Exploring the influence of resilience on midwives' and student midwives' career-related decisions

A Constructivist Grounded Theory Study

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Abstract

A national shortage of midwives, coupled with the increasing complexity of maternal health issues and the rising age of childbearing women, has resulted in the role of the midwife being an increasingly challenging one. Many midwives experience emotional distress, low morale, and job dissatisfaction and are making the decision to leave the profession as a result. Recruiting and retaining resilient individuals who can survive and thrive in complex and demanding working environments in the NHS has been widely suggested as a key strategy for improving retention in the midwifery profession. However, limited evidence exists on the influence of resilience on midwives' career experiences, choices, and trajectories, particularly during the early phases of stress and job dissatisfaction.

This thesis presents a Grounded theory (GT) study which explored the influence of resilience on midwives' and student midwives' career-related decisions. Thirty-six participants from the North of England took part in individual semi-structured interviews. Data were collected and analysed following Charmaz's (2014) Constructivist Grounded theory approach and constant comparative methods.

The substantive Grounded theory (GT), 'Time to change' was developed comprising four core concepts: 'Fitting in', 'Being valued,' 'Feeling in control' and 'Getting the balance right'. Central to the theory was the importance of confidence, experience, and perceived support on fluctuating levels of resilience, and midwives' subsequent ability to make career-related decisions including changes in role, work-life balance, and the decision to remain in the profession.

Findings from the study indicate that participants perceived resilience, alongside a number of other influences, had a significant role to play in midwives' and student midwives' career-related decisions. The findings provide novel insight into the influence of resilience in midwifery that has relevance for the profession and the potential to inform midwifery policy, practice, and education for the future.

Contents

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Author's Declaration

I declare that this thesis is a presentation of original work, and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as references.

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Chapter One: Introduction

1.1 Introduction

This thesis examines the influence of resilience on midwives' and student midwives' career-related decisions, using Constructivist Grounded theory. This introductory chapter provides the background and context for the research study presented in the thesis. It presents an overview of the current workforce challenges facing healthcare in the United Kingdom (UK) and specifically maternity services. It also reviews resilience as a potential solution to the retention crisis and provides a rationale for the focus of the study, identifying the current gaps in relation to midwives' and student midwives' career-related decisions and resilience. The chapter concludes with an overview of the subsequent structure of the thesis.

1.2 Workforce Challenges

The National Health Service (NHS) is increasingly being reported as grappling to meet the pressures of patients due to reduced staffing, unskilled or inappropriate skill mix, and limited resources available (Department of Health (DoH), 2020a). There is growing acknowledgement that the current UK healthcare workforce does not meet the demands of the healthcare system (The Kings Fund, 2018). The poor retention of NHS staff is frequently highlighted as an increasingly challenging issue (NHS Employers 2022; NHS England, 2020). Historically, the retention of staff has continued to be a cause for concern and has been exacerbated during the post COVID-19 period (Schmitt, Mattern, Cignacco, et al., 2021).

Mainstream media frequently scrutinise the NHS staffing crisis with headlines such as 'work pressures driving nurses and midwives away' (BBC News, 2023). More than ten percent of the nursing workforce left NHS employment between 2014-2017 and more than half of those who resigned in 2017 were under the age of forty (NMC, 2017a). One of the three priority areas (train, retain and reform) identified by the recently published NHS Long Term Workforce Plan (NHS England, 2023) includes a major drive on retention, with better opportunities for career development and improved flexible working options for staff. The plan includes offering 24,000 more nurse and midwife training places a year by 2031.

Midwives and nurses make up the two largest professional groups working across health and social care in England (Health Education England (HEE), 2017) and there is now significant data demonstrating that retention is a growing problem (HEE, 2018; HEE, 2019; NMC, 2023b). Data for both of the professions is often coupled together and therefore will be presented together in the first instance to provide an overview of the statistics for these professional groups. At the time this study presented in this thesis commenced, figures from the Nursing & Midwifery Council (NMC) (NMC,2017a) indicated that for the first time, more nurses and midwives were leaving the register than joining it. Similarly, there was a nine percent increase in the number of graduates leaving the professions in 2017 compared to 2016, and an increase of sixty-seven percent of nurses and midwives from Europe leaving the register (NMC, 2017a). However, since then, more recent statistics published by the NMC (NMC, 2023) indicate that some improvements to figures for registrants leaving the nursing and midwifery profession have been made (see Table 1.1). Despite retirement remaining the lead reason for a registrant deciding to leave the NMC register (NMC, 2023c), other frequently mentioned factors also include burnout, workload and staffing and lack of colleague support. One particular concern the recently published data from the NMC (NMC, 2023c) also indicated is that there appears to be a trend of leaving the register earlier than planned, with no intention to return for the majority of leavers.

Table 1.1: Table showing NMC latest figures for 2022-23 (NMC, 2023b)

Nursing & Midwifery Council (NMC) Registrant Details	**Figures for 2022-23**	**Trend**
Total registrants (nurse, midwives, and nursing associates) on NMC register	808,488	↑ 2.5%
Total registrants in England only	610,359	↑3.2%
Midwives only	42,974	↑3.0%
Midwives in England only	34,342	↑3.7%
Dual registrants (nurse and midwife)	5,327	↓2.7%
Joining the register in England total registrants	29,383	↑6.5%
Leaving the register in England total registrants	20,080	
Midwives (initial registration was in the UK)	1,082	↑
Midwives (international)	143	↑

Gender on register (identity as female)	88.8%	
Gender on register for midwives (female)	42,847	
Gender on register for midwives (male)	127	
Midwives joining register	1751	
Midwives leaving register	686	

Key reasons for poor staff retention include burnout and work-related stress in healthcare, both of which have received considerable research and attention (Matos et al., 2010; Ruston et al., 2015; NMC, 2023c), particularly for healthcare professionals working in settings such as operating theatres, emergency rooms and intensive care units. Stress and burnout among midwifery and nursing staff has been found to significantly correlate with their intention to leave (Lafer et al., 2003; Heinen et al., 2013). Having an understanding of the importance of the influence of resilience on career-related decisions for midwives and student midwives in the earlier stages of workplace stress, and ideally, before they reach burnout is vital. In a European nursing survey, forty-two percent of UK nurses reported burnout (the highest of all the European countries surveyed), compared to the European average of twenty-eight percent. Newly qualified nurses turnover rates tend to be high in the first year of nursing and remain high; or even rise, during the second year, before declining (HEE, 2018). If this situation is not addressed, stress for staff accumulates and, if left untreated, typically continues through the three stages of burnout (emotional exhaustion, depersonalisation, and personal accomplishment) (Maslach, Schaufeli and Leiter, 2001). Spinetta, Jankovic, Ben Arush, et al., (2000) identify how an individual transitions through five stages of stress to burnout, beginning with mental and physical exhaustion, indifference, failure as a professional, failure as a person and finally complete burnout. During these stages there is often a discord between expectations, reality, and stress and/or frustration and job dissatisfaction. It is in the final stage where a healthcare worker will contemplate leaving the profession.

Working conditions in healthcare continue to be highlighted as a concern with patient safety being compromised by inadequate staffing levels and staff burnout (Tamburello, 2023; Kirkup, 2022). In late 2022 and early 2023 members of the Royal College of Nursing (RCN) in England took strike action and negotiations between trade unions and the government remain volatile (RCN, 2023). Union members are concerned that people will be reluctant to

join the NHS or stay in their jobs without better pay and conditions, exacerbating existing staffing problems further (UK Parliament, 2023). Jones, Warren, and Davie's (2015) report, 'Mind the Gap', focused on exploring the needs of early careers for nurses and midwives in the workplace, concluding that the era an individual is born in, may influence their commitment to remain within the role. For example, Generation Y (born between 1981-1996) and Generation Z (born between1997-2012) show preferences for greater flexible working and seeking a better work-life balance. A recent publication by Capper, Haynes, and Williamson (2023) aimed to explore how the early workforce experiences of newly qualified midwives influenced their career plans, suggesting the development of appropriate strategies to minimise early attrition from the midwifery profession and promote career longevity are required.

1.3 Midwifery

There is a national shortage of midwives and despite the government initiative to increase these numbers, many midwives are making the decision to leave the profession (RCM, 2021; NMC 2023b; NMC, 2023c). Kirkham (2006) reported these concerns over sixteen years ago, anticipating that this situation was only going to get worse as the role of the midwife became more physically and emotionally demanding. Despite a small fall in the overall vacancy figures of the NHS workforce from 130,000 in December 2022 to around 112,000, there has been little growth in midwifery numbers (NHS Employers, 2023) with the RCM's latest figures indicating that England is short of 2500 midwives (RCM, 2023). In 2018, the RCM published data suggesting that every time thirty new midwives join the workforce, it only increases the workforce by one due to the concurrent attrition rates (RCM, 2018). The Royal College of Midwives (RCM, 2021) also reported several underpinning reasons contributing to an ongoing staffing crisis in maternity services. The midwifery profession in the UK has an ageing workforce and data published by the NMC (NMC, 2017a) indicates that one of the largest age groups (between 41-50) on the NMC register saw a substantial decrease (over 5000 midwives). This is concerning as midwives within this age category are often those with experience and expertise of the profession. This ongoing premature attrition combined with an ageing workforce (Oliver and Geraghty, 2022), is likely to lead to a serious midwifery shortage over the next ten years as a considerable number of the remaining workforce reach retirement age and leave (Callander et al., 2021). In addition, increasing maternal health issues such as obesity, mental health disorders, infertility, and the rising age of childbearing women (RCM, 2023; RCM, 2018) contribute to making the role of the midwife an increasingly

challenging one. Capper, Haynes, and Williamson (2023) suggest that there are two ways to tackle the growing shortage of midwives; by educating and supporting midwifery students who want to join and remain in the profession, and by retaining the existing midwifery workforce.

There are, of course, legitimate reasons why a midwife may choose to leave the profession, for example when one decides to retire, has personal issues, requests a career break, or is made redundant (Buchan, 2012). However, within the NHS, various strategies have been considered to retain midwifery staff (NHS Employers, 2022). It is less expensive to retain staff than to recruit, train, and employ new ones; therefore, investing in improved working environments is a key strategy that has been used to retain midwifery staff (NHS Employers, 2022). NHS England (2020; 2021) recognises that no single approach is likely to prevent individuals within the profession leaving, but by adopting several different options, it is expected that there may be significant gains in retaining them. Midwives are more likely to report feeling pressured at work than other NHS staff, with almost half recording having suffered from work-related stress (National Maternity Review, 2016). In addition, more midwives reported feeling unsupported in the workplace compared with other clinicians (National Maternity Review, 2016).

In more recent years, negative stories about contemporary midwifery practice have had a detrimental impact on its attractiveness as a career choice. The recently published investigations of maternity services at Morecambe Bay and East Kent (Kirkup, 2015; Kirkup, 2022;) and The Shrewsbury and Telford Hospital NHS Trust (Ockenden, 2022) have highlighted patterns of repeated poor care and failures in governance and leadership, contributing further to unfavourable public perceptions of midwifery practice and overall emphasising significant threats to patient safety. Bonar (2022) reports midwives having such extensive workloads that they have no time even to get themselves a glass of water when they are thirsty. The main reasons why midwives reported wanting to leave the profession are often because of staffing, workload, negative cultural practices, such as bullying, work-life imbalance and not having enough time to spend with women and their families to provide quality care (Merrifield, 2017). Nearly twenty years after its first publication (Ball, Curtis, and Kirkham, 2002) the RCM (2016a) revisited the seminal piece *'Why Do Midwives Leave'?* The main findings from the second report highlighted that midwives were not happy with staffing levels at work (Ball, Curtis, and Kirkham 2013; RCM 2016a). They were also not satisfied with the quality of care they were able to give, their workloads, support from managers, and overall, they were dissatisfied with their working conditions. Following the publication of this

key report, the RCM (RCM, 2016a) made several recommendations in relation to the number of midwives leaving or considering leaving the profession. These included recommending that NHS organisations should review their midwifery turnover rates and vacancy data to identify posts that have recruitment and retention issues.

Overall, there is growing evidence that elevated levels of emotional distress continue to contribute to low morale and attrition among midwives in the UK (Ball, Curtis, and Kirkham 2013; RCM, 2015a; RCM 2016a; Sheen, Spiby, and Slade 2015; Yoshida and Sandall 2013). Previous studies (Ball, Curtis, and Kirkham, 2013; RCM, 2016a; Smith, 2021) identified important concerns in relation to midwives' workplace stress and low morale but left many questions unanswered. This prompted a further study which was commissioned by the RCM *'Work, Health, and Emotional Lives of Midwives'* (WHELM) study for the UK (Hunter et al., 2018; Hunter et al., 2019). The aim of the WHELM study (Hunter, Henley, Fenwick et al., 2019) was to explore the relationship between the emotional well-being of UK midwives and their work environment, using a cross-sectional research design. Some of the key objectives of this study included: determining the level of burnout, depression, anxiety, and stress in midwives, identifying intention to leave the profession, and the reasons and factors associated with an intention to leave. It explored midwives' perceptions of the workplace (relationships, practice environment and midwifery empowerment) and associations with burnout, depression, anxiety, and stress. It identified whether an intervention designed to improve emotional well-being might be acceptable to midwives. The key results were worrying and indicated that the UK's midwifery workforce is experiencing significant levels of emotional distress. Specific recommendations from the WHELM study suggested that evidence-based interventions for workforce well-being support should be introduced (e.g., clinical supervision, mindfulness, and complementary therapies) and also ensure that midwives are given protected time to access these. It also identified that proactive support for younger, recently qualified midwives, identified as vulnerable was required (Hunter et al., 2019). The two most influential midwifery related studies (Kirkham's 2007; Hunter and Warren, 2013; 2014) in relation to experiences of midwives' working lives have clearly indicated that further research into the influence of resilience as a potential solution during a midwife's career trajectory, particularly during the early phases of stress and job dissatisfaction as key to the retention of midwives.

1.4 Resilience and midwives' and student midwives' career-related decisions

Resilience is a dynamic process (Luthar, 2006), and can be defined as the ability of individuals to bounce back or to cope successfully despite adverse circumstances (Rutter 2008). As discussed in detail in Chapter Three of the thesis, the origins of the concept of resilience in the literature can be found in relation to child development, psychology, physiological stress literature (Hodges et al., 2008) and social work (Collins, 2007). It has been widely debated whether resilience can be learnt or whether it is innate and/or whether it is a static or a dynamic process. Neenan (2009) suggests that resilience uses adaptable cognitive, behavioural, and emotional responses to adversities and is a resource that can be developed by anyone. However, perceptions and experiences of professional resilience are influenced by context and over the past decade, resilience in healthcare has become a contemporary topic of debate for managing the challenges of healthcare and workforce retention (Pines et al., 2014; Cameron and Brownie, 2010; Mealer, Jones, and Moss, 2012).

As is discussed in Chapter Three of the thesis, it is being increasingly argued that resilience is an essential quality for healthcare professionals to foster in order to manage stressful and traumatic working environments or situations. Hart, Brannan, and De Chesnay (2014) acknowledges that resilience is viewed as a personal capacity enabling professionals to cope with workplace demands. However, studies to date concerning resilience and healthcare professionals have focused primarily on nursing (Jackson, Firtko and Edenborough, 2007; Pitt et al., 2012; Zander, Hutton, and King 2013; Cope, Jones, and Hendricks, 2014) and medicine (Walters et al., 2015; Kjeldstadli et al., 2006; Potter, Pion, and Gentry 2015a; Stevenson, Phillips, and Anderson, 2011). Moreover, as presented in the scoping review of the research literature in Chapter Two, to date, evidence on the influence of resilience in health professionals' careers has been largely limited to intention to leave (attrition). Although the RCM have suggested that seeking and retaining resilient individuals who can survive and thrive in complex and demanding working environments in the NHS is required (RCM, 2022b), there is sparse evidence on the influence of resilience on midwives' professional lives.

A small number of studies, including Bloxsome, Bayes, and Ireson (2020) have explored why midwives choose to remain in the profession and the connections between their perceived autonomy and increased resilience levels. Results from this study highlighted three main reasons that midwives reported were fundamental to them remaining in the profession; midwives expressed the ability to be 'with woman' and the difference they feel they make to them, the colleagues they work with and the opportunity to 'grow' the next generation. In addition, choosing to study midwifery is influenced by personal and extrinsic factors,

including the willingness to help others and altruism (Güner, Karaaslan, and Orhun 2019). Hunter and Warren (2013; 2014) explain that midwives may demonstrate their professional resilience when they continue to practise and positively adapt in the face of workplace adversity. Lerner (2006) goes on to state that that the expression of resilience will often be affected by the context, not only the immediate context, but the larger contexts of age cohort, family history, social class, nation/culture, history, and sex. Absent from the current literature is an examination of how resilience influences the career choices and trajectories of midwives more broadly. As the scoping review in Chapter Two highlights, limited work has focused on if and *how* resilience influences aspects of midwives' and student midwives' career-related decisions more broadly, such as choice of clinical speciality, changing employer, work-life balance, choice of profession and reasons for remaining in the profession.

Whilst there are limited specific definitions available for career-related decisions in relation to midwifery practice, there are some broader explanations available originating from psychology that can help guide this study. Spokane and Oliver's (1983, p100) definition of career or vocational intervention as *'any treatment or effort intended to enhance an individual's career development or to enable the person to make better career-related decisions*'. Whiston, Rossier and Hernandez Barón (2017, p39) more recently defined career and workforce development interventions as *'any treatment or effort intended to enhance an individual's career, occupational, or work-related development, or to enable the person to make better work-related decisions and help the individual to manage work transitions*'. In relation to the study presented in this thesis, career-related decisions have been defined *as 'when a participant refers to their career experiences and choices, including whether their resilience levels at the time influenced this decision'*.

A focus on the influence of resilience on career-related decisions beyond intention to leave the profession is important in order to better understand contributing factors, and the need for resilience and successful strategies to build resilience which can help in the recruitment and retention of staff (Hart, Brannan, and De Chesnay 2014). Identification of the reasons why midwives remain and flourish in midwifery is essential to the sustainability and longevity of the profession. For example, research in other study populations has highlighted the relationship between resilience and career-adaptability (Maree, 2017; Pang, Wang, Liu et al., 2021). Developing this knowledge in the context of midwifery could help inform actions to strengthen resilience and improve morale, job satisfaction, and emotional distress and avoiding midwives reaching the point they feel unable to continue in their role. This is

particularly relevant as healthcare professionals, including midwives, are increasingly faced with staffing shortages, higher patient acuity, proliferation of innovative technology, regulatory requirements, physical and psychological demands, and ethical dilemmas (Hart, Brannan, and De Chesnay, 2014). Ultimately, increasing, and demanding roles in the workplace creates challenges for the retention of midwives. Therefore, it is essential that the phenomenon of resilience is explored in relation to midwives' and student midwives' career-related decisions and whether it has any influence over them, which in turn, could improve the overall retention levels of midwives.

1.5 Rationale for study

It is evident that there is a clear gap in the existing literature and a need to explore further the influence of resilience on midwives' and student midwives' career-related decisions. There is little focus on resilience in midwifery, and those studies which have explored this have focused on reasons for leaving. Absent from the current literature is an examination of how resilience influences the career choices and trajectories of midwives and student midwives, and the role it plays prior to a decision to leave the profession. This is important because actions could be taken to help improve morale, job satisfaction, and emotional distress and avoid midwives reaching the point they feel unable to continue in their role. Resilience has been shown to be an important concept in a range of healthcare-related occupations, including a small number of studies focusing on the midwifery profession (McDonald et al., 2012; Hunter and Warren, 2014; McDonald et al., 2013 and Foureur et al., 2013). However, current research has been largely limited to exploring reasons for leaving or promoting retention. Although resilience has been identified as a key concept for supporting midwives to adapt in the face of workplace adversities, little is known about the influence of resilience on other career-related decisions beyond attrition. This represents the rationale for the research question examined in this thesis:

'What is the influence of resilience on midwives' and student midwives' career-related decisions?'

1.6 Structure of thesis

This thesis contains ten chapters. The subsequent chapters, following this introduction are as follows:

Chapter Two- Scoping review

Chapter Two presents a scoping review of the current empirical literature in relation to resilience and healthcare professionals, including midwives and student midwives. The review presents what is currently known about resilience among healthcare professionals and where the gaps in knowledge exist, which informs the research question that is the focus of the thesis. The review identified some common findings such as the retention of staff and strategies to maintain an optimum work-life balance. The relevant literature is explored and critiqued and presented in five themes (Resilience, burnout, and job satisfaction; Professional Resilience; Resilience and Retention; Strategies and Interventions to promote and maintain resilience and Resilience studies in students and education).

Chapter Three- A Conceptual Analysis of Resilience

Chapter Three presents a review of the theoretical literature on resilience, examining its historical origins and meanings. Key theories of resilience that have been applied in previous research in the context of midwifery are considered, and application of resilience in midwifery practice is discussed. Resilience in relation to retention and contemporary practice, policy, and education is also highlighted as key to the research question for the study.

Chapter Four- Methodology

Chapter Four describes the Grounded Theory (GT) methodological approach adopted to address the research question identified from the gaps in knowledge discussed in Chapters Two and Three. The research paradigm and rationale for the chosen methodological approaches used in the thesis are presented. An explanation in relation to the chosen data collection methods, and exploration of the quality and generalisability of the approach is considered.

Chapter Five- Research Methods

This chapter provides a comprehensive account of the methods used for the GT study. It provides a detailed explanation of how the GT methodology discussed in Chapter Four, were applied to the study. The chapter includes an in-depth description of the GT approach and conduct of the study, including a rationale for the use of reflexive memos.

Chapter Six- Introduction to Findings

This chapter introduces the initial findings from the study and identifies the participant information and the three stages of coding using constructivist GT. It then discusses the data analysis process and the emergence of the core concepts. Reflexive memos are also included throughout the chapter.

Chapter Seven- Findings

Chapter Seven presents, analyses, and interprets the findings from the semi-structured interviews of the GT study that explored the research question, *'What is the influence of resilience on midwives' and student midwives' career-related decisions'*? Details of the participants' excerpts from the semi-structured interviews are presented throughout the chapter and in relation to the emerging concepts and the GT- *'Time to change'*. The 'Time to change' GT occurred when participants recognised their perceived resilience levels altering (up or down) and then reflected upon this and often took action. Finally, reflexive memos are used throughout the chapter to illustrate the key findings and GT.

Chapter Eight- Discussion of Findings

Chapter Eight analyses and interprets the findings from the study in the context of current midwifery practice and wider literature of relevance. This chapter highlights the significance of the key findings and how the current study extends existing knowledge and understanding of the influence of resilience on midwives' and student midwives' career-related decisions.

Chapter Nine- Recommendations for Practice and Areas for Future Research

In Chapter Nine the recommendations for practice and areas for future research are presented with eight key themes forming the focus for this chapter. The themes are explored in relation to the study's research question, main findings, and the GT- *'Time to change'.*

Chapter Ten- Conclusion

In the concluding chapter of this thesis the strengths and limitations of the study methods and findings are presented. The overall conclusions of the study and last thoughts on the influence of resilience on midwives' and student midwives' career-related decisions are presented.

1.7 Conclusion

This chapter has presented an overview of the rationale for the focus on exploring midwives' and student midwives' experiences and perceptions about resilience in relation to any career-related decisions. It is evident that there is burnout, work-related stress, and dissatisfaction among several midwives. For many, a change in role or even choice to remain in the profession is becoming a decision midwives are increasingly considering making. If an explanation for the reasons for midwives' dissatisfaction, poor retention issues and potential reason to leave the profession is influenced in any way by resilience, then this requires further exploration. The following chapter presents an in-depth scoping review of the literature that was undertaken to identify the current knowledge and gaps in understanding that, together with the review of the theory in Chapter Three, formed the basis of the rationale for the research question examined in this thesis: '*What is the influence of resilience on midwives' and student midwives' career-related decisions?*'

2.1 Introduction

This chapter presents a scoping review of the empirical literature examining the concept of resilience among healthcare professionals. The review aimed to establish what is known about the research topic and identify where the gaps in current knowledge are in relation to midwifery practice. The chapter initially describes the review methodology and methods, which were informed by Arksey and O'Malley's (2005) framework. The remainder of the chapter details the review findings, which are presented as a narrative synthesis of sixty-one included studies, categorised in five key themes (burnout and job satisfaction, professional resilience, retention, strategies, and interventions to promote and maintain resilience, and resilience studies in students and education). The chapter concludes with a summary and rationale for the research question presented in this thesis.

2.2 Methodology

There are various review methodologies available and therefore it was essential to ensure the most appropriate to meet the review aims were selected. The main aims were to become acquainted with the body of knowledge around resilience among healthcare professionals and students and also refine the research question. Initial searches around resilience indicated that little is known about resilience in midwifery. A broad perspective of this literature was required and because a specific research question had not been established yet, a scoping review was the preferred methodology. Scoping reviews allow for a more general question and exploration of the related literature, rather than focusing on providing answers to a more limited question (Moher et al., 2015).

A scoping review approach was chosen to explore what is already known about resilience in healthcare professionals and students. Alternatively, a comparison to a scoping review would be a systematic review which generally starts with a clearly defined question and explores, and analyses high-level research studies focused on narrow parameters. Whereas a scoping review has less depth, but a broader conceptual range (Arksey and O'Malley, 2005). Another benefit for selecting a scoping review over any other methodology was that it enabled diversity between relevant literature and studies using a variety of methodologies to be considered which would not be feasible in a traditional review. A scoping review is an appropriate alternative to a systematic review when literature is vast and complex (Arksey

and O'Malley, 2005). Arksey and O'Malley (2005) published the first framework detailing the purpose of this method and included detailed steps to guide researchers. This framework incorporates four main purposes for scoping reviews. Primarily, the first is to provide a quick overview of a field of research, examining the extent of research done on a particular topic or area. The second is to determine the feasibility, relevance, and/or costs of conducting a full systematic review. The third purpose is to provide focused synthesis and the fourth is to draw conclusions and identify gaps in the existing literature.

Peterson et al., (2016) highlight that the popularity of scoping reviews has gradually increased, and the number of scoping reviews indexed in PubMed and CINAHL has increased substantially, from a single report in 2000 to 151 in 2015. Scoping reviews are increasingly being used in health research to determine the key concepts underpinning a research area and the main sources and types of evidence available (Arksey and O'Malley, 2005). They are particularly useful for bringing together evidence from heterogeneous sources and for examining emerging evidence when it is still ambiguous, and as such, well aligned with the aims identified in the study in this thesis. One of the strengths of the scoping review methodology was that it enabled gaps in the existing literature in relation to resilience to be identified. Although this could be also true for other types of reviews, a scoping review is best designed for large complex subjects, for example, where there is limited research available in relation to resilience and midwifery, (which will be discussed in more detail in Chapter Three).

Scoping reviews summarise and disseminate research findings and can also be used to identify the relevance and necessity of a full systematic review. A scoping review is not concerned with assessing the quality of the studies but focuses more on mapping the existing literature. A broad overview of the current evidence available in relation to resilience and healthcare professionals was required, irrespective of the quality of the studies. Despite some inconsistencies in the conduct and reporting of scoping reviews, the Joanna Briggs Institute (JBI) published methodological guidance to assist the undertaking scoping reviews (Peters et al., 2015).

A scoping review methodology was chosen for this study because it lends itself well for the topic of resilience among healthcare professionals to be explored. It also determined what kind of evidence (quantitative and/or qualitative) was available in a broad approach. It

allowed the breadth of research to be examined, in an area that is complex and still misunderstood as its approach is not linear, it is iterative. Not only did the scoping review enable further clarity of what constitutes resilience among healthcare professionals, it provided a summary of the existing literature and identified gaps which can be considered for the development of a research question. The methodological approach applied in this scoping review was primarily guided by Arksey and O'Malley's (2005) five/six stage framework which includes: 1. Identifying the research question: 2. Identifying relevant studies: 3. Study selection: 4. Charting the data: 5. Collating, summarising, and reporting the results: and 6. Consultation (optional).

As with all methodologies, there are some limitations to the scoping review to take into consideration prior to choosing this as a preferred method. Peters et al., (2015) emphasise that scoping reviews may take longer than systematic reviews, there may be more citations to screen, and they can often lead to a more broad and less defined search. There may also be more of a need for hand searching and the allocation of larger teams to undertake the research due to the volume of the literature and finally, the conduct of the scoping reviews can be inconsistent. However, overall, and despite the recognised limitations, this framework was logical to follow and aligned with the scope and overall objectives of the review. In contrast to a systematic review, it set out clearly the specific stages, ensuring that a broadly defined research question could be achieved. Although this framework was chosen as the primary methodological guidance for this review, consideration of the work by Levac, Colquhoun, and O'Brien (2010), which provided further clarity and enhancement to the Arksey, and O'Malley (2005) framework was also utilised (as detailed in the description of the methods). The original review protocol was registered with the International Prospective Register of Systematic Reviews, registration number: CRD42016043689 (PROSPERO, 2016) and titled *Understanding resilience among registered healthcare professionals and students: a literature review protocol*. The full protocol can be viewed at: https://www.crd.****.ac.uk/PROSPERO/display_record.asp?ID=CRD42016043689 (see Appendix B).

2.3 Justification and explanation for conducting a scoping review when using GT

Traditionally, in a GT study, concepts are generated from empirical data rather than from existing literature (Hallberg, 2010). As a result, misconceptions and disputes exist in relation to the conduct of a literature/scoping review when using GT. To truly undertake GT

objectively, established theorists of GT (Glaser and Strauss, 1967) advise that researchers are expected to minimise preconceptions and ensure that their findings are grounded in their data (not in other researchers). However, El Hussein, Kennedy, and Oliver (2017) suggest that the issue of conducting a literature review remains a conundrum and a controversy within the discourse on grounded theory methodology. This is particularly the case when researchers and postgraduate research students are often expected to evaluate existing literature to justify research questions and support institutional practices.

The timing and role of the literature review in GT has been debated for several years. Recommendations to not engage with the existing literature until after data analysis been widely challenged based on an assumption that it is not desirable or possible to not have *any* previous knowledge (Giles, King, and de Lacey, 2013). Although Glaser (1967) argue that early reading of the literature (i.e., before conducting the study) can be problematic, Hallberg (2010) has suggested that one way to stay open and undertake robust GT studies, is to maintain theoretical sensitivity through constant comparisons of the data. Charmaz's (2014) approach to the conduct and timing of a literature review is interpreted with less caution than Glaser and Strauss's (1967). Charmaz's approach suggests a literature review is justified as long as it does not '*stifle creativity'* (Charmaz, 2014, p. 308). Dunne (2011) highlights the dilemma of how and *when* to engage with the existing literature when conducting GT. One potential solution to counteract the possible negative impact of early engagement with extant literature on the GT process is the consideration of reflexivity. Addressing how reflexivity was included during this study is discussed in detail in Chapter Four and the use of memoing, a key principle of GT, is evidenced throughout the thesis.

In summary, Giles, King, and de Lacey (2013) argue that growing evidence suggests that a preliminary review can enhance theoretical sensitivity and rigour and may even lead to innovative insights. If researchers are aware of the potential influence of prior knowledge during the data analysis and theory development, bias will be avoided. If used reflexively, a preliminary literature review may well enhance grounded theory research (Charmaz, 2014). This study in this thesis has mirrored Charmaz's constructivist viewpoint (Charmaz, 2006, p166), allowing a preliminary literature review prior to the study, which is then put aside and *'allowed to lie fallow'*, until the researcher has begun to develop categories during analysis. The main aim of the scoping review in this thesis was to enable the researcher to gain enough knowledge to critically assess the topic and realise what needed to be researched, but without it commanding the entire process. It was necessary to conduct an early scoping

review to identify the gaps in the current evidence and if the planned study, or something similar as the planned study in this thesis, had been undertaken. The review also provided context and background to the research area and was in keeping with the requirements of a PhD student, demonstrating the necessary skill to conduct such a study. As such, the review presented in this chapter reflects the methods and findings that helped shape the direction of the GT study presented in this thesis and has therefore not been retrospectively updated. Instead, up-to-date literature relevant to the findings presented in the thesis are discussed in Chapter Eight to provide context around how the novel findings from the study add to what is currently known.

2.4 Methods

2.4.1 Identifying the research question: Stage One

Arksey and O'Malley (2005) suggest the aim of stage one of the framework is to consider the purpose of the scoping study and establish and envisage the intended outcome to help determine the purpose. The research question developed to guide the review was: *'What is known about resilience among registered and student healthcare professionals?* The three key concepts underpinning the review question were therefore: 'resilience,' 'healthcare professionals' and 'students'. Having some precision in relation to the three key concepts in the review question, assists in developing the protocol, facilitates effectiveness in the literature search, and provides a clear structure for the development of the scoping review report (Levac et al., 2010). Relevant aspects of the question must be clearly defined as they have ramifications for search strategies, such as the choice of terms of 'healthcare professionals' or 'healthcare workers.' The question also steers and directs the development of the specific inclusion criteria for the scoping review. It is essential in a scoping review to ensure that distinct boundaries are set before embarking on identifying the relevant studies (Arksey and O'Malley, 2005). This was of particular significance to the concept of resilience as the term has been used liberally, with different meanings in the contemporary healthcare literature.

The word resilience originated in psychology in the 1970s and focused on children who had the ability to 'bounce back' from negative life experiences, such as maltreatment and violence, with seemingly minimal long-term effects (Anthony, 1974; Rutter,1979). Further research from patients' perspectives in relation to resilience has also been undertaken (Herrman et al., 2011) however issues including patients were not the focus of this review; therefore, studies involving samples of patients, carers or families were excluded. To establish the existing

literature about 'resilience' among registered and student healthcare professionals, the term 'resilience' had to be reported as a concept in all the included studies. For example, viewing resilience as a vital attribute for healthcare professionals to foster and develop (Gillespie, Chaboyer, and Wallis, 2009).

2.4.2 Identifying relevant studies: Stage Two

Arksey and O'Malley (2005) state that the main aim of stage two is to balance breadth and comprehensiveness of the scoping study with the feasibility of resources. Levac et al., (2010) state that this stage involves identifying the relevant studies and developing a decision plan for where to search, which terms to use, which sources are to be searched, time span, and language. Sources can include electronic databases, reference lists, hand searching of key journals, and organisations. Breadth is important; however, practicalities of the search are as well, for example time, budget, and personnel resources were all potential limiting factors for this review. Arksey and O'Malley (2005) propose that broad keywords and search terms should be used to ensure that the breadth of the literature is included. In the context of this review, studies were limited to those involving samples of registered (qualified) or student healthcare professionals; therefore, studies involving samples of unregistered healthcare workers, such as healthcare assistants were excluded.

Search terms were developed relating to the three key concepts underpinning the review question: 'resilience,' 'healthcare professionals' and 'students.' These were identified further into specific healthcare professions, such as 'nurses' and 'midwives' and combined using Boolean operators. A Population, Concept and Context (PCC) table was used which included the terms, healthcare professionals, midwife, clinician, physician, nurse, and healthcare students under 'population,' resilience under 'concept' and healthcare related settings under the 'context.' The comprehensiveness and breadth were also important in the search. To ensure breadth of the review, six databases were searched: CINAHL (Cumulative Index to Nursing and Allied Health Literature) Plus (EBSCO), Maternity and Infant care (Ovid), EMBASE (Ovid), MEDLINE, PsycINFO (Ovid), and AMED (Allied and Complementary Medicine) on 27th June 2016. Search strings were tailored to each database, to consider variations in exploded terms. These databases were specifically chosen as they encompass the major healthcare professional literature.

A draft strategy search was developed in MEDLINE (see Text Box 1.1) and following testing against a sample of papers, was finalised, and adapted to run in the other five identified databases. Restrictions to English language only papers were applied due to limited resources available for translation. No lower limits to the restriction for the date of publications were made; but an upper limit of 27th June 2016 was included. Searches were then customised to the following five databases. CINAHL (Cumulative Index to Nursing and Allied Health Literature) Plus (EBSCO), Maternity and Infant care (Ovid), EMBASE (Ovid), PsycINFO (Ovid), and AMED (Allied and Complementary Medicine. The draft strategy search in MEDLINE produced 505 hits. See PRISMA flow diagram illustrating literature search process (Figure 2.1).

Text Box 1.1: Example of search string in Medline

1.	Health Personnel/
2.	"Attitude of Health Personnel"/
3.	Physicians/
4.	Allied Health Personnel/
5.	Students, Nursing/
6.	Students, Medical/
7.	midwives.mp. or Midwifery/
8.	Nurses/
9.	Nursing/
10.	clinician.mp. or Nurse Clinicians/
11.	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10
12.	Resilience, Psychological/ or resilien*.mp.
13.	11 and 12

Search strategies included a combination of subject headings and keywords, and searches were devised with guidance from an information specialist. The same keywords and subject headings for each database were applied for consistency. Truncation * or $ was applied depending on which databases. A leading author in the field of healthcare resilience, Helen Robertson, was contacted on 13th June 2016 to identify any additional data/information on published or unpublished literature. Helen Robertson expressed how similar findings had been yielded in relation to irrelevant studies with no reference to resilience; therefore, the search was simplified until eventually publications that met all the criteria were identified.

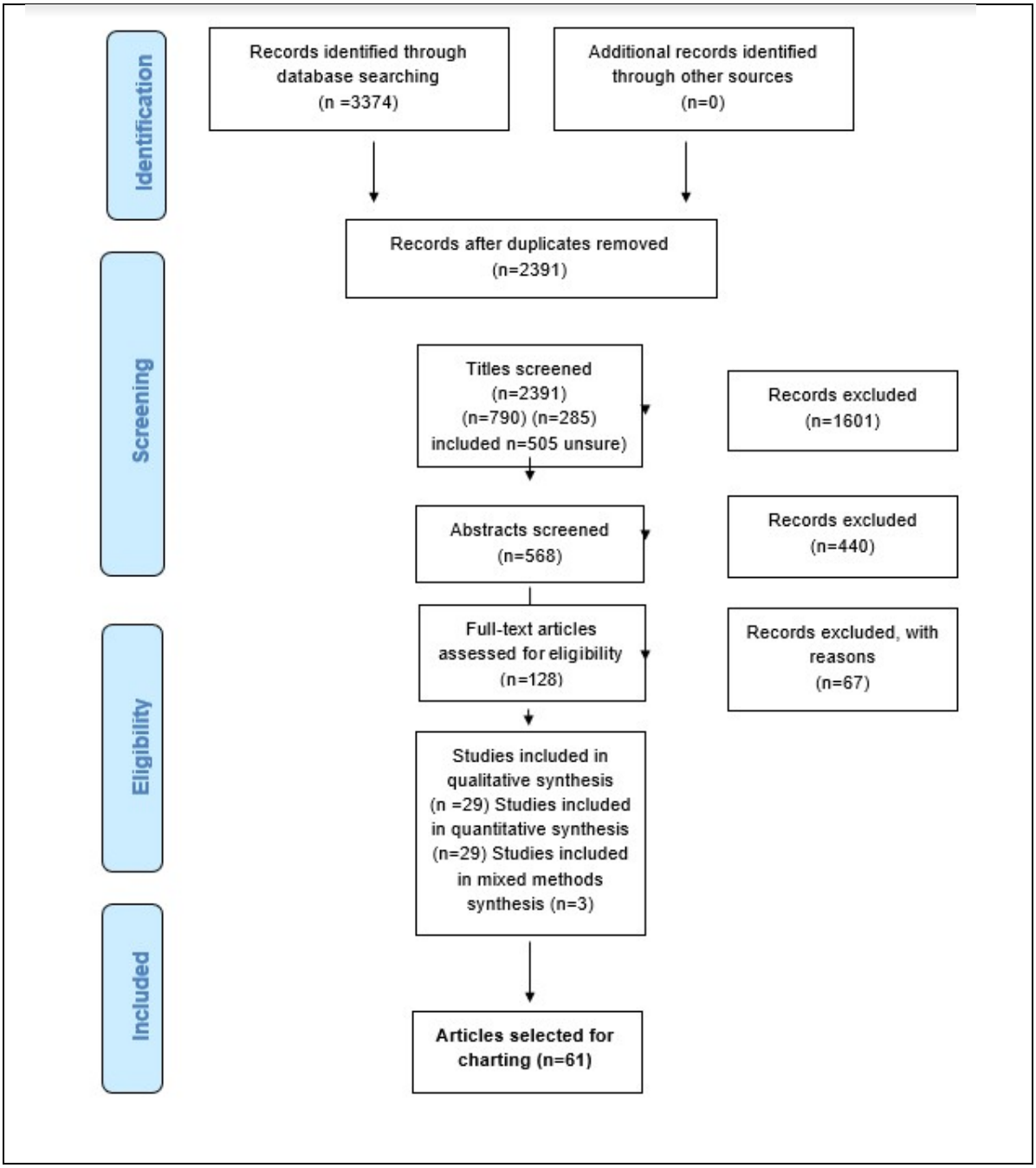
Commentaries, editorials, position papers and reviews were also considered for relevance, but excluded for the purpose of the scoping review. Titles and abstracts were screened to identify suitability for full-text extraction.

2.4.3 Study selection: Stage Three

Arksey and O'Malley (2005) identify that the main aim of stage three is to use an iterative approach to the selection of studies and extraction of data. The study selection stage involves developing post-hoc inclusion and exclusion criteria, based on the increasing familiarity within the literature. For example, it became apparent when reviewing the literature that there were several studies which focused on social care workers or prison wardens and not healthcare workers. These were excluded from the included to studies as they were not relevant to the population identified and the focus of this study was only on healthcare professionals and students. Further details are discussed below in relation to exclusion and the rationale for this during the second stage screening. Levac et al., (2010) suggest that these criteria are based on both the details of the research question and on new knowledge with the subject matter through reading the studies. Records were imported into EndNote (Version 8.1) and subjected to a three-stage screening process. First stage of screening involved examining titles of records against the inclusion criteria. Second stage screening then involved the review of the title and abstracts of the articles. Finally, third stage screening involved reading full texts of articles.

Three academics (PhD supervisors) independently screened a random sample of twenty articles against the inclusion criteria. Discussions in relation to reject papers were undertaken, and if discrepancies were identified, rationales to accept or reject papers were agreed. Guidance and rationale for the inclusion of articles was given by each supervisor and the final decision to include was made by the lead researcher. One hundred and twenty-eight full text articles were assessed for eligibility. Six articles (Dyess, Prestia, and Smith 2015; Brennan and McGrady 2015; Pines et al., 2014; Vesel et al., 2015; DeLuca 2010; and Rushton et al., 2015) were identified for further discussion in relation to inclusion/exclusion. A decision was agreed to keep all six papers included in the study selection, as on repeated review of the papers the focus of the studies were in relation to resilience. At the end of the literature searching process, sixty-one articles were identified that reported the findings of studies of relevance to resilience among healthcare professionals and students (see Figure 2.1).

Figure 2.1: PRISMA Flow diagram illustrating literature search process



Following the first phase screening of titles, a discussion took place regarding some of the included studies which were examining resilient characteristics in healthcare professionals following natural disasters, such as earthquakes. At this stage, there was still a large amount of literature (over 2000 articles) to screen. It was agreed that these would not be included in the second phase screening; likewise, studies which had a military base setting were also discarded, as they were deemed to not be relevant to the research question. This refined the search and excluded a further 1601 articles. No time restrictions were applied to the review inclusion criteria. Although the concept of resilience in contemporary healthcare has become

increasingly popular, it was felt studies included, regardless of the year of publication, may provide valuable information.

Out of the sixty-one included full text articles the oldest paper was published in 1998 and the most recent in 2016. Following the initial scoping search which generated over 6000 hits, this was deemed an unmanageable amount of hits for one researcher to review. A discussion therefore took place, resulting in an agreement to make a change to the population to help manage this. A decision was made to limit the population to healthcare professionals (and not social care) to reduce the number of hits and ensure they were relevant. Records were screened against the following criteria:

1. Article reported primary research using any study design including randomised controlled trials (RCTs), cohort, case-control, case reports, qualitative interviews/questionnaires, or mixed methods.
2. Study focus is regarding resilience relating to healthcare professionals or students.
3. Study participants are male or female healthcare professionals, including midwives, doctors, nurses, healthcare students or other healthcare professionals.
4. Study published only in English language.
5. Study was conducted in any country within a healthcare setting (defined in the study setting).

The review also considered all studies covered by the above databases where the focus of the paper was on resilience in registered (qualified) or student healthcare professionals. Included studies explored the concept and definitions of resilience and any strategies or interventions used to develop resilience among registered healthcare professionals and/or students. Studies which included the relationship between workplace adversity and resilience were also included.

2.4.4 Charting the data: Stage Four

Arksey and O'Malley (2005) reiterate that this stage is also an iterative process with the aim of determining which variables to extract with regards to the research question. Levac et al., (2010), recommend that a data-charting form should be developed and used to extract data from each study. A 'narrative review' or 'descriptive analytical' method should be used to extract contextual or process-oriented information from each study. In accordance with

Arksey and O'Malley's framework (2005), data from each of the sixty-one articles selected for final inclusion were extracted and charted using the following categories: *author; year of publication; title; aim of study; study design; data collection (e.g., interviews, questionnaires); key findings; conceptualisation of resilience; limitations; analytical theme; implications for practice/research*. Charted findings were then thematically analysed by the lead researcher and entered onto a template spreadsheet (see Appendix C). It was recognised that this is a potential limitation of the review, only having one researcher at this stage interrogating the included papers and this is discussed in the limitations of the study in Chapter Four.

The studies originated from eleven countries: the UK, Australia, Canada, United States of America (USA), China, Germany, Brazil, Norway, Italy, Mexico, and Sierra Leone. Many of the studies were undertaken in the USA (22 studies) and Australia (20 studies). Three of the studies took place in the United Kingdom (UK). Of these sixty-one studies, twenty-nine of the included studies were quantitative, twenty-nine were qualitative and three were mixed methods. Many of the quantitative studies were cross-sectional surveys and over a third of the qualitative studies used a phenomenological approach.

Study participants were predominantly qualified nurses, students, and doctors. Other participants included radiologists, occupational therapists, and staff referred to as 'professional' or 'healthcare workers'. Thematic analysis involves pinpointing, examining, and recording patterns within the data. For the relevant literature available it entailed repeatedly identifying patterns through a rigorous process of data familiarisation, theme development and revision. Thematic analysis of the study findings resulted in the identification of five categories (1. Resilience, burnout, and job satisfaction; 2. Professional Resilience; 3. Resilience and Retention; 4. Strategies and Interventions to promote and maintain resilience and 5. Resilience studies in students and education). These themes were adopted as they were the focus, title, or subject of the articles. Abstracts, introductions, methods, results, discussion, and conclusions/implications for practice were all examined to determine the focus of each study. It had already been established at stage one screening that each article's focus was in relation to resilience, however many of the articles discussed resilience with another concept, such as retention. Most of the articles were uncomplicated to categorise, although there were a few studies which could have been positioned in at least two of the themes. Where this occurred, the study was revisited to determine its focus in relation to its overall outcome and aim.

2.4.5 Collating, summarising, and reporting the results: Stage Five

Arksey and O'Malley's (2005) framework recommend that a thematic analysis should be presented in the results section to aid clarity and consistency, which are both required when reporting results. An analytic framework or thematic construction is used to provide an overview of the breadth of the literature, but not a synthesis. A numerical analysis of the extent and nature of studies using tables and charts should then be presented. Initially an excel spreadsheet was developed with all the included studies; this was used as a foundation to begin to summarise the content of the studies. This developed over time and was revisited, and additions made to it were iterative in nature; the included studies were then divided into the five identified themes and transferred into a table pf included studies (Appendix C).

Once this task had been achieved, the process of summarising and reporting the results commenced. This framework was then used to examine all the included papers. The themes added some clarity in relation to the researcher being able to evaluate a relatively substantial number of studies and present them in a comprehensive manner. Placing the included studies into the themes ensured a good overview of the key issues to be considered, but without tedious reporting and repetition of key issues. Having established the context of the papers, the results were then examined considering the five themes below. The first theme to be discussed is resilience in relation to burnout and job satisfaction.

2.5 Results

2.5.1 Resilience, burnout, and job satisfaction: Theme One

This theme focused on studies examining or reporting on healthcare professionals building resilient behaviours to counteract the pressures of working within a healthcare environment and experiencing symptoms of burnout. Thirteen studies were identified (Brennan and McGrady, 2015; Mealer et al., 2012; Rushton et al., 2015; Cooke, Doust, and Steele, 2013; Kemper, Mo and Khayat, 2015; Ingham et al., 2013; Matos et al., 2010; Streb, Haller and Michael, 2014; Pietrantoni and Prati, 2008; Stevenson et al., 2011; Perez et al., 2015; Potter et al., 2015a; Edward, 2005). Over half of the studies were undertaken in the USA (Potter, Pion, and Gentry, 2015b; Rushton et al., 2015; Brennan and McGrady, 2015; Mealer et al., 2012b; Perez et al., 2015; Kemper et al., 2015; Ingham et al., 2013). Four were conducted in Australia (Edward, 2005; Matos et al., 2010; Cooke et al., 2013; Stevenson et al., 2011) and only one was undertaken in the UK (Ingham et al., 2013). Four studies used qualitative methods

(Edward, 2005; Perez et al., 2015; Potter et al., 2015a; Stevenson et al., 2011) and three of these used semi-structured in-depth interviews for data collection. Eight studies used quantitative methods (Kemper, Mo and Khayat, 2015; Cooke, Doust, and Steele., 2013; Rushton et al., 2015; Mealer et al., 2012; Ingham et al., 2013 and Matos et al., 2010; Pietrantoni and Prati., 2008; Streb, Häller. and Michael., 2013), seven of these were surveys and one an observational study. One of the studies used mixed methods (Brennan and McGrady, 2015).

Burnout was frequently conceptualised in the literature as 'compassion fatigue,' relating to healthcare professionals describing that they were no longer able to commit to their job at a psychological level. Elevated levels of stress have been shown to lead to decreased job satisfaction in healthcare professionals (Rushton et al., 2015; Cooke et al., 2013), which can have significant consequences on the attrition of staff. The main aims of the thirteen studies were to establish if there was any association between resilient characteristics and burnout, and if there were strategies that could be implemented for staff to address this, and subsequently improve attrition rates. The current literature on resilience and burnout has primarily focused on healthcare professionals working in acute and particularly challenging environments, such as prisons, intensive care units (ICUs) and primary healthcare practices. Resilience in these studies was commonly understood and conceptualised as relating to an ability to develop and adapt coping strategies to minimise distress and mitigate burnout. Commonalities with objectives, findings and implications for practice were evident across the studies.

Many participants in these studies were working in high acuity or critical care environments, mainly nurses, but some studies did include some medical professionals in their samples. Two cross-sectional surveys were undertaken with nurses working in high-stress areas such as critical care, paediatrics, and oncology. Both reported elevated levels of burnout and found that nurses who were repeatedly exposed to stressors at work can suffer from post-traumatic stress disorder (PTSD) and burnout. The studies identified that highly resilient nurses, as defined by Mealer et al., (2012) and Rushton et al., (2015) were less likely to have negative perceptions related to their work. They also identified that resilient characteristics reduced nurses' vulnerability to emotional exhaustion. Similarly, Streb et al's., (2013) cross-sectional study undertaken in Germany, aimed to examine whether a good 'sense of coherence' (SOC) and high resilience lowered the risk for developing PTSD. The concept of a 'sense of coherence' was defined by Antonovsky (1987 p453) as *'the global orientation of a person*

having a dynamic feeling of confidence to be able to cope with stressful challenges in life'. The findings of the study highlighted the researchers' hypothesis; both resilience and SOC were negatively correlated with PTSD symptoms. SOC was a better predictor than resilience for PTSD severity as it accounted for more unique variance. Nevertheless, the study conclusions suggested that enhancing resilience and SOC were both encouraging methods in minimising PTSD symptoms in high-risk groups such as paramedics (Streb et al., 2013).

Like Streb et al., (2013), Pietrantoni and Prati's (2008) study involving 961 first responders in South Africa examined 'resilient factors' such as self-efficacy and a sense of community, which they hypothesised were protective of mental health in a high-risk occupational group. The results of the questionnaires were consistent with the hypothesis and with previous findings in the literature, suggesting that resilience following critical events is common in first responders. Resilience was measured using the Italian Sense of Community Scale (Tartaglia, 2006) to assess *'Sense of Community,'* the Perceived Collective Efficacy instrument to measure *'Collective Efficacy '*and the Perceived Personal Efficacy instrument to measure *'Self-efficacy.'* This study highlighted that first responders experienced a satisfactory level of job satisfaction and low level of burnout despite their exposure to critical incidents, due to their elevated levels of resilience as measured by the combination of the above instruments. The study also demonstrated that first responders may utilise personal and social resources to protect their mental well-being in relation to work-related stressors and critical events.

Cooke et al., (2013) conducted a similar cross-sectional survey which aimed to measure resilience, burnout, compassion, and satisfaction in general practice registrars. Similar findings were reported to those in the Pietrantoni and Prati (2008) study, showing that resilience was linked to high compassion satisfaction and low burnout. Matos et al's., (2010) exploratory survey examined the relationship between resilience and job satisfaction and was conducted on a small group of psychiatric nurses working in inpatient units in a large, urban medical centre. Two of the studies included a combination of healthcare professionals, including nurses and doctors (Ingham et al., 2013; Kemper, Mo, and Khayat, 2015). Similarities were evident across all the above studies with an association identified between high levels of resilience, high job satisfaction and lower levels of burnout syndrome and PTSD.

Four studies used qualitative methods to explore the experiences of healthcare clinicians working in perceived stressful working environments (Edward, 2005; Perez et al., 2015; Stevenson et al., 2011; and Potter et al., 2015a). Potter et al's, (2015a) qualitative resilience pilot training programme involved oncology nurses, and Perez et al's., (2015) study focused on exploring common stressors, coping strategies, and training needs among palliative care clinicians. The programme combined teaching with numerous small group activities and discussions which focused on five key strategies: self-regulation; intentionality; perceptual maturation; connection and self-care. The programme evaluation involved the collection of narrative from the training programme facilitators. Over a nine-month period, the facilitators were asked to write a short anonymous narrative describing how the programme had affected them. In this study, fifteen participants completed in-depth semi-structured interviews to explore the perspectives of the staff from one medical institution in Boston, USA. Three fundamental areas of stressors were identified: 1. systematic challenges related to managing large and emotionally demanding caseloads, 2. patient factors including meeting the needs, expectations and demands of patients and their families, 3. personal challenges such as demarcating professional boundaries. One of the most common methods of coping with stressors for the participants was ensuring that they frequently engaged in healthy hobbies and behaviours. The need for resilient attributes was expressed by a few of the clinicians who had concerns about staying in role and not burning out.

Overall, the results of the Perez et al., (2015) study suggested that interventions aimed at targeting stress and promoting resilience were fundamental to reducing attrition for clinicians in this environment. The clinicians in the study requested that brief strategies such as meditation, yoga, and cognitive strategies to reduce negative thoughts should be available in the workplace. A resounding theme was the need to develop skills to enhance resilience in the face of adversity. Clinicians reported that they needed to learn skills that would enable them to focus their care for patients and at the same time manage their continual exposure to stress in the workplace. Edward's (2005) study that aimed to explore the phenomenon of resilience among six Australian healthcare professionals also found the need for the introduction of workplace strategies to support staff and reduce the risk of burnout. Comparable findings were reported between Perez et al.'s (2015) and Edward's (2005) studies, suggesting that strategies to promote resilience are recommended to reduce burnout. All four qualitative studies (Edward, 2005; Perez et al., 2015; Stevenson et al., 2011; and Potter, Pion, and Gentry., 2015a) recommended that intervention programmes to support staff with the demands and stressors in the workplace should be considered. The literature suggested that if the potential to reduce burnout among staff is achievable, then this in turn

could provide long term benefits for organisations such as increasing overall staff satisfaction and promoting staff retention.

Generally, the literature on burnout demonstrates similarities in how the concept of resilience has been defined in relation to its complexity, desirability, and common human response to potentially traumatic events. Mealer et al., (2012a) define resilience in the literature on burnout as a psychological characteristic that enables an individual to thrive, even after being exposed to a traumatic event. Edward (2005) concurs that the resilience narrative around burnout encompasses the ability of an individual to bounce back from adversity. The literature indicates that healthcare professionals who do not possess the necessary resilient characteristics, particularly those that are exposed to acute environments, are at risk of potential burnout due to stressors within their job. This can lead to feelings of job dissatisfaction and ultimately affect the retention rates of staff. Most of the studies acknowledged that resilient characteristics can be developed to mitigate this, and are learnable, multi-dimensional characteristics, which facilitate success even in the face of adversity (Mealer et al., 2012). The studies also recognised, within the healthcare professional workforce, that it is essential to develop these characteristics to circumvent this negative outcome of burnout of staff.

2.5.2 Professional Resilience: Theme Two

This theme primarily comprised studies which focused on the building of resilience within a professional healthcare setting. The term 'professional' encompasses both personal and professional resilience, as these terms were frequently used interchangeably within the literature. Seventeen studies focused on the promotion of resilience and the influence of personal characteristics on resilient behaviours when working in professional healthcare settings (Wei and Taormina, 2014; Mealer,, Jones and Moss, 2012; Ablett and Jones, 2007; Hsieh et al., 2016; McDonald et al., 2012; Mache et al., 2014; O'Connor and Batcheller, 2015; Dyess et al., 2015; Laschinger et al., 2013; Kim and Windsor, 2015; McDonald et al., 2013; Gillespie, Chaboyer, and Wallis, 2009; Cameron and Brownie, 2010; Walters et al., 2015; Ashby et al., 2013; Hunter and Warren, 2014; Chan, Chan and Kee, 2012). This theme contained the largest number of studies and included diversity in the definitions for both personal and professional resilience.

McDonald et al., (2012; 2013) suggest that personal resilience has been conceptualised in the same way as other studies within this theme. They recommend that effective personal resilience requires the promotion of personal responses that emphasise positive ways to support and learn from each other about 'surviving' as a nurse or midwife. Most studies within this theme focused mainly on what qualities and characteristics contribute to resilience. Significant characteristics of personal resilience are comparable to those in the general literature on resilience, and include qualities such as hardiness, hope, self-confidence, optimism, flexibility, emotional insight and intelligence, reflection, and a positive outlook (Jackson, Firtko, and Edenborough, 2007). There were several similarities in the findings of these studies, recognising many of the participants who were considered to have resilient characteristics had demonstrated a healthy attitude to their work and had a good work-life balance.

Nine studies used qualitative methods to explore the relationship between personal characteristics and resilient attitudes and/or behaviours (Ablett and Jones., 2007; Kim and Windsor., 2015; Mealer et al., 2012; O'Connor and Batcheller, 2015; Walters et al., 2015; Cameron, 2010; Ashby et al., 2013; Hunter and Warren, 2014; McDonald 2012; 2013). Similar themes emerged from these studies relating to personal skills and optimistic attitudes that healthcare professionals possessed that made them more resilient. Ablett and Jones (2007) undertook an interpretative phenomenological analysis (IPA) on a purposive sample of ten palliative care nurses who worked in a hospice in the northwest of England. Semi-structured interviews were conducted and aimed to describe the nurses' experience of their work. The study specifically focused on interpersonal aspects that enabled the nurses to maintain a sense of well-being but still be resilient in an often-stressful environment. Findings indicated that interpersonal factors articulated as hardiness and a sense of coherence may positively contribute to reducing the stressful effects of working in palliative care and could be developed through training packages if necessary.

Mealer et al's., (2012) study reported similar findings to Ablett and Jones (2007). It was undertaken on thirteen intensive care unit (ICU) nurses in the USA and concluded that highly resilient ICU nurses utilise positive coping skills. The study found that psychological characteristics such as cognitive flexibility can also enable staff to continue to work in a demanding environment. Cañas et al., (2003) define cognitive flexibility as the human ability to adapt the cognitive processing strategies to face new and unexpected conditions in the environment. Kim and Windsor (2015) also considered the meaning of resilience for twenty

first-line managers recognising the benefit of a healthy work-life balance for participants was vital. Participants' perceptions of their workplace shifted from negative to positive experiences and from rigidity to flexibility if they frequently drew on personal characteristics. Maintaining a positive work-life balance among healthcare professionals has been recurrently identified as a rationale for the need for further research on resilience in this group. Cameron and Brownie's (2010) phenomenological study with nine registered nurses in Australia also concluded that a positive attitude and work-life balance were important factors of resilience.

Three of the qualitative studies explored personal and/or professional factors that contributed or acted as barriers to resilience among healthcare professionals (including general practitioners (GPs), midwives, and occupational therapists) (Walters et al., 2015; Ashby et al., 2013; Hunter and Warren., 2014). In these studies, professional resilience was understood to mean when practitioners adopted strategies to reduce their vulnerability and assist in the response to occupational stressors and life challenges, whilst also maintaining the professional values that maintain career sustainability (Ashby et al., 2013; McGee, 2006). Two of the studies (Walters et al., 2015; Ashby et al., 2013) involved semi-structured interviews, although Hunter and Warren's (2014) study used closed online discussion groups where common themes were later reviewed and analysed. The concept that professional resilience was linked to professional identity was found to be vital, and professional development and support were both considered crucial strategies for enhancing resilience in individuals.

Hunter and Warren's (2014) and Ashby et al.'s (2013) studies both highlighted the significance of professional identity associated with developing professional resilience. This was defined by the participants as a keen sense of collective identity and public service. There was an agreement among the participants that a feeling of professional belonging and *'love of the job'* contributed to resilience. Participants described being a midwife as something someone *is* rather than what they *do,* and that professional identity was integrated within personal identity. Ashby et al., (2013) developed The PRIOrity (Professional Resilience, Identity, Occupation) model based on their study findings, which demonstrated how professional resilience supports, and leads to the maintenance of professional identity in occupational therapists' practice. Hunter and Warren's (2014) study drew similar conclusions to Ashby et al. 's. (2013) study. Despite being undertaken by distinct groups of healthcare professionals (midwives and occupational therapists), both studies identified that

a strong sense of professional resilience can be maintained and built by a strong professional identity.

McDonald et al's., (2012; 2013) case study provided an evaluation of a work-based educational intervention focusing on personal resilience in fourteen female nurses and midwives, aged between 26-59 years, working in a busy clinical environment. The study aimed to devise, implement, and evaluate a work-based education intervention to enhance resilience and provide protection against workplace adversity (McDonald et al., 2013). Three key themes emerged from the semi-structured interviews that took place: personal gains from resilience workshops; professional gains from resilience workshops; and personal resilience initiatives. The study concluded that it was possible for healthcare professionals to learn the skills and knowledge necessary for developing personal resilience through a work-based, educational programme.

Five cross-sectional surveys have investigated the relationship between personal and organisational resources such as optimism and peer support (Hsieh et al., 2016; Wei Wei and Taormina., 2014; Mache et al., 2014; Laschinger et al., 2013; Gillespie et al., 2009). Mache et al., (2014) makes comparisons between personal resources such as resilience and optimism, highlighting that both characteristics are essential for employees to cope with work-related stress. Associations between resilience, optimism, and self-efficacy all show a positive influence on employees' health and work performance and the ability to compete with job stress. Similar findings were reported in the other surveys (Brooks, Chalder and Gerada 2011; Helmich et al., 2011) which all concluded that healthcare environments are becoming increasingly stressful places to work, and organisations need to provide employees with support and decent working job conditions to maintain a quality care service. Resilience and good working conditions were both considered as key factors in determining and improving work engagement of healthcare professionals.

Two of the studies offered interesting and similar conclusions on the relationship between resilience and personality traits (Mache et al., 2014; Hsieh et al., 2016). Mache. et al., (2014) undertook a study involving 320 hospital doctors using a cross-sectional questionnaire in Germany. This was the second largest cross-sectional survey study identified in the current literature, with only Gillespie et al., (2007) superseding it with 1430 participants. The aim of the study was to examine relationships between personal and organisational resources as

essential predictors for work engagement of German healthcare professionals. The study explored if healthcare professionals' work engagement was associated with personal resources, for example, resilience, self-efficacy, and optimism. Personal strengths, working conditions and work engagement were measured using the Self-Efficacy, Optimism and Pessimism (SWOP-K9) (Scholar, Fliege and Klapp, 1999), the Coping Orientation to Problems Experienced (COPE) Brief Questionnaire, Perceived Questionnaire (Carver, 1997), the Copenhagen Psychosocial Questionnaire (COPSOQ) Kristensen et al., (2005) and Utrecht Work Engagement Scale (UWES) (Schaufeli, Bakker, and Salanova, 2006).

Findings indicated that working conditions and resilience were vital in determining and improving work engagement of hospital physicians. The participants who rated 'influence at work,' 'opportunities for development,' and 'social support' highly, also scored work engagement with high values. Hsieh et al's., (2016) smaller, cross-sectional study included 187 participants and aimed to investigate the relationship among personality traits, social network integration, and resilience in emergency department nurses. They defined social network integration as individual participation in a wide range of social relationships, informal connections, such as family and friends, and formal organisations. Similar conclusions to Mache et al., (2014) were drawn, suggesting that peer support can enhance resilience for nurses who had suffered from physical or verbal violence by patients or their families. Furthermore, higher degrees of extraversion were found to be associated with greater resilience, whereas neuroticism was inversely associated with resilience.

Overall, resilience has unanimously been presented in this literature as a positive characteristic for healthcare professionals to possess. Minor difference in the definitions of personal resilience and professional resilience are evident in the current research, and the terms were used interchangeably within the literature. However, the studies within this theme indicate that resilience has the potential to support nurses and midwives to maintain job satisfaction, and good mental and physical health and well-being. Optimism, self-efficacy, reflective practice, flexibility, and a sense of professional identity have all been reported as contributory factors that can enhance resilient characteristics within a healthcare professional. It is apparent from the studies that professional resilience may have the potential to address key issues within healthcare organisations (McDonald et al., 2013), such as retention, work-related stress, and work-life balance dichotomies. The literature is consistent in suggesting that healthcare organisations need to recognise potential strategies for promoting resilience and implement these effectively. This in turn may benefit staff

development and happiness, such as the impact staff and peer support and development can have on improving staff well-being.

2.5.3 Resilience and Retention: Theme Three

Studies included in this theme related to the relationship between resilience and reducing the number of healthcare workers leaving the existing role or ultimately the profession. Five studies were identified (Glass, 2009; McGarry et al., 2013; Zander, Hutton, and King, 2013; Cope et al., 2014; Hodges, Keeley, and Troyan, 2008). Although some studies also considered burnout, unique to the literature within this theme was a substantive focus on the retention of healthcare professionals. Evident within this theme, were similarities in the way resilience was an important coping strategy for stress. Cope et al., (2014) suggested that resilience is the ability of an individual to adjust positively to adversity and Hodges et al., (2008) propose that resilience is the ability to thrive in unpredictable healthcare environments. However, overall, in these studies, resilience was generally understood to mean the ability to 'bounce back' despite adversity. Four studies were qualitative (Glass, 2009; Zander et al., 2013; Cope et al., 2014; Hodges et al., 2008) and one was quantitative (McGarry et al., 2013). McGarry (2013) undertook a cross-sectional survey which aimed to investigate the impact of regular exposure to paediatric medical trauma on multidisciplinary teams in a paediatric hospital and the relationship between psychological distress, coping skills, and resilience. The researchers defined resilience as the capacity to positively adapt and cope despite adversity and used the Connor Davidson Resilience Scale (CD-RISC) (Connor and Davidson, 2003) to explore its relationship with psychological distress in 54 staff. Findings were like those reported across the resilience literature, highlighting that healthcare professionals who have resilient traits such as optimism and coping strategies are more likely to remain in their jobs.

Cope et al., (2014) qualitative study explored why Australian nurses chose to remain within the workforce and if they displayed any fundamental characteristics of resilience (such as self-care, staying positive, valuing social support and passion for the profession). Eight themes common among those in the broader resilience literature were reported. For example, 'passion for the profession,' whereby participants spoke of their sense of professional pride and value of their nursing role, was reported as a key reason nurses remained in their job (Cope et al., 2014). This has been described in other studies, such as Hunter and Warren (2014), as professional identity. Hodges et al's., (2008) study also described one of the three themes identified akin to professional identity as 'discerning fit'. It

focused on sensing discrepancies and reconciliation of participants' identity as a professional nurse.

Hodges et al's., (2008) study also identified two other themes from the narratives provided during in-depth semi structured interviews which were undertaken with eleven nurses. These were referred to as learning the milieu and moving through. *'Learning the milieu'* was explained in the study as learning the culture and formal and informal rules of the workplace and developing competence and confidence with skills, techniques, time management and pace of the environment. The second theme of three within this study was referred to as *'moving through.'* The findings of Hodges et al's., (2008) study suggested that the acute care environment is an adverse one for the newly qualified nurse, and that resilient behaviours can be recognised in some but not all new nurses during this challenging period.

Similarly, the third theme identified by Cope et al's., (2016) study was *'valuing social support.'* This referred to the significance of support that the nurses valued from peers and colleagues alike. The findings from the nine portraits suggested that an acknowledgment of such attributes of nurses' resilience can assist in staff retention issues and current pressures on the healthcare service. This concept of identifying strategies to improve resilience within healthcare workers in several studies (Glass, 2009; Zander et al., 2013; Cope et al., 2014; Hodges et al., 2008) was also evident and comparable in the key strategies identified to support resilience and career longevity.

In summary, studies within this theme were generally predicated by an assumption that shortages in the health professional workforce are primarily a result of attrition rather than supply of newly qualified professionals (Glass, 2009). The studies therefore explored why healthcare professionals with certain characteristics such as resilience remained in the workplace. Generally, the findings equated optimism, hope, utilising social support and having a passion for their profession as resilient characteristics, which were associated with being more likely to remain within the profession. The studies within this theme explored why some healthcare professionals had chosen to leave the profession and offered some insights into the potential role that resilience of nurses and other healthcare professionals may have on this. Definitions of resilience within this theme had comparisons to other themes, although discussion around retention and resilience was not always explicit.

2.5.4 Strategies and interventions to promote and maintain resilience: Theme Four

This theme related to research which focused on strategies or interventions in relation to the potential role of developing resilience for healthcare professionals. Fourteen studies were identified (Mealer et al., 2014; Vesel et al., 2015; Mallak, 1998; DeCastro et al., 2013; Zwack and Schweitzer, 2013; Gillespie et al., 2007; Foureur et al., 2013; Kemper and Khirallah, 2015; Lee et al., 2015; Sood et al., 2011; O'Connor and Peyton, 2015; Kornhaber and Wilson, 2011; Sood et al., 2014; Chan, Chan and Kee, 2012). Strategies and interventions on either an individual or organisational level have been frequently identified as beneficial for promoting a more resilient workforce. All the studies in this theme encouraged a form of training programme to enhance resilience and decrease stress among healthcare professionals. Differences in how resilience was defined and measured were evident across the studies. These differences chiefly related to whether resilience was seen as innate or developmental; a process or an outcome; focusing on deficit or well-being; and emphasising benefits for individuals or workplaces (Grafton, Gillespie, and Henderson, 2010; Kabat-Zinn, 2005; Seibert, 2005).

Vesel et al., (2015) used a mixed methods approach involving a quantitative survey of 271 participants, and in-depth interviews and focus group discussions with participants from a variety of healthcare professions. The aims of the study were to: a) identify the effects (if any) of counselling and psychosocial training on coping, stress and healthcare worker and patient relationships; b) examine the associations between coping skills, stress levels and change in relationships; and c) identify ways the uptake of coping skills is linked to a change in relationships. The findings of the study demonstrated that the intervention had a positive effect on participants' coping skills, stress levels and interpersonal relationships. Findings indicated that the Helping Health Workers Cope is a model and tool that could be used to effectively build resilience. The study demonstrated how this psychosocial intervention can have an impact on the well-being and stress levels of health providers and the relationships they have with colleagues. The main themes reported from the qualitative analysis were aligned with those identified in other studies discussed hitherto; perspective-taking and awareness, empathy, mutual accountability and striking a work-life balance. This study offered a potential model and tool that could be used to build resilience, specifically by improving coping skills and stress management of healthcare workers.

Three studies focused on using mindfulness as a self-care strategy for developing resilience (O'Connor and Peyton, 2015; Kemper and Khirallah, 2015; Foureur et al., 2013). O'Connor and Peyton (2015) conducted a pilot project that entailed attending an eight-week mindfulness group training programme for twenty-eight participants in Australia working with people in crisis. The aim of the study was to train the participants, who were mostly working in palliative healthcare environments, to use mindfulness techniques to help them find ways to be calm during times of stress; develop self-awareness and develop and practice resilient mind habits and behaviours, both in their work and personal life. The main changes that the participants reported following the training were that they had developed the ability to 'stand back' from workplace situations that had previously caused them stress and respond in a more positive way. The findings of the project suggested the benefits of mindfulness training for healthcare professionals resulted in increased self-awareness, well-being and empathy, reduced anxiety levels and an ability to practise resilient mind habits and behaviours. The implementation of regular mindfulness training following this study became part of the participants' in-house training.

Kemper and Khirallah (2015) and Foureur et al., (2013) also conducted a prospective cohort study and a mixed methods study examining the potential benefits of mindfulness programmes for healthcare staff. Kemper and Khirallah's (2015) participants included graduate trainees in the healthcare professions and Foureur et al., (2013) focused on twenty nurses and twenty midwives. Both came to similar conclusions, suggesting that there are constructive benefits for introducing mindfulness programmes into mandatory training to support staff dealing with stress and improving resilient behaviours. Kemper and Khirallah's (2015) study demonstrated significant improvements in stress, mindfulness and in particular resilience following training programmes. In a previous study, Olson, Kemper, and Mahan (2015) identified that mindfulness was correlated with resilience. Both studies recommended that mindfulness programmes should be embedded within the culture of the organisation to enhance a resilient workforce.

Four studies used qualitative methods to examine strategies and interventions to enhance resilience (Kornhaber and Wilson, 2011; Mallak, 1998; DeCastro et al., 2013; Zwack and Schweitzer, 2013). Zwack and Schweitzer (2013) study used semi-structured interviews to explore key aspects of resilience-fostering preventative actions. They defined resilience in 200 physicians as *'the ability to invest personal resources in a way that initiates positive resource spirals, despite stressful situations'* (p388). Three familiar themes were identified: 1)

job-related sources of gratification; 2) resilient building practice and routines, (such as leisure-time activity and limitation of working hours); and 3) attitudes to promote resilient behaviours (for example, self-awareness, accepting personal boundaries and appreciating the good aspects of the role). Conclusions and recommendations of the study highlighted the need for physicians to develop resilience within their role and programmes that promote resilience through preventative behaviours should be customary for medical training. Three other similar qualitative studies (Kornhaber and Wilson, 2011; DeCastro et al., 2013; Mallak,1998) that have examined strategies and interventions to build resilience in healthcare also arrived at analogous conclusions and recommendations. They all indicated the need to develop strategies for healthcare professionals, in particular coping strategies such as positive thinking to foster resilience, and in turn improve retention rates.

Sood et al., (2011; 2014) undertook two pilot RCTs with twenty-six radiologists and forty physicians to test the efficacy of a Stress Management and Resiliency Training programme (SMART). Resilience was defined in both the pilot studies as the ability of an individual to withstand adversity. The interventions both involved a single ninety-minute session, with the radiologists undertaking this in a group and the physicians undertaking the session on a one-to-one basis. Interestingly, the findings from the two trials were slightly different in relation to resilience outcomes even though they included different disciplines. The trial which involved the radiologists showed a significant improvement in perceived stress, anxiety of life and mindfulness, and although resilience did improve, changes were not substantial (Sood et al., 2014). When the SMART programme was undertaken on the physicians the results were positive for stress, anxiety, quality of life *and* resilience. Sood et al., (2011; 2014) used the Connor Davidson Resilience Scale utilised in other studies across the resilience literature. Mealer et al., (2014) RCT presented similar conclusions to Sood et al., (2014) in relation to the efficacy of a twelve-week intervention resilient training programme undertaken on intensive care unit nurses. Nurses included in the study, both in the control group, and the treatment group, showed a significant decrease in PTSD, however those in the treatment arm had a significant improvement in perceived stress, anxiety, quality of life and mindfulness, but not resilience. The training programme was also successful at promoting individual coping strategies as a mechanism to enhance resilience.

Three further studies in this theme conducted by Chan, Chan, and Kee (2013), Gillispie et al., (2007) and Mallak (1998) aimed to examine resilience as a means of managing workplace stress and work-related crises of healthcare workers. Gillispie et al., (2007) cross-sectional

survey of 1430 Australian operating room nurses concluded that five variables – hope, self-efficacy, coping, control, and competence–were associated with higher levels of resilience. Interestingly, age, experience, education, and years of employment were not positively correlated with resilience; a finding was at variance to some of the other studies previously reported in the review (Lee et al., 2015; Hunter and Warren 2014). Lee et al., (2015) undertook a descriptive study which aimed to promote staff resilience in the paediatric intensive care unit. The study highlighted that staff with more than seven years clinical experience scored higher on individual resilience scales (RS-14 resilience scale-can range from 14-98). Similarities between Gillispie et al., (2007) study and Lee et al., (2015) highlighted that the 'individual factors' that have been suggested in previous studies, showing a relationship with resilience such as self-efficacy, competence and confidence were also evident in both these studies. Chan, Chan, and Kee (2013) and Mallak's (1998) findings also showed promising results that were congruent to Gillispie et al's., (2007) study. Self-efficacy, self-confidence and competence were highlighted once more as key characteristics that can be acquired and developed through some sort of intervention training to measure resilience in healthcare workers such as mental health training in the Chan, Chan, and Kee (2013) study.

In summary, the literature described suggests that strategies and interventions, such as mindfulness, coping skills and psychosocial education can have a positive impact on reducing an individual's anxiety and stress management in the workplace and can contribute to building resilience. Some of the studies within this theme found that resilience has been associated with increased quality of life. They have also indicated that models of resilience training should be implemented into mandatory training for staff at an organisational level; whereas others have suggested that strategies and interventions to improve resilient behaviours should be the responsibility of the individual and be developed by maintaining a good work-life balance and increased sense of self-awareness and professional identity. Study findings have consistently demonstrated associations between positive attitudes, hope, coping, self-efficacy, and resilience. However further studies with larger sample sizes have been recommended to fully determine this.

2.5.5 Resilience studies in students and education: Theme Five

The final theme focused on studies exploring the concept of resilience in health professional students, or in the context of health professional education, such as a student midwife or nurse and/or a medical student. Twelve studies were identified (Pines et al., 2014; Shi et al., 2015; Pines et al., 2012; Reyes et al., 2015; Kjeldstadli et al., 2006; Peng et al., 2012; Dyrbye et al., 2010; Greenhill et al., 2015; Tempski et al., 2015; Elizondo-Omana et al., 2010; Olson et al., 2015; Haglund et al., 2009). Of these, six focused on the role of resilience and effective stress management in relation to student well-being and life satisfaction (Haglund et al., 2009; Tempski et al., 2015; Kjeldstadli et al., 2006; Peng et al., 2012; Greenhill et al., 2015; Shi et al., 2015). Two of the studies sought to explore a greater understanding of stress resiliency and conflict management within the workplace (Pines et al., 2012; Pines et al., 2014) and two of also considered burnout among medical students (Dyrbye et al. 2010; Olson et al., 2015). Two studies used qualitative designs and the other ten were quantitative.

Resilience in this literature was broadly conceptualised, similarly to the other four themes; as the ability to adapt and overcome adversity but with personal growth and transformation (Tempski et al. 2015; Reyes et al. 2015). In relation to the papers that considered resilience and stress, Kelley, (2005) offered a useful definition of resilience, as a preventative strategy that inhibits the potentially debilitating effects of chronic stress. Emerging evidence and interest in educational interventions to promote resilience suggests that positive outcomes for psychological well-being and life/job satisfaction of students can be improved (Olson, et al., 2015). Preventative strategies, interventions and coping mechanisms are examples within the literature which foster student resilience. None of the studies were conducted in the UK.

Two qualitative studies investigating resilience in health professional students were identified (Reyes et al., 2015; Greenhill et al., 2015). Reyes et al., (2015) undertook a GT study in Canada to explore the relationship between resilience and coping with stress and adversities successfully among nursing students. Thirty-eight second- and third-year nursing students from one university took part in semi-structured interviews that explored some of their experiences of stress, difficulties and/or adversities as a nursing student. A process of pushing through was a phrase used by several participants to describe their perception of dealing with challenges they had faced in their academic lives. The study described three main phases of the *'pushing through'* process: *'Stepping into,' 'staying the course'* and *'acknowledging.'* The results indicated resilience as more than an innate trait or characteristic but also as a 'dynamic' process suggesting that resilience can be developed, and it is not only present in certain individuals. This concept will be explored in further detail in Chapter

Three. Overall, the study did present some interesting findings in relation to developing resilience in nursing students over their time on a programme.

Greenhill et al., (2015) have undertaken a similar qualitative study which aimed to understand medical student resilience during the first year of clinical training in Australia. The purpose of the study was to develop a conceptual framework for student resilience in a medical curriculum. In-depth interviews were conducted with a purposive sample of nineteen medical students. The results suggest that students in their first year of training experience some form of adversity due to challenges encountered in the learning environment. By creating a secure, supportive learning environment this distress was moderated. Three key themes ('journey within', 'staying on course' and 'safe haven') were discussed and outlined and the study concluded that a conceptual framework, such as the longitudinal integrated clerkship can build resilience in students through continuity of relationships, providing guidance in their learning and reinforcing their personal growth.

Three quantitative studies have focused on resilience in nursing students (Reyes, et al., 2015; Pines et al., 2014; Pines et al., 2011). Pines et al., (2014), outcome of the Pine's (2011) pilot study examined relationships between stress, resiliency, psychological empowerment, and conflict management styles in nursing students. This correlation study involved a convenience sample of 166 Baccalaureate Hispanic, mainly female nursing students, and was undertaken in the southwest of the USA. The findings indicated that ethnic heritage was not related to stress resiliency, empowerment, or styles of conflict management. Stress resiliency and psychological empowerment, defined as human traits, combining to strengthen the capacity of an individual to respond to stressors, were predictive of empowerment and students in this study had a higher-than-average stress predisposing score and used avoiding and accommodating styles rather than competing and collaborating styles to manage conflict. The authors argued that the study was useful in addressing the challenges that nursing students (and nurses) face on a daily occurrence in relation to conflict management. Similarly, Pine et al., (2011) earlier pilot study also concluded that it is paramount to integrate conflict resolution skills throughout curriculums.

Nine of the twelve studies in this theme examined resilience and stress in medical students (Shi et al., 2015; Kjeldstadli et al., 2006; Haglund et al., 2009; Peng et al., 2012; Olson et al., 2015; Dyrbye et al., 2010; Elizondo-Omana et al., 2010; Tempski et al., 2015; Greenhill et al.,

2015). Kjeldstadli et al., (2006) undertook a longitudinal questionnaire in Norway to examine the course of life satisfaction during medical school and compared the level of satisfaction of medical students within four universities to identify resilient factors. Results indicated that life satisfaction decreased during study at medical school. Initially, medical students were as satisfied as other students in their first year of study; however, they were less satisfied by their final year. The study sought to find out if medical students who were identified as resilient differed in personality, perceived stress, and coping strategies.

In contrast to Kjeldstadli et al., (2006), Peng et al., (2012) survey of 2069 Chinese medical students that aimed to test the moderating effect of resilience on negative life events and mental health problems found that males scored higher than females on resilience. Studies sometimes differ in relation to the context. For example, only one study within this theme, but still focusing on medical students in America, explored resilience in the context of traumatic events. Haglund et al., (2009) prospectively measured medical students' (n=125) exposure to stressful events during their first year caring for patients. Trauma exposure was common but not associated with poor outcomes, suggesting that students were resilient. The study identified that there are still gaps in the literature in relation to how healthcare students can be adequately supported and prepared to deal with these; this was a significant outcome throughout this theme.

Tempski et al's., (2015) study evaluated data from a random sample of 1350 medical students from Brazilian medical school selected by convenience. Students' quality of life was assessed by using a questionnaire by the World Health Organisation (WHO) (1995). The study evaluated the association among resilience levels, quality of life and educational environment perceptions. The hypothesis was that there is a positive association among resilience, quality of life and educational perceptions. The study concluded that medical students with higher resilience levels had a better quality of life and a better perception of the educational environment. This finding is consistent with the concept that resilience is a core competency for the medical school admission process. Whereas Elizondo-Omana et al., (2010) observational study in Mexico, aimed to assess resilience in students during the first and second semesters of medical school and correlate this personal trait with academic performance using the Connor-Davidson resilience scale. The findings of the study suggest that resilience does not predict academic performance in gross anatomy and is not the most influential determinant of academic achievement, and further research is required to identify the factors that influence students' achievements.

Building on Kjeldstadli et al., (2006) study, Shi et al., (2015) conducted a large multi-centre cross-sectional questionnaire survey to examine the relationship between stress and life satisfaction and the mediating role of resilience among 3500 Chinese medical students. Both stress and resilience were found to play a significant role in life satisfaction among Chinese medical students. Like several other studies examining healthcare students and resilience, Shi et al., (2015) recommend that Higher Education Institutions (HEIs) should be encouraged to adopt strategies and programmes to support healthcare students to enhance their resilience and therefore promote life satisfaction.

Both Dyrbye et al., (2010) and Olson et al., (2015) undertook cross-sectional surveys with 1321 medical and paediatric students. The aims of the studies were to gain an understanding of the factors that protect against and promote burnout to guide student wellness programmes. Surveys were used in the Olson et al., (2015) study to evaluate burnout, quality of life, fatigue, and stress. Students who did not burnout at either time-point (classed as resilient students) were compared with those who indicated burnout at one or both time-points (classed as vulnerable students). Sixty per cent of students completed the burnout inventory. Findings indicated that resilient students were less likely to experience depression, had a higher quality of life, were less likely to be employed, had experienced fewer stressful events, reported higher levels of social support, perceived their learning climate more positively and experienced less stress and fatigue than vulnerable students. Similarly, findings in the Dyrbye et al., (2010) study indicated mindfulness and self-compassion were positively associated with higher resilience and less emotional exhaustion; suggesting that mindfulness and self-compassion may be appealing for training paediatric residents. Emotional intelligence was also found to be associated with higher resilience, but this was not related to burnout.

In summary, burnout, life satisfaction, personality characteristics, educational interventions and coping strategies have all been highlighted as fundamental elements to the discussions around resilience and healthcare students. The current literature acknowledges the importance of creating opportunities for students to thrive in their clinical and academic environments and may have implications for the design of pre-registration programmes. The studies identified included medical and nursing students and consisted of mainly quantitative, but some qualitative designs. Key themes evident in the findings of the twelve studies suggest that it is vital that educators understand resilient characteristics in students,

and they should be responsible for developing and maintaining an academic environment conducive to academic success. Authors have argued that it is essential that educators foster resilience in students and identify ways in which the topic of resilience can be integrated and beneficial in curriculum development, therefore supporting students to manage stressors when dealing with the healthcare environments they are exposed to.

To foster resilience, the literature suggests that students should be encouraged to spend time on their social and personal lives whilst studying and highlighted the significance of health-promoting coping strategies. Although the evidence in relation to healthcare students and resilience is sparse, all the studies identified suggested that HEIs are beginning to recognise the importance of resilience for students, to support and retain them in nursing or medical careers to benefit the quality of both patient and professional outcomes (Olson et al., 2015). It is evident from exploring studies that have examined resilience and healthcare students, that there is an increasing interest in investigating strategies to promote resilience among healthcare students, nevertheless, important gaps in knowledge remain.

2.6 Summary of scoping review

This chapter has presented a scoping review of the current literature on resilience in registered healthcare professionals and students. The primary aim of the review was to map the existing literature to establish what is currently known and identify if the gaps in the current evidence-base exist. Although engagement with the existing evidence is contentious in GT, the review presented in this chapter followed the approach of Charmaz (2014) and the rationale for specifically choosing constructivist grounded theory because the data and theories are constructed through the researchers' past and present experiences (Charmaz, 2014). Literature relevant to the findings presented in the thesis published during the period of doctoral study have been incorporated into the discussion in Chapter Eight to provide up-to-date context on how findings from the study add to what is currently known.

Five themes were identified (burnout and satisfaction, professional resilience, resilience and retention, strategies, and interventions to promote and maintain resilience, and resilience studies in students and education) which have offered some insight into how resilience has been conceptualised in the context of healthcare professionals. This thematic analysis develops understanding of what is meant by resilience among healthcare professionals,

particularly in relation to developing resilience to potentially avoid burnout and improve retention. The key thread running through all five themes was that resilience has been viewed as a positive attribute to possess or foster in healthcare professionals.

The five themes have all highlighted some major areas for future research, particularly in relation to strategies for healthcare professionals to potentially adopt. There were clearly some commonalities identified between the themes and key elements that have been extrapolated; however, this scoping review has limitations. The review was based on sixty-one studies sourced from six databases, which may have narrowed the focus of the literature. Although, studies were not assessed for methodological rigour, as this is beyond the remit for a scoping review, some limitations of the scoping review were apparent, for example the approach is typically broad at the expense of depth and does not usually include risk of bias or other assessment of included studies (Arksey and O'Malley, 2005). As previously highlighted, the main purpose of the scoping review was to identify any gaps in the evidence at the time (2016) of the search. The scoping review searches are time and context bound and therefore a decision to not repeat the searches again was made. However, more recently published literature since this scoping review was undertaken is important and relevant literature and will be incorporated into Chapter Eight.

Resilience has been conceptualised in diverse ways in the current literature and the scoping review has highlighted that resilience is context specific. Common among all the conceptualisations is an underpinning assumption that it relates to healthcare professionals' ability to cope with adversity and that resilience can be learnt and developed. In all the literature reviewed, resilience has been seen as important and valuable for health professionals to possess or develop. The evidence suggests that being resilient or developing resilience can lead to improvements in quality of life, job satisfaction and can reduce attrition rates, and work-related stress. This evidence has led to an increased interest in developing resilience in pre-registration students prior to them embarking on a future profession in a health-related area or field of practice. Recommendations from the studies indicate that strategies and interventions to build resilient healthcare professionals should begin during the education of healthcare professionals and acknowledge that any strategy to promote staff well-being and resilient characteristics is ultimately a benefit for service users.

The review has identified that resilience has been conceptualised in diverse ways, and different tools have been used to measure resilience in the intervention literature. Several strategies have been identified, which require further exploration. Peer support, resilience

development, self-reflection, development of clinical skills, effective education and mentoring all apparently have a part to play in ensuring that healthcare professionals remain in the workplace and are suitably equipped to face the contemporary challenges and demands of a stressful healthcare environment. Further research is required to explore if experience over time influences resilient behaviours and attitudes in healthcare professionals.

The evidence is insubstantial in some professions, and existing evidence has mainly focused on healthcare professionals working in acute settings. Important gaps still exist, particularly in midwifery practice, where limited studies have been undertaken which involved midwives. A greater understanding regarding the integration of resilient strategies in healthcare and education is required. The increased focus for resilience to be seen as a panacea for healthcare professionals maintaining a healthy work-life balance is becoming progressively more evident in the literature.

2.7 Key issues identified from scoping review

Two key issues were deduced from the review that required further discussion. The first being that there was limited evidence available regarding resilience among midwives. The second, which authors frequently referred to, was the discussions and relationships made between resilience and retention. Although five distinct themes were identified in the literature, three of these were predominant in terms of weight of evidence (burnout; retention; and professional resilience). Burnout and the retention of staff or students and how staff can develop and foster resilient characteristics, have received the most research attention to date. The importance of, and association between, resilience and retention (likelihood to leave one's job or the profession) has received particular attention. As discussed in Chapter One, this likely reflects the growing policy focus to address healthcare staff deciding to leave their profession, often early into their careers. The retention of staff is essential for the sustainability of healthcare professionals such as midwives, who may decide not to leave the profession if they are adequately equipped with the appropriate skills to be able to meet the demands of the role.

Overall, the research examining resilience within healthcare has considered the concept as a positive and a valuable attribute, and one which healthcare professionals, including midwives, can benefit from possessing or developing. Lacking from the evidence is an examination of individuals' perspectives of whether developing resilience is always a positive endeavour. It has been acknowledged in the narrative that supporting individuals to develop resilience, particularly nurses, is seen as a key priority (McGowan and Murray, 2016). However, no literature identified in the review challenged the prevailing view that lacking resilient characteristics may be advantageous to an individual. Crowther et al., (2016) suggest that learning resilient behaviours does not necessarily result in people developing resilience over time.

Indeed, individual resilient responses may be masking organisational and practice harmful ways of working. Crowther et al., (2016) has made this argument in the context of midwifery, suggesting that one midwife's resilience is another's vulnerability and probability for burnout. The focus of healthcare organisations appears to have shifted from the need to establish effective working conditions for employees, to them having to adapt in the current economic and organisational crisis as *normal* practice. There is intense pressure on healthcare services to do more for less, and experienced midwives bring practice wisdom and knowledge, but they cost more (Crowther et al., 2016). Healthcare professionals' battles to survive such challenging and stressful conditions have been redefined as 'resilient.' Instead, these individuals have been deemed to require further training and development to ensure they acquire the desirable attributes of resilience to deal with the current pressures and complexities of healthcare and working in clinical environments. Crowther et al., (2016) proposes that the notion of resilience in midwifery as a remedy to resolve such concerns needs reconsidering.

There was less agreement within the literature regarding who was liable for developing resilience and whether this was the responsibility of the individual healthcare professional, or of the organisation. This is reflective of the wider policy and professional narrative that has also taken a relatively broad acceptance of personal resilience as a positive characteristic and that resilience training may be of benefit to health professionals (Cleary et al., 2018). Recommendations in the research literature broadly suggest that it is not the sole responsibility of either an organisation or an individual to initiate and/or build resilience; it is the responsibility of them both. Sull, Harland, and Moore (2015) highlight the need for strengthening organisational resilience and suggest that the role of resilience as a positive organisational factor can be developed and reaps significant individual and organisational

benefits. However, they go on to say that healthcare professionals can reduce their vulnerability to workplace adversity by also developing their own personal resilience. There was a consensus within the available literature to recommend that resilience training is incorporated into pre-registration education programmes, such as nursing and midwifery, and that professional support should be encouraged through mentorship programmes (Sull, Harland, and Moore, 2015).

Studies examining resilience in relation to midwifery practice were limited. Much of the published literature has studied samples of nurses, medical staff, or students. Despite widespread use of the term 'resilience' in professional midwifery practice, only four studies at the time of the scoping review were identified that involved the midwifery profession (McDonald et al., 2012; Hunter and Warren, 2014; McDonald et al., 2013 and Foureur et al., 2013). Most of the other included studies centred on nursing and medical staff working in acute environments such as trauma units and emergency departments. The findings from the four studies involving midwives made similar recommendations to those in studies involving other healthcare professionals which characterise resilient individuals as adaptable and self-aware. It is potentially problematic to generalise this for midwifery practice, as it should be recognised for its unique aspects and approach to caring for women and their families who are not always experiencing ill health. The scoping review demonstrated that further scrutiny and consideration in relation to resilience and retention in midwifery practice was still required.

2.8 Conclusion

In the literature, resilience for healthcare professionals has been understood in the main, as an essential attribute to have or develop. Certain dimensions to resilience, such as self-efficacy, flexibility, positivity, and a healthy work-life balance were all recognised within the literature as qualities that are important for healthcare professionals to possess. Previous research has demonstrated that resilience is a complex construct that is defined differently in the context of individuals, organisations, professions, and cultures. The scoping review presented in this chapter has demonstrated a universal consensus that resilience, within the healthcare environment is worthy of fostering. However, whilst recognition of the importance of resilience within the literature was ubiquitous, the challenge of how and who develops this, requires further attention. Many of the included studies acknowledged the emerging relationship between resilience and retention. With the increasing numbers of

healthcare professionals such as midwives and nurses intending to leave the profession, lack of job satisfaction, and increasing stressful demands on clinical staff, the pressure to maintain staff who can 'bounce back' from difficulties in practice is paramount. This scoping review has demonstrated a need to examine further the theoretical concept of resilience, which will be addressed in Chapter Three.

Chapter Three: A Conceptual Analysis of Resilience

3.1 Introduction

This chapter reviews the literature around resilience and critically considers the key findings from the current research in the context of midwifery practice. The chapter will unravel what is currently known about the meaning of resilience in midwifery by primarily exploring the theoretical and historical origins of the concept and its relevance within healthcare. First, the key issues arising from the review will be summarised, identifying any gaps evident in the literature. Then a conceptual analysis of resilience and its historical origins will be considered in the context of current statistics relating to midwifery retention. Finally, this chapter concludes with a rationale for the research question addressed in this thesis.

The conclusions and implications in much of the previous research reviewed in Chapter Two discussed ways in which 'resilient characteristics' can be developed, fostered, and promoted. Many authors referred in their studies to the burden of working in healthcare and many of the challenges and difficulties healthcare professionals face in their everyday work. These challenges can lead to feelings such as stress, anxiety, pressure, and fatigue; hence this was often a rationale for exploring resilience and career-related decisions further. The scoping review enabled a thorough overview of resilience in healthcare professionals to be examined, highlighting that resilience is a complex phenomenon which warrants greater exploration in midwifery practice. A thorough understanding and interpretation of its meaning in healthcare, and particularly for midwifery practice and the potential influence it may have on midwives' and student midwives' career-related decisions is required.

3.2 Definitions and Terminology

Resilience can be defined as the ability to adapt well to an adverse environment without any lasting significant psychological or physiological disruption (Seery, Holman and Silver, 2010). A resilient individual is one who responds positively and consistently to adversity (Blamire, 2014). The variations in explanations about resilience are presented in the literature, depending on which disciplines authors are referring to. Hunter and Warren (2014, p21) describe resilience in midwifery practice *'as simply doing better than one might expect under the circumstances'*. Some disputes still exist between authors as to whether resilience can be

learnt and developed like a coping mechanism or dynamic process, or whether it is a particular personality trait that is inherent to an individual (Luthar, Cicchetti and Becker, 2000). Richardson's (2002) work in relation to resilience described it as more of a process that can be improved through learning and adaptation to life experiences. This description is pivotal to further research in relation to resilience in midwifery practice and essential to examine in further detail.

The dictionary definition of resilience is *'the capacity to recover quickly from difficulties; toughness'* (Oxford Dictionary of English, 2022). Grant and Kinman (2011, p262) define resilience as *'a complex and multi-faceted construct, referring to a person's capacity to handle environmental difficulties, demands and high pressure without experiencing negative effects'*. In simple terms, resilience can be understood as a relative resistance to adversity (Rutter, 1999). Although there seems to be consensus in the definition of resilience here, significant differences exist within the literature regarding how it is conceptualised; in particular, whether it is an innate trait or a behaviour. Resilience represents a combination of abilities and characteristics that interact dynamically to allow an individual to 'bounce back,' cope successfully, and function above the norm, despite major stress or adversity (Rutter, 1993). Many, but not all, definitions, including Reyes et al., (2015); Olson, et al., (2015) and Greenhill et al., (2015), describe resilience as a dynamic process, where individuals can bounce back despite significant experiences of adversity and trauma. Masten, Best, and Garmezy (1990) have distinguished among three groups of resilient phenomena: those where (1) at-risk individuals show better-than-expected outcomes, (2) positive adaptation is maintained despite the occurrence of stressful experiences, and (3) there is a good recovery from trauma.

Luthar, Cicchetti, and Becker (2000) suggest that when the term resilience is examined, researchers have tended to be concerned with identifying two main factors; vulnerability and protection, and that these factors might modify the negative effects of adverse life circumstances. Luthar, Cicchetti, and Becker (2000, p858) breakdown the definition of resilience into two parts; they suggest that '*resilience is a two-dimensional construct that entails exposure to adversity and the materialisation of positive adjustment outcomes*.' The origins of vulnerability and protective themes may be influenced by a few factors such as environment, family, and community. Vulnerability factors or markers encompass those signs that exacerbate the negative effects of the risk condition, whereas protective factors are those that modify the effects of risk in a positive direction. For example, with healthcare professionals, a vulnerability factor could be the duration of the timing in a professional's

practice, such as a newly qualified nurse or midwife, and the protective factor could be represented by an identified assessor, mentorship programme, or supervisor to support the newly qualified member of staff in the transition from student to registrant. Luthar, Cicchetti, and Becker (2000) suggest that whether a particular construct is labelled a vulnerability factor, protective factor, or both, depends on a number of influences. Although there is some consensus of the definitions of resilience reviewed in Chapter Two, the origins of the concept reveal a more complex picture. On examination of the literature, most authors suggest that resilience is the ability of an individual to be able to 'bounce back'. There is some disagreement, particularly with regards to whether resilience is an innate personal trait, or one that is a learnt process. However most agree that it is a socially constructed concept and based on the collective views of a social group, such as midwives.

3.3 Historical Origins

Findings from early research examining the meaning of resilience are paramount to consider, as much of this material influences how resilience is conceptualised and understood in the context of healthcare professionals today. The word resilience originates from the Latin term '*resilire',* meaning to rebound. Resilience concepts were primarily established within child development, physiological stress, and psychology literature (Hodges, Keeley, and Grier, 2005). Pioneering research in the 1970s (Pines, 1975) considered resilience in children who were exposed to severe risk. Studies of children of mothers with Schizophrenia played a crucial role in the emergence of childhood resilience as a concept (Garmezy, 1974; Garmezy and Streitman, 1974; Masten, Best and Garmezy, 1990). Studies of resilience and multiple adverse conditions and catastrophic life events, such as natural disasters (O' Dougherty-Wright et al.,1997) also dominate the existing early literature. Key theorists in this field include Connor and Davidson (2003) who concluded in their study that resilience was associated with physical and mental health as well as with lower severity of post-traumatic stress disorder. Literature drawn from social work can also offer some explanations about the meaning of resilience for example, Collins (2007) explored the influence of resilience among social workers and found that resilience as well as positive emotions and optimism had a major part to play when coping with workplace stress. Collins (2007) identified that resilience is an adaptative trait, but may be influenced by many variables, such as culture, this is similar to a finding from this study, which will be discussed in Chapter Seven in detail. Like midwifery practice, social work is a rewarding role, although there is also significant evidence of stress, poor resources, limited support, and high turnover of staff (Collins, 2007). Collins

(2007) suggests that positive emotions can help staff working in social work by providing a 'breather', or a break, and acting as a 'sustainer' and 'restorer'. Educating and teaching such skills in relation to developing resilience by managing positive emotions and optimism for social workers may also support midwives to cope more readily with the demands of their work.

Another significant field where resilience has been well-documented is in studies related to the armed forces. Much of the literature in the initial screening stages of the scoping review included studies related to military personnel and their ability to remain resilient, despite circumstances such as war and conflict. McManus, et al., (2016) explored the published literature relating to UK military forces and attempted to draw conclusions about the reasons for the apparent resilience shown by most of the regular forces and how UK military regular personnel have remained resilient despite prolonged combat missions in Iraq and Afghanistan. The research has also highlighted the vulnerability of certain groups of at-risk personnel, namely, those deployed in combat roles and reserve personnel. It also revealed certain groups who demonstrate increased resilience such as the elite forces. There appears to be evidence that good training, leadership, and unit cohesion promote resilience to mental health problems among service personnel (McManus, et al., 2016). Similarly, to resilience of healthcare professionals, the review concludes that there is a need for further research to explore the nature of resilience in service personnel exposed to extreme or prolonged stress in the longer term.

Acknowledgments to resilience in the context of health professionals are recorded as far back as Florence Nightingale (Magpantay-Monroe, 2015) suggesting that she portrayed characteristics of resilience to adversity during the milieu of the Crimean war. Early researchers (Masten and Garmezy, 1985; Rutter, 1979) tended to view resilience as a fixed trait or personality attribute, whereas more recent researchers have suggested that resilience is a dynamic process (Earvolino-Ramirez, 2007) that can be developed or enhanced (Stephens, 2013). The main theorists in relation to resilience within healthcare professions include Garrosa et al., (2010); Larrabee et al., (2010) and Gillespie et al., (2009), all who appear repeatedly in most of the included studies. Their studies aimed to identify how best to foster resilience and promote career longevity and they unanimously agreed that resilience can be developed. Tusaie and Dyer (2004) propose that resilience does not function uniformly and automatically, but increases and decreases in response to contextual variables, such as increased workload and staff shortages.

3.4 Context Specific

One vital observation about resilience, noted by Lerner (2006) is that the expression of resilience will be affected by the context; not only the immediate context, but the larger contexts of age cohort, family history, social class, nation/culture, history, and gender. This is fundamental when applying the concept to an increasingly complex environment, such as the NHS and maternity provision. Attempting to make the comparisons between 'resilient' healthcare professionals within present healthcare settings to those of twenty or more years ago is therefore incomparable. With an increase in the current political and economic pressures, working in healthcare is becoming significantly more stressful (Reiger and Lane, 2013; Koinis et al., 2015; Giga et al., 2018). Throughput and efficiency are frequently measured and pressurised, making it an increasing challenge for healthcare professionals to sustain and endure the current demands. Recent data from the 2022 NHS Staff survey results (NHS Employers, 2022) indicate a continued decline in relation to the perception of staff and adequate staffing levels. Only 26.4 percent of participants in the survey said that there are enough staff at their organisation for them to do their job properly (NHS Employers, 2022). One viewpoint of resilience is that it is not static and continues to evolve and mould to the environment and context it is applied to (Silk et al., 2007). Cicchetti et al., (1993) and Luthar (1993) also describe resilience as being domain specific; similarly, Silk et al., (2007) and Luthar and D'Avanzo (1999) also suggest that resilience is context specific. This is a fundamental observation to the discussions surrounding resilience within healthcare and different healthcare professional groups, as much of the empirical literature took place with diverse groups of healthcare professionals, in a variety of settings. Therefore, resilience is relative and dependent on the context.

3.5 A personal trait versus a dynamic process

Tempski et al., (2015) suggest that resilience is a concept that is still in debate. However, there was some unanimity within the literature reviewed suggesting that resilience is a dynamic process, and one that can be learnt and developed over time; for example, as reflected in the body of literature focussing on resilience building interventions in healthcare staff. Nearchou (2018) summarises the ongoing debate in relation to resilience as a dynamic process, meaning it is not a fixed or static quality, but a personality trait, whereby resilience pre-exists, despite exposure to adversities. Although not all the literature addressed resilience in this way, it was evident that further clarity is still required. Tusaie and Dyer

(2004) propose that the origins of the constructs of resilience sit in two areas of literature: the psychological aspects of coping and the physiological aspects of stress.

Contemporary studies have explored resilience among healthcare employees, focusing on resilience as a dynamic process that can be developed (Britt et al., 2016). However, some disagreement remains around whether resilience is a fixed trait or a personal attribute (Masten and Garmezy, 1985). Several definitions are available in the literature for resilience, and although there are similarities between these there is also a dissonance with limited conceptual models available (Sanderson and Brewer, 2017). Windle, Bennett, and Noyes (2011) propose that these differences indicate that multiple facets must be included to accurately define resilience.

The current empirical literature on resilience and health professionals identifies two main schools of thought in relation to the understanding and origins of resilience. Primarily, researchers have considered that resilience may be a personal trait, or it may be one which is a dynamic process; however, it was also apparent that researchers used these terms interchangeably (Ashby et al., 2013; Gillespie et al., 2009). A recently published systematic review (Cleary et al., 2018) which reviewed a total of thirty-three studies, including ten randomised controlled trials and three qualitative studies concluded that resilience training may be of benefit to health professionals, although not all interventions enhanced resilience. This is fundamental to the discussions surrounding assessing resilience as a trait, which supports coping mechanisms or a coping mechanism itself. Cleary et al's., (2018) main findings suggest that interventions that demonstrate improvements in mental health, for example reduced levels of burnout and stress did not always improve resilience. The potential innate characteristic of resilience may hinder the capacity to enhance resilience by interventions. Referring to a resilient individual or particular trait is dependent on the specific area and circumstance it is being applied to. Masten, Best, and Garmezy (1990) suggest that, applying the term resilien*cy* in such situations should be used with caution, because this term carries the inference of a personality trait, rather than a dynamic process.

Block and Block (1980) developed the theory of 'ego resilience', referring to a personal characteristic of an individual. Ego resiliency encompasses a set of traits reflecting general resourcefulness and sturdiness of character, and flexibility of functioning in response to varying environmental circumstances (Luthar, Cicchetti, and Becker 2000). Ego-resiliency is a

personality characteristic of the individual, whereas resilience is a dynamic developmental process. Masten (1994) attempted to untangle the confusion between resilience as a personality trait or as a dynamic process; Masten (1994) suggests that competence, despite adversity should be referred to by the term 'resilience' and never 'resiliency,' which carries the misleading connotation of a distinct personal attribute.

Nevertheless, Luthar, Cicchetti, and Becker (2000) argue that much of the confusion lies about resilience as a personality trait or a process because of the origins of resilience within child psychology. The term 'resilient children' is often referred to in the literature, although 'resilient children' is not an attribute but more of an explanation of the two conditions of resilience-the presence of threat to a child's well-being and evidence of positive adaptation in this child, despite the adversity they have come across (Richters and Weintraub, 1990; Luthar, 1993; Luthar and Cushing, 1999). It follows that if resilience is considered a trait, then some people are naturally more resilient and capable of dealing with adversities (Tempski et al., 2015). By contrast, Masten (2001) claims that everyone can develop resilience. Within the broader literature, some authors maintain that characteristics, such as self-confidence, curiosity, self-discipline, self-esteem, and self-control all are examples of the defining attributes of resilience (Beardslee, 1989).

Block and Kremen (1996) describe resilient individuals as those who display energy, optimism, enthusiasm and are open to new challenges. In stark contrast, Walsh (2004) affirms that individuals are not born resilient, instead resilience is gained through exposure to adversity, implying that resilience is more of a process than a personality trait, and one that can be developed and built on throughout life. As a process, the individual must have such characteristics assessed, and as a system, resilience is defined as *'the result of the interaction among the individual, their social support environment, and the adversity, which includes their values, cultures, and social and ethical influences'* (Tempski et al., 2015, p2). Cameron and Brownie (2010) concluded in their study that enhancing resilience in registered nurses, with collegial support, humour and meaningful working relationships can all promote well-being and build resilience in nurses.

There is a dichotomy in the notion of resilience and on how resilience is conceptualised, depending on the context. This is paramount and pertinent for how resilience is approached as part of a research study and for any potential strategies and/or interventions to develop

resilience. Teaching coping mechanisms may or may not influence resilience, depending on how it is conceptualised (Cleary, et al., 2018) and is also significant in relation to discussions about whether it is a personality trait or a dynamic process. From the reviewed literature, the latter is the dominant theory, whereby the ability for resilience to be learnt and developed over a period is feasible. However, a combination of an individual having some innate characteristics and developing strategies to achieve increased resilience may be the optimum ideology for both organisations and individuals, when considering developing and promoting resilience in a healthcare environment.

3.6 Resilience and Midwifery

Although the meaning of resilience in a healthcare environment often varies, the review of empirical literature presented in Chapter Two identified that it was broadly defined as the ability for an individual to 'bounce back,' positively respond, and develop, despite chronic or acute work stressors or adversity. In the context of healthcare, resilience was examined in different organisational settings. Therefore, it is essential that consideration of how this concept will be understood in this thesis is explored further. It is widely recognised that resilience is a challenging area to study, due to inconsistent definitions, no standardised, valid, or reliable measurements, what the predictors of resilience are, and whether resilience is even related to improved patient care (Leppin et al., 2014; Windle, Bennett, and Noyes, 2011; Ahern et al., 2006). It has become an increasingly common term in healthcare; so much so, that its popularity has meant that it has been used misguidedly (Hunter and Warren, 2014), and therefore warrants clarity of its definition and how it is conceptualised for midwifery practice.

Only one study in the current literature has examined the relationship between resilience and retention in midwives alone. Hunter and Warren's (2013; 2014) small study exploring resilience in midwives, highlighted points in a midwife's career that were deemed 'critical', such as when newly qualified or following an adverse incident. This small but influential qualitative study by Hunter and Warren (2013; 2014) explored experienced midwives' understanding and experiences of resilience. Online professional discussion groups were used, and participants self-selected to be part of the study. Inclusion criteria required that they be practising midwives, with at least fifteen years of experience. Key findings and themes were identified from the study which included 'challenges to resilience' and

'strategies for building resilience'. Although this study generated considerable interest in the field of midwifery it did have limitations. The study only included eleven participants who self-identified as resilient and included no demographic data of the midwives. Despite this, the study findings shaped the research question for this study. It was instrumental in providing a platform to consider and investigate further areas into the concept of resilience in midwifery practice and attempt to address some of the unanswered questions.

3.7 Retention statistics in midwifery

Statistics from the NMC (2023) show the number of professionals leaving the register fell marginally, but still indicate more than half of registrants left sooner than planned and most do not plan to return. Previously reported workforce pressures, such as burnout or exhaustion; lack of support from colleagues; concerns about the quality of people's care; workload; and staffing issues (NMC, 2023a) remain topical. The concerns regarding midwives' emotional health and how work-related stress influences the distress of midwives is concerning. Despite the number of midwives increasing by 0.9 percent (201 full-time equivalent (FTE)) in 2018, a higher rate of growth than in the previous year, with a total of 21,482 FTE midwives in employment in 2018 (Buchan et al., 2019) there is still an existing shortage of more than 2000 midwives (RCM, 2022b). Maternity services across England continue to struggle with no obvious solution to the recruitment and retention crisis. Challenging working conditions have been exacerbated by the pandemic, burnout, and low morale with alarming figures of 3000 midwives, the highest number in twenty years, leaving the profession over a two-month period being reported in 2021 (NHS Digital, 2021).

Published data from the RCM (2022b) suggests that the number of midwives in England is now lower than at the time of the last general election and the latest figures show a worsening trend with a decline of 552 midwives within the last twelve months. In addition, the recently published RCM report (RCM, 2023)-England State of Maternity Services 2023 continues to illustrate this grave statistics in maternity provision, highlighting that the NHS is not retaining older, experienced staff. Retention and attrition statistics suggest that the number of midwives increased by less than one percent in comparison to other professionally qualified healthcare staff such as ambulance staff, which increased by around three percent or more (Buchan et al., 2019). The RCM (2021) reports that of the 57 percent respondents who said they were considering leaving midwifery the highest proportion are

midwives who have worked five years or less in the NHS. The retention of registered midwives in all settings is critical to the delivery of high-quality services (NHS Employers, 2022) and therefore if a solution to the current retention issues in maternity services can be found, midwives may be more satisfied and have the ability to 'bounce back' from workplace adversities.

3.8 Rationale for the research question

Resilience has been defined as a means of adapting to stress in the workplace (Gillespie et al., 2007) and has been found to be related to job satisfaction (Aronson 2005; Gillespie et al., 2009). Demonstrating one's effectiveness to cope in a stressful environment is often described and associated within the literature as how resilient that healthcare professional is alleged to be. There is growing evidence for midwives and nurses leaving the professions, and despite some of the emerging developments for the government to introduce strategies to encourage healthcare professionals to remain in the workforce, numbers leaving continue to increase (RCM 2021; RCM 2022b; RCM 2023; NHS, 2022). The development of resilience in individuals and organisations has been presented in the literature as the potential remedy to the managing stress in workplace environments (Jackson, Firtko, and Edenborough, 2007; Neenan, 2009).

It is increasingly apparent that serious concerns are being raised regarding the well-being of the current NHS healthcare workforce. After reviewing the relevant literature and policy in relation to addressing the retention of healthcare professionals and students, action needs to be taken to restore and support staff working in these challenging and demanding roles. Due to the increasing and repeated exposure midwives face to emotional and physical demands in an overstretched and often stressful environment (Hunter et al., 2018) they have been repeatedly identified as a high-risk group among the healthcare workforces (NHS, 2022). It is evident that retention within healthcare professionals, such as midwives, is approaching crisis point and improvements need to be made. A series of reports from the RCM, the professional organisation and trade union for the voice of midwifery, have identified important concerns in relation to midwives' workplace stress and low morale (RCM 2015a; RCM 2015b; RCM 2016a; RCM, 2016b; RCM 2021; RCM 2022a; RCM 2022b; RCM 2023; NHS Employers, 2022). The impact on this work-related stress is resulting in existing midwives making the decision to leave the profession.

An increasing focus on such strategies to manage retention has prompted an appetite in healthcare around the understanding and insights surrounding resilience, including in the midwifery profession. The current paucity of midwifery literature surrounding resilience and retention requires further analysis. The midwifery profession has had limited studies that have focused on midwives' and student midwives' career-related decisions beyond the intention of to leave, and whether the development of resilient staff and organisations plays a role in this. There is a pressing need to explore whether the building of resilience influences the decisions midwives' make relating to their careers. It has also been identified that there are critical periods and more vulnerable groups of midwives who would benefit from further support and strategies in their role (Hunter and Warren, 2013; 2014; Warren and Hunter, 2014). One such time is at the point of qualifying when the individual is making the transition from student to newly qualified midwife.

Much has been documented about the promotion and development of a resilient workforce in healthcare. The term 'being resilient' has been recently referred to as a panacea to the overstretched system of the NHS. Some authors have suggested ways that resilience can be improved by both individual and organisational strategies; often with the solution to improving a resilient workforce by the former, however recognition that this might not be the solution; is beginning to emerge. Griffith (2019) suggests that building resilience is not a solution to the problem. Instead, it should be viewed that the restoration of resilience is an indication that a plan is working.

3.9 Chapter Summary

Chapters Two and Three have established that resilience has been broadly defined in the literature as the ability to *'bounce back'* in a response to adversity. Its conceptual origins were established in psychology literature, based around childhood abuse and trauma. Resilience is seen as a positive attribute for healthcare professionals to possess and most of the literature indicates that resilience is a dynamic process which can be developed. Much of the available literature identified in Chapter Two was around other healthcare professionals and focused on retention of staff and strategies to promote and develop resilience. However, there are few studies which have explored resilience in midwifery, and to date, none that have focused on

the influence of resilience on midwives' and student midwives' career-related decisions. Recent studies and data show an increase in midwives leaving the profession and a few midwifery focused studies have identified that there are vulnerable groups and times during a healthcare professional's career, such as transitioning from student to qualified status. Resilience has been considered in the literature as a remedy to the retention issues, albeit this is only a small part of managing retention of staff. Overall, the theoretical literature has identified that there is an existing gap surrounding the understanding of resilience and the midwifery profession. Little is known about what influence resilience has on midwives' and student midwives' career-related decisions. Therefore, this study will explore how midwives and student midwives understand and perceive resilience in the context of midwifery practice and the career-related decisions they may make.

Research Question:

'What is the influence of resilience on midwives' and student midwives' career-related decisions?'

Objectives:

To understand how midwives and student midwives perceive and experience resilience.

1. To explore if and how resilience influences midwives' and student midwives' career-related decisions.
2. To develop a theoretical explanation about the influence of resilience on midwives' and student midwives' career-related decisions.

The next chapter (Chapter Four) outlines the study design and methodology to address this question.

Chapter Four: Methodology

4.1 Introduction

This chapter presents an account of the chosen methodology and study designed to address the research question. The aim of this chapter is to present a clear rationale and justification for a qualitative research paradigm and for the choice of GT as a methodological approach. Key elements of the chapter include exploring the research paradigm for the chosen methodological approaches used in this thesis. Following this, discussion about the procedures of GT will be examined. The rationale for the chosen data collection method, (semi-structured interviews) will be provided, and an exploration of the quality and generalisability of the approach will be considered. Finally, the chapter will conclude with details in relation to reflexivity, theoretical sensitivity, and the research limitations of a GT approach.

4.2 The Research Paradigm: The Qualitative Approach

A research paradigm is *'the set of common beliefs and agreements shared between scientists about how problems should be understood and addressed'* (Orman, 2016 p48). The two major paradigms are known as positivism and constructivism, although often, researchers also refer to a third paradigm known as pragmatism:

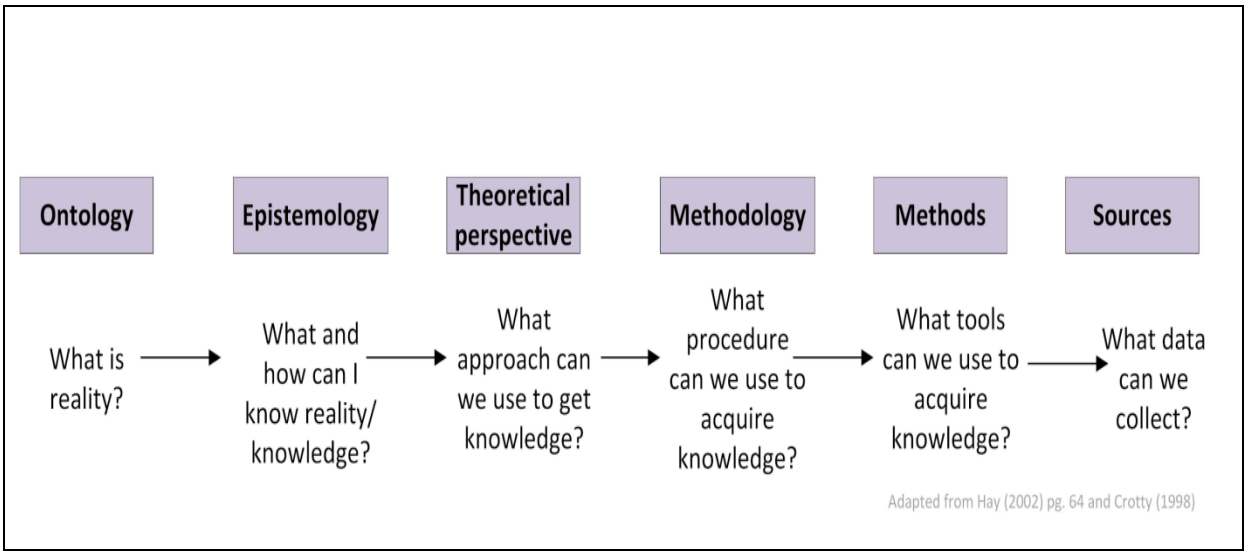
- **Positivists** believe that there is a single reality, which can be measured and known, and therefore they are more likely to use quantitative methods to measure this reality.
- **Constructivists/interpretivists** believe that there is no single reality or truth, and therefore reality needs to be interpreted, and therefore they are more likely to use qualitative methods to get those multiple realities.
- **Pragmatists** believe that reality is constantly renegotiated, debated, interpreted, and therefore the best method to use is the one that solves the problem.

According to Guba (1990), research paradigms can be characterised through three different lenses:

- Ontology – What is reality?
- Epistemology – How do you know something?

- Methodology – How do you go about finding it out?

Figure 4.1: A diagram understanding the research paradigms and the relationship between them:



Crotty, (1998 p64)

Research studies often sit between one of two paradigms. A constructivist/interpretive approach assumes there is no single reality or truth, and that reality is created by individuals in groups; therefore, reality needs to be interpreted (Crotty, 1998). In contrast, a positivist approach to a research study, would assume that there is a single reality or truth which can be measured by reliable and valid tools. Experimental research would assist the researcher in finding out the methodology, often by methods such as questionnaires, sampling, and statistical analysis. This study followed a constructivist/interpretive approach, where the reality of the midwives' and student midwives' experiences in relation to resilience and its influence on career-related decisions was interpreted and subsequently formed the research question.

Crotty (1998, p10) defines ontology as *'the study of being'* whereas epistemology, or the study of knowledge is *'a way of understanding and explaining how I know what I know'* (Crotty, 1998, p3). Birks and Mills (2015) describe ontology as the study of the nature of reality and epistemology as the nature of justifiable knowledge, and suggest they are both intrinsically connected. Mills, Bonner, and Francis (2006 p9) acknowledge that working out as a researcher where you 'sit' methodologically *will 'overtly reshape the interactive relationship between researcher and participants in the research process*'. Understanding as a researcher my personal beliefs and influences with participants needs to be acknowledged throughout

data collection. Guba and Lincoln (2004) suggest that the question of 'truth' or the nature of reality is fundamental when considering methodological preferences. Indeed, Mills, Bonner, and Francis (2006) claim that researchers must choose a research paradigm that is fitting with their beliefs about the nature of reality. Individuals are influenced by their history and cultural context, which influence the way they view the world, the forces of creation and the meaning of truth (Mills, Bonner, and Francis 2006). For example, when considering the question of how *we* define ourselves, several roles for an individual are likely. This can be applied to me as the researcher and personal view of myself as an expert in their professional field, although a novice researcher, who is drawing on my overall life experiences in deciding how to proceed with research decisions.

Qualitative research can be defined as a collection of interpretative techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world (Al-Busaidi, 2008). The aim of qualitative research is to develop concepts that can help us understand social phenomena in natural settings, giving emphasis on the meanings, experiences, and views of the participants (Mays and Pope, 1995). Qualitative research methods are the most suitable for the research question explored in this thesis because of the emphasis on people's lived experience, i.e., the experience of midwives and student midwives' practice. Gehrels, (2013) emphasises that making choices regarding the methodological approach to research is part of the doctoral process. Therefore, it is paramount to provide a clear explanation for the choices made; one of the most significant choices to make was the methodology. This was not just about considering what the best research method was but more about what the best research method was for answering the research question most effectively and efficiently (Mays and Pope, 1995). Qualitative methods are well suited for locating the meanings that people place on the events, processes, and structures of their lives and their perceptions, presuppositions, and assumptions. Starks and Trinidad (2007) offer a useful summary of qualitative research, suggesting that:

'Qualitative research methods enable health sciences researchers to investigate questions of meaning, examine institutional and social practices and processes, identify barriers and facilitators to change, and determine the reasons for the success or failure of interventions' (Starks and Trinidad, 2007, p1372).

Qualitative research was first used by sociologists and anthropologists in the early twentieth century. It has had a steady increase in its use since the 1960s, starting with its focus with GT

(Al-Busaidi, 2008). Although initially, its use was limited, qualitative research has increased in the last twenty years, particularly within healthcare. The ontological and epistemological paradigms of qualitative and quantitative research usually differ. A constructivist/interpretive perspective suppose that there is no single reality or truth, and reality is created by individuals in groups and the reality needs to be interpreted. Whereas a positive paradigm considers that there is a single reality or truth which can be measured and therefore the focus is on reliable and valid tools to obtain this information (Scotland, 2012).

Qualitative research is often described as the opposite to quantitative research, which is based on structure, and practically uses experiments and surveys as methods. Quantitative research is deductive in nature, and uses statistical sampling methods, whereas qualitative research relies more on observation and interview methods. In contrast, qualitative research is inductive in nature and depends on the purposeful selection of participants. Despite qualitative and quantitative research in healthcare often being antagonists, qualitative methods now hold the deserved recognition in today's NHS research and are increasingly important as a technique of assessing and improving the quality of care (Chapman, Hadfield, and Chapman, 2015). Al-Busaidi, (2008) emphasises that neither qualitative nor quantitative research is superior to the other and each method has different strengths and weaknesses. Later in this chapter a detailed account for the rationale of semi-structured interviews as a chosen data collection will be addressed and limitations to the chosen methodology will be considered.

Patton (2002) lists several conditions that are suitable for a qualitative study. These include:

- Questions about people's experiences; inquiry into the meanings people make of their experiences.
- Studying a person in the context of her or his social/interpersonal environment. Research where it is difficult to develop a standardised instrument due to the lack of knowledge on the phenomenon.

All these points above highlighted by Patton (2002), are relevant to the aims and objectives of this thesis. The interpretative nature of qualitative methods and being able to fully understand the underlying meaning of the experiences of midwives inherent in the research question, suit a constructivist/interpretive paradigm. In addition, the theoretical perspective,

where reality needs to be interpreted by an approach such as *Symbolic Interactionism* (Blumer,1969) is indicative of a constructivist paradigm.

It became apparent quite early into this thesis that a methodology which was akin to the above conditions would fit well with exploring midwives' and student midwives experiences and perceptions of resilience within their working environment and therefore, an appropriate approach to consider. There is a lack of knowledge surrounding the phenomenon of resilience within midwifery practice and as little is known about the topic under investigation and a qualitative (inductive), rather than a quantitative (deductive) methodology was deemed more suitable. The chosen constructivist paradigm was therefore well-suited with the conceptualisation of resilience, for example, resilience is understood not as a static trait but as a dynamic process that is actively constructed in behaviours. Once the methodological approach was ascertained, a suitable method to explore the midwives' perceptions of resilience was then considered. Semi-structured interviews, which will be discussed in more detail later in this chapter, was the technique used to find this out.

4.3 Rationale for Grounded Theory (GT)

The research design is the plan or strategy researchers use to answer the research question, which is underpinned by philosophy, methodology and methods (Creswell, 2013). GT is an interpretive, qualitative approach and one of the most popular research designs in the world (Birks and Mills, 2015). Tie, Birks, and Francis (2019) state that one of the key benefits of GT is that it is a structured, yet flexible methodology. It is a methodology which is appropriate when little is known about a phenomenon, as is the case with resilience and its influence on midwives' and student midwives' career-related decisions. Although there is a vast amount of literature available about other healthcare professionals developing professional resilience, this is not the case for midwives. The GT method focuses on generating new theories through inductive analysis of the data gathered from participants rather than from pre-existing frameworks, so it is particularly suited to addressing the research question which was developed. The intention of GT is to produce or construct an explanatory theory that uncovers a process inherent to the substantive area of inquiry (Bryant and Charmaz, 2010). One of the defining characteristics of GT is that it aims to generate theory that is grounded in the data.

4.3.1 Why Grounded Theory and not an alternative qualitative approach?

In general terms, qualitative research can be defined as the systematic inquiry into social phenomena in natural settings. These phenomena can include how people experience aspects of their lives, how individuals and or groups behave, how organisations function, and how interactions shape relationships (Teherani et al., 2015). Therefore, in relation to this study presented in this thesis, exploring the perceived experiences and perceptions of midwives and student midwives in relation to their understanding and experiences of resilience was a well-suited phenomenon for this approach. The focus of this study included in this thesis, and in keeping with GT, was about constructing a theory from data following data collection and analysis, rather than seeking to prove or disprove a theory.

Grounded theory is widely used across a wide range of disciplines including healthcare (Bryant and Charmaz, 2007), however its main purpose is to develop theories grounded in the study data. Other qualitative methodologies commonly used in addressing health-related research questions, such as ethnography or phenomenology, focus more on the understanding the perspectives of individuals lived experience. Padgett (2012) suggests that the main purpose of a GT study is to explain a process or action, whereas in a phenomenological or ethnological analysis it often has a 'freeze-frame' approach. A particular attraction to adopting a constructivist GT approach for the current study was the focus being about the researcher's influences and positioning in relation to the participants' analysis of the data and representation of participants' experiences into grounded theory. Charmaz (2014) suggests that the rationale for specifically choosing constructivist grounded theory is because neither the data or the theories are discovered but are constructed through the researchers' past and present experiences. Mills, Bonner, and Francis (2006) highlighted that with constructivist GT the researcher constructs theory as an outcome of their interpretation of the participants' stories which was akin to the study in this thesis. Although other methodologies could have been used to examine the research question in this study, GT was determined to be the most appropriate qualitative approach and one which the theory is capable of being used to guide future research or alter clinical practice. Grossoehme (2014) summarises a key rationale for choosing GT as it is an ideal qualitative approach to choose where the investigator notices subtle nuances in the data and arguably more than in any other qualitative methodology, the person or the investigator is the crucial.

4.4 Commonalities and Variants of Grounded theory Methodology

4.4.1 Historical Context and Approaches to GT

Since the development of GT over fifty years ago in the seminal publication of *The Discovery of Grounded Theory* (Glaser and Strauss, 1967) in medical sociology, there has been methodological confusion and unconscious replication of the theory by several researchers. Aldiabat and Navenec (2011) suggest that GT has experienced significant development during the past four decades and since then, various iterations and approaches of the method have been adopted by other researchers claiming to embrace it (Holton, 2008). Despite this, it continues to be a popular qualitative research methodology. Three broad variations in GT are evident in the literature:

1. Realist-interpretivist (post-positivist, or Straussian GT) (e.g., Strauss and Corbin 1990)
2. Constructivist–interpretivist GT (constructivist challenge) (e.g., Charmaz 2006)
3. Realist–positivist, or Glaserian GT (postmodernists, traditional) (e.g., Glaser 1992)
4. .

The variations primarily differ in their ontological and epistemological underpinnings (Weed, 2017). A post-positivist approach to GT assumes that there is an objective reality that exists outside of human perception but is only ever incorrectly perceived. Whereas constructivists and postmodernists assume what is known as a relativist position, where reality is understood as *'relative to a specific conceptual scheme, theoretical framework, paradigm, form of life, society, or culture.... there is a non-reducible plurality of such conceptual schemes'* (Bernstein, 1983, p8). However, the three approaches also share several commonalities: Urquhart, Lehmann, and Myers (2010) identify that there are four key characteristics of the GT method, irrespective of philosophical orientation:

1. The main purpose of the GT method is theory building.
2. Researchers should make sure that they have no preconceived theoretical ideas before starting their research.
3. Analysis and conceptualisation are engendered through the core process of constant comparison, where every slice of data are compared with all existing concepts and

constructs, to see if it enriches an existing category (by adding to/enhancing its properties), forms a new one or points to a new relation.

4. 'Slices of data' of all kinds are selected by a process of theoretical sampling, where researchers decide, on analytical grounds, where to sample from next.

Proponents of all variants agree that the main drive of GT is to develop higher level understanding that is grounded in the data collected rather than predetermined by existing theories or frameworks (Lingard, Albert, and Levinson, 2008).

4.4.2 Philosophical Underpinnings

Grounded theory is a systematic qualitative research approach emphasising the generation of middle range theory from data at a substantive or formal level (Glaser, 1978). GT originates from sociology, specifically from symbolic interactionism which places emphasis on eliciting and understanding the way meaning is derived in social situations (Stern 1994; Schwandt 2000). The scoping review presented in Chapter Two concluded that resilience can best be interpreted in healthcare professionals and students as a socially constructed phenomenon. Symbolic interactionism is therefore a suitable approach to decipher understanding about behaviour as part of an individual's social role and relationship with others. Grounded theorists aim to inquire about how social structures and processes influence, and how factors are accomplished, through a given set of social interactions (Starks and Trinidad, 2007). Strauss and Corbin (1998) suggest that GT examines the 'six Cs' of social processes (causes, contexts, contingencies, consequences, covariances, and conditions) to understand the patterns and relationships among these elements. For example: examining whether resilience influences midwives' and student midwives' career-related decisions and if workplace environments, strategies, and other possible factors such as, burnout and stress exacerbate this.

Symbolic Interactionism (SI) in GT is a well-known research methodology that has grown vast interest for a range of disciplines due to explanatory power. It is sometimes understood by asking the question-*what is going on in this area?* (Mills, Bonner, and Francis,2006). Charmaz, (2014, p262) defines symbolic interactionism as a *'dynamic theoretical perspective that views human actions as constructing self, situation, and society'*. Charmaz (2014) goes on

to explain that symbolic interactionism is a perspective, and not an explanatory theory that specifies variables and predicts outcomes. Its approach encourages the researcher to learn about people and places, times and troubles, actions, and accomplishments as members of the studied *world* understand them. Aldiabat and Navenec, (2011) highlight the main concepts of symbolic interactionism as the self-concept (the 'I' and 'Me'), the object (e.g., self as an object), role-taking, looking-glass self, and definition of a situation. This theoretical perspective can be applied well to how participants in this study interpreted and viewed their experiences of midwifery practice and how they may be seen as 'active beings,' in their workplace worlds.

Aldiabat and Navenec, (2011) highlight that GT and SI are compatible in their goals and their assumptions. The key goal of GT is compatible with the general goal of SI, which is to provide a theory that explores human behaviour, or an approach to study human conduct and group life. Aldiabat and Navenec (2011) suggest that to understand these behaviours in GT it is important to understand how to use SI assumptions and concepts to inform the data collection and analysis. The significance of highlighting the relationship between GT and SI for this study is that it is essential to understand how the participants' behaviours have been shaped through social interaction in their context. Therefore, the aim is to understand the behaviour and the meanings participants' give to their experience in their natural setting to discover the basic psychosocial process (Glaser, 1978).

4.4.3 The Development of a Constructivist Grounded theory

Constructivist grounded theory originates from the work of Strauss (1987) and Strauss and Corbin (1990; 1994; 1998). Its ontological grounding is a relativist one and is exemplified in the belief that the researcher constructs theory as an outcome of their interpretation of the participants' stories. A key aspect of this approach is creative writing as a form of expression and enables a platform for participants to communicate how they construct their worlds. Several authors identify GT when it is underpinned by a constructivist paradigm (Charmaz, 1994, 1995, 2000; McCann and Clark, 2003a, 2003b; Nelson and Poulin, 1997; and Norton, 1999). Constructivism is a research paradigm that denies the existence of an objective reality, *'asserting instead that realities are social constructions of the mind, and that there exist as many such constructions as there are individuals'* (Guba and Lincoln, 1989, p43). Charmaz and Henwood (2008) summarise the defining features of the process of GT as follows:

*'We gather data, compare them, remain open to all possible theoretical understandings of the data, and develop tentative interpretations about these data through our codes and nascent categories. Then we go back to the field and gather more data to check and refine our categories.' (*p241).

Epistemologically, constructivism highlights the subjective interrelationship between the researcher and the participant (Hayes and Oppenheim, 1997). Rather than the researcher being an objective observer, they become part of the research endeavour. This is crucial when determining the researcher's methodological position, as this will dictate if the researcher views themselves as an objective instrument of data collection from participants, or alternatively, a subjective active participant in data generation *with* the participants (Birks and Mills, 2015). As discussed above, it is essential as a researcher to have an insight into your own philosophical position for you to be methodologically congruent in the research design.

To understand where in the continuum of GT, constructivist GT lies; Annells (1997) explains that Charmaz's theory applies the strategies of traditional GT within a constructivist paradigm, consequently discarding the concepts of emergence and objectivity. Charmaz's modified approach to GT has been used in disciplines such as education, psychology, and nursing (Annells, 1997; McCann and Clark, 2003a). Treatment of the data and analytical outcomes is the key premise of Charmaz's (2000) explanation of how researchers undertake studies using GT. Charmaz's theory of revealing the researcher as the author of a co-construction of experience and meaning is fundamental for a GT researcher. Adopting the key premise of constructivist grounded theory for this research study is a well-suited choice as the sole researcher and interviewer of the participants,' *I was able to construct theory as an outcome of my interpretation of the participants' stories*, which Charmaz (2000; 2014) suggests is exactly what a researcher should do.

4.5 Defining the Procedures of Grounded theory

There are seven key characteristics associated with this process that are common to all GT methods (McCann and Clark 2003a):

1. Theoretical sensitivity
2. Theoretical sampling
3. Constant comparative analysis

4. Coding and categorising the data
5. Theoretical memos and diagrams
6. Literature as a source of data
7. Integration of theory

4.5.1 Theoretical Sensitivity

Theoretical sensitivity is defined as the ability to recognise and extract from the data elements that have relevance for the emerging theory (Birks and Mills, 2015). My professional experience as a midwife and midwifery lecturer provided an understanding of the field of investigation and is necessary to acknowledge to interpret what Strauss and Corbin (1990 p42) refer to as *'events and actions seen and heard'*. For example, my understanding of the demands and pressures of a clinical midwife and working in the NHS in the UK facilitated an understanding of participants' accounts of their perceptions and experiences and the meaning of resilience. In addition, theoretical sensitivity was also gained from Chapter Two and Chapter Three. One way in which Charmaz (2014) advocates improving theoretical sensitivity of the researcher in a study is to utilise *gerunds* in the coding stage. Gerunds are defined as words which end in *'ing'* and are meant to assist the researcher to identify participant characteristics and setting as a means of managing the vast amount of data. Charmaz (2014) suggests that using gerunds can foster theoretical sensitivity by shifting a researcher's thinking from static topics and concepts to enacted processes. This approach was helpful during the initial coding stages of this study and Appendix M which presents the initial (open) codes includes the use of gerunds, for example, 'compartmentalising', 'bullying', 'not coping' and 'moving on'.

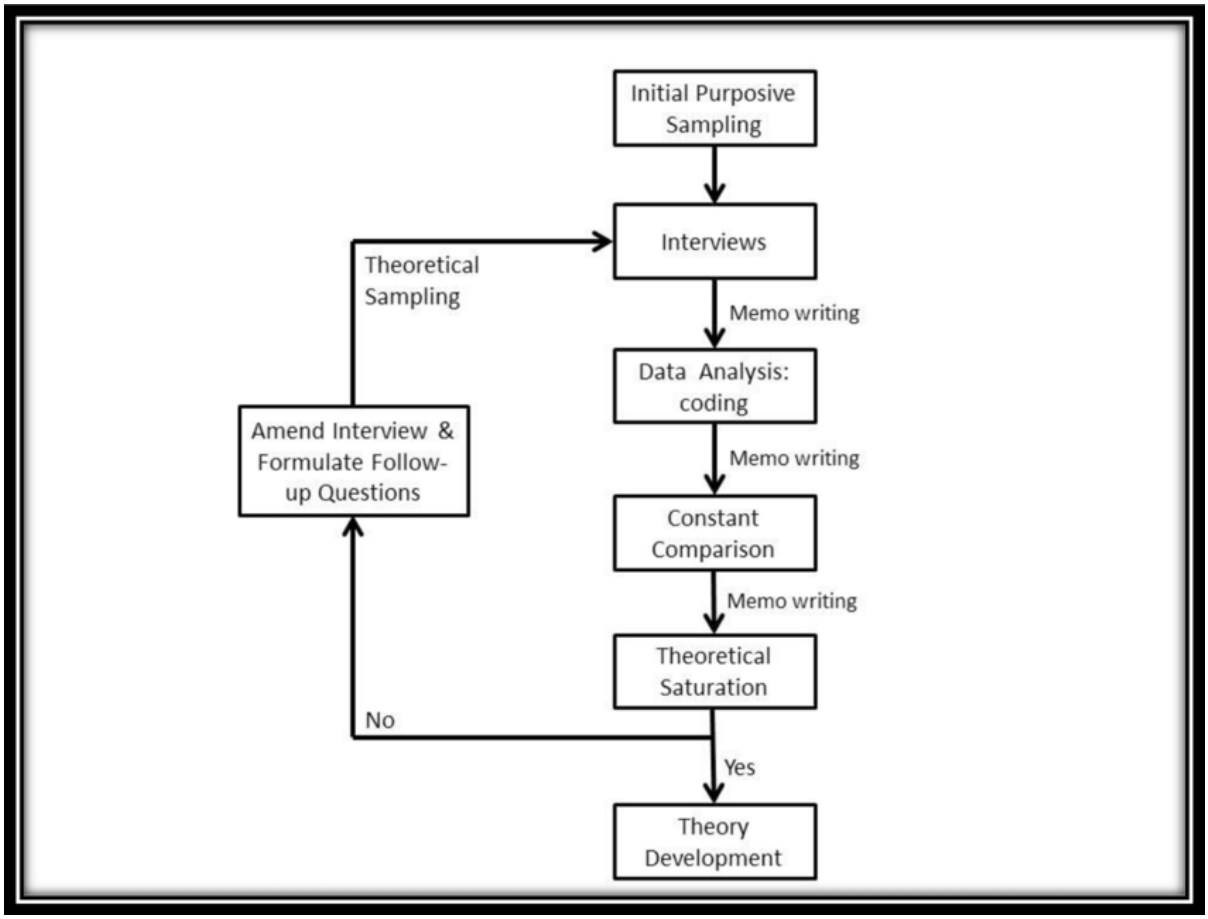
4.5.2 Theoretical Sampling and Saturation

Flick (2018, p144) defines theoretical sampling *'as the procedure in GT research where cases, groups or materials are sampled according to their relevance for the theory that is developed and against the background of what is already the state of knowledge after collecting and analysing a certain number of cases'.* Sampling in qualitative research, particularly in GT research, has a different approach and purpose than sampling in quantitative research. Initially, decisions regarding recruitment of participants and the setting are purposive in nature. A purposive sample, also referred to as a judgmental or expert sample, is a type of

non-probability sample. The main objective of a purposive sample is to produce a sample that can be logically assumed to be representative of the population (Lavrakas, 2008). For example, student midwives on an approved programme of study or qualified midwives currently on the NMC register. Theoretical and purposive sampling for the study presented in this thesis are discussed in detail in Chapters Five and Six and a sampling diagram is used to demonstrate the process for purposive and theoretical sampling. As data are collected and analysed, decisions about participants and sample size are then based on emerging theory.

Charmaz (2014) suggests that much confusion lies with regards to saturation in GT research and saturation of data are different from saturation of theoretical concepts; these two should not be muddled. Moreover, Charmaz (2014) emphasises how researchers often state saturation by 'claim, or by definition', when true saturation of concepts has not been achieved. McCann and Clarke (2003a) suggest that the quality of the data in theoretical saturation is more important than the frequency in which it recurs. Both precision and flexibility in relation to the research question is required to ensure saturation is achieved (Morse, 1995). A significant amount of time was spent forming the research question to ensure there was flexibility regarding the phrase 'midwives' and student midwives' career-related decisions.'

Figure 4.2: Diagram showing iterative process of sampling in grounded theory analysis (Osman et al. 2016).



4.5.3 Constant Comparative Analysis

Constant comparative analysis is the principal approach to data analysis in GT and where data collection and analysis take place simultaneously. Constant comparative analysis is a key component to GT and one of the essential methods that differentiates it from other qualitative designs. It is an analytical process in which incoming data are compared with existing data in the process of coding and category development (Birks and Mills, 2015). Constant comparative analysis is the constant comparison of the different conceptual levels of data analysis that steers theoretical sampling and the ongoing collection or generation of data. The process of constant comparison continues until a theory with adequate detail and abstraction is generated.

Birks and Mills, 2015) suggests that the decision-making process when constantly comparing data rely on a combination of inductive and abductive thought. Bryant and Charmaz (2010 p608) explain the difference between an inductive and an abductive thought. They define an inductive thought as *'a type of reasoning that begins with study of a range of individual cases and extrapolates patterns from them to form a category.'* Whereas abduction is defined as *'a type of reasoning that begins by examining the data and after scrutiny of it, considers all potential explanations and forms hypotheses to confirm or disconfirm the interpretation*' (Bryant and Charmaz, 2010 p603).

4.5.4 Coding and Categorising the Data

Coding can be defined as the process of taking data apart, defining, and labelling what the data are about, it is usually the first analytic step in the process of GT (Charmaz, 2014). Researchers develop codes as they study and interact with their data. Charmaz (2014) explains that coding is the crucial link between collecting data and the development of theory to explain these data. Initial, focused, and theoretical coding usually form the three stages to coding using the GT approach by Charmaz (2014). Depending on the specific approach adopted at this phase during GT it is likely that researchers will alternate between the distinct phases of coding throughout a study. Table 4.1 depicts the process and interchangeable nature of initial, intermediate, and advanced coding.

Table 4.1: Demonstrating Initial, Intermediate, and Advanced Coding:

	Initial coding	**Intermediate coding**	**Advanced coding**
Glaser and Strauss (1967)	Coding and comparing incidents	Integrating categories and properties	Delimiting the theory
Glaser (1978)	Open coding	Selective coding	Theoretical coding
Strauss and Corbin (1990, 1998)	Open coding	Axial coding	Selective coding

Charmaz (2014)	Initial coding	Focused coding	Theoretical coding

Charmaz, (2000; 2014) states that coding initiates the process of theory development. Three steps to the coding and categorising of data can be undertaken. Initially *in vivo* open coding, sometimes referred to as substantive coding can be practised and patterns in the raw data can be coded and given conceptual labels. Line-by-line coding should initially be adopted, although when familiar themes are identified in the data, initial coding can then be undertaken by paragraph and/or sections. Charmaz (1999; 2014) emphasises that the practice of line-by-line coding is beneficial for avoiding undue influence of any preconceived ideas the researcher may have. At this initial coding stage, Strauss, and Corbin (1990), emphasise that the researcher needs to constantly interrogate themselves regarding the early decisions in which they make and begin to take ownership of them (Saldãna, 2013).

There are several approaches in the various GT alternatives in relation to the coding process, however this study adopted the key premise of coding by Charmaz (2014), using a GT approach, ensuring that through coding the researcher defines what is happening in the data and begins to wrestle with what it means. Following the initial (open) coding, focused (axial) coding can be undertaken. During this stage, links between categories and subcategories can be made. Asking questions, proposing, and making comparisons with the data were the focus at the stage. Finally, the third stage of coding, known as selective or theoretical coding is employed. The aim of this final stage is to determine an overarching category and ascertain connections between this and other categories. Birks and Mills (2015) offer a valuable series of questions when undertaking the task of coding:

- *Are there elements of process or action apparent in the early analysis?*
- *What is left unsaid in the data analysis to date?*
- *Are there more questions than answers? If so, what are they?*
- *Who are the key stakeholders in the field?*
- *Where else do I need to go to get more data? What should that data consist of?*
- *Are there contextual influences at play?*
- *Is the original research question/substantive area of enquiry/unit of analysis remaining constant?*

4.5.5 Theoretical Memos and Diagrams

Theoretical memos and diagrams are often used as part of the analytical process in GT. McCann and Clarke (2003a) encourage the use of diagrams as they can assist the researcher in identifying the consistency of the relationships. Many researchers suggest the use of memos throughout the analysis of data and consider a memo to be an essential tool for capturing the idea and developing a theory (Charmaz, 2000; Glaser, 1978; Stern, 1994). Charmaz (2014) advocates the use of memos like 'diary writing' and no structure is required for them when undertaking GT. Flick (2018) explains how memoing is not a standardised procedure but depends on the personal style of the researcher and is a learnt skill. Lempert (2007, p262) suggests that there are four fundamental principles in memo writing:

1. The intention is the discovery and development of theory rather than application and confirmation.
2. Both memo writing and diagramming of concepts are key to analysing raw data and concepts.
3. Memo writing and diagramming aid further data collection and analysis.
4. Memos are written, reread, and rewritten to advance more abstract levels of theorising.

Drafting a research diary throughout the GT process is recommended by many authors (Flick, 2018). In addition, impressions, descriptions of the setting in which an interview was done,

circumstances and intriguing events in relation to the field and the interviewee should be noted to compliment the recording and transcription of what has been said in the interview.

4.5.6 Literature as a source of data

Reviewing the existing research prior to the commencement of GT research has several benefits. A preliminary scoping review of the literature surrounding resilience among healthcare professionals, was able to confirm there was a lack of consensus and gaps in the evidence relating to midwifery practice. There were inconclusive definitions and understanding the meaning of resilience, depending on context and limited research undertaken with midwives and/or student midwives only; therefore, clear justification to undertake this study. Strauss and Corbin (1998) outline five positive ways which literature can be used in GT research, which were adopted in the study presented in this thesis:

1. Preliminary review enhances theoretical sensitivity
2. Useful secondary source of data
3. Give rise to questions about the data
4. Important means of theoretical sampling
5. Approach to validating the theory

4.5.7 Integration of theory

To demonstrate integration of theory during this study, the three main strategies identified by McCann and Clarke (2003a) were considered to develop and add weight to the emergent theory.

1. Category reduction

   Category reduction describes a strategy where initially, several categories are identified. Clustering and subsuming categories can reduce the number.

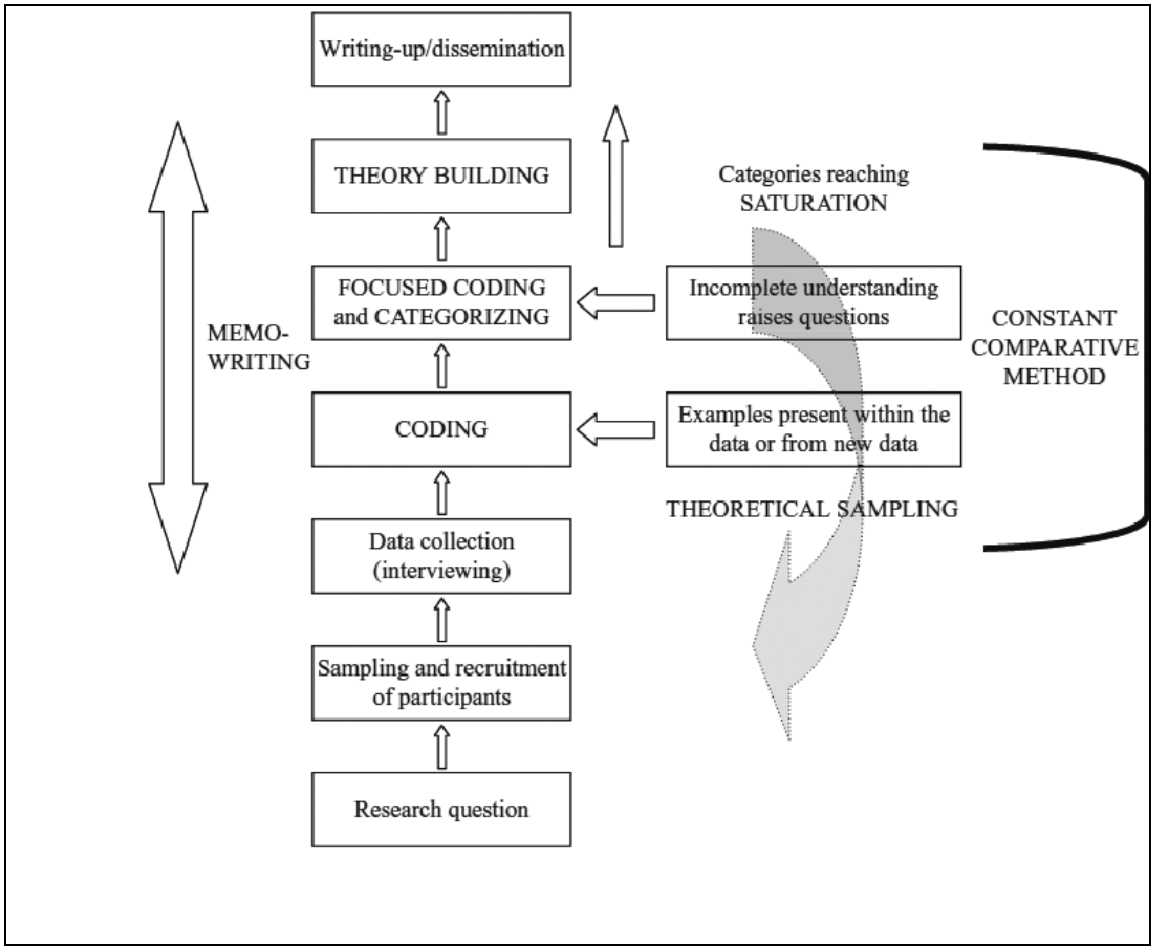
2. Selective sampling of the literature

   The second strategy, selective sampling of the literature is where the existing literature is another form of data, and these are integrated within the emerging theory, categories, and subcategories.

3. Selective sampling of the data

The third strategy used to develop and add density to the emergent theory is selective sampling of the data, where more data continues to be collected to develop and test hypotheses and reveal features of the main categories. The diagram in Figure 4.3 demonstrates the GT process and methods which guided this study.

Figure 4.3: Research design framework: summary of the interplay between the essential GT methods and processes:



GT process (Tweed and Charmaz, 2012)

4.6 Quality

Evaluating and ensuring quality of research are essential considerations for both practitioners and researchers in healthcare. Strategies for rigour as well as concepts of quality will be examined in this section. The quality of a GT can be related to three distinct areas underpinned by (1) the researcher's expertise, knowledge, and research skills; (2)

methodological congruence with the research question; and (3) procedural precision in the use of methods (Birks and Mills, 2015).

Historically, debate regarding what makes a good piece of qualitative research has been noted by Seale (1999) as elusive. The common criteria used for evaluating quantitative research, such as reliability which is defined as *consistently* being accurate (Birks and Mills, 2015) and validity which is defined as, reflecting the study variables accurately (Birks and Mills, 2015) cannot assist in the interpretation of quality research in qualitative studies. For example, reliability is not an appropriate criterion for measuring qualitative research as qualitative approaches acknowledge multiple realities, often using a combination of ontological and epistemological approaches. Braun and Clarke (2014a) recommend that for qualitative research, thinking more broadly in relation to reliability being about 'trustworthiness' or 'dependability' for data collection and analysis should be encouraged. These are defined as the extent that the study could be repeated by other researchers (Braun and Clarke, 2014a).

Guba and Lincoln (1994) offered alternative interpretations for qualitative research and translated internal validity into credibility; external validity to transferability; reliability to dependability; and objectivity into confirmability. More recently, Charmaz (2014) proposed criteria for evaluating GT research from a constructivist perspective. These include credibility (i.e., sufficient data and systematic comparison), originality (i.e., new insights and novel categories), resonance (i.e., which includes sense-making for participants) and usefulness (i.e., transferability and contribution to making a better world). Likewise, Beck (1993) proposed credibility, auditability, and fittingness as three main standards of thoroughness well-known to qualitative methods. Baillie (2015) concludes that auditability, rich description, and reflexivity are all central to evaluating and ensuring quality in qualitative research.

Table 4.2: The table below demonstrates criteria to evaluate trustworthiness in qualitative research:

Traditional or quantitative research criteria	Naturalistic or qualitative research criteria	Explanation	Example of techniques to promote rigour
Validity	Credibility	The findings make sense.	• Member checking. • Prolonged time in the field. • Triangulation. • Peer debriefing. • Negative case analysis.
Reliability	Dependability	The research has been conducted in a dependable way that can be audited.	Audit trail of decision making throughout the research process.
Generalisability	Transferability	There is potential for findings to be transferred to another setting.	Rich description of the setting and participants.
Objectivity	Confirmability	Confirmation of the researcher's position and influence.	Reflexivity – reflective journal.

(Adapted from Guba and Lincoln, 1994)

A constructivist qualitative study is considered credible if it demonstrates precise descriptions of individuals' experiences (Hammersley 2006). Hammersley (2006) suggests specific criteria below for the evaluation of qualitative research. For this study this was demonstrated by including a comprehensive account of decisions made during the research process (in Chapter Five) and rich descriptions of the participants' experiences and perceptions with analytical memos throughout Chapter Six.

Criteria for theory development in qualitative research:

1. The degree to which generic/formal theory is produced.
2. The degree of development of theory.
3. The novelty of the claims made.
4. The consistency of the claims with empirical observations and the inclusion of representative examples of the latter in the report.
5. The credibility of the account to readers and/or those studied.

6. The extent to which findings are transferable to other settings.
7. The reflexivity of the account: the degree to which the effects on the findings of the researcher and the research settings employed are assessed and/or the amount of information about the research process that is provided to readers (Hammersley, 1992, p.64).

4.6.1 Techniques to promote rigour in qualitative research

Particular focus for this study to promote rigour was in relation to reflexivity enabling any emerging patterns in the analysis to be explored and examined in more detail. Similarly, peer debriefing provided by supervisors throughout the process ensured any challenges and support be considered. Other techniques to promote rigour in qualitative research can be illustrated in Table 4.3.

Table 4.3: Techniques to promote rigour in qualitative research

Technique	Explanation
Reflexivity	The researcher consciously recognises and addresses their effect and influence on the research.
Peer debriefing	The researcher and research are scrutinised by a peer researcher, who can challenge the researcher and provide support.
Prolonged engagement in the research setting	The researcher spends sufficient time in the research setting to allow familiarity to develop and ensure data may be contextualised.
Triangulation	This technique involves including two or more theories, groups of participants, methods, instruments, or investigators.
Member checking	The researcher returns to research participants to check that the transcripts represent what the participant's feel they said and/or to check findings at various stages of analysis.
Examining negative or exceptional cases	Not all evidence will fit into the pattern emerging in an analysis. The researcher should examine negative cases and report on them.

Rich description	The researcher provides a sufficiently detailed description of the research setting and participants to enable readers to decide whether the findings are transferable to other contexts.
Audit trail	The researcher keeps records of all stages of their research and records their decisions and the thinking behind them, so that a full audit trail is available.

4.7 Reflexivity

Birks (2014) suggests that prior to designing a research study and examining methodological literature, it is necessary to decide how you position yourself philosophically, as each individual views the world differently and each of our worlds are influenced by our history and the context in which we find ourselves. Birks (2014 p14) defines philosophy as *'a view of the world encompassing the questions and mechanisms for finding answers that inform that view'*. Therefore, it is paramount to consider as a researcher, one's personal philosophy as it defines what we believe to be real and how we rationally obtain knowledge about the world. Tie, Birks, and Francis (2019) highlight that researchers reflect their philosophical beliefs and interpretations of the world prior to commencing research, hence the significance of recognising as a researcher your personal paradigm.

Regardless of methodological position, Birks, and Mills (2015) suggest that it is paramount for grounded theorists to be reflexive researchers. Reflexivity can be defined as an active process of systematically developing insight into your work as a researcher, to guide future actions. Attia and Edge (2017) explain that reflexivity involves a process of on-going mutual shaping between the researcher and research, and it is seen by many researchers as an essential requirement for high quality research. Subjectivity in the qualitative paradigm can be viewed as a positive value. Braun and Clarke (2014b) suggest that the subjectivity of a researcher can be used as a research tool and should not be criticised, instead it should be well thought-out, and the way to do this is by being reflexive.

The practice of incorporating the researchers' perspective within the design and interpretation of data has gained increasing credit in fields such as sociology and healthcare. Earlier criticisms of qualitative research in relation to avoiding potential 'bias,' is vital to unravel. Braun and Clarke (2014b) suggest that all research activity is seen as *influenced* and

theoretical understanding of reflexivity is easier than achieving it in practice. It is significant as a researcher that a good understanding of reflexivity is obtained to appreciate one's role when critically reflecting on the knowledge produced as a researcher and the role in producing that knowledge. Braun and Clarke (2014, p36) affirm that the influence of *'the researcher is just one of many influences, albeit often a significant one'*.

An understanding as a researcher of one's own attitudes, values and biases is a useful tool for gaining deeper insight into the research, but also in ensuring that the focus remains on the research and its participants. Patnaik (2013) suggests that reflexivity recognises the role of the researcher as a participant in the process of knowledge construction and not simply an outsider-observer of a phenomenon. Wilkinson (1988) describes two types of reflexivity-functional and personal. Functional reflexivity considers how the tools and research processes may influence the research, whereas personal reflexivity focuses more on involving the researcher into the research and making them visible. Keeping a research journal which records thoughts, feelings, and reflection about the research process is seen as good practice for researchers undertaking qualitative research and one which has been discussed in Chapter Four.

Two potential perils to credibility that commonly occur in qualitative studies are the bias of the researcher(s), and reactivity which is the effect the researcher has on the setting or the study (Bickman and Rog, 2008). In this study, sampling bias, such as self-selection of participants must be taken into consideration. Miller (2011) states that self-selection bias is a concern in any activity where participation is voluntary. For example, midwives and student midwives who identified or perceived themselves to be a resilient individual, may have been more likely to volunteer to be participants in the study and those that viewed themselves 'less resilient' may have turned down this opportunity. However, many qualitative researchers associate 'bias' with a positivist approach to research and dispute the existence of bias in GT or any other qualitative research. Braun and Clarke (2014a) argue that bias as a concept does not apply as a valid critique of qualitative research and the suggestion that the researcher brings their personal and cultural values, perspectives, and assumptions into their research, making it subjective, is a quality and seen as a strength by most qualitative researchers. Another threat to validity in qualitative research can be the researcher themselves. Being a reflexive researcher must feature continuous appreciation of reflecting, examining, and exploring his/her relationship through all stages of the research process

(Conrad et al., 1993). Reflexivity and some of the challenges of insider research during the current study are discussed in more detail in Chapter Five.

4.8 Generalisability (and Transferability)

Generalisability can be defined as whether the results generated in a study can be applied to wider or different populations (Braun and Clarke, 2014a). Like validity, some researchers (Johnson, 1997; Schofield, 1993) in qualitative research, argue that it has little relevance or value for qualitative studies. Nonetheless, others (Sandelowski, 2004; Yardley, 2008) claim that qualitative research results can be generalisable, but just not in the same way as quantitative research. As Charmaz (2014), recurrently addresses the significance of paying attention to language and the implicit meanings that occur during qualitative research, *'considering generalisability in discursive research requires sensitivity to context and the flexible nature of language'* (Braun and Clarke, 2014b, p281). The term, therefore, which derived from the work of Guba and Lincoln (1994) more frequently used in relation to flexible generalisability, is transferability. Guba and Lincoln (1994) define transferability as the extent to which (aspects of) qualitative results can be 'transferred' to other groups of people and contexts. It is evident that comparisons between criteria for assessing quality of qualitative research should not be made with quantitative research. This does not equate to qualitative research being less favourable or robust than quantitative research, but it does mean that a qualitative study should be evaluated on its own terms.

4.8.1 Member Checking and Triangulation

Braun and Clarke (2014b) suggest that two of the most popular, although somewhat contentious techniques for measuring quality in qualitative research are member checking and triangulation. Seale (1999, p61) defines member checking, or member validation *'as the practice of checking your analysis with your participants'.* The process involves asking a select number (maybe all, but not necessarily) of participants to review and comment on the analysis to ensure that the researcher is not misrepresenting the participants' views. This technique is meant to demonstrate the trustworthiness of the analysis and is used as a type of 'credibility check' for the research (Guba and Lincoln ,1994).

Member checking was not seen as theoretically or methodologically appropriate in this study. It was not considered as a suitable method to ask participants to verify the researcher's interpretation of their perceptions and therefore was not built into the research design. It was not deemed appropriate to ask the student midwives who participated in the interviews, to be included in this process. It was thought that they may be reluctant to engage due to perceived power and authority between the researcher seen as 'the expert' and the student seen as the 'novice.' Similarly, the midwives were not asked to engage in member checking as it was thought this process might discourage participation and they simply would not have the time to undertake it. Instead, the researcher ensured that consistent clarity and understanding of meanings during the interviews were undertaken and these can be evidenced in the theoretical memos identified in the following chapter (Chapter Five).

Although historically, the use of triangulation has routinely been associated with quantitative research, triangulation in qualitative research was initially supported some time ago, by US sociologist Norman Denzin (Denzin, 1970). Glesne and Peshkin (1992) highlight the goal of obtaining triangulation, and that it is primarily for the enhancement of validity and trustworthiness. Triangulation can be understood in research terms as a process whereby two or more methods of data collection or sources of data are used to assess the same phenomenon; the goal being to get as close to the 'truth' of the object of study as possible (Smith, 1999). Although for this study, triangulation via methods (using different methods of data collection and data analysis) and via researchers (using a team of researchers to collect and analyse data) were considered, but not undertaken, triangulation via data (collecting from various sources) was achieved. The research question posed; with regards to the influence of resilience on career-related choices required the perceptions of not only experienced midwives, but those who had also left the profession.

4.8.2 *In Vivo* Coding

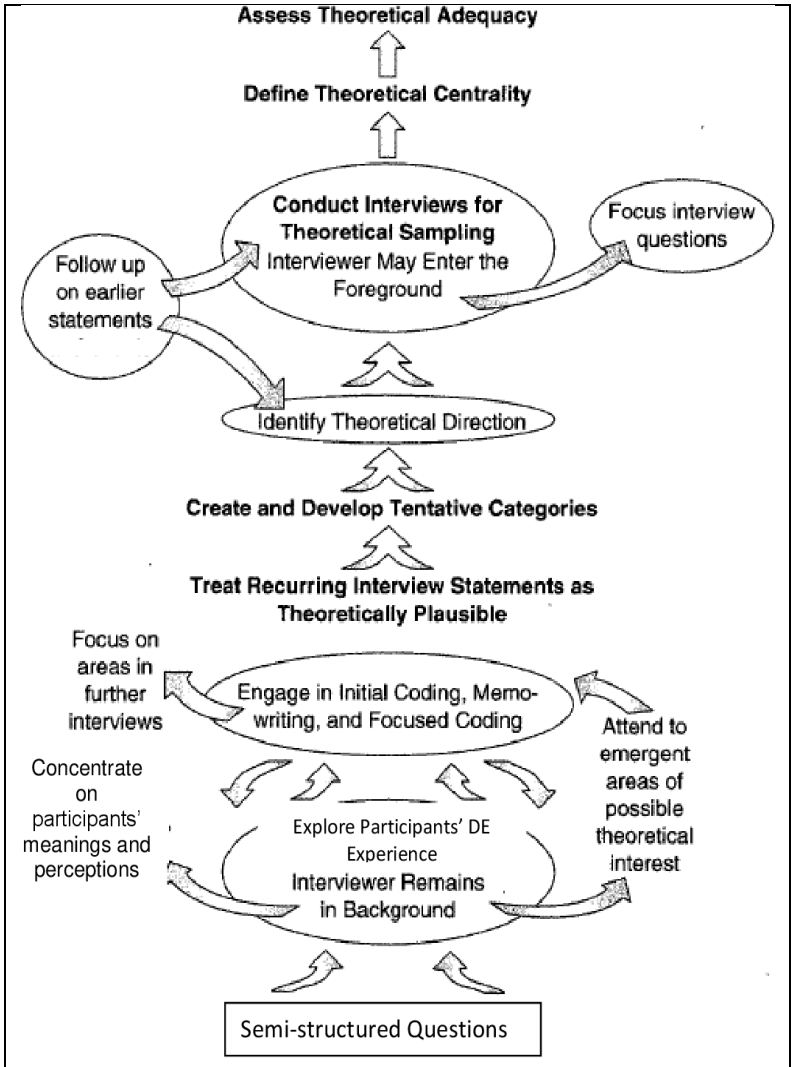
In vivo coding refers to the use of participants' own words to encapsulate a broader concept in the data. Both Charmaz (2014) and Strauss and Corbin (1990) suggest that using the own words of participants during all stages of the coding process adheres to the original concepts of GT as it ensures theory remains 'grounded' in the actual data. For example, if a participant in the interviews expressed how they 'find it difficult to cope' whilst on a busy shift, an *in vivo* code for this account would be *'difficult to cope.'* In vivo coding was used throughout the initial, focused, and theoretical coding methods and is highlighted further in Chapter Five.

4.9 Data Collection

When generating data in GT, the researcher is actively involved in the production of material that will be analysed using a chosen method (Birks and Mills, 2015). This may involve conducting interviews with participants or facilitating focus groups or even collecting field notes and memos. Birks and Mills (2015 p72) highlight that *'the dynamic nature of theoretical sampling in GT is best supported by the active nature of these strategies*'. It is worthy of note that GT usually focuses on data analysis rather than data collection (Charmaz, 2000); however, data collection is still a significant step of the research design to consider. Charmaz's work has shown that interviews (as a method) are not central in the methodological literature available, apart from in Charmaz's revisions of GT.

It is paramount that when undertaking interviews for a GT approach, connections between the research question and methodology are constantly compared. Charmaz (2014) suggests that there are two overall objectives for interviewing: 'Attending to your research participants' and 'Constructing theoretical analyses'. Achieving both objectives may require the researcher revisiting and building on previous data. Charmaz (2014) identifies that because of the iterative nature of GT, it is not unusual to return to earlier participants for a second or subsequent interview and it is likely that a project and purpose will alter and change direction, as the study proceeds. Charmaz (2014) proceeds to identify that there are four theoretical concerns which may affect which data you seek and how you collect them: theoretical plausibility, direction, centrality, and adequacy and supersedes interviewing. Interviewing gives more control over generating data than most other forms of qualitative data gathering because it allows exerting control. Charmaz (2014) addresses these theoretical concerns, offering a diagram (in Figure 4.4) of the interplay between interviewing and theoretical concerns.

Figure 4.4: Interviewing process in Grounded theory Studies



(Charmaz, 2014 p88)

4.9.1 Rationale for Semi-Structured Interviews

Aurini, Heath and Howells (2016) suggest that there are five basic structures of interviews: conversational, narrative, guiding, semi-structured, and fixed response. Semi-structured interviews can be defined as '*standardised, but with an open-ended interview schedule. All interviewees should be asked the same set of questions, but they are free to approach the question and answer it in any manner they choose*' (Aurini, Heath and Howells, 2016 p82). Often, semi-structured interviews are based on an interview guide (see Appendix J) encompassing a series of questions to be answered. Whereas narrative interviews are usually considered for use in biological research and the interaction of the interviewer is less

apparent. Flick (2018) however highlights that there are two types of interviews: semi-structured interviews, and narrative and episodic interviews.

Braun and Clarke (2014b) suggest that interviews are often divided into three types; structured, semi-structured and unstructured and point out that semi-structured interviews are the most popular type of interview in qualitative research. Birks and Mills (2015) suggest that the greater the level of structure imposed, the less the interviewer will be to take the optimal route. Therefore, less structure is seen as better when adopting a GT approach as it will encourage the researcher to follow where the conversation takes them. However, this does not mean that the interviewer should be passive during the interview process but seen more as a coordinator of the conversation with the aim of generating data for the developing theory (Corbin and Strauss, 2008). As previously mentioned, key to data collection is the concept that theoretical sampling should direct where to sample from next (Urquhart, 2013). Sampling approaches will be discussed in more detail in Chapter Five.

4.9.2 Limitations of Grounded Theory

Grounded theory shares similar limitations as other qualitative research methodologies. Chapman, Hadfield, and Chapman (2015) suggest that because of the subjective nature of qualitative studies, there are more opportunities for error and bias. Bodgan and Bicklen (2006) discuss the potential for bias sampling from purposive and theoretical sampling in qualitative research and that the researcher should be aware of these potential limitations and of their own personal view of the world, which may influence the study. However, the subject of bias in qualitative research has been discussed earlier in this chapter, with researchers in the field of qualitative research having differing opinions about its relevance and even existence in qualitative studies. In summary, the experiences, and influences of the researcher (during interviews) in the current study was seen as being beneficial and not necessarily a negative contribution.

A common criticism of GT is that an entirely inductive analysis is not achievable (Chapman, Hadfield, and Chapman, 2015). Prior knowledge from either the researcher's own experience or from the initial reading around the literature which for this thesis, was undertaken for the scoping review, can potentially influence the process and cause pitfalls during the data

collection (semi-structured interviews). As was the case in the current study, GT theories often produce a large amount of data to analyse which can often be difficult to manage. Being decisive but still thorough at each stage of the coding ensured that this exercise did not become overwhelming. Criticisms of the GT theory approach also include the challenges that researchers have due to the limited structure that the GT approach has. Throughout the interviews it was essential to develop a critical subjective personal awareness to enhance the reflexivity of the analysis process. The specific limitations of the current study are presented in Chapter Ten, section 10.3.

4.9.3 Chapter Summary

This chapter has provided a thorough explanation for the chosen methodology-GT, to answer the research question and study aims in this thesis. The rationale for the chosen methodology, GT, was primarily adopted based on its ontological and epistemological fit with the research question and the overall aims of the study. The chapter has specifically included a comprehensive approach to echo the work of Charmaz's, (Charmaz, 2000; 2014) Constructivist GT. The various approaches to GT and an exploration of the processes for the methodology have also been considered. Rationale has been included in this chapter in relation to using interviews as a method of data collection, considering both the perceptions and experiences of midwives and students. The rigour of the chosen methodology has been considered, with particular emphasis on grounded theorists becoming reflexive researchers. As with all methodological approaches, GT has limitations, these have been discussed and the extent to which GT can be generalised has been explored. The following Chapter Five (Research Methods) outlines how a GT design was applied to address the research question in the study presented in this thesis.

Chapter Five: Research Methods

5.1 Introduction

This chapter describes the research methods used in the study presented in this thesis. The aim of the chapter is to offer a comprehensive rationale and account of the methods used. It begins by revisiting the rationale for the research question and then goes on to describe the chosen study setting. Following on from this, the process and aims of conducting the pilot study and ethical considerations are also considered. Details in relation to the sampling strategy and the recruitment of participants are addressed. Data collection, including the interview process, guide, and development of the semi-structured interviews are then discussed. Reflexive memos are included throughout, consistent with the GT methodological approach. The chapter concludes with reference to the impact of COVID-19 during the interview process.

5.2 The development of the research question

As discussed in previous chapters, the research question was developed based on professional interests and the gaps in the literature identified in the reviews presented in Chapters Two and Three. Discussions took place during PhD supervision meetings to explore and determine what method was most suited to the research question. Initially, a research proposal for the study (see Appendix E) was developed to capture the key methodological approaches and deliberate issues such as ethical considerations. The GT approach was determined as it is well-suited to the research question and aims addressed in this thesis which are to '*explore the influence of resilience on midwives' and student midwives' career-related decisions.'* Below is the definitive version of the research question and the aim and objectives of the study:

Research Question:

'What is the influence of resilience on midwives' and student midwives' career-related decisions?'

Aim:

The aim of this study is to explore midwives' perceptions, attitudes, and experiences of the influence of resilience in relation to any decisions they make about their careers.

Objectives:

1. To understand how midwives and student midwives perceive and experience resilience.
2. To explore if and how resilience influences midwives' and student midwives' career-related decisions.
3. To develop a theoretical explanation about the influence of resilience on midwives' and student midwives' career-related decisions.

The following sections detail the study methods used following the GT design described in the previous chapter. Included are reflexive memos which are paramount in GT for demonstrating and recording the researcher's thinking during the process of the study.

5.3 Study Population and Sampling Strategy

People were eligible to participate in the study if they met any of the following criteria:

- Currently registered with the NMC as a midwife, OR
- Is a student midwife who is currently enrolled on an approved midwifery programme leading to registration with the NMC, OR
- Has been previously registered with the NMC as a midwife (this group was considered following the initial interviewing of the above two other groups).

Consideration regarding including participants from vulnerable groups was acknowledged in the research governance application and it was deemed that those included in the above criteria were not classed as vulnerable. There was no concern for this study regarding any participants who did not understand English well as midwives and students recruited for the study will be required to speak English and meet the NMC (2020a) criteria for English language requirements. Finally, no incentives or payments were provided to any participants who took part in this research. Taking part in interviews for research purposes may inconvenience participants. Therefore, when the interviewing initially commenced in November 2019, participants were offered a choice of times and location for the interviews (University of ****, home premises or employer workplace). When participants agreed to any face-to-face interviews, travel to meet them was arranged, so no travel costs for participants

were incurred. Interviews from March 2020 then proceeded to take place remotely, due to COVID-19. As home premises were used for the purpose of the interviews, careful consideration regarding lone working and personal safety was considered. For example, interviews did not take place out of office hours or during the evenings/night-time. Where possible, participants were encouraged to meet in a place which was most convenient for them. All the interviews lasted between 40-70 minutes.

5.3.1 Rationale for inclusion of student midwives as participants

Participants in GT are recruited based on their different experiences of a phenomenon and often researchers must fit their data-gathering strategies to clarify their participants' experience (Charmaz and Thornberg, 2020). The phenomenon of interest in the current study was the influence of resilience on midwives' and student midwives' career-related decisions. Student midwives were seen as a key group who could offer a unique insight into their experiences and perceptions of resilience and how it was influencing their future career-related decisions, for example, choice of employer, clinical area, speciality, work-life balance. It was therefore deemed important to include a sample of students to capture their views and contribute to the understanding of the phenomenon. A further rationale for the inclusion of student midwives (as well as qualified midwives) in the study originated following the completion of Chapter One and Chapter Two when exploring the background and literature with regards to workforce challenges in healthcare.

The findings of the scoping review clearly identified as one of the five themes published in relation to 'students and education'. Once it was established from the existing literature that resilience can be developed, this was key to acknowledging in this study where, and if, the development of resilience in midwifery education for the included participants was perceived and experienced in the same way. Retaining students in the midwifery profession is as significant as it is for the nursing and medical professions (Olson et al., 2015) in relation to benefiting the quality of both patients (women) and professional outcomes. A total of twelve studies were identified in the theme in relation to students and education. This was deemed a considerable amount not to ignore and therefore a decision was made to include student midwives as participants for this study. Following the pilot study, recruitment of participants began from October 2019. Once ethical approval for the study had been agreed, flyers (Appendix F) were circulated by email between 14th October and 11th November 2019 to the Heads of Midwifery (HoM) for the three allocated NHS Trusts and Lead Midwives for

Education (LME's) in the two partnering universities. Participants then either contacted the lead researcher by email or telephone to organise a convenient time and place to undertake the semi-structured interview.

The study population was student and qualified midwives, and the sample was recruited from the Humber, Coast, and Vale study setting (see section 5.3.2). The sampling strategy followed the conventions of GT - theoretical sampling. Theoretical sampling is often considered in qualitative research as a type of purposeful sampling (Coyne, 1997). Theoretical sampling is determined by the data and the emerging theory. A decision regarding where to sample next according to the emerging codes and categories is the core tenet of theoretical sampling (Glaser, 1992). The rationale for adopting theoretical sampling for this study is that it is part of the GT approach. It also encouraged creativity and enabled considerable flexibility because it was on-going throughout the study.

5.3.2 Study Setting

Initially, the identification of the study setting was the Yorkshire and the Humber region. This was identified as a large enough area to capture data from and be potentially representative to other areas in England. However, geographically, this was quite quickly identified as too large for one researcher to cover independently. A balance between gaining a broad study setting and a range of study participants had to be weighed up against the feasibility of achieving this as a sole researcher. Therefore, the original area of Yorkshire and the Humber for the study setting was reconsidered and replaced by the Humber, Coast, and Vale. Below are two maps which identify the two: one illustrating the Yorkshire and the Humber area, and one illustrating the Humber, Coast and Vale.

Memo 5.1: Familiarity and participants

Some participants recruited were from the trust and maternity unit where I had worked previously as a midwife. I was mindful of my existing relationships with some of the participants and whether this familiarity with the researcher would help or hinder the interview process. I approached the participants and the interview process in the same way, regardless of whether I knew the participant previously or not. The main difference I found for participants who I did not know before, was that I ensured there was a slightly longer opportunity at the start of the interview to build a rapport with the participant, put them at ease and ensure a sufficient

'preamble 'was included. Once the interview schedule commenced the differences to the interviews of those I know and those I had not met before was minimal. The only difference that I did observe with participants who I had met before was that they would respond to me with my name more and they would also make references such as…. 'You know what it is like Helen, you worked there….'

This geographical boundary, the Humber, Coast, and Vale, is in a partnership of organisations known as the Local Maternity System (LMS). Similarly, the excluding areas within the Yorkshire and the Humber regions have also been placed in an LMS. There are a number of these throughout England, mainly to help plan and deploy CoC models (see Appendix A for the key initiatives of Better Births) in these areas, following the Maternity Transformation Programme Publishing Implementing Better Births: Continuity of Carer (NHS England, 2020). Each LMS aims to establish a shared vision and plan to implement Better Births by the end of 2020/21. NHS England has asked LMS's to put in place local plans to deliver how most women will receive continuity of the person (midwife) caring for them during pregnancy, birth, and the postnatal period. NHS England identified 44 'footprints' known as Sustainability and Transformation Plans (STPs) and these were also used to geographically divide the country into 44 areas, the Humber, Coast, and Vale, being one of them.

It is evident in the two included maps (Figure 5.1 and Figure 5.2) how amending this boundary reduced the area to cover for potential interviews of participants. It excludes the West of Yorkshire (such as Leeds, Sheffield, Bradford, and Harrogate), although still includes recruitment from the three identified NHS Trusts within the LMS.

Figure 5.1: Map illustrating the Yorkshire and Humber region

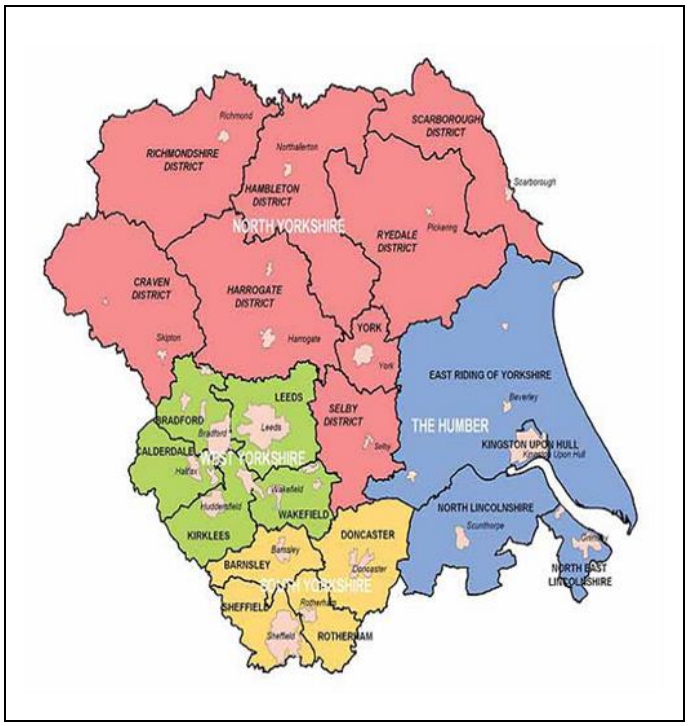
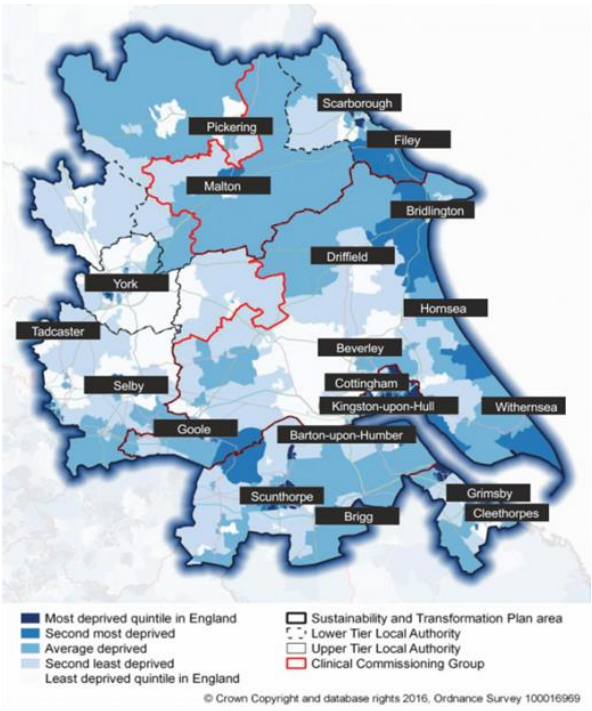


Figure 5.2: Map illustrating the Humber, Coast, and Vale area



Partnering HEIs to these NHS Trusts, were also included and student midwives enrolled on midwifery programmes between November 2019 and December 2020 who would be gaining experience of midwifery practice within these areas whilst studying midwifery. The University I work in was not included in the study as this was my main area of work and not

appropriate to involve student midwives in the study whilst also supporting them on their programme as a member of staff.

5.4 Data Collection

The chosen method of data collection was semi-structured interviews. Although interviewing as a form of data collection in GT is the most common and Birks and Mills (2015) suggest many researchers rely on it as the principal mechanism for the generation of data. However alternative methods of data collection in GT, such as conducting focus groups and producing fieldnotes and memos may also be considered, it was deemed that the value of interviewing in a semi-structured way for this study was the most appropriate method.

The structure of the interview depends on several factors, including the research question. A semi-structured interview type was regarded as the most suitable choice for the interviews for the participants. It provides some structure to initiate the relevant conversations and generate the participants to consider the questions posed, and it also offers some flexibility when required. Rubin and Rubin (1995 p42) provide a useful résumé to effective interviewing types and refer to the ideal qualitative interview as *'on target while hanging loose'*. Often in GT methods, data collection tends to focus on interviews and the idea of 'slices of data' that are many and varied (Urquhart, 2013).

5.4.1 Interview Schedule and Approach

Consideration regarding the strengths and limitations of face-to-face interviews was considered during the earlier stages of the planning of the study. It was decided on where practically possible, semi-structured interviews would be undertaken face-to-face, despite this being time consuming for both participants and researcher, detailed data can be captured and probed, and unplanned questioning can take place if required. The intention of the interview is for the interviewer to play an active role in the interview. Braun and Clarke (2014b) emphasise that it is neither possible nor is it advantageous, to attempt to lessen the interviewer's role. Recognising a personal interview style and that variation between participants would be likely; was the start of becoming a reflexive researcher. Following the

four pilot interviews, six purposive samples of interviews took place, followed by a further six face-to-face interviews during the period between November 2019 and March 2020.

5.4.2 Pilot Study

The purpose of a pilot study was to examine the feasibility of an approach that is intended to be used in a larger scale study. Conducting a pilot study is often part of the research process that is overlooked. Malmqvist et al., (2019) propose that a well-organised and managed pilot study has the potential to improve the quality of the research and inform subsequent parts of the research process. Having limited experience of interviewing participants in this manner before, it was deemed a positive and crucial step to conduct a pilot study where the interview technique and approach could be developed prior to data collection for the main study. The data from the pilot study was not included in the analysis of the study.

The main aims of conducting the pilot study were to:

- Develop confidence and a suitable technique/approach as a researcher to posing the interview questions
- To refine the interview guide and revise the questions as necessary
- Consider any practical issues during the interview process such as gaining consent and using the audio digital recorder.

A total of four interviews were conducted for the pilot study. Three interviews were undertaken with current student midwives from the University in which I work, and one interview was conducted by a senior midwife. The interviews for all the pilot studies were conducted on campus in a private office, face-to-face. This was for convenience reasons, particularly for the students who were already on campus for lectures. All the interviews were audio recorded, to ensure familiarity with equipment during the pilot. The interviews from the pilot participants were not transcribed but revisited to listen to the recordings again. The pilot study identified that there was a good amount of interest from student midwives who wanted to know more about my research study. The pilot study also highlighted that confidence was gained during the pilot interviews, and the more interviews which were conducted, the more this increased (see memo 5.2 below for further analysis). Although the data from the pilot study was not directly used during the final

analysis it was a very helpful part of the process to undertake for a novice researcher and gain confidence in the research methods and processes. Following the pilot interviews, minor amendments to the interview schedule were made, for example, in relation to the order of the questions asked during the interview.

Memo 5.2: The pilot interviews

The pilot interviews enabled me to develop some confidence in conducting semi-structured interviews. Despite being an experienced midwifery lecturer and clinician, I still felt nervous initially, undertaking the interviews. My approach evolved during the pilot study and instead of following the interview schedule and order of questions 'to the letter' I became more relaxed and fluent in my delivery of the semi-structured questions. I was less conscious of the digital audio recorder, which in turn I think also enabled the participants to be more at ease too. I ensured that my pace for posing questions was not too fast, which in the first couple of interviews, I felt that it was. I was trying to ensure, (at the detriment of the interview), that all the interviews were the same. I realised that this did not have to be the case. GT does not set out to test an existing hypothesis (Kennedy and Lingard, 2006), but rather seeks to generate a research theory for the field it is exploring. Once I had accepted that I had a potential impact (as the researcher) on the data and this became part of the research record, I began to feel more comfortable with the part I was contributing to in the interview process. Although I kept to the main questions in the interview schedule for all four of the pilot interviews the same, I became more comfortable moving away, a little, from the questions. If the participant responded or commented on a question in a way, I felt required further exploration or clarity, I would probe them further and begin to feel more confident doing this, the more interviews I conducted.

5.4.3 Gaining ethical approval

Although processes for gaining ethical approval differ between organisations, Maylor and Blackmon (2005) identify three common ethical issues for a researcher to think about and which were taken into consideration for this study:

1. Maintaining privacy
2. Reporting and analysing data honestly
3. Taking responsibility for the findings

On 18th March 2019, the study was approved by the Health Sciences Research Governance Committee (HSRGC) at the University of **** (see Appendix E for letter) (log number: HSRGC/2019/326/A). Although the committee was reassured about how well-equipped, I was to deal with any potential distress of participants, they identified that more thought should be given to the potential risk of participants becoming distressed by the interviews, including strategies for dealing with distressed participant's interviews (e.g., student midwives and those who left the profession for sensitive reasons). Further clarity and details were added to the application which addressed that if this were to occur, strategies including recommendation for further discussion with a Professional Midwifery Advocate (PMA) or in the case of a student midwife, a personal supervisor maybe considered.

Approval was also obtained from the Health Research Authority (HRA) through the Integrated Research Application System (IRAS) which is a single system for applying for the permissions and approvals for health, social and community care research in the UK. On 25th September 2019 the HRA and Health and Care Research Wales (HCRW) approval was given for the study, on the basis described in the application form (see Appendix E), protocol, supporting documentation and any clarifications received. Following approval from the HRA, the additional process of obtaining local hospital research governance approval from the identified NHS Trusts to undertake the interviews was also a requirement. On 4th October 2019, Confirmation of Capacity and Capability for the three identified NHS Trusts involved in the study was approved.

a) Respect for anonymity and confidentiality

Anonymity in a research context, is frequently referred to and used interchangeably with confidentiality (Kaiser, 2009; Tolich, 2004). Confidentiality is a generic term that refers to all information that is kept concealed from everyone except the primary research team. Anonymity is one form of confidentiality, which aims to keep participants' institutions, organisations, and locations identities undisclosed. It is essential that respect for participants confidentiality and anonymity is adhered to during any research study, however, Saunders, Kitzinger, and Kitzinger (2015) suggest that anonymising qualitative research data can be challenging because of the nature in which qualitative data from such as semi-structured interviews are reported.

General Data Protection Regulation (GDPR) (Information Commissioner's Office, 2018) is the core of Europe's digital privacy legislation. The European Parliament adopted the GDPR in April 2016, replacing an outdated data protection directive from 1995. It carries provisions that require almost all businesses to protect the personal data and privacy of EU citizens for transactions that occur within EU member states. This includes researchers who are conducting research in HEIs. Again, during the HSRGC application, it was identified that data should be pseudonymised and not anonymised, as stated in the submission, because it would be possible to link data to the consent form, which contains names. This then brought the study under GDPR restriction. It was clearly stated on all study documents (including Information sheet and Consent Form) (Appendix G and Appendix H) that the data will be pseudonymised and comply with GDPR.

The digital audio recorder used for the interviews was password encrypted and the upload of the interviews were undertaken as soon as possible following the interview to the secure university drive and deleted from the recorder. Each interview name followed a number to identify the participant and the following format: 01M20190923 (Interview number SM (student midwife) or M (midwife) year, month, and date) again, to maintain anonymity of the participants.

Some of the content of the interview schedule addressed potentially sensitive topics for participants, for example raising/discussing a concern regarding a bullying culture in a workplace. Therefore, it was paramount that participants felt their experiences could be voiced but remain anonymous. Similarly, to obtain informed consent from the participants, and adhering to the NMC Code (NMC, 2018a), it was also fundamental to respect the participants confidentiality during the process. The NMC (2018a) confirms that as a nurse, midwife, or nursing associate, you owe a duty (as a registrant) of confidentiality to all those who are receiving care. The same principle of *'5.1 respect a person's right to privacy in all aspects of their care'* (NMC, 2018a p 8) was adhered to for the participants in this study.

b) Respect for privacy

Participants were given the choice of the most suitable and convenient venue to undertake the interviews in. A balance between ensuring privacy during the interview and a relaxed atmosphere was required. Participants were not asked to give their name at the start of the interview; however, some participants referred to colleague's names and other individuals during the interview which had to be given pseudonyms. In the early interviews, (prior to COVID-19, in March 2020) most of the interviews either took place at the trust site in a private room where the participant worked or had booked especially for the interview to take place or in their home. One interview with a student midwife was conducted in a local cafe, which at the time was quiet in terms of other people nearby; however, the background noise that was apparent on the recording and during the transcription made it a difficult interview to interpret well. For this reason and for my anxieties of this environment not really being suitable to protect the privacy of the participant, no further interviews were conducted in public places. As noted earlier, once the national lockdown due to COVID-19 was in place, all the interviews were then undertaken remotely to adhere to social distancing guidelines. In March 2020, the single most important action advised by the government in the UK in relation to reducing the spread of coronavirus was to stay at home to protect the NHS and save lives. Three key measures (DoH, 2020b) included:

- Requiring people to say at home, except for extremely limited purposes
- Closing certain businesses and venues
- Stopping all gatherings of more than two people in public.

This resulted in the interviews of participants taking place at home, in a private room where no other individuals were present at the time.

When I began conducting the interviews with the midwives and the students, I was vigilant at every interview to ensure I had asked the participant to read, understand and sign the consent form and made it clear to them that the interview would be audio recorded. This I found was particularly important when the interviews were being undertaken via the telephone, and the participant might have forgotten that the interview was going to be recorded.

Fouka and Mantzorou (2011) identifies that the four major ethical issues when conducting research are:

a) Informed consent

b) Beneficence-Do no harm

c) Respect for anonymity and confidentiality

d) Respect for privacy

Considerations of all four of the above major ethical issues have been considered below in relation to this study.

c) Informed consent

Although the participants identified in this study were not perceived as a high-risk group, (such as a child or young person, a vulnerable adult or an adult who does not have capacity) the General Medical Council (GMC) considers that gaining informed consent from anyone who participates in research is still vital (GMC, 2020).

The Health Sciences Research Government Committee (HSRGC) at the University of **** suggested that the process regarding participants potentially wanting to withdraw from the study needed to be made more explicit and version control should also be included in the application. Both these recommendations were amended before the commencement of the study. The principle of obtaining informed consent was based on the principles for patient care which are set out by the professional regulatory body, the NMC for nurses, midwives, and nursing associates. The NMC (2018a p7) stipulates that all registrants should always act in the best interest of people. '*To achieve this, you must: make sure that you get properly informed consent and document it before carrying out any action.*'

Once participants had volunteered to be part of the study, they were provided with verbal and written information prior to the interview. Participants were asked at the start of the interview if they had any further questions regarding the study and after reading the participant information sheet., They were also reminded that if they decided to withdraw from the study at any point this was completely acceptable to do so. Informed consent was obtained prior to the interview in writing (see Appendix G and H for participant information sheet and consent form) for every participant who took part in the study. The process for seeking consent was the same for all participants.

d) Beneficence-Do no harm

The main principles of biomedical ethics include beneficence.

1. Respect for autonomy
2. Non-maleficence (do no harm)
3. Beneficence
4. Justice

Beneficence requires healthcare professionals to not only treat participants autonomously and refrain from harming them, but that they also contribute to their welfare (Henderson, 2014). The principles of beneficence require more than those of non-maleficence, as healthcare professionals should take positive steps to help people, and not just prevent them from harm. In relation to beneficence and conducting a research study, it was paramount that thorough processes in relation to obtaining ethics approval were made. This included ensuring that no harm to any individuals involved in the study is caused.

Memo 5.3: Ethical considerations

Having experience as a clinician (as a nurse and a midwife) and experience as a lecturer in midwifery, I felt that I had a good understanding of ethical considerations (at least for women and patients) which I could apply as a researcher to this study.

I have a thorough understanding of my professional conduct and behaviours and how these are governed by the NMC. The Code (NMC, 2018a) sets out a clear framework for all its registrants regarding the standards they expect the professional to adhere to. These standards include ethical considerations such as preserving dignity, obtaining informed consent, respecting individual right to choose and being aware of my scope of practice, including my limitations. However, what I did not have a lot of knowledge and experience of was in relation to the rigorous process for gaining ethical approval to conduct a research study. Although I appreciated and understood the necessity of ensuring that no-one who was involved in my study was at risk or harm, I still found the application for gaining ethical approval for my research long-winded, complex, and bureaucratic.

5.5 Practical Considerations for Interviewing

Interview Schedule

Using an interview schedule (Appendix J) can assist the researcher during the interview process and can be used as an aide-memoire. Birks and Mills (2015) emphasise that although an interview schedule is helpful, especially to a novice researcher, it should be used in a flexible way and expect that it will evolve as the study progresses. This chapter identifies the development of the interview schedule and how this was modified as the study progressed.

Recording

Interview transcriptions can provide, in conjunction with memos, a rich data set for the researcher to draw on (Birks and Mills, 2015). Although some experts in GT report that the recording of interviews is not necessary and inefficient (Glaser, 1998), they are often audio recorded and then transcribed for the purposes of analysis. Glaser (1998) considers that a researchers' skill development will be hindered by audio recording. Having an audio recording, particularly for a novice researcher does however provide an additional security and backup to return to the data later.

How many interviews is enough?

Deciding in relation to how many interviews is a sufficient or adequate sample is one which is ubiquitous to qualitative research in general, and not just GT methods. It is feasible for a small sample to produce an in-depth interview study of lasting significance; however, what is more imperative when adopting a GT approach is to address the fundamental questions about epistemology. Charmaz (2014) suggests these include:

- *What do you seek to know?*
- *What might you need to learn?*
- *How can interviews inform these questions?*
- *How will you develop your interview questions and skills to minimise preconceiving the data?*
- *How do you intend to use GT methods to shape your interview study?*

Guest, Bunce, and Johnson (2006) conducted an experiment using codebooks from an earlier qualitative interview study to try and conclude how many interviews researchers needed/*should* complete. Although their approach to this experiment was in conflict to the iterative, emergent approaches to GT, their aim was to saturate data, rather than categories. Saturating data are different to saturating categories and concepts and Charmaz (2014) argues that it requires much less engagement with data. Nonetheless, the study concluded that twelve interviews was sufficient for most qualitative research studies when the aim of the researcher is to distinguish common themes in relation to experiences and opinions of a relatively homogenous group. Charmaz (2014, p107) argues this arbitrary figure, stating that *'twelve interviews may generate themes but may not command respect'*.

It is apparent from the available literature, that there are fundamental inconsistencies to conducting qualitative interviews, which makes it challenging to determine how many interviews require undertaking. Charmaz, (2014) suggests that it is unlikely that this will be known until the data are deciphered and analysed. Often novice researchers will focus on the number of interviews to conduct, rather than the quality of them. Charmaz (2014) advises that it is essential that as a researcher you learn what constitutes excellence rather than adequacy in your field of practice, and therefore undertake as many interviews as needed to achieve this. In summary, Charmaz (2014, p108) identifies that the following guidelines may assist the researcher in deciding how many interviews to conduct. Increase your number of interviews when you:

- Pursue a controversial topic (interviewing managers about a bullying culture)
- Anticipate or discover surprising or provocative findings (about age and the menopause)
- Construct complex conceptual analyses (the influence of resilience on career-related decisions)
- Use interviewing as your only source of data (only semi-structured interviews used for study)

- And seek professional credibility (end goal to achieve doctorate).

Charmaz (2014) also suggests numerous key points for evaluating questions in interviews:

1. Why do you ask this specific question?
   - What is its theoretical relevance?
   - What is the link to the research question?

1. For what reason do you ask this question?
   - What is the substantial dimension of this question?

2. Why did you formulate the question in this way (and not differently)?
   - Is the question easy to understand?
   - Is the question unambiguous?
   - Is the question productive?

3. Why did you position this question (or block of questions) at this specific place in the interview guide?
   - How does it fit into the rough and detailed structure of the interview guide?
   - How is the distribution of types of questions spread across the interview guide?
   - What is the relation between single questions?

Figure 5.3: Initial Interview Guide: Key topics and exemplar questions (full guide in Appendix L)

A. (Topic) General demographic information
How long have you been a qualified midwife?

B. (Topic) Practice, Experience and Education

What is it most you enjoy about being a midwife?

C. (Topic) Understanding of the meaning resilience

In your own words, can you describe what you understand by the term resilience to mean?

D. (Topic) Strategies and Coping mechanisms

Can you tell me how you achieve a good-work life balance?

E. (Topic) Valuing the Role

What are the key factors which make you stay working as a midwife?

5.6 Theoretical and Purposive Sampling

Charmaz (2014 p199) proposes that *'theoretical sampling involves starting with the data, constructing tentative ideas about the data, and then examining these ideas through further empirical enquiry'.* As the process for collecting data and analysing it in GT are concurrent, incomplete categories and gaps in analysis may start to emerge that require further consideration. The difference between initial (purposive) sampling and theoretical sampling is that the latter guides where the researcher goes, whereas initial sampling in GT gets the researcher started. The participants in this study shared certain demographic characteristics, such as being registered as a midwife, and therefore the purposive sample also reflected this. However, purposive sampling is not exactly the same as theoretical sampling which Charmaz (2014) suggests is not about representing a population or increasing the statistical generalizability of the results. This was identified early in the interviewing process and developed from a memo made in the notebook that needed further investigation. Charmaz (2014) suggests that memo-writing encourages theoretical sampling. An example of how theoretical sampling was applied in the current study is evident below:

Participant: (no.) raising concerns again about a culture of 'bullying.'

'Negative perception of management kept referring to the manager's lack of support.'

Some of the participants referred to cultural practices and a frequently negative attitude towards senior staff. To ensure that this was taken into consideration in line with the theoretical sampling approach, a revision to the original interview guide was made to include a few focused questions directed to senior midwives to learn more about the categories. Charmaz (2014) suggests that when the researcher engages in theoretical sampling, they are seeking statements, events, or cases that will illuminate the categories. Adding new participants, such as senior midwives in new settings might be ways in which the researcher delves further into the enquiry (Charmaz, 2014). This study followed the GT theoretical sampling approach of Charmaz (2014) by considering recruiting senior midwives as

participants which elaborated and refined the existing theoretical categories. Charmaz (2014) suggests that this strategy assists the researcher to delineate and develop the properties of a category and its range of variation. For example, one of the questions which managers/senior midwives were asked was:

1. *Do you think the relationships and dynamics between managers and staff has any impact on building a resilient workforce? Explain.*

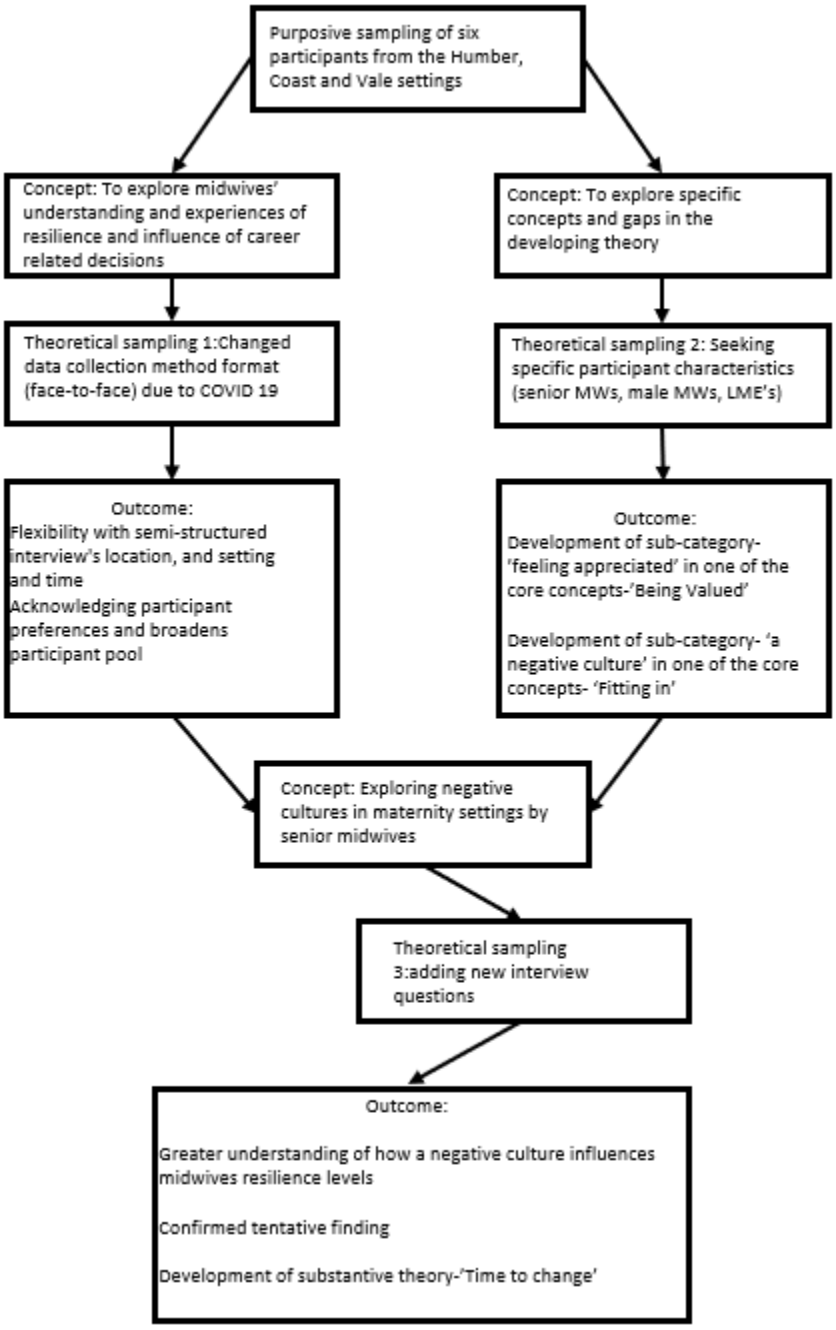
Identifying the theoretical category of senior midwives not only enabled the categories to be checked and qualified, it also was also useful later in the theoretical sampling process, where it assisted with making the links among categories, such as negative cultures, hierarchy, and the menopause.

The theoretical sampling diagram in Figure 5.4 identifies three key concepts, to explore midwives' understanding and experiences of resilience and influence of career-related decisions; to explore gaps in the developing theory and thirdly to explore negative cultures of senior midwives developed initially from the purposive sample. In turn, these three concepts during the theoretical sampling process emerged a further three outcomes that influenced the theoretical sampling in this study and eventually the development of the substantive GT theory, 'a Time to Change'.

Butler, Copnell, and Hall (2018) explains how theoretical sampling is a core process of grounded theory studies, and often evolves as a study progresses. Initially, this study began with identifying a purposive sample of six participants. The first step following this occurred during the COVID-19 pandemic when the data collection approach was changed from face-to-face interviews to remote. This initial theoretical sampling decision became necessary in order for the data collection during this time to continue. The second key theoretical decision involved seeking new participant characteristics, such as senior midwives. Although Butler, Copnell, and Hall (2018) clarify that there is no requirement to sample population representativeness in a constructivist grounded theory study, many theorists do seek out certain characteristics to explore specific concepts in order to identify gaps in their developing theory. This certainly became the reason and decision for this theoretical sampling step. Finally, theoretical sampling decision 3 involved the development of new interview questions. Butler, Copnell, and Hall (2018) suggest that adding new interview questions is one of the most common forms of theoretical sampling as it aids the development of emerging concepts and 'tests' the developing theory. This final step of

theoretical sampling for this study enabled the tentative concepts of negative cultures (particularly by senior staff on the labour ward) to be examined and gained a more detailed picture of the relationships between the categories. Coupled with theoretical memoing, theoretical sampling decision 3 enabled the core concept 'Fitting in' to emerge and ultimately contributed to the development of the GT theory, a Time to change'.

Figure 5.4: Diagram demonstrating the development of theoretical sampling



Memo 5.4: Theoretical sampling

During the interview process and as the theoretical sampling was evolving regarding emerging data, the discussion with supervisors took place in relation to interviewing male midwives. One of the interview questions in the schedules asks participants if they consider:
Any other factors such as age, gender etc. that you think contribute to a resilient individual and midwife?

Due to the small numbers of registered male midwives in the UK, which the NMC (2023) last recorded as 127, it became apparent that conducting an interview from the identified LMS where there are limited numbers of male midwives within it would be very difficult in terms of maintaining the male participants confidentiality and anonymity. Therefore, it was decided to instead contact the male midwife who is currently working within the LMS for an informal discussion and contribution to the study, instead of being one of the participants who was interviewed for the semi-structured interviews.

5.7 Reflexive Memos

Memo writing is an integral part of the GT process and 'a practiced art' (Bryant and Charmaz, 2010). It is part of the process that cannot and should not be left out. Glaser (1978) and Turner (1983) both highlight that if the researcher omits this stage by going directly to sorting and writing up, after coding, they are not doing GT. Charmaz (2014) proposes that memos expedite analytic work and accelerate productivity. Memos in GT should not be viewed as a business communication, or formal procedure. Bryant and Charmaz (2010) discuss that memos used for GT should be informal, unofficial, and used for personal use, rather than public consumption. Clarke (2005) suggests that creating a 'memo bank' will be helpful as you go through each analytical stage in the research process. Two types of memos were developed during the study. The first were analytical memos and the second were reflexive memos which were created during the data collection process.

Text Box 5.2: Example of a Memo- 'Cultural Practices'

Early into the interviews, participants referred to 'culture.' Once initial coding took place, this was coded as 'cultural practices.' Explaining 'cultural practices' means describing participants' observations and experiences of the negative behaviours of staff, often senior staff, in the workplace. Understanding what a participant means by 'cultural practices' meant analysing what the participant had said and how they had said it when they referred to the term culture. When the participants (see examples) described the 'culture' in which they were working in, it

was always referred to in a negative way. Using the term culture was a way for the participants to express what they were describing as actually 'bullying' and it made the participants feel more comfortable to share these observations and experiences during the interview. It was assumed by the participants that using the term 'culture' would be understood by the researcher (myself) to mean that bullying practices (or perceived) bullying practices took place, and this was an unsaid and a shared phenomenon.

The basic questions suggested by Charmaz (2014, p169) to aid memo writing in the initial stages were also followed.

What is going on in the field setting or within the interview accounts?

Participants are using the term 'culture' to describe a negative observation of senior staff bullying midwives

Can you turn it into a pithy category? Examples: 'avoiding disclosure,' 'surrendering to illness, and 'losing a valued self.'

'*Avoiding disclosure about bullying'*

What are people doing?

Participants are trying to find the right words to describe their perceptions of what they feel is occurring in certain environments in the midwifery settings.

What are people saying or trying to say? What do they remain silent about? What accounts for their silence? When, if at all, do secrets shape what is happening?

Participants are finding it difficult to express their colleagues portraying bullying behaviours and not wanting to identify or admit that these practices even occur.

What do research participants' actions and statements take for granted?

Participants took for granted that me, as the researcher understood what they were referring to when they stated 'culture.'

How do structure and context serve to support, maintain, impede, or change their actions or statements?

What connections can you make?

Asking participants about any observations of bullying practices directly, enables them to be more open about sharing their observations. Initially participants raised this issue without any probing.

To revisit codes if a participant refers to the culture-do they mean they are referring to bullying practices?

What comparisons can you make?

Midwives working in different units reporting similar 'cultures' on the labour ward.

Memo 5.5: Memo writing

I had read and been informed by my supervisors that memo writing was a key component of the GT process. I decided at the start of my interviews that I would hand-write my memos in a designated notebook following each interview and after initial coding. Initially, I found memo writing difficult and contrived. However, as I began to get into a regular pattern of doing memos after my interviews, the process became a little easier. At first, I was not sure who I was writing these memos for, until I explored more of the rationale for writing memos by Charmaz (2014) which reassured me that they were for me to record what I was 'seeing' happening to the data. I did not want to write the memos 'wrong' but became more relaxed about this anxiety once I realised that I should not worry about the coherence of the memos. If I knew what I meant, this was sufficient, and I could 'clean the memos up' at a later stage. Charmaz, (2014 p181) recommends that 'writing memos quickly, without editing them, fosters developing and preserving your natural voice'.

5.8 Reflexivity Reflections

A key challenge in the collection and analysis of the data in the study related to my role and position as an 'insider'. An insider researcher can be defined as someone who shares a particular characteristic such as gender, ethnicity, or culture, whereas the outsider researcher is usually someone who does not share the same characteristics (Mercer, 2007). Saidin and Yaacob (2016) suggest that the insider researcher who is often more familiar to the group to be studied (for this study, midwives, and student midwives), in contrast to the outsider researcher. Historically, quantitative researchers have had reservations regarding the interpretative nature of data collection and the overall reliability of qualitative research, especially GT (Charmaz, 2014). Some researchers argue that becoming an insider researcher could lead to a loss of objectivity and bias, however other researchers maintain that it has potential to balance the ways issues are researched (Saidin and Yaacob, 2016). Charmaz (2014) constructivist GT approach suggests that the entire research process is an interpretative one and recommends taking a reflexive stance towards it.

Therefore, the emerging core concepts were shaped by my interpretation and relied on the interaction between the participants and the data. Indeed, where there are challenges there are also opportunities of being an insider researcher, including being able to capture momentary thoughts and emerging ideas. For example, reflecting on my personal decision to work part-time whilst working in clinical practice and the feelings which I sometimes encountered in relation to a negative culture were similar to some of the participants. The experiences I encountered during the recruitment of the participants for this study were akin to the findings from Saidin and Yaacob (2016) study which explored interviewing teachers and revealed that the researcher had a good understanding and knowledge of the 'life problems' they faced. Charmaz (2014 p156) confirms that *'every researcher holds preconceptions that influence, but may not determine, what we attend to and how we make sense of it'*. Although Charmaz (2014) considers that grounded theorists are able to start from their own preconceptions about what a particular experience means and entail, it is still paramount that the GT researcher has an awareness for preconceptions which may permeate the analysis, such as class, age, or gender. An example of this during this study was in relation to the age of some of the participants and can be highlighted in the Memo 5.6:

Memo 5.6: Preconceptions

I first became aware of some of my preconceptions as the research undertaking this study when I was engaging in the iterative process of coding, memo-writing, and collecting data during the semi-structured interview. One particular participant (Xavier), who described how she had discussed with some of her colleagues about how their resilience and confidence levels had declined around the age they were experiencing the menopause. At this point I began to question my preconceptions about age, which I had originally determined by, the older the midwife is, the more resilient and confident they will be. I began to make the connections at this stage with some of the participants' perceived experiences of their resilience levels declining and the menopause. Despite my preconceptions at this stage being shaken by this revelation, it enriched my understanding of the complexities of the GT process and hopefully benefitted my analysis. I had to be mindful of this preconception in subsequent interviews to ensure that this did not influence my preconceptions, but rather made me more aware of my 'insider status'.

5.8.1 COVID-19 and impact on study

On 23rd March 2020, The Prime Minister for the UK at the time (Boris Johnson), placed the UK in lockdown due to the fast growth of Coronavirus across the country. Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus (World Health Organisation, 2022). Restrictions during lockdown included making only necessary journeys and only going to work if you could not work from home. Initial government advice was to 'Stay at home.' This unprecedented and constantly evolving situation occurred after interviewing twelve participants between November 2019 and March 2020, face-to-face. Consideration regarding stopping the progress of the interviews was initially thought to be the only solution at this time. However, after further thought and a transition time to working at home, it was decided to continue the interviews in other ways to face-to-face. Either the use of FaceTime, Skype, or a telephone call was therefore offered to all participants from this date onwards. Agreement of this amendment was agreed on 12th February 2021 (via email) on Chair's action of the University of **** Research Governance Committee commented that 'I *think we can consider this as a non-substantial amendment on the grounds that it is a well-motivated and ethically low-risk extension to the original recruitment plan'*.

During the period between March 2020 and October 2020 a further fifteen interviews were conducted. The majority of these were undertaken over the telephone primarily, because this was the first choice of the participant(s) and some others over Zoom. One interview was

conducted via FaceTime, and poor internet connection and the fragmented discussion negatively affected the overall interview and made transcribing the interview also challenging.

Undertaking the interviews over the telephone initially evoked some feelings of anxiety. This way of interviewing might negatively impact the rapport and engagement that had been able to develop during face-to-face interviews with the participants. However, as more participants were interviewed over the telephone the writing of memos, including perceptions of the overall experience aided this process. However, this did not feel it was having any negative impact on obtaining the information from any of the participants. In fact, some of the participants made comments that an interview by phone was more convenient for them and felt it did not require as much of their time as a face-to-face meeting might have. For some of the interviews conducted over the telephone, observations as the researcher included that the participant quite quickly became relaxed in the conversation. Participants appeared more able to share what they perceived as challenging discussions such as experiences of bullying and a negative working culture where they worked.

5.9 Chapter Summary

This chapter has described the research methods used in the study presented in this thesis. It has presented the study population and setting and included details of the data collection processes. A total of thirty-six participants were interviewed between November 2019 to November 2020. In March 2020, the face-to-face interviews were interrupted by the Coronavirus (COVID-19) pandemic. Face-to-face interviews were abandoned due to social distancing and government restrictions, therefore from this period, interviews were undertaken remotely. This change in the interview approach did not appear to negatively impact the interview process. Amendments were made to the original interview schedule, based on the evolving theoretical propositions within data collection. In addition, consideration of the ethical processes and practical considerations of different sampling methods has been explored and reflections on the influence of reflexivity has been presented. Throughout this chapter the rationale for the inclusion of reflexive memos, consistent with the chosen methodology of a GT approach have supported the process. An introduction to the findings will be presented in the next chapter, Chapter Six- 'Introduction to Findings'.

Chapter Six: Introduction to Findings

6.1 Introduction

This chapter introduces the initial findings from the GT study presented in the subsequent Chapter Five. The aim of this Chapter is to provide a detailed audit trail of the key methodological and theoretical decisions made throughout the research process, to enhance its rigour and transparency. The chapter begins with an overview of the participant characteristics, including the participant type, employment details and if they were purposively or theoretically identified. The coding processes using the constructivist GT approach is then detailed, including data analysis processes and the emergence of the four core concepts ('Fitting in', 'feeling in control', 'being valued', and 'getting the balance right'). Reflexive memos are included throughout the chapter.

6.1.1 Participant Categories

In total, thirty-six participants took part in the study (plus four participants who took part in the pilot study). As discussed in Chapter Five, a combination of purposive and theoretical sampling was adopted for this study. This included four pilot study participants, six purposively sampled participants and thirty theoretically sampled participants. A table employment/recruitment criteria can be found in Chapter 6.2.

Table 6.1: Included participant categories

Demographic	Description	Total Number
Student midwives	Student midwives can be defined as students who are currently on an approved NMC midwifery degree programme in the UK.	2
Independent midwife	An independent midwife is a midwife who has chosen to work outside the NHS in a self-employed capacity to provide care for women during their pregnancy, birth, and postnatal periods.	1

'Midwife leavers'	'Midwife leavers' can be defined as midwives' who are no longer practising as a midwife. Some of the 'midwife leavers' practiced as a nurse, and some had completely left all healthcare professions. All the 'midwife leavers' worked in clinical roles.	9
Clinical Midwives-Hospital	For this study, clinical midwives were defined as midwives who were either Band 5 or Band 6 working in the hospital setting. Two of these midwives were research midwives in hospital settings.	9 (+2)
Clinical Midwives Community or CoC	For this study, clinical midwives were defined as midwives who were either Band 5 or Band 6 working in the community setting or a CoC model. Two of the MWs were working in a CoC model.	4 (+2)
Senior Midwives	For this study, senior midwives were defined as any midwives at Band 7 or above.	7
TOTAL		**36**

Each participant who took part in the study was given a pseudonym (see Table 6.2: Participant Information table). Banding is used for midwives and other NHS staff. Newly qualified midwives start their employment on a Band 5 and then typically progress to a Band 6 within 18-24 months. For this study, all senior staff (Band 7 and 8) have been identified as Band 7 or above, to ensure the anonymity of the participants was maintained. Further details in relation to national job profiles can be found here: https://www.nhsemployers.org/articles/national-job-profiles See Appendix O which illustrates the NHS staff structure banding system, including for midwives.

6.2 Participant Information Table

Table 6.2 details the role and education level of the four pilot participants and thirty-six included participants. The content of the table is a visual summary which identifies participants key employment and education details and helpful for making comparisons between them. A pseudonym for each participant was used.

Table 6.2: Table illustrating details of the participants interview type and employment/recruitment criteria:

Name	Participant	Interview Type	Role	Hours worked	Entry/ Education level	Theoretical (T) /purposive (P)
Pilot 1	1	Face	Senior midwife Band 7 or above	Full-time*	18-month degree	N/A
ANNA	2	Face	Student midwife	Full-time	Direct entry degree	P
BRENDA	3	Face	Clinical midwife Band 6	Full-time	Certificate diploma	P
Pilot 2	4	Face	Student midwife	Full-time study	Direct entry degree	N/A
Pilot 3	5	Face	Student midwife	Full-time study	Direct entry degree	N/A
CATHERINE	6	Face	Clinical midwife Band 6	Full-time	18-month degree	P
DEBBIE	7	Face	Clinical midwife Band 6	30	Direct entry degree	P
Pilot 4	8	Face	Student midwife	Full-time study	Direct entry degree	N/A

EVE	9	Face	Clinical midwife Band 7 or above	Full-time	Certificate diploma	P
FIONA	10	Face	Student midwife	Full-time study	Direct entry degree	P
GEORGINA	11	Face	Clinical midwife Band 5/6	30	Direct entry degree	P
IVY	12	Face	Independent midwife	Full-time	18-month degree	P
JUDE	13	Face	Clinical midwife	22.5	18-month Degree	P
KAY	14	Face	Clinical midwife Band 6	Full-time	18-month degree	P
LINDA	15	Face	Clinical midwife Band 7 or above	Full-time	Direct entry degree	T
MELISSA	16	Face	Clinical midwife Band 6	30	Direct entry degree	P
NATALIE	17 (in lockdown)	Telephone	Clinical midwife Band 6	30	18-month diploma	P

OLIVIA	18 (in lockdown)	Telephone	Clinical midwife Band 6	Full-time	18-month diploma	P
POLLY	19 (in lockdown)	Telephone	Senior midwife Band 7 or above	Full-time	18-month degree	T
QUINN	20 (in lockdown)	Telephone	Clinical midwife Band 6	Part-time	18-month degree	P
	21				WITHDREW PRIOR TO INTERVIEW	
ROSE	22 (in lockdown)	Facetime	Senior midwife Band 7 or above	Full-time	Direct entry degree	T
SARAH	23 (in lockdown)	Telephone	Clinical midwife Band 6	Full-time	Direct entry degree	P
TRACEY	24 (in lockdown)	Telephone	Clinical midwife Band 6	Full-time (nights)	Direct entry degree	P

UNA	25 (in lockdown)	Telephone	Clinical midwife	Part-time 22.5	Direct entry degree	P
VICTORIA	26 (in lockdown)	Telephone	Senior midwife Band 7 or above	Full-time	Direct entry degree	T
WILLOW	27 (in lockdown)	Telephone	Clinical midwife Band 6	30	Certificate Diploma/Degree	P
XAVIER	28 (in lockdown)	Telephone	Senior midwife Band 7 or above	Full-time	18-month degree	T
YASMIN	29 (in lockdown)	Telephone	Senior midwife Band 7 or above	Full-time	18-month degree	T
ZOE	30 (in lockdown)	Telephone	Clinical midwife Band 6	ft/mat leave	Direct Entry degree	P
ALICE	31 (in lockdown)	Zoom	Senior midwife Band 7 or above	Full-time	12-month conversion diploma	T
BEATRICE	32 (in lockdown)	Telephone	Senior midwife Band 7 or above	Full-time	18-month	T

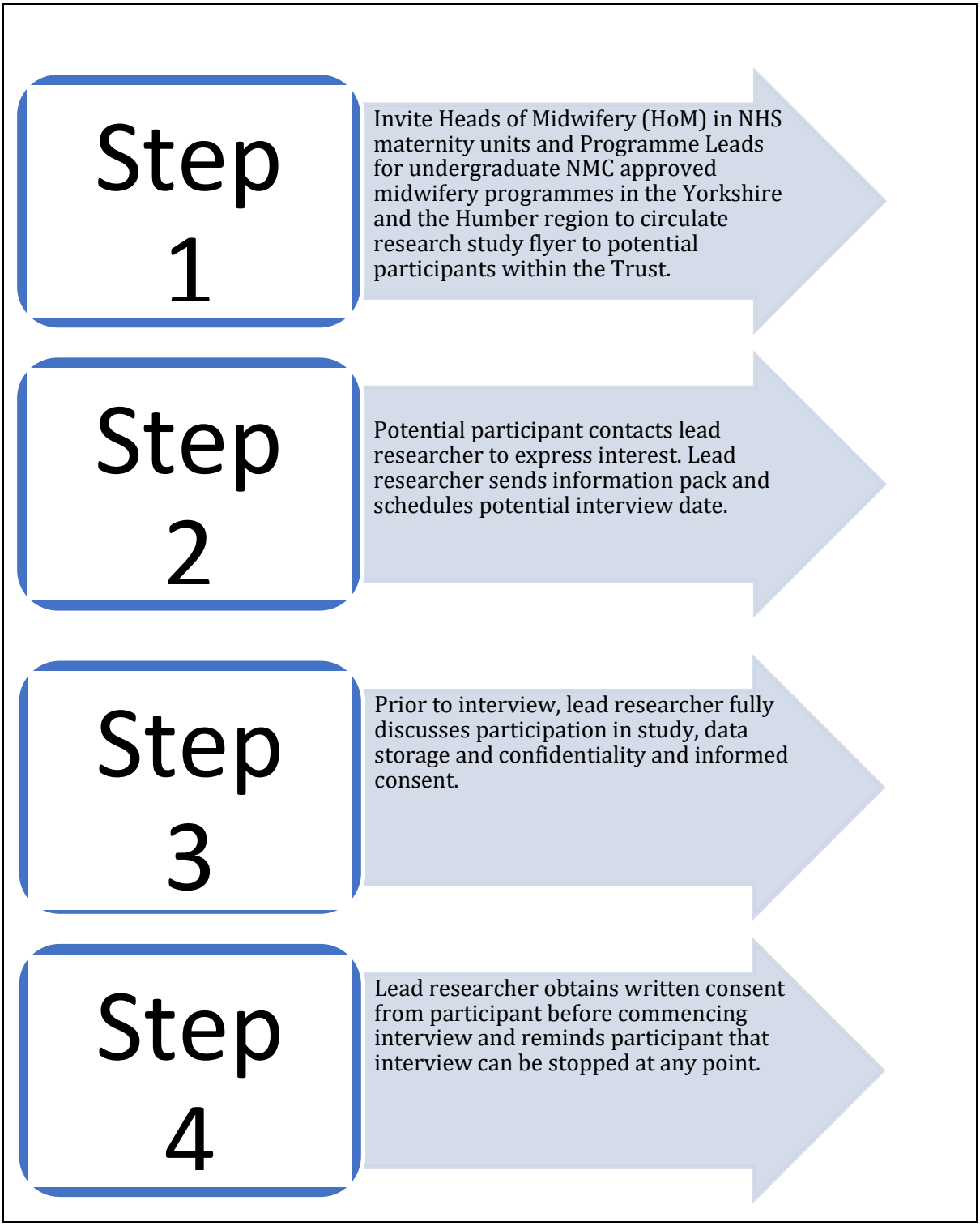
	33				NO RESPONSE NO INTERVIEW	
CLAIRE	34 (in lockdown)	Zoom	Midwife leaver	N/A	Adult Nurse 18-month degree	T
DONNA	35 (in lockdown)	Telephone	Midwife leaver	N/A	Adult Nurse 18-month degree	T
EMILY	36 (in lockdown)	Zoom	Midwife leaver	N/A	Adult Nurse 12-month conversion	T
FREYA	37 (in lockdown)	Telephone	Midwife leaver	N/A	Adult Nurse 18-month degree	T
GRACE	38 (in lockdown)	Zoom	Midwife leaver	N/A	Adult Nurse 18-month degree	T
HEIDI	39 (in lockdown)	Zoom	Midwife leaver	N/A	Direct entry Degree	T
INDIGO	40 (in lockdown)	Telephone	Midwife leaver	N/A	Adult Nurse 18-month degree	T

JANET	41 (in lockdown)	Telephone	Midwife leaver	N/A	Adult Nurse 18-month degree	T
KAREN	42 (in lockdown)	Zoom	Midwife leaver	N/A	Adult Nurse 18-month degree	T

***Full-time hours = 37.5**

HoM in NHS maternity units and LMEs (excluding at the University of ****my workplace) in the Humber, Coast, and Vale LMS were asked via email to circulate a research study flyer (see Appendix F) to potential participants (midwives or student midwives) within their Trust or University. The potential participant then made contact and expressed an interest in the study. An information pack (including a cover letter, a participant information leaflet, and a consent form) was sent and an interview date and time scheduled. The participant information form included some example questions for the participants.

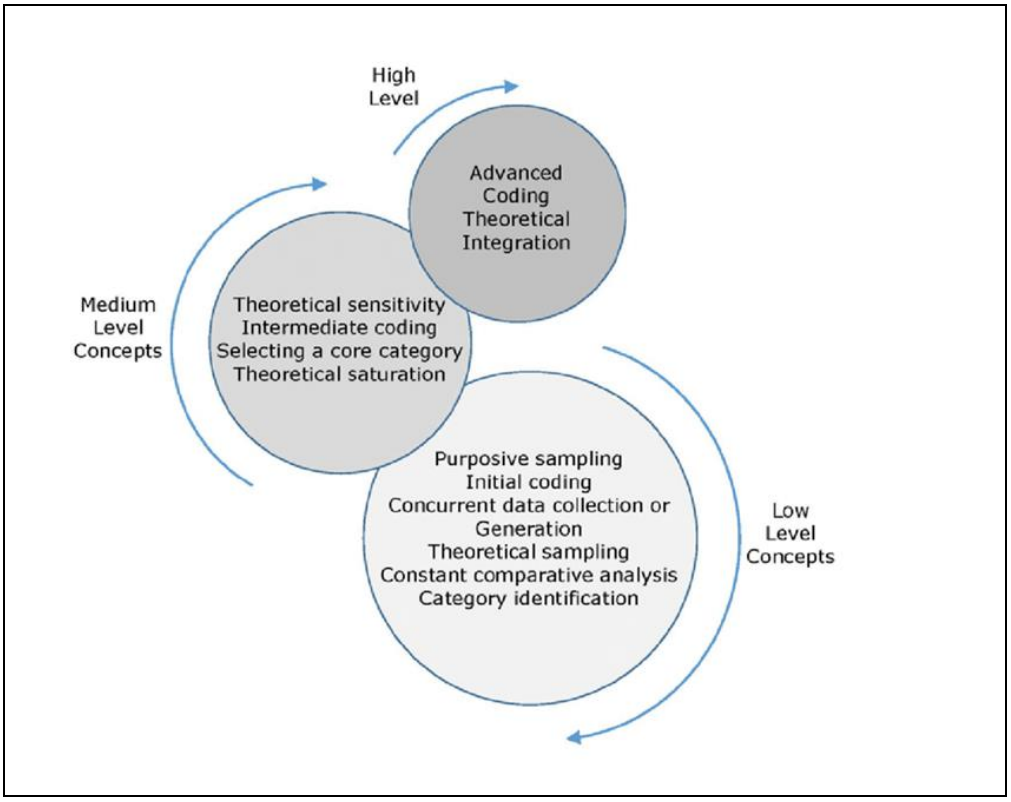
Figure 6.4: Illustration of the process for identifying and recruiting participants:



6.3 The Analytical Process

As outlined briefly in Chapter Five, the GT (Charmaz (2014) approach to coding was used for this study. This essentially involved three stages: initial, intermediate, and advanced coding, which are introduced below. Birks and Mills (2015) illustrates the three stages of the coding process in Figure 6.5. Section 6.3 will discuss the Analytical Process in detail.

Figure 6.5: Conceptual ordering of general GT diagram



Birks and Mills, (2015)

Initial coding

This first stage of initial coding involved conceptualising the data through open coding. This initial was achieved by undertaking a line-by-line technique, which involves applying codes to each line or small chunk of the text in every transcript and is described in detail, later in this chapter.

Intermediate coding

This second phase of the coding process entailed developing 'codes within codes' for the initial stage. This part of the process involves identifying any patterns in the data, such as 'cultural practices' and grouping these into commonalities. Sixteen 'codes within codes' were generated in stage two (see Table 6.3). Theoretical sampling regarding interviewing senior

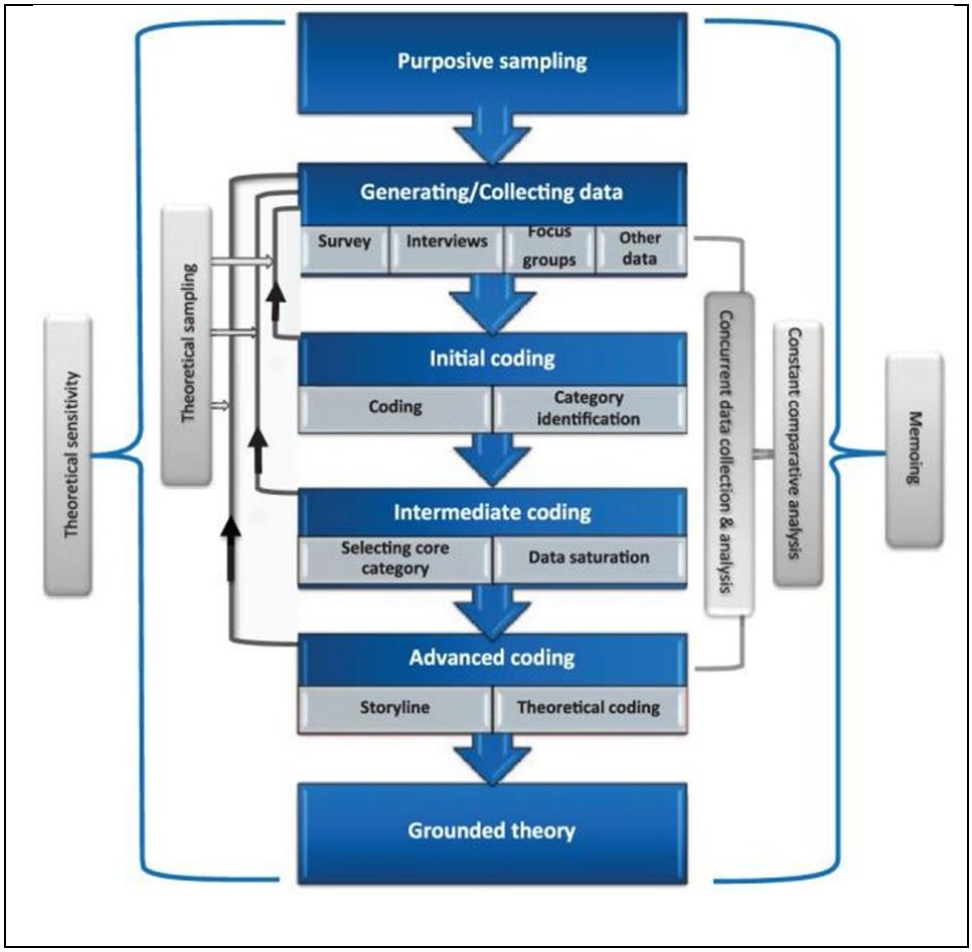
midwives and midwife leavers was made at this stage. Theoretical saturation for some themes, for example, bullying practices, and unsupportive seniors was beginning to emerge.

Advanced coding

The final stage of the coding, often referred to as advanced coding is where the core concepts begin to evolve from the identified advance codes. At this stage patterns in these data were occurring and considerations regarding the GT- 'Time to change' was in its early stages.

Following the pilot, an initial interview guide (Appendix L) was developed based on the research question, main objectives and the concepts from the findings and unanswered questions in the literature review. Thereafter, the content of the interview schedule evolved in accordance with a theoretical sampling strategy. In the analytical process, examples are provided of how the interview schedule was amended in accordance with the emerging theoretical propositions (in relation to career-related decisions and cultural practices).

Figure 6.6: Research design framework: summary of the interplay between the essential grounded theory methods and processes (Birks and Mills, 2015)



Overall, Figure 6.6 illustrates the connections between the GT methods and processes. The framework highlights that the process of doing a GT research study is not linear, rather it is iterative and recursive.

As discussed in Chapters Four and Five, the analytical process also follows a GT approach. The first part of analysis in a GT approach begins with coding. Charmaz (2014) proposes that coding requires the researcher to stop and ask analytic questions of the data which has been gathered. As highlighted in Chapter Four, coding consists of *at least* two phases: initial and focused. However, Charmaz (2014) refers to the coding practice usually as three stages: Open coding, intermediate (axial) coding, and advanced coding (theory building). This section will address the analytical processes using these three stages. This section will focus the discussions on a step-by-step account of the analytical decision trail and reflective accounts which were made at each stage during the development of codes, themes, and concepts.

Initially, the analytical process began by each audio interview being digitally recorded and transcribed verbatim by a professional transcribing service and imported into NVivo version 12.4.0 (QSR International Pty Ltd., 2018). Transcriptions were crossed-checked for accuracy with the digital audio recordings and where words or phrases were inaudible, or voices overlapped were corrected in the transcription. If the environment was a quiet one, the transcriptions for most of the interviews were fully accurate. Primarily, in the GT process, initial coding of the data needs to take place. Charmaz (2014) suggests this is an opportunity to study fragments of data-words, lines segments and incidents-closely for analytic import.

The computer assisted qualitative analysis software (CAQDAS)-NVivo was used. NVivo is a qualitative data analysis (QDA) computer software package produced by QSR international (QSR International Pty Ltd., 2018). The purpose of the package is to enable qualitative researchers to organise, analyse, and find insights in qualitative data like interviews which require in-depth analysis for large volumes of data. The NVivo software is not meant to be used to replace a researcher making notes by hand, but more to accompany it. One advantage of the NVivo package is that it makes it easier to organise and determine the codes and categories that are emerging in the data. In addition, the NVivo package can use the inputted data to interpret findings and present them as charts, or graphs if required.

6.3.1. Initial (open) Coding

The first stage of open coding involves fragmenting the data, line-by-line, into initial codes. Charmaz (2014) suggests that through coding each line of data, the researcher can gain insights about what kinds of data to collect next. Charmaz (2014) explains that if the line-by-line coding remains at a mundane level, then the researcher should 'code these codes'. In the current study, this involved coding the initial codes to fewer codes- 'codes within codes' (see Table 6.4). Table 6.3 lists the initial (open) codes that were identified at the start of the coding process.

Table 6.3: Initial (open) Codes:

'30 hours'	Development of resilience	Perception of resilience and 'not coping'
'A Tribe'	Emotional strength	Positive aspects of role
Age	Empowerment	Positive attitude
Altruism	Environmental factors	Pragmatism
Appreciated and valued	'Even if you have a really bad shift'...	Resentment
Belief system	Expectations	Resilience and Menopause
Bravery	Flexibility	Self-preservation
Bullying between staff and managers	Gender	'Sense of Belonging'
Career Progression	Guilty	'Shared understanding'
Career-related decisions	'Hardiness'	Short staffing
Common Sense	Hierarchy	'Snowflake'
Compartmentalising-strategies to cope	High opinion of self	Stigma
Confidence and competence in role	Identity	Stress and coping
Consequences of continuity of care	Independent midwifery	Support mechanisms
Coping with change	Martyr	Terminology for women

Cultural practices	'Moving on'	Unappreciated
Decision to leave or stay	Optimism	Unsupported
Defensive practice	Panacea	'Work family'
Definition of resilience	Passion and commitment for role	Working in a 'system'

Memo 6.1: Coding

When I first started to undertake the initial coding for the interviews which had been transcribed, it felt that this would take forever. To initially code an interview of approximately 45 minutes took me over five hours. As I became more fluent with the process, this time was significantly reduced. On reflection, I think this occurred for two reasons. Firstly, I started to feel more comfortable using the NVivo software. Practically this took a while to adjust to as it was something I had not used before. Accessing some basic training for NVivo which was available at the University and researching some of the numerous tutorials which are accessible on the internet assisted me with using the package. What I realised is all I needed to do, was to sort the data and begin to make sense of it! One useful piece of advice from an NVivo trainer helped me with this. They suggested that it was not necessary to be able to know all the complex uses of NVivo, instead, to see it 'as a digital library' that you accessed and were going to sort the resources into different shelves or compartments.

Secondly, I began to feel more confident in the actual process of line-by-line coding. Being decisive about the codes which I was going to apply for a particular section of text was becoming easier to recognise, the more transcripts that I analysed. Patterns in the data started to emerge for some of the codes, for example the definition of perceived resilience for many participants included similar phrases and terms which could quite easily be placed in the identified code. Charmaz (2014) suggests that line-by-line coding enables the researcher from becoming too immersed in the participants' perceptions and accepting these without contesting them. This was something I was conscious about, especially because I was interviewing participants from my own professional field. Charmaz (2014) goes on to say that this problem is common when researchers study members from their respective professions. To remain critical about the data it was useful to keep asking myself questions about them. For example, what is the participant's behaviour indicating when I ask them 'whose responsibility they think it is for developing a resilient workforce'?

6.3.1 Intermediate (axial) Coding

As described in Chapters Four and Five, intermediate coding is the second major stage of data analysis. At this stage, subcategories within the initial codes were developed and seeing patterns and any connections such as competence and confidence within the codes was emerging. Table 6.4 illustrates the 'Codes within the Codes.' This method helped manage the amount of data that was being analysed and also reconnect the data which had been fractured during the initial coding stage. Developing fewer codes enabled a critical approach to the analytical process to be adopted. Charmaz (2014 p128) identifies that *'by coding the codes, you push yourself to look for patterns and think more analytically-and you keep interacting with your data and codes'.* Core categories were beginning to emerge at this stage which eventually became the four key concepts.

Table 6.4: 'Codes within Codes':

Code	Code within code
Age	Age and association with burnout Defining role in area of work Describing different areas of work Direct entry Distinguishing between direct entry and nursing before midwifery Qualification Working hours
Bullying between staff and managers	Perception of management
Confidence and competence in role	Autonomy Confidence and resilience Inexperience and fear Knowing boundaries The midwife as an advocate You are on 'eggshells'

Consequences of continuity of care	Consequences in current practice
Decision to leave or stay	Increasing intolerance to role Job satisfaction
Defence practice	'Covering each other's backs' 'It is just covering our own backsides' Safety
Definition of resilience	Attributes associated with resilience
Emotional strength	Feelings of exhaustion Kindness and compassion
Environmental factors	Influence of previous experiences Institutionalisation
Passion and commitment to role	Negative aspects of role Obligation and loyalty to role Personal factors and perception of role
Self-preservation	Self-awareness
Shared understanding	'Z' generation
Stress and coping	Humour 'Someone who can put up a shield' The 'Swan' effect
Work-life balance strategies	Social factors
Working in a team	Supporting students Trust and loyalty for colleagues

Axial coding (intermediate) can be defined as *'a type of coding that treats a category as an axis around which the analyst delineates relationships and specifies the dimensions of this category'* (Bryant and Charmaz, 2010 p 603). Sixteen categories were developed during the axial (intermediate) coding (see Text Box 6.1). Bryant and Charmaz (2010) go on to discuss that axial coding aims to bring the data back together again into a coherent whole after the researcher has fractured them line-by-line.

Text Box 6.1: Axial (intermediate) coding:

Axial (intermediate) code	**Description**
Ability to cope	All codes in relation to a participant referring to coping/not coping with work-related stress were placed in this category.
Age	A code which had any description regarding the age of a midwife, particularly if this was discussed in relation to a younger aged midwife having less resilience.
Characteristics	A generic category which included codes that were usually identified early in the interview process, such as degree classification, direct entry, working hours.
Commitment and obligation	Where codes have been developed from participants referring to their loyalty to remain in the profession, despite its challenges.
Confidence and competence	Any code in relation to participants describing confidence and competence in their role was placed in this category. Many participants made associations with increased resilience and competence, but not all.
Contemporary challenges to practice	Codes involving expectations of women, increased workload, changing models of care, such as Continuity of Carer (CoC) were placed in this category.
Decision to leave or stay	Codes where participants were asked specific questions in relation to their career patterns and trajectories. This included attitudes to leaving their role, or the profession entirely were placed in this category.
Defensive practice	Codes were placed into this category when participants referred to behaviours or practice, they adopted which were to protect themselves from manager, guidelines, etc.
Development of Resilience	Codes where participants referred to developing resilience but excluding the definition of resilience was placed in this category.
Emotional strength	Sometimes referred to by participants as part of their definition of resilience, but not always. Emotional strength codes also included feelings of exhaustion, kindness, and compassion.

Environment	Codes were placed into this category if the environment was mentioned in the participants' observations/discussions. For example, where a participant worked, either in a community setting or a hospital one would fit this category.
Perception of management	Management decisions and practices, some negative, but not all, were coded and then placed within this category.
Self-preservation	Categorised for codes which included self-awareness, self-preservation behaviours/attitudes and 'survival' language.
Strategies	Several codes were developed for strategies used to maintain and develop a good work-life balance.
Understanding of resilience	Any definitions of resilience, explanations, or examples of resilience by participants were placed into this category.
Ways of coping	Where a participant referred to coping with stress in the workplace. Some overlap with this category and development of resilience one noted.

6.3.2 Clustering

Clustering is a shorthand prewriting technique for getting started with analysis. The idea with this method is that the researcher can develop their skills in creativity. Charmaz (2014) suggests that clustering involves writing a central idea, category, or process; then circling it and drawing spokes off it, forming smaller circles demonstrating the relationships between each category. During the analysis of the data, the technique of clustering was used to explain several ideas, including 'cultural practices.' Charmaz (2014) identifies that there are many advantages to using clustering in GT, including that it expedites lying out the form and content of memos for the novice researcher.

Charmaz (2014) suggests that following the directions below when you begin to explore codes will aid the analytical process.

- Start with the main topic or idea at the centre
- Work quickly
- Move on from the nucleus into smaller sub-clusters
- Keep all related material in the same sub-cluster
- Make the connections clear between each idea, code, and/or category
- Keep branching out until you have exhausted your knowledge
- Try several different clusters on the same topic

- Use clustering to play with your material

Kay, Una, and Sarah describe below their observations and experiences of culture, particularly on the labour ward, offering a good example of using Charmaz's (2014) clustering technique.

Text Box 6.2: Excerpts from three participants describing their observations and experiences of the 'culture':

'So, I think the ***culture****…we've had some poor results from the staff survey on* ***culture*** *in the last two years. And in fact, the trust got everybody together and had some sessions on why did you put these things, it was like an interactive thing where they gave you a little iPad to put in…what did you put in, but don't just say bullying, say exactly what it was, be more specific.':* ***(Kay: an 18-month midwife, Band 6, hospital, full-time)***

Yeah. So, I think if you're in with the crowd on labour ward, the core midwives, you're in and it's fine and they're very supportive and take you in. I'm quite reserved. I'm quiet., And I think they don't quite know how to take me. They are supportive if you ask them a question, but it's just more on other wards they're really lovely and people make an effort to get to know you and what you're about and where you're from, and there's less of that on labour wards.' ***(Una: A direct entry midwife, Band 6, hospital midwife, full-time)***

*'Yeah, I think labour ward midwives are definitely a particular breed****.'*** ***(Sarah: a direct entry midwife, Band 6, hospital, full-time)***

6.3.3. Treating an In Vivo Code as a category

In Vivo coding can be defined as codes that researchers adopt directly from the data, such as *'telling statements they discover in interviews, documents, and the everyday language used in a studied site'* (Charmaz, 2014 p343). In the initial coding stage, Nine *In Vivo* codes were identified. These descriptions were the most suitable for the code and explicitly described what the participant was meaning when they used that term or phrase. For some codes *In Vivo* coding was the optimum code to make sense of the data, without losing the true meaning of it.

Text Box 6.3: *In Vivo* codes:

***In Vivo* code**	**Description**
A 'Tribe'	A 'tribe' means a term used by a participant to describe a supportive group of midwives who they work with. Those identified by the participant as a tribe, are worthy of being relied on and are trustworthy, should you need them for anything.
'Covering each other's backs'	Used by a participant to describe a defensive practice adopted by some midwives, where each of them would protect each other if needed.
'It is just covering our own backsides'	A particular type of practice, developed by midwives, which is defensive in nature. A participant used this term to describe what they need to do to stay on the right side of management and avoid any litigation.
'Even if you have had a really bad shift...'	A term used by a participant to express the feelings after a hard or challenging day at work. Despite feelings of exhaustion, stress, and fatigue, it is an ability for an individual to 'be able to 'pick themselves back up' and deal with what has happened without it impacting on the midwife returning for the next shift, to potentially do it all again, an alternative code for a resilient character.
'Sense of belonging'	Participants used this phrase to explain their perception of being part of a team at work. A 'sense of belonging' was seen as a positive trait to have, and one which would enable midwives to feel valued and respected by colleagues and managers alike.
'Snowflake'	A relatively new and contemporary term used to describe a particular generation. The 'Snowflake' generation is the generation of the young adults of the 2010s. The term usually has negative connotations to it when it is used and is often referred to by previous generations who perceive they are not snowflakes. The term 'Snowflake' is used to describe this generation for their inability to hardiness and resilience. O'Neill and Summers (2016) defines a 'snowflake' 'as a derogatory shorthand to refer to millennials' a generation said to be easily offended, attention-seeking and lacking resilience'.
'Buddy'	Like a 'tribe' but used to identify one individual (midwife), not a group of people in the workplace to share work-related issues with. A 'buddy' was described by some participants as a significant strategy to 'find,' adopt' early in a career as a midwife. Having a 'buddy' was also seen by some participants as a way of developing resilience.
'Work family'	Like a 'tribe,' this is a term used by a participant to describe a supportive group of midwives. Those identified by the participant as a 'tribe,' are worthy of being relied on and are trustworthy, should you need them for anything.

'Someone who can put up a shield'	'Someone who can put up a shield' is a midwife who cannot disclose on the exterior her inner emotions. Putting up a shield was an *In Vivo* term used to describe individuals who have developed coping mechanisms to deal with workplace stress and develop their resilience. It is seen as an ability to be able to separate between what they may be feeling and portray a 'coping' attitude to colleagues.

Memo 6.2: Impact of CoC model

The National Maternity Review: Better Births, which was published in February 2016 (NHS England, 2016), set out a five year forward vision for NHS maternity services in England. It recognised that the vision could only be realised through local groups, or LMS's. Within this vision, 'CoC for most women' was one of the goals.

The CoC model involves a major organisational change to the configuration of current maternity services in the UK. It requires existing systems to alter the way they deliver maternity care to women during pregnancy, birth, and the postnatal period. Currently, most women receive some CoC during their pregnancy and birth continuum, particularly during their antenatal and postnatal episodes of care, where this tends to be well-established. However, it is less likely within the current structure of maternity services, that women receive care from the same carer (or identified small care team) for the intrapartum period (in labour) as well as before and after birth. The recent publication of Better Births Four Years On: A review of progress (NHS England, 2020), has identified that good progress is being made in relation to reducing perinatal and maternal mortality, although there is still room for improvements through the implementation of CoC and the LMS's being the agents for change for this model.

I anticipated early into the interview process that such an organisational change to the delivery of maternity services would likely be highlighted during the interviews by the midwives and student midwives who had volunteered to take part in the study.

Even though women want this type of model of care and there is overwhelming evidence in relation to the benefits of the CoC model for women and their families (NHS England, 2016), there are still growing concerns and anxieties from midwives with regards to how this organisational change to the way maternity services is being implemented (Hollins Martin et al., 2020). Therefore, a change to the way that midwives work (working patterns, hours, on-calls, load holding teams etc.) will potentially impact on their work-life balance.

One of the identified topics for discussion in the interview schedule is in relation to work-life balance strategies for midwives. During the interviews, some participants included in their

discussions the CoC model and some participants referred to the model of CoC in a negative manner. Therefore, it is pertinent to highlight the potential influence the CoC model might have on the participant's responses, and experiences in relation to resilience, especially with regards to the challenges and strategies of achieving an 'optimum' work-life balance.

Some of the participants' described the need to feel part of their workplace, able to make decisions about the way in which they worked, and wanted to be valued for their work, particularly by senior colleagues, balancing this with their home lives. If any of the four core concepts were not achieved, participants often reported feelings of job dissatisfaction, frustration, stress and ultimately a change in their resilience levels. Many participants either referred to or reflected on during the interview by developing resilience in their role and discussing if resilience had increased or decreased over their careers. For some participants, their self-reports of resilience were found to go up, for some it declined, and for some it remained static. Often, when a participant reported any career-related influences such as bullying, a clinical incident or work life imbalances, this often impacted on their perceived resilience. The four core concepts were identified as follows: 'Fitting in', 'Feeling in control,' 'Being valued' and 'Getting the balance right.'

Table 6.5: Summary of the four core concepts and GT:

Core Concept	Description
1. *'Fitting in'*	The notion of 'Fitting in' as a concept applied to participants who referred to the negative cultures and reports of bullying present in midwifery practice, particularly in certain settings such as the labour ward. This core concept also incorporates the working expectations which participants reported, the challenges and barriers of hierarchy and the increasing amount of bureaucracy and change within the organisation that at times, negatively impacted their working lives.
2. *'Feeling in control'*	'Feeling in Control' encompassed participants feeling in control of their lives at work, for example where they worked and when and what shifts these might be. Having choices in relation to provision and procedures at work such as self-rostering (off-duty) and being part of decisions around maternity models of care such as CoC. Participants reported wanting to be part of the decision making in their roles, be made to feel they were being empowered and had some autonomy over their working practices.

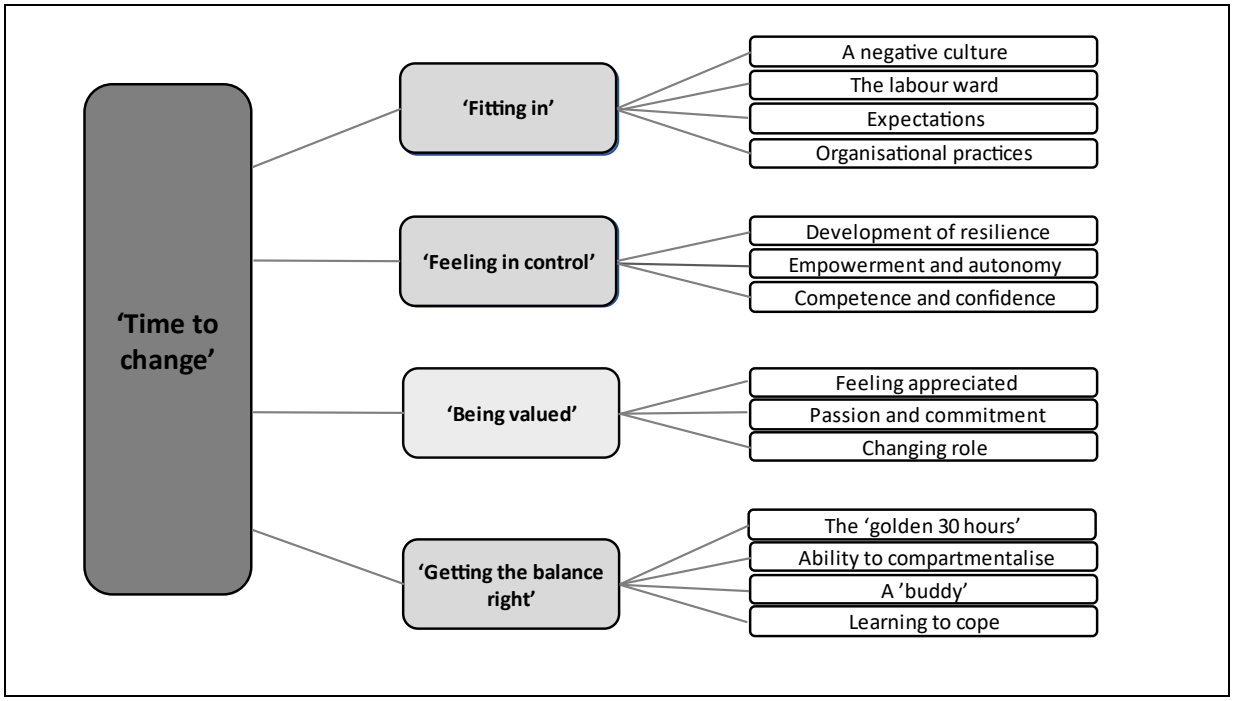
3. *'Being valued'*	The notion of 'being valued' by employer(s) was fundamental to participants' attitudes to their positivity to work. Feeling valued, including feeling appreciated and supported, particularly by senior staff was reported to be necessary by several participants. 'Being valued' also included participants referring to their professional identity, obligation, perceptions of role as a 'vocation' and loyalty and commitment to role.
4. *'Getting the balance right'*	The concept of 'getting the balance right' refers to participants' strategies to achieve an optimum work-life balance or their identified needs to improve this balance to remain positive about their workplace. A key factor in this concept was around participants' suggestion of having a 'work wife'/buddy.' This concept also included practical and psychological coping strategies such as exercise, meditating, walking a dog, socialising, and using alcohol to compartmentalise work and home life. A significant finding from participants in relation to this concept was with regards to working a maximum of 30 hours per week to achieve 'getting the balance right'.
GT: *'Time to change'*	Findings identified the need for midwives to consider a 'Time to change' during their midwifery careers to build and/or acknowledge their perception of their resilience levels, going up or down. An inability to consider career-related opportunities in their midwifery career had an overall negative impact on perceptions of resilience levels, job satisfaction and considerations of leaving the profession. The four core concepts included career-related influences which had an impact on the participants' resilience levels. Once the participants' had made the career-related decision, their resilience levels resumed.

6.4 Advanced (theoretical) coding

The final stage described by Charmaz (2014) during the data analysis is advanced coding. This stage is fundamental to the development of the overall GT, which for this study became a 'Time to change'. This final stage seemed to take a long time, where emerging themes had to be revisited and revisited again. Birks and Mills (2015) identify that theoretical integration is the most difficult of the essential GT methods to accomplish. Initially the four core concepts, 'Fitting in', 'Feeling in control,' 'Being valued,' and 'Getting the balance right' developed from the categories which had been developed during the axial coding stage. At this point, these categories and concepts were beginning to come together and make sense, however further theoretical integration was still required to develop the overall GT of a 'Time to change'. The use of memos supported this stage of the process as they facilitated the meanings to come to life. Once the four core concepts had been identified, further sub-categories were created, which are illustrated in Figure 6.7.

These four core concepts developed following the advanced coding stage where patterns between the codes appeared significant and frequent. The four core concepts titles were created as they made the most analytical sense and encompassed precision and clarity to the data and ultimately fitting the substantive theory, 'Time to change' well. These core concepts with their associated subcategories bring together participants' perceptions of resilience in relation to career-related decisions they may have made, including the possibility of leaving the profession. The four core concepts were all fundamental to the development of the substantive GT of 'Time to change'. The majority of participants included in the study identified with the 'Time to change'-GT. All four concepts were equally significant to the substantive theory and so were the subcategories which emerged by constant comparative analysis, the three main theoretical sampling decisions, and the use of memos.

Figure 6.7: The substantive GT, four core concepts and associated subcategories



6.5 Chapter Summary

This chapter initially introduced the participant categories and demographic information. It then presented the initial findings of the study conducted in this thesis. Data collection, data analysis, and the emergence of the four core concepts have been discussed. The chapter concludes with exploring the analytical process and identifying the four core concepts and GT- 'Time to change'. Throughout this chapter the inclusion of reflexive memos, consistent with the chosen methodology of a GT approach have supported the process. The identified GT theory will be analysed in Chapter Seven.

Chapter Seven: Findings

7.1 Introduction

Chapter Seven presents the findings of the GT study which explored the research question: *'What is the influence of resilience on midwives' and student midwives' career-related decisions?'* The aim of this chapter is to present the four core concepts all which collectively became part of the substantive theory 'Time to Change'. The chapter begins with a summary of the overall substantive theory, 'Time to Change'. It then presents the key findings of the study and demonstrates how the four core concepts, 'Fitting in', 'Feeling in control' 'Being valued,' and 'Getting the balance right' and proposed theoretical framework, 'Time to change', were developed. Discussion with regards to how resilience is related to career-related decisions will also be addressed. Throughout this chapter, direct quotations from participant interviews and memos relevant to the core concept, will be included.

7.2 Summary of overall substantive theory- 'Time to change'

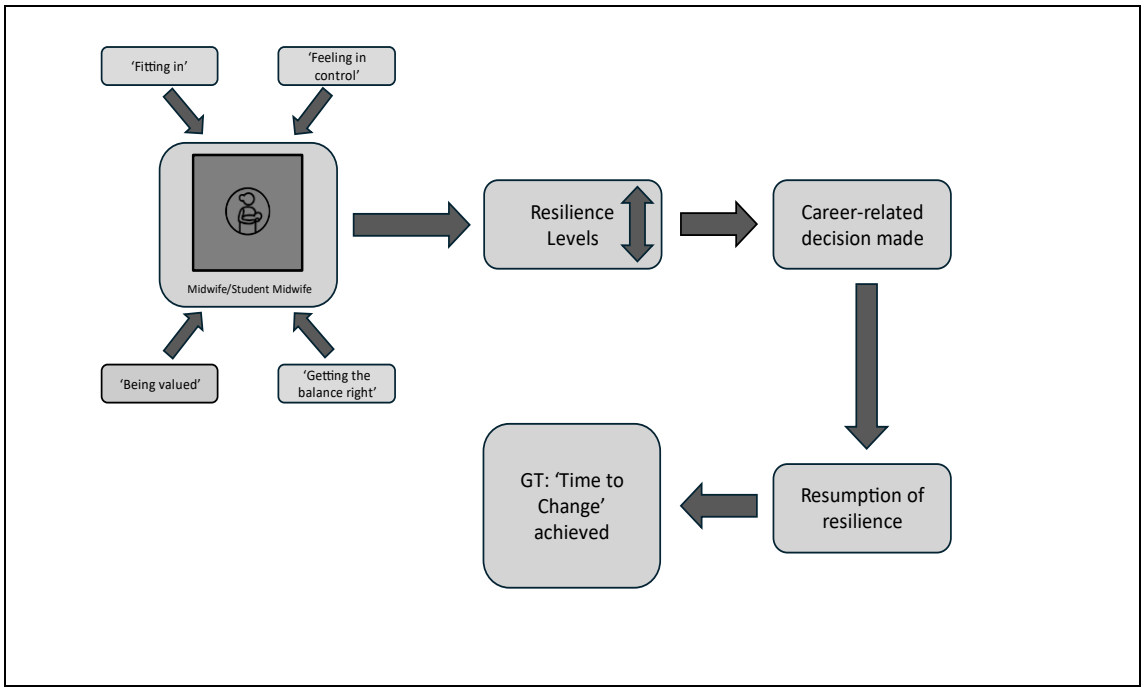
The overarching substantive theory a 'Time to change' explains the process by which participants recognised and reflected upon their perceived resilience levels altering (up or down) and how one, or more than one, of the core concepts then prompted them to make a career-related decision. The four concepts comprising the theory are- 'Fitting in', which refers to organisational practices and negative cultures; 'Feeling in control', which related to participants developing confidence and autonomy in their role; 'Being valued', which refers to participants feeling appreciated and having a passion for their role; and finally, 'Getting the balance right', which referred to midwives finding an optimum work-life balance.

The grounded theory, 'Time to change', characterises the overall process of participants identifying a need to change their role, career pathway, or other career-related decision such as leaving the profession, with the aim of regaining a sense of job satisfaction, confidence and resilience that may have been lost. The theory explains how participants may recognise feelings of work burnout and stress and consider if they can resolve these by making changes

to their working lives. Perceived challenges in any of the four core concepts was the point at which they may often acknowledge a fluctuation in their resilience levels. In turn, this was a trigger to decide to make a career-related decision such as a change in role, or a change in working practices, for example, reducing working hours, or possibly considering leaving the midwifery profession entirely.

Once a participant had made a relevant career-related decision, or acted on for example being bullied, or changed working hours/role re: work-life balance, they often reported feeling more resilient as a result. Participants who had opportunities during their midwifery careers, such as working in a specialist role, also appeared more fulfilled in their perceptions and positivity felt towards work, overall.

Figure 7.1: The theoretical framework: 'Time to change'



Section 7.3 onwards describes the core concepts that make up the GT- 'Time to change'.

7.3 'Fitting in'

The first of the four core concepts that comprise the substantive theory a 'Time to change', was the notion of 'Fitting in'. It describes the perceptions of some of the participants who felt that the workplace was sometimes a negative place to be with unnecessary demands and practices. This core concept of 'Fitting in' is multi-faceted and will be presented within the following four subcategories below. A negative culture, The labour ward, Expectations and Organisational Practices. It is noteworthy that several subcategories within the four core concepts were not exclusive to one core concept; potentially they could have related to any of the four core concepts. However, they have been placed within the core concept in which the subcategory has the most prominence. The core concept 'Fitting in' relates to the negative cultures within maternity practice. The concept incorporates the challenges and barriers of the NHS, including increasing bureaucracy, bullying, and the challenges of settings such as labour ward.

'Fitting in' and a 'Time to change'

The core concept 'Fitting in' highlights how some participants in the study described a negative working environment, where a bullying culture existed and one which contributed to participants' overall resilience levels declining and consideration that it was 'time to change' and make a career-related decision because of it. This feeling for some participants, occurred on the labour ward and exacerbated their stress and anxiety levels, which in turn affected their perceived resilience. For some participants, 'Fitting in' was the start of the process where they considered making a career-related decision, such as a change of role or working patterns.

7.3.1 A negative culture

Overall, most participants referred to their experience of working in settings which have an underlying culture of negativity and were manifested in several ways. The terms 'negative culture' and 'bullying' were often used interchangeably by the participants. In response to questions about negative cultures, many participants reported that other midwives they worked with made them feel like they were not very welcome, or even part of the team, such as Tracey, who described the midwives on the labour ward as 'a particular breed.' Tracey's understanding of a 'particular breed' referred to how the behaviours and attitudes of the

labour ward midwives, which were often described as negative and perceived by other midwives working on the labour ward as toxic.

'Yeah, I think labour ward midwives are definitely a particular breed.' ***(Tracey: a direct entry, Band 6, hospital midwife, working full-time (nights))***

The participants' experiences of negative cultures were also highlighted by Georgina who expressed her feelings of vulnerability to her colleagues when she was having a difficult day at work. Georgina reflected on a discussion with her senior colleague which had taken place in a public area and was in relation to her requesting to go home following her return to work after minor surgery. Georgina felt that her senior colleague lacked compassion and thought she should be 'tougher' than what she was if she was at work. Georgina had realised once she had got to work that she was actually not well enough to work as she remained in pain and in hindsight should have stayed off work for a few more days.

'Maybe I should have said exactly what it was [feeling unwell] but there were other people around and I was like, I can't even say it without crying. But I thought the fact that I was saying I'm having a bad day, please be nice.' ***(Georgina: a direct entry, Band 6, hospital midwife, working 30 hours)***

Jude described recognising bullying practices in her work setting involving her colleagues and also experienced it herself.

'But there are people who go into that and have really struggled, and I know there has been a lot of talk about bullying. And it definitely occurs, maybe I am so thick skinned and resilient that I don't really notice it. But there have been, and lots of those people who made life very difficult, and I've come across it myself on a personal level, they have now left, they have retired or whatever. ***(Jude: an 18- month midwife, Band 6, hospital, part-time)***

It was not only inexperienced or newly qualified midwives who reported feelings about a negative environment and negative culture. These also came from midwives who had several years of experience, such as Zoe. There was inference that a lot of the negative culture that participants had either observed or been party to came from the senior midwives and their

participation in contributing to this unpleasant environment. Interviewing participants who were senior midwives enabled a broader perspective of this to be explored further.

'Yes. I feel like any of them [senior midwives] would be supporting in those situations, it's more the culture that some band sevens [senior midwives] can create.' ***(Zoe: a direct entry midwife, Band 6, hospital midwife works full-time (currently on parental leave)***

One aspect of the negative culture and bullying practices described by some of the participants was the challenge with trying to improve the culture and how to develop strategies needed to make all midwives, including themselves, feel more included and supported. Senior midwives were described by participants as pivotal in this positive change. Alice described how influential senior midwives can be to improving the overall working environment.

'But like I say, we've had a changeround in leadership on there now, and we've had a changeround in some of the Band 7 labour ward coordinators and people are saying now that it's a different place to come to work.' ***(Alice: an 18- month, midwife, previous nurse, Senior midwife, hospital, full-time)***

Memo 7.1 reflects on how some of the participants' perceptions about the negative cultures and bullying practices of their colleagues had generated similar memories when working as a clinical midwife.

Memo 7.1: Negative cultures

Interviewing the participants who referred to the labour ward as particularly challenging to work in at times, completely resonated with me from my first-hand experiences of working on the labour ward, particularly as an inexperienced midwife. It saddened me to think that these negative working environments continue to the present day creating an unwelcoming and unsupportive atmosphere. I recall, on frequent occasions I would enter the labour ward for a shift with feelings of anxiety and self-doubt that I could even survive the shift and if I did need to ask for help, I would think very carefully who I was going to ask, depending on how supportive I thought they were. At the end of a shift on the labour ward I would resist looking at the off-duty rota to see which senior midwife was coordinating the next shift when I was working, as this

may determine in many ways the atmosphere of the entire labour ward for my next thirteen working hours.

7.3.2 The labour ward

Overall, several of the participants referred to their experience of working in settings which have an underlying culture, the labour ward was one particular setting that participants frequently referenced. Some of the participants who described not feeling like they were part of a team and found it hard to integrate into a new area with existing staff working there, referred to the labour ward being the most difficult environment in the maternity unit to 'fit in' to. It was described by some participants as quite a hostile environment. Una and Tracey both described well the perceptions of the participants, who raised issues in relation to a negative culture on the labour ward.

'Yeah, it seems to be the place [labour ward]. If it does go on [bullying] in any of the areas, it seems to be labour ward that's quite high up on the list, I think. Labour ward's challenging, but it's more the culture and the environment that I find challenging there.' ***(Una: a direct entry midwife, Band 6, hospital midwife, full-time)***

'Yeah, I think it can be [a bullying environment]. And there are the cliques, and if your face doesn't fit it's not easy for you to get on [work] on a labour ward. Whereas the wards seem to be far more cooperative.' ***(Tracey: a direct entry, Band 6, hospital midwife, working full-time nights)***

Similarly, Una observed that when she worked on the labour ward, she felt she did not find it as supportive as other areas in the maternity unit and thought it was her quiet and reserved personality which attributed to her feelings of exclusion.

'Yeah. So, I think if you're in with the crowd on labour ward, the core midwives, you're in and it's fine and they're very supportive and take you in. I'm quite reserved. I'm quiet., And I think they don't quite know how to take me. They are supportive if you ask them a question, but it's just more on other wards they're really lovely and people make an effort to get to know you and what you're about and where you're from, and there's less of that on labour wards.' ***(Una: A direct entry midwife, Band 6, hospital midwife, full-time)***

It's a horrible experience, because when I was a student nurse, I remember going to the labour ward, and the sisters (senior staff) were hideous. Yeah, we have struggled. So, the past few surveys that we've had have been really critical of labour ward and about the culture on there, about people being frightened to come to work. But like I say, we've had a change round in leadership on there now, and we've had a change round in some of the Band 7 labour ward coordinators. And people are saying now that it's a different place to come to work.' ***(Alice: an 18-month, midwife, previous nurse, Senior midwife, hospital, full-time)***

In relation to bullying practices, Indigo discussed how she had noted a change in attitude by senior staff when she made the decision to leave their substantive post and work as a midwife on the 'bank' ('ad hoc,' non-permanent contract).

'I noticed a massive, massive difference when in terms of a negative culture, there was a massive difference from being a contracted midwife to being on the bank…' ***(Indigo: a midwife leaver)***

'Definitely, without a shadow of a doubt, yeah. Yeah, so that was a very positive thing, being on the bank. And I think as well because you were…I think once you're on the bank, you're slightly on the periphery and you don't get involved in all the politics and bureaucracy as much, because… So, I think I felt as though there was…from a negative culture, being on the bank, I felt as though…from an outsider looking in, I could see that there was bigger fish to fry than you, do you know what I mean, there were more…I felt as though the people that were responsible for that negative culture had other people to prey on rather than somebody that was on the periphery, do you understand what I mean?' ***(Indigo: a midwife leaver)***

Observing colleagues being 'targets' at times was acknowledged as being difficult, as highlighted by Claire:

'And it was very much if you're in the clique, you're in the clique, you know. And I did used to feel sorry for those that their faces didn't fit or, you know. And people criticising other people's work and, you know, how they coped with their work, and just…I didn't like being among all that really.' ***(Claire: a midwife leaver)***

Participants who worked predominantly on the labour ward (often referred to as 'core staff' who were experienced midwives, confident and competent with key skills in that area) were often perceived as 'different,' less sensitive, and less kind than midwives working in other

maternity settings. This then exacerbated the negative environment perceived between the midwives on the labour ward and those who worked elsewhere in the maternity unit.

This was illustrated by Tracey, who expressed her view that labour ward midwives had a sense of superiority to other midwives who worked elsewhere and the labour ward, by far, was the most busy and challenging area for a midwife to work in. Inferring those midwives who did not frequently work on the labour were less skilled, and maybe less competent than others elsewhere. For the participants who described the labour ward as their less favourable place to work in the maternity unit, inversely described the labour ward midwives as less willing to work as a team and even seen as unsupportive as they were unwilling to work for in other areas in the unit, such as the postnatal ward.

'Absolutely. It's like you know if labour ward's busy and staff are pulled from everywhere else to go and help out on labour ward, and that's only right. Safety needs to be maintained on labour ward. But if labour ward staff are sat there twiddling their thumbs because they've only got one woman in labour, they never volunteer to go anywhere else and help…' ***(Tracey: a direct entry, Band 6, hospital midwife, working full-time (nights))***

7.3.3 Expectations

The subcategory, 'expectations' refers to the discrepancy between the participants' expectations and the expectations of senior staff. Many of the participants felt that the expectations of their seniors were a barrier to them feeling like they were able to 'fit in.' There were several occasions during the interviewing of participants when the expectations of what the participants felt was required of them was increasing, unsustainable and unrealistic. Reference to the evolving role of a practising midwife was identified as challenging for some of the participants and made them feel even more stressed and under pressure at work. For example, Willow and Xavier describe how the role of the midwife has shifted from predominantly caring for women and their babies to now the role requiring a much larger skill set, with expectations that all practising midwives are able to achieve these. So, for some participants like Willow and Xavier, they felt that there were unrealistic expectations from both their seniors and the women they cared for.

'I think you're just expected to do everything now, aren't you? I think When I first started, it was…we couldn't do hardly any of the things that we do now. We just physically cared for the women. The rest of it was…it just didn't happen or…I don't know…because the expectations were different. And you're almost, sort of, in…this is probably not the right way to describe it, but as midwives, you were, sort of, in charge of it all, whether…now the emphasis I feel has changed and you're there to serve the women almost.' ***(Willow: degree, Band 6, community, part-time)***

'I think I feel sad that after working all these years I've got the role and it's no longer the role that I've kind of aimed for because it's morphed so much. That's right and it's the way of the world, it's how things go, and I understand that. But it is just unrecognisable from where it was.' ***(Xavier: an 18-month, midwife, previous nurse, Senior midwife, hospital, full-time)***

One of the midwife leavers, Claire, summarised some of the changes to practice she had observed over the years she was practising and how the pace of practice had gradually become faster due to women going home after a hospital birth sooner. Victoria expressed how it was not only the expectations of staff that had altered, the expectations of the women midwives cared for had also changed dramatically. The accessibility and availability of midwives had both increased, making it in one sense, a positive change for women. However, some participants felt that this increased the overall pressures midwives felt in their roles and made it more difficult to easily 'switch off' from their job. This challenge is discussed in further detail in Section 7.6 'Core Concept four: 'Getting the balance right.'

'Yeah, I think that probably I think it's a combination of the pace of the work, the expectations and I mean if you think, you know, at one time, you know, women would easily be in…on the postnatal ward for longer than what they are now. The turnaround is just ridiculous isn't it. I mean, I think when I was leaving…the, you know, sections [lower segment caesarean section [LSCS]] were leaving the day after if they've had normal sections [LSCS], so they're only in a night. When you think about, you know, that is such a quick turnover isn't it, and so that's got to have an impact hasn't it, but… ***(Claire: a midwife leaver)***

'The same with mental health. We weren't available in the same way. I think the expectations that women had of the service were probably different and I think they were probably more in the minds of, you know, you do as you're told, and you turn up at the right appointments. Whereas now they have a more constant relationship with their midwives by text or, you know,

they have their phone numbers, and I think they use that a lot more.' **(*Victoria: a direct entry midwife, Senior midwife, hospital, full-time)***

One participant, Jude, also referred to the education they received during their midwifery degree, suggesting that it did not always meet the reality of what was expected as a practising midwife.

*'I think some of the training – in my experience in ****, I think a lot of…kind of these really…the reality doesn't necessarily meet expectations….'* ***(Jude: an 18- month midwife, Band 6, hospital, part-time)***

Interestingly, not all the participants felt that increased expectations of their role were a negative issue. Georgina, a direct entry midwife, reflected on how she felt having a breadth of different skills such as suturing, prepared her more for situations where she felt out of her depth, but in hindsight she was grateful of this exposure and increased expectation of her.

'And I think the fact that expectations have increased, clinically like I said earlier, about cannulating, suturing et cetera. At the time it's pretty rubbish and under a lot of pressure, but after I'm glad I've been shoved through it because I feel like I can cope with more because I've had more exposure to, let's say, nerve wracking situations or situations in which I'm forced to learn things which I don't necessarily want to learn just yet and I feel like I'm not ready for.' ***(Georgina: a direct entry, Band 6, hospital midwife, working 30 hours)***

The aspect of 'expectations' had an underlying relevance to the perceptions of resilience levels and the career-related decisions they made among some participants. Janet, (midwife leaver) suggested that there was a shared understanding (when she qualified) and knowledge of what the role of the midwife (and a nurse) entailed, and this was something that students nowadays were not necessarily prepared for.

'I think the expectation in those days was very different, you know, you just were expected to get on, you know, I don't think people ever talked about resilience. It was an expectation as a nurse,

you qualified, you would be working on the wards, you would be doing shifts and that's why you went into nursing. So, I think it was deemed very much, well, that's what you do.' ***(Janet: midwife leaver)***

Similarly, Yasmin suggested that student midwives required preparation before they considered the profession to manage the expectations of midwifery practice and appreciate what they were embarking on. This was also interpreted by Yasmin who suggested that student midwives did not observe the same practices now as they used to do (when Yasmin first qualified), skewing their expectations further.

'I think I would make sure they had a level of expectation that it is an extremely rewarding job to do, that it can evolve in different ways, that it will make you a responsible person and be very fulfilling, but that it can…that it's hard work physically and emotionally and to prepare them [students] for that, I think.' ***(Yasmin: 18-month degree, Band 7, hospital, full-time)***

'Yeah. It bewilders me that some students can get to the end of their training, and they've never seen an episiotomy done. Even with the forceps they've never even seen it, never mind do one, but they've never seen one.' ***(Alice: an 18-month, midwife, previous nurse, Senior midwife, hospital, full-time)***

Memo 7.2: Significance of women and families

When interviewing the participants, I was conscious of making sure I tried to get a good balance of both negative and positive aspects of their role, therefore developed the questions to ensure I asked both. Although this section of the findings focuses mainly on the negative aspects and challenges of 'Fitting in,' there were undoubtedly many positive aspects that participants also reported that will be discussed later in the thesis. One observation I realised with all the distinct characteristics of participants which took part in the interviewing, was that not one participant ever referred to the women or families they cared for as a negative aspect of their role. Although some midwives referred to not having enough time to care effectively for women, especially women with complex social, cultural, physical, or psychological needs, the women remained the reason for many participants to stay in the profession.

7.3.4 Organisation Practices

Several participants frequently referred to management styles which they perceived as punitive, and poor staffing levels which had a negative influence on their ability to do their job effectively; both were placed in the subcategory of organisational practices. Many of the participants referred to organisation practices, often without any prompting, but also when asked about the negative aspects of their role as a midwife. In the main, these negative observations and experiences of the role of the midwife as perceived by the participants, were in relation to poor staffing levels and increasing occasions when low staffing levels were having a negative impact on providing optimum care for women and contributing to them making a career-related decision.

In addition to poor staffing levels, participants also reported that challenges with 'Fitting in' were often related to the bureaucratic management style of the NHS, which was frequently described as punitive. Many practices, including increased paperwork and/or implementing change, were reported to be very frustrating. Jude, an experienced Band 6 clinical midwife, describes this infuriation, and refers to the repetitive paperwork she must undertake within her role.

'I suppose I really hate the politics. I hate politics at work, I hate the bureaucracy, the 'ticky' box exercises.' 'So, I have worked in the NHS all my working life, some little blips in between but mostly. You see the changes over time, and I think there is less…there is much more corporate – I don't like the corporate nature and I think that there is this, having to apply this business model to a caring profession takes away your ability to really care. If you have got to do this many 'ticky' boxes or these many pieces of paperwork.' ***(Jude: an 18-month midwife, Band 6, hospital, part-time)***

Similarly, some participants described the role requirements as making them feel stressed. For example, the increase in safeguarding issues which midwives are now expected to manage were also a source of frustration.

'Some of the safeguarding stuff I find challenging. I've had a couple where we've had removal orders, and I always find that difficult because it just feels like it's going against everything that

we do and everything we stand for when you remove a baby from its mum. I know obviously there are reasons for it, but it still doesn't sit right.' ***(Tracey: a direct entry, Band 6, hospital midwife, working full-time (nights))***

Some participants reported finding it hard to fit in effectively as they were increasingly worried about doing 'something wrong.' The increased litigation within the maternity profession and the midwives having to think about practising defensively was also a challenge. Beatrice and Eve describe below how practising defensively as a midwife was a negative aspect to the role.

'Yeah. The biggest aspect of the role that I dislike is the increasing sense of defensive practice and the culture of blame within that…' ***(Beatrice: an 18-month midwife, previous nurse, Band 7, hospital, full-time)***

'…. it's like the risk team, everything's a bit more risk averse isn't it, and I can see why that's come, because of litigation and all that, and that's the negative thing, and it's the political correctness.' ***(Eve: a certificate midwife, previous nurse, Band 6, community, full-time)***

Challenging organisation practices were often a key reason why participants felt less resilient over time which, in turn, could lead to a feeling that it was 'Time to change'. For example, the fear and increased perception of defensive practice for Indigo, was enough for her to decide to leave the professional altogether.

'So, I was acutely aware of things that do go wrong, and it sort of highlighted how unfortunate you could be in the fact that you were turning up on that shift in that room with that patient, you know, it's as simple as that as to how clinical negligence can occur. And it was the staffing that really worried me, I felt quite…I was acutely aware of obvious clinical negligence [for herself], but I was acutely aware of that with staffing levels being so dangerously low at times, I felt as though I was flying by the seat of my pants….' ***(Indigo: a midwife leaver)***

Melissa also suggested that it was not just the lack of staff that was increasing stress levels for midwives, but it was also the senior midwifery staff, managers, and doctors, who particularly

contributed towards this. Melissa reported that sometimes she felt that as a midwife she had to support the junior doctors who lacked experience and expertise in midwifery practice.

'Yeah, managers! Am I allowed to say that'?

'…and the other thing that I find challenging – you've got me on a roll now – on xxxx [ward name] especially is the junior doctors that come, and no fault of their own, they have not got a clue some of them, not got a clue. ….'

'The one thing that I think is getting everybody down at the minute is all the red tape and the management side of it, massively. Absolutely massively and I think that is the main thing for a massive decline in morale if you like. It's huge, huge at the moment.' ***(Melissa: a direct entry, Band 6, hospital midwife, 30 hours)***

Organisational frustrations were also commented on by Rose and Yasmin.

'I think working in the NHS is quite frustrating in terms of resources and what you can do. You know you're confined to what somebody else says that you ought to do, I feel like the management structure in the NHS is quite top heavy, so everything seems to be done by committee. Nothing is very straightforward, and I get a bit frustrated about how sometimes we're just not very supportive towards each other. I think working in a group of all women can be the worst….' ***(Rose: a direct entry, Band 7 midwife, hospital, full-time)***

'I think as a clinical midwife it has to be staffing constraints, so feeling sort of pulled in lots of different directions, not being able to provide the time and the care that you would want to provide. So, I guess again if I'm thinking about acute situations as a Band 6, that kind of, you know, looking after too many women at once probably, not being able to have a chance to finish your paperwork, then that stays with you, did I write that, did I do this, because you're rushing.' ***(Yasmin: 18-month degree, Band 7, hospital, full-time)***

A lack of staffing was not just a concern in the acute hospital setting, but it was also an increasing challenge for the community midwives. A previous community midwife (midwife leaver) describes below how she had observed how practices had evolved over the years of her work and an expectation to accept an increase in paperwork within the role.

'And literally I found that the notes that we were using were very medicalised anyway. When I first started out and, on the community, work was more manageable and if you are called out the night before to home delivery or whatever, then your work could always be covered, however, in the latter years there will always be massive clinics to cover. And all your paperwork and stuff like that so increasingly I found it difficult.' ***(Emily: midwife leaver)***

7.4. 'Feeling in Control'

'Feeling in control' was the second core concept in relation to the GT a 'Time to change'. The concept relates to participants' perceived levels of autonomy in their lives at work. Examples included having choices in relation to provision and procedures at work such as ERostering (off-duty) and being part of decisions around the implementation of new models of care such CoC. Participants reported wanting to be part of the decision making in their roles, including feeling empowered and having some autonomy over their working practices. For many participants, a feeling of control was established when the midwife felt confident and competent in their role. Three subcategories have been identified to explore the findings of this core concept: Development of resilience, empowerment and autonomy, and competence and confidence.

'Feeling in Control' and 'Time to change'

The core concept 'Feeling in Control' was fundamental to the overarching GT- 'Time to change'. For many participants feeling competent and confident in their role as a midwife ran parallel to them feeling resilient. If a participant in the study described occasions when they felt they had been disempowered or lacked autonomy, in particular in relation to working practices, was when they felt it was time to consider making a career-related decision.

7.4.1 Development of Resilience

How participants perceived they developed resilience varied. Participants such as Catherine, Claire, and Polly, who had undertaken their nurse education prior to their midwifery

education, reported that this had prepared them for midwifery practice and had made her more resilient.

I think I got my resilience when I was nursing – I got that confidence and that if things go wrong, you do bounce back from it and you're able to carry on.' ***(Catherine: an 18-month midwife, previous nurse, community, full-time)***

'Yeah, I think then you were expected…because you were already a qualified nurse you were already expected to come along with a level of resilience, and so, it wasn't deemed important because you'd already been doing the job for quite a length of time. So, no, it wasn't, no.' ***(Claire: a midwife leaver)***

'No, it was all about being with woman, I think the resilience side of it, for me, came from my nursing background and working those shifts that nobody ever wanted to work, and it was busy, when you had people dying on your shift and things like that. So, I think that was built up over my nursing.' ***(Polly: an 18- month midwife, Band 7, hospital, full-time)***

There was, however, overwhelming agreement that none of the participants had undertaken any training during their pre-registration education in relation to resilience or how to develop it. For the participants who were more recently qualified, they spoke about reflective practice and learning to become reflective practitioners, but not resilience per se. Natalie was an exception to this, as she felt being an effective reflective practitioner went hand in hand with being resilient.

'Reflective practitioners, it was about reflective practitioners, and I think resilience is part of…reflection is part of building on resilience, isn't it, I feel, because if you're reflecting on your practice, that's helping you to rationalise which develops resilience.' ***(Natalie: an 18-month midwife, Band 6, hospital, 30 hours)***

Similarly, Indigo and Grace did not recall learning anything about resilience in their education but felt they had been equipped with the tools to reflect on practice and had the ability to be good reflective practitioners.

'No, I can't…not specifically, I don't think that was a word that was…that wasn't a spec…I can't recall that being a buzzword at the time Obviously, reflection, reflection, the buzzword for us at the time was reflection, reflective practice, that seemed to be the in thing……. But I can't actually remember the word resilience as such being a theme, being a skill…because it is a skill, isn't it, you know, it is a skill that you have to acquire over the years, and that's probably more of an experiential learning curve. But I can't actually remember it being taught to us….' ***(Indigo: midwife leaver)***

'Though it's no good just teaching, we were taught about reflection we were given some skills that you could use, and you know reflection I use that on many occasions personally to empower myself.' ***(Grace: midwife leaver)***

This pattern was similar for most participants who were asked about developing their resilience during their training/education. Polly, Olivia, Sarah, and Xavier all suggested that they did not remember learning about building their resilience.

'I can't really recall anything [in relation to resilience] in my midwifery training.' ***(Polly: an 18-month midwife, Band 7, hospital, full-time)***

'No. Do you know; I don't think it was even a word [resilience] that was on the radar at that point in my training.' **(*Olivia: A CoC midwife, full-time)***

'I don't, to be honest. I don't remember that being part of the curriculum at all. I think that was more once you're a newly qualified…the RCM was doing resilience workshops and things. I never actually attended any, but no I never did it as part of my training.' ***(Sarah: a direct entry midwife, Band 6, hospital, full-time)***

'No, I really don't at all. I feel that the word resilience has only sort of become more prevalent in the last probably ten years.' ***(Xavier: an 18-month, midwife, previous nurse, Senior midwife, hospital, full-time)***

Many participants suggested that the development of resilience should be an individual responsibility when their views on training were explored in further depth. However, some participants highlighted that their employers should facilitate and support their employees in relation to managing work-related stress, and this might include resilience building, but it should not be their sole responsibility. Some participants' perceptions indicated that this was because the attribute resilience was innate, meaning midwives either had it, or they did not.

'Well, you know, I always think the responsibility starts with yourself of course, but of course, you might not have insight into the fact that you're not very resilient.' 'A question I ask myself, that…is it only resilient people that come into midwifery? Or does midwifery make you resilient and I'm not sure which way around it is.' **(*Janet: midwife leaver)***

In the main, being a resilient character was deemed by many participants as a positive attribute to possess. However, Indigo suggested that one of her colleagues may have *too much* resilience and would not ask for support and help from her colleagues when she needed it. This made Indigo feel unsettled as she worried that her colleague would agree to undertaking any work which she was asked to do regardless of considering protecting herself and the potential for burnout.

'And I worry about it because I worry that she has too much resilience, which is really interesting because anything you ask her anything she does she'll just say yeah, I'll do it and…. I think you could do this business on your own should yeah that's fine I'll do it, so I worried that she had too much [to deal with], and she wasn't talking about it enough.' ***(Indigo: midwife leaver)***

7.4.2 Empowerment and Autonomy

7.4.3 Competence and Confidence

Overall, the majority of participants referred to their experience of developing confidence in a comparable way, and for some, competence and confidence were congruent. Many participants suggested that the more competent they became within their role, the more confidence they seemed to build and the less likely they perceived the need for 'Time to Change'. For some, this directly impacted on the perception of their resilience levels. Una thought that her confidence, competence, and resilience had all developed simultaneously, whereas Donna suggested that, although she felt this was the case for herself, it was not necessarily applicable to all midwives. As an experienced midwife, Una had seen her colleagues' resilience and confidence levels decline over time. However, from her own experience she found her resilience and confidence levels had increased simultaneously.

'Yeah, I think they would because I think resilience and having confidence probably go hand in hand. And if you're specialising and you've got that role, hopefully someone's got that confidence in you as well that you can do it, and that would help with resilience. ***(Una: a direct entry midwife, Band 6, hospital midwife, full-time)***

'I think I've always had quite good resilience because I've always stuck with things, and if I've failed at something I'll always try and try again if it's something I want. If it's not something I want, then I won't. But if it's something I want then I will keep trying and trying again. And so, I think it's actually grown. It's grown along probably with my confidence and my competence and my knowledge as well. I think they all come together and grow together. I think none of them can be standalone. I think it's…you need those basic things, like a certain level of confidence and a certain level of resilience, but I think that you have to accept that they grow as well, in my personal opinion. But then I guess I see colleagues that resilience becomes less.' ***(Donna: midwife leaver)***

Two of the participants, Sarah, and Zoe, felt that their confidence and competence as a midwife developed after three years of being qualified. It is often around this time that many midwives transition from a Band 5 (newly qualified position) to Band 6 (experienced staff member) on the NHS agenda for change pay scale. During this time, an increased level of confidence also influenced some participants' perceptions around their careers. For example, as Sarah states below, her developing confidence contributed to her feeling of contentment in her current role.

'Because I think it takes you about three years just to find your feet really and feel confident. So, I'm probably just coming out of where I feel confident, and I've got a role and I'm quite happy in work at the minute. So, to me I think things feel better when I compare it to the last three years than they ever were…' ***(Sarah: a direct entry midwife, Band 6, hospital, full-time)***

'Three years, a few other midwives have said around about three years there seems to be that time where they think, oh, I know what I'm doing now, type of thing, not that you didn't know what you were doing but…' ***Zoe: a direct entry midwife, Band 6, hospital midwife works full-time (currently on parental leave)***

A couple of the participants felt a reluctance to ask for help or support from their senior colleagues, even if they knew they needed it. Olivia, an experienced CoC midwife, and Una felt that she did not have the confidence to ask for help from some of the labour ward coordinators when she was newly qualified.

'And, you know, there's still times when I doubt myself, am I doing it right and that, but I just think well, I'm just going to have to get on with it, someone will soon tell me if I'm doing it wrong.' ***(Olivia: A CoC midwife, full-time)***

'Yeah. But it was mostly okay. There was a couple of coordinators that weren't as…Some of them were really good. If you didn't appear from your room they'd just come and knock and say is everything all right, do you need anything. Whereas others you were just left a lot more to it. And I definitely didn't have the confidence to always come out of the room and ask for the help.' ***(Una: a direct entry midwife, Band 6, hospital midwife, full-time)***

Some of the participants perceived increased competence and confidence was related to their increased age. It was evident in the accounts below from Eve and Alice that they perceived younger midwives to be less resilient. The discussion around the age of a midwife and whether the younger midwife was less likely to be committed to the role materialised in some of the interviews. The discussion about age resulted in a mixed response and opinion in relation to the impact of age and the influence it may have on the commitment and resilience of the role of a midwife. Willow was positive about working with some of the younger

midwives, whereas Eve suggested that with more experience they (the midwives) would be able to protect themselves.

'You're a bit more vocal. I think as you get older and more mature you've seen such a lot and you get to a point where you're thinking actually, I'm not having that.' ***(Eve: a certificate midwife, previous nurse, Band 6, community, full-time)***

'We've had a couple or three younger midwives that have been qualified…what have they been…about five or six/seven years coming to the team. And they've been a breath of fresh air. And actually, I think they…like the…I found with the studying, they almost give your life, and you think, actually there's enthusiasm there, there's a different way of thinking, that actually, you know, I can go with that and that almost ups your resilience a little bit because it makes it feel better.' ***(Willow: degree, Band 6, community, part-time)***

'As they get more experience as the years go on, that they will learn to protect themselves really, which is part of the experience as well isn't it I think learning how to protect your emotional self and not get too involved as well.' ***(Eve: a certificate midwife, previous nurse, Band 6, community, full-time)***

Eve and Alice both referred to the midwives who were younger in age needing more support and labelled them as 'Generation X' (born between 1965-1980), which was interpreted to mean 'Generation Z' (born between 1997-2012).

'It's the ability to cope in some ways and maintain your strength and health. I mean, we do say the younger generation are lightweights, but they aren't all like that. And I think we don't always help them, do we? ***(Eve: a certificate midwife, previous nurse, Band 6, community, full-time)***

'Absolutely. So, they've picked up with the action learning sets now. And I don't know if it's this, whatever you call you them, Generation X or whatever, everything is to hand, isn't it, these days. ***(Alice: an 18-month, midwife, previous nurse, Senior midwife, hospital, full-time)***

For some of the participants, including Willow, an increased age had the reverse effect on their competence and confidence, and overall perceived resilience to their role. Willow reported that her resilience, which waned due to her being older in age and this had just as much impact as those participants who were younger. Some of the participants also discussed being older in age in relation to the menopause and hormonal changes they had recognised and thought these might be having an impact on their resilience levels.

'Because I think as you get older, it does get hard. And I think things like the menopause and things like that that isn't always recognised and…that doesn't help either. That's distractive again. That makes you less resilient. Definite…well for me it has. It's definitely made me less resilient.' ***(Willow: degree, Band 6, community, part-time)***

'Yeah. Well, I have wondered. I've talked to quite a lot of people who've said that once they get to sort of the menopausal age, it's really affected their ability to cope and the resilience and performance. I have wondered if some of that is true. Because I've certainly seen it in other individuals who've always been absolutely great, fine, suddenly not doing as well.' ***(Xavier: an 18-month, midwife, previous nurse, Senior midwife, hospital, full-time)***

The subject of the menopause was not routinely asked to all participants; however, it was brought up by those participants who were older, or closer to the menopause age. Some participants, such as Janet and Emily, reported that the menopause was having a negative influence over their perceived resilience levels and incurred the feeling that a change in career circumstances might be necessary.

'I think, well, there'd be a couple of reasons probably. I mean, generally as some people get older…you know, you think of the women going through the menopause et cetera, and just physical health could have a negative impact on resilience.' ***(Janet: midwife leaver)***

'So yeah, that that's I think that's probably a really, really influential thing [menopause].'
(Emily: midwife leaver)

7.5 'Being Valued'

Overall, the notion of 'Being valued' at work and by managers was significant for many of the participants and to the GT a 'Time to change'. Feeling valued by employers and colleagues was fundamental to participants' attitudes to their positivity to work. Feeling supported, valued, and appreciated by colleagues and the team the midwife worked in, particularly by senior staff, was reported to improve happiness at work by several participants. 'Being valued' also included participants referring to their professional identity, obligation, perception of the role of a midwife as 'no longer a vocation,' and overall loyalty and commitment to the role. Over time, this impacted some participants' feelings of worth, and also made them question if they would therefore be appreciated in another role or even a different career. There were three subcategories identified within this core concept: Feeling appreciated, Passion and Commitment, and Changing role.

'Being Valued' and 'Time to change'

The core concept 'Being valued' was critical for participants, as without it, they felt less positive, and in turn, less resilient at work. For some participants, their passion and commitment to their role had waned because they no longer felt they were appreciated for what they did at work. Over time, this impacted some participants' feelings of worth, and also made them question if they would therefore be appreciated in another role or even a different career.

7.5.2 Feeling Appreciated

Some participants made specific reference to the importance of being valued at work. For some this was more important in determining their perceived levels of resilience than the amount of work they were asked to do. If they felt appreciated for what they were doing, often by senior staff, they did not mind so much about the pace and increased work pressures.

'And in terms of workload I don't mind if there's a lot of work that peaks and troughs and all the rest of it, but team dynamics is really important to me, and I get frustrated if I don't feel valued or

if I don't feel I can air my opinion, I guess.' ***(Victoria: a direct entry midwife, Senior midwife, hospital, full-time)***

Georgina echoed Victoria's feelings of needing to feel valued at work. She alluded to how important it was to her to feel appreciated, which in turn, was motivating.

'It doesn't matter where you work or how much you hate your job and like the task you actually have to do. If you're working with friends and you're still going every day and you will look forward to it, I think some of it is appreciation, it might sound a bit selfish but if you know you're doing a good job and you feel valued, you're more likely to go above and beyond and keep going.' ***(Georgina: a direct entry, Band 6, hospital midwife, working 30 hours)***

Willow referred to the matron in her area of working, supporting the clinical midwives when the unit was busy and participating in caring for the women when it was busy.

'That she's [the matron] the one that will go round in a morning, and she will say, you know, how is everybody? And if they're short, she will roll her sleeves up and get stuck in. And I think that's what you want. You want to feel that you're valued.' ***(Willow: degree, Band 6, community, part-time)***

Donna discussed how she perceived feeling valued at work would also make her more resilient. This also had connections with the first core concept, 'Fitting in,' as this participant felt that being part of a team and the culture of the maternity unit would enhance this.

'…because that goes along with resilience as well because if you're resilient…if you feel valued you feel more resilient, you feel more part of the team and the culture, don't you'? ***(Donna: midwife leaver)***

7.5.3 Passion and Commitment

Overall, a number of participants described their passion for their role as a midwife, especially caring for women and their families. This was seen by several participants as the primary driving force for continuing to stay working as a midwife.

'To me, relationship-based midwifery is the most important thing. But, you know, that doesn't mean I don't keep my skills up-to-date obviously but that is the thing that is always going to be my focus, that is what is the most…you know, being with women and families and doing that stuff, that is what is important to me.' ***(Ivy: 18-month midwife, previous nurse, independent midwife, full-time)***

*'It is a love-hate relationship [midwifery practice]. It is definitely a love-hate relationship [midwifery practice]. I do love the job, I want to look after women, I want to make a difference, and I want to make them have the best experience that they can have and even though it is really sh*t sometimes you go back, and you do it again because that's…I think to be really passionate about it and to put up with the stuff we have to put up with at work you have to really love that job or people do just walk really easily.'* ***(Melissa: a direct entry, Band 6, hospital midwife, 30 hours)***

However, for some participants, (regardless of how long they had worked as midwives), their passion was not grounded in the care they delivered to women but with the relationships they fostered with their colleagues.

'I guess, all in all, deep down, I do love the job. And I do love some of my colleagues. And I do like caring for women, I guess.' ***(Quinn: an 18-month community midwife, previous nurse, part-time)***

'I love all my colleagues. I love my work. I love the fact that it's absolutely bonkers. You know, you never know what what you're going to get., I think...I can't imagine doing anything else.' ***(Rose: a direct entry, Band 7 midwife, hospital, full- time)***

7.5.4 Changing Role

Overall, the 'Changing role' subcategory identifies the disharmony some of the participants felt in relation to their obligation, expectations, and 'loyalty' to the role. For some participants, their personal perceptions of this changing role was key to whether they felt valued at work. Some of the 'midwife leaver' participants, particularly the midwives who were experienced or more senior in their role at the time, described how the midwifery profession was no longer a vocation, like how they had remembered it used to be. In keeping with the 'Changing role' and obligation and loyalty to being a midwife, two of the midwife leavers identified how challenging it was to leave the profession despite knowing they needed to for their health, they still had feelings of guilt.

'I think when we qualified, it was a vocation, wasn't it? You're doing this, and you want to do it, and that's part of, you know…I've struggled leaving the profession, and I know I've got lots of reason for why I've done it, and I've said that. But I've still really struggled with it, and I've felt bad for doing it.' ***(Claire: a midwife leaver)***

'Whereas I think when I started nursing it was, you were a nurse, this is your vocation, this is what you will do. And that didn't necessarily help with resilience. But then I think I had really good general training, so I must have been…I must have learnt resilience from there because as a student nurse it's…it was never very pleasant…' ***(Donna: midwife leaver)***

Emily described how she disagreed with her manager over her perception of what a midwife 'should be' and her expectation of a midwife was incongruous to her manager's. Whereas her line manager expected a midwife to still give *above and beyond* in her role. It is possible that Donna, Claire, and Emily had these feelings in relation to midwifery no longer being a vocation, because they had all undertaken their nurse training prior to becoming a midwife, and therefore had the opportunity to gain some understanding of the role of either a nurse or midwife working in healthcare system. It is also possible that Donna, Claire, and Emily all felt this way because they had established what the expectations of a healthcare professional were in their original nursing education. They all perceived nursing and midwifery as a vocation rather than a profession and had held this view since they qualified.

'And whereas I don't think modern women's lives should be like that now. What she quoted that we, we have to give above and beyond.' ***(Emily: midwife leaver)***

One of the midwife leavers described her feelings of vulnerability before deciding to leave the profession, which ultimately resulted in her feeling obliged to eventually leave.

'…a professional obligation and a moral obligation that was what prompted me to stop being a midwife in the end, because I just felt as though I was…the more often I went on duty, the more I was exposing myself to that clinical risk. And that was one of the – well, the predominant reason for leaving, because of staffing levels, I just felt so vulnerable'. ***(Indigo: midwife leaver)***

Similarly, Karen also referred to her own expectations and how midwives were no longer able to provide the care they wanted to for women and their families.

'I'm not really sure that women are getting the care that they should be getting any more so. I think I'm quite a principal person and like I said before, feel that I think we're not doing the best for women and that I found really, really difficult.' **(Karen: *midwife leaver)***

As discussed in the core concept, 'Fitting in', participants described how their changing role had an impact on their expectations. Expectations of participants also referred to not only their own and their colleagues' expectations of midwifery practice changing, but that of the women they cared for too. The introduction of the CoC model, where midwives care and support women throughout the pregnancy, birth and postnatal period may be seen as more challenging than caring for them for only part of their care. Grace, and Victoria all discussed how much the expectations of women had also increased. They reported how the care for some women was now more complex and they felt some women expected them to be constantly available to contact. It is possible that advancements in technology such as the use and reliance of mobile phones has exacerbated this issue, making the participants feel that they are more accessible, all of the time.

'And I know it's all working together, but at the end of the day, and people have changed in that you know technology, not just technology but choices people women want.' **(*Grace: midwife leaver)***

'The same with mental health [care and provision]. We weren't available in the same way. I think the expectations that women had of the service were probably different and I think they were probably more in the minds of, you know, you do as you're told, and you turn up at the right appointments. Whereas now they have a more constant relationship with their midwives by text or, you know, they have their phone numbers, and I think they use that a lot more.' ***(Victoria: a direct entry midwife, Senior midwife, hospital, full-time)***

7.6 'Getting the balance right'

Overall, the fourth core concept 'Getting the balance right' describes many of the participants who identified strategies to achieve an optimum work-life balance or identified that they needed to improve this balance to remain optimistic in their workplace and consider a 'Time to change'. Similarly, to the first core concept, 'Fitting in', 'Getting the balance right' is multi-faceted and will be presented within the following four subcategories: The 'Golden 30 hours', Ability to compartmentalise, A 'buddy', and Learning to Cope. 'Getting the balance right' was crucial to the participants being able to effectively develop their resilience and ultimately make career-related decisions and also consider the GT, a 'Time to change'. A further key factor in this concept was around the participants' suggestion of having a 'work wife'/buddy.' This concept also included practical and psychological strategies to compartmentalise work and home life.

'Getting the balance right' and 'Time to change'

The core concept 'Getting the balance right' highlights how some participants had developed strategies to increase, or at least maintain, their resilience levels at work. Thus, enabling them to remain in their role, and/or indeed the profession. Participants who found strategies to achieve an optimum work-life balance felt that they could pursue choices about their career-related decisions which would continue to fulfil reaching an optimum balance between work and home.

7.6.1 The 'Golden 30 hours'

Some participants identified an optimum number of hours to work which would preserve a good work-life balance and ensure they were able to maintain their resilience levels and for some make career-related decisions which informed their decisions relating to their careers. This has been titled the 'Golden 30 hours'. Out of all the thirty-six participants interviewed, eight identified as working part-time hours. The number of hours varied between fifteen hours and thirty-three hours.

The participants' in the study worked part-time for several reasons such as competing caring commitments they may have with children or other relatives and working this around their partners' full-time job. Some participants reported that they had some flexibility in their home life, regarding how many hours they 'need' to work. When all the participants were interviewed, they were asked about how many contractual hours they worked as a midwife, and whether this had changed or stayed the same. Choosing to work 30 hours, and not full-time hours (37.5) for participants such as Melissa, Emily, Debbie, and Natalie, meant they felt they had a good balance between their time at work and their time spent at home.

'I think the 30 hours is great because you've got three days, you are either working three days, or three nights a week and you've got the rest of the time off. And it's great.' Quite a lot of midwives work 30. But then you have got the opportunity to do an extra if you want to. Whereas if I worked full time, I probably wouldn't pick up many extras.' ***(Melissa: a direct entry, Band 6, hospital midwife, 30 hours)***

'I dropped my hours (for parental leave) and then worked four days a week, until pretty much my leave and return.' ***(Emily: midwife leaver)***

It was also echoed by Natalie about the significance and benefits of working 30 hours a week.

'They [midwives] don't want to work full-time, they don't want to have that stress all those hours, I work 30 hours and I get a good balance on that'. ***(Natalie: an 18-month midwife, Band 6, hospital, 30 hours)***

Similarly, Georgina (a Band 6 clinical midwife) recommended that a 30-hour working week was enough time working to develop her midwifery role and confidence without it having a negative impact on her perceived amount of time away from work.

'I'd probably recommend people start at like 30 hours because that extra seven and a half hour a week can be the difference between that fourth night and then you're back in two days. And it just gives you more time, and with it being 30 hours, your full time is enough to build up your confidence and consolidate your learning, it's not going to extend your Preceptorship.' ***(Georgina: a direct entry, Band 6, hospital midwife, working 30 hours)***

Rose highlighted that choosing to work 30 hours maximum in a week, was not just a choice for midwives with children/caring responsibilities. The decision to work 30 hours as a maximum, for some of the midwives who were younger in age, and less experienced was a conscious one, which was seen as beneficial for protecting themselves from work-related stress.

'A lot of people don't want to work full-time hours because they want to have that separation, and I think that sometimes that can be seen as being a weakness if you drop your hours, so like you are a weaker person, so I think it's to do with age and number of hours you work. I think some of the younger ones do it as managing to cope with it because they don't want to be consumed by their work.' ***(Rose: a direct entry, Band 7 midwife, hospital, full-time)***

Nonetheless, Rose did not necessarily agree that working less hours was a positive action by midwives. Rose worked full-time and perceived that working less than this may be seen as a weakness by senior staff.

7.6.2 Ability to Compartmentalise

Ability to compartmentalise refers to some participants' descriptions of their strategies to manage and deal with challenging or stressful situations at work. For many of the participants it was fundamental to their ability to achieve a healthy work-life balance and maintain their resilience. The participants who referred to compartmentalising work and

home found this a highly effective strategy they could rely on to ensure they felt they were still able to cope and 'bounce back' from work-related issues, even in the face of adversity. The ability to compartmentalise was spoken about in relation to how a midwife divides, organises, and separates challenging work issues at the same time as juggling other home and everyday life events. Although this strategy was not always undertaken consciously, it was in the main, seen as an extremely positive defence mechanism for some of the participants. For instance, Debbie was able to recognise and consciously compartmentalise, stating that she was able to put things into 'boxes' in her head with ease, for example if she had been involved in a situation/incident at work, she had learnt how to work through her feelings about it and then move on emotionally, or consider a 'Time to change'.

'…. I'm also able to put things into little boxes in my head and shut it and forget about it …' ***(Debbie: a direct entry midwife, Band 6, hospital, 30 hours)***

Catherine, Linda, and Polly similarly identified how they were able to effectively separate work and home.

'…. I don't know how you manage to get up in the morning and come to work, but because I can separate the two, I don't bring that to work with me. That's happening at home, and nor do I take the work home with me.' ***(Catherine: an 18-month midwife, previous nurse, community, full-time)***

'Yeah, I think…it is having that ability to separate, you know, I mean, I know it's a vocation but we're not nuns, it's not, you know, so it's having an ability to separate.' ***(Linda: an 18-month midwife, Band 6, hospital, full-time)***

Olivia highlighted that compartmentalising for her, was a conscious decision, as she had to swap roles very quickly when she returned home from working as a midwife.

'An element of escapism just to come back to the house and being a mum, it kind of forces you to sort of take one hat off and put another one on really. So that in itself is enough for me.' ***(Olivia: A CoC midwife, full-time)***

Likewise, Rose suggested that moving on and not dwelling too much on the working day were essential survival techniques for her.

'Yes. I mean, you need to be...I think, to survive it you need to be able to put that day behind you and then move onto the next stage. Like wipe the slate clean to a certain extent...' 'Yes. I mean, sometimes I...I mean, I walk to and from work, so sometimes that's quite good because it adds a level of separation because it's like I leave that ….and I'm thinking about things and putting them behind me and going to work and then from work going home I'm doing the same thing, but just in reverse really, so I can think...process it all through and try and move on from it a bit'. ***(Rose: a direct entry, Band 7 midwife, hospital, full-time)***

Although some participants found compartmentalising easy to achieve, others found it difficult to do. This could have been dependent partly on the role of the participants, and their working practices. For example, the participants who were in senior levels (like Willow) had to work hard to ensure they maintained their work and home boundaries.

'…. But sometimes it can cause a little bit of like an almost internal animosity really because you feel like, why am I doing all this, I'm not even getting paid for this right now and why am I waking up at three o'clock in the morning thinking about something to do with work.' ***(Willow: degree, Band 6, community, part-time)***

Xavier, a senior midwife participant, emphasised the importance of separating home life from work. She reflected on her own experience when she recognised the point for the need to consider a 'Time to change', recommending other midwives should access support before this occurs.

'So, yeah, I think if you can achieve that…if at home you're able to completely separate, switch off, gain pleasure and enjoyment in the things outside of work and sleep, I think you can cope much better with everything at work. I think it's really important for midwives to be able to do that and

as soon as they start…if they're able to recognise any interruptions in that pattern balance and ask for help, I would encourage them, if they're starting to feel worried or stressed about anything, to seek some help.' ***(Xavier: an 18-month, midwife, previous nurse, Senior midwife, hospital, full-time)***

Similarly, Sarah and Willow referred to being able to easily switch off when they returned home from work or were on holiday, but Tracey found it much more difficult to achieve.

'So, I pretty much leave work at work when I come home.' ***(Sarah: a direct entry midwife, Band 6, hospital, full-time)***

'Absolutely, yeah. I think because of how I feel at the minute, I'm finding it easier to think, right, actually I'm on holiday this week, I am not doing it. Whereas before, I would bring stuff home, you know, make…maybe make a few phone calls and that sort of thing.' ***(Willow: degree, Band 6, community, part-time)***

'Yeah. It's probably not something I'm particularly good [compartmentalising] at. I'm on a day off today and I've already answered a work call and three work texts….' ***(Tracey: a direct entry, Band 6, hospital midwife, working full-time (nights))***

The ability to compartmentalise (or not) was often discussed by participants in relation to their perception of being resilient (or not). For the participants who found compartmentalising a challenge, also were those who were considering making a career-related decision and recognising it was 'Time to change'. Some participants perceived that if they had the ability to compartmentalise their work and home lives, then they felt they were a more 'resilient individual.' However, as Kay commented on, it was not always as easy or simple to do this, depending on what was happening at the time in the individual's work or home life.

'If you've got something coming up at home, some people are able to leave it at home and blank it off, but some people will naturally want to bring it with them to work type of thing, yeah, and then they're not going to be as resilient at work are they; they're not going to be as focused

because they're going to be thinking about the other thing as well.' ***(Kay: an 18-month midwife, Band 6, hospital, full-time)***

Overall, compartmentalising was seen as a positive skill to have by most participants who referred to it. Participants had diverse ways of achieving this, some consciously and others unconsciously.

'It's what things you can do at home to separate your home life from your work life so you can go home, forget about the day, reflect on it, 'pocket it,' carry on with your life.' ***(Polly: an 18- month midwife, Band 7, hospital, full-time)***

It was not just the clinical midwives who reported feelings of vulnerability, this also included the senior midwives. They equally grappled with work-related stress, overworked environments, and not enough time to achieve everything in a working day. The work-related stress for all staff, regardless of their seniority was relative to their role. In fact, for some of the senior staff there appeared an immense amount of guilt that had been built up over the years about not being 'resilient enough' themselves. Some senior midwives also reported feeling guilty for the circumstances that their workforce (the clinical midwives) was having to constantly endure.

7.6.3 'A Buddy'

The 'buddy' was used by the participants to describe an individual or small group of colleagues who they referred to as their support network at work and who they could discuss work-related issues with, especially if the participant was considering a 'Time to change'. For most of the participants interviewed, these were fellow midwives. Alternative phrases in addition to 'a buddy' were also described by some participants which included a 'work-wife,' 'a tribe,' your 'work-family' and 'a mentor,' generally all terms which the participants felt described colleagues who they perceived like themselves. In terms of the overall strategies identified by participants to manage work-related stress and be able to maintain resilience, 'a buddy' was overwhelmingly the ultimate strategy over any other, mentioned by participants.

Ivy encouraged student midwives to identify early on in their careers their 'tribe' or group of other midwives they worked with to sound off with and be able to de-brief about issues that had happened at work.

'I mean, I always say to student midwives, find your tribe, like find your little group of people that will be able to have your back if you needed, you know, that you can, you can go to them, you can whinge, you can whine about things, you can process, talk, debrief, whatever you want to call it, you can, you know, rant about things, you can do…but just find your people that are on the same wavelength as you, they get you, they know what is important to you, it's probably the same things that are important to them.' ***(Ivy: 18-month midwife, previous nurse, independent midwife, full-time)***

Victoria was of a similar mindset as Ivy, also suggesting it was essential in midwifery practice to identify with other colleagues who they can trust.

'Yeah, I think…what do I mean by that? I think in your work family you need…you…well in my experience you end up with a few people that really are your friends. You end up with a few people that you know you can really trust and go to with anything, and you almost need like the mentor role, don't you? So, you sort of need to identify these people and…I don't know about group stuff.' ***(Victoria: a direct entry midwife, Senior midwife, hospital, full-time)***

Where the participants worked (for example in the hospital or the community setting) influenced the amount of (or lack) of reliance they had from the colleagues in relation to support.

*'Yes. I've got a good team that I work with, my colleagues in the **** team, and we do all look after each other emotionally, so I've got a nice team that I work with, and the ***** teams as well; so that's good because I like the team that I work with. It's, like you say, friendly and supportive.'* ***(Catherine: an 18-month midwife, previous nurse, band 6, community, full-time)***

'I think if I didn't have the support at that time of some really lovely colleagues and fellow students, I don't know that I would have gone back, because that was a really big deal at the time.' ***(Tracey: a direct entry, Band 6, hospital midwife, working full-time (nights))***

'Yeah, yes. I mean, I feel…in terms of colleagues and peers, I thought that was very supportive, it felt as though…we [midwives] often felt as though we were all in the same boat, everybody could resonate with how you, you know, if you managed to get a break, you all resonated with how busy it was, that you've not had a break, you were off late again, everybody could resonate with how you were feeling because everybody was in the same position'. ***(Indigo: midwife leaver)***

Not all the participants interviewed utilised the same support mechanisms. Some such as Willow, Victoria, and Melissa, found that their partners and family were just as effective as another healthcare professional.

'I think talking about it. I talk to my husband about it. And I've got friends that…not within midwifery but still within nursing and we'll contact each other as well and we can download on each other. So, it doesn't matter, does it, whether you're a midwife, a nurse or whatever, it's fairly similar sort of things. So, I talk to them…' ***(Willow: degree, Band 6, community, part-time)***

'That's my biggest support mechanism or coping mechanism, is my family.' ***(Victoria: a direct entry midwife, Senior midwife, hospital, full-time)***

*'You go home, you can debrief, I mean obviously you don't go into details of patient details with your husband or anything like that, but you will talk about what you've done during the day. I mean I'm lucky, my sister is a nurse as well so I can debrief with her if I'm not debriefing at work. So, we can have a good…or I will phone **** [sister's name] As I'm on my way home after a long day, we have a debrief.* **(*Melissa: a direct entry, Band 6, hospital midwife, 30 hours)***

Participants also discussed different support mechanisms in their place of work. For some, there were several formal and structured support mechanisms in place that they were aware of accessing if they wanted to. A lot of the participants referred to counselling and coaching

resources that were available within the NHS for all staff, but some were not keen to utilise these.

'You can have private counselling sessions. They'll only do six, but if you were really bad; they would signpost you elsewhere. Occupational health. You can have a health check over the age of 40. There're courses available for health and wellbeing.' ***(Eve: a certificate midwife, previous nurse, Band 6, community, full-time)***

'I think there are support mechanisms through the NHS, aren't there, think there's definitely coaching, and I think there is some sort of – don't know what it's called, but I'm sure if I wanted to access it, I think there's some local groups I think, aren't there, not really sure.' ***(Yasmin: 18-month degree, Band 7, hospital, full-time)***

Beatrice described what was known as the 'wobble-room' which was a place for staff within her trust to visit as a 'drop in' (only between Monday and Fridays) and talk to a member of the human resources team about work-related issues. Despite this being available for all staff, including midwives to access, Beatrice alluded that many of her midwifery colleagues did not use this service, but she still tried to encourage them to.

'But within the trust, a lot of it has been postponed, I get that, but a lot of them are actually about psychological support and counselling support and things. I know this is trust wide, it's not just for midwifery. But I actually do encourage the midwives to access……' ***(Beatrice: an 18-month midwife, previous nurse, Band 7, hospital, full-time)***

Although most of the midwives relied on informal support mechanisms, such as socialising with their colleagues and family, going out for dog walks, and undertaking hobbies, for some participants there were alternatives to these. Alice described how she had accessed the pastoral care team, which included a chaplain or religious figure for both patients and staff to access if they wanted to.

'Yeah. And the pastoral care team here are really, really good as well so yeah. I think there are little things. A friend died on Good Friday this year, and that put me off kilter for a bit because we

couldn't go and see her, couldn't see her family, and you can't go to the funeral, can you'? [due to COVID-19 restrictions at the time]. ***(Alice: an 18-month, midwife, previous nurse, Senior midwife, hospital, full-time)***

Several of the participants were aware of the role of the PMA. Those midwives who had been qualified for several years, understood that this role had replaced the role of a Supervisor of Midwives (SoM), and some found accessing the PMA more beneficial than others, but most participants understood that a PMA or SoM were for professional support, especially if they were considering a 'Time to change'.

'We've got our new supervisor of midwives…professional midwifery advocates…well, before I went on maternity, they were quite visible in our trust, so they were available for conversations and debriefs.' ***(Zoe: a direct entry midwife, Band 6, hospital midwife works full-time (currently on parental leave))***

'So now at work they've got the PMA's, the midwifery advocates. I've not used them particularly yet.' And I know there's groups on Facebook as well. I've joined a couple. Like self-care for midwives and stuff, about just looking after yourself, different ideas. ***(Una: a direct entry midwife, Band 6, hospital midwife, full-time)***

'….and they've got the PMA's now as well. So, you can go to the PMA. I don't think they're things that I would personally do, but that's only because I feel like I'm more supported by my colleagues now.' ***(Sarah: a direct entry midwife, Band 6, hospital, full-time)***

There were mixed perceptions overall, about the value of the PMA as a support for midwives from some of the participants. It may be possible that this was more apparent for the midwives who had been qualified for longer and made comparisons to the previous regulation of midwifery practice known as the supervision of midwives, they were familiar with. PMA's replaced the role of the Supervisor of Midwives when the statutory regulation of midwifery supervision ended in 2017 (NMC, 2017b). This model has been replaced by A-EQUIP – Advocating for Education and Quality Improvement – which is led by PMA's[1].

*'Yeah Yeah, the PMA's are coming more to the forefront now. I think supervision has gone, you know we've had that lull and the PMA's are finding their feet and what their role is. At [Trust name] ***** there is a good support role from the PMAs, and I've seen it changing in ***** as well since more midwives have gone and done the PMA course. And I think it's good that you don't have to like to speak to a specific PMA. You know, like we've had a specific supervisor.'* ***(Polly: an 18- month midwife, Band 7, hospital, full-time)***

7.6.4 Learning to Cope

Overall, some of the participants referred to their experiences as Learning to Cope which describes how they had to regularly face managing stress at work, despite knowing for some, it was having a negative impact on their health. Participants discussed their understanding and perception of resilience in relation to coping, reflecting about the benefits and challenges of admitting that they might be struggling at work and accessing the support they required to overcome this. What was apparent from most of the participants who referred to coping (or not) was that it was not sustainable to carry on at the pace they were doing for much longer. There were participants who expressed physical, emotional, and mental symptoms in relation to their increased stress levels. Some of the participants were very honest in relation to [1]their perception of being able to cope (or not) with working as a midwife. For example, Una explained how when she felt anxious it affected her sleep.

'Yeah. I can be quite anxious. I definitely notice sleep wise if I'm feeling stressed if work's really getting to me. Yeah. Can't sleep. Go over situations in my head over and over and over. I think my partner can probably see it as well. I get snappy at home.' ***(Una: a direct entry midwife, Band 6, hospital midwife, full-time***

It was not just a difficulty with sleeping for some participants, some physical and mental symptoms were really concerning.

[1] The A-EQUIP model is made up of three distinct functions: restorative, personal action for quality improvement and education and development. It aims to address the emotional needs of staff and support the development of resilience (Pettit and Stephen, 2015).

'No, yeah, so when I start to get really quite stressed and anxious, I do sometimes get a bit of chest pain… And I don't sleep. Yeah, and I don't sleep, so it goes round in my mind at night as well.' ***(Natalie: an 18-month midwife, Band 6, hospital, 30 hours)***

'I think there is a huge element of mental health isn't there. So, I think mental health definitely has an impact and I think probably is there more mental health issues now than there were when I did my training – probably there is. If you are newly qualified, you have to give it time, and you are not the first and you won't be the last to struggle with that if you find you are having a mental breakdown, and that it's stressing you out, it's not worth – the job is not worth you damaging yourself to come and do.' ***(Jude: an 18-month midwife, previous nurse, Band 6, hospital, part time)***

'Because I think having had experience of things and being at a point where you potentially feel like you're losing your mind, and I think I would never, ever in my life would have thought I could have even a little bit felt like that….. think I don't know whether I'm going to survive that long because I'm at the point where I'm like breaking point really.' ***(Eve: a certificate midwife, previous nurse, Band 6, community, full-time)***

It was apparent that the participants who discussed their ability (or inability) to cope with work-related stress, could all do so to a certain extent. However, it was the perpetual and incessant nature of the workload and demands that felt overwhelming for many. For example, Debbie described how many midwives she knew constantly felt worried or anxious and this impacted their ability to function and remember tasks at work to achieve.

'I can see things in midwives where they don't cope, so like if they live on their nerves, you can see they live on their nerves and they're always like, [gasps] what about this, what about that, and it's just like, calm down, it's fine, it's fine, but they can't, so they live like that all the time, and then they struggle to cope with anything that's quite big.' ***(Debbie: a direct entry midwife, Band 6, hospital, 30 hours)***

'Forgetfulness as well: when I've got too much on my mind things will start to drop. I'll start to forget even simple things, even if I've written them down, and start to feel nervous all the time.' ***(Catherine: an 18-month midwife, previous nurse, community, full-time)***

Some participants had been, or knew of, colleagues who were currently off work with stress-related absences. However, one participant, Catherine described how she was able to identify how she could cope surprisingly with larger crises but not the less significant ones.

'Yes. So yes, it's that being able to cope. I find that sometimes as a midwife, you can cope with the big things, the crises, the big events but you're not as able maybe to cope with little, trivial things.' ***(Catherine: an 18-month midwife, previous nurse, community, full-time)***

Learning to cope was unattainable for many participants and for some, caused feelings of frustration, job dissatisfaction, ultimately leading to a career-related decision and consideration for a 'Time to change'. It also made some participants feel incredibly inadequate within their role. It questioned their understanding of resilience and if being resilient as a midwife was beneficial. Learning to cope was not an automatic solution for midwives and neither did it necessarily mean that they were more resilient. Rose captured in her statement the feelings of many of the participants interviewed, in relation to their reaction to coping at work.

'I struggle with resilience. Actually, I struggle with it. I think, because it, kind of, has an implication that you've got to cope with whatever anything throws at you as opposed to the fact that your reaction to things are perfectly normal.' **(*Rose: a direct entry, Band 7 midwife, hospital, full-time)***

7.7 Participants who remained and participants who left ('Midwife Leavers') experiences

An interesting observation in relation to participants' perceptions of resilience was identified between the participants who remained working as a midwife and those who had made the decision to leave the profession (midwife leavers). Although a small number of the 'midwife leavers' reported feeling that their resilience levels had no influence over their decision to leave healthcare or the midwifery profession, the majority of them did acknowledge they felt

there was a relationship between the two. For example, Claire, a midwife leaver, reported feeling vulnerable and anxious about making a clinical error prior to her handing her notice in.

'See, I think that's quite a difficult question [whether resilience had any influence over the decision to leave] to and…I think it depends on the reason for you leaving in the first…it depends why you're leaving in the first place really. I think like in my case, I left because I didn't feel…because I felt vul… [vulnerable] because I felt I was frightened to make a mist… [mistake], I was frightened I was going to make a mistake. ***(Claire: a midwife leaver)***

'So, it's really…so I think my resilience and my confidence…again it's your resilience…it's your confidence and your resilience together, isn't it, and your mental health wellbeing. I think they were massively knocked, and they were knocked when I started my role as practice nurse'. ***(Claire: a midwife leaver)***

Claire considered that her resilience levels might not have being the primary reason for her decision to leave, but the decision had been related to her feelings of not coping and stress at work.

'I don't know, I don't think so 'cause I would consider myself that I was quite a resilient person at work, and I did…but I just…I had the opportunity to not need to continue, and I could, you know, change my career. So, I, kind of, took that, but then I guess if I'm saying all the things that I maybe wasn't coping with, then my resilience to those did tire out [voices overlap] ***(Claire: a midwife leaver)***

Whereas, for Xavier and Georgina, this was different. They both felt that the resilience levels of themselves or what they had observed in their colleagues had an influence over the career-related decision which they made.

'Yeah, perhaps so. There is only me that can make the decision to what to do and I think perhaps you're right, perhaps that is a mechanism for building that resilience back up again, in knowing that, where I am. I wouldn't say that I would consider leaving the NHS, but certainly, because I'm still dual registered I would consider going back into a general

area if the right role came up'. ***(Xavier: an 18-month, midwife, previous nurse, Senior midwife, hospital, full-time)***

'So, you need staff to be resilient because if more people are leaving the profession than joining, we're not doing very well and in terms of the NHS care provision's going to go downhill because there's not the staff to do it. There was five or six of us, within a year three or four of them had quit and after handing in their notice they told the matron or labour ward manager it was due to bullying and because of that attitude'. ***(Georgina: a direct entry, Band 6, hospital midwife, working 30 hours)***

Claire, a midwife leaver made an interesting observation in relation to the midwives who had decided to leave the profession deeming them less resilient, although this was not necessarily the case, and this assumption should not automatically be made.

'I think, as well, it is a confidence thing actually leaving is quite brave and it's quite it's quite hard to do and because you get very institutionalised, and you get very. I think it used to be used as a good excuse didn't sit well, they weren't resilience, so they didn't they didn't last the course and it can almost be seen if someone isn't resilience then it's a negative on their personality, rather than how do we build our, how do we work on resilience'. ***(Claire: a midwife leaver)***

The similarities noted between the participants who decided to leave the profession and those who did not also included a lack of flexibility the workplace offered in relation to shift choice and the feeling of been unsupported at times. Donna, Melissa, and Claire all reported feeling that there was a lack of flexibility and support and contributing to the overall decision to leave for Donna and Claire.

*'….it became increasingly difficult because work became less flexible, but one time you could, kind of, organise your shifts and do swaps quite easily, change your shifts around. You could request shifts and so it meant that I could organise my childcare et cetera quite easily. That became massively harder to do towards the end where we were really struggling to juggle who picked the children up from wherever, and with***** [husband's name] working away a lot as well, so I think that it became quite inflexible'.* ***(Donna:***

midwife leaver)

'…. if we could have a job that was flexible on hours, 'cause we are pretty lucky and I know shift work has disadvantages and advantages, it works for some, it doesn't work for others. I actually like shift work, so the flexibility, the hours, the annual leave, your pension, that's all the good things. If I could have that in a different profession with the same money I'd go. I absolutely would'. **(*Melissa: a direct entry, Band 6, hospital midwife, 30 hours)***

'Yes, that was the pivotal point. And I…even all these years later I still remember that that was the pivotal point, that I just felt very alone, that I didn't feel supported through it. And so that was definitely the pivotal point. 'I think obviously I'm not going to mention any names, but I think there was a lack of support or a lack of empathy or…in terms of approachability, approaching line managers I just thought was – well, it was basically you didn't even…it wasn't up for negotiation really, I just didn't feel particularly well-supported'. ***(Claire: a midwife leaver)***

Although it is significant to highlight the similarities and differences of the participants who decided to remain in the profession and those who decided to leave, the decision for participants was multifactorial and was influenced not only by resilience but other factors such as confidence, lack of support, inflexibility, and feeling like they are no longer coping. In summary, it is evident from the perceptions of the participants in this study, that their resilience levels did influence and contribute to some of their decisions to leave; however, resilience was not the only factor that influenced this.

7.8 COVID-19 impact

As discussed in Chapter Five, COVID-19 undoubtedly had an impact on the recruitment and methods of data collection for the study, but it also had an impact on the career-related decisions made for some of the participants. For some participants, COVID-19 influenced and possibly exacerbated their feelings at the time as some reported feeling under more pressure

and had increased workload because of the pandemic. For example, Beatrice, mentions COVID-19 and how this inhibited her making progress in her role because of it.

'COVID's had a big impact on it as well you see. I've not had the chance to do things I wanted to do there.' ***(Beatrice: an 18-month midwife, previous nurse, Band 7, hospital, full-time)***

One of the midwife leavers had volunteered to support the vaccination programme at the start of COVID-19. She explained how proud she had felt to work for the NHS and offer her skills and support during this time.

'Yeah, and as soon as that door opened and as soon as I went down that route, I thought, this is what I want to do, this is…and I feel so honoured and so privileged, I cannot believe how lucky I am to have had this opportunity, it's absolutely remarkable. ***(Indigo: midwife leaver)***

'…. if that's how I end my career on the NHS, being involved in this vaccination rollout, I couldn't have wished to have ended on a more high note, it's remarkable.' ***(Indigo: midwife leaver)***

One participant, Karen, described how for her, the pandemic was the last point where she decided to no longer work as a midwife. Karen had been working on the bank until COVID-19, but then decided that it was now time for her to stop working as a midwife altogether.

'Yeah, and I was on the Bank, but then then lockdown happened……and then I've got to the point that you know I need to re-validate or I need to stop.' ***(Karen: midwife leaver)***

Similarly, Heidi, a midwife leaver, expressed her anxiety in relation to returning to work as a midwife because of the pandemic, if she was redeployed. Some previous midwives (and nurses) who had left their professions were being asked by the NMC and in public campaigns by unions (RCN 2020), to return to clinical practice to support the pressures of the pandemic.

'So, I ended up ringing XXXXXXX [matron name] and saying to her look, so I don't really know where I stand, but I'm nine years out of midwifery now and, and I'm not sure that mentally I could cope with going back onto a ward after this length of time….got by, but it was I sort of I

felt like had less for a reason and I never I never really wanted to go back into it, you know and, and I was being sort of thrown back into it'. ***(Heidi: midwife leaver)***

Memo 7.3: Interviewing challenges

Even though a number of the interviews were conducted remotely, during COVID, one potential participant postponed, rearranged, and then ultimately cancelled their interview. I was conscious of asking the participant too many times to take part in the interview as a close family member of theirs had been critically ill with COVID-19, they had had a period of self-isolating and the workload and pressures had increased because of the pandemic. I wanted to interview the participant, but I didn't want them to feel like I was pestering her and badgering her when she had personal issues that were taking precedence. This interview did not take place in the end.

7.9 Chapter Summary

Chapter Seven has presented the findings of the GT study that explored the research question *'What is the influence of resilience on midwives' and student midwives 'career related decisions'?* It has highlighted that all four core concepts are fundamental to the development of the substantive GT, 'Time to change'. The subcategories of the core concepts have also been explored in relation to the influence of resilience and the overall GT 'Time to change' and how these interrelate to this. The findings of the study have highlighted that perceived resilience levels differed depending on influential factors such as age, experience, and confidence. Those participants who had the opportunity to consider making career-related decisions often spoke of a more positive outlook and perception of their work, resilience levels, and job satisfaction than those that did not. Participants who had had the ability to reflect on their careers and the choices they made in them, were in the main, able to recognise their resilience levels fluctuating and either decide to change their role or leave the profession. The findings have also identified that for many of the participants, the ability to make career-related decisions is vital for their resilience. That said, the career-related decision was not necessarily the same for each participant, as some reported times where career-related influences, such as the negative culture, had influenced their overall perception of work and ultimately their resilience. Whilst for some of the participants who may not have been able to leverage a career move, they nevertheless attempted to consider a change, but it was constrained in some way. Chapter Eight will discuss and interpret the key findings.

Chapter Eight: Discussion of Findings

8.1 Introduction

This chapter discusses, interprets, and analyses the findings of the study presented in Chapters Six and Seven, in the context of the extant theoretical and empirical literature. The chapter will begin by examining the overall GT- 'Time to change' and how this interconnects with the four core concepts. The main body of the chapter will then present how the four core concepts all contribute to the overarching GT theory- 'Time to change'. The chapter presents the four core concepts and summarises how each of them and their associated subcategories are key to resilience in workplace socialisation, as a strategy for an optimum work-life balance, perceived support, and autonomy at work. Without these, participants found it challenging to make any career-related decisions and develop resilience.

8.2 A 'Time to change'

The GT 'Time to change' offers a deeper understanding of the influence of resilience on midwives' and student midwives' career-related decisions. Much of the literature in relation to resilience in relation to healthcare professionals has focused on the retention of staff (Glass, 2009; McGarry et al., 2013; Zander et al., 2013; Cope et al., 2014; Hodges, Keeley, and Troyan, 2008). Few studies have examined how resilience influences career-related decisions beyond intention to leave. The current study has provided novel insights into this phenomenon in the context of midwifery practice. The GT has highlighted that, overall, resilience has an important influence on midwives' and student midwives' career-related decisions. Participants in the study who had been given and/or sought such opportunities to consider a change in role were more positive towards their working lives and felt able to cope with any challenges they faced. The study findings highlighted that where midwives can have some control over the decisions, they make in relation to their career pathways, in turn, this can support and enhance their perception of their resilience levels too.

8.3 'Fitting in': the importance of resilience in workplace socialisation

The importance of resilience in workplace socialisation, represented by the core concept 'Fitting in', reflects how midwives felt about the organisation (predominantly the NHS) they worked in. Often participants reported that they did not feel a positive part of the workplace

culture particularly in certain areas such as the labour ward. For some participants, the inability to 'fit in' was a challenge, and one which negatively influenced their perceptions, experiences of the culture they worked in, and their overall resilience levels. Negative cultures and bullying practices were reported by several participants in the current study, reflecting previous findings of studies in midwifery (Hunter, Fenwick, Sidebotham, and Henley, 2019; Ball et al., 2002). For some participants in the current study, these experiences had contributed towards the midwife deciding to leave their role or the profession entirely. The two main points for discussion within this core concept were in relation to the impact of bullying in midwifery practice and the recognition for some of the participants that at certain life points, such as the peri/menopausal period these both contributed to midwives feeling less resilient.

'Fitting in' encompassed the notion of how participants had mainly referred to the negative cultures and bullying practices within midwifery practice. Participants referred to a certain environment, the labour ward, where observations of negative cultures were more apparent. Bullying and negative workplace cultures were key to the GT- Time to change' on midwives' perceived resilience; a theme not identified in the scoping review, though Hunter, et al., (2018) reported similar findings about bullying in midwifery practice becoming more ubiquitous.

There are similarities evident in the study findings and previous research exploring why midwives decide to leave the profession, such as Ball et al., (2002) and Finlayson et al., (2002). Workplace bullying in midwifery practice, sometimes referred to as Workplace violence (WPV), incivility or mobbing (Capper, Thorn, and Muurlink, 2022) is often classified behaviours targeting those of equal (horizontal) or lesser (vertical) power (Zhang and Wright, 2018). Van Fleet and Van Fleet (2022) define WPV as intentional inappropriate behaviour or unfair treatment of an individual in the workplace. Catling, Reid, and Hunter (2017) suggests that WPV is ingrained in midwifery culture whereby the future midwifery workforce is being socialised to replicate these poor behaviours (Capper, Thorn, and Muurlink, 2022). A growing body of literature, primarily from the United Kingdom, suggests that WPV in midwifery has adverse far-reaching impacts for individuals, employing organisations and the profession as a whole. The study presented in this thesis also builds upon what is already known about bullying practices in midwifery practice where participants reported not feeling like they fitted into certain 'cliques,' which again, were particularly apparent on the labour ward.

For some participants, this working culture had a negative impact on the participants' resilience as they perceived that they were not as robust, strong, or 'hardy' as the well-established midwives in these groups. Likewise, some of the participants referred to the labour ward and the midwives who worked there frequently, to be *'a particular breed.'* They highlighted that the labour ward environment and culture within it, to be more challenging for the midwives to feel included in, than any other area they worked. If bullying practices were a contributory reason for a midwife to decide to leave their role, the challenging aspect for participants was evidencing this.

These findings resonate with Silk et al., (2007) who suggests that resilience levels are not static, fluctuate at various times and are context specific (Luthar and D'Avanzo, 1999). Findings from the current study also provided further insight about the relationship between the menopause[2] and midwives' resilience levels declining. Some participants openly shared in the interviews the difficulties they had faced during their menopause and how this period had reduced their resilience levels. Interestingly, there has been little consideration of how the menopause may impact on resiliency, as the predominant focus has been on building competence and confidence (Jackson, Firtko and Edenborough, 2007). In addition, existing studies have not focussed on gender and resilience which may offer further insights relevant for the midwifery profession. In contrast, participants in the current study were asked whether they thought their resilience had developed over time and experience, and for some, they disputed this because of the menopause. Interestingly, no other significant life cycle episodes were identified by the participants in this study, it was predominantly the menopause. Participants suggested that this period in their life made them think differently about how they 'coped' with work-related stress. To assist in interpreting these findings about the menopause and resilience, Ilankoon, Samarasinghe, and Elgán (2021) suggest that this period during a woman's life can increase stress, anxiety, and depression.

Up to three in five women are negatively affected at work due to the menopause. NHS Employers (2022) reports that ten percent of women leave their jobs and many more are

[2] The menopause can be defined as a time in a woman's life (typically between the ages of 45 and 50) when menstruation stops. It is a biopsychosocial phenomenon encompassing the transition in a woman's life from being fertile to infertile (Ilankoon, Samarasinghe and Elgán, 2021, p1). It can span over a relatively long period of time, starting with the perimenopause, a transitional period prior to the menopause, where oestrogen levels begin to decrease and menopause-like symptoms, such as hot flushes, irregular periods, anxiety, mood swings and brain fog occur (NHS, 2022).

reducing their hours or passing up promotions because of their menopausal symptoms. NHS Employers (2022) goes on to highlight how it is not just a gender or age issue, as it can affect all colleagues both directly or indirectly, and for this reason it should be deemed as an organisational issue. Nearly 900,000 women in the UK left their jobs because of menopausal symptoms (UK Parliament, 2021) and unfortunately, some employees face workplace discrimination hence why further legislation protecting women going through the menopause against discrimination at work is crucial. The way that participants reported that the menopause affected their ability to manage work-related stress in the current study may reflect changes in hormones that are recognised to impact on women's mental and physical health. Though few women in the current study reported mental health problems, feelings of anxiety, stress or even depression are widely recognised as common menopausal symptoms in the wider literature (Moghani, Simbar, Fakari et al., (2018). Moghani, Simbar, Fakari et al., (2018) correlation study highlighted that during the menopause, women reported higher levels of anxiety, depression, and stress but made no reference to resilience specifically. However, there was difference and diversity evident in women's accounts in the current study. Midwives who were usually perceived as portraying resilient attributes up to this point, may cope less well with 'bouncing back' after the menopause. Strategies and support will be considered in relation to the menopause in Chapter Nine.

8.3.1 A female dominated profession

The current study generated novel insights into midwifery as a female dominated profession and its relation to resilience and career-related decisions. According to the NMC (2023) 89 per cent of people on the permanent NMC register identify as female (NMC, 2023b). Records suggest that there are only 127 male midwives on the Nursing &Midwifery Council (NMC,2023b) register in the country, with a further 67 who are registered with a dual specialism in nursing and midwifery (East Suffolk and North Essex NHS Foundation Trust, 2019). Kirkham (2001) reported that midwifery was traditionally the work of women, 'with women'. The discussions surrounding the influence that gender has on maternity provision, is not a new concept. Within the literature, midwives are often seen as an oppressed group in comparison to their male dominant counterparts. Midwives are low in the hierarchy and their position is often seen as that of *`subcontractor'* (Schwartz 1990 p. 58) to *`medicine as the engineer repairing faulty machinery'* (Littlewood and McHugh 1997 p.109). Such suggestions are relevant to the wider implications of resilience within midwifery and although the current literature reviewed in Chapter Three did not conclude if characteristics such as age and gender have any influence over one's ability to overcome adversity, it is fundamental to acknowledge in a predominantly female dominated workforce.

According to the NMC (2017a), out of 43,168 registered midwives in the UK at the end of March 2017, some 188 were men, by 2022 this figure was down to 127 (NMC, 2023b). [3] Similarly, the study showed that the age of a midwife has implications in relation to their perceived resilience levels. Although existing literature and national publications (NMC, 2017a; 2017b) have highlighted concerns in relation to an 'ageing workforce' they have not suggested whether the gender or age of midwives had any influence over the levels of perceived resilience. Due to most midwifery education programmes being delivered over a three-year period rather than an additional 18-month, to an adult nursing education, several students entering training/education for the midwifery profession are 18 years old. This contrasts with those in earlier decades where most students were at least 21 years of age when they commenced their training, having a little more time arguably, to develop resilience.

The NMC (2018a) suggests that for many of its registrants entering the midwifery profession some can lack personal growth, which fostering resilience could potentially support. Although with the evidence to suggest that resilience can be developed over time (Tempski et al., 2015), this could be taught during their education, so may not matter. This GT has demonstrated that depending on the age of a midwife, their resilience levels vary, for example, during the menopause participants perceived this to influence their overall resilience. As previously discussed, the menopause was key to how many midwives in the current study perceived their resilience and considered a 'Time to change' in their career-related decisions they made. Overall, the findings from the 'Fitting in' concept extend our existing knowledge of some midwifery environments having negative cultures and perceived organisational barriers of hierarchy for midwives; ultimately influencing participants' career-related decisions.

8.4 'Feeling in control': empowering midwives and making career-related decisions to develop resilience

[3] This equates to only 0.4% of the total. Albeit the average age of a midwife is lower than it was five years ago, the RCM (2018) published their 'State-of-maternity-services' report which highlighted that '*the proportion of midwives in their twenties or thirties has jumped from thirty-four percent in October 2010 to forty-five percent in October 2017. This equates to an extra 3,511 midwives under 40. the proportion of midwives in their fifties and sixties to twenty-eight percent to almost a third (thirty-two percent)* (RCM 2018, p3).

Key to participants' sense of perceived resilience and their subsequent career-related decisions was feeling part of the decisions that affected them at work. Midwives wanted to be consulted and listened to in relation to issues such as the way they practiced. Some of the participants reported that they felt disempowered in their work and lacked autonomy. One fundamental issue was the implementation of the CoC model which some of the participants reported their unhappiness with, mainly due to the non-consultative execution of the model (Walton, 2022). This study builds on Gillispie et al., (2007) cross-sectional survey of 1430 Australian operating room nurses concluding that five variables, including control, were associated with higher levels of resilience. Similarly, the participants in this GT study referred to wanting to be part of the decisions made at work that had a potential impact on them. For example, the relatively new and debated model of care- 'CoC' impacted the balance between the midwives' work-home lives and made them feel like they had not been listened to when changes to the way care was delivered was introduced. Grant and Kinman (2014) identify that when professionals lack control and support in the workplace is when managing situations of complexity and uncertainty then become increasingly challenging.

The RCM supports the aim of the model of CoC (RCM, 2018; RCM, 2023) and suggests it should be the central model of maternity care for women. However, some midwives working in maternity services disagree, suggesting that the model has not taken into consideration the needs of the midwives (Taylor, Cross-Sudworth, Goodwin et al., 2019). Participants raised their anxieties and concerns in relation to the continuity of care model and its relatively rapid implementation, at the time[4]. They perceived the model to be negative for them as midwives, as although there is evidence that it offers flexibility, the participants' feelings contrasted with this. Participants reported inflexibility, lack of autonomy, resentment, and disempowerment due to the changes the implementation of the CoC [4] model had had. The midwives who worked in the community setting had the most concerns in relation to the model as they anticipated that it would *'tip the balance'* between their work and home lives, which for some, they had worked extremely hard to achieve, often choosing a different environment, such as the community to establish a better work-life balance in the first place. The model was an example of where some of the participants felt that they lacked control and autonomy in relation to key decisions within their working lives.

[4] It is paramount to highlight that the latest Ockenden Review (Ockenden, 2022), has included in one of its fifteen 'immediate and essential actions' (IEAs) in relation to safe staffing levels, a recommendation that *all* Trusts must review and suspend, if necessary, the existing provision and further roll-out of midwifery CoC models. The report suggests that the reinstatement of CoC should be withheld until robust evidence is available to support its restoration.

A significant element of 'Feeling in control' was in relation to the development of resilience and how and 'who' participants felt this responsibility lies with. The findings from the participants in relation to whose responsibility it was for building and developing resilience, was not dissimilar to the literature. Sull et al., (2015) focused on who's responsibility, (the individual, or the organisation) it was for developing resilience and achieving a good work-life balance. It concluded that healthcare professionals can reduce their vulnerability to workplace adversity by developing their own personal resilience. This was also highlighted by a number of participants who were asked about developing resilience and felt it should be owned by the individual and not the responsibility of the organisation.

This study has extended knowledge and understanding in relation to how closely resilience levels are linked to how much confidence a midwife has in their practice. Similarly, Chan, Chan, and Kee's (2013) and Mallak's (1998) studies identified that having self-efficacy, self-confidence and optimism as a healthcare professional were intrinsically linked with their perceived resilience levels being higher. Gaining a balance for some midwives in relation to building their confidence levels was required. For many participants who reported confidence and resilience together, suggested that if one grows, so will the other. One participant suggested that having resilience and having confidence, *'go hand in hand,'* one helping the other. Kinman (2014) suggests that promoting students to utilise reflective practice during their programme of study alongside educators adequately preparing them for the realities of work may encourage them to be assertive in seeking out support to protect their well-being and develop the confidence (and resilience) they require for practice.

A unique finding from this study was reported by some of the participants in relation to the optimum time they considered their confidence and resilience levels to develop. Some participants suggested that on average, a period of three years after qualifying was the time they began to feel confident and resilient in their role. Prior to this, some participants reported feeling vulnerable at work and lacking confidence, skills, and resilience. There were exceptions to the perception of participants who did not feel that their confidence and resilience levels continued to grow with experience in the role. This was reported in relation to the potential impact of the menopause on some participants, which inversely affected the outcome in relation to their levels of resilience. Overall, the findings from the 'feeling in control' concept confirms existing knowledge of individuals being able to foster resilience and also extends understanding of the relationship between competence and confidence. The

participants in this study who felt that they had some autonomy over their working lives felt more resilient.

8.5 'Being valued': the relationship between perceived support, retention, and a sustainable, resilient workforce

The findings from this study in relation to the third core concept - 'Being valued' support previous studies findings (Ashby et al's 2013; Hunter and Warren 2013; 2014) in relation to professional identity and a feeling of belongingness. Participants reported that they like to feel appreciated for their contributions at work and in turn making them feel more resilient. The study also extends knowledge and understanding of building resilience as a potential remedy for the retention crisis in midwifery practice, extending the findings of Edward (2005); Perez et al., (2015); Stevenson et al., (2011); and Potter, Pion, and Gentry (2015b) who examined strategies and solutions to address the retention crisis. The findings from this study increase understanding further in relation to retention, and potential reasons for leaving the profession. Retention of midwives is a leading national concern and the responses from the participants in relation to 'being valued' in the study identified similar themes evident in the literature. The study has generated novel insights into how retention of midwives could be improved if the midwives just felt more valued at work.

Most of the previous research in relation to healthcare professionals developing their resilience levels included discussions in relation to retention, which is progressively worsening for many healthcare professionals, including midwives (Glass, 2009; McGarry et al., 2013; Zander et al., 2013; Cope, Jones, and Hendricks, 2014; Hodges et al., 2008). Indeed, 'resilience and retention' was one of the five identified themes originally highlighted in the scoping review. Although there was limited evidence in relation to retention in midwifery practice specifically, key messages from the literature were in relation to retention and building resilience as a potential solution. Findings from the study highlight that for some participants who found their resilience levels to be declining, would cause them to consider leaving the profession, or at least changing their role. Thus, highlighting the relationship between resilience levels and retention further. The literature demonstrates growing evidence with connections between emotional distress, low morale and attrition, and findings from the study confirm these themes (Ball et al., 2002; RCM, 2016a; RCM, 2015a; 2015b; Sheen, Spiby, and Slade 2015; Yoshida and Sandall, 2013). Participants reported that even when the workload was demanding, if they felt valued, especially by senior staff, they could 'cope.'

There was no single factor evident in the data to understand what 'Being valued' might resemble in practice, it differed between individuals. However, it was seen as fundamental to many participants' attitudes and overall positivity to their work, and therefore their decision to remain in their current role. One participant suggested that seeing senior staff contributing and participating with the workload during a shift and *'rolling her sleeves up'* was reassurance that they were working as hard as the clinical midwives, which made the midwives feel more valued. The sense of being undervalued and under-recognised, which some of the participants reported, also resonates with the work published in the WHELM report (Hunter et al., 2018). For example, similar themes in relation to not being valued by senior staff and managers was apparent in this study. In addition, and in contrast to the participants reporting feeling undervalued by managers, the sense of being under-valued as a profession on a national level, with the pay freezes and other lack of investment into the maternity services was also highlighted in the WHELM study (Hunter et al., 2018; Hunter et al., 2019). This study extends on a number of the themes identified in the WHELM study in relation to midwives feeling valued and supported, and when they were not, this negatively contributed to burnout, depression, anxiety, and stress (Hunter et al., 2018). Similarly, participants in this study did not refer to not being valued by others outside of their employment, the focus remained with managers and occasionally colleagues only, akin to perceived low levels of manager support found in the WHELM study.

There was a keen sense from participants that when they did not feel valued it triggered them to consider either leaving the profession or their existing role. A new finding in relation to 'Feeling valued' was highlighted by one participant, who reported that when she resigned from her substantive post but returned as a 'bank midwife,' one of the first observations she remembers was how much more she was appreciated and valued for the work she had done during that 'extra' shift. When participants in the study did not feel valued, they experienced feelings of frustration and dissatisfaction. Interestingly, participants who reported feeling valued, also felt more resilient. This is significant as it highlights the overarching GT of a 'Time to change' and how it interplays with the four core concepts, including 'Feeling valued.' If this is not possible, then some participants described questioning their professional identity and potentially considering a change in role or career decision, often because they did not feel valued. At this stage, the participants who made the decision to leave the profession recognised their perceived resilience levels having an influence on this. Unless the midwife feels valued and empowered within their role, it is not possible for them to resume job satisfaction and maintain their resilience levels.

Some participants reported feeling guilty at times when they had considered leaving their role or midwifery practice entirely. However, for some of them their sense of 'identity' was what stopped them from leaving their role. Hunter and Warren's (2013; 2014) and Ashby et al.'s (2013) studies also highlighted professional identity being key for other healthcare professionals to possess. 'Being a midwife' as something someone *is* rather than what they *do* was frequently reported and was consistent with the literature by Hunter and Warren (2013; 2014) and Ashby et al., (2013). Findings from both the study and literature that a feeling of professional belonging and passion for the job also contributed to their overall resilience. Hunter's (2014) findings described by a participant as being like *'a stick of rock'*, suggesting that being a midwife was a core part of themselves, similar to the writing woven through a stick of rock. These midwives find separating midwifery practice and their identity impossible. Similarly, Hodges, Keeley, and Troyan (2008) encompassed professional identity in the literature and placed it in a theme known as *'discerning fit'* for nurses.

The RCM (2022b) suggests that feeling valued does not just occur due to increase in pay rises. Valuing staff needs to start at the beginning, i.e., at the start of the journey to becoming a midwife. As previously highlighted, Smith (2021) concur the need to value maternity students working in midwifery. The work of Hunter (2001) suggests that to retain midwifery students, midwifery educators need to ensure that students are realistically prepared for the realities of working in the NHS as a midwife. Hunter and Warren (2014; 2015) suggests that understanding the meaning of resilience for student midwives needs embedding into midwifery programmes. Hunter and Warren (2013; 2014) propose that the development of *'resilience discussions'* need to be integrated throughout the programme. It is paramount that all staff working in maternity services, including students, feel valued at work (Hunter et al., 2018). West, Bailey, and Williams (2020) identified three core needs that need to be addressed if staff are to flourish and thrive. These included autonomy-control over work-life and being able to behave in a way that is compatible with a midwives' personal values, belonging-feeling connected to colleagues, valued, and cared for and contribution-feeling effective at work and able to do what matters. These could be the basis of the discussion workshops, and students could be encouraged to share their experiences and observations of practice to develop the core needs further.

The one independent midwife in this study offered their perceptions of not working for an organisation like the NHS. For most midwives, the NHS is the main place of work and practising as an independent midwife brings its own set of challenges (for some). However,

the independent midwife reported that they would have made the decision to leave the profession much sooner, had they worked within the restraints of the NHS. This demonstrated further how a number of participants had passion and commitment to remain in their role, and for some this was the reason they stayed.

There were some participants who however did not feel that their passion and identity as a midwife was enough for them to remain in the profession' particularly those that had been qualified for a longer period. They reminisced about midwifery and nursing no longer *'being a vocation.'* The study findings provided a sense that even the most obliging midwives had feelings of despair at times, which impacted their resilience and made them consider leaving. This was in keeping with the findings from Ball, Curtis, and Kirkham's (2013) study, where midwives found it challenging to meet both the organisational requirements and midwifery ideals. The same challenges for the participants caused them to feel guilty for not providing the care they wanted to for women, and they also felt vulnerable.

An area of interest which will warrant further research and exploration beyond the scope of this study was from one of the midwife leavers. It was contrary to most leavers who had referred to their perceived resilience levels impacting this decision, as in relation to their vulnerability. They had not left the profession because they no longer felt resilient, they had left because they felt they were repeatedly exposing themselves to risk, with short staffing levels making them feel vulnerable to something 'going wrong.'

8.6 'Getting the balance right': Resilience as a strategy for an optimum work-life balance

The concept which the participants made most reference to in the study was about 'Getting the balance right.' This was in relation to participants' ability to have an optimum work-life balance and identifying strategies to support them to achieve this. Cameron's (2010) phenomenological study with nurses, highlighted that a positive attitude and work-life balance were both important factors of resilience. Recognising the benefits of an optimum work-life balance was a key message in several previous studies which have consistently reported it as a strategy to develop resilience in other professional groups; however, few studies have been undertaken in midwifery. Grant and Kinman (2014) found that resilient practitioners were those that were able to maintain an effective work-life balance, in addition

to other qualities such as flexibility, reflective skills, social confidence and solid social networks.

The current study is the first to identify that there may be an optimum number of hours for a midwife to work to maintain their work-life balance. This was termed as the 'Golden 30 hours'. Although many of the studies within the literature were not focused on the midwifery profession, the message about maintaining an optimum work-life balance was the same.

Despite the recognised benefits of an optimum work-life balance across a range of healthcare professionals, solutions to achieve this have not been made. For example, Vesel et al., (2015) highlighted the importance of striking a work-life balance for health care workers but did not allude specifically to how to achieve this in practice. However, for participants in this study, the concept of the 'Golden 30 hours' was reported by several participants as a solution to achieve an optimum work-life balance. This ensured that they did not feel consumed by work and that there was an equal amount of time spent at work and time spent at home, undertaking activities of their choice, ultimately contributing to feelings of relaxation and less stress.

Some participants in the study reported that they had learnt how to compartmentalise at work. Understanding why they may have done this can be interpreted from a psychological perspective in relation to the origins of compartmentalisation. Aron et al., (2019) recognise that traumatic experiences can sometimes mean that individuals may compartmentalise to emotionally detach themselves. This psychological perspective is helpful for understanding why some of the participants described doing this as a protective mechanism when they were working as a midwife. Aron et al., (2019 p780) suggests that *'An individual can develop a subjective sense of 'compartmentalization' regarding a traumatic experience, which can lead to emotional detachment from the event'.* Compartmentalisation allows individuals to live with otherwise irreconcilable conflicts (Fisher, 2017). It is a common strategy that in the context of psychology, can be defined *'as a defence mechanism that we use to avoid the anxiety that arises from the clash of contradictory values or emotions*' (Ashkenas, 2012, p11). The ability to compartmentalise was seen as a key strategy to achieve a good work-life balance among some participants who reported purposely emotionally detaching themselves at times from incidents or traumatic events in the workplace.

Participants in the study who perceived they had the ability to 'bounce back' suggested that this was because they were able to compartmentalise aspects of their work as a midwife, and effectively separate personal and professional aspects of their lives. One participant defined this aptly, stating that she was able to put things *'into boxes in her head'* easily. The ability to compartmentalise is also a common coping mechanism for trauma victims such as those who have experienced traumatic events such as survivors of war and conflict, natural disasters, or sexual and psychological abuse (Ashkenas, 2012; Sanderson, 2010). For trauma victims, compartmentalising involves an individual separating or isolating thoughts and feelings in their mind. It was evident in the current study that midwives also used this approach for optimising their work-life balance and managing how they dealt with potential trauma in the workplace.

Compartmentalising is usually perceived as a positive solution to achieving an optimum work-life balance for healthcare professionals such as midwives. However, separating all issues or incidents that have occurred does not necessarily mean they should not be explored, reflected upon, and shared with like-minded other midwives, or colleagues. Findings from the current study highlighted that several of the participants were well-versed at reflecting on their practice. Interestingly, the ability to compartmentalise did not necessarily improve with age and experience for the participants; it varied at different times during participants' careers, depending on other personal factors. This is in keeping with the literature around the conceptualisation of resilience which reported that resilience levels are not static, but more of a dynamic process and one which can be developed (Masten, Schaufeli, and Leiter, 2001). Participants in the study who were in senior roles found 'compartmentalising' particularly difficult. As their responsibilities increased, the ability to separate their home and work-life decreased. This may be because they were working more than their contractual hours and 'taking their work home with them,' 'not switching off' and leaving little time for winding down and relaxing. For some participants in senior roles in this study, such as Xavier, this was an indicator that they were able to recognise that this was indeed 'burnout.'

Achieving an optimum work-life balance for midwives during the pandemic was an additional challenge. Many midwives and maternity staff felt the pandemic had a negative impact on their mental health, increasing anxiety levels, depression, and stress (Scmitt, Mattern, Cignacco et al., 2021). However, not all experiences during the COVID-19 pandemic were perceived as negative by the participants. One 'Midwife Leaver' reported how proud she was

to volunteer to support the vaccination programme at the start of the pandemic. She felt honoured to work for the NHS and offer her skills during this time. Hunter, Renfrew and Downe, (2020) also highlighted that there were some positive aspects of working reported by midwives during the pandemic; including an increased sense of pride, more time to spend with women and a general sense of comradeship. Some of the participants' responses in the study were in relation to the impact of COVID-19 on their overall perceived resilience levels and ability to maintain an optimum work-life balance during this time.

Similarities exist between the studies in relation to perceived resilience among healthcare professionals (Edward 2005; Perez et al., 2015; Stevenson, Phillips, and Anderson 2011; and Potter, Pion, and Gentry 2015a) and the findings from participants who identified needing some sources of support to deal with work-related stress; however, what this looked like was hugely different. Similar studies (Edward 2005; Perez et al., 2015; Stevenson et al., 2011; and Potter, Pion, and Gentry 2015a) also recognised that to support staff in healthcare and ultimately reduce the risk of burnout, intervention programmes, were required to support staff with the demands and stressors of the workplace. Likewise, other formal and structured strategies were identified by Kemper and Khirallah (2015) and Foureur et al., (2013) in relation to the potential benefits of mindfulness programmes being introduced for mandatory training for all healthcare staff. Although some participants did refer to organisational strategies and programmes to assist them in 'Getting the balance right,' most positive strategies and/or coping mechanisms were individual, and not institutional ones, such as going for a dog walk, exercising, or meditating. In addition, some participants referred to drinking alcohol, potentially as a maladaptive behaviour used to manage environmental or situational stressors in the workplace.

The GT offers further insight between the concepts of hardiness and resilience in relation to strategies to develop resilience. It is well-established that resilience is 'an ability to recover or bounce back from difficult situations.' Whereas hardiness can be defined as *'the ability to bear extreme conditions or difficult situations*' (Cambridge Dictionary, 2022). However, both can be used to address the unmanageable and stressful environments that continue to contribute to midwives' feelings of stress and burnout, and the ability to achieve a good work-life balance. The findings from this study are akin to Smith (2021 p16) observations regarding resilience and hardiness, suggesting that sometimes midwives feel *'they're not tough enough'* to work in maternity services.

Many previous studies have involved participants working in high acuity or critical care environments such as accident and emergency (Mealer et al., 2014; Lee et al., 2015; and Rushton et al., 2015) similar in pace and complexity to a labour ward. They found that nurses who were repeatedly exposed to stresses at work can suffer from post-traumatic stress disorder (PTSD) and burnout. The studies identified that highly resilient nurses, as defined by Mealer et al., (2012b) and Rushton et al., (2015) were less likely to have negative perceptions related to their work. Previous literature has highlighted that resilient characteristics reduce nurses' vulnerability to emotional exhaustion (Mealer et al., 2012; Rushton et al., 2015). However, a fine balance between effective resilience levels and emotional attachment appears necessary, and this was captured by participants in the study who referred to *'not getting too involved'* (in the care) and learning to *'protect themselves,'* which was perceived by some participants to develop more with experience. Participants in the current study, defined a lack of 'emotional strength' within their overall description of resilience, including feelings of exhaustion, kindness, and compassion. This relates to a previous study by Smith (2021) who highlighted that compassion is fundamental to most staff working in maternity services, although findings from the study underline why some participants found it necessary to protect themselves, developing resilience should not mean a midwife no longer has any compassion to care for women and their families.

Having an attribute of 'hardiness' as a midwife, or indeed any healthcare professional, may be regarded as dissonant with many of the fundamental values of a healthcare professional, in particular compassion. The accounts of the participants in the current study, reflected in the core concepts of 'Being valued' and 'Getting the balance right,' suggests that becoming 'hardy' as a midwife, may not be a strategy for achieving an optimum work-life balance and should not be considered akin to developing resilience. However, Hunter and Warren (2013; 2014) include the term hardiness as one of the characteristics for resilience, alongside optimism and self-efficacy. The findings from this study extends what is known about midwives' perceptions of the meaning of hardiness, with participants reporting feelings of inadequacy at times.

More relevant were the several practical and emotional strategies that participants used to achieve an optimum work-life balance. These included, walking their dog, exercise, playing music, socialising, and having a drink with friends out of work, baking and watching television. Some of the participants were also aware of counselling sessions for all staff within their trust to also access. Akin to the findings in the literature, strategies such as meditation,

yoga (Perez et al., 2015) or any coping strategies such as positive thinking to build resilience were also highlighted (Kornhaber and Wilson, 2011; DeCastro et al., 2013; Mallak, 1998). Although none of the studies were conducted in the UK which explored educational strategies and interventions to promote resilience, two qualitative studies (Reyes et al., 2015; Greenhill et al., 2015) whose findings about nursing students resonated the most with participants in the study was in relation to the description of 'pushing through', 'stepping into', and 'staying the course'. These phrases were used to describe their perception of dealing with challenges they had faced in their academic lives. They were of a similar tone to participants who described their colleagues as struggling to cope with anything *'that's quite big.'*

Many participants referred to different strategies to ensure they were addressing their self-care, for example by achieving an optimum work-life balance. However, the impact of the COVID-19 pandemic made this increasingly challenging, with fewer staff to spread the workload, putting pressures on the remaining staff to feel overwhelmed, stressed, anxious, depressed, or burnt-out (Gemine, Davies, and Tarrant et al., (2021). Not being provided regular meal-breaks, staying hydrated or simply not sleeping well are all contributory factors and described by some participants as increasing their stress levels at work. RCM guidance to support midwives' emotional well-being during the pandemic emphasised the importance of optimising well-being (Hunter et al., 2020). Similar findings to the earlier published WHELM study in 2019, (Hunter et al., (2018; Hunter et al., 2019) identified what worked to protect midwives' mental health, such as supportive relationships with colleagues, love of the work, and the capacity to give good quality care (Cull et al., 2020). The GT presented in this thesis extends this and identifies that as one of the four core concepts, 'Getting the balance right,' must be considered in order for a midwife to consider a 'Time to change'.

As noted earlier, the menopause was seen as a particularly vulnerable period for many midwives and a time where they found 'being resilient' particularly challenging. Providing opportunities for positive experiences e.g., team get-togethers was seen as important (Hunter et al., 2020). Similarly, participants who were able to identify when they felt stressed at work, relied on 'a buddy' to support them and try to improve their self-care. Overall, Hunter, Renfrew, and Downe (2020) identified that midwives' individual demographic characteristics and personal circumstances must be acknowledged. A similar finding from the current study central to the 'Time to change' theory was that midwives' levels of perceived resilience fluctuated over different periods of time, such as the menopause.

Anxieties about not feeling able to cope with the increased pressures of working in a maternity unit were common across the accounts of midwives in this study. This was reported in a comparable manner by Hodges et al., (2008) as 'learning the milieu' and 'moving through'. 'Learning the milieu' and 'moving through' were explained as learning the culture and formal and informal rules of the workplace and developing competence and confidence with skills, techniques, time management and pace of the environment. Grant and Depending on the level of experience and 'time served' as a midwife, often correlated with how the participants perceived themselves with 'learning to cope,'. This finding was akin to studies by Kornhaber and Wilson (2011); DeCastro et al., (2013) and Mallak (1998) which all highlighted coping strategies such as positive thinking to build resilience around coping and managing stress at work.

Building upon what was previously known about the benefits of reflection (NMC, 2019b), an emergent pattern in previous data were midwives who had been working fewer than twenty years being more likely to refer to their understanding and meaning of resilience in relation to learning how to effectively reflect on practice. Those who had been midwives for a longer period appeared less inclined to want to reflect on practice in a formal way but appreciated that 'talking' about a situation at work, positive or negative, had benefits too. So, although no participants had any formal training or education on developing resilience as a student midwife, they had learnt the benefits of reflective practice for becoming a more resilient practitioner. The NMC (2019b p1) suggests reflective practice *'allows you to make sense of a situation and understand how it has affected you. Reflective practice is a way for you to consider how you can put changes or improvements into action in your everyday practice'*. Overall, findings from this study about how participants use reflective practice to cope at work was in keeping to other literature. Reflection has been identified as important by other authors who have explored resilience in healthcare professions (Jackson, Firtko, and Edenborough 2007; Grafton et al., 2010) and important for building resilience. In Chapter Nine the value of reflective practice will be addressed.

The overwhelming key message from several of the participants in the study was in relation to the benefits of *less formal* support structures in the workplace, between colleagues. This is significant in respect to resilience as the findings from the study may offer insights into focusing less on a midwives' individual perceived resilience and instead supporting them to negotiate challenges in the workplace. Participants referred to their 'work-wife,' 'buddy,'

'work-family,' or 'tribe.' Identifying 'a buddy' early on in many of the participants' journeys as a midwife was seen as the pinnacle strategy, over any other, to ensure that they were able to achieve a good work-life balance. These individuals and/or small groups of colleagues were perceived by participants as critical to their ability to maintain a positive outlook in the workplace and were influential in them developing their professional resilience. Many publications such as The Ockenden Review (Ockenden, 2022) have highlighted the need for effective and collaborative team working between multidisciplinary members which are significant in maternity care. However, the less formal relationships that develop between colleagues should also not be dismissed, and participants in this study emphasised the value of these. Identifying 'a buddy' is critical to the midwives being able to move through the process of the four core concepts and ultimately reach the substantive theory of a 'Time to change'.

8.7 Chapter Summary

This chapter has discussed, analysed, and interpreted the findings of the study in relation to the four core concepts and overarching theory- 'Time to change'. The study was undertaken to further explore and develop the understanding of perceived resilience among midwives and if it influences the career-related decisions made by midwives. The study findings provide important insights about the impact of resilience which may be relevant for many healthcare professionals, including midwives. Significant similarities and some differences in relation to the existing literature have been highlighted, which build upon what was previously known about the influence of resilience among healthcare professionals. New findings have also been discussed in relation to the importance of the menopause, the 'Golden 30 hours' to achieve an optimum work-life balance, and the influence of resilience on midwives' and student midwives' career-related decisions. The study has highlighted that a range of organisational and professional factors that create workplace adversity for midwives may compromise their emotional well-being and in turn impact their overall resilience and whether they consider it 'Time to Change'.

It is apparent from this study that when midwives feel valued, empowered, part of the team and able to achieve a good work life balance, they also perceive their resilience levels in the workplace to be good. When any of the four core concepts, 'Fitting in', 'Feeling in control' 'Being valued,' and 'Getting the balance right' are threatened, then this can negatively impact the overall resilience of the midwife. Those participants who could consider changes in their role and make choices about their working lives and careers felt more resilient. Midwives

who were part of making decisions in relation to their career pathways and opportunities appeared not only happier, but also more resilient. The findings from this study have highlighted that developing individual resilience as a midwife is only one part of the remedy; the focus should be about supporting midwives to consider 'Time to change' and balance their work-life throughout their careers.

Chapter Nine: Recommendations for Practice and Areas for Future Research

9.1 Introduction

This chapter outlines recommendations for practice, and areas for future research in relation to the novel findings presented in the thesis. The central finding from the current study, represented by the 'Time to Change' theory, brings to light the important role of resilience in midwives' and student midwives' career-related decisions, including changes in role, work-life balance, and the decision to remain in the profession. The chapter is structured in eight key areas where the findings have relevance for informing midwifery practice and future research. These are:

1. Maternity staffing
2. The menopause
3. Flexible working
4. Workplace culture
5. Clinical supervision and reflection
6. Self-care
7. Student Midwives
8. Exit Interviews

9.2. Maternity Staffing

The findings from this study have contributed to understanding and acknowledging how resilience may influence midwives' and student midwives' career-related decisions and in turn, retention of staff. Participants frequently mentioned how inadequate staffing levels at work had a negative impact on their resilience levels, making it difficult for them to consider a 'Time to change'. Some participants reported that the staffing constraints added to their stress levels at work and impacted the overall quality of care they were able to provide to women. Central to the 'Time to change' GT was the increased challenges when working as a midwife, often due to a lack of staff or inappropriate skill mix where they were working. Some participants reported that a lack of staff and a lack of time to complete activities at work resulted in less time to achieve an optimum work-life balance, feel in control at work, and subsequently make career-related decisions.

Several participants in the study referred to the increased pressures in workload, which were predominantly due to lack of staff. Some participants reported that this pressure influenced their resilience levels negatively. The RCM (2022b) reports that there is a national shortage of at least 2000 midwives, and these numbers are increasing. These shortages impact the experiences of the midwives at work and the safety and quality of care for women, babies, and their families (RCM 2022b). Smith (2021) suggests that investment in adequate staffing levels is also an investment in staff well-being. However, the findings presented in this thesis suggest that it may be misplaced to focus on midwives building individual resilience to mitigate the risk of them choosing to pursue other career-related opportunities. This GT study has offered some insights into how the perceived resilience of a midwife may influence this and recommendations from the findings of this study have focused on the retention of midwives, which is paramount. Tackling retention and investing in staff to support recruitment is one way of increasing the staffing crisis in midwifery (RCM, 2021; RCM 2022b).

9.3 The Menopause

Some of the participants in this study shared their experiences of how they felt the menopause may have impacted their overall ability to cope at work, manage stress, and also influenced their resilience levels (to go down) during this time. The importance of employer awareness of the menopause and on reducing the stigma is increasingly being recognised (NHS Employers, 2022). The study's findings have emphasised that the resilience levels of midwives can be influenced by the menopause and lend support to recent NHS initiatives such as the 'Menopause Workplace Pledge' (Well-Being of Women, 2022). Recognition of the potential impact of the perimenopause and menopause for women at work is beginning to emerge in national policy, largely due to the implementation of the Equality Act, (2010) (Equality and Human Rights Commission, 2020), which protects three characteristics in relation to the menopause: age, sex, and disability discrimination (UK Parliament, 2021). Further research is required into how to effectively make workplace environments and attitudes supportive when it comes to the perimenopause and menopause (NHS England, 2020). Further research is also warranted to increase awareness of the impact of the menopause for midwives, which may consequently benefit midwives at this stage in their lives in relation to their resilience levels *and* any career-related decisions they may also make. The needs of older members of the midwifery workforce, such as those reported by some participants in relation to decreasing confidence and resilience levels could be addressed by employers making reasonable adjustments for midwives working practices.

The RCM (2024) highlights that with recent changes to the guidance on menopause in the workplace, employers will be legally obliged to do this or face disability discrimination accusations. Findings from the current study add weight to recommendations for simple strategies such as installing fans or cooling systems or amending uniform policy in order to support midwives during this time (RCM, 2024). In terms of additional recommendations to support older members of the midwifery workforce, a more a flexible approach to working patterns may also need to be considered, as addressed in section 9.4 below.

9.4 Flexible working

Flexible working arrangements were a key theme in the career-related decisions that were influenced by midwives' levels of resilience. There has been limited research focused on this topic to date, and whether it can play a part in helping mitigate attrition. Further research in this area is clearly warranted. The current study draws to attention the potential importance of achieving work-life balance in order to maintain resilience and overall well-being in midwifery practice. However, the 'Time to Change' theory demonstrates that achieving an optimum work-life balance as a midwife can be challenging. The findings support previous recommendations that midwives should be afforded more opportunities to work flexibly across their career trajectory to promote well-being and aid retention (Lindsay and May 2022). For example, the GT presented in this thesis suggests that changes to working hours or approaches to flexible working requests may be one way that midwives, may be able to establish a better work-life balance that enhances their perceived resilience. This adds weight to the recent amendment to the introduction of the right to request flexible working for employees, enabling employees to make these requests from the first day of their employment (UK Parliament, 2024).

9.5 Workplace Culture

Workplace culture, reflected in the core concept: 'Fitting in', had an important influence on midwives' resilience and subsequent career-related decisions. Participant accounts resonated with previous reports of midwives being bullied and traumatised in the workplace (Hunter et al., 2018; RCM, 2021) with labour ward cited as an environment where this behaviour was more prevalent. The current study indicates these negative experiences can influence participants' perceived resilience levels and overall ability to consider a 'Time to change'. The findings emphasise the importance of leaders acting with compassion to ensure that those compassionate cultures are created and be a role model to staff and their colleagues

(Smith, 2021). The theory developed in the current study has highlighted that providing a sympathetic environment may have a key role to play in the decisions midwives' make about their careers. Recommendations are continued efforts to tackle bullying and/or harassment in midwifery practice by strengthening equality and diversity policies in Trusts to promote inclusivity and encourage midwives who raise concerns about negative cultures to feel listened to and valued (RCM, 2022a). The findings also support Smith's (2021) recommendations that staff need to feel valued, respected, and psychologically safe, which some of the participants in this study did not always feel. However further research is necessary to fully explore the impact of toxic cultures, when it does occur, and its influence on career trajectories for midwives.

9.6 Clinical supervision and reflection

The current study has added weight to the importance for midwives to have the opportunity to discuss and reflect on their experiences and perceptions of practice. Evident across participants' accounts was the positive influence on resilience when a colleague, 'buddy' or PMA was available to discuss experiences that occur at work and how they manage these on an emotional level. Some participants in this study were aware of the role of the PMA but did not access them. A PMA is not an alternative for a 'buddy', it should be seen as an additional support mechanism for the midwife. Therefore, further research to explore the value of the role of the PMA may be fruitful. Restorative clinical supervision (RCS) should not just be exclusive to qualified staff, as there is emerging evidence to suggest that it benefits student midwives in the classroom too (Andrews, Todd, and Armato-Harris, 2023). Power and Thomas (2018) suggests that it can positively impact student experiences, reduce attrition rates, encourage the development of resilience, and foster an ethos of support. The findings from the current study suggest that opportunities for both qualified and non-qualified staff to access RCS is key to maintaining a healthy, positive, and reflective workforce. Study findings clearly highlighted the benefits and value of both informal and formal supervision for midwives. Enhancing reflective skills by introducing regular opportunities for midwives to access RCS, in groups or on an individual basis, facilitated by a PMA, may contribute to midwives fostering resilience and mitigating workplace stress.

9.7 Self-Care

The theory generated in the current study highlighted that educating midwives to practice self-care may have an important influence on their perceived resilience and may also have implications for what career-related decisions they make. Many participants were able to relate to strategies to improve or address their self-care, some being more able than others to achieve this. The well-being of midwives, both mental and physical, needs to be addressed, and although some participants in the study were aware of external support in their workplace, they also appreciated the need for self-care. Smith (2021, p26) that the practice *of 'reaching in' and routinely checking on ourselves, our family and friends and other acquaintances'* is essential to maintain a midwife's mental well-being. Working under the pressures in which midwives are reportedly working in (RCM, 2023; 2022b) is not sustainable and therefore Smith (2021) goes on to recommend that looking after oneself, primarily, should be valued and modelled by the organisation's leaders. O'Connell (2020) believes it is essential for everyone to practice self-care and it may be one way a midwife can maintain and develop their resilience. Participants in this study have highlighted the value of practising regular self-care strategies, with a number of them making reference to ways to optimise a good work-life balance. For example, self-care strategies might usefully be promoted to midwives by introducing mindfulness skills and techniques into workplace environments to benefit all staff (Grant and Kinman, 2014).

9.8 Student Midwives

Although this study only included a very small number of student midwives, many perceptions and reflections of these participants recognised and draw attention to the need to consider further strategies for improving and enhancing resilience awareness through the education of student midwives. Registered participants perceived students and some newly qualified midwives as being 'less resilient'. This has highlighted that realistic recommendations such as regular opportunities for student midwives to consider strategies which foster resilient attributes is fundamental. For example, all midwifery curriculums could ensure emphasis, and space for developing student midwives emotional resilience at all stages during their training (Grant and Kinman, 2014). Student midwives could also individually improve their overall resilience by undertaking some simple strategies throughout their programmes of study. For example, Williams, Lathlean, and Norman (2021) study identified that using conceptual models such as Wagnild and Young's (1993) (updated 2015) True Resilience Scale© can help strengthen and develop resilience of students. Midwifery educators have a responsibility to ensure that students are adequately and

realistically prepared for practice, including managing student expectations, and developing resilience to manage and adapt to some of the pressures of midwifery practice.

One recommendation arising from the current study which may further support the resilience of student midwives is the introduction of buddy systems into all midwifery programmes across the UK. Programmes could usefully draw on the Nursing & Midwifery Council (NMC) (2019a) Future Midwife Standards in Domain 5 relating to how a student midwife can be aware about incorporating compassionate self-care into their personal and professional lives and recognising signs of vulnerability in themselves and colleagues as a foundation to implement this change. Findings from this study have also highlighted the value of the 'buddy' or tribe' and, in particular, the importance of continuing with informal and formal support systems such as the 'sister scheme' (Hunter et al., 2019; Hunter and Warren, 2015) or 'buddy' once qualified are also positive solutions for increasing self-awareness and resilience. Similarly, enabling student midwives to access Group RCS sessions by embedding these into midwifery curriculums may also support students in a challenging environment. The 'Time to Change' GT suggests valuing students is key to supporting perceived resilience and therefore future research could usefully be directed to investigating this further. Similarly, exploring the 'Time to change' GT and engaging with midwives in different settings or with alternative samples of midwives would also be beneficial.

9.9 Exit Interviews

Some of the 'Midwife Leaver' participants shared their experiences of discussions they had had with managers prior to them leaving their employment, recognising a 'Time to change' was needed. These conversations often take place in an 'exit interview' (see glossary), which may determine the reasons behind why the employee had decided to leave their post. Some participants had reported that one of the reasons for leaving included bullying practices and feelings of exclusion in the workplace, but they had decided not to share this information with their managers at the time. Although they may have already made the decision to leave, this study highlights the importance for midwives to have honest conversations at the exit interview, even if the reason for leaving includes being bullied. The exit interview would be an optimum opportunity to share with the employer the real reason for leaving, although it may be a difficult conversation at the time to have.

During the interviews, the 'Midwife Leavers' discussed their experiences of their employment 'exit interview,' (if they had one), and if any senior staff asked them the reason for leaving at

the time. Often exit interviews are undertaken when an employee has already decided to resign their employment and participants reported that there was no point sharing this information, as they were leaving anyway. Some participants said they shared other reasons, such as personal ones, rather than bullying for the reasons they had decided to leave. Recommended is a strengthening of policies to ensure all midwives leaving their roles have a formal opportunity to discuss their reasons.

9.9.1 Conclusion

This chapter has discussed recommendations in eight key areas where the findings presented in this thesis have relevance for informing midwifery practice and future research. Attention has been drawn in particular to the important role of resilience in changes in role, work-life balance, and decisions to remain in the profession. The proceeding Chapter Ten concludes the thesis with a summary of its strengths and limitations.

Chapter Ten: Conclusion

10.1 Introduction

This chapter presents a conclusion to this thesis. The purpose of the chapter is to provide an overview of the study's key findings and how these have informed the GT- 'Time to change'. The chapter initially identifies the strengths of the study and then discusses the limitations. The chapter concludes with summarising how the study has strengthened an understanding of midwives' perceptions and experiences of resilience and how these influence midwives' and student midwives' career-related decisions. It concludes with last thoughts and considerations in relation to how the study can contribute to midwifery policy, practice, and education in the future.

10.2 Strengths

This thesis has presented a GT that offers new insights into the influence of resilience on midwives' and student midwives' career-related decisions. Currently there is limited research in relation to resilience and the midwifery profession and this is the first known study to consider the influence of resilience on midwives' and student midwives' career-related decisions.

As an experienced educator and midwife, personal expertise, and knowledge of the midwifery profession was undoubtedly helpful. It enabled a sensitive approach to the interviewing of the participants and an empathetic understanding for some of their meanings and explanations. It may not have been possible to do this as effectively without previous experience and understanding of the midwifery profession and cultures the participants frequently referred to. Overall, this contributed to effective interpretation of the participants' experiences and increased theoretical sensitivity.

The study stayed true to the GT methodology of Charmaz (Charmaz, 2014). It closely followed the key components of the methodology, including concurrent collection, sampling, analysis, and saturation of data. The construction of codes and categories and the use of constant comparative analysis and memo-writing were all adhered to rigorously throughout, enabling achievement of the GT- 'Time to change'. Thirty-six interviews generated a vast amount of qualitative data to code and categorise as an independent researcher. To ensure this process

was undertaken thoroughly, supervisors, at various stages during the study, provided a constructive viewpoint. Although this does not abate the limitations of conducting the study as a sole researcher, triangulation via data (collecting from various sources) was achieved and therefore this was an overall strength.

Finally, the Coronavirus pandemic in 2020 occurred midway through the study and had the potential to be a major setback during the data collection. However, this offered an alternative opportunity for the data to be collected in several ways, offering the participants flexibility and choice on how to undertake the interview, i.e., by telephone, Zoom or Facetime. This made the interviewing process for participants more accommodating, especially when maternity services the participants worked in were already under pressure. It also enabled participants to be open and honest about their experiences without the observation and potential scrutiny of the researcher.

One key strength of the study's findings is its potential contribution it has to the midwifery profession. It has identified that midwives and student midwives entering the profession are facing unprecedented challenges in the workplace which are exacerbating stress and burnout among staff. Making a career-related decision that may enhance well-being, job satisfaction, and retention of staff can provide a feasible strategy to improve the working lives and environment of the midwifery profession. The study findings have identified that midwives need to access support to help them flourish in the workplace which may include making a decision or change related to their career. If they do this, they may remain positive and feel they have the confidence and resilience to safely care for women and their families and also continue to support the midwives of the future.

10.3 Limitations

It is significant to highlight that the experiences, attitudes, and perceptions of the participants in this study are not necessarily representative of all midwives in the UK. The way that the participants have understood and perceived resilience in their workplace may not be the way that all midwives working in the UK would. Several characteristics have affected the participants' responses such as experience, age, role and working environment. In addition, the identified geographical location of the participants was potentially limiting and not transferable to all midwives. Likewise, the study did not involve any midwives who worked in

higher education, despite trying to recruit to this group, no participants volunteered. It would be useful to test the theory of 'Time to change' in other contexts and acknowledge theoretical generalisability of this study, as it was only based on a specific sample. In addition, the participants chose to take part in the study and may have already had a personal interest in the development of resilience in midwives.

There may also be limitations to characteristics and diversity of the participants. All participants who took part in the study were female, and despite identifying a male midwife to take part in the study, it was decided this may risk the anonymity of the participant and therefore was not pursued. Although the representation of the participants from this study is not dissimilar to the national picture, particularly in relation to midwives being predominantly female, the findings of the study cannot be presumed to apply to a broader context.

10.4 Conclusions and last thoughts

This thesis has strengthened the understanding of midwives' perception of resilience and how it influences their career-related decisions. Prior to this study, only a small number of studies had explored resilience among the midwifery profession. The study aimed to identify what the influence of resilience has on midwives' and student midwives' career-related decisions. It found that the resilience of an individual midwife is not static, it fluctuates at different points during a midwife's career and can be influenced by several factors. This study contributes to a growing body of evidence related to the development of resilience and healthcare professionals but specifically explores midwives' experiences and understanding of resilience and whether resilience influences the career-related decisions they make or not. Findings from this study in relation to resilience can contribute to positively improving policy, practice, and education for midwives and their career-related choices they may make. The study findings and contribution to the existing literature have the potential to be applied to other healthcare professionals and applied disciplines. The findings also highlight that informal as well as formal support structures are crucial for midwives to have an effective support network, such as 'a buddy' or 'tribe', reported by participants as someone to identify with early on in their careers.

The study findings recognised that perceived resilience is often contingent on midwives and student midwives' feeling valued, empowered, and nurtured at work. Participants were passionate about feeling valued at work and recognised they were often working in a negative culture or environment. For many, this influenced their resilience levels, as did other personal factors such as confidence, experience, age, and the menopause. Participants in the study who considered a 'Time to change' and pursue a career choice or decision felt more resilient generally, at work. The GT, 'Time to change' presented in the study, demonstrates that there were four core concepts ('fitting in', 'feeling in control', 'being valued', and 'getting the balance right') which influenced a midwife arriving at a career-related decision. In turn, the findings of the study highlighted that their career-related decision they made is likely to positively impact their resilience levels. This study provides a unique contribution to existing literature as scant research has been undertaken with midwives that specifically explores the relationship between resilience and career-related decisions midwives may make.

The GT findings in this study echo recent national findings, indicating that many midwives do not feel valued at work (RCM, 2021). Although this study highlighted that there are several effective strategies midwives can adopt to achieve an optimum work-life balance, it should not be expected by employees to be solely responsible for fostering resilience. Similar to the previously published literature, participants in this study recognised that it is the responsibility of both the individual midwife, and the employer to provide and achieve this. Participants also highlighted that they found that working a maximum of 30 hours a week was one way to maintain their work-life balance, flexibility from employers to enable this should therefore be recognised.

The midwifery profession is facing some of the most acute challenges it has ever encountered, and the retention of the midwifery workforce is a major national concern (NMC, 2023c). Many midwives feel exhausted, and burnout among midwives and all maternity staff is higher than ever (RCM, 2022b). Despite national strategies to recruit midwives, there are still many deciding to leave the profession (NMC, 2023). Cultural practices and norms are embedded in the profession, and it is acknowledged that these take a significant amount of time to alter. However, if midwives can gain some control and autonomy over their working practices and begin to feel valued this would be the start of a resilient midwifery workforce for the future. It is paramount that through changes in policy, practice, and education, midwives remain in the profession and are supported to be able to make positive career-related decisions. The

findings presented in this thesis may contribute to resilient midwives remaining in the profession.

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Appendices:

Appendix A: Better Births: Seven Key Recommendations: (National Maternity Review, 2016)

1. **Personalised care**, centred on the woman, her baby, and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.
2. **Continuity of carer (CoC),** to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.
3. **Safer care**, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong
4. **Better postnatal and perinatal mental health care**, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby, and family.
5. **Multi-professional working**, breaking down barriers between midwives, obstetricians, and other professionals to deliver safe and personalised care for women and their babies
6. **Working across boundaries** to provide and commission maternity services to support personalisation, safety, and choice, with access to specialist care whenever needed.
7. **A payment system** that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety, and choice.

National Maternity Review, (2016).

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Understanding resilience among registered health care professionals and students: a literature review protocol

Helen Joyce (Recchia), Paul Galdas, Helen Bedford, Mona Kanaan

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Review question

What is known about resilience among registered and student health care professionals?

Searches

Relevant studies will be identified through
(i) searches of electronic databases,
(ii) hand searching of reference lists of included papers.
Published literature in the following electronic bibliographic databases will be searched. CINAHL (Cumulative Index to Nursing and Allied Health Literature) Plus (EBSCO), Maternity and Infant care (Ovid), EMBASE (Ovid), MEDLINE, PsycINFO (Ovid), and AMED (Allied and Complimentary Medicine). These chosen databases encompass the major healthcare practitioner literature. A draft strategy will be developed in MEDLINE and following testing against a sample of papers, will be finalised, and adapted to run in the other identified databases. Reference lists of all included papers will be hand searched for additional studies by the lead researcher.
Restrictions to English language only papers will be applied due to limited resources available for translation. No restrictions to date of publications will be made.

Types of study to be included

The review will consider all studies covered by these databases where the focus of the paper is on resilience in registered (qualified) or student health care professionals. Studies included will explore the concept and definitions of resilience and any strategies/interventions used to develop resilience among registered health care professionals and/or students. Studies which include the relationship between workplace adversity and resilience will be included. No restrictions on the design of a study will be made; therefore qualitative, quantitative, and mixed methods will all be included. No time restrictions will be applied. Studies will be limited to those involving samples of registered (qualified) and/or student health care professionals; therefore, studies involving samples of only unregistered health care practitioners such as health care assistants will be excluded. Studies involving samples of only patients, carers or families will be excluded. Search strategies will include a combination of subject headings and keywords. The same keywords and subject headings for each database will be applied for consistency. Truncation * or $ will be applied depending on which databases. The lead researcher will contact leading authors on this subject for additional data/information on published or unpublished literature. Commentaries, editorials, position papers and reviews will also be considered for relevance by the lead researcher. The lead researcher will independently screen the titles and abstracts to identify suitability for full-text extraction. One of the co-authors will independently select a small sample of articles against the inclusion criteria to ensure consistency and risk of bias.

Condition or domain being studied

This review aims to synthesise current evidence about resilience among registered and student health care professionals.

Participants/population

Types of participants/population will include:
1. Registered (qualified) health care professionals including but not limited to doctors, midwives, nurses, allied health professionals.
2. Studies involving any registered student health professionals.
3. Participants aged 18 years or above.

Intervention(s), exposure(s)

None

Comparator(s)/control

None

Context

Resilience

Main outcome(s)

1. Establishing the existing literature about resilience among registered and student health care professionals.
2. Identifying characteristics and components associated with resilience in registered health care professionals and students. All studies must report 'resilience' as a concept.
3. Identifying what measures and interventions of resilience are available.

Additional outcome(s)

Establishing what is (if any) the relationship between resilience, workplace adversity and retention rates of registered health care professionals and students.

Data extraction (selection and coding)

Title, abstract and full paper screening will be carried out by the lead researcher and a sample will be interdependently checked by a member of the review team. This will be undertaken in two phases. The first phase will involve selecting potentially relevant papers by the title and abstract of the publication. The second phase will consist of evaluating and selecting the full-text articles. The study selection process will detail reasons for exclusion of studies that are 'near-misses.'

Risk of bias (quality) assessment

To minimise bias, the selection process will be piloted by applying the inclusion criteria to a sample of papers. This will ensure that the process can be reliably interpreted and that it classifies the studies appropriately. Appraisal of quality of the included studies will be based on tailored assessment tools appropriate for each methodology included in the literature. Any discrepancies in reviewer selections will be resolved through discussion at a supervisory meeting between lead author and co-authors prior to selected articles being retrieved. Duplicate studies will be removed by the lead researcher. Quality rating of the reviews will be reported in a table, identifying the title, author, source, location, and the database from which they were sourced. The purpose of quality appraisal will be to provide an overview of the quality of the included studies.

Strategy for data synthesis

The review will be conducted using thematic analysis. The lead researcher will identify and collate the main recurring and most significant themes in the body of literature. To ensure the final themes have emerged clearly from the literature and a transparent and robust approach has been considered, the lead researcher will engage in coding. Following the coding process themes will be developed which involve grouping the codes (Coughlan, Cronin, and Ryan, 2013). Examining possible similarities and differences between studies will enable a more critical approach when evaluating the existing evidence.

Reference:
Coughlan, M. Cronin, P. Ryan, F. (2013) Doing a Literature Review in Nursing, Health, and Social Care London: SAGE Publications.

Analysis of subgroups or subsets

None planned

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Organisational affiliation of the review

None

Review team members and their organisational affiliations

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Type and method of review

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01 August 2016

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Health Personnel; Humans; Students

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27 July 2016

Date of first submission

Stage of review at time of this submission

Stage	Started	Completed
Preliminary searches	Yes	No

Stage	Started	Completed
Piloting of the study selection process	Yes	No
Formal screening of search results against eligibility criteria	No	No
Data extraction	No	No
Risk of bias (quality) assessment	No	No
Data analysis	No	No

The record owner confirms that the information they have supplied for this submission is accurate and complete and they understand that deliberate provision of inaccurate information or omission of data may be construed as scientific misconduct.

The record owner confirms that they will update the status of the review when it is completed and will add publication details in due course.

Versions

27 July 2016

PROSPERO

This information has been provided by the named contact for this review. CRD has accepted this information in good faith and registered the review in PROSPERO. The registrant confirms that the information supplied for this submission is accurate and complete. CRD bears no responsibility or liability for the content of this registration record, any associated files, or external websites.

Appendix C: Charted findings from scoping review

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
1. Ablett (2007) UK	Resilience and well-being in palliative care staff: A qualitative study of hospice nurses' experience of work	Describe hospice nurses' experience of work, and to determine aspects of interpersonal style that enabled them to be resilient and maintain a sense of well-being whilst continuing to work with terminally ill patients and their families	Qualitative-Inter-pretative phenomenol ogical analysis	Interviews 10 palliative care nurses	10 themes that emerged from the analysis related to interpersonal aspects and to each individual's perspective of their 'job-person fit - how they described and conceptualised their work. Findings illustrate the interpersonal factors that may enable hospice workers to remain resilient and effectively buffer or moderate the stressful effects of working in palliative care --> specifically the theoretical personality constructs of hardiness and sense of coherence. Hardiness might explain some nurses' resilience at work, whereas sense of coherence explains others	Sample = homogenous group of hospice nurses	Staff training packages could be used to develop staff training and support to promote resilience, hardiness, and a sense of coherence. Those staff that are considered resilient are more likely to remain in palliative care nursing.	Professional resilience

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
2. Ashby et al. (2013) Australia	Factors that influence the professional resilience of occupational therapists in mental health practice	Sought to understand the theoretical knowledge valued and used by OT's in metal health practice.	Qualitative	18 OT's with two years' experience in mental health only 9 (2 m) ended up in study. two phases of interviews. Narrative thematic analysis	Professional resilience was linked to professional identity, expectations on OT's to work outside their professional domains and use generic knowledge and lack of validation of occupation focussed practice. For OT's professional resilience is sustained and enhanced by s strong professional identity and valuing an occupational perspective on health. Identifies the Priority model (professional resilience, identity, occupation)	Further research required to evaluate its applicability to the wider OT community. Small sample size and only one geographical location.	Greater understandin g of strategies that support professional resilience required could assist with tension. A greater understandin g can help prepare graduates to the transition to practice and increase retention.	Professional resilience
4. Cameron (2010) Australia	Enhancing resilience in registered aged care nurses	To identify the factors that impact the resilience of registered aged care nurses, and the personal strategies used by experienced RNs to manage workplace stressors	Qualitative – phenomenol ogy	Interviews 9 female RNs working in residential aged care facilities	Eight common thematic clusters relating to resilience Clinical expertise, a sense of purpose in a holistic care environment, a positive attitude and work–life balance are important determinants of resilience in aged care nurses RNs use a range of strategies to build resilience in response to workplace adversity	Sample = homogenous group of nurses	Nurses should be supported through adjustments to their workload, to undertake training which has been shown to foster resilience. Creating stronger links with universities	Professional resilience

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
					Close and intimate, long-term relationships with residents and their families foster resilience in aged care nurses Resilience is experienced when cohesive working teams, colleagues or mentors provide physical or psychological support including opportunities to self-reflect, debrief or validate as well as provide relief through humour and team camaraderie.		and hospitals including preceptorship and mentoring programs will reduce isolation.	

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
5. Chan et al. (2012) Singapore	Improving Resistance and resiliency through Crisis Intervention Training	To explore the use of a localised crisis intervention course and its impact on resistance and resiliency in the participants after 2 days training.	Quantitative	958 participants. training course and pre-and post quizzes. 74.2% females. Half of them (doctors, nurses, and allied health) had contact with patients	Overall resistance and resiliency scores improved at the end of the two-day programme from 50% to 81%for resistance and 46% to 78% for resiliency.	Not stated. However, generalisability could be an issue as study took place in Singapore.	Organisations should view training the training of employees as paramount.	Strategies and interventions

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
6. Cooke et al. (2013) Australia	A survey of resilience, burnout, and tolerance of uncertainty in Australian general practice registrars	To measure resilience, burnout, compassion satisfaction, personal meaning in patient care and intolerance of uncertainty in Australian GP registrars.	Quantitative, cross-sectional survey.	128 responses (90%)	Resilience was positively associated with compassion satisfaction and personal meaning in patient care. Resilience was negatively associated with burnout, secondary traumatic stress, inhibitory anxiety, general intolerance to uncertainty, concern about bad outcomes and reluctance to disclose uncertainty to patients.	Single item questionnaire may not be reliable. Surveys were distributed at educational events, where registrars may feel more positive towards their work compared to usual work.	Burnout has significant consequences for a doctor's own health and that of their patients.	Burnout/job satisfaction

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
7. Cope et al. (2016) Australia	Why nurses chose to remain in the workforce: Portraits of resilience	Explored why nurses chose to remain in the Western Australian workforce and to develop insights into the role of resilience of nurses and to identify the key characteristics of resilience displayed by them.	Qualitative	Portraiture. Vignettes and interviews. 9 nurses. (3 from residential aged care, 3 from academic setting, 3 nurse managers)	Eight themes were identified. Managing self, focusing on the positive, valuing social support, paying it forward (from film, undertake acts of kindness to, or for others with deliberate intent without the expectation of recompense), a passion for the profession, the taking on of challenge, experiencing adversity and growing thorough it, and leadership	Only 9 participants. Generalisable	A need for resilience-based approach to early intervention and the application of strategies for learning resilience as a key component of all curricula for all health professionals	Retention
8. DeCastro et al. (2013) Michigan	Batting 300 is good: perspectives of faculty researchers and their mentors on rejection, resilience, and persistence in academic medical careers	Explore the issue of professional rejection and academics' responses to it.	Qualitative analysis	Semi-structured, in-depth telephone interviews. 128 participants. Purposive sampling.	Responses to rejection vary. Resilience is unlikely to be an immutable characteristic. Both positive and negative elements affect resilience. Protective and vulnerability factors were identified. Good mentoring seems to bolster resilience. Differences in male and female success rates (women less).	Results not generalisable to those who have different capabilities or career focus.	Strategies such as training mentors to foster resilience may be helpful in improving faculty retention in academic medicine.	Strategies and interventions

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
9. Dyess et al. (2015) USA	Support for caring and resiliency among successful nurse leaders	To consider the practices of nurse leaders that support caring, resiliency, and ultimately, their success.	Qualitative, secondary analysis	Audiotapes, transcripts, and interviews. 20 chief nursing officers in USA of 8 states. 18 women and 2 men with average age of 56.	Successful navigation toward patient-centred solutions, through the intentional and inextricably linked living with caring and resiliency, was enhanced with practices of self-care, accountability, and reflection.	Original data were not collected in this study	A caring and resiliency model for leadership that incorporates self-care, accountability, and reflection to support attrition challenges facing nurse leaders	Professional resilience
10. Dyrbye et al. (2010) USA	Factors associated with resilience to and recovery from burnout: a prospective, multi-institutional study of US medical students	To explore how medical students who are resilient to burnout perceive their learning environment and their level of social support, and how experiences may differ between students who are resilient to burnout and those who are not.	Quantitative	1321 medical students from five institutions. Surveys	Resilient students were less likely to experience depression, had a higher quality of life, were less likely to be employed, had experienced fewer stressful life events, reported higher levels of social support, perceived their learning climate more positively and experienced less stress and fatigue than vulnerable students.	Perceptions of social support and the learning climate were assessed only at baseline. Stress, employment, and fatigue were only assessed at the 1-year follow-up. Therefore, are they causally	Further research required to explore causal relationships and determine optimal approaches to promoting student well-being.	Students and education

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
11. Edward (2005) Australia	The phenomenon of resilience in crisis care mental health clinicians	Exploring the phenomena of being resilient as experienced by crisis care mental health clinicians	Qualitative phenomenol ogical	In-depth focused, individual interviews. Six participants (5 f, 1 m). Including nursing, allied health and medicine. Mental health services.	Five themes emerged. The team is a protective veneer to the stress at work, sense of self, faith, and hope, having insight, and looking after yourself.	Study was conducted in 2003	Findings can inform organisations in mental health about the promotion of resilience in clinicians, reduce burnout and attrition.	Burnout/job satisfaction
12. Elizondo-Omana et al. (2010) Mexico	Resilience does not predict academic performance in gross anatomy	To evaluate resiliency in medical students as it relates to academic performance in gross anatomy.	Quantitative, observational study	Anonymous surveys. 113 students, 58 male and 55 female	No overall correlation between resilience score and anatomy grade, regular students with resilience scores of 75 or greater showed slightly better academic performance than their classmates. Remedial students with resilience scores of 87 or greater fared better academically. resilience does not predict academic performance in gross anatomy, and they are independent variables.	Generalisabilit y of medical students in Monterrey Mexico.	The design of new educational strategies to enhance student success is required.	Students and education

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
13. Foureur et al. (2013) Australia	Enhancing the resilience of nurses and midwives: pilot of a mindfulness-based program for increased health, sense of coherence and decreased depression, anxiety, and stress	Aim to pilot the effectiveness of an adapted mindfulness-based stress reduction intervention on the psychological wellbeing of nurses and midwives.	Mixed methods approach	Pilot study. Using a pre and post intervention study design and one-on-one interviews or focus group. Convenience sampling of 20 nurses and 20 midwives from 2 hospitals in NSW.	Quantitative findings showed significant improvements on the GHQ-12, SOC, and the stress sub-scale (DASS). Qualitative findings support the acceptability of the intervention, and highlighted a number of issues related to feasibility of any future RCT.	Relatively homogenous group and self-identified	Need for an RCT. Mindfulness required to the support of healthcare staff.	Strategies and interventions
14. Gillespie et al. (2007) Australia	Resilience in the operating room: developing and testing of a resilience model	To examine the relation of perceived competence, collaboration, control, self-efficacy, hope, coping, age, experience, education, and years of employment to resilience in operating room nurses.	Quantitative, cross-sectional survey	1430 (772 completed, 53.9% response rate) Australian operating room nurses, random sampling. Questionnaires.	Resilience model suggested hope, self-efficacy, coping, control, and competence were found to explain 60% of the variance in resilience in operating room nurses. Highly statistical association between hope and self-efficacy and resilience.	Response rate (just over half)	introduction of stress management programmes on teaching coping strategies to foster resilience. Programmes to identify nurses 'at risk'. Promotion of five behaviours may retain	Strategies and interventions

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
							nurse in this field?	
15. Gillespie et al. (2009) Australia	The influence of personal characteristics on the resilience of operating room nurses: a predictor study	to quantify resilience and to identify the level of resilience and investigate if age, experience, and education contribute to resilience in Australian operating room nurses.	Quantitative, predictor study	A predictive survey design. A random sample of 1430 operating nurses. Connor-Davidson resilience scale	Resilience is not necessarily dependent on nurses' age, experience, and education. Study suggests other variables that may also be correlated with resilience need consideration.	response rate (just over half) 53.9%, difficult to generalise results. Relied on self-report survey	Recruitment of nurses in the operating room should not be based exclusively on age and experience as these are not necessarily indicative of ability to cope with stressors.	Professional resilience
16. Glass (2009) Australia	An investigation of Nurses' and Midwives' Academic/Clinical Workplaces	To investigate the significance of hope, resilience, and optimism to nurses' and midwives' practice and responsibilities and the degree to which hope, resilience, and optimism were implemented in their work environment.	Qualitative, ethnography.	Three sites, 20 participants (18 f, 2 m), participant observation, semi-structured conversational interviews, and art-based and written reflections.	Thematic analysis. Hope and optimism were considered min components of resilience. Use of personal and professional resilience was identified as integral to intrapersonal strength, personal growth, and concurrent job satisfaction. Developed a strategic model with 3 components. 1. understanding persuasive nature of hope, optimism, and resilience, cognitively reframing views on self in workplace, drawing on psychological flexibility, adaptability, and emotional intelligence and grounding	Small study in Australia.	If nurses and midwives are not nurtured and respected there will not be a future workforce.	Retention

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
					positive connections with friends and the environment.			
17. Greenhill et al. (2015) Australia	Towards an understanding of medical student resilience in longitudinal integrated clerkships	To address gap in literature by developing a conceptual framework for student resilience in a LIC curriculum.	Qualitative, interpretive approach	In-depth interviews with a purposive sample of 19 medical students, professional staff, and clinician teachers.	Longitudinal integrated clerkships (LIC) experienced adversity during the first clinical year of medicine due to challenges in learning environment. This distress was found to be moderated by a secure, supportive environment, profound learning journey and utilisation of organisational structures to stay on course. (Flinders Model of Resilience).	Small sample size and recruitment from one university program only. Reliance on the students' self-reported level of resilience	Use of this model for students to help build resilience through continuity of relationships, providing guidance in their learning and reinforcing their personal growth.	Students and education
18. Haglund et al. (2009) New York	Resilience in the third year of medical school: a prospective study of the associations between stressful events occurring during clinical rotations and	aimed to prospectively measure stressful events medical students encounter during their first year on clinical rotations and to investigate both the acute and cumulative impact of these events on students' psychological well-being.	Quantitative	Surveys (paper or online) conducted at Mount Sinai school of medicine. 125 third year medical students	Trauma exposure was positively associated with personal growth at years' end. Exposure to other stressful events was positively associated with endpoint levels of depression and other stress symptoms.	Unreported stressful events as many students did not complete monthly surveys. Timings of collecting data were only monthly. Clinical impact of the risk and resilience factors identified as	How to better prepare students for clinical placements? Significance of good support systems in education for students.	Students and education

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
	student well-being					potentially relevant to mental health outcomes at the end of the third year may be limited.		
19. Hodges et al. (2005) USA	Professional resilience, practice longevity, and Parse's theory for baccalaureate education				Parse's human science theory, the Human Becoming School of Thought, is a fitting theoretical framework for a model of teaching-learning for undergraduate baccalaureate nursing education. In addition, as a theory of dynamic relational synchrony, Parse's work provides an appropriate framework with which to promote professional resilience and career longevity by purposefully engaging students within student-faculty dyads to explore personal meanings and philosophies of caring, and to create strong professional identities.			Professional resilience

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
20. Hodges et al. 2008) USA	Professional resilience in baccalaureate-prepared acute care nurses: first steps	to explore the nature of professional resilience in new baccalaureate-prepared nurses in acute care settings and to extrapolate pedagogical strategies that can be developed to support resilience and career longevity.	Qualitative	Hybrid model of concept development. In-depth semi-structured interviews, observation, and narrative description. Purposive and network sampling with 11 BSN nurses (10 f). Aged between 23-31 in a south-eastern city of US.	Findings revealed a common process of evolving resilience among participants. Three major themes 1. learning the milieu (learning the culture-people, formal and informal rules) and learning RN skill sets (techniques, time management, and pace). 2. Discerning fit (sensing discrepancies and reconciliation). 3. Moving through (turning points and street smarts).	Study age (2008). Generalisability of findings as US	To develop intentional teaching and support strategies that foster professional resilience behaviours and career longevity	Retention

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
21. Hsieh et al. (2016) Taiwan	Factors of Resilience in Emergency Department Nurses Who Have Experienced Workplace Violence in Taiwan	To examine and confirm that two forms of social support and religious belief affect individuals' resilience and personality traits are predictive factors for resilience in abused ED nurses.	Quantitative, cross-sectional survey	Structured questionnaires, convenience sampling. 265 participants from the medical centre and three regional hospitals in Taiwan.	Higher degrees of extraversion and peer support were associated with greater resilience among all abused nurses, neuroticism was inversely associated with their resilience.	A few eligible nurses did not participate which may have led to underestimation of the violence rates. Self-reporting and cross-sectional	Health managers should provide and enhance peer support to intensify their resilience for prevention of consequences of workplace violence.	Professional resilience
22. Hunter and Warren (2014) UK	Midwives' experiences of workplace resilience	To explore clinical midwives' understanding and experience of professional resilience and to identify the personal, professional, and contextual factors considered to contribute to or act	Qualitative, descriptive study	Thematic analysis online closed, discussion group. 11 midwives.	Four key themes identified. Challenges to resilience, managing and coping, self-awareness and building resilience. Particular attention given to 'critical moments' in a midwives career when they are vulnerable to workplace adversity.	Small self-selected sample of UK only midwives with 15 years' experience. No demographic data were obtained.	Study highlighted strong sense of professional identity for building resilience. Building resilience by education and supervision.	Professional resilience

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
		as barriers to resilience.						
23. Ingham et al. (2013) UK	An initial evaluation of direct care staff resilience workshops in intellectual disabilities services	Examines whether a brief workshop that aims to develop resilience within care staff through addressing unhelpful cognitions and negative emotions is associated with a shift in emotional response to the individual staff who are supporting and also shifts in job-related factors such as burnout.	Quantitative	A naturalistic, pre-post design. Workshops undertaken by 37 staff working with people with intellectual disabilities.	The workshop was associated with a significant reduction in negative emotional responses experienced by direct care staff in relation to challenging behaviour. It was not associated however with changes in burnout.	Similar workshops may support staff in helping reduce staff stress and improve client outcome within the context of the model.	Need for a controlled trial	Burnout/job satisfaction

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
24. Kemper and Khirallah (2015) USA	Acute Effects of Online Mind-Body Skills Training on Resilience, Mindfulness, and Empathy	1. will health professionals and trainees enrol in free elective online MBST and complete at least 1 hour of training? How do online MBST enrolees' score on standard measure of stress, resilience, and burnout compare with previous studies? 3. Are there any acute changes associated with completing a 1-hour online module in enrolees' stress, mindfulness, resilience, or empathy?	Prospective cohort study	(online programme) 513 dieticians, nurses, physicians, social workers, clinical trainees, and health researchers- about a 1/4 were graduate trainees in health professions.	Four major findings. MBST was popular; enrolment occurred among diverse health professional and trainees. Participants reported high levels of stress and burnout, suggesting that the training was attractive to those who might benefit from it. Most popular modules include not just mindfulness, but a variety of mind-body skills, including relation and completing even brief 1-hour modules online outside of a group setting was associated with significant acute improvements in stress, empathy, resilience, and mindfulness.	Needs replicating in community settings elsewhere. Even larger sample size is required to determine differences between professions and trainees. Did not randomize participants and no control group so may be self-selection bias, limiting generalizability .	Further research required to compare long-term effectiveness of online and in-person mind-body skills training	Strategies and interventions

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
25. Kemper et al. (2015) USA	Are Mindfulness and Self-Compassion Associated with Sleep and Resilience in Health Professionals ?	To describe the relationship between trainable qualities (mindfulness and self-compassion), with factors conceptually related to burnout and quality of care (sleep and resilience) in young health professionals and trainees	Quantitative, cross-sectional survey	Large Midwestern academic health centre. 213 clinicians and trainees 73% were female; 76% were trainees. Dieticians, nurses, physicians, social workers, others	Sleep disturbances were significantly and most strongly correlated with perceived stress and poorer health, but also with mindfulness and self-compassion. Resilience was strongly and significantly correlated with less stress and better mental health, more mindfulness, and more self-compassion.	Self - selected participants. No control group therefore cannot establish causality, and inferences about whether training in mindfulness or self-compassion can positively affect sleep or resilience. Study measured dispositional mindfulness by standard measure only.	Further studies needed to determine whether training to increase mindfulness and self-compassion can improve clinicians' sleep and resilience or whether decreasing sleep disturbance and building resilience improves mindfulness and compassion.	Burnout/job satisfaction

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
26. Kim and Windsor (2015) Australia	Resilience and work-life balance in first-line nurse manager	To explore how first-line nurse managers constructed the meaning of resilience and its relationship to work-life balance	Qualitative, grounded theory	20 first line nurse managers. In-depth interviews in 6 hospital in Korea.	Participants perceived work-life balance and resilience to be shaped by dynamic, reflective processes. Features consisting of resilience included positive thinking, flexibility, assuming responsibility, and separating work and life.	Average number of years of career experience and therefore cannot be generalised to new first-line managers	Institutional support should be prioritised to promote work-life balance for nurses.	Professional resilience
27. Kjeldstadli et al. (2006) Norway	Life satisfaction and resilience in medical school--a six-year longitudinal, nationwide, and	Examined the relationship between life satisfaction among medical students and a basic model of personality, stress, and coping.	Quantitative, longitudinal	Questionnaires 421 students, 375 response rate (high), 54% women. Four Norwegian universities	Life satisfaction decreased somewhat during medical school. In final year level of study satisfaction was lower than that of other comparable students.	Employment as a single outcome measure, which may reduce reliability of responses.	Stress management courses should be considered at medical school	Students and education

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
	comparative study							
28. Kornhaber and Wilson (2011) Australia	Building Resilience in Burns Nurses: A descriptive phenomenol ogical inquiry	To explore the concept of building resilience as a strategy for responding to adversity experienced by burns nurses.	Qualitative, phenomenol ogical	In-depth individual semi-structured interviews (7 participants, all female) using open-ended questions. Conducted in six-bed burns unit in large acute care public hospital, Sydney.	Six categories identified. Toughening up, natural selection, emotional toughness, coping with the challenges, regrouping, and recharging, and emotional detachment. Findings demonstrate it is vital for burns nurses to build resilience to endure the emotional trauma of nursing patients with severe burn injury.	Cannot be generalised. All female, small study. Possibility of researcher bias.	Knowledge about building resilience could be incorporated into nursing education for both undergradua te and experienced nurses. Potential implications for retention.	Strategies and interventions

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
29. Laschinger et al. (2013) Canada	Workplace Incivility and New Graduate Nurses Mental Health: The Protective Role of resiliency	To examine the relationships between co-worker, physician, and supervisor workplace incivility and new graduate nurses' mental health and the protective role of personal resiliency	Quantitative, longitudinal	Survey consisting of 3 standardised questionnaires to newly graduated nurses in acute care hospitals across Ontario.	Workplace incivility had a negative effect on new graduates' mental health and resiliency appeared to have a protective effect. Study confirms workplace incivility to lower workplace well-being.	Generalisability of study in Canada	Nurse management need to eliminate negative behaviours to assist transition for new graduates	Professional resilience
30. Lee et al. (2015) USA	Promoting staff resilience in the paediatric intensive care unit	To describe the availability, use and helpfulness of resilience-promoting resources and identify an intervention to implement across multiple paediatric intensive care units.	Quantitative, descriptive study	Voluntary, anonymous surveys completed by 1066 leadership teams from 20 paediatric intensive care units at 84 member institutions. 51% response rate.	The two lost useful and impactful resources were 1-on-1 discussions with colleagues and informal social interactions with colleagues out of hospital. Utilisation an impact of resources differed significantly between professions, between those with higher versus lower resilience, and between individuals in units with lower versus high teamwork climate.	Survey not previously tested for validity and reliability. Study measured staff members resilience but not their underlying stress or burnout symptoms. Speculate about causality only.	Institutions could facilitate access to peer discussions and social interactions to promote resilience	Strategies and interventions

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
31. Mache et al. (2014) Germany	Exploring the impact of resilience, self-efficacy, optimism, and organizational resources on work engagement	To examine relations between personal and organisational resources as essential predictors for work engagement of German health care professionals	Quantitative, cross-sectional	320 questionnaires sent to physicians. 223 (69,7% return rate) in five hospital departments in Germany.	Resilience, participation, and influence at work are significant predictor of work engagement. Significant relations between physicians' personal strengths (e.g., Resilience and optimism) and work engagement were evaluated. Work-related factors showed to have a significant influence on work engagement. Differences with socio-demographic variables were also found.	Measurement bias due to self-reporting. Cannot imply cause and effect between independent and dependent variables	Hospital management /admin should provide more resources to enable health professionals to become more engaged in their work.	Professional resilience
32. Mallak (1998) USA	Measuring resilience in health care provider organizations	Explores the development and testing of several scales designed to measure aspects of resilience in the health care provider industry.	Quantitative	Surveys. pre-tested on 50 graduate students enrolled on master programme at a Midwestern US university. Nursing executives in Michigan hospitals.	Six factors were found including: goal-directed solution seeking, avoidance, critical understanding, role dependence, source reliance and resource access.	Reliability and validity of the scales in other settings	These factors can be used to begin to design interventions targeted at producing a more resilient workforce	Strategies and interventions

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
33. Matos et al. (2010) USA	An exploratory study of resilience and job satisfaction among psychiatric nurses working in inpatient units	Examine the relationship between resilience and job satisfaction among psychiatric nurses	Quantitative, descriptive, correlational	Approx. 69 (32 in study) psychiatric nurses working in in-patient units in a large, urban medical centre, New York. 81.2 % in study were female	The nurses reported a high level of resilience and high job satisfaction. Job satisfaction subscale of professional status had the highest mean rating, and the physician-nurse interaction subscale had the lowest mean score.	Small sample size, the single site for data collection, and the cross-sectional nature of the study.	Nurses who are positive about their professional status are more satisfied in their professional work. With shortages it is paramount to identify ways to enhance personal growth and professional and work satisfaction among nurses.	Burnout/job satisfaction
34. McDonald et al. (2012) Australia	A work-based educational intervention to support the development of personal resilience in nurses and midwives	Aiming to develop, strengthen and maintain personal resilience among nurses and midwives.	Qualitative	Workshops. Women and children's health service. 14 nurses and midwives, all female aged between 26 and 59.	Post-intervention participants reported positive personal and professional outcomes, including enhanced self-confidence, self-awareness, communication, and conflict resolution skills. Also, intervention used new ways of engaging nurses and midwives exhibiting the effects of workplace adversity-fatigue, pressure,	Potential for the changes predicted pre-intervention to be observed.	Possible to learn the skills and knowledge requisite for personal resilience through a work-based, educational programme.	Professional resilience

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
					stress, and emotional labour.			
35. McDonald et al. (2013) Australia	Personal resilience in nurses and midwives: effects of a work-based educational intervention	Aim to devise, implement, and evaluate a work-based educational intervention to potentially enhance resilience and provide protection against workplace adversity.	Qualitative, case study	Instrumental collective case study. 14 participants. Nurses and midwives (all female) in a women's and children's health service in a large, tertiary referral hospital in Australia. Face-to-face semi-structured interviews.	Three major themes emerged in relation to the intervention. Personal gains from resilience workshops; professional gains from workshops; and personal resilience initiatives. Sub-themes included an experiential learning opportunity, creative self-expression, exposure to new ideas and strategies, increased assertiveness at work, improved workplace relationships and communication, increased collaborative capital and understanding self-care practices.	Self-selected participants. Inter-subjectivity during intervention as researcher was the group facilitator of workshops.	Work-based educational interventions that focus on personal resilience have significant potential to empower clinicians and students to with stand workplace adversity.	Professional resilience

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
36. McGarry et al. (2013) Australia	Paediatric healthcare professional relationships between psychological distress, resilience, and coping skills	To investigate the impact of regular exposure to paediatric medical trauma on multidisciplinary teams and the relationships between psychological distress, resilience, and coping skills.	Quantitative	Paediatric staff working with children with severe acquired brain injury in a tertiary hospital. 68 eligible staff (54 agreed) to participate. Tools and questionnaires.	Findings demonstrate that the use of functional coping strategies had a greater influence on the individual health professional's psychological wellbeing compared with a variety of other key factors. Cumulative exposure to paediatric medical trauma places health professionals at risk of developing more symptoms of STS and burnout while having less resilience and compassion satisfaction than general population samples.	No control group. Cross sectional design means that conclusions cannot be drawn about the causal direction of identified relationships highlighting need for longitudinal research.	Study should help develop organisational systems to facilitate optimal mental health and coping strategies in health professionals reducing sick leave, absenteeism, early retirement, and staff turnover.	Retention
37. Mealer (2014)	Feasibility and acceptability of a resilience training program for intensive care unit nurses	To determine if a multimodal resilience training program for ICU nurses was feasible to perform and acceptable to the study participants.		12-week intervention study. Included a 2-day educational workshop, written exposure sessions, event-triggered counselling sessions, mindfulness-	Both nurses randomized to the treatment group and nurses randomized to the control group showed a significant decrease in PTSD symptom score after the intervention.		A sufficiently powered, randomized clinical trial is needed to assess the effect of the intervention on improving individuals' level of resilience and improving psychological	Strategies and interventions

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
				based stress reduction exercises, and a protocolized aerobic exercise regimen.			outcomes such as symptoms of anxiety, depression, burnout syndrome, and PTSD.	
38. Mealer et al. (2012a) USA	A qualitative study of resilience and posttraumatic stress disorder in United States ICU nurses	To identify mechanisms employed by highly resilient ICU nurses to develop preventative therapies to obviate the development of PTSD in ICU nurses.	Qualitative, constructivist epistemological	Semi-structured telephone interviews. 13 ICU nurses resilient nurses and 14 nurses with PTSD.	Data analysis identified four major domains: worldview, social network, cognitive flexibility, and self-care balance, highly resilient nurses identified spirituality, a supportive social network, optimism, and having a resilient role model as characteristics used to cope with stress in their work environment. Those with PTSD had several unhealthy characteristics such as lost optimism, regret, poor social network.	Self-selected participants. Did not ensure ethnic and gender diversity. Convenience sample may bias findings.	Can be used to develop resilience training programs to help improve the work environment and ameliorate symptoms of PTSD in future nurses.	Professional resilience
39. Mealer et al.	The presence of resilience is associated with a	To determine the prevalence of resilience in ICU nurses and to	Quantitative	National survey. 3500 randomly selected ICU	The presence of psychological resilience was independently associated with a lower prevalence of	Relative racial and gender homogeneity	Because resilience can be learned, education	Burnout/job satisfaction

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
(2012b) USA	healthier psychological profile in intensive care unit (ICU) nurses: results of a national survey	determine whether its presence is associated with fewer psychological symptoms.		nurses. 1239 returned with a response rate of 35%.	posttraumatic stress disorder and burnout syndrome in ICU nurses. Resilience may serve as a protective mechanism to prevent symptoms associated with psychological disorders related to a stressful ICU work environment.		programmes for ICU nurses may result in fewer distress symptoms, improved job satisfaction, and potentially decrease the high turnover rate for IC nurses.	
40. O'Connor and Batcheller (2015) USA	The Resilient Nurse Leader: Reinvention after experiencing job loss	1. How has unexpected job loss affected the personal and professional lives of the nurse leader? 2. What strategies can the nurse leader employ to reinvent her or his professional career?	Qualitative, descriptive study	12 in-depth interviews (2 face-to-face and 10 by phone) of the experience of nurse leaders who underwent unexpected job loss.	Thematic analysis. Including the grief stages of denial and anger; and recovery and reinvention of the self and the career. Most of the CNOs who were interviewed experienced job loss and had a sense of loss from their experience. They all demonstrated resilience.		Helpful to share experiences to support others	Professional resilience

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
41. O'Connor and Peyton (2015) Australia	Mindfulness for resilience-a self-care strategy for staff working with emotionally distressed individuals	Participants were trained to use mindfulness techniques with the aim of helping them to find ways to be calm during times of stress and distress, develop self-awareness in challenging situations, and develop and practise resilient mind habits and behaviours, in their work and personal life.	Pilot project	28 participants started the programme: attendance at programme/training and follow-up questionnaires. Completed by 82% palliative care staff	Three dominant themes emerged. The impact on personal life, the management of work; and approaches to work. Participants found that the mindfulness training programme benefited them in their personal lives as well as in their management of, and approach to, work.	Part of a quality improvement project. No ethical approval obtained.	Regular training required such as mindfulness to in-house management sessions	Strategies and interventions
42. Olson et al. (2015) USA	What factors promote resilience and protect against burnout in first-year paediatric and medicine-paediatric residents?	To test a conceptual model that defined selected factors that are related (and maybe causative) to burnout in first year paediatric and medicine residents.	Quantitative, cross-sectional survey	Questionnaires. 45 first year paediatric/ medical residents	Physical empathy and emotional intelligence were not significantly correlated with burnout or resilience. Self-compassion and mindfulness were positively associated with resilience and inversely associated with burnout.	Only one paediatric residency sample, results cannot be generalised to other training programmes	Training for mindfulness and self-compassion in trainees/students.	Students and education
43. Peng et al. (2012) China	Negative life events and mental health of Chinese medical students: the	To test the moderating effect of resilience on negative life events and mental health	Quantitative, cross-sectional design	Questionnaires. 1998 Chinese medical students	Key findings suggest that resilience moderated the relationship between negative life events and mental health problems. Negative events, personality	Population group still needs to be verified in other groups. Only cross-	Promoting resilience may be helpful for the adjustment	Students and education

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
	effect of resilience, personality, and social support	problems in medical students.		(849 m, 1149 f)	traits, social support, and resilience were all found to be related to mental health problems among Chinese medical students.	sectional design. Possible under-reporting due to self-reporting	of college students.	
44. Perez et al. (2015) USA	Promoting resiliency among palliative care clinicians: stressors, coping strategies, and training needs	To explore common stressors, coping strategies, and training needs among palliative care clinicians in efforts to inform the development of a targeted resiliency program.	Qualitative study	15 in-depth semi-structured interviews (face-to-face). Nurse, social workers, physicians	Three main areas of stressors. Systematic challenges related to managing large, emotionally demanding caseloads within time constraints, patient factors, e.g., Managing family dynamics and meeting expectations and personal challenges of delineating emotional and professional boundaries. Common methods of coping with stressors were engaging in healthy behaviours and hobbies and seeking support from colleagues and friends.	Only one medical institution included in study. Convenience sample, findings limited in generalizability .	Implications aimed at targeting distress and promoting resilience among palliative care clinicians	Burnout/job satisfaction

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
45. Pietrantoni (2008) Italy	Resilience among first responders	Examined the resilience factors that protect mental health among first responders.	Quantitative, cross sectional	Survey. 961 first responders. On-line questionnaires	Was predicted by self-efficacy, collective efficacy and sense of community, compassion satisfaction was predicted by self-efficacy and sense of community. First responders reported high level of compassion satisfaction and low level of burnout and compassion fatigue. Compassion fatigue was predicted by self-efficacy, burnout Self-efficacy and sense of community could be considered resilience factors that preserve first responders' work-related mental health.	Cross-sectional methodology precludes any inference of causality. No qualitative methodology and resilience is a multidimensional construct	Need for interventions aimed at the promotion of resilience factors	Burnout/job satisfaction
46. Pines et al. (2012) USA	Stress resiliency, psychological empowerment, and conflict management styles among baccalaureate nursing students	To examine relations of stress resiliency, psychological empowerment, selected demographic characteristics (age, ethnicity, semester in school) and conflict management styles of baccalaureate nursing students	Quantitative, a correlational design	Private Hispanic-serving university. A convenience sample of 171 generic nursing students and freshmen pre-nursing majors in six courses	Empowerment scores were significantly correlated with stress resiliency scores. Students with high scores on empowerment had high scores on the skill recognition subscale of the stress resiliency profile, suggesting more resilience; high scores on empowerment were related to high necessitating subscale scores of the stress profile suggesting a predisposition to stress.	Low reliability of the PEI. Generalisability of the findings due to convenience sample.	Neuman systems model may provide guidance for educators to strengthen student nurses' management of stressors in the workplace	Students and education

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
47. Pines et al. (2014) USA	Enhancing resilience, empowerment, and conflict management among baccalaureate students: outcomes of a pilot study	What are the pre and post differences in perceptions of resiliency, psychological empowerment, and conflict management style among a sample of UG nursing students who participated in simulated training exercises to manage intimidating and disruptive behaviours of others. What is the relationship of selected attribute characteristics of UG nursing students and perceptions of resiliency, psychological empowerment, and conflict management style?	Quantitative, quasi-experimental	60 undergraduate nursing students. Small private, faith-based university in south-west United States.	Integration of conflict resolution skills throughout the curriculum, with repeated opportunities to practice using a variety of styles conflict management in relation to situational factors, may be beneficial to prepare students for the challenges of modern healthcare.	Relatively small sample size may have reduced the power. Intervention may not have been robust enough or contained sufficient repeated doses to change ways of thinking	Conflict resolution training recommended in training programmes	Students and education

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
48. Potter et al. (2014a and b) Mid-Western USA	Compassion fatigue resiliency training: The experience of facilitators	Describes the facilitators' perceptions of the effects of participating in a compassion fatigue resiliency training program.	Qualitative, phenomenological evaluation	13 oncology nurses. 15 of 25 staff members who completed facilitator training programme submitted narratives.	Long-term benefits identified. Both burnout and secondary traumatic stress levels decreased during the 6 months following the program. Three key symptoms of compassion fatigue (avoidance, hyperarousal, and intrusions) also decreased significantly in the 6 months following the program.	Small study.	Programme offers many indirect benefits to large healthcare organisations, retention, patient satisfaction, fewer medical errors, and improved staff morale.	Burnout/job satisfaction

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
49. Reyes et al. (2015) Canada	Nursing students' understanding and enactment of resilience: a grounded theory study	Explore nursing students' understanding and enactment of resilience.	Qualitative-CGT	Interviews 38 nursing students (4 males, 34 females)	Grounded theory of 'Pushing through' which represents nursing students' understanding and enactment of resilience = based on competing demands of nursing programme and the students' extracurricular demands family commitments, social pressures and outlets, leisure pursuits, self-care, and well-being)	Participants came from only one university/majority female and white	Findings highlight significance of integrating the topic of student resilience into the nursing curriculum	Students and education
50. Rushton et al. (2015) USA	Burnout and resilience among nurses practising in high-intensity settings	To support creation of healthy work environments and to design a 2phase project to enhance nurses' resilience while improving retention and reducing turnover.	Quantitative, cross-sectional survey	114 nurses in 6 high-intensity units	Association between burnout and resilience was strong. Greater resilience protected nurses from emotional exhaustion and contributed to personal accomplishment. Higher levels of resilience were associated with increased hope and reduced stress. Physical	114 of 180 (63%) were enrolled from a single health system. Different results may have occurred on different geographical locations and other health care systems.		Burnout/job satisfaction

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
51. Shi et al. (2015) China	The mediating role of resilience in the relationship between stress and life satisfaction among Chinese medical students: a cross-sectional study	to investigate related demographic factors of life satisfaction among Chinese medical students, to examine the relationship between stress and life satisfaction and to explore the mediating role of resilience in this relationship	Quantitative, cross-sectional survey	Self-reported questionnaires to 2925 students at four medical colleges and universities in Liaoning province, China.	Life satisfaction was significantly different in gender and study programs. Stress was negatively correlated with life satisfaction and accounted for 12% of the variance in life satisfaction while resilience was 18% variance. Resilience functioned as a partial mediator in the relationship between stress and life satisfaction	Cannot draw causal relations. Was self-reporting, possible response bias. Generalisability.	University and medical school authorities could undertake evidence-based measure to reduce perceived stress among medical students and enhance resilience in order to promote life satisfaction	Students and education
52. Sood et al. (2014) USA	Stress Management and Resiliency Training (SMART) program among Department of Radiology faculty: a pilot RCT.	To test the efficacy of a stress management and resiliency training (SMART) program for decreasing stress and anxiety and improving resilience and quality of life among radiology physicians.	Quantitative, randomised, wait-list controlled pilot	26 faculty members of department of radiology. Baseline questionnaires	A statistically significant improvement in perceived stress, anxiety, quality of life, and mindfulness at 12 weeks was observed in the study arm compared to the wait-list control arm; resilience also improved in the active arm, but not statistically significant when compared to control arm.	Small sample size, open-label intervention, selection bias and incomplete data from attrition in two arms of study.	Further studies with larger sample size required.	Strategies and interventions

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
53. Sood et al. (2011) USA	Stress management and resilience training among Department of Medicine faculty: a pilot randomized clinical trial	Designed to assess the effect of a Stress Management and Resiliency Training (SMART) program for increasing resiliency and quality of life and decreasing stress and anxiety among Department of Medicine (DOM) physicians at a tertiary care medical centre.	Quantitative	Forty DOM physicians. Thirty-two physicians completed the study. Tertiary medical centre	A statistically significant improvement in resiliency, perceived stress, anxiety, and overall quality of life at 8 weeks was observed in the study arm compared to the wait-list control arm.		Further, the intervention provided statistically significant improvement in resilience, stress, anxiety, and overall quality of life. In the future, larger clinical trials with longer follow-up and possibly wider disseminatio n of this intervention are warranted.	Strategies and interventions

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
54. Stevenson et al. (2011) Australia	Resilience among doctors who work in challenging areas: a qualitative study	To describe attitudes to work and job satisfaction among Australian primary care practitioners who have worked for more than 5 years in areas of social disadvantage	Qualitative study	Semi-structured interviews with 15 primary healthcare practitioners working in prisons, drug and alcohol medicine or youth and refugee health. Doctors with 5 years or more experience.	All doctors were motivated by the belief that helping a disadvantaged population is the right thing to do. They were sustained by a deep appreciation and respect for the population they served an intellectual engagement and the ability to control their own working hours.	? Small sample size, urban location, did not explore the perspectives of those working in more remote areas	Doctors need supporting by experienced mentors. Efforts to increase medical workforce for socially marginalised patients is necessary and so is support	Burnout/job satisfaction
55. Streb et al. (2014) Germany	PTSD in Paramedics: Resilience and sense of coherence	To examine whether SOC (sense of coherence) and resilience are associated with PTSD severity in paramedics	Quantitative, cross-sectional survey	Questionnaire. Response rate 49.0%. 75 out of 76 emergency services in German speaking Switzerland and the principality of Liechtenstein included.68 paramedics. 210 women and 447 men	Both resilience and SOC are associated with PTSD symptoms. Resilience and SOC were negatively correlated with PTSD symptoms, SOC was a better predictor than resilience for PTSD severity.	Indications of resilience and SOC being able to predict severity of PTSD symptoms cannot be interpreted causally. Can not be generalised to other occupational groups other than paramedics. Statements	Specific training/methods which promote SOC and indirectly lower the risk of PTSD required for individuals facing traumatizing situations.	Burnout/job satisfaction

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
						regarding the stability of resilience and SOC overtime are limited due to cross-sectional survey.		

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
56. Tempski et al. (2015) Brazil	Relationship among Medical Student Resilience, Educational Environment and Quality of Life	To study the association among resilience, quality of life (QoL) and educational environment perceptions in medical students.	Quantitative, cross sectional	Online survey, random sample, 1350 medical students from 22 Brazilian medical schools.	Medical students with higher resilience levels had better quality of life and educational environment perceptions. Significant association between higher resilience scores and lower scores of anxiety and depression.	Generalisation of results to other populations, cross sectional design does not allow inferences of causality.	Developing resilience may become an important strategy to minimise emotional distress and enhance medical training	Students and education
57. Vesel et al. (2015) Sierra Leone	Psychosocial support and resilience building among health workers in Sierra Leone: interrelations between coping skills,	To achieve 3 objectives. 1. Describe the effect of counselling and psychosocial training on coping, stress and provider-provider and provider-client relationships. 2 to	Mixed methods approach	A quantitative survey, in-depth interviews and focus group discussions.2 71 health workers from	Results demonstrate that HHWC project intervention had a positive effect on coping skills, stress levels and provider-provider and provider-client relationships. Overall intervention resulted in improvements in relationships. Coping skills	Transferability of findings to high income countries. The lack of baseline constitutes the main limitation. Biases associated with	A rollout of the HHWC approach could improve health and survival through health service	Strategies and interventions

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
	stress levels, and interpersonal relationships	examine the associations between change in coping skills, stress levels and change in relationships. 3. identify keyways through which the uptake of coping skills is linked to a change in relationships.		74 facilities in 12 0ut of 14 chiefdoms in Kono district.	of health workers was significantly associated with lower stress levels. Findings indicate that HHWC is a model and tool that could be used to build resilience.	retrospective questioning and with surveys of satisfaction and motivation may have affected results.	access and delivery.	
58. Walters et al. (2015) Australia	Exploring resilience in rural GP registrars--implications for training	To explore GP registrars perceptions of their resilience and strategies they used to maintain resilience in rural general practice. Workplace shortages is an issue.	Qualitative interpretive	GP registrars from Australian College,.18. semi-structured interviews	Six main themes emerged, tensions for GP's apparent. Clinical caution versus clinical courage, flexibility versus persistence, reflective practice versus task-focused practice; and personal connections versus professional commitment. Personal skills for balance which facilitated resilience including optimistic attitude, self-reflection and metacognition and GP registrars recognised the role of their supervisors in supporting and stretching them to enhance their clinical resilience.	Are studies unique to rural general practice only? Self-selected participants (may be bias to those who are resilient?)	Educators should formally assist GP registrars to recognise and reflect on tensions	Professional resilience

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
59. Wei et al. (2014) China	A new multidimensional measure of personal resilience and its use: Chinese nurse resilience, organizational socialization, and career success	To develop a measure to test whether nurse resilience actually does have a beneficial effect on nurses' work and careers.	Quantitative	Questionnaires. Southern city of mainland China. Two hospitals. 244 Chinese nurses (169 f, 75 m)	Refining the concept of resilience by using four personality facets (endurance, adaptability, determination and recuperability) in questionnaires. Resilience should be positively related to career success.	All nurses from on ethnic group	Resilience should be positively related to career success	Professional resilience
60. Zander et al. (2013) Australia	Exploring resilience in paediatric oncology nursing staff	Explore the concept of resilience among paediatric oncology nurses who work at the bedside and the process they underwent in order to develop resilience.	Qualitative, thematic analysis	Interviews. Five paediatric oncology nurses. Eight-bed in-patient unit with adjoining outpatient unit.	Five nurses interviewed about their definition, perception and understanding of the concept of resilience, coping strategies and mechanisms and their day-to-day work. Seventeen initial themes. Findings then refined into 7 major aspects. Individual conceptualization of resilience, the issues and challenges faced, actions and strategies, the need for support, insight, processing situations through reflection and personal and professional experience.	Small study. Limited participant feedback regarding the final seven aspects of forming resilience.	Nurses can develop resilience in the context of their work environment over time. Organisational support is vital for resilience development and maintenance.	Retention

Authors (year) Origin	Title	Aims and Research question	Design	Sample, Data collection and Context	Key Findings	Limitations	Implications for Practice and Research	Scoping review theme
61. Zwack and Schweitzer (2013) Germany	If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians	To identify health promoting strategies employed by experienced physicians in order to define 'prototypical' resilience processes and key aspects of resilience-fostering prevention actions	Qualitative	200 Semi-structured interviews. Content analysis method. Physicians of different ages, disciplines, and status across Germany.	Findings suggest that whatever the stressor is question is (paperwork, time pressures etc.) a well-diversified pool of social resources and fields of interest, together with realistic expectancies and good self-knowledge will support sustainable coping. This creates experiences of efficacy that confirm health promoting behaviours.	Self-selection may lead to positive bias. Frequency of coded attitudes and practices does not reveal their relative importance for individual health. Answers given may be 'state' dependant e.g. Not transferable	Useful for individuals or groups seeking to develop physician resilience.	Strategies and interventions

Appendix D: Research Approval Letter

HRA and Health and Care Research Wales (HCRW) Approval Letter	 **Email: hra.approval@nhs.net** **HCRW.approvals@wales.nhs.uk**

25 September 2019

Dear Ms Recchia

Study title:	**Exploring perceptions of resilience in relation to its influence on career decisions in midwifery practice**
IRAS project ID:	**270001**
REC reference:	**19/HRA/5009**
Sponsor	**University of ******

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

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

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

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set, and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

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

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

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research

- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **270001**. Please quote this on all correspondence.

Yours sincerely,

[redacted]

Approvals Specialist

Email: hra.approval@nhs.net

Copy to:	***(sponsor representative)***	

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
HRA Schedule of Events [HRA Schedule of Events (HRA Assessed)]	2	25 September 2019
IRAS Application Form [IRAS_Form_05092019]		05 September 2019
Letters of invitation to participant	Version 4	30 August 2019
Organisation Information Document		
Participant consent form	Version 3.2	30 August 2019
Participant information sheet (PIS) [PIS]	Version 3.3	17 September 2019
Research protocol or project proposal [Proposal]	Version 4	30 August 2019
Summary CV for Chief Investigator (CI) [CV]		
Summary CV for Chief Investigator (CI) [CV]		22 August 2019
Summary CV for student [CV]		30 August 2019
Summary CV for supervisor (student research) [CV]		30 August 2019
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only)		19 July 2019

Appendix E: Research Governance Application form

RESEARCH GOVERNANCE COMMITTEE

SUBMISSION FORM

Please refer to the Guidance Notes at the end for help with filling in this form.

Please complete the following checklist before submitting the completed form:

✓ I have completed all relevant sections of the Submission Form having read the 'Guidance Notes.'

✓ I have signed my Submission Form.

✓ [Student submissions only] My Supervisor(s) have read and signed my Submission Form

✓ I have attached all supporting documents (information sheet, consent form, etc.) to my Submission Form.

✓ I agree to inform the HSRGC of any major changes to my research.

GENERAL INFORMATION

1. Please give the full title of your study and provide a short title for reference.

Full title	Exploring perceptions of resilience in relation to its influence on career decisions in midwifery practice
Short title	Resilience and career decisions in midwifery

2. If you are an academic member of staff, please provide the following details about yourself.

Name and title	N/A
Post	
Institution (including address if other than Health Sciences)	
Email and telephone number	

3. If you are a research student, please provide the following details.

Your name and title	Ms Helen Recchia
Name and level of course/degree	PhD (P/T)
Institution (including address if other than Health Sciences)	Health Sciences, University of ****
Email and telephone number	helen.recchia@****.ac.uk 01*** 321***
Name and email address of supervisor(s)	

4. Please briefly describe the specific expertise, including experience and training, you and your research team will bring to the study.

I am a third year (part-time) PhD student at the University ****I have successfully completed an MSc in Health Sciences in 2014. This master's programme included the completion of the qualitative methods module. I am also an experienced midwifery lecturer and programme lead for the BA (Hons) Midwifery Practice Programme. My experience and knowledge of midwifery practice and midwifery undergraduate education

will be paramount for the effective conduct of this study. In addition, I am being supervised for my PhD by three experienced members of the department. My lead supervisor is a Professor of Nursing and Deputy Head of the Department. His specific expertise in qualitative research, particularly in GT, will contribute to the quality of this research. Similarly, my two other supervisors (are experienced lecturers and researchers in the department with specific expertise in research, education, and midwifery practice.

5. If the research is funded, please provide the following details.

Name of funding body	Department of Health Sciences, University of ****
Duration of the grant	6 years part-time PhD
Describe any influence the funding body has on the conduct or dissemination of the research	None

6. If the research is to be reviewed by an ethics committee other than HSRGC, please provide details.

No, I have completed the brief survey on the NHS Health Research Authority at: http://www.hra-decisiontools.org.uk/ethics/ which confirmed that **I do not require NHS REC approval**.

THE PROJECT

7. Explain the aims, objectives, and scientific justification of the research, in a maximum of 200 words, and in language comprehensible to a layperson.

Research Question:

'What is the influence of resilience on midwives' and student midwives' career-related decisions?'

Objectives:

1. To understand how midwives and student midwives perceive and experience resilience.
2. To explore if and how resilience influences midwives' and student midwives' career-related decisions.
3. To develop a theoretical explanation about the influence of resilience in midwives' and student midwives' career-related decisions.

Rationale:

This research project forms part of my PhD thesis exploring resilience in midwifery practice. Resilience can be defined as the ability of an individual to cope with and adapt positively to adverse circumstances (Hunter and Warren, 2013). Following the completion of a review to establish what is already known about healthcare professionals and students in relation to resilience, the findings highlighted that there is limited research available regarding resilience among midwives.

There is emerging evidence to suggests that increasing numbers of nurses and midwives are leaving the profession (NMC, 2017) and retention of staff in the NHS is becoming an increasing and challenging concern (HEE, 2018). There is also a growing interest in the literature in relation to the current healthcare workforce and staff having the necessary attributes to meet the demands of this current healthcare system and remain within it. There is a national shortage of midwives and despite the government initiative to increase these numbers; some midwives are making the decision to leave the profession (RCM, 2010). Numerous strategies to promote healthcare professionals remaining within the NHS, such as the NHS England (2018) major new recruitment and retention campaign, continue to attempt to tackle this issue.

Recent studies (Hunter and Warren, 2014; Jackson, Firtko, and Edenborough, 2007) have suggested that resilience is a positive attribute for a healthcare professional to possess and develop, and a potential panacea for the retention crisis in healthcare. It is anticipated that the completion of this study will fulfil the existing gap in the evidence that exists around resilience and midwifery practice. It will offer an understanding and explanation regarding resilience and its influence on the decisions midwives make during their career or following leaving the profession.

8. Please provide a summary of the research design/method, in a maximum of 200 words, and in language comprehensible to a layperson.

Careful consideration and discussion have taken place with the support of my supervisors, to ensure the most suitable design/methodology for this research study is applied. Following identifying the possible methods, I have decided the chosen methodology is GT.

- GT is a well-established and now, a well-respected qualitative design that is commonly utilised for healthcare and education research (Birks and Mills, 2017).
- The key features of a GT approach are to develop theory from the data. It often comprises the identification of core categories and concepts (McCann and Clark, 2003).
- The primary focus of the approach is on generation of theory, which is what is lacking in relation to resilience, retention, and midwives.

Information will be collected via interviews. A series of interviews will be undertaken, until no new themes appear (Gehrels, 2013). Written consent via interviewing will be obtained and participants will be informed that the interview will be audio recorded on a digital recorder and stored as MP3 files. These will be initially transcribed onto a word document and then transferred onto a qualitative computer software package (either ATLAS.ti or NVivo). Interviews are expected to be undertaken for a period of approximately 60 minutes. Audio recordings will then be deleted at the end of the analysis of the data. The interviews will focus on objectives 1-3 of the study. They will include asking participants to share their understanding and experiences of individual and organisational strategies to support and effectively manage any stress in the workplace. The interviews will also aim to ascertain how participants achieve a health work/home balance and consider ways to develop resilient attributes to face the demands of the role and remain in the profession.

Anyone who participates in this study will be given sufficient time to consider taking part in the study (one week) and be informed that they can cease participation at any stage, without sanction. This will be communicated to participants prior to interviewing and recorded in the consent form. It is hoped that the study will be completed within 10 months (Mar-Dec 2019). For data collection and analysis, participants will consent to the interviews being audio recorded to transcribe data accurately. The volume of participants

volunteering to take part in the study will be managed by me. Participants will be informed that they may be asked to take part in interviews, depending on the data and emerging themes. If no new themes are occurring, then participants will be informed that they are no longer required to take part in the study.

9. Please outline any patient and public involvement (PPI) in the study.

This research study does not intend to include any patients/women using midwifery/maternity services. The study will be involving midwives currently registered with the NMC, students who are enrolled on an undergraduate, NMC approved midwifery programme, or midwives who have decided to leave the profession.

10. If the study requires statistical analysis, please explain your statistical methods.

Not applicable

11. For qualitative studies, please outline your method of analysis.

The data analysis will proceed in relation to the research question, aims and objectives of the study. Data collection and analysis will occur concurrently and therefore is iterative in nature. Simultaneous collection of codes and the analyses of the data to decide where to sample next according to the emerging codes and categories known as theoretical sampling (Coyne, 1997).

A theoretical sampling strategy will be used for this research study. This process of collecting the data will continue until each category is saturated and no new data are being identified.

Three types of coding will be used during the analysis (see below) where the merging of concepts into groups occurs (Evans, 2013).

1. Initial
2. Focused
3. Theoretical

Initial coding will be used to 'fracture' the data. This process will involve naming initial phenomena in the form of 'codes.' It will identify a phenomenon or any patterns emerging and comparison between the codes will then be applied. Each transcript will be analysed sentence by sentence, to select key words.

During stage two of coding, attention will be turned to generating codes; the most significant codes will be classified into categories. Memo writing will support the organisation of a potentially substantial number of codes. Gehrels (2013) also suggests using diagramming to make any visual representations or connections between the categories. As the data pours in during the study, codes will be used to direct further data collection and the development of theories within categories until each category is saturated.

In this focused stage of analysis, emphasis will be directed to theoretical sampling until theoretical saturation is achieved. Similarities and differences between codes should occur with constant comparative analysis, ultimately developing theoretical ideas for the final stage.

RECRUITING PARTICIPANTS

12. Please explain how research participants will be (a) identified (b) approached and (c) recruited.

Initially a purposeful sample will be used according to the objectives and needs of the study. Marshall (1996) suggests that this is the most common sampling technique in qualitative research and arguably all sampling in qualitative research is purposeful.

Specifically, a sampling technique known as theoretical sampling will be utilised for this research study (see Appendix 1-Page 11: Visual representation of GT Method). Theoretical sampling is often considered in qualitative research as one of the types of purposeful sampling (Coyne, 1997). Theoretical sampling is determined by the data and the emerging theory. A decision regarding where to sample next according to the emerging codes and categories is the core tenet of theoretical sampling (Glaser, 1992).

The rationale for adopting theoretical sampling for this study is that it encourages creativity and enables considerable flexibility because it is on-going throughout the study.

Illustration of the process for identifying and recruiting participants:

1. Invite Heads of Midwifery (HoM) in NHS maternity units and Programme Leads for undergraduate NMC approved midwifery programmes (excluding University of ****) in the Yorkshire and the Humber region to circulate research study flyer to potential participants within the Trust.
2. Potential participant contacts lead researcher to express interest. Lead researcher sends information pack and schedules potential interview date.
3. Prior to interview, lead researcher fully discusses participation in study, data storage and confidentiality and informed consent.
4. Lead researcher obtains written consent from participant before commencing interview and reminds participant that interview can be stopped at any point.

a) Identifying participants

People will be approached to participate in the study if they meet any of the following criteria:

- Currently registered with the NMC as a midwife
- Is a student midwife who is currently enrolled on an approved midwifery programme leading to registration with the NMC
- Has been previously registered with the NMC as a midwife within the last five years (this group may be considered following the initial interviewing of the above two other groups)

b) Approaching participants

I will invite Heads of Midwifery (HoM) in NHS maternity units and Programme Leads (excluding at the University of ****) in the Yorkshire and the Humber to circulate research study flyer (see attached) to potential participants within their Trust or University.

c) Recruiting participants

The potential participant will contact me to express an interest in the study. I will then send an information pack (including a cover letter, a participant information leaflet, and a consent form) and schedule an interview date. The participant information form will include some example questions for the participants to give an indication to them of the type of questions they will be asked. Prior to the interview I will fully discuss participation in study, data storage and confidentiality and informed consent. Anyone who participates in this study will be given sufficient time to consider taking part in the study (one week) and be informed that they can cease participation at any stage, without sanction. Participants will retain a copy of the signed consent form and I will keep a further copy. I will obtain written consent from participants before commencing interview and reminds participant that interview can be stopped at any point. Participants will be asked whether they would like to receive a summary of the study findings and if so, provide their contact information to forward this.

I will not include any personal details such as my home address or personal mobile number on any of the above documents. I will use my work email address for any correspondence. I do not think I require any training to gain participants consent to take part in the study and have experience as a clinician of gaining consent for several procedures/investigations and therefore appreciate the principles of informed consent.

13. If participants are to receive incentives to take part in the study, or reimbursement of expenses, please give details and rationale.

No incentives or payments will be provided to any participants taking part in this research. However, if there is travel costs, participants will receive reimbursement.

14. If your study includes participants from vulnerable groups, please provide details and rationale.

Not applicable

15. Please explain any arrangements for participants who do not understand English well.

Not applicable, as midwives and students recruited for the study will be required to speak English and meet the NMC (2018a) criteria for English language requirements (further information available at: https://www.nmc.org.uk/registration/joining-the-register/english-language-requirements/

ETHICAL ISSUES

16. Please clarify and justify potential harms to participants.

There are no expected harms to participants in taking part in this study; their contribution is voluntary. If midwives and/or students have consented to take part in the interviews they will be informed that they are entitled to leave the study at any point and decline to answer questions during the interview. Should this occur, participants will also be informed that they can withdraw their interview data from the study up to 10 days following interview. Taking part in the interviews may inconvenience participants. Participants will therefore be offered a choice of times and location (University of ****, employer workplace or other suitably agreed venue) for interviews and any travel expenses will be reimbursed. Careful consideration regarding lone working and personal safety will be considered for all interview venues. For example, an interview will not take place out of office hours or during the evenings/night-time. In all circumstances I will encourage the participants to meet with me in a place which is most convenient for them. If for any reason the interviewing of participants' causes any distress, recommendation to a suitable support, such as a PMA for practising midwives or a personal supervisor/link lecturer for student midwives will be made.

17. If your study is likely to elicit information requiring disclosure – such as incidental medical findings, evidence of professional misconduct or neglect, or criminal behaviour – please explain how you will proceed.

This situation is unlikely, however still possible. Prior to the commencement of the interview they will be reminded that they have a professional obligation to adhere to the NMC Code (2015), available at: https://www.nmc.org.uk/standards/code/If information requiring disclosure is made during the interviewing process by any of the midwives, then This would ensure that the participant understands that any information shared that potentially places patient safety, a member of the public or other individual (e.g. other members of staff) at risk then concerns and escalation is required. Similarly, the NMC Code (2015) ensures that registrants must adhere to the laws of the country they are practising in.

As a current registrant, I have many years of experience in healthcare practice and higher education working with and supporting a wide range of people. In addition, I consider that I have insight into recognising the complexities of dealing with sensitive data, particularly because I have previous experience as a Supervisor of Midwives, which was a role that often involved dealing with sensitive and confidential information of staff, students, and women, when undertaking clinical investigations. If during the interviews, a

participant raises any concerns or discloses information which requires escalating then I will (as a registrant myself) follow the guidance available in the Raising Concerns- guidance for nurses, midwives, and nursing associates (NMC, 2018b) at: https://www.nmc.org.uk/globalassets/blocks/media-block/raising-concerns-v2.pdf. I recognise that ultimately; I have a duty of care to ensure that the interests of people in the midwives' care is paramount and I will take action to protect the public if I consider they may be at risk.

18. Please explain and justify any deception of participants required by the study.

There will be no deception of participants in this study.

19. Please describe any potential benefits to participants.

Whilst there are no immediate benefits for those people participating in the project, it is anticipated that this research will have a beneficial impact on how midwives perceive their workplace environment and ultimately remain in the profession. A summary of the results will be shared with participants on request.

20. Please clarify and justify potential harms to researchers.

Participating in the research for both participants and researchers is not anticipated to cause any disadvantages or discomfort to either party. I have accessed the Department's University of **** Lone Worker Policy for guidance and where necessary, a fieldwork risk assessment will be conducted prior to the interviews. All interviews will take place in either the participants work environment, in a private place/room, their NMC approved university for study, the University of ****offices, or an alternatively agreed suitable and private venue, all suitable for private discussion.

21. Please provide details of any conflicts of interest created by the research and explain how they will be resolved.

There are no anticipated conflicts of interest for this research study.

22. Please provide details of any personal material benefits researchers will receive for undertaking this study, including personal payment over and above their normal salary.

There should be no benefits or rewards given to any researchers involved in this study. Only reimbursement for travel expenses is expected, which should not cause any undue influence.

23. Please describe any other ethical problems you think the proposed study raises, explaining what steps you will take to address them.

Ethical issues have been considered for this research study. There are no ethical issues raised. Participants can withdraw from the study at any point without giving a reason and this is documented in the consent form. The conduct, behaviour and attitudes of the researcher's study should not have a negative impact on the reputation of the Department of ****at the University of ****.

DATA MANAGEMENT

24. Please explain what, where, and for how long data will be stored.

Data management will be compliant with The General Data Protection Regulation (GDPR) and Data Protection Act 2018 and in line with the University Research Data Management Policy. Interview discussions will be audio recorded for the purpose of transcribing the data on a digital recorder and stored as MP3 files. These will be initially transcribed onto a word document and then transferred onto a qualitative computer software package (either ATLAS.ti or NVivo). The audio recording will then be deleted. The data will be stored on the University's centrally managed network and in my personal file store (P: drive); this is automatically and regularly backed up by IT services. I will also use the university VPN to connect to the personal file store to access and work on the files if not on campus. Any paper documents from participant interviews will be stored in a locked cabinet in my locked office.

I have completed the data management tutorial and have attached a data management plan (DMP) to clearly demonstrate that consideration for the management, transfer, storage and archiving of data has been considered. However, in summary, data and documentation files will be stored in separate folders. Data files will be organised according to data type, i.e., data analysis (sub-folders-categories, coding, theory, and memo writing and diagramming) and data collection (subfolders-interview recordings and interview transcripts).

25. Please explain the process by which data will be transferred.

In accordance with 'Regulation 12: Intellectual property' of the University's ordinance and regulations, University of York is the owner of the copyrights and associated intellectual rights of the data. Following completion of this study, data will be transferred to the

University Research Data York service in accordance with the University's Research Data Management Policy. Standard university indemnity arrangements apply to this study.

26. Please set out how anonymity of data will be ensured; if data are not anonymised, explain why not, and describe how data confidentiality will be maintained.

Data will be pseudonymised by assigning a unique identification code to each participant. Although the unique identification code will also be recorded on each participant's consent form, this will be the only document linking identifiable information to the assigned unique identifier and will only be known to me.

No information that could identify participants will be included in interview transcripts. Direct quotations used in published work will be pseudonymised and any information that might directly identify participants (e.g., identity of clinical setting or university) will also be pseudonymised.

Potential for loss of data during transport during process of interviewing will be minimised by keeping electronic devises and paper-based data (e.g., handwritten notes or consent forms) always secure in a bag and in the presence of me until transferred into a locked filing cabinet (see section 24) and then onto a secure computer. Data will not be left unattended at any time, for example in an unoccupied vehicle.

27. Please state who will have access to data generated by the study.

PhD supervisors and possibly TAP members (from the University of ****-) will have access to the pseudonymised data.

28. Please state who will act as custodian of data generated by the study.

This will be the lead supervisor of the project-Helen Recchia.

29. Please state whether the study requires a Privacy Impact Assessment.

No

DISSEMINATION

30. Please explain how you plan to disseminate your results.

I plan to disseminate my results in a variety of ways. 1. This will include inclusion as part of my thesis. 2. Publication of study in peer reviewed academic journal. 3. Sharing of findings of study at relevant conferences. 4. Midwifery Education/curricula.

31. If results will be made available to participants and the communities from which they are drawn, please explain how.

On request, participants who have requested to receive a summary of the findings will also be informed of dissemination arrangements and sent a summary of results (referred to in information sheet).

INDEMNITY

32. Please confirm the indemnity arrangements for your study.

Standard University of ****indemnity arrangement	
Other indemnity arrangement	

Your signature: 

Helen Recchia

Supervisor(s)' Signature: 25/02/19

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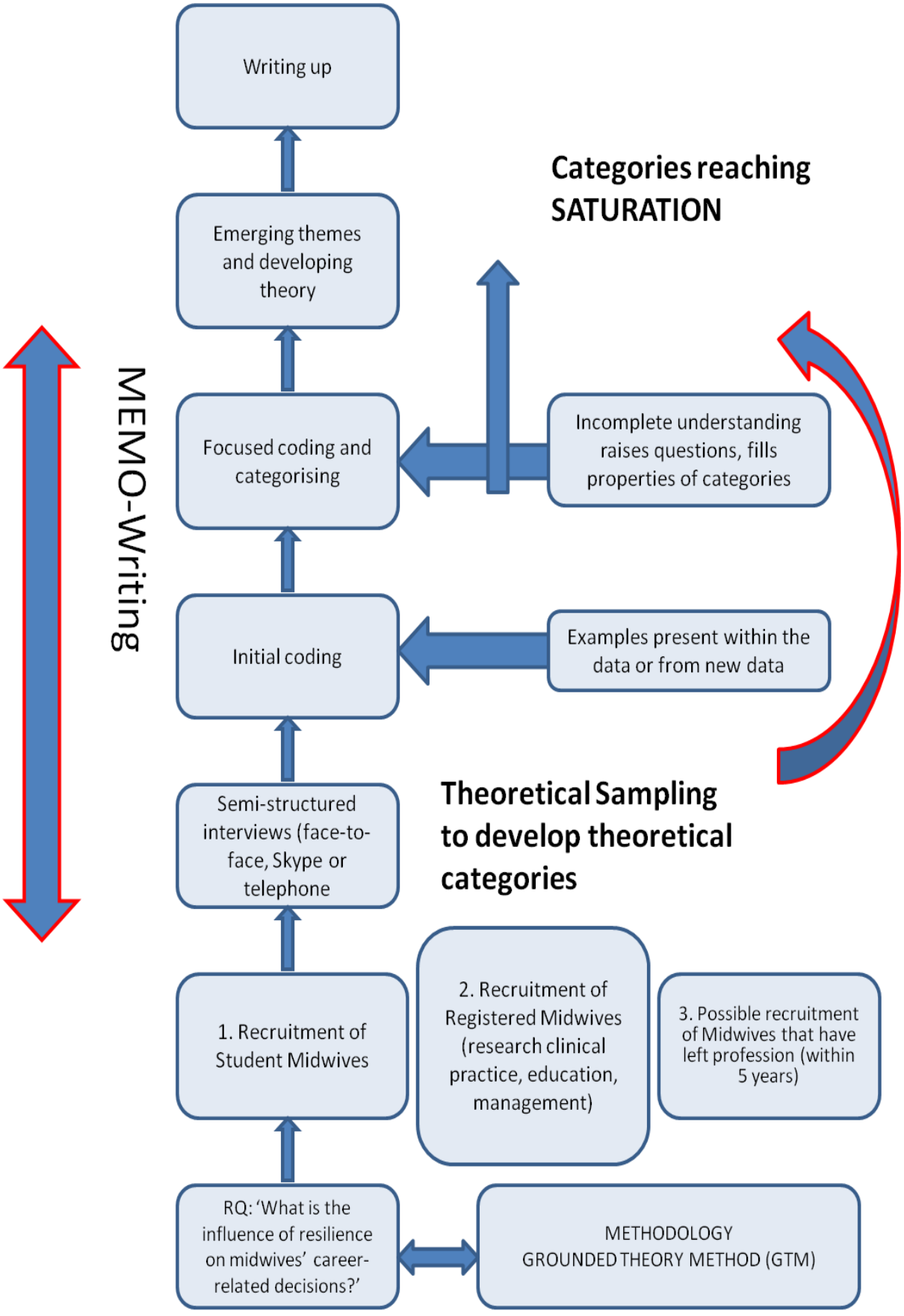


Appendix 1: Visual representation of Grounded Theory Method

RESEARCH GOVERNANCE COMMITTEE

GUIDANCE NOTES TO HELP COMPLETE THE SUBMISSION FORM

General points

- The HSRGC web pages on the staff and student intranets contain further details about the committee's procedures – including upcoming deadlines and dates of meetings, and an explanation of who should complete, and how to submit, the Submission Form – and links to other key documents: https://www.****.ac.uk/**** /research-information/rsg/
- For advice about whether your study is research and whether it needs NHS approval, go to: http://www.hra-decisiontools.org.uk/research/
- Copies of all additional relevant material – e.g., information sheets, consent forms, questionnaires, topic guides, and ethics approval given by external bodies – should be attached to the Submission Form as appendices. All appendices must have a date and version number.
- Templates of the sort of Information Sheets and Consent Forms the committee expects are included at the end of the Guidance Notes, but these are for guidance only and should be amended or replaced to suit your study.
- Provide full references for publications cited on the form, but not a general bibliography of your area of research.
- Substantial amendments to a project will require further approval. Inform the HSRGC Chair of significant changes to the protocol; to discuss whether a change is sufficiently substantial to require further approval, contact the HSRGC Chair.
- In order to request permission to access Department of Health Sciences' staff or students as participants, you must first contact the Head of Department with a brief one-page summary of your research before submitting the study to the HSRGC for approval.

Question-specific Advice

Box number	Advice

4	The committee does not require full researchers' CVs but does want evidence of competence to complete the study. Students (and less experienced research staff) should refer to specific modules, courses, etc., relevant to their study. For example, a researcher who has completed the Qualitative Methods module at master's level should cite the module if their study involves qualitative research.
5	For example, describe any restrictions on who can access your data, where and whether it can be published, etc., imposed as a condition of funding.
6	For details as to whether a study being reviewed externally also requires HSRGC approval, please see the section, 'Application procedures' on the HSRGC Terms of Reference at: https://www.****.ac.uk/healthsciences/research-information/rsg/ If your study requires both HSRGC and external approval, please send the outcome of the decision by the external committee to the Chair of HSRGC once it is known. Some studies take place in cultures vastly different to ours, including vastly different research ethics standards and processes. The view of the HSRGC is that research ethics concerns are universal, but these can be met in ways appropriate to the research locale. For example, that participation is in accordance with participants' wishes is a universal concern; but how this is ensured – by reference to the notion of 'voluntary, informed consent,' by signing consent forms, etc. – will depend on the local research context. Researchers must demonstrate that universal research ethics concerns are met, albeit in locally appropriate ways.
7	The committee wants evidence that your study will build on the existing knowledge base, so show how relevant evidence has been considered by, for example, citing systematic reviews, databases, and search strategies you have utilised. If your study has been done before, explain why it is worth repeating.
8	This section, and the form in general, must be written in plain English to be intelligible to the HSRGC's lay member. Make clear what will happen to anyone who participates in the research. Give an indicative timeline for the study.

	If you plan to make audio or visual recordings of participants, provide details such as how participants will be informed of and consented to this, and what will happen to the recordings during and after the study. Give details of any interventions or procedures – clinical or non-clinical – that will be provided to, or withheld from, participants during the study. Make sure the information given in this section matches up with the documentation attached to the Submission Form as appendices (e.g., letters, information sheets, consent forms, questionnaires, etc.).
9	The Department supports patient and public involvement (PPI) in research. Briefly outline any PPI relating to the study, and include relevant documentation (e.g., letter of invitation to a discussion panel).
10	State the primary and secondary outcome measures for the study. If the size of the study has been informed by a statistical power calculation, give sufficient information to allow the committee to replicate the calculation. If you have consulted a statistician, provide their name, position, and email address, and clarify their input to your study. If your study involves a randomisation process, or cases and controls, give details, including inclusion and exclusion criteria.
11	Include the rationale for the sample size of the study.
12	State and justify any inclusion or exclusion criteria, with special regard to gender, race/ethnicity, age, social condition, sexual orientation, faith, or disability. If you need to access Department of ****staff or students as participants, you must contact the Head of Department with a brief one-page summary of your research to request permission. The committee expect potential recruits to be first approached by a third party – i.e., someone other than the researcher (e.g., a clinician) – who will inform them of your study, inviting them to contact you if they are interested in participating. Any initial approach other than this must be justified. Include copies of patient information sheets, consent forms, and any other materials related to participant recruitment, as numbered appendices to your submission.

	Information sheets and consent forms should clearly reflect the study protocol, in language suitable for a layperson (e.g., technical words should be avoided or fully explained); the tone of information sheets should be invitational and not coercive. Information sheets and consent forms must be on University headed paper; they must both carry a date and version number, and any cross-reference between the two must include the relevant date and version number. It is good practice to provide copies of the information sheet and consent form for participants to keep for reference. The information sheet and consent form should have details of who to contact if a participant wants further information. In the case of research staff, this should be the PI or another member of the research team; research students should provide their own or their supervisor's contact details. The information sheet and consent form should have details of who to contact if a participant wants to make a complaint. In the case of research staff, this should be someone other than the PI or another member of the research team; research students should provide their supervisor's contact details. No personal contact details – home address, personal mobile phone number, etc. – should be provided on the information sheet or consent form. If you do not intend to provide a written information sheet about your study or obtain a signed record of consent from participants, explain, and justify your recruitment method. Non-written consent – such as a thumb print of a non-literate participant – would normally be formally documented and witnessed. Explain how you will communicate to participants their right to leave a research study at any time, without sanction. Data collected on participants who decide to leave a study can still be used provided this is made clear in the information sheet and consent form. Describe any training or experience you will draw on in gaining consent to participate in the research.
13	The information sheet should clearly explain any incentive or reimbursement. Examples of incentives to participate include cash payments, and cash equivalents such as vouchers and gift cards.

	As a rule of thumb, incentives should not encourage people to take part in studies against their better judgement. Concerning reimbursement, participants should not be substantially out of pocket because of taking part in a research study. If it is not possible to reimburse expenses incurred by participation, this should be made clear in the information sheet.,
14	Examples of vulnerable groups include children under 18; learning disabled; mentally ill; severely or terminally ill; elderly and dementia patients; patients in emergency situations; substance users; prisoners and young offenders. When research participants have a dependent relationship with the investigator (e.g., that of student and course tutor) explain how you will ensure that consent is voluntary and without coercion.
15	Examples of arrangements include providing translations of written information, such as information sheets, and involving translators/interpreters in focus group discussions.
16	Harms include any risks to participants' wellbeing, such as pain, discomfort, distress, embarrassment, or inconvenience. The presumption is that people should not be harmed by participating in research, but where harm, or risk of harm, are unavoidable, this should be clarified and justified, including describing procedures to minimise risk of harm, and to ameliorate unavoidable harm.
17	Describe any training or experience you can draw on when dealing with disclosure of sensitive or 'special category' data.
18	If your participants will be deceived, give details of whether and if so, how participants will be debriefed at the end of your study.
19	Benefits to participants can be direct, including positive experiences from involvement in a study, such as meeting people with shared interests in focus groups. Indirect benefits to participants include contributing to the knowledge base, and potential for future treatment, of a condition in which they have an interest.

20	The presumption is that researchers should not be harmed by undertaking research, but where harms – or risk of harm – are unavoidable, this should be clarified and justified, including describing procedures to minimise risk of harm, and to ameliorate unavoidable harm. Researchers should be aware of, and comply with, the Department's Lone Worker Policy which mitigates risks to researchers: see 'Key documents' at https://www.****.ac.uk/healthsciences/research-information/rsg/
21	Conflicts of interest might arise from, for example, researchers' direct personal or financial involvement in the organisation sponsoring or funding the research.
22	Benefits include 'in pocket' financial rewards or additional benefits, such as free equipment, paid to researchers for conducting a study; as a rule of thumb, such benefits should not be at a level to cause undue influence.
23	This is an opportunity to show that you are aware of ethical issues raised by your study, especially issues not covered elsewhere on the Submission Form, and how they will be dealt with. Describe any training or experience you can draw on in addressing ethical issues raised by your research. Address any ethical issues raised by Public and Patient Involvement. Ethical issues include risks to the University of York or the Department of Health Sciences' reputation.
24-29	Data management must be compliant with the General Data Protection Regulation (GDPR) and Health Sciences' data management policies. For further advice and university policies on GDPR go to https://www.****.ac.uk/records-management/dp/ Research must abide by the principle of data protection by design and default, including collecting the minimum amount of data necessary for the project, and anonymising or pseudonymising data wherever possible.
24	Storage of personal and sensitive or 'special category' data – for example, use of personal addresses, postcodes, faxes, emails, or telephone numbers – should be clearly explained and justified. For further guidance on data storage go to:https://www.****.ac.uk/library/info-for/researchers/data/storing/

	Describe and justify any unusual data storage methods (e.g., on websites). Clarify and justify the examination of medical records.
25	Personal and sensitive or 'special category' data must be transferred in a way that ensures it is protected (e.g., via the University's secure server). If data are to be exported outside the European Union, explain the steps taken to ensure that it is protected.
26	Data must be anonymised wherever, and as soon as, possible; if you need to gather personally identifiable, as opposed to anonymised data – including pseudonymised and re-identifiable data – this must be clearly justified. Collecting personal and sensitive or 'special category' data will be scrutinised especially closely by the committee, so this needs to be clarified and justified. The minimum amount of personal and sensitive or 'special category' data required to meet the research objectives should be collected. If data will be published in ways that might allow re-identification of individuals – for example, direct quotation – explain how confidentiality will be preserved.
27	The names of individuals and institutions with whom you will share data must be provided. The details of data sharing agreements, including how shared data will be protected, must be provided.
28	The custodian of data are the contact point for any data management queries; typically, this will be the Chief Investigator (or the most senior member of a research team).
29	The General Data Protection Regulation (GDPR) introduced a new legislative requirement to undertake a Data Protection Impact Assessment (DPIA) before carrying out 'data processing likely to result in a high risk to individuals' interests.' For the information needed to decide when to conduct a DPIA and the process to be followed go to https://www.york.ac.uk/records-management/dp/dataprivacyimpactassessments/ If you have any further questions, email dataprotection@****.ac.uk; if you are still unsure, discuss this with the Chair of HSRGC.

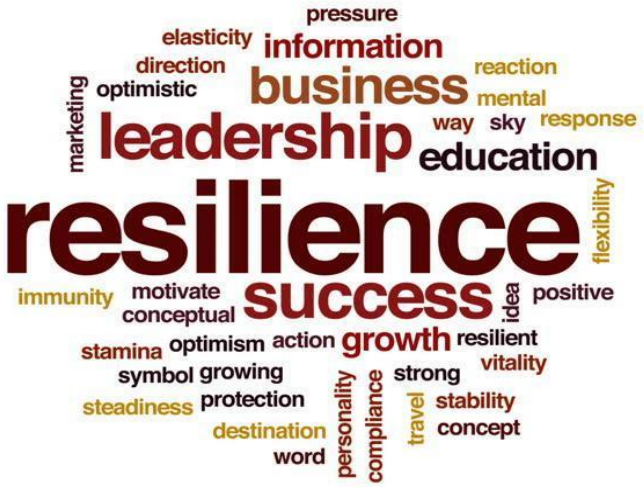
30-31	Examples of dissemination methods include reports, conference presentations, peer reviewed academic journals, other academic publications, submissions to regulatory authorities. Participants should be informed of dissemination arrangements and, as far as possible, results of research should be disseminated in a way that can be easily accessed by research participants and the communities from which they are drawn.
32	Research undertaken in Health Sciences is usually covered by standard University of ****indemnity arrangements. If this is not the case, or if you have indemnity cover in addition to the University's, provide details. Indemnity arrangements should be included in the information sheet., Further information about university insurance and indemnity is available at: http://www.****.ac.uk/admin/hsas/safetynet/Insurance/human_participant_trials.htm
Signatures	Where the applicant is a student, a signature is also required from their supervisor(s). The committee will not consider submissions unsigned by applicants or supervisor(s).

Appendix F: Flyer

Are you either:

- **A student midwife currently on a programme of study leading to NMC registration**
- **A registered midwife working in the Humber, Coast and Vale Local Maternity System (LMS) as a clinical midwife, manager, educator, researcher, or any other role using your midwifery registration?**

Would you like to take part in a study exploring midwives' perceptions and experiences of resilience in relation to career- related choices?



If you are interested in participating, please contact me on 01904 321***or helen.recchia@****

Taking part in the study will involve me asking you some questions about your perceptions and experiences of developing and maintaining resilience in your workplace or placement.

Cover Letter

Title of Study:

'What is the influence of resilience on midwives' and student midwives' career-related decisions?'

Thank you for your interest in this study exploring perceptions of resilience in relation to career choices in midwifery practice

In this pack you will find a:

1. Participant Information Sheet
2. Participant Consent Form

The Participant Information Sheet provides you with details about the study and some information about what you can expect, should you choose to take part in an interview. The Participant Consent Form includes information to ensure you are clear and understand fully what taking part in the study involves. I will go through the Consent Form with you in detail before the interview and answer any queries you may have. You would be asked to sign the Consent Form before taking part in the interview.

If you would like more information and details about the study before we meet for the scheduled interview, please do not hesitate to contact me on:

Helen Recchia

Lead Researcher and PhD student,

Email: helen.recchia@****

Appendix G: Participant Information Sheet

Participant Information SUMMARY Sheet

Full Title of Study:

Exploring perceptions of resilience in relation to its influence on career decisions in midwifery practice

In this research study we will use information from [you] which you have provided during the semi-structured interviews. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

At the end of the study, we will save some of the data [in case we need to check it] **AND/OR** [for future research].

We will make sure no-one can work out who you are from the reports we write.

The information pack below tells you more about this.

***Please note:**

Any reference to 'we' means the sponsor and not the local site.

Participant Information MAIN Sheet

Full Title of Study:

Exploring perceptions of resilience in relation to its influence on career decisions in midwifery practice

You are being invited to take part in this research project. Before you decide to do so, it is important you understand why the research is being done and what it will involve. Please read the following information carefully and discuss it with others if you wish.

Please do not hesitate to ask if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part. Thank you for reading this.

<u>How will we use information about you?</u>

We will need to use information from [you] from your interview for this research project.

This information will include your [initials/ contact details].

People will use this information to do the research to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will draft our reports in a way that no-one can work out that you took part in the study.

<u>What are your choices about how your information is used?</u>

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

We need to manage your records in specific ways for the research to be reliable. This means that we will not be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- by asking one of the research team
- by sending an email to], or
- by ringing us on].

Additional Information:

What is the purpose of this study?

The purpose of this study is to explore if resilience influences midwives' decisions during their careers.

Research Question:

'What is the influence of resilience on midwives' and student midwives' career-related decisions?'

Objectives:

1. To understand how midwives and student midwives perceive and experience resilience.
2. To explore if and how resilience influences midwives' and student midwives' career-related decisions.
3. To develop a theoretical explanation about the influence of resilience in midwives' and student midwives' career-related decisions.

Who is doing the study?

This research project forms part of a PhD thesis exploring resilience in midwifery practice. I will be undertaking the research for this study.

I am currently a fourth year (part-time) PhD student at the University of ****in the Department of ****. I am also an experienced midwifery lecturer, Programme Lead for the BA (Hons) Midwifery Practice Programme and Lead Midwife for Education (LME).

I am being supervised for my PhD by three experienced members of the department. My lead supervisor *****is a Professor of Nursing and Deputy Head of the Department and ***** and ***** are both experienced lecturers and researchers in the department with specific expertise in research, education, and midwifery practice. The Department of ****at the University ****is funding this research as part of my PhD.

Why have I been asked to participate?

You have been chosen because you are either:

- Currently registered with the Nursing & Midwifery Council (NMC) as a midwife
- A student midwife who is currently enrolled on an approved midwifery programme leading to registration with the NMC
- A previously registered midwife with the NMC, within the last five years.

Do I have to take part?

It is up to you to decide whether to take part. If you do decide to take part, you will be able to keep a copy of this information sheet and you should indicate your agreement on the consent form; and you can withdraw at any time.

What will be involved if I take part in this study?

You will be asked to complete an in-depth 'semi structured' interview which will take approximately 60 minutes. Interviews may take place (face-to-face) in either the participants work environment, in a private place/room, their NMC approved university for study, the University of ****offices, or any other private and suitably arranged venue. Alternatively, interviews may also be conducted via Skype or telephone for your convenience.

What are the advantages/benefits and disadvantages/risks of taking part?

It is anticipated that the completion of this study will fulfil the existing gap in the evidence that exists around resilience and midwifery practice. It will offer an understanding and explanation regarding resilience and its influence on the decisions midwives make during their careers.

Participating in the research is not anticipated to cause you any disadvantages or discomfort. Similarly, taking part in the study should not cause you any unnecessary harm or risk.

Can I withdraw from the study at any time?

1. **Withdrawal from the study:**

You can withdraw from the study at any time.

If you have consented to take part in the interviews, you will be informed that you are entitled to leave the study at any point and decline to answer questions during the interview.

2. **Withdrawal of my data:**

You will also be informed that you can withdraw your interview data from the study up to 10 days following interview.

You do not have to give a reason for your withdrawal from the study or of your data.

Although you will not incur any costs for taking part in the research study and any travel costs will be reimbursed you will be giving your time if you decide to contribute to the study.

How will the information and personal data I give be handled?

The University of ****is the sponsor for this study. We will be using information from you to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly.

The University of ****uses personally identifiable information to conduct research to improve health, care, and services. As a publicly funded organisation, we must ensure that it is in the public interest when we use personally identifiable information from people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use your data in the ways needed to conduct and analyse the research study. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally identifiable information possible.

Health and care research should serve the public interest, which means that we must demonstrate that our research serves the interests of society. We do this by following the UK Policy Framework for Health and Social Care Research.

Interviews will be audio recorded on a digital recorder and stored as MP3 files. Any paper documents from your interviews will be stored in a locked cabinet in my locked office. Once data has been transcribed and analysed, it will be deleted from the files and any paper documents will also be deleted. De-identified data research data will be retained by the University of ****for 10 years at the end of the research.

Following completion of this study, data will be transferred to the University Research Data ****service in accordance with the University's Research Data Management Policy. Any information that could identify you will be pseudonymised. Direct quotations used in published work and any information that might directly identify you (e.g., identity of clinical setting or university) will also be pseudonymised.

Potential for loss of data during transport during process of interviewing will be minimised by keeping electronic devises and paper-based data (e.g., handwritten notes or consent forms) always secure in a bag and in the presence of me until transferred into a locked

filing cabinet and then onto a secure computer. Data will not be left unattended at any time, for example in an unoccupied vehicle.

PhD supervisors and possibly TAP members (will have access to the pseudonymised data).

What will happen to the results of the study?

I plan to disseminate my results in a variety of ways. 1. This will include inclusion as part of my thesis. 2. Publication of study in peer reviewed academic journal. 3. Sharing of findings of study at relevant conferences. 4. Midwifery Education/curricula.

On request, participants who have requested to receive a summary of the findings will also be informed of dissemination arrangements and sent a summary of results to the preferred contact information provided.

Who has reviewed and approved this study?

The planning and review of this research study has involved my lead and co-PhD Supervisors at the University of ****(see above). The University of **** Health Sciences Research Governance Committee (HSRGC) (ethics approval committee) has approved my research study in March 2019.

Who do I contact for more information about the study?

For further information regarding the study please contact:

Lead Researcher and PhD student:

Helen Recchia
Lecturer in Midwifery

Tel: (+44) 01***321***
Email: helen.recchia@****.ac.uk

Who and what is a sponsor?

The sponsor is the individual, company, institution, or organisation, which takes on ultimate responsibility for the initiation, management (or arranging the initiation and management) of and/or financing (or arranging the financing) for that research. The sponsor takes primary responsibility for ensuring that the design of the study meets appropriate standards and that arrangements are in place to ensure appropriate conduct and reporting.

Name of Sponsor:

Who do I contact in the event of a complaint?

Lead Supervising Researcher:

Participants who are unhappy with the way their personal data has been handled have a right to complain to the University's Data Protection Officer at****; if they are still unsatisfied, they have a right to report concerns to the Information Commissioner's Office at www.ico.org.uk/concerns.

Thank you for taking the time to read this information sheet

Participant Consent Form

Title of Study:

Exploring perceptions of resilience in relation to its influence on career decisions in midwifery practice

Research Question:

'What is the influence of resilience on midwives' and student midwives' career-related decisions?'

	Please confirm agreement to each statement by putting your initials in the boxes below
I have read and understood the participant information sheet dated 30.08.19: Version 3.2	
I have had the opportunity to ask questions, discuss this study and received satisfactory answers to all my questions	
I have requested a summary and findings of the results to be sent to me YES/NO (delete)	
I have received enough information about the study	
I understand my participation in the study is voluntary and that I am free to withdraw from the study at any point: - 1. Without having to give a reason for withdrawing 2. I can also withdraw my interview data from the study up to 10 days following interview.	
I understand that my interview will be audio-recorded.	

I understand that any information I provide, including personal data, will be kept confidential, stored securely and only accessed by those carrying out or overseeing the study.	
I understand that any information I give may be included in published documents, but all information will be pseudonymised.	
I understand that an original copy of the participant information sheet (PIS) and completed informed consent form will be given to me, in addition to the original copy that is filed in the investigator file.	
I agree to take part in this study	
Participant Signature …… Date:	
Name (and contact details if sending summary/findings) of Participant	
Researcher/PhD Student Signature …….. Date:	
Name of Researcher/PhD Student HELEN RECCHIA	

Appendix I: Preparing for semi-structured interviews:

Preparing for Semi-Structured Interviews

Practical Issues:

1. Make sure that you are on time
2. Check to see if the location is suitable
3. Refreshments
4. Equipment check
5. Including: digital recorder, spare batteries and/or mains adapter, notepad/pen or pencil, tissues
6. Be familiar with the interview schedule
7. Have a box of paper tissues ready!
8. Be alert and keep in mind what is the purpose of the interview (i.e., consider research question)
9. Have all documentation ready: including PIS, consent form
10. Relax and be confident

Things NOT to do during Interviewing:

1. Don't be busy taking too many notes and not listening
2. Don't be frightened about not sticking to the interview schedule (it's only a guide)
3. Don't sit there and try to find out what the participant is really thinking
4. Don't simply listen for the things that you want to hear
5. Don't relate things back to yourself during the interview
6. Don't tell the participants that they are wrong
7. Don't try to make the participant like you
8. Don't change the subject abruptly

Pilot Interview Considerations:

How long did it take to complete?
Were the instructions clear?
Were any questions ambiguous?
Were any questions objectionable?
Was the layout clear and easy to follow?
Were any topics omitted?

Preparing for Semi-Structured Interviews

Key Features of semi structured interviews:

Schedule in advance at a designated time
Location normally outside everyday events
Organised around a set of predetermined questions
Other questions emerge from dialogue
Usually last from 30 minutes to several hours
(DiCicco-Bloom and Crabtree, 2006)

Phases of the Interview:

Building rapport (engage in general conversation, put participant at ease)
Apprehension phase (use prompting but not leading questions)
Exploration phase (use open-ended questions and probing questions)
Co-operative phase (participant reaches comfort level, free discussion may occur, do not degenerate into a 'chat')

Participation phase (not always reached, but can be where greatest rapport is developed between interviewer and participant)

Concluding the interview (end on a positive note, use humour where appropriate)

The Interview:

Listen and work through the answers

Use appropriate language

Let the participants tell their own story in their own way

Use 'Could you tell me'

Reassure participants

If a participant becomes distressed during the interview give the participant time to gather their thoughts and then ask them if they wish to continue.

Take notes-considering non-verbal cues, silences, laughter etc.

Tips in preparing and using an interview schedule:

Do not start the interview with a question probing into personal information of the interviewee

Start with 'lighter questions'

The general rule is for you to group your questions in a logical manner

If using open-ended and closed questions, it would be a clever idea to mix them up

Keep the participants in mind when preparing questions

The wording of the questions must be clear

Provide adequate space where you can record or write the answers or responses to each question

Familiarise yourself with the interview schedule

Interview Preparation Checklist:

Purpose of the interview

Clarification of topic under discussion

Format of the interview

Approximate length of the interview

Assurance of confidentiality

Purpose of digital recorder-gain consent. Explain who will be listening to the recording

Assure participant that he or she may seek clarification of questions

Assure participant that he or she can decline to answer a question

Assure participant that there will be opportunity during the interview to ask questions

(Whiting, 2008)

Appendix J: Interview Schedule:

Interview Schedule for Participant (Midwife/Student Midwife):

I. Opening A. (Establish Rapport) [shake hands] My name is **Helen** and **as part of my PhD study I am wanting to find out more about midwives/student midwives' perceptions and experiences of resilience and therefore interview you, so that I can contribute to the limited reach that already exists in relation to resilience and midwifery practice.**

B. (Purpose) I would like to ask you some questions about **your background, your education/practice, some experiences you have had, and some of your potential strategies or ideas you may have for building and developing resilience as a midwife/student midwife**

C. (Motivation) I aim to use this information to support me with my PhD but also help add to the existing debate and influence and support future practice.

D. (Timeline) The interview should take about approx. 45 minutes and will not exceed 60 minutes.

Are you happy for me to go through the participant consent form and Patient Information Sheet with you?

Do you have any questions you would like to ask me so far?

(Transition: Let me begin by asking you some questions about where you work and your experience as a midwife)

II Body A. (Topic) General demographic information

1. How long have you been a qualified midwife?
2. Where did you undertake your midwifery training?
3. At what educational level did you study midwifery at?
4. Where have you worked during this time?
5. What is it most about being a midwife you enjoy?

(Transition to the next topic: _____)

B. (Topic) Practice

(Transition to the next topic: _____)

C. (Topic) Experiences

(Transition to the next topic: _____)

D. (Topic) Strategies and Coping mechanisms

1. What campus and/or community activities are you involved in besides the Human Services program?

2. You listed on your Bio-Sheet that you love to windsurf, and you compete professionally.

a. What do you like best about windsurfing?

b. What was your most memorable windsurfing experience?

c. Do you ever give windsurfing lessons?

d. Where is your favourite place to windsurf? Why?

(Transition: Well, it has been a pleasure finding out more about you. Let me briefly summarize the information that I have recorded during our interview.)

III Closing

A. (Summarize) You are involved in _____ You plan to pursue a career in _____. Your hobbies and interests are _____.

B (Maintain Rapport) I appreciate the time you took for this interview. Is there anything else you think would be helpful for me to know so that I can successfully introduce you to our class?

C. (Action to be taken) I should have all the information I need. Would it be all right to call you at home if I have any more questions? Thanks again. I look forward to introducing you to the rest of our class.

Research Question: 'What is the influence of resilience on midwives' and student midwives' career-related decisions?'

Objectives:

1. **To understand how midwives and student midwives perceive and experience resilience.**
2. **To explore if and how resilience influences midwives' and student midwives' career-related decisions.**
3. **To develop a theoretical explanation about the influence of resilience in midwives' and student midwives' career-related decisions.**

1. In your own words, can you describe what you understand by the term resilience to mean?

2. Can you explain what key attributes you think that a midwife requires to being resilient?

3. Has your resilience as a midwife increased or decreased since you first qualified? Explain your answer.

4. Are there any other factors such as age, gender etc. that you think contribute to a resilient individual and midwife?

5. What factors within your working environment do you enjoy?

6. What factors/elements of your working environment do you dislike?

7. What aspects about your role do you like?

8. What aspects about your role do you dislike?

9. What are the key factors which make you stay working as a midwife?

10. What prevents you leaving practice as a midwife?

11. Can you tell me how you achieve a good-work life balance?

12. When you have had a difficult day at work, how do you manage to 'bounce back' and return for your next shift?

13. Can you identify stress triggers or warning signs when you feel you your working day/life is having an impact on your physical or mental health?

14. When you experience a stressful day at work what support mechanisms (if any) do you access?

15. Whose responsibility do you think it is for building and developing a resilient work force?

16. Do you think your 'resilience levels' would be affected by moving to another area/workplace?

17. How would you describe your job as a midwife to someone who was keen to join the profession?

18. Has there being any points during your time as midwife where you have felt more vulnerable in your role?

Interview Schedule for Participant (Midwife 'Leaver')

I. Opening

A. *(Establish Rapport)* [acknowledge remote interviewing and COVID-19 etc.] My name is **Helen** and **as part of my PhD study I am wanting to find out more about midwives' perceptions and experiences of resilience and therefore interview you, so that I can contribute to the limited research that already exists in relation to resilience and midwifery practice.**

B. *(Purpose)* I would like to ask you some questions about **your background, your education/practice, some experiences you have had, and consider the rationale for**

your decision to leave the profession and explore if resilience had a part to play in this or not.

C. *(Motivation)* **I aim to use this information to support me with my PhD research but also help add to the existing debate in relation to resilience in healthcare professionals to influence and support future practice.**

D. *(Timeline)* **The interview should take about approx. 45 minutes and will not exceed 60 minutes.**

Confirm participant has read, understood, and returned the Participant Consent Form (PCF) and Patient Information Sheet (PIS).

Do you have any questions you would like to ask me so far?

Confirm audio recording will begin.

(Transition:* Let me begin by asking you some questions about where you work and your experience as a midwife*)

II Body

A. (Topic) General demographic information

1. How long have/had you been a qualified midwife?

2. Where did you undertake your midwifery training?

3. At what educational level did you study midwifery at?

4. Where did you work during this time?
5. Did you work full-time/working hours?

(Transition to the next topic____)

B. (Topic) Practice, Experience and Education

1. What did you most you enjoy about being a midwife?

2. What aspects about the role did you dislike?

3. Do you consider that how and when you were educated as a midwife has had any impact on your resilience in the workplace?

4. Do you consider the current training for a midwife in the UK prepares a newly qualified midwife for the role?

5. What aspects of the role of the midwife has exacerbated the role since you qualified?

(Transition to the next topic____)

C. (Topic) Understanding of the meaning resilience

1. In your own words, can you describe what you understand by the term resilience to mean?

2. Resilience as a term has become a popular phrase and has been used frequently in the last few years in relation to healthcare, why do you think that is?

3. If you think about a midwife, or colleague you work/worked with that you see as a resilient person, what key attributes do you think they have?

4. Over the years you worked as a midwife, did your resilience increase or decrease? Explain your answer.

5. Are there any other factors such as age, gender etc. that you think contribute to a resilient individual and midwife?

(Transition to the next topic____)

D. (Topic) Valuing the Role

1. What advice would you give to a student midwife or a newly qualified midwife entering the midwifery profession now?

2. How would you describe a job as a midwife to someone who was keen to join the profession?

3. Do you think your 'resilience levels' would be affected by moving to another area/workplace?

4. Whose responsibility do you think it is for building and developing a resilient work force?

5. When you made the decision to leave the profession, did you discuss/or were you asked why you had come to this decision by anyone?

6. Would you ever return to the midwifery profession/healthcare setting?

(Transition to the next topic____)

E. (Topic) Career-related decisions and resilience (might already have been discussed earlier)

1. Can you tell me about points in your career as a midwife when you have had changes to your role?

2. Were these changes your choice or choices made by management or service driven?

3. If you made these career choices, did your resilience levels at the time influence the decision you made?

4. What other factors/variables may influence any career-related decisions you have made?

5. On reflection of these career-related decisions, do you think your resilience towards your profession is related or significant?

(Transition to the next topic____)

F. (Topic) Reason to leave

1. Can you tell me about the time when you decided to consider not working as a midwife anymore?

2. Did your decision to leave, include leaving healthcare completely, or was it just midwifery practice?

3. As you know my study is exploring if resilience has any influence over midwives' and student midwives' career-related decisions, including deciding to leave the profession, is this something you think is relevant in your experience? Can you explain this please?

4. Do you think your decision to leave the profession had anything to do with your resilience levels at the time?

5. Were there particular triggers, such as environment at work, colleagues, or maybe work-life balance issues which contributed to your decision to leave?

6. During my study so far, many of the practicing midwives have spoken to me about a negative 'culture' (sometimes using the term bullying) of midwifery practice, is this something you think might have had an impact on your resilience levels? Can you explain why.

7. Would anything or anyone at the time you left encouraged you to possibly stay?

(Transition: Well, it has been a pleasure finding out more about you. Let me briefly summarise the information that we have discussed during our interview.)

III Closing

A. (Summarise) you had been a midwife for (yrs.) _____ your experiences include (…) you understand resilience to mean (….). You decided to leave to profession because (…)

B (Maintain Rapport) I appreciate the time you took for this interview. Is there anything else you think would be helpful for me to know to help me with my research about resilience and midwifery practice?

C. (Action to be taken) I should have all the information I need. However, should I need to contact you to for clarity of the content of your interview, would it be all right to contact you if I have any further questions? If you would like a summary of my results when I complete my study, I am more than happy to send you these?

Thanks again.

F. (Topic) Career-related decisions and resilience

1. Can you tell me about points in your career as a midwife when you have had changes to your role?

2. Were these changes your choice or choices made by management or service driven?

3. If you made these career choices, did your resilience levels at the time influence the decision you made?

4. What other factors/variables may influence any career-related decisions you have made?

5. On reflection of these career-related decisions, do you think your resilience towards your profession is related or significant?

Appendix K: Additional Interview Questions for Managers

Additional Interview Questions for Managers:

1. It has been recognised that resilience can be developed, with that in mind, whose responsibility do you think it is to do this? (I already ask this, but I will probably move it to this section).

2. Some of the midwives who I have interviewed have mentioned the challenges of increased activity in the maternity unit with short staffing; do you think that being a resilient individual can help deal with these types of issues?

3. Do you think the relationships and dynamics between managers and staff has any impact on building a resilient workforce? Explain.

4. Previous studies about resilience have highlighted that the culture of a maternity unit, particularly the labour ward can be a negative experience for some midwives. If there are strategies to improve cultures in your organisation, do they include developing resilience in midwives?

5. How can managers create positive and supportive working environments for midwives?

6. Some midwives perceive absence from work as 'letting their team down' or admitting that they are not resilient enough. Would you consider or measure increased sick time as being a 'less resilient' workforce?

Appendix L: Initial Interview Guide in detail

A. (Topic) General demographic information

How long have you been a qualified midwife?

Where did you undertake your midwifery training?

At what educational level did you study midwifery at?

Where have you worked during this time?

Do you work full-time?

B. (Topic) Practice, Experience and Education

What is it most you enjoy about being a midwife?

What aspects about your role do you dislike?

Do you consider that how and when you were educated as a midwife has had any impact on your resilience in the workplace?

Do you consider the current training for a midwife in the UK prepares a newly qualified midwife for the role?

What aspects of the role of the midwife have exacerbated the role of the midwife since you qualified?

C. (Topic) Understanding of the meaning resilience

In your own words, can you describe what you understand by the term resilience to mean?

Resilience as a term has become a popular phrase and has been used frequently in the last few years in relation to healthcare, why do you think that is?

Can you explain what key attributes you think that a midwife requires to be resilient?

Has your resilience as a midwife increased or decreased since you first qualified? Explain your answer.

Are there any other factors such as age, gender etc. that you think contribute to a resilient individual and midwife?

D. (Topic) Strategies and Coping mechanisms

Can you tell me how you achieve a good-work life balance?

Would you consider leaving your current role to protect your work-life balance?

When you have had a difficult day at work, how do you manage to 'bounce back' and return for your next shift?

Can you identify stress triggers or warning signs when you feel your working day/life is having an impact on your physical or mental health?

When you experience a stressful day at work what support mechanisms (if any) do you access?

Tell me about the area you work in and how your colleagues might support each other in the workplace.

Has there been any points during your time as midwife where you have felt more vulnerable in your role?

E. (Topic) Valuing the Role

What are the key factors which make you stay working as a midwife?

What prevents you leaving practice as a midwife?

What advice would you give to a student midwife or a newly qualified midwife entering the midwifery profession now?

How would you describe your job as a midwife to someone who was keen to join the profession?

Whose responsibility do you think it is for building and developing a resilient workforce?

Do you think your 'resilience levels' would be affected by moving to another area/workplace

Appendix M: Initial (Open) Codes:

Initial (Open) Codes

'30 hours' Where a participant refers to their contractual working hours, with 30 being implied as an optimum work-life balance.
'A Tribe' Participants reference for describing a supportive working group they belong in.
Age Participants referring to their perception of resilience with age (some experienced midwives thinking that a younger aged midwife might be less resilient?).
Altruism When a participant perceives their role and profession is superior to their own needs.
Appreciated and Valued When a participant referred to feeling that what they do at work is being recognised (often alluding to being recognised by their managers).
Belief system An observation from a participant that having a faith is a supportive tool for them and for women.
Bravery When a participant sees in relation to their sense of identity, when they put their uniform on (like 'shield').
Bullying between staff and managers

Participants expressing when they have experienced or observed bullying type behaviour in the workplace, particularly from senior staff.
Career Progression When a participant refers to a decision, they have made in their career which has usually been a positive one.
Career-related decisions When a participant refers to their career experiences and choices, including whether their resilience levels at the time influenced this decision.
Common Sense A midwife describing what the role of a midwife needs to include.
Compartmentalising-strategies to cope Participants making sense of their ways of coping with stress in the workplace and separating these. An ability to put home and work life into different 'boxes' to deal with everything at once.
Confidence and competence in role Participants referred to having increased competence within their role gave them confidence in the workplace too.
Consequences of continuity of care Many midwives, regardless of their role referred to the current challenges that CoC has brought for them, including feeling less/more resilient because of it.
Coping with change Participants describing how they deal with change in the workplace
Cultural practices

Participants referring to 'culture' in the workplace, often used to describe a negative one that might include bullying practices.
Decision to leave or stay Participants referring to choosing to stay in midwifery practice, move to another role, or leave the profession entirely.
Defensive practice Some midwives' perceptions of the increased pressures to midwifery practice, including the increased risks of litigation.
Definition of resilience Participants describing in their own words what they understand resilience to mean.
Development of resilience Responses of participants including how they express how they have developed their resilience.
Emotional strength Included by some participants to mean an individual is a resilient one if they have a good amount of emotional strength.
Empowerment Occasionally used by some participants to describe their ability to empower women, although referred to by participants to want this, or be grateful of having some control over their input to their ways of working.
Environmental factors Used to describe the working environment of the staff, such as a midwifery led unit lending itself to more flexibility with the normalisation of labour and birth practices.
'Even if you have a really bad shift'...

Returning to work in the face of adversity, even when you might not feel like you want to.
Expectations The feelings of the participants regarding the increased perception of women depending on the midwife, and the expectations that they referred to for those entering (often at a younger age) the profession.
Flexibility A trait described by many midwives as a positive one for those that they perceived to be resilient individuals.
Gender Used to address if this has any impact on developing resilience in relation to a workforce that is predominantly female.
Guilty Feelings of guilt described by some participants if they did choose to leave the profession.
'Hardiness' Sometimes used to describe those that are resilient individuals.
Hierarchy Refers to participants describing the organisational structure of their workplace and the potential divisions that sometimes exist between senior and junior staff members.
High opinion of self Where a participant has responded to a question and alludes to sound like they are superior to others.
Identity Used by several midwives to describe why they would not leave the profession because of this and being a midwife is 'part of them'.

Independent midwifery A model of midwifery practice that is outside of the NHS.
Martyr An attitude by some participants to their approach to work.
'Moving on' Where a midwife does not ruminate over experiences they have been involved with-getting over them 'quickly'.
Optimism Descriptions by some participants as a mental attitude characterised by hope and confidence.
Panacea Resilience seen as a potential remedy to all challenges in the NHS
Passion and commitment for role Where participants describe the love of their job with enthusiasm.
Perception of resilience and 'not coping' When participants describe if they are not resilient or less resilient, others may see this negatively.
Positive aspects of role When participants describe what they enjoy about being a midwife the most.
Positive attitude Having this, was perceived to be an attribute for being or becoming more resilient.
Pragmatism Some participants attitude to the way it is at work 'nowadays'.

Resentment Feelings described by some participants for their attitude to work becoming negative.
Resilience and Menopause Some participants making an association with their perception of decreasing resilience due to the stage in life (peri/menopausal) as a reason.
Self-preservation Described by participants as a necessary attitude to oneself as a way of protection.
'Sense of Belonging' A helpful feeling shared by some participants for contributing to developing resilience in the workplace.
'Shared understanding' An unsaid feeling of knowing what it means to be a midwife and the challenges that come with this role.
Short staffing A reason described by many participants for their negative attitude to their workplace.
'Snowflake' Used to describe the previous generations attitude to the younger generations way of coping with life experiences.
Stigma Used to describe members within the midwifery workforce who may feel that not being a resilient individual, has negative connotations.
Stress and coping A generic code derived by participants for managing workload stress, includes a 'sense of humour'.

Support mechanisms Several strategies described by participants to assist them with dealing with work-related stress.
Terminology for women 'Women' described by an independent midwife as 'clients'.
Unappreciated Feeling expressed by some participants for not feeling valued by senior staff for what they contribute at work.
Unsupported Described by some for the attitude of senior staff when midwives seek out and ask for help.
'Work family' A term used to describe a supportive group by some participants of the colleagues they work with.
Working in a 'system' An often-negative perception and result by some participants of work in a large organisation, such as the NHS.

Appendix N: Illustrating details of banding and roles and responsibilities

BAND	DESCRIPTION and ROLE/ RESPONSIBILITY
1 Nursery Assistant	These roles require routine procedures that are gained through simple induction or training. These roles are unskilled and require limited qualifications. *Examples of roles at band 1 - domestic support worker, housekeeping assistant, driver, and nursery assistant.*
2 Healthcare Assistant	Roles in this band would require a period of induction. The employee would be required to understand a range of procedures, that although are routine, may be performed outside of their immediate work area. *Examples of roles at band 2 - domestic support worker, domestic team leader, security officer and healthcare assistant.*
3 Emergency Care Assistant	Employees would be expected to use their knowledge to apply to new situations within a range of work procedures. Roles would require a level of formal training or relevant experience. *Examples of roles at band 3- emergency care assistant, clinical coding officer, estates officer and occupational therapy worker.*
4 Theatre support worker	In more detail than band 3, these positions would require further application of theory to a job role. Band 4 roles would require a candidate to have relevant experience or complete a detailed training programme. *Examples of roles at band 4 - assistant practitioner, audio visual technician, pharmacy technician, dental nurse, and theatre support worker.*
5 Newly qualified nurse/ midwife	Employees would be expected to understand a wide range of procedures and practices. Candidates likely have expertise within a specialist area, which will have been gained through qualifications or relevant experience.

	Examples of roles at band 5 (includes many newly qualified clinical professionals) - operating department practitioner (ODP), learning disability nurse, midwife, and practice manager.
6 Nursing specialist or Senior nurse/midwife	Specialist roles gained through study or extensive practical experience. *Examples of roles at band 6 - school nurse, experienced paramedic, clinical psychology trainee, midwife, and biomedical scientist.*
7 Advanced Nurse/Nurse Practitioner	Highly developed specialist knowledge across the range of situations. Employees will have gained skills through extensive study and relevant practical experience. *Examples of roles at band 7 - communications manager, high intensity therapist, labour ward coordinator and advanced speech and language therapist.*
8 Modern Matron or Chief Nurse	(a)Advanced knowledge through study and practical experience over a range of work procedures and practices *Examples of roles at senior midwife a - consultant prosthetist/orthotist, project and programme management, modern matron (nursing/midwifery) and nurse consultant (mental health nursing).* (b) Specialist knowledge covering more than one discipline acquired through extensive experience. *Examples of roles at senior midwife b - strategic management, head of education and training, clinical physiology service manager and head orthoptist.*

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Abbreviations:

Acronym	Definition
AEI	Approved Education Institution
CoC	Continuity of Carer
DoH	Department of Health
GMC	General Medical Council
GT	Grounded Theory
HEE	Health Education England
HEI	Higher Education Institution
LME	Lead Midwife for Education
LMS	Local Maternity System
NHS	National Health Service
NMC	Nursing & Midwifery Council
PMA	Professional Midwifery Advocate
PTSD	Post-traumatic stress disorder
RCT's	Randomised controlled trials
RCS	Restorative Clinical Supervision
RCM	Royal College of Midwives
RCN	Royal College of Nurses
UK	United Kingdom
USA	United States of America

Glossary:

Certificate Midwife

The qualification required to be a registered midwife, prior to the introduction of Diploma and Degree qualifications.

Exit interview

An interview held with an employee about to leave an organisation, it may include discussions about the employee's reasons for leaving and their experience of working for the organisation.

Lead Midwife for Education (LME)

Lead midwives for education (LME's) help to ensure high standards in midwifery education. LME's are based at, and employed by, the Approved Education Institution (AEI) providing pre-registration midwifery education.

Post-traumatic stress disorder (PTSD)

An anxiety disorder that develops in reaction to physical injury or severe mental or emotional distress, such as military combat, violent assault, natural disaster, or other life-threatening events.

Professional Midwifery Advocate (PMA)

PMA's support midwives to ensure that women and babies receive excellent quality, safe care. PMA's provide direct support for women within a restorative approach, supporting midwives to advocate for women.

Syntocinon

Syntocinon belongs to a group of medicines called oxytocics. It is a synthetic form of oxytocin and frequently used in midwifery and obstetric practice to induce or enhance labour by stimulating the uterus to contract.

Vulnerable Adults

Vulnerable adults are defined as those adults' lacking capacity or having potentially impaired capacity and who are unable to make all or some decisions for themselves.

Wobble-rooms

A place for staff in the NHS to ‘drop in’ and talk to a member of the human resources team about work-related issues.