Trust Board. The provision of mandatory training is essentially to ensure that services delivered to patients are safe, effective and of a high quality. The CQC (2011) survey report highlights that the majority of NHS staff, 95%, undertook employer supported training (mandatory) on at least one occasion during the last 12 months.

Trusts have an obligation to ensure their employees work within the health and safety guidelines for their own safety as well as that of patients. According to Cervero (1988) mandatory schemes for CPD have been developed for the less active practitioner as a means to ensure they undertake some CPD. This move is considered to be a response from the

professions to the increased sense of accountability demanded by the public today. However, an extensive report undertaken by the Audit Commission (2001) reported that some Trusts were not meeting their responsibilities in providing mandatory training to minimise risks to patients and staff. However, in the latest CQC survey report (2011) it suggests that health and safety training and infection control training are the commonest areas of training for staff. Mandatory training takes place usually annually to ensure knowledge and skills are up-to-date and information on new equipment or systems is included. Records of attendance at mandatory sessions are required and held by the Trust.

The midwives were asked through the questionnaire and in the focus groups if they were required to attend local mandatory sessions. The findings demonstrated that 94% (n=136) of midwives attended mandatory study days at their employing NHS Trust. A common view held by midwives may be demonstrated by the following comment,

I feel that the Trust is more interested in education to reduce risk than in an individual's aspirations or in any collective attempt to achieve specific clinical outcomes within the Trust.  
(T1MW1).

It may also be considered that in providing mandatory training within the organisation reduces cost in terms of funding support for external CPD activities. Supervisors of Midwives also felt that this was a real issue and although the topics were reviewed each year the content was driven by management because of CNST and is highlighted by the following comment,

That's why it's mandatory, isn't it? It's whether its fire and flood which is mandatory from a health and safety perspective or whether it's mandatory because you want them to know it (T3SOM4).

Within the NHS Litigation Authorities Clinical Negligence Scheme for Trusts (NHSLA CNST) Maternity Clinical Risk Management Standards there are key subject areas which incorporate aspects of training. Each maternity service must therefore ensure the following areas are included in risk management training, see table 12.

**Table12: Summary of NHSLA CNST Standards**

Standard 1 – Skills and drills: cord prolapse, shoulder dystocia, vaginal breech, antepartum and postpartum haemorrhage and eclampsia.

Standard 2 – Continuous electronic fetal monitoring, Care of women following operative interventions, early recognition of severely ill women, maternal resuscitation.

Standard 3 – assessment and management of all types of perineal trauma, shoulder dystocia, postpartum haemorrhage.

Standard 4 – maternal antenatal screening tests (including fetal anomaly, infectious diseases, sickle cell and thalassaemia), mental health training.

Standard 4 – full physical examination of the newborn, breast and artificial feeding, neonatal resuscitation.

Source: [www.nhsla.com/publications](http://www.nhsla.com/publications)

Supervisors of Midwives also felt that the word 'mandatory' needed changing to 'compulsory' to make the meaning clearer to midwives,

I think that they understand the difference but I think it's the Trust mandatory or are they going to be called compulsory days, that's the one that leads the way because (named supervisor) was saying about most of her supervisees attend the compulsory days and therefore don't devote any time to any further studies and how do you motivate them to do that? (T1SOM1).

It may be argued that skills based short courses tend not to be offered by Universities but by the Trusts themselves to meet service changes or needs with the emphasis being on skill acquisition. This raises the contentious issue of questioning the need for training versus that of academic education for health professionals (Watson 2002). This is important particularly as the knowledge and skills with which a professional begins their career has a short 'shelf-life' (Sturrock and Lennie 2009) and the estimated useful lifespan of education prior to qualification is 4 years. Therefore, mandatory CPD frameworks aim to enable professionals to retain their capacity to practise safely and meet the increasing demands for quality, competency and accountability from employers, the public, regulatory bodies and the government but do not enable further professional development but merely maintain the existing level of knowledge and skills. Peck, McCall, McLaren and Rotem (2000) suggest that most CPD systems are of a 3 to 5 year cycle with a set requirement per cycle and this fits with the NMC Prep requirements (NMC 2010a) for registered practitioners.

The midwives were also asked in the questionnaire to provide details of the subjects covered on mandatory days at their Trust. Table 13, provides a list of subjects cited by the midwives in the questionnaire. This list does present similarities with the standards to meet CNST requirements and therefore it is understandable that both midwives and Supervisors of Midwives felt that mandatory Trust study days were management led as a result of meeting CNST requirements.

**Table 13: Subjects included within mandatory training at each NHS Trust.**

Subject Area	NHS Trust 1 responses	NHS Trust 2 responses	NHS Trust3 responses
Maternity emergencies	✓	✓	✓
Child protection	✓	✓	✓
Resuscitation(Adult and neonatal)	✓	✓	✓
Infection Control	✓	✓	✓
CTG interpretation	✓	✓	✓
Fire safety/ drills/lectures	✓	✓	✓
Breastfeeding	✓	✓	✓
Drugs and alcohol/ substance misuse	✓	✓	✓
Clinical governance/ risk management/ accountability	✓	✓	✓
CEMACH			✓
Drug administration			✓
Customer care		✓	✓
Baby friendly	✓		
Mentorship update		✓	✓
Active birth			✓
Moving and handling		✓	✓
Communication issues			✓
Screening		✓	✓
Equipment training			✓
Suturing			✓
Blood transfusions		✓	
High risk pregnancy		✓	
Supervision of midwives	✓	✓	
Domestic violence	✓	✓	
Trust procedures update/ policies	✓	✓	
Sharps awareness		✓	
SANDS		✓	
Alternative therapies		✓	
Current Issues/ topical issues	✓	✓	✓
Health and safety issues	✓	✓	
Conflict resolution	✓		
ANTT	✓		
HIV training	✓		
Psychiatric disorders	✓		
Smoking cessation	✓		

The topics included in the mandatory days across the Trusts have some common themes and although these relate to CNST these should also relate to the themes reported by the NMC (NMC 2011, NMC 2010b) each year that have led to supervised practice programmes. These recurrent themes continue to be poor decision making, assessment of fetal condition, fetal heart interpretation in labour, record keeping, communication skills, drug errors, assessment of maternal condition and referral to more experienced personnel. It is important that learning from incidents takes place if these issues are to be adequately addressed and although the

LSA's report CPD initiatives are in place they need to be more effective if these themes are to be resolved. This affirms to the need for Supervisors to have more influence on the content of these mandatory training days if the practice of midwives is to be improved.

A number of midwives in this study did not consider the Trust mandatory days to be different to meeting CPD requirements through other educational activities as all could be counted for PREP purposes. However, Supervisors of Midwives views were different,

there is a slight difference isn't there I mean mandatory training is mandatory training which they have to do but if somebody wants, I mean one of the things I do is in supervisory meetings ask them where they want to be in five years, CPD would then come into that then wouldn't it, so if somebody says well actually I'm going to perhaps go into management and what I am thinking of doing is this, then you would say then well you are used to a discussion to get to that point and surely that is part of their CPD (T2SOM1).

The Trust mandatory training is very blanket topics they are not specific, they are not job specific, one of them are our sort of midwifery sort of mandatory training that we have but if you are looking at the Trust days in isolation, then sort of, there is a hospital wide day they are not particularly specific to midwifery practice, obviously our midwifery days are. But I think the CPD is about that individuals' needs as opposed to midwife (a) might have this, midwife (b) might have that, but looking at their particular needs rather than just a general overview (T2SoM 2).

Rather than enhancing learning and enabling further professional development the midwives generally considered that,

some parts of it, you are ticking boxes, because some of the stuff they are expected to do in the past, we've done, handling and stuff and that's just not relevant at all to my practice, but you have just got to sit there and go through it all. But the time could be better spent doing something else (T3MW1).

The requirement to attend mandatory training removes a practitioner's choice in deciding how to achieve their own educational needs and this conflict with the concept of adult learning which include self motivation and self direction. It may also be viewed as a direct invasion of the autonomy of the individual (French and Dowds 2008).

Supervisors tended to comment that midwives needed to maintain competency and confidence to practice as a midwife. One supervisor was critical of midwives and commented,

Some midwives however, do not look beyond Trust provision of mandatory study days, which does not meet individual needs only in part (T1SoM9).

Supervisors also commented that both mandatory training and CPD identified through individual review were equally important and the initial type of activity was important for safety whereas individual needs being met would provide true development of knowledge and skills.

Individualised CPD was felt to be challenging as newly qualified midwives particularly were required to undertake the mandatory days as well as achieve additional competencies through Trust education packages for example, intravenous cannulation, administration of medicines, perineal repair and epidural top-ups before they could progress through to the next salary scale. Compounding this progression was the way midwives were required to rotate around the different midwifery clinical areas within the

unit which many Supervisors considered did not assist in achieving the additional competencies required by the Trust.

The Supervisors at Trust 2 were pleased with the arrangements made within their Trust to enable midwives to attend mandatory days and stated that midwives did not get taken off these days to staff the unit whereas this was considered to be a regular event in other units. This concern is reiterated in the NMC (2010b) report with increased clinical activity being stated as the reason for cancellation of training in the Trusts.

#### **4.6.4 Clinical Guideline Development**

30% (n=10) Supervisors in this study considered that midwives should use and take part in guideline development although this activity was not mentioned by the midwives themselves as being an activity in which they were involved although it is expected that these guidelines are used in every day practice by midwives.

As the general public's knowledge of issues in relation to childbirth has increased and so too is the expectation that professionals should be knowledgeable and competent to deal with these issues. Guidelines therefore become of importance when legal claims or possible claims are examined following a clinical incident. The creation of guidelines should be a multi-disciplinary process with users of the service also involved to give a lay perspective. Based on current research, evidence and the needs of women and their families' guidelines provide a tool rather than a rule for practitioners in every day practice. As these guidelines only really have a



short shelf life they require regular review and updating. Therefore by enabling midwives to participate in guideline development creates ownership and an understanding of the rationale and evidence supporting these tools.

MacDonald (2002) suggests that practitioners will 'unlearn' traditional and trusted practice when presented with new evidence in the form of research or guidelines. The practitioner is described as critically reflecting on the old practices and engaging in the process of 'unlearning' to be able to take on the new evidence. The development of guidelines based on new evidence enables practitioners to debate the evidence and challenge current practices with peers enabling learning and changing practice.

The participation of midwives in guideline development and review would again be a low cost informal CPD activity that facilitates the development of knowledge and skills and enables reflection in an on practice. This area could be further facilitated by Supervisors by enabling midwives to shadow practitioners on these Trust forums. This would enable development of their role is protecting the public and enabling the professional development of midwives.

#### **4.6.5 Audit of clinical activities**

The midwives in this study did not include audit as a learning activity but 9% (n=3) of the Supervisors viewed this as a method of achieving CPD. According to Duerden (2003) and Reid (2007) midwives can contribute to

clinical governance by participating in clinical audit and therefore Symon and Wilson (2002) argue that this should be encouraged. Audit is a systematic process aiming to ensure that the standards of care are continually improving. Therefore it is argued that it is a valuable educational process for midwives in relation to identifying ineffective and inappropriate practices, where practice is not at an acceptable standard and encouraging change to improve clinical outcomes. This process assists midwives in becoming more aware of their own practice as well as the standard of practice of their peers and other colleagues. In practice most midwives have their own 'way of doing things' based on experiences, habits or working in other units and audit provides a method of reviewing these practices and offering different and better care.

The development of knowledge and skills in audit can be achieved by practitioners undertaking degree and higher degree programmes as part of their CPD. According to Symon and Wilson (2002) professional bodies are also requiring that all specialists training should include audit as a key component. The sharing of information through audit is seen as a means to ensure that lessons are learnt by practitioners and so should not exclusively be an activity for senior staff in health care but rather all staff if learning in and from practice is to develop.

This issue needs taking forward by Supervisors so that midwives can participate in this activity and that learning from audit is seen as an educational process for all practitioners. Again this is a relatively low cost informal educational activity which benefits the midwife, the employer and the women as users of the service.

#### 4.6.6 Shadowing other practitioners

In this study only 0.7% (n=1) respondent identified keeping up-to-date by this method of learning. Opportunities to shadow other midwives were mentioned in focus groups by midwives as a means to develop their knowledge either in clinical practices or in understanding other practitioner's roles.

In Trust 1, the Supervisors already encouraged such a scheme of shadowing with examples given on the questionnaire as: shadowing specialist midwives; infant feeding midwife; drug specialist midwife; visiting other units to see practice developments of triage and birthing centres. Although the Supervisors also agreed that there were limitations in what they could actually enable the midwives to attend in term of shadowing outside of the trust. Comments from these Supervisors at the focus group were:

*Yes, I've encouraged some of my supervisees to do it, certainly. Whether they have actually gone and done it I'm not always sure, and certainly when you are looking at developmental packages I know that some people have shadowed particular people as well, but I think that there is a raft of knowledge within our colleagues (Midwives agree) and we are often very insular in our practice, we don't look at what everybody else is doing, I think on the delivery suite you are in your room, you don't necessarily see like we did when we were training and qualified, there was probably two of you together and you saw somebody maybe squatting and supporting somebody in the third stage, things like that, I think that those learning opportunities are probably a little bit more reduced because of the tightness of the environment, same on (named ward) really, isn't it, there's not that (unfinished pause), and I think there is a big opportunity for staff to shadow, whether it's leadership,*

*shadowing with (named senior midwife), shadowing with (named specialist midwife), specialist in mental health, diabetes, there is so much out there isn't there?. I've sent a few people who have said how much they have learned from shadowing the specialists in particular but there is so much to learn other than from specialists I think (T1SOM2).*

One Supervisor of Midwives who worked in a specialist role commented about offering midwives the opportunity to shadow her in this role,

And I'm certainly finding, from a (role stated) perspective, by trying to do 3 hours minimum with every member of staff, it is facilitating that individual growth and I put supervision into it about record keeping and various things like that, and the accountability and responsibility, but I think that, I hope that it's making a difference, and certainly people say "Well, I didn't know that". They have learned from it (T1SOM2).

