



UNIVERSITY OF  
BIRMINGHAM

# **Evaluation of NHS England's Perinatal Culture and Leadership Programme**

**Final report – August 2025**

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**Co-Principal Investigators:** Prof Sara Kenyon MBE and Dr Nimarta Dharni

**Co-Investigators:** Prof Graeme Currie, Ms Samantha Russell, Prof Justin Waring and Prof Sam Watson

**Researchers:** Dr Laura Noszlopy and Dr Tommer Spence

**Additional statistical analysis:** Dr Yixin Wang

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## Background

Organisational culture is a long-recognised determinant of the quality of care provided across different areas of health. Although there is no universally agreed definition, the culture of an organisation is often described as ‘the way we do things around here’ and ‘how we behave when no one is looking’ or the ways in which staff routinely work together (Woodward 2020), and the shared ways of thinking that are ‘then translated into common and repeated patterns of behaviour’ at localised levels (Davies & Mannion 2013). In a scoping review of organisational culture in maternity care, Frith et al (2014) found that professional conflicts, alongside time pressures and procedural imperatives, were the main organisational barriers to the practice of good maternity care.

In the UK, successive maternity safety reports and inquiries have highlighted culture and team working as key contributory factors to avoidable harm to women, babies, and their families (Draper et al 2019; Knight et al 2019; Rowe et al, 2020; NHS Resolution 2019; Ockenden 2022; Kirkup 2022). The independent Ockenden (2022) review of maternity services at the Shrewsbury and Telford Hospital NHS Trust and the investigation led by Kirkup (2022) into maternity and neonatal services in East Kent each made specific recommendations about improving leadership, communication, and culture as a core part of the wider work of improving safety in maternity and neonatal services. These included a set of ‘immediate and essential actions’ from Ockenden regarding improvements to leadership and governance; addressing poor team working and ‘lack of psychological safety’ in teams; and the need to improve multi-disciplinary working (2022). As of September 2024, the Care Quality Commission (CQC) reported that the safety of maternity services in England ‘remained a key concern’ (2024), with 65% of services rated as ‘inadequate’ or ‘requiring improvement’ – and no services rated as ‘outstanding’ – for safety.

Culture change interventions in the NHS take place within a vast and complex system, with variation between sites, services, teams and individuals. Organisational culture has been viewed as complex, elusive, and contested, yet culture is often identified as ‘both diagnosis and prescription’ (Mannion 2022). Research has found that cultivating effective cultural change in healthcare systems, where it is possible at all, takes time, contextual sensitivity, and sustained effort across all levels (Mannion 2022, Davies & Mannion 2013). Although it was the latest in a succession of national maternity improvement interventions in recent years, the Perinatal Culture and Leadership Programme (PCLP) was the first seeking to improve leadership and culture across all maternity and neonatal services using a novel approach to cultural change, which focused on building capability within a quadrumvirate (quad) of senior perinatal leaders.

## **Overview of the PCLP**

The PCLP was part of the NHS three-year delivery plan for maternity and neonatal services (NHS England, 2023). Launched in October 2022, it brought together senior leaders within maternity and neonatal services – including Directors/Heads of Midwifery, Clinical Directors for Obstetrics and for Neonates, Operational Directors, and sometimes other combinations of senior staff – as a quad to engage in the programme.

The broad aims and objectives of the PCLP were compiled in a Theory of Change (ToC) document in January 2024 (Appendix 1). The ToC, along with the content of the PCLP, set out the programme’s objectives to improve relationships within the quad and equip them to be a locus of culture change, through leadership training, insight into the culture within their services, and facilitated support to develop a culture improvement plan. It assumed that the impact on quads would ‘ripple up/across and down services’, resulting in wider culture change in the longer term. Key assumptions included that Phase 1 would lead to quads being ‘in a better place’ for the latter phases, that quads would have the capacity to engage throughout the programme, and that focusing on leadership development would lead to more positive cultures and, ultimately, better experiences for staff and those using services.

The programme was rolled out in stages, with five intakes covering all 120 NHS Trusts providing maternity and neonatal services (across 156 sites) in England. Each intake had between 19-30 quads; Trusts with services across more than one site were able to send multiple quads. The first intake started the programme in November 2022 and the final intake commenced in November 2023; it took each intake approximately 15 months to complete. Programme development and delivery took an iterative, appreciative inquiry approach, adapting where necessary to meet the jointly-identified needs of each quad. This phased approach was also determined by NHS England funding processes, which saw phases of programme activity funded in separate stages, rather than comprehensively at the start. This contributed to the programme ending later than initially anticipated, in March 2025. The PCLP comprised three phases, which are outlined in Table 1.