Other specialist midwives commented in the focus group at Trust 1 that:

I was proactively shadowing people when I came into this post because it was such a steep learning curve that I felt that shadowing was extremely important to see what people were already doing within the (specialist area stated) if I was meant to be the co-ordinator, but it wasn't discussed or planned by anyone else, it was just something that I identified as something that I needed to do because I thought that it was important for my role but I wasn't discouraged from shadowing but it was easier for me to be released because I wasn't yet tied up (T1MW1).

I know in (Named speciality stated) recently I have not been involved in it but two midwives went over to (named maternity unit) to look at the (specialist area stated) area and as you know these (named) services are a higher profile now in the unit (named) and becoming higher so yes I think that the Trust would be really supportive if you wanted to do that so long as it was for a purpose and it was going to mean something (T1MW1).

The Supervisors in Trust 2 commented on midwives being able to shadow specialists and Supervisors of Midwives;

Well funnily enough (Named) and I were talking today and we have suggested that people who want to be Supervisors might like to watch what Supervisors all look like, shadowing to a certain extent a supervisor, or as I thought myself (T2SOM1).

But I have offered this to individuals who could be a supervisor or any midwife who is interested and might want to shadow me in my role as (specialist role stated) and then take their education forward that way so that's another way of gaining CPD without actually going on a study day or whatever, that insight into other roles within the midwifery profession that can then take them forward (T2SOM1)

There was no mention of shadowing opportunities from the Supervisors of Midwives at Trust 3.

The LSA Officers also supported the opportunity for midwives to shadow peers and that Supervisors of Midwives should facilitate visits to other units through the supervisory networks.

The midwives views from the focus group support this strategy and firmly believed that if they wanted to shadow a peer or colleague in the Trust (2) that their supervisor would be able to arrange for this to take place.

However, this was not the impression given by the Supervisors. Even though they agreed that shadowing was a good opportunity for midwives to learn from each other they felt that as Supervisors they were limited in

what they could actually enable the midwives to attend in term of shadowing outside of the trust due to resource issues.

Two midwives commented on the questionnaire that they were able to work with colleagues in other areas and gave examples of community midwives and staff within antenatal specialist areas being shadowed. Some midwives in the focus groups at Trust 1 and Trust 3 felt that specialist midwives were more likely to be given the opportunity to shadow practitioners at other Trusts but this was less applicable to the rest of the midwives. Some of these midwives were however able to shadow peers within their own Trust.

Opportunities to shadow other midwives were mentioned in focus groups by midwives as a means to develop their knowledge either in clinical practices or in understanding other practitioner's roles. In addition, to gaining an insight into other roles a Supervisor of Midwives argued that some midwives did not just want academic studies to further their development and argued,

*I think for some people they are updating and they want to be very practical based as opposed to academic study and there are practical updates that are out there it does not have to be a sort of an academic exercise at a push there is a lot of things that they maybe, going to look at a different area, in like there may be somebody that if they are looking at post natal care, it might be trying to facilitate an update on special care, something like that. You know that is still CPD, I don't see it is necessarily course topping or credits, you know getting credits and sort of academic bits. For a lot of people it is because they use that pathway to sort of work towards a degree or whatever, but it is not suitable for everybody and I think it is looking at their*

*individual needs and what they want to do.*  
(T2SoM2).

The Supervisors alluded to midwives being anxious about their ability to cope with academic study a view supported by Ellis and Nolan (2005). It is reported in the literature that some practitioners may not want to undertake academic activities as this would mean stepping outside of their comfort zone (Schuller 2000) with doubts about their own abilities to meet academic requirements. It must be recognised that anxieties regarding academic ability may also be influenced by other commitments that the individual practitioner may have for example, family and or financial pressures which requires balancing with work life.

Shadowing may be argued to be a proactive approach to professional development as it encourages learning. The professional being shadowed will usually be a clinical specialist with technical expertise, content knowledge and are credible with colleagues. These practitioners will work with students during their pre-registration programmes and enable their knowledge and skill development. Qualified midwives need also to be able to utilise opportunities for shadowing as practice developments are often complex and unless midwives rotate into these areas they become less knowledgeable about the new services offered. Alternatively, an experienced midwife with leadership potential may benefit from shadowing a manager to develop leadership skills. In formal education many modules on management do require participants to 'shadow' or be 'mentored' by senior staff to enable work based learning to take place thereby applying the theory to practice with the support of a 'coach'.

Locke (2008) argues that organisational outcomes are linked to investment in human capital and can only be achieved through the workforce although education and training alone are insufficient to meet these outcomes.

Therefore it is argued that by enabling learning opportunities within an organisation through activities, for example, preceptorship, coaching and shadowing the gap between learning and practice is bridged. Supervisors of Midwives are themselves experts in practice and enabling shadowing of their role should influence the CPD of midwives and promote improvements in practice.

#### **4.6.7 E-learning or Flexible Learning**

From the questionnaire completed by midwives it was found that 9% (n=13) respondents utilised this type of activity as a means of keeping up-to-date. The type of activity was specified as either E-learning generally or use of computer to search the internet, use of computer to undertake literature searches, completing CD Rom or computer packages, open learning and distance learning. These activities are all described under the umbrella term of flexible learning (Sadler Smith and Smith 2004) as these indicate the means of delivering learning for the acquisition of work based knowledge and skills using some form of technology. Flexible learning requires learners to demonstrate autonomy and self direction in order to engage in the learning process via these means.

The term self directed learning varies in the literature and is usually contrasted with teacher directed learning. The term implies that learners take the initiative to identify their own learning needs and decide what they will learn by formulating aims, identifying resources, implementing the activity and then evaluating the outcome (Spencer and Jordan 1999). The



process of learning is based on the principles of adult education which is also acknowledged in the literature as the learner is in control over the planning and management of learning.

E-learning was identified by 15% (n=5) of the Supervisors of Midwives as an activity they would advise midwives to undertake to meet CPD requirements. The low number of Supervisors advocating this type of activity could be due to the lack of understanding of the term self direction as described in the literature however it is argued that the benefits of this approach, according to O'Shea (2003), relate to increased confidence, autonomy, motivation and preparation for lifelong learning. All of which are valued in an accountable midwife practitioner.

An e-learning culture is developing in higher education and is seen as an important element in future educational provision. The e-learning agenda is set to provide a flexible framework that is student centred and one that ensures the development of lifelong learning and is supported by the government and higher education (DfES 2003, HEFC 2005, DH 2001a). According to the CQC (2011) report there has been a continued rise specifically in the availability of E-learning and on-line learning training for NHS staff.

Effective e-learning is dependent on computer literacy and in a number of studies Adams (2004), Atack (2003), and Washer (2001) found that women were less likely to use computers which is clearly of significance in relation to a profession what is made up of predominantly female staff.

However, McVeigh (2009) found that levels of computer literacy were 'encouragingly high' suggesting that nursing professionals' abilities were keeping in line with the developing technological agenda. This study also did not obtain any evidence to support the gender findings that females were less likely to use computers or be less likely to be confident in this use. Cole and Kelsey (2004) also found that age also influenced computer usage especially if it had been a number of years since participation in formal education.

The ability to achieve an effective work/ life balance is viewed as advantageous by practitioners. However, time management and the amount of time needed for e-learning were considered to increase the dropout rate from courses particularly when factors like competing for access to the computer with other family members or work priorities were evidenced (Atack 2003). In addition course attrition was also noted to be influenced by an individual's level of computer literacy. Smith (2010) also identifies that the learning styles of practitioners will also influence the uptake of E-learning opportunities and this needs to be taken into account when developing courses and packages of learning.

E-learning is also dependent on access to and availability of computers which may lead to inequalities if practitioners cannot afford this technology (Washer 2001). Time at work does not always allow for access to e-learning packages and so this, according to Adams (2004), leads to frustration and a reduction in motivation on behalf of the individual. McVeigh (2009) also found that in the current climate of information technology driven by government policies to underpin education and health

access to computers and intranet in the workplace was perceived by practitioners as poor. This may relate to actual numbers of computers available or the number of people accessing the computers. The cost for both educational establishments and NHS Trusts to provide up-to-date technology and software to support e-learning may result in inaccessibility and lead to inequalities in professional development opportunities.

However, taking into account the pressures of work in practice settings time to access computers in reality is just not possible. From an organisational and management perspective allowing staff time to access computers in the workplace to enable CPD may actually minimise the problems of releasing staff from the clinical setting. This lack of time places more pressure on individuals to utilise their own time for study to ensure ongoing professional development as well as meeting PREP requirements. Arguably in the NHS with a climate of increasing financial pressures time there are implications for both managers and educators in terms of facilitating practice/ service developments, competency and lifelong learning.

In addition to e-learning there has been a rapid growth in distance learning courses for qualified health care professionals according to Cook, Thynne, Weatherhead, Glenn, Mitchell and Bailey (2004). Although a number of factors has led to this development which include for example, shortages of qualified staff and difficulties in releasing staff from practice, it is acknowledged that there is a need to enable practitioners to continually develop their professional knowledge and skills in order to provide effective care. The diversification of teaching methodologies has been promoted by

the DH (1999a, 2000a, 2000b) and by the NMC which has resulted in a number of Universities providing distance learning. The advantages of distance learning include learning at an individual pace, from any area, at any time of day as well as increasing student autonomy. This provides an increased flexibility for those who have to balance work and personal responsibilities alongside travel and meeting professional requirements.

Rogerson and Harden (1999) found that courses with work based learning and problem-based learning were ideally suited to nurses and midwives in terms of enabling them to achieve CPD and lifelong learning a view endorsed by Carnwell (2000) and Chapman (2000) in later studies. These later studies found that distance learning courses widened access to post-registration professionals who previously had been marginalised as a result of their personal and professional commitments.

To meet CPD requirements distance learning offers the individual the opportunity to learn alongside their personal and professional commitments thereby enabling them to gain qualifications for career progression. Those with financial difficulties who could not afford to take time out of work to study could access this type of course. Those who lived a distance from the educational site could also access courses.

#### **4.6.8 Discussions with colleagues**

Within the increasing complexity of the modern maternity care environment it can be very difficult for midwives to identify their CPD needs due to the limited time available within the working day. Ultimately,

the identification of learning needs within the CPD process is important if midwives are to provide the care needed by childbearing women and their families. Any strategy must be realistic to enable the midwife to meet her learning needs and therefore should be validated to ensure the outcomes will not only meet the midwife's needs but also the needs of the women and the maternity service.

If formal learning is limited in terms of access and uptake then informal strategies are needed and the opportunities for discussion with colleagues may require a more formal approach. This strategy for learning should enable problem based learning in the practice environment but will require active support from peers, Supervisors of Midwives, midwives in educational roles and liaison with AEI lecturers.

Discussion with colleagues was cited by 92% (n=133) of respondents so this would appear to be the most significant strategy after mandatory days for meeting CPD needs for midwives. Supervisors of Midwives cited this less frequently with 78% (n=26) of respondents identifying this strategy. The literature reveals that Mitchell (1997) argued that if discussion with colleagues was to be enhanced then practitioners needed to be aware that this process was taking place. Ideally, this strategy should be encouraged within an organisation and valued by all practitioners in order to create a climate of learning which will promote CPD, as advocated by the Department of Health (2001a), as a vehicle for developing the workforce through the development of effective strategies at professional and policy levels.

Practitioners are increasingly relying on technology for communicating with peers and email and social networking sites are enabling dialogue to take place at a distance when time for work placed discussion opportunities are not overtly available. Brown, Clay and Lees (2010) describe projects using information communication technology to enable mobile learning by take place through the supervision of midwives. Workshops and 'talking heads' were filmed, power point presentations and Trust guidelines were then uploaded to mobile hand held devices and offered to midwives at their annual supervisory review meeting. This innovation was welcomed by the majority of midwives in this project although the disadvantages were reported to be the lack of interaction with peers, and the solitary nature of using the device. This implies that midwives value discussion with colleagues as an approach to meeting CPD needs.

Dewing (2010) suggests critical personal dialogue and critical dialogue with others form part of the central principles of active learning. This approach involves reflection on personal feelings and interacting with others through social and communicative processes in applying learning in the work environment. Dialogue is considered to be a process of sharing and learning about individual values, beliefs, feelings and interests to develop a common understanding with the intention to refine practice activity (Dewing 2010). This approach is connected to work based learning with the aim of improving and transforming practice.

Work based learning is also a strategy that is not only valuable because employers do not need to release staff from the practice area but also, according to Presho (2006), work based learning engenders integration of practitioners into communities of learning. Work based learning also

inevitably requires support from peers in the clinical practice environment but also HEI support mechanisms to ensure standards are established, maintained and monitored and that learning outcomes are understood, agreed and achieved (DH 2001a, Moreton-Cooper and Palmer, 2003). An effective means of achieving support for practitioners in the clinical practice areas is to provide the practitioner with on-line access to course materials. In practice, this promotes shared learning experiences and a feeling of connectivity with the University alongside increased work based support for the midwife.

#### **4.6.9 Reading Journals**

The midwives also identified reading journals and discussion with colleagues as being important strategies for keeping up-to-date. Reading journals was seen to be important by both the midwives and Supervisors of Midwives in this study.

Comments from Supervisors of Midwives in relation to reading as a means of achieving CPD were made at Trust 1 only:

and I don't see why when your MIDIRS comes through the door that that's not your own personal PREP time and that's what I do a lot of (T1SoM2)

as an individual not just as a supervisor, I am constantly seeking information, if I am sitting in a waiting room waiting to go to the dentist, I will pick something up to read, I am constantly looking for something to just keep going in (T1SoM3)

Some midwives commented on the questionnaire that they self funded journals such as the British Journal of Midwifery and undertook Internet searches to keep up-to-date. There were no further comments at the focus

groups with the midwives or Supervisors of Midwives relating to the activity of reading.

Evidence of learning through reading should be made available at the annual supervisory review to enable reflection on the topic and enable discussion on the application to practice. The reflection on reading also needs to be entered in the personal profile/ portfolio as evidence of meeting PREP requirements. If Supervisors of Midwives are not reviewing the portfolio of learning then this is a lost opportunity in terms of engaging in dialogue regarding practice and fails to verify that PREP requirements have been met although the latter is the responsibility of the individual midwife rather than that of the supervisor.

#### **4.6.10 Mentoring students / teaching others**

Only 3% (n=5) midwives identified being a mentor and teaching others as a CPD learning activity, whereas, Supervisors did not.

In a study by Fisher and Webb (2008) midwife mentors reported that supporting students improved their confidence, that they became better at employing different teaching methods to support students, were able to challenge practice and that it provided opportunities for professional development. In addition, for some midwives it had been the catalyst for their own CPD as students were undertaking diploma and degree courses which motivated the midwife mentors to embark on courses themselves at these academic levels.



All midwives are required to be sign-off mentors and support students in practice placements (NMC 2008d, NMC 2009). Some mentors do not hold formal qualifications for this role but rather have been accredited for prior learning, whereas others have since 2001 (ENB 2001) completed formal preparation courses and are likely to be well prepared for their role. The role of mentor is part of the contract of employment and all midwives are required to undertake this role.

It is not surprising that midwives value being a mentor as a learning activity as knowledge is shared between mentors and their students. Carlson, Wann-Hansson and Pilhammar (2009) found that mentors with longer experience tended to ask more reflective questions and put more emphasis on planning time for reflection with students than those mentors with less experience. Gray and Smith (2000) also argue that mentors want to offer good support to their students and therefore they rely on managers to provide guidance on how to prioritise clinical activities with the mentor role. The mentor role is complex and difficulties are often experienced supporting students but it is this complexity that Cavanagh (2002) considers to make the role worthwhile.

The mentor role in failing students who do not achieve in placements creates a feeling of responsibility by the mentor such that according to Duffy (2004) they feel that a failing student identifies them as a poor mentor. Indeed, Pulsford, Boit and Owen (2002) highlighted that mentor's need time to plan student learning and time to enable them to read and

understand assessment documents and that a lack of time resulted in ineffective reflection and discussion.

Mentors, according to Orland-Barak (2002), benefit from mentor group discussion and peer support which enables them to reflect on incidents and discuss practice issues therefore the Supervisor of Midwives could offer support in this area and not just be 'called in' to support mentors where students are in difficulty or failing. However, Bacon (2010) questions whether a midwife mentor would actually call upon her Supervisor of Midwives if she was experiencing difficulties with mentorship.

All of the Supervisors in this study agreed that the mentor preparation course was protected in terms of time to attend and in being funded as the importance of the role is vital for the development of future practitioners. Although this is commendable further investment in this area would be beneficial to provide mentors with ongoing support and in parallel achieve the NMC (2008d) mentor standards through annual and triennial review as well as CPD through discussion and reflection on mentoring. This would be a low cost informal learning activity that would benefit mentors and students and provide additional opportunities for dialogue with link midwife lecturers.

#### **4.6.11 Reflection**

As discussed in the literature review, the theories supporting reflection in and on practice are considered as challenging for practitioners in terms of

enabling them to examine their practice and account for the actions they undertake and in turn offers to inform future actions through changes in perspectives.

Reflective learning offers valuable informal CPD opportunities through the national supervisory framework (Kirkham 2000, Jones 2000), assisting midwives in developing reflective skills to fulfil PREP requirements and at the same time increase confidence and competency. The benefits of reflection need to be measured against the time taken to reflect and the importance of the outcome as perceived by the practitioner or others (Dalley 2009). Ghaye (2007) also argued that there is a personal risk of disclosure through reflection that may be weighed against any benefit reflection may bring particularly if this is being measured against professional standards by Supervisors of Midwives.

The findings of this study highlight that midwives do value reflection as an important component to CPD whereas Supervisors tended to prefer discussion with colleagues as the strategy they would advise midwives to achieve CPD (79% n=26). Discussion with colleagues may well be viewed as peers reflecting on practice issues but this was not clarified within this study. Almost all of the midwives in this study held a reflective journal but in the majority of cases this was not reviewed by the Supervisors of Midwives. Therefore the opportunity to reflect on practice either currently or in retrospect could be lost.

The NMC (2004c, NMC 2010c) specifically identify self assessment through reflection on practice as a prerequisite for all practitioners, with many attempts to integrate this further into clinical practice since the 1990's. However, it is argued in the literature that reflective ability requires critical thinking, higher order thinking and reasoning skills (Mezirow 1991, Schumacher and Severson 1996, Wallace 1999). Reflection must also be seen as an active process that should result in learning, changing behaviours and practice. Taylor (2006) highly regards reflection as a skill that specifically enables practitioners to become self aware and therefore empowered to improve care. The concept of clinical supervision in nursing and statutory supervision in midwifery is underpinned by reflection in and on practice to improve performance and increase the quality of care.

The Supervisors of Midwives at Trust 1 in this study collectively commented on the value of reflection as a learning strategy and as a means of enabling professional development:

I know it's an old cliché but you don't ever stop learning, because when I meet with a supervisee, I say to them "You know, it's not about going off and doing the big modules, diploma or degree, it's about learning on a daily basis, it's about every day you should be taking something away with you that you didn't have at the beginning of the day, albeit very little and at the end of the week you can have a whole raft of things that you can reflect on (T1SOM3).

I find that happens with mine and even getting them to reflect upon a journal article or "Well are you reading journals, and what are you reflecting on that, or if you are working with another member of staff and are you reflecting on that as a learning opportunity they don't seem to do much around that, they seem to focus on what the Trust want and they see that as part of their 35hours of PREP and they don't see beyond that (T1SoM2).

Reflection is further described by Nakielski (2005) as a result of a sudden insight into one's own perceptions or assumptions and is therefore, essential for professional practice and needs to be undertaken in a structured way through the use of a model of reflection. Many models exist in the literature and individuals need to select a model from those available or develop one according to their personal preference. Through the model midwives should be able to answer the questions of who, what, why, where and when focusing on their professional practice (Nakielski 2005).

The Nursing and Midwifery Council (NMC 2010a) require midwives to provide evidence of lifelong learning as part of Post Registration and Practice (PREP) and this includes reflection upon practice and to be able to link theory to practice in order to improve care. Reflection encourages midwives to revisit the evidence based theories underpinning practice and identify areas in which they need to improve their learning to meet their CPD. The NMC also make it clear, within The Code (NMC 2008a), that midwives are professionally responsible and accountable for actions and omissions in their practice, which Paul and Heaslip (1995) consider can only be achieved through the process of continued reflection otherwise women and their families are put at unnecessary risk.

A critical incident or event in practice often leads to a reflective discussion between the midwife and her Supervisor of Midwives and/or the midwife and her peers. Therefore, it is understandable why midwives consider reflection to be an important tool for CPD.

Yearly (2003) considers reflection to be a potentially cost-effective resource tool for achieving CPD. She describes a group-guided reflection forum facilitated by a Supervisor of Midwives focusing on midwifery issues and concerns of midwives that have been successfully implemented in a birth unit. The aim of the forum was to encourage open debate and increase personal effectiveness which according to Church and Raynor (2000) encourages the development of reflective skills enabling midwives to cope with the demands of an ever changing maternity service. Jackson (2002) considers the Supervisor of Midwives to be well positioned within existing organisational structures to facilitate reflective practice but individual expertise and midwives confidence in the process are issues that need addressing before such a forum can be implemented.

If reflection is to be effective in terms of enabling personal and professional learning and continuing reflective practice a clear understanding of reflection and the skills required are needed. The current Standards for Pre-registration Midwifery Education (NMC 2009), requires students to achieve the essential skills clusters one of which is communication, prior to registration as a midwife. The requirements for this under the domain of 'Developing the individual midwife and others' is shown in table 14.

**Table 14: Developing the individual midwife and others.**

Review, develop and enhance the midwife's own knowledge, skills and fitness to practice. This will include:

- Making effective use of the framework for the statutory supervision of midwives
- Meeting the NMC's continuing professional development and practice standards
- Reflecting on the midwife's own practice and making the necessary changes as a result
- Attending conferences, presentations and other learning events

Essential Skills Cluster – Communication

Source: NMC 2009.

Qualified midwives may not have developed skills in reflection during their pre-registration education and therefore may need assistance in doing so. Reflective skills are needed to enable review of personal practice and changes in practice based on the developing evidence. Programmes of continuing education encourage midwives to develop reflective skills and skills necessary to search, analyse and evaluate the literature to ensure evidence based practice can be achieved. The NMC also support self assessment by the midwife through reflection and evaluation as a means of encouraging professional growth and development fostering lifelong learning and documentation of learning within the professional portfolio. Reflective accounts need to be documented in a personal reflective journal, diary, portfolio or profile which may also be used to evidence continuing professional development. Gallo (2006) considers a portfolio to be an important tool for recording professional activities and achievements, the preparation and maintenance of which is essential for all midwives to demonstrate that they have undertaken the required amount of continuing professional development for continued registration with the NMC (2004).

The NMC requires a reflective portfolio from each practitioner and journal entries must also adhere to maintaining confidentiality and the anonymity of women and their families (NMC 2008b NMC 2008c).

In this study 96% (n=138) of midwife respondents stated that they had a personal profile for recording CPD activity. Only 4% (n=6) did not have a personal profile. Only 1 midwife further commented that she did have a personal profile but that it was not up-to-date.

One midwife commented within a focus group:

"...if there was a gap in my portfolio of something I felt that I needed to address, and I had actively sought to address that, but then the manager of the area was not able to facilitate that, and the following year I would come back [to my supervisor of midwives] and explain that, then what happens? The onus is still on the individual supervisee to just keep trying and I have found that particularly difficult."(T1MW2)

The Supervisors of Midwives were asked if they reviewed a midwife's CPD activity records each year. 94% (n=31) Supervisors responded with a 'Yes' to this question. However, 6% (n=2) of Supervisors stated 'No' they did not review their midwives CPD record of activity. 33% (n=11) commented that they reviewed the midwife's CPD activity at the annual supervisory review meeting via the methods identified in table 15.



<b>Table 15: Methods of reviewing a midwife's CPD records.</b>	
<b>Stated method:</b>	<b>Number of responses</b>
Discussions	(n=7)
Attendance certificates	(n=2)
PREP folder	(n=3)
Documentation in supervision document	(n=5)
Access to training records	(n=1)
Personal file	(n=1)
Liaison with midwife's manager	(n=1)
Personal knowledge	(n=1)
LSA website	(n=4)
Completion of learning packages	(n=1)
Mandatory study day attendance	(n=1)
Completion of study leave learning activity forms	(n=1)
Application for promotion	(n=1)

It can be seen that a reflective profile was not specifically identified by Supervisors of Midwives as a means of reviewing the midwife's reflections in or upon personal practice. The different terminologies of the type of tool utilised for this documentation is acknowledged and reflects the terms used in the literature, but these have been taken to mean the same for the purposes of this study. However, 6% (n=2) of the Supervisor of Midwives respondents identified attendance certificates and 9% (n=3) of these respondents also identified the PREP folder which can be considered to be aspects of a professional portfolio/ profile. The Supervisors of Midwives, 21% (n=7), identified discussion or the annual review documentation as a means of reviewing a midwife's continuing professional development. It may be argued that discussion is an important element of the annual

review meeting between the supervisor and the midwife but descriptions of events from practice may become inaccurate and lead to misinterpretation due to the degradation of memory over time. This is supported by Newell (1992) who suggests that not only does memory become faulty but the teller may recount events differently according to place and time in order to be seen in the best light and to prevent any damage to self esteem. It therefore becomes difficult to ascertain what learning has taken place as a result of the event or reflection on practice or indeed more importantly of any changes in personal practices as a result of experiences.

The process of developing a portfolio of work can foster skills such as reflection, critical thinking and self assessment (Scholes et al, 2004), therefore portfolio development is considered to be an effective teaching tool however facilitation is required if learning through portfolio development is to be a successful as it is a very complex process (Robertson et al 2004). This facilitation was not evidenced within this study. In addition the knowledge and skills acquired through informal and self directed learning activities may be captured by the practitioner within a learning portfolio. McMullan et al (2003) state that a portfolio needs to demonstrate a collection of evidence as well as the process followed and the products of learning for personal and professional development.

Mifflin, Campbell and Price (2000) also suggest that professional portfolios can provide a tool to assist practitioners in evidencing self directed study activities to meet CPD requirements and in doing so enable the development of lifelong learning practitioners who accept responsibility for their learning and are able to evaluate how their learning affects their practice. The self directed approach to learning is based on the principles of adult learning with the emphasis on development of one's own learning

needs with learning methods based on experience and evaluation grounded in the needs of the individual practitioner and the organisation in which they practice. O'Shea (2003) further argues that self directed learning increases a practitioner's autonomy, confidence and choice in developing knowledge and skills to meet the challenges of healthcare practices.

Reflective learning, self directed study activities and professional portfolios have collectively the opportunity to offer valuable CPD opportunities which may be enhanced by the statutory national supervisory framework but this needs proactive facilitation.

#### **4.7 Summary of this chapter**

The finding from both the questionnaire and focus groups have been analysed and linked to the literature where available. Overall, this study has identified the influences of the Supervisors of Midwives in relation to CPD of midwives. Whilst there is very little evidence in the literature specifically on the influences on professional development in midwifery the nursing literature has been drawn upon to provide some context as nursing and midwifery professionals are often combined under the nursing heading

The three themes formulated from the aims and objectives of this study were:

- i. The purpose of the supervision of midwives
- ii. The management and organisation of professional development
- iii. The actual learning activities that take place within this context.

The conclusions and implications for policy and practice highlighted by this study will now be consolidated in the final chapter of this thesis.

# Chapter 5:

## Conclusions

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### 5.1 Overview

This study has explored the influences of the supervisors of midwives in relation to one aspect of their role, enabling the CPD of midwives. Whilst very little evidence is available in the literature specifically on the influences on professional development in midwifery the nursing literature has been drawn upon to provide some context as nursing and midwifery professionals are often combined under the term 'nursing'.

The initial aims of this study were to explore the influences of supervisors of midwives in the context of the Lifelong Learning (CPD) of practising midwives. The research questions were:

- How do supervisors of midwives identify and influence midwives learning to meet CPD requirements?
- What actual learning activities are undertaken by midwives to meet their identified CPD requirements?

Three themes for discussion were formulated from the aims of this study and these were:

- i. The purpose of the supervision of midwives
- ii. The management and organisation of professional development
- iii. The actual learning activities that take place within this context.

## **5.2 Reflections on the Rationale and Strengths of the study**

The rationale for the study stemmed from my experiences as I am a full time midwife educator working within a university setting and hold an honorary contract at a local NHS Trust to undertake the role of supervisor of midwives which I have done since 1995. I have a changeable case load depending on movement of midwives to other Trusts, retirements etc, but mainly comprising 15 midwives from various backgrounds e.g. managers, primary care midwives, specialist midwives and acute midwives. All of the midwives have different needs in relation to CPD and are presented with similar opportunities and barriers to achieving their CPD needs. As an educationalist I have valued the formal educational opportunities available to midwives and have been disappointed when midwives have been unable to access educational events to meet their CPD requirements. Also as an educator I had developed an increasing awareness that some midwives were frequently able to attend formal educational events to meet CPD whereas others appeared to meet their CPD requirements through Informal methods of learning. This situation has appeared to increase in recent years.

The system in which supervisors practice and engage with midwives was an area of interest I felt was worthy of exploration as very little evidence is available about the role of the supervisor of midwives in relation to enabling midwives CPD. The experiences of midwives and supervisors of midwives have been captured along with the expectations of supervision from the LSA midwifery officer perspective. In addition, the views of the Lead Midwife for Education, a role required by the NMC (2009) and placed within the universities, were incorporated to enable the degree of

collaboration to be identified in supporting the provision of educational activities from Universities to meet the CPD needs of midwives.

### **5.3 Limitations of this study**

As with any study this research is subject to limitations which may have affected its findings. Limitations according to LoBiondo-Wood and Haber (2006) refer to the weaknesses of a study particularly in respect of the study design and procedures. Hek and Moule (2006) also highlight that health care practitioners must be as meticulous, accurate and reliable in collecting research data as they are within their daily professional practice and must also uphold the principles of their professional rules and code of conduct.

As a midwife lecturer and practitioner undertaking research my ability in terms of research knowledge and skills needs to be identified as a limitation of this study. In the role of supervisor of midwives and midwife lecturer working with midwives and supervisors of midwives at the Trusts included within this research placed me in a privileged position for data collection and analysis. This may have resulted in bias and assumptions being made which can lead to omission of important data.

The aim of the research was to understand the lived experiences of participants from their own perceptions in relation to the subject being explored. Although the response rates have been stated it is acknowledged that not all qualitative researchers provide details of a response rate. The use of questionnaires and focus groups enabled the subject area to be studied using a mainly qualitative approach in relation to the open ended questions on the questionnaire and focus groups providing triangulation of

approaches to add weight to the findings which offsets the relatively low response rates for some respondent groups. Some quantitative data was generated through the questionnaires enabling cross comparisons to be made and provided some context to the study. Previous research in similar areas has utilised these approaches and adds to the justification of design of the study as it adds different insights to the question being examined. What it does not do is result in an objective 'truth' about the question being examined as there is no right or wrong answer, just different perceptions or views of the participants lived experiences. This means generalisability cannot be claimed as the key issue of qualitative research is not whether the findings can be replicated but the significance of the findings.

In relation to the focus groups the success of these forums depends on the researchers abilities in facilitating the groups and in personal and professional qualities. The focus groups latterly were facilitated with more confidence and competence than the earlier groups due to inexperience with this method and this may have affected the collection of data. The use of focus groups can also be considered as a limitation in this study due to the small numbers attending and so the alternative of using individual interviews may have provided more in depth discussion. Again, being known to some of the participants may have affected their responses and conversation at the focus groups by providing what they thought the researcher wanted. In addition as the role of the researcher was also known as a supervisor of midwives may have affected participants' comments at the focus groups to prevent the researcher viewing their experiences and practices of supervision as inferior to those in other Trusts. Some comments implied this in terms of not knowing how they compared to other units/ Trusts or statements of being better than other



units/ Trusts. The numbers attending some of the focus groups was disappointing and this may have influenced the depth of discussion. The researcher being new to transcription of data from focus groups may have resulted in errors or subjective interpretation about the meanings and significance of the data (Polit and Beck 2004).

As a result of this study my views of CPD as a formal activity have changed and the value of informal learning such as reflection and discussion provide a considerable source for learning as do the formal events of doing modules, courses or study days. My views as an educator perhaps were very limited at the start of this study with the valuing of more formal education activities rather than less formal ones and it should be acknowledged that as a result of my development during this study these views have changed.

#### **5.4 Conclusions drawn from this study**

It was highlighted in the literature review that there is a lack of evidence regarding the specific aspect of a supervisors' role in terms of enabling midwives to identify areas for professional development and agree the means by which midwives can maintain and develop their midwifery experience. A number of researchers, identified within the review of the literature, have published research findings in relation to midwives perceptions of the role of the supervisor and have focused particularly on support mechanisms but they have not explored the educational aspect of the role. The literature has been explored to ascertain the similarities and differences between midwives experiences of CPD and those from other professional groups namely nursing or other health professionals.

The NMC (2006, 2008d) require supervisors of midwives to be available to midwives to discuss their practice and to provide them with support and this could be clearly evidenced from the data collected in this study for the majority of midwives. The supervisors met with their case load midwives on an annual basis and CPD and practice issues were discussed at these meetings and this was agreed by the majority of midwives. Although the areas for the individual midwife's professional development were identified at these meetings the supervisors indicated that they often generated the discussion rather than the midwives having given any prior thought to their development needs.

The annual review meeting was agreed by all participants in the study to be the relevant forum for this discussion on CPD. This meeting also included a review of practice issues, reflection on practice and discussion of clinical incidents. In addition to the annual meeting midwives stated that they could obtain support from their supervisors as required and that supervisors were supportive.

In addition to identifying CPD needs the means by which expertise can be maintained and developed requires further consideration. Supervisors of midwives were considered by midwives to lack influence compared to that of managers in agreeing the means by which they would be able to achieve their CPD needs especially if time and funding were required. The supervisors and midwives both agreed that the main focus for maintenance of expertise was in attending the employer mandatory days as these could be accommodated within work time and were the 'easiest option' in terms

of achievement and ensuring midwives at least met the minimum requirements for PREP (NMC 2010a).

Advice was provided on CPD by supervisors in the majority of cases although some supervisors did refer their supervisees to others for this advice, these being educationalists and managers. The majority of midwives considered their supervisor was aware of educational events to meet their CPD needs and this correlated with the views of the supervisors. As a result most midwives chose not to seek advice from others although 44% did seek alternative advice and this was predominantly from managers.

Supervisors in this study commented on the questionnaire that they were prepared for advising midwives on CPD but in the focus groups this was not supported as in the reality of practice the evidence pointed to supervisors being less confident and unsure of how they can actually advise and influence midwives development. To offset this situation supervisors referred their supervisees to others for CPD advice, an action supported by the LSAMO's and the LME's although this referral was generally to managers and other supervisors rather than to educationalists. Even though supervisors are educationally prepared for their role more guidance and support is needed to create a workforce of midwives willing to share experiences, knowledge and skills based in practice to benefit women and their families. The exploration of this issue enabled Supervisors in this study to identify their own professional development need and this was to be discussed with their LSAMO as most of the supervisors felt they had 'learnt how to do this as they had gone along' and that their preparation for the role of supervisor in advising midwives on CPD had either not

included this or was insufficient to meet their needs. This supported the views of the LME's as they felt midwife educationalists were better prepared to give CPD advice and that assumptions were made that a supervisor should be able to do this when in fact there is no evidence to suggest this is done effectively by supervisors.

Almost all of the midwives (97% n=138) reported to have personal profiles which contained evidence of their professional development but this was only reviewed by 15% (n=5) of supervisors of midwives. Others described mainly management tools as a means of reviewing CPD midwives records. There is no formal requirement for supervisors to review the profile at the annual review meeting but this is a lost opportunity in reflecting on a midwife's achievements and motivating further development. However, an intention to practice form completed annually by the midwife does require the supervisor of midwives to confirm that evidence of CPD is provided to ensure midwives have met the requirements to practise as a midwife. It would appear that rather than use the available PREP professional portfolio compiled by midwives, supervisors use a variety of resources to confirm CPD requirements are met. There is an opportunity to review the system for review of CPD activity and one way of simplifying the system could be that midwives have access to the LSA database and add in their CPD achievements. This would enable the supervisor and LSAMO to review this information regularly and enable access to records held on midwives by supervisors. It would also enable audit to be undertaken by the NMC. This proposal would also allay the fears of midwives regarding the confidentiality of records.

The midwives alluded to the provision of educational events following an incident in practice and considered this to be a reactive approach rather than being proactive which was management led rather than led by supervisors. This view was not endorsed by the supervisors as they believed they influenced and led educational activities following an incident in practice even though the approach was still reactive.

All NHS Staff are required to participate in management or performance appraisal (IPR) on an annual basis and this approach is underpinned by the Agenda for Change, Knowledge and Skills Framework (DH 2004b, DH 2004c). The Personal Development Plan (PDP) created at the IPR meeting forms an agreement between the midwife and manager on CPD in order to meet the individual's needs and those of the organisation. This plan is not usually made available to supervisors by their supervisees and so the CPD discussion that takes place at the annual supervisory review may not correlate with the PDP. The supervisors of midwives all agree and believed that they should ask supervisees to produce their personal development profile at the annual supervisory review meeting to reduce any area of overlap in preparation for the meeting. This was generally agreed to be an area which could be taken forward.

The role of manager automatically includes the role of supervisor of midwives and this needs careful consideration to avoid the re-emergence of a policing role, rather than a supportive and enabling process. A number of supervisors at one Trust specifically stated that the dual role of manager and supervisor was an advantage for them to be able to exert their influence and authority. It is acknowledged that supervision and

management are two different activities and bringing together these elements could create a misunderstanding between the two for the midwives which historically has been problematic as management and supervision are entwined within the changes in the NHS. The differentiation of roles lacks clarity in the minds of midwives as the role of the supervisor is considered to be in relation to the practice element of CPD whilst that of the manager relates to the theoretical aspect particularly formal learning activities. Thus some midwives are viewing the theory and practice of CPD as separate issues rather than application of theory to their practice. This situation is compounded by the fact that some supervisors of midwives are also managers and this dual role leads to midwives having concerns regarding the confidentiality of discussions at annual supervisory review. Some midwives, particularly those at Trust 1, chose to have a supervisor who was not a manager so that issues raised with supervisors would not be disclosed to managers. Some of the supervisors also alluded to the tensions between the roles and how supervision should be deliberately separated from management but in relation to CPD this was difficult to achieve.

The supervisors considered that the main formal learning activity was the Trust mandatory day and that this was mainly influenced by the managers in order to meet CNST requirements. This drive to meet CNST was felt to be the main influence for the content included on these days rather than issues raised through supervision. This left supervisors feeling they had little influence in decision making in this area.

The management of CPD is not a coherent activity between managers and supervisors of midwives and this is partly due to the limited communication between the two groups. There would also appear to be a lack of transparency about how each supervisor works as supervisors did not readily share information regarding their supervisees CPD needs at supervisors meetings but would if required write to managers with this information. There should be more formal mechanisms for discussion of midwives needs with the Supervision team to identify common CPD issues for action before it gets to the point of midwives having to undertake developmental practice or supervised periods of practice as this could be considered to lead to reactive practice rather than supervisors being proactive.

There also appears to be a limited attempt to relate professional development activities to the strategic organisational objectives as managers act as gatekeepers to professional development and may block access rather than motivate and empower staff thereby impeding both individual and service developments. This may also relate to the lack of influence the supervisor has in terms of enabling access to resources for formal education activities as many midwives sought support from managers rather than supervisors. This was particularly the case for experienced midwives who also sought additional support from managers in planning their CPD activities. This differed for midwives qualified for 5 years or less as they did not refer to any other source for CPD advice other than their supervisor of midwives. This group of midwives were the ones who commented on their self funding of further studies and many had already undertaken a variety of modules and courses to achieve degree level status. It may be argued that those midwives qualified for a greater

number of years were familiar with a system where resources for CPD was readily provided which had been the situation over the past few decades whereas within the current health care economic climate with limited funds the newly qualified midwives do not have the same expectations for acquiring resources for CPD and take greater responsibility for their learning. Overall, the midwives did not view the supervisor as being influential in their Trusts and many sought managerial support for CPD.

The actual practicalities of enabling midwives to achieve their CPD needs is further compounded by limitations imposed by managers and the processes for contracting educational events to meet midwives CPD needs. The supervisors in this study were aware of the contracting process but did not understand how it worked as they were not involved in the process unless they held a dual role of manager/ supervisor. This lack of knowledge should be rectified and supervisors should be part of the contracting process with managers.

The LMEs believed it to be crucial to develop the relationships between education and service as in some areas this was lost in the move to HEI's and has since had an adverse effect on both service (clinical practice) and education. The reliance on LSAMO's and LME's working closely together enabling collaboration offers limited scope in terms of how this can achieve development of CPD activities specific to the local needs of midwives. This is due to the geographical area in which each LSAMO works as each may have a number of NHS providers and education providers in their area. This is also dependant on whether local maternity services will support CPD activities at a distance to their service.



The LSA Midwifery Officers also agreed that collaboration was insufficient between education providers and supervisors of midwives to ensure appropriate continuing professional development activities were available to meet the CPD needs of midwives and that this was an area that really needed to be enhanced. This view was supported by comments from the LME's agreeing collaboration needed improving. Even though some midwife lecturers/ teachers also held the role of supervisor of midwives this was not seen to improve the collaboration and communication any more than through the link teacher role in some areas. The lack of formal mechanisms and reliance of ad hoc working was felt to be unsatisfactory. The recommended action would be to improve local networking between universities and their local maternity service providers with the aim of improving educational opportunities for midwives. The data also suggests that the representation of supervisors as well as managers in Trusts and in wider forums should be considered to ensure supervision is able to influence the activities and CPD of midwives.

The data collected in this study demonstrates that many midwives do, to some extent, utilise their own resources to achieve their CPD needs. The majority of midwives are required to attend employer mandatory learning events and although these events provide midwives with the minimum requirements to meet the PREP criteria these events do not enable further development. Indeed, the midwives reported the content of these events to be very superficial and that they did not meet their CPD needs. The supervisors and midwives held a common view on this and additionally

agreed the priority for mandatory events was to meet the Trust requirements for CNST purposes.

The midwives reported on the barriers they faced in trying to achieve their CPD needs and how this led some to just undertake the mandatory events provided by the Trusts as this allowed them to achieve the learning activity in work time and with no expense to themselves.

There was a high expectation of midwives for attending the employer mandatory events and they considered it to be unacceptable that they could be withdrawn from the event due to service needs. This situation was a common feature at all Trusts and in some cases the supervisors had tried to influence managers to allow midwives to stay to complete the day and arrange alternative service cover although this was not always achieved. This situation was reflected by the NMC (2010b) in their analysis of the LSAMO's 2008-9 annual report as a concern that training in Trusts was being withdrawn due to clinical activity. The data in this study demonstrates that this is still an ongoing concern.

In addition a lack of information on CPD activity is noted by the researcher in the LSA reports collated by the NMC (2010b, 2011). The reports contain information regarding supervisory activities in relation to pre-registration midwifery programmes, preparation of supervisors of midwives programmes and return to practice programmes but there is very little emphasis on CPD which fails to acknowledge the developmental role of the supervisor and instead focuses on the investigatory processes and supervised practice programmes. This needs to be reviewed and

highlighted if supervisors are to be proactive in undertaking the developmental aspect of the role and in influencing CPD for qualified midwives.

It is the actual responsibility of the individual midwife and not the employer to ensure that CPD needs are achieved therefore the supervisor can encourage and attempt to motivate the midwife to create an action plan for achievement. The literature suggests that the motivation of employees is increased when they are provided with the funding to undertake CPD and this is also believed to influence a practitioners' confidence in practice.

Midwife expectations in relation to their accountability needs to be more actively managed as within the current economic climate it is unlikely that the current level of support for CPD will continue and midwives need to consider utilising their own resources rather than expecting their employer to meet the cost. The annual supervisory review was the key event for supervisors to influence midwives CPD and a discussion took place at these meetings. The data highlighted that supervisors primarily encouraged midwives to attend formal study in the form of mandatory events, study days, conferences, courses and modules. This finding does link with that found in the latest CQC report (2011) where NHS staff reported to have taken part in at least one mandatory employer led learning event.

Attendance at formal education activities for example courses, modules were usually made possible through the managers and a personal development plan agreed at IPR. The supervisors were not able to access

the PDP as it was not shared by the midwife with the supervisor and therefore it may be argued that this is a lost opportunity to create a coherent strategy for achieving CPD needs as both discussions were kept separate. This is understandable to some extent as management and supervision issues are kept separate to ensure the distinct nature of roles is not blurred as has been the case in the past. However, there should be some correlation between the two especially when service needs and CPD needs overlap and any plan for addressing these needs can benefit both personal and organisational developments. It may also be argued that employers do not see the value of formal higher education in terms of relevance to improving practice and prefer internal organisational opportunities or work based programmes to benefit the organisation, a view also supported by Munro et al (2004). However, this may result in inhibiting the practitioner through lack of support for formal external education which also limits sharing of knowledge and skills between practitioners from other organisations.

The main informal methods of learning promoted by supervisors at the annual supervisory review meeting were reading journals, discussion with colleagues and being involved in guideline development. The midwives views supported those of the supervisors in relation to discussion with colleagues and reading journals as the most popular activities but rather than guideline development e-learning was also reported to be a popular learning activity. There has been a continued rise in the e-learning and on-line learning activities of NHS staff which is documented in the latest CQC (2011) report and this may be as a result of Trusts making more learning packages available to staff for completion in their own time as some midwives reported in this study. Those individuals who do not achieve the

resources to undertake formal CPD activities need encouragement and here supervisors have a role to play in facilitating learning in the practice environment as informal learning needs to be seen to be of equal value. Also if for the majority of midwives informal learning is the preferred option as it does not need to cost anything, as agreed by the NMC, then consideration needs to be given to whether it can be accommodated through approved Trust activities. Supervisors of midwives are themselves experts in practice and enabling shadowing of their role should influence the CPD of midwives and promote improvements in practice. Supervisors should argue for more opportunities for midwives to become involved in activities such as guideline development and audit as these would clearly relate to practice improvements and service developments. These activities would enable more work based /learning on the job and could improve the motivation of midwives. Midwives need to be encouraged to feedback their learning in the organisation to benefit others and to further build their community of learning. A forum for this needs formally developing and supported by supervisors and managers to enable cascading of learning and to discuss the possibility for changes in practice within the local Trust.

Reflection in and on practice is a vital component of professional development and supervisors need to value the impact that reflection can have on clinical practice and the educational development of the midwife and therefore utilise reflective activities to promote learning. This needs a higher profile within practice to further develop work based learning and as an effective means to meet PREP requirements. Reflection should be a key strategy for practice development and needs to be valued more. Although reflection is more explicit within pre-registration education, qualified practitioners need to learn more about this style of learning to truly

become reflective lifelong learners. Reading and discussions with peers and others is also vital for development and again given little priority. It is recommended that through IPL team working is enhanced but this needs developing as a means of CPD and learning reflectively from each other. If supervisors of midwives are not reviewing the midwife's portfolio of learning then this is a lost opportunity in terms of engaging in reflective dialogue regarding practice and fails to verify that PREP requirements have been met although the latter is the responsibility of the individual midwife rather than that of the supervisor.

The literature also supports the notion of work based educators and suggests these practitioners are able to exploit the resources in clinical environments and enable professional development of practitioners. Rather than just relying on specific midwives in professional development posts the supervisor of midwives could achieve this if provided with specific time to develop their role in enabling the professional development of midwives and to meet the NMC standards for supervision. The supervisors would need to focus their influence more on the informal learning activities that need developing and being viewed as valuable to support CPD especially in the workplace. The recognition of learning in the work place needs to be considered and linked to formal education activities to enable a framework of lifelong learning for midwives.

There needs to be recognition that education providers working with the midwife and the supervisors of midwives can support informal learning to enable practitioners to achieve their CPD requirements and this could be through a tripartite arrangement. This working arrangement would require

a contract agreement but would take place in the work environment and therefore reduce the need for time out of practice and funding would therefore be shared equally between practitioners in the Trust.

All of the supervisors in this study agreed that the mentor preparation course was protected in terms of time to attend and in being funded as the importance of the role is vital for the development of future practitioners. Although this is commendable further investment in this area would be beneficial to provide sign-off mentors with ongoing support, meeting the NMC standards for mentors (NMC 2008c) and in parallel achieve hours for CPD through discussion and reflection on their mentoring experiences. This would be a low cost informal learning activity that would benefit mentors and students and provide additional opportunities for dialogue with link midwife lecturers.

### **5.5 Originality and contribution to the understanding of the Developmental Role of the Supervisor of Midwives.**

The peer reviewer for this study considered it to be a good topic to study and agreed that no research had previously been conducted in this area and that CPD for midwives was pivotal in protecting the public.

This study has already achieved a change in practice related to the forum for discussion between educationalists (LME's) and supervisors of midwives in that,

'CPD provision would now become an agenda item for discussion' (LME12).

However, collaboration between supervisors and educationalists needs to be explored at local level between Trusts and universities as the data in this study suggests that this clearly needs attention to ensure a cohesive approach to the CPD of midwives.

There is relatively little evidence regarding the supervisor of midwife's knowledge in relation to CPD and assumptions are made regarding their ability to identify and advise midwives in this area. Therefore, additional education for supervisors of midwives is needed. This was endorsed by the supervisors participating in this study.

This study has also raised the need for supervisors of midwives, the LSAMO's and educationalists to explore together a framework to strengthen the CPD opportunities for midwives. The specific suggestion of a tripartite arrangement with education, management and supervision is again advocated and worthy of debate.

This study also identified that there is still an issue for some midwives of the dual role of manager and supervisor and the tensions this role potentially brings in practice. The dual role also inhibits the influence of supervisors in forums where a different perspective on issues should be presented rather than these being from managers thereby raising the role and increasing the influence of the supervisor at all levels in the Trusts. Therefore further research may be of benefit in this area.



Supervisors need a better understanding of the management processes of contracting for education and should have more influence over the allocation of resources.

The main CPD event for midwives is identified in this study as the mandatory training provision offered within Trusts. This is influenced predominantly by CNST rather than the needs of the midwives as identified in NMC reports. Supervisors should be able to influence the content of these days to ensure CPD needs of midwives are being addressed.

This study also confirms that informal learning for the majority of midwives forms a large part of their CPD achievements. Supervisors need to be more proactive in influencing, developing and facilitating informal CPD opportunities the Trusts so that midwives can access these events to meet their CPD needs and improve practice.

The value of informal learning needs to be given a higher priority and the evidence from these activities kept under review by supervisors to ensure midwives do maintain their confidence and competency.

In summary, this study has provided a variety of evidence specifically on the developmental role of the supervisor of midwives which has not been explored previously.

Supervision does achieve its aim of protecting the public but with further exploration of the following issues it could be more proactive and further improve the protection of the public:

- Supervisors need more preparation for the developmental aspect of their role in enabling the identification of and advising midwives on their CPD.
- Advice for midwives is available from other sources but this needs a more coherent approach to be effective.
- Collaboration between supervisors, managers and educationalists is insufficient and therefore the actual CPD needs of midwives are not being communicated appropriately to ensure midwives are afforded the opportunities to meet their needs.
- The process of education contracting between NHS service providers and education providers is not understood by supervisors unless they hold the dual role of manager and this needs addressing if midwives are to have equal opportunity in accessing resources.
- The dual role of manager and supervisor needs further research as an emergence of the 'policing' role has been raised by some midwives in this study.
- There is an increasing emphasis on Informal learning to meet CPD and these need to be given a higher priority for achievement within the work environment and supervisory framework.

## **5.6 Implications for Policy and Practice.**

### **5.6.1 Policy**

The professional body (NMC) standards in relation to the role of the supervisor of midwives in enabling professional development of the midwife requires further consideration as even though areas for development are being identified the means by which they can be maintained and developed needs further exploration. This is highlighted in this study through the limited influence of the supervisor in enabling access to resources to achieve CPD needs. The reporting of this activity also needs a higher profile within the collation of the LA reports annually.

Supervisors of Midwives have to balance competing demands within their protected time to undertake their role which leaves little specific time to oversee the professional development of the midwife. Therefore, additional protected time should be made available for the developmental aspect of the role as this will influence the quality and standards of midwifery care. This protected time could also include the facilitation of informal learning activities with supervisees for example, reflective sessions in groups, reading, discussions groups and mentor support forums.

Supervisors of midwives should be represented at relevant forums concerned with educational activities/ continuing professional development of practitioners in order to raise the profile of supervision and ensure the needs of midwives are being considered. These forums should provide a formal mechanism for supervisors to communicate with managers in the

Trusts and with educationalists in the universities regarding CPD opportunities.

The system for recording and review of CPD activity needs review and one way of simplifying the system could be that midwives have access to the LSA database to add in their CPD achievements similar to the system for supervisors. This would enable the supervisor and LSAMO to review this information regularly and enable access to records held on midwives by supervisors. It would also enable audit to be undertaken by the NMC.

### **5.6.2 Practice**

The dual role of manager/ supervisor should be re-examined with a view to increasing the influence of supervision in the allocation of resources for CPD as inequity currently exists.

Additional training/ education for supervisors of midwives in advising midwives on CPD needs should be created as this was a specific need identified within this study.

Discussion between education providers and supervisors of midwives should take place to examine the concept of a tripartite forum for addressing midwives CPD needs.

Supervisors should develop a good understanding of education contracting and work on an equal level with managers influencing and allocating resources within this process.

A formal mechanism for sharing of information on the CPD needs of midwives should be created to enable allocation of limited resources in a fair and transparent way and one in which the outcomes are disseminated to midwives.

Employer led mandatory learning should be influenced more by supervisors of midwives as well as meeting CNST requirements.

Midwives should share their PDP with their supervisor of midwives to enable further support and facilitation in meeting their CPD needs.

A midwife is required to complete a professional portfolio under the PREP (NMC) requirements for re-registration and is also required to complete an Intention to Practice form declaring that PREP requirements have been fulfilled. A supervisor of midwives will sign the intention to practice form confirming that the midwife has met the requirements for re-registration but according to the data collected the supervisors do not review the portfolio but use a variety of other means to confirm this. The practice of supervisors should therefore be reviewed regarding the way in which evidence of CPD activities is confirmed. A consistent approach would be for supervisors to view the midwife's PREP professional portfolio of learning which would increase the importance of both the maintenance of this document and its value as a resource and thus also provide further triangulated evidence of CPD activity with the NMC.

Informal learning activities require further development and prominence as midwives are not always able to pursue formal education to meet CPD needs. This needs to extend beyond the mandatory days and inter-professional emergency skills drills already in place in the Trusts.

## **5.7 Dissemination of findings**

The final stage of the research process is to communicate the findings of the research undertaken (Hek and Moule 2006). The term dissemination of research findings is used and is essential in order to justify its conduct and to evaluate its robustness by being scrutinised by others (Morse and Field 1996). Researchers therefore have a responsibility to ensure dissemination of their research findings to relevant people, in the case of this research, the participants, other midwifery practitioners, supervisors of midwives nationally, Local Supervising Authority Midwifery officers nationally, academic colleagues particularly the Lead midwife for education and educationalists that practice as supervisors of midwives. There is also some usefulness for other stakeholders in relation to commissioning education from higher education.

The research may also be relevant to other researchers and policy makers as there is very little literature available with this particular focus. The research could also prove valuable in the preparation of supervisors of midwives and be considered for inclusion as an area for debate in the resource pack underpinning these courses.

The dissemination of this research will include feedback in the form of presentations to groups in local Trusts, nationally at midwifery conferences and by writing articles for publication, to ensure all levels and groups within the sphere of the midwifery profession are able to develop an increased awareness of the issues arising within this subject area. Changes in practice take more than just dissemination of research findings, indeed practitioners and policy makers determine ways in which new

evidence may bring about change throughout all levels of organisational structures. The policy and practice implications emerging from this study require consideration if the supervision of midwives is to further develop and modernise in line with the dynamic changes in health care services and continue to be a valued strategy for public protection.

## **5.8 Recommendations**

- The dual role of the supervisor and manager should be re-evaluated.
- The developmental role of the supervisors of midwives should be given more emphasis in the preparation and ongoing support of supervisors.
- A tripartite approach in relation to the identifying midwives CPD needs should be reconsidered.
- The presence of supervisors of midwives in Trust forums needs re-evaluating to proactively increase the influence of supervisors in CPD discussions.
- The issue of confidentiality within the supervision forum needs evaluation to improve communication and planning of midwives CPD needs collaboratively.
- The LSA database could be developed to allow midwives to enter their CPD achievements prior to their annual review meeting.
- The documentation for annual review should be modelled around the professional profiles of midwives.
- Informal learning activities in the workplace should be given greater support and priority.

## **5.9 Further Research**

As a result of this study it has become evident that some midwives do not prepare for their annual review meeting with their supervisor of midwives. Although this was not a question posed through the use of either the questionnaire or focus group prompts it was raised by the supervisors in the study.

The supervisors stated in the focus groups that some midwives did not prepare for the meeting and this left little time for explicit discussion on CPD needs and how these could be achieved. The numbers of midwives who did not prepare for the meeting is not quantifiable from this study.

This is clearly an important finding which should be further explored to specifically determine midwives agency in relation to CPD as ultimately midwives are accountable, autonomous practitioners and are responsible for recognising their own learning needs and rectifying any deficits.

The specific focus of further research should therefore be on 'exploring the agency of midwives in meeting their CPD needs'.



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**Appendix 1**

**Questionnaire to Midwives**

**Study Area:**

An Exploration of how Supervisors of Midwives influence the continuing professional development (CPD) of practising midwives.

.....  
**Please tick the appropriate boxes, some of the questions ask for your personal comments.**  
 .....

1. How many years have you been qualified as a midwife?

Please tick appropriate box

5 years or less		6 - 10 years	
11 - 15 years		16 or more years	

2. Do you work full time or part time?

Please tick appropriate box

Full Time		Part time	
-----------	--	--------------	--

3. What is your grade band?

Please state.....

4. What is your job title?

Please state.....

5. In what area do you currently practice?

Please tick appropriate box

Hospital setting	
Primary care setting	
Mixture of both hospital and primary care	
Education	
Other	

6. Which of the following activities describes the way(s) in which you keep-up to date  
(Please tick as many as is applicable)

Reading journals	
Discussion with colleagues	
Attending professional study days/ conferences	
Attending courses/ modules	
Attending mandatory sessions	
Other	

If Other please specify the activity:

.....  
 .....

7. Do you have a personal professional profile for recording your continuing professional development (CPD) activities?

Please tick appropriate box

Yes

No

8. Have you ever been funded to achieve your CPD needs?

Please tick appropriate box

Yes

No

If Yes, please specify how funding was obtained:

.....  
 .....

9. Do you get protected time to attend/ achieve your professional development needs (CPD)?

Please tick appropriate box

Yes

No

Comments:

.....  
 .....



10. Have you ever self funded your CPD needs?

Please tick appropriate box

Yes

No

If yes, please comment:.....

.....

11. Do you have a named supervisor of midwives?

Please tick appropriate box

Yes

No

12. Do you meet at least once per year with this supervisor for an annual supervisory review?

Please tick appropriate box

Yes

No

If No, please comment:.....

.....

13. Do you discuss your Continuing Professional Development (Lifelong Learning) needs with your supervisor of midwives?

Please tick appropriate box

Yes

No

14. Does your supervisor of midwives advise you on how you can achieve your CPD?

Please tick appropriate box

Yes

No

If yes, please comment:

.....

.....

15. Do you think your supervisor of midwives is aware of educational events designed to help midwives achieve CPD?

Please tick appropriate box

Yes

No

Don't know

16. Do you think supervisors of midwives influence the development of educational events to support midwives CPD?

Please tick appropriate box

Yes  No  Don't Know

17. Do you think your supervisor can influence your attendance at educational events to meet CPD needs?

Please tick appropriate box

Yes  No  Don't Know

18. Do you think your supervisor of midwives is more likely to support you to attend Trust mandatory events to meet service requirements rather than to meet your individual CPD needs?

Please tick appropriate box

Yes  No  Don't Know

19. Do you discuss practice issues with your supervisor of midwives to help you develop professionally?

Please tick appropriate box

Yes  No

If Yes, please comment:.....

.....

20. Do you obtain any other advice about how you can achieve CPD?

Please tick appropriate box

Yes  No

If yes, who would provide this advice?

.....  
.....  
.....

21. Are you required to attend local mandatory training sessions?

Please tick appropriate box

Yes

No

If yes, what subject areas would this day include?

.....  
.....  
.....  
.....

22. Do you have any other comments?

.....  
.....  
.....  
.....

**Thank you very much for completing this questionnaire. Please return to Colleen Drury in the envelope provided.**

## **Appendix 2**

# **Questionnaire to Supervisors of Midwives**

Study Area:

An Exploration of how Supervisors of Midwives influence the continuing professional development of practising midwives.

.....  
Please tick the appropriate boxes , some of the questions ask for your personal comments  
.....

- 1. How many years have you been qualified as a supervisor of midwives?

Please tick appropriate box

5 years or less		6 - 10 years	
11 - 15 years		16 or more years	

- 2. Do you work full time or part time?

Please tick appropriate box

Full Time		Part time	
-----------	--	-----------	--

- 3. What is your job grade?

Please state:.....

- 4. What is your job title?

Please state:.....

- 5. What number of midwives do you support as a Supervisor of Midwives?

Please state:.....

6. Do you meet at least once per year with your supervisees for an annual supervisory review?

Please tick appropriate box

Yes

No

If No please comment:.....  
.....

7. Do you discuss with each midwife you supervise their Continuing Professional Development (CPD) needs?

Please tick appropriate box

Yes

No

8. Do you have access to a database on professional qualifications of the midwives on your caseload?

Please tick appropriate box

Yes

No

9. Do you review the midwives CPD activity records each year?

Please tick appropriate box

Yes

No

If yes please comment how this is achieved:

.....  
.....

10. Do you discuss practice issues with your supervisees to help them to identify their professional development needs?

Please tick appropriate box

Yes

No

11. Do you advise midwives on the different ways in which they can meet their CPD needs?

Please tick appropriate box

Yes

No

12. Which of the following describes the way(s) in which you would advise midwives to keep-up to date/ meet their CPD needs?

Please tick appropriate box

Reading journals	
Discussion with Colleagues	
Attending professional study days/ conferences	
Attending courses/ modules	
Attending trust mandatory study days/sessions	
Other	

If other please specify the activity:

.....  
 .....

13. Do you believe that midwives should be funded to achieve their CPD needs?

Please tick appropriate box

Yes

No

Any Comments:

.....  
 .....

14. Do you think that midwives should get protected time to attend/ achieve their professional development needs (CPD)?

Please tick appropriate box

Yes

No

Any Comments:.....

15. Do you encourage midwives to obtain advice on CPD activities from other sources, for example, midwife teachers?

Please tick appropriate box

Yes

No

If yes, who would you recommend to provide this advice? Please state:

.....  
.....

16. Are you as a supervisor of midwives aware of the educational events designed to help midwives achieve CPD?

Please tick appropriate box

Yes

No

Any comments?.....

.....

17. Do you feel prepared as a supervisor of midwives to be able to discuss a midwife's CPD needs?

Please tick appropriate box

Yes

No

Any comments?:.....

.....

18. Do you discuss your midwives CPD needs with your team of supervisors of midwives?

Yes

No

Any comments?:.....

.....

19. Are you aware of the education contracting process within your unit?

Please tick appropriate box

Yes

No

Any comments?:.....

.....



20. How do you communicate your midwives CPD needs to the managers within your unit?

Please comment:.....

.....

21. Are you as a supervisor of midwives able to influence the development of educational events to support midwives CPD needs?

Please tick appropriate box

Yes

No

Any comments?:.....

.....

22. Do you feel you are able to influence midwives attendance at educational events to meet CPD needs?

Please tick appropriate box

Yes

No

Any comments?:.....

.....

23. Do you think supervisors of midwives are more likely to support midwives to attend professional development activities to meet Trust mandatory requirements rather than to meet individual midwives needs?

Please tick appropriate box

Yes

No

Any comments?:.....

.....

24. Do you consider there is sufficient collaboration between supervisors of midwives and education providers to ensure CPD activities are available for midwives?

Please tick appropriate box

Yes

No

Any comments?:.....

.....

.....

25. Do you have any other comments?

.....

.....

.....

.....

**Thank you very much for completing this questionnaire. Please return to Colleen Drury in the envelope provided.**

## **Appendix 3**

# **Questionnaire to Local Supervising Authority Midwifery Officers**

**LSA Midwifery Responsible Officer Questionnaire. Id No:**

Study Area:

An Exploration of How Supervisors of Midwives influence the continuing professional development (CPD) of practising midwives.

.....  
**Please tick the appropriate boxes, some of the questions ask for your personal comments.**  
 .....

1. How many years have you been an LSA Midwifery Responsible Officer?

Please tick appropriate box

5 years or less		6 - 10 years	
11 - 15 years		16 or more years	

2. What strategies in your opinion should Supervisors of midwives promote to midwives in order for them to achieve their Continuing Professional Development (CPD) needs?

Please state:

.....  
 .....  
 .....  
 .....

3. How should Supervisors of midwives encourage midwives to record their continuing professional development (CPD) activities?

Please comment:

.....  
 .....  
 .....  
 .....

4. Should midwives be funded to achieve their CPD needs?  
(Please tick appropriate box)

Yes

No

Further comments:

.....  
.....  
.....

5. Should midwives get protected time to attend/ achieve professional development activities?  
(Please tick appropriate box)

Yes

No

Further comments:

.....  
.....  
.....

6. What strategies should be employed by supervisors of midwives to ensure midwives have the opportunity to discuss their CPD needs?

Please comment:

.....  
.....  
.....  
.....

7. Do you think that supervisors of midwives are aware of local/ regional educational events designed to help midwives achieve CPD?

(Please tick appropriate box)

Yes

No

Further comments:

.....  
.....  
.....

8. How do you think supervisors of midwives influence the development of educational events to support midwives CPD?

Comments:

.....  
.....  
.....

9. Do you think supervisors of midwives can influence attendance at educational events to meet CPD needs?

(Please tick appropriate box)

Yes

No

Further comments:

.....  
.....  
.....

10. Do you think supervisors of midwives can influence attendance at other activities to meet CPD needs?

(Please tick appropriate box)

Yes

No

Further comments:

.....  
.....  
.....

11. Do you think that supervisors of midwives are more likely to support midwives to attend mandatory events to meet Trust requirements rather than the individual CPD needs of midwives?

(Please tick appropriate box)

Yes

No

Further comments:

.....  
.....  
.....

12. Do you think that Supervisors of midwives are clear about what constitutes meeting CPD needs as opposed to meeting Trust requirements?

Please comment:

.....  
.....  
.....

13. Do you feel supervisors of midwives should refer midwives to other sources to obtain advice about how they can achieve their CPD needs?

Please tick appropriate box

Yes

No

Further comments:

.....  
.....  
.....

14. Do you feel supervisors of midwives are appropriately prepared to be able to give CPD advice?

(Please tick appropriate box)

Yes

No

Further comments:

.....  
.....  
.....

15. Do you feel there is sufficient collaboration between education providers and supervisors of midwives to ensure appropriate CPD activities are available for midwives?

(Please tick appropriate box)

Yes

No

Further comments:

.....  
.....  
.....

16. Any other comments?

.....

.....

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.....

**Thank you very much for completing this questionnaire.**

**Please return to Colleen Drury in the envelope provided.**



## **Appendix 4**

# **Questionnaire to Lead Midwife for Education**

**Lead Midwife Educators Questionnaire.**

**Id No:**

**Study Area:**

An Exploration of How Supervisors of Midwives influence the continuing professional development (CPD) of practising midwives.

.....  
**Please tick the appropriate boxes. Some of the questions ask for your personal comments.**  
.....

1. How many years have you been a Lead Midwife Educator?  
(Please tick appropriate box)

5 years or  
less  
11 - 15  
years

<input type="checkbox"/>
<input type="checkbox"/>

years  
years

6 - 10  
16 or more

<input type="checkbox"/>
<input type="checkbox"/>

2. What is your job title?

Please state.....

3. Are you involved in the contracting of education for midwives with NHS organisations?

(Please tick appropriate box)

Yes

No

Comments:

.....  
.....  
.....  
.....  
.....  
.....

4. Do you feel there is sufficient collaboration between education providers and supervisors of midwives to ensure appropriate Continuing Professional Development activities are available for midwives?

(Please tick appropriate box)

Yes

No

Comments:

.....  
.....  
.....

5. Is any of the midwife teachers within your educational establishment qualified as supervisors of midwives?

Yes

No

If Yes, please go to question 6.  
If No, please go to question 9.

6. How many of your teachers are qualified as Supervisors of Midwives?

Please state number:.....

7. Do you consider that there is an expectation that these supervisors of midwives will influence the provision of education activities provided by the University for midwives?

Yes

No

Comments:

.....  
.....  
.....

8. Do these supervisors of midwives feedback the CPD needs of midwives in the local Trusts to the University?

Yes

No

Comments:

.....  
.....  
.....

9. Do you think supervisors of midwives generally influence the development of educational events to support midwives CPD?  
(Please tick appropriate box)

Yes

No

Don't Know

Comments:

.....  
.....  
.....

10. Do you think supervisors of midwives can influence attendance at educational events to meet CPD needs?  
(Please tick appropriate box)

Yes  No  Don't Know   
Comments:

.....  
.....  
.....

11. Do you think that supervisors of midwives are more likely to support midwives to attend professional development activities to meet service developments rather than meet individual midwives needs?  
(Please tick appropriate box)

Yes  No  Don't Know   
Comments:

.....  
.....  
.....

12. Do you feel supervisors of midwives should refer midwives to midwife teachers or other sources to obtain advice about how they can achieve their CPD needs?  
(Please tick appropriate box)

Yes  No   
Comments:

.....  
.....  
.....

13. Do you feel supervisors of midwives are appropriately prepared to be able to give CPD advice?  
(Please tick appropriate box)

Yes  No  Don't Know   
Comments:

.....  
.....

14. Do you have any other comments?

.....

.....

.....

.....

.....

.....

.....

.....

.....

**Thank you very much for completing this questionnaire.  
Please return to Colleen Drury in the envelope provided.**

**Appendix 5**

**Covering letters to accompany  
Questionnaires**

**REC Ref No. 08/H0406/127**

**This letter will be sent out on University headed paper**

**Midwives Information Letter**

To: Midwives

Unit:

Date: 2<sup>nd</sup> January 2009

Dear Midwife,

I am writing to request your participation in a study relating to Supervision of Midwives and the continuing professional development (CPD) of Midwives.

I am a Supervisor of Midwives and a Midwife Educator at the University of Nottingham and am currently studying for a Doctor in Education qualification. As a Supervisor of Midwives I am interested to find out how Supervisors of Midwives influence the provision and uptake of continuing professional development activities practising midwives.

The purpose of this questionnaire is to find out your views on this subject area.

I would be grateful if you would take the time to consider filling in the questionnaire and returning it to me in the envelope provided. All questionnaires are anonymous and individuals will not be identified. The ID code on the questionnaire is simply to identify the unit and the number of participants returning the questionnaire.

If you would like to participate in the next stage of my research which involves focus groups then please complete the detachable form at the end of the questionnaire.

Thank you for taking time to read this information and considering participation. Further information can be found in the participant information sheet enclosed.

I would be grateful if you could also complete the form indicating your interest in participating in a focus group and return it to me in the separate envelope provided.

**Please return all documents by the 28<sup>th</sup> January 2009 if possible.**

Yours faithfully,

Mrs Colleen Drury  
Supervisor of Midwives  
Midwife Educator.

**Supervisor of Midwives  
Information Letter**

To: Supervisor of Midwives

Date: 2<sup>nd</sup> January 2009

Dear Supervisor of Midwives,

I am writing to request your participation in a study relating to Supervision of Midwives and the continuing professional development (CPD) of Midwives.

I am a Supervisor of Midwives and a Midwife Educator at the University of Nottingham and am currently studying for a Doctor in Education qualification. As a Supervisor of Midwives I am interested to find out how Supervisors of Midwives influence the provision and uptake of continuing professional development activities practising midwives.

The purpose of this questionnaire is to find out your views on this subject area.

I would be grateful if you would take the time to consider filling in the questionnaire and returning it to me in the envelope provided. All questionnaires are anonymous and individuals will not be identified. The ID code on the questionnaire is simply to identify the unit and the number of participants returning the questionnaire.

If you would like to participate in the next stage of my research which involves focus groups then please complete the detachable form at the end of the questionnaire.

Thank you for taking time to read this information and considering participation. Further information can be found in the participant information sheet enclosed.

I would be grateful if you could also complete the form indicating your interest in participating in a focus group and return it to me in the separate envelope provided.

**Please return all documents by the 28<sup>th</sup> January 2009 if possible.**

Yours faithfully,

Mrs Colleen Drury  
Supervisor of Midwives  
Midwife Educator.



**This letter will be sent out on University headed paper**

**LSA officers Information Letter**

To: LSA Officers  
Address

Date

Dear LSA Midwifery Responsible Officer,

I am writing to request your participation in a study relating to Supervision of Midwives and the continuing professional development (CPD) of Midwives.

I am a Supervisor of Midwives and a Midwife Educator at the University of Nottingham and am currently studying for a Doctor in Education qualification. As a Supervisor of Midwives I am interested to find out how Supervisors of Midwives influence the provision and uptake of continuing professional development activities practising midwives.

The purpose of this questionnaire is to find out your views on this subject area.

I would be grateful if you would take the time to consider filling in the questionnaire and returning it to me in the envelope provided. All questionnaires are anonymous and individuals will not be identified. The Id code on the questionnaire is simply to identify the area and the number of participants returning the questionnaire.

Thank you for taking time to read this information and considering participation. Further information can be found in the enclosed participant information sheet.

I would be grateful if you could complete the participant consent form and return it to me in the envelope provided.

Yours faithfully,

Mrs Colleen Drury  
Supervisor of Midwives  
Midwife Educator.  
**LME Information Letter**

To: Lead Midwife Educators

Date: 2<sup>nd</sup> January 2009.

Dear Lead Midwife Educator,

I am writing to request your participation in a study relating to Supervision of Midwives and the continuing professional development (CPD) of Midwives.

I am a Supervisor of Midwives and a Midwife Educator at the University of Nottingham and am currently studying for a Doctor in Education qualification. As a Supervisor of Midwives I am interested to find out how Supervisors of Midwives influence the provision and uptake of continuing professional development activities of practising midwives.

The purpose of this questionnaire is to find out your views on this subject area.

I would be grateful if you would take the time to consider filling in the questionnaire and returning it to me in the envelope provided. All questionnaires are anonymous and individuals will not be identified. The Id code on the questionnaire is simply to identify the unit and the number of participants returning the questionnaire.

Thank you for taking time to read this information and considering participation. Further information can be found on the enclosed participant information sheet.

I would be grateful if you could complete the participant consent form and return it to me in the envelope provided.

**Please return all documents by the 28<sup>th</sup> January 2009 if possible.**

Yours faithfully,

Mrs Colleen Drury  
Supervisor of Midwives  
Midwife Educator.

# **Appendix 6**

## **Participant Information Sheet**

**08/H0406/127**

**Date: 2<sup>nd</sup> January 2009**

## **PARTICIPANT INFORMATION SHEET**

### **Study title:**

**An Exploration of how Supervisors of Midwives influence the continuing professional development (CPD) activities of practising midwives.**

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

### **The purpose of the study**

The researcher is undertaking an educational qualification and part of the course requires a research project to be completed. As the researcher is also a Supervisor of Midwives it is anticipated that the topic area selected will inform future practice.

### **Why have I been invited to participate?**

The research study will invite all midwives and Supervisors of Midwives within the Trust to participate. The data generated will then be compared to that obtained at two other similar NHS Trusts within the East Midlands Strategic Health Authority Area.

I am also inviting Lead Midwife Educators and Local Supervisory Authority Midwifery Officers in England to participate in this research to provide a wider perspective of these issues.

### **Do I have to take part?**

Taking part in this research is entirely voluntary. If, when you have read this information sheet you decide you want to participate then please complete the consent form enclosed. You are free to withdraw from the study at any time without giving a reason. Your participation in the study will be kept confidential.

If you withdraw from the study after involvement in the focus group then no direct quotes will be used in any of the study reports but data from the focus group will still be used.

### **What will happen to me if I take part?**

If you decide to take part in the study you will need to complete the enclosed questionnaire and return it to me in the envelope provided. This should only take about 10 – 15 minutes. This is the first stage of the study.

Stage 2 involves attending a focus group meeting in the Unit which will take about 30 minutes of your time. Lead midwife educators and Local Supervisory Authority Midwifery officers will not be involved in stage 2 of this research.

The Midwives focus group will comprise approximately 6 – 8 midwives.

The Supervisors of Midwives focus group will comprise approximately 6 – 8 supervisors.\*

If you want to take part in this stage of the study then you will need to indicate this at the end of the questionnaire. The researcher can then get in touch with you to let you know the date and time of the relevant focus group meeting.

At the focus group the researcher will audio-tape the discussion to enable later transcribing and understanding of the context and issues raised. Confidentiality will be adhered to and participants will not be identified.

### **What are the possible advantages and disadvantages of taking part in the study?**

Advantages – there is a lack of information available on the topic and it is not commonly known how Supervisors of Midwives fulfil their role in this area. Therefore information collected from midwives, Supervisors of Midwives, Lead Midwife Educators and Local Supervisory Authority Midwifery Officers should help to inform practice and enable future discussions and developments to meet midwives professional developmental needs. Disadvantages – the study will require participants to give a minimum of 15 minutes of their time to complete the questionnaire. For those taking part in the second stage of the research a further 30 minutes time will be required to attend the relevant focus group.

### **What happens to the collection of the data?**

All data collected will be stored securely and will only be accessible to the researcher and the academic supervisor. It will be retained for a period of time, 7 years by the University of Nottingham, as required by the Research Ethics Committee and the Research and Development Department. The data will be destroyed securely after this time.

### **What happens when the research study ends?**

At the end of the study the results will be disseminated to participants locally.

### **Who is funding the research?**

The research is part of an educational course and is funded by the researcher.

### **Who has reviewed the study?**

The study has been reviewed by an independent group known as a Research Ethics Committee. This Committee looks at all research undertaken in the NHS and aims to protect your safety, rights, wellbeing and dignity. The research is also monitored by the Research and Development Department at each of the Trusts in which the research is being carried out.

### **Further information and contact details**

Specific information regarding this research can be obtained from the following:

Name of Researcher: Mrs Colleen A Drury.  
[Colleen.drury@nottingham.ac.uk](mailto:Colleen.drury@nottingham.ac.uk)  
Telephone No. 01332 785195

Academic Supervisor: Dr Simon McGrath  
[Simon.mcgrath@nottingham.ac.uk](mailto:Simon.mcgrath@nottingham.ac.uk)  
Telephone No. 0115 951 4508

For research enquiries/ advice about research undertaken within your Trust please contact your local R&D Department.

## **Appendix 7**

### **School of Education Research Ethics approval documents.**

## SCHOOL OF EDUCATION – STATEMENT OF RESEARCH ETHICS



The University of  
**Nottingham**

Name (Student): Mrs Colleen A Drury Supervisor: Dr Simon McGrath  
 Course of Study: EdD Lifelong Learning  
 Title of Research Project: An exploration of how supervisors of midwives influence the continuing professional development (CPD) of practicing Midwives.

	Tick where appropriate
1. I have read and discussed with my supervisor(s) the British Educational Research Association's Revised Ethical Guidelines for Educational Research (BERA, 2004).	✓
2. I have read and discussed with my supervisor(s) the Research Code of Conduct of the University of Nottingham: <a href="http://www.nottingham.ac.uk/rso/policy/code_of_conduct.dgs">http://www.nottingham.ac.uk/rso/policy/code_of_conduct.dgs</a> .	✓
3. I am aware of and have discussed with my supervisor(s) the relevant sections of the Data Protection Act (1998): <a href="http://www.hmsa.gov.uk/acts/acts1998/19980029.htm">http://www.hmsa.gov.uk/acts/acts1998/19980029.htm</a> .	✓
4. Data gathering activities involving schools and other organizations will be carried out only with the agreement of the head of school/organization, or an authorised representative, and after adequate notice has been given.	✓
5. The purpose and procedures of the research, and the potential benefits and costs of participating (e.g. the amount of their time involved), will be fully explained to prospective research participants at the outset (see BERA, 2004, paras 10, 11, 12, 21).	✓
6. My full identity will be revealed to potential participants.	✓
7. Prospective participants will be informed that data collected will be treated in the strictest confidence and will only be reported in anonymised form, but that I will be forced to consider disclosure of certain information where there are strong grounds for believing that not doing so will result in harm to research participants or others, or (the continuation of) illegal activity (see BERA, 2004, paras 27-28).	✓
8. All potential participants will be asked to give their explicit, normally written consent to participating in the research, and, where consent is given, separate copies of this will be retained by both researcher and participant.	✓
9. In addition to the consent of the individuals concerned, the signed consent of a parent, guardian or 'responsible other' will be required to sanction the participation of minors (i.e. persons under 16 years of age) or those whose 'intellectual capability or other vulnerable circumstance may limit the extent to which they can be expected to understand or agree voluntarily to undertake their role' (BERA, 2004, para 14-16).	N/A
10. Undue pressure will not be placed on individuals or institutions to participate in research activities.	✓
11. The treatment of potential research participants will in no way be prejudiced if they choose not to participate in the project.	✓
12. I will provide participants with my contact details (and those of my supervisor), in order that they are able to make contact in relation to any aspect of the research, should they wish to do so.	✓
13. Participants will be made aware that they may freely withdraw from the project at any time without risk or prejudice (see BERA, 2004, para 13).	✓

Please outline any areas of risk, which have not been referred to above, associated with your research, and how you intend to deal with these (continue on a separate sheet if necessary):

No risks identified.

**Checklist:**

**Please check that you have attached the following and return with the form to the Postgraduate Research Students Office**

- (1) a brief statement of my research aims or questions and proposed methods of data generation (maximum 200 words);
- (2) a brief statement of how I plan to gain access to prospective research participants;
- (3) a draft information sheet to be provided to prospective participants;
- (4) a draft consent form to be used with prospective participants.

NB Please do NOT include copies of research instruments (e.g. questionnaires).

Signed (student) *C A Drury* Print Name (Student) Mrs C A Drury. Date 27/3/08

Signed (supervisor 1) \_\_\_\_\_ Print Name (supervisor 1) Dr Simon McGrath. Date 03/04/08

Signed (supervisor 2, \_\_\_\_\_ Print Name (supervisor 2, \_\_\_\_\_ Date \_\_\_\_\_  
 where appropriate) where appropriate)

yes
yes
yes
yes

PLEASE RETURN THIS FORM WITH SUPPORTING DOCUMENTATION TO THE POSTGRADUATE RESEARCH DEGREES OFFICE (A77)



**School of Education – Research Ethics Approval Form**

Name Colleen Drury  
Main Supervisor Simon McGrath

Course of Study EdD  
Title of Research Project an exploration of how supervisors of midwives influence the continuing professions development (CPD) of practicing midwives

Is this a resubmission? No


Date statement of research ethics received by PGR Office: 3 April 08

Research Ethics Coordinator Comments:

This ethics proposal is basically sound though you could do a little more to ensure that prospective participants are able to give their fully informed consent to participate - eg by stating your perceptions of the potential benefits and costs of participation; and see my comments on your draft PI sheet for midwives. Please discuss and finalize with the approval of your supervisor. Good luck with your research. (Remember that professional development and learning doesn't just come about via 'CPD activities')

Outcome:  
Approved

Revise and Resubmit

Signed:   
(Research Ethics Coordinator)

Name: A.J. Hebbson Date: 24 April 2008

## **Appendix 8**

# **National Research Ethics Committee Approval letter**



## National Research Ethics Service

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1

1 Standard Court  
Park Row  
Nottingham  
NG1 6GN

Telephone: 0115 912 3344 ext 39428  
Facsimile: 0115 9123300

30 July 2008

Mrs Colleen A Drury  
Associate Professor  
University Of Nottingham  
29 Kedleston Drive  
Ilkeston  
Derbyshire  
DE78UA

Dear Mrs Drury

**Full title of study:** An exploration of how supervisors of midwives influence the continuing professional development (CPD) of practising midwives.  
**REC reference number:** 08/H0406/127

Thank you for your letter of 21 July 2008, responding to the Committee's request for further information on the above research and submitting revised documentation, subject to the conditions specified below.

The further information has been considered on behalf of the Committee by the Chair.

### 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 as revised]

### Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority.  
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	AB/131496/1	05 June 2008
Investigator CV: : Supervisor		19 March 2008
Investigator CV		28 March 2008
Protocol	1	11 June 2008
Letter from Sponsor		06 June 2008
Peer Review		24 April 2008
Questionnaire: Midwives	2	21 July 2008
Questionnaire: Supervisors of Midwives	2	21 July 2008
Questionnaire: Lead Midwife Educators	1	11 June 2008
Questionnaire: LSA Midwifery Responsible Officer	1	11 June 2008
Letter of invitation to participant: : Lead Midwife Educators	1	11 June 2008
Letter of invitation to participant: LSA Midwifery Responsible Officers	1	11 June 2008
Letter of invitation to participant: Supervisor of Midwives	2	21 July 2008
Letter of invitation to participant: Midwives	2	21 July 2008
Participant Information Sheet	2	21 July 2008
Participant Consent Form	2	21 July 2008
Response to Request for Further Information		21 July 2008
Evidence of Insurance		09 August 2007
Midwives Interested in Participating in a Focus Group	1	21 July 2008
Supervisors of Midwives interested in Participating in a Focus Group	1	21 July 2008
Letter to participants not selected to take part in a focus group	2	21 July 2008
School of Education – Research Ethics Approval Form		24 April 2008

### Statement of compliance

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.

### After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.


We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

**08/H0406/127**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely



**Dr Carl Edwards / Miss Jeannie McKie**  
**Chair / Committee Coordinator**

Email: [jeannie.mckie@nottspct.nhs.uk](mailto:jeannie.mckie@nottspct.nhs.uk)

Enclosures: "After ethical review – guidance for researchers" SL- AR2

Copy to: *Mr Paul Cartledge*  
*R&D office for NHS care organisation at lead site – Derby Hospitals*

# **Appendix 9**

## **Peer Review Form**

**R&D Project Peer Review Form**

**Lead Investigator**

Colleen Drury

**Reference Number**

**Full Title of Proposed Project**

An exploration of how supervisors of midwives influence the continuing professional development (CPD) of practising midwives.

Thank you for your help in refereeing this project. Please could you give us your views on the overall quality and relevance of this project to Clinical Research, listing your comments (by tick) as outlined below.

**Study Assessment and Recommendation**

Is this study:		Please select			
		Yes	No	Yes	No
A+/A	Excellent project	<input type="checkbox"/>	<input type="checkbox"/>	Approved with no changes	<input type="checkbox"/> <input type="checkbox"/>
B+/B	Good project	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Approved, but with minor changes required	<input checked="" type="checkbox"/> <input type="checkbox"/>
C	Requires further information/work	<input type="checkbox"/>	<input type="checkbox"/>	Not approved and requires resubmission following corrections/additions	<input type="checkbox"/> <input type="checkbox"/>
D	Rejected	<input type="checkbox"/>	<input type="checkbox"/>	Rejected	<input type="checkbox"/> <input type="checkbox"/>

**Study Changes Required**

Please select		Yes	No
a)	<input type="checkbox"/> <input type="checkbox"/> Is(are) the hypothesis(es) clear and appropriate for the project?		
b)	<input checked="" type="checkbox"/> <input type="checkbox"/> Is(are) the study aim(s) and objective(s) well defined and relevant for the project?		
c)	<input checked="" type="checkbox"/> <input type="checkbox"/> Is the methodology to be used appropriate for the project and is the study design suitable to achieve the aims of the study?		
d)	<input checked="" type="checkbox"/> <input type="checkbox"/> Is the clinical and/or background information suitable and adequate for the proposed study, and are the references relevant?		
e)	<input checked="" type="checkbox"/> <input type="checkbox"/> Is the study likely to be completed in the time stipulated?		
f)	<input checked="" type="checkbox"/> <input type="checkbox"/> Are study numbers justified?		
g)	<input checked="" type="checkbox"/> <input type="checkbox"/> Is the statistical analysis proposed appropriate?		

**Referee's Comments to Applicants**

This is a good study with clear justification regarding the need for research in this important area and triangulation of data collection methods will enhance the methodology. Minor changes are suggested and these are as follows:  
 Questionnaire: You need to review one of the questions in terms of validity, also consider inclusion of a question in relation to the Lead Midwife Educator on the SOM questionnaire.  
 Focus Group: Consider how you intend to generate questions from the questionnaires. Also how do you intend to proceed if you get a poor response in relation to recruitment for this data collection method?  
 Descriptive statistics highlighted although you could elaborate further and explicitly state the package to be utilised for this purpose (SPSS); do you intend to use visual descriptive statistics in addition to measurements of central tendency?  
 Participant information sheet needs to be formulated.

Please select  
Yes No

In your opinion do the investigator(s) have the experience/expertise to perform the study satisfactorily?

I declare that I have not been involved in the design of this study and that I have no conflicts of interest in acting as a referee.

Signature: ..... *J.L. Charity* ..... Date: ..... *20/3/08* .....

Printed Name: ..... *J.L. Charity* .....

Position Held: ... *SENIOR MIDWIFE TEACHER / SUPERVISOR OF MIDWIVES* ..... Dept: ..... *20/03/08* .....

Contact Address: *UNIVERSITY OF NOTTINGHAM ACADEMIC DIVISION, MIDWIFERY, DEBURY CITY GENERAL HOSPITAL, UTTERCOTE RD, DECSY*

Tel no: ..... *01332 785197* ..... E-mail: ..... *j.charity@nottingham.ac.uk* .....



**Appendix 10**

**Research and Development  
Approval Letter**

SDAH R + D OFFICE  
ISSUED  
18 NOV 2008

Research & Development Office

TRUST APPROVAL LETTER

Derby Hospitals **NHS**

NHS Foundation Trust

Derby City General Hospital  
Uttoxeter Road  
Derby  
DE22 3NE

Tel: 01332 340131  
Minicom: 01332 254944  
contactus@derbyhospitals.nhs.uk  
www.derbyhospitals.nhs.uk

Mrs Colleen Drury  
Faculty of Medicine and Health Sciences  
School of Human Development  
Academic Division of Midwifery  
A Floor  
Medical School  
Queens Medical Centre  
Nottingham  
NG7 2HA

Dear Mrs Drury

**Re: An exploration of how supervisors of midwives influence the continuing professional development (CPD) of practising midwives (Ref. DHRD/2008/058).**

Further to the Research Ethics Committee approval for the above study, I am pleased to confirm Trust management approval for you to proceed in accordance with the agreed protocol, the Trust's financial procedures for research and development and the Research Governance Framework (which includes the Data Protection Act 1998 and the Health & Safety at Work Act 1974).

Please supply the following to Dr Teresa Grieve, Assistant Director of R&D:

- the actual start and end dates of this study (**before the study commences**).
- details of any publications arising from this research project.
- a final report and a report every six months if the study duration is greater than six months.
- notification of any adverse event or changes to the protocol or if the trial is abandoned.

Please note that approval for this study is dependent on full compliance with all of the above conditions.

I would like to take this opportunity to wish you every success with this study.

Yours sincerely,



Prof. Richard Donnelly MD, PhD, FRCP, FRACP  
Director of Research & Development

# **Appendix 11**

## **Consent Form for Participants**

**PARTICIPANT CONSENT FORM**

**Project title:**

**An Exploration of how Supervisors of Midwives influence the continuing professional development (CPD) of practising midwives.**

**Researcher's name: Mrs Colleen A Drury.**

**Academic Supervisor's name: Dr Simon McGrath**

Please place your initials in each box

I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me.

I understand the purpose of the research project and my involvement in it.

I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.

I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.

I understand that I will be audio-taped during the focus group interview.

I understand that data will be stored on the computer of the researcher and University computer but access will be by password and limited to the researcher and the academic supervisor. Paper copies and audio-tapes of data will be stored in a locked cupboard accessed only by the researcher. The University policy in relation to storage of data will be adhered to.

I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if I wish to make a complaint relating to my involvement in the research.

I agree to take part in the study.

**Signed .....**(Research participant)

**Print name .....Date .....**

**Name of Researcher obtaining consent: Colleen Drury.**

**Date.....**

**Contact details**

Researcher: Mrs Colleen Drury.  
Email address: [colleen.drury@nottingham.ac.uk](mailto:colleen.drury@nottingham.ac.uk)  
Telephone number: 01332 785195

Supervisor: Dr Simon McGrath  
Email address: [simon.mcgrath@nottingham.ac.uk](mailto:simon.mcgrath@nottingham.ac.uk)  
Telephone number: 0115 951 4508

School of Education Research Ethics Coordinator:  
[andrew.hobson@nottingham.ac.uk](mailto:andrew.hobson@nottingham.ac.uk)

## **Appendix 12**

# **Consent Form for Participants in Focus Groups**

**PARTICIPANT CONSENT FORM FOR FOCUS GROUP INVOLVEMENT**

**Project title:**

**An Exploration of how Supervisors of Midwives influence the continuing professional development (CPD) of practising midwives.**

**Researcher's name: Mrs Colleen A Drury.**

**Academic Supervisor's name: Dr Simon McGrath**

Please place your initials in each box

I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me.

I understand the purpose of the research project and my involvement in it.

I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.

I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.

I understand that I will be audio-taped during the focus group interview.

I understand that data will be stored on the computer of the researcher and University computer but access will be by password and limited to the researcher and the academic supervisor. Paper copies and audio-tapes of data will be stored in a locked cupboard accessed only by the researcher. The University policy in relation to storage of data will be adhered to.

I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if I wish to make a complaint relating to my involvement in the research.

**I understand that the discussion at the focus group is confidential and any identifiable information should not be discussed outside of the group.**

I agree to take part in the study.

**Signed .....**(Research Participant)

**Print name ..... Date .....**

**Name of Researcher obtaining consent: Colleen Drury.**

**Date.....**

**Contact details**

Researcher: Mrs Colleen Drury.  
Email address: [colleen.drury@nottingham.ac.uk](mailto:colleen.drury@nottingham.ac.uk)  
Telephone number: 01332 785195

Supervisor: Dr Simon McGrath.  
Email address: [simon.mcgrath@nottingham.ac.uk](mailto:simon.mcgrath@nottingham.ac.uk)  
Telephone number: 0115 951 4508

School of Education Research Ethics Coordinator: [andrew.hobson@nottingham.ac.uk](mailto:andrew.hobson@nottingham.ac.uk)