**Table 1: Overview of the PCLP**

<b>Phase (average duration)</b>	<b>Component</b>	<b>Description</b>
One (6 months)	Leadership development modules x3	Workshops with cohorts of up to 6 quads (24 members) from different Trusts, designed to support understanding of their role in creating a positive safety culture through inclusive and compassionate leadership. Organised in central locations with most quads spending 1-3 nights away.
	Action learning sets (ALS) x4	Facilitated sessions with a coach for up to 6 quad members from different Trusts, exploring PCLP learning, what they wanted to achieve, and what they might struggle with. First session held face-to-face and others online.
	Self-directed 360 [Voluntary]	Opportunity for quad members to learn, and reflect on, how self-nominated team members experience their leadership. Supported by a 1:1 coaching session with their ALS facilitator.
Two (3-4 months)	Culture survey	Diagnostic exercise supporting the quad to identify key strengths and opportunities in the local culture. The Safety Culture, Operational Risk, Reliability/burnout and Engagement (SCORE) survey was utilised to support this. All staff in maternity and neonatal services encouraged to respond.
Three (5-6 months)	Culture coaching with quad x3	Quads provided with an individual 'culture coach' to support development of shared values, vision, purpose, a communication plan, and a culture improvement plan. Quads were encouraged to identify a local 'change team' of staff to cascade the culture work. Sessions offered face-to-face and virtually.
	Cultural conversations with staff x4	Conversations with wider staff, facilitated by the 'culture coach', to discuss the results of the culture survey, which then informed the culture improvement plan. 'Change team' members offered training by NHS England to facilitate further cultural conversations. Sessions offered face-to-face and virtually.
	Quad check-ins x3	Short follow-up calls with the 'culture coach' to review progress on communication plan, culture improvement plan and quad working.

The PCLP was implemented during – and in response to – a period of considerable scrutiny and demand on maternity services in England. As well as the published independent Ockenden and Kirkup investigations into three maternity services of concern, with another investigation of services in Nottingham underway, the CQC conducted an inspection of every service between 2022 and 2024, as part of a national maternity review (Kirkup 2015, Kirkup 2022, Ockenden 2022, NHS England 2023, Care Quality Commission 2024). The years between 2010 and 2023 saw dozens of improvement initiatives directed towards maternity services, including NHS Resolution’s Maternity Incentive Scheme, which financially rewards NHS Trusts which successfully implement ten safety actions, and targets to implement continuity of carer across all Trusts (Mcgowan, Attal et al. 2024, NHS Resolution 2025). The COVID-19 pandemic had caused immense strain on healthcare services, including a psychological burden on staff, and were followed by successive years of industrial action, most notably prolonged strikes by junior doctors which occurred during the PCLP timeframe. These pressures, together with financial constraints within the NHS and longstanding staffing and retention challenges within maternity services, meant that senior leaders were under considerable pressure (Royal College of Obstetricians & Gynaecologists 2022, Moncrieff, Downe et al. 2023).

The PCLP has been a substantial piece of work, given the significant time commitment required of quad participants and the programme’s implementation across all maternity and neonatal Trusts nationally. NHS England therefore commissioned this independent evaluation to understand the implementation and impact of the PCLP on the quads and wider perinatal teams in terms of changes in leadership behaviours and organisational culture.

### **Aim of the evaluation**

To evaluate the PCLP in terms of its impact on multi-professional relationships, leadership behaviours, and creating the conditions for a positive organisational culture in participating NHS maternity and neonatal units.

## Methods

### Study design

The evaluation used an iterative, mixed methods approach developed in consultation with NHS England, involving:

- semi-structured interviews with a purposive sample of quad members
- a survey of all PCLP participants (quad survey), developed from the quad interviews
- rapid focused ethnography in a purposive sample of maternity and neonatal services
- a survey of staff at every maternity and neonatal service in England (staff survey)

Focus groups were also conducted with NHS England and PCLP providers to gather contextual information on the development and delivery of the programme. The PCLP ToC was used as a reference point to inform the evaluation.

Each phase of the evaluation was informed by preliminary findings from the previous phases, with the variety of methods enabling exploration of both PCLP participants' and other staff members' perspectives on leadership and culture within their services.

### Interviews

#### ***Sampling and recruitment***

We adopted a purposive sampling approach which involved every Trust that participated in the PCLP being assigned a Red, Amber or Green (RAG) rating based on an assessment by staff at NHS England of their quad's stability and levels of engagement with the PCLP. As this did not account for circumstances in Trusts before the PCLP, or the wider contexts in which they were operating, we also took into consideration the leadership component of their most recent CQC report, the geographical location of sites, the number of births and whether they were a single- or multi-site Trust, to ensure diverse representation across these categories. For each of the five PCLP intakes, we selected a primary and a back-up site to reflect each RAG category.

Quad members at each primary site were approached by the NHS England team to let them know they had been selected to participate in an interview, giving them the opportunity to opt out at that stage. Those who did not opt out had their contact details passed to the evaluation team. We sent each prospective participant three emails over successive weeks, with information about the evaluation and an invitation to take part. If quad members did not respond after three weeks, they were not contacted further.

The sampling was reviewed as recruitment progressed and, if there was little or no participation from quad members at any of the sampled sites, the recruitment process was initiated for the back-up site in the same intake and RAG category with the objective of identifying 12-15 quads and undertaking up to 60 interviews.

### ***Consent***

Participants received a participant information leaflet (PIL) prior to their interview. On the day of the interview, participants were reminded of the contents of the PIL and given an opportunity to ask questions. Verbal consent was audio recorded prior to the interview. Participants were reminded that they could stop the interview or withdraw at any time without needing to explain why. Once the interview was complete, participants were able to withdraw their consent within one week; this was detailed in the PIL.

### ***Data collection***

Interviews were conducted on MS Teams using a semi-structured approach between June and October 2024. Questions covered the participant's professional role and service, their perspectives on the PCLP, their relationships with quad colleagues, their relationships with senior leaders, their approach to leadership and the culture in their services. The interview topic guide is included in Appendix 2. Interviews were recorded and transcribed intelligent verbatim by a professional transcriber.

### ***Data analysis***

Interviews transcripts were uploaded to QSR NVivo 14 software for analysis. We initially coded a small number of transcripts inductively, which – alongside the PCLP ToC, provided by NHS England – informed the development of a coding framework used for subsequent transcription. The framework, which was discussed and refined by the wider evaluation team, covered four overarching categories: quad relationships; leadership; contextual factors influencing culture and change; and views on the PCLP. Each interview was single-coded by one of the researchers, who discussed the analysis periodically with the wider team to refine the coding framework. We continued coding until it became clear that no new themes were being identified; we ended coding at this stage, following discussion with the wider team.

## **Surveys**

### ***Sampling and recruitment***

The quad survey questionnaire was emailed by NHS England staff to everyone who had participated in any phase of the PCLP, except for three Trusts at which all quad members had participated in an interview. Each Trust was sent a unique questionnaire link to enable response tracking. NHS England staff sent three reminders to all recipients to participate in the survey until all quad members at a Trust responded, at which point they

would stop receiving reminders. All survey responses were visible only to the evaluation team.

The staff survey was distributed by NHS England to a survey lead at each site, who was either a member of the quad or another staff member who had been given responsibility for facilitating participation in the survey during Phase 2 of the PCLP. Survey leads were provided with a template email to send to all staff in the maternity and neonatal services. They were also asked to send reminders on three occasions, on a weekly basis. NHS England staff sent reminders to survey leads to encourage them to do this. All survey responses were visible only to the evaluation team.

### ***Consent***

Information regarding the storage, handling and anonymity of the data was made clear at the start of the questionnaire; consent was implicit on completion of the survey. Once the survey was submitted, it was not possible to withdraw as the responses were anonymous.

### ***Data Collection***

The quad survey was developed from the quad interviews, with questions designed to test emerging themes. It asked participants several questions exploring how the PCLP had changed their relationships with quad colleagues and their leadership style. It also asked about their organisation's support for the PCLP and their personal views on the PCLP, including two qualitative free text questions. It was conducted between October and December 2024.

The staff survey asked participants several questions based on desired outcomes expressed within the PCLP ToC and emerging themes from the interviews. These included questions on their senior leaders' visibility and engagement with staff and the culture in their workplace, including three externally validated questions on psychological safety and a question on whether they felt the overall culture in their service was improving compared to 12-18 months ago, a time period covered by the PCLP. Each individual question also asked staff whether there had been any change over the previous 12-18 months. It was conducted between September 2024 and March 2025.

The survey questionnaires are included in Appendix 3.

### ***Data analysis***

We summarised the number of respondents by professional cadre, PCLP intake, and RAG rating. Responses to each survey question are presented as a histogram. For statistical analysis, we used ordinal logistic regression models with adjustment for intake and RAG rating and including site random effects to capture unexplained site-level variation to get

the odds ratios is the proportionate change in the odds of being in a higher category. An odds ratio greater than one indicates that that group has higher odds of disagreeing with the question.

We used Microsoft Copilot – University-approved, encrypted generative AI software – to synthesise qualitative data collected via the survey tool, to support our analysis. The software was given the following prompt, tailored to each question, before the data were uploaded: *I am going to share responses to a survey of NHS senior leaders who work as part of a quadrumvirate (or 'quad') and took part in the Perinatal Culture and Leadership Programme (PCLP). They were asked the question: [Question] I would like you to summarise their responses in no more than 250 words.*

### **Rapid focused ethnography**

We used rapid focused ethnography methods to collect qualitative data on the PCLP and its impact, via non-participant observations of relevant cultural and behavioural information, focused on human experiences, interactions, and practices. These methods are well established at enabling understanding of focused topics and broader culture during intensive visits to sites (Kumpunen & Vindrola-Padros 2022).

### **Sampling and recruitment**

Purposive sampling for the rapid focused ethnography was derived from the 18 sites where the quad interviews took place, again with every effort made to ensure diverse representation by geographical region, both single- and multi-site Trusts, perspectives from different intakes, and equal representation of Red, Amber and Green Trusts. Quads were asked to indicate whether they were open to a potential site visit at the interview stage. Following the sampling, we made direct email contact with the selected quads with a formal request to visit.

### **Consent**

Site visits had the agreement and support of each participating quad at the outset. The quad was asked to nominate a link person (e.g. a matron or secretary) who acted as a conduit to access the wider staff team. We asked each link person to circulate a staff-facing email and shared posters explaining the evaluation and introducing the visiting researcher for display in the units. Obtaining full informed consent is challenging where researchers are engaged in ethnographic data collection because observations rarely involve just one person at a time, sites may include busy areas with unexpected people and due to the relatively unstructured and fluid nature of this type of data collection. In addition to displaying posters in visible locations, we provided copies of the PIL where possible and offered staff the opportunity to opt out of interactions. We accepted verbal consent to observations and informal ad hoc interviews as sufficient during site visits; this also applied to longer interviews and focus groups, though we gave participants the

option to provide written or verbal consent where possible and when audio recording took place.

### ***Data collection***

The site visits involved informal conversations with staff in a wide range of roles – particularly key roles such as matrons and safety champions – and observations of non-patient-facing, day-to-day work such as quad meetings, other leadership and governance meetings, handovers, huddles and routine operational tasks. We also conducted some more formal interviews and focus groups. Visits took place between November 2024 and January 2025, ranging between 3 and 6 days.

While the focus remained on the quad and its response to the PCLP, the researchers also observed and spoke with perinatal staff members at all levels in order to glean the broadest possible understanding of the local culture and interprofessional dynamics, and to capture the ‘synergistic character’ of the features of safe care in maternity units (Liberati et al 2021).

All staff members in each maternity unit selected for the focused ethnography (n=6) were informed about the site visit via emails from their respective quads and through posters displayed in busy areas. The identities of all Trusts, sites and individuals are protected through anonymisation. No women, babies, or families were included or observed during site visits.

Across all observations, researchers aimed to capture instances and extent of the following behaviours, actions and interactions based on the PCLP Theory of Change and emerging findings from the interviews:

1. Social capital and belonging within the quad team
2. Leadership behaviours
3. Culture within maternity and neonatal services
4. The impact of organisational structures

### ***Data analysis***

Data were collected using anonymised notes and audio recordings, then collated in Rapid Assessment Procedure (RAP) sheets based on resources created by the Rapid Research, Evaluation and Appraisal Lab (RREAL) at UCL; these were customised to the PCLP evaluation and focused on key areas of interest, including quad and perinatal working, leadership behaviours, culture and organisational structure (Appendix 4). They included space for researcher observations alongside supporting evidence. RAP sheets were completed after each day of data collection and consolidated into a final rap sheet

at the end of each visit. The evaluation team discussed the data across several meetings, in relation to other data from the evaluation, to establish findings.

### **Ethical considerations**

Ethical approval was obtained from the University of Birmingham Ethics Committee (Ref: ERN2116-Feb2024) before data collection began. NHS HRA approval was not required as this was a service evaluation and not research based on the Health Research Authority (HRA) defining research algorithm. Site specific approval was sought from each unit that participated in the rapid focused ethnography part of the evaluation. Researchers held DBS clearance and ensured that they did not observe women, babies or families in clinical contexts. Detailed information on the data management processes is available in Appendix 5.

## Results

### Participants

The characteristics of interview, quad survey and staff survey participants are presented in Table 2. The response rate to the quad survey was 53% of quad members, with representation from 88% of sites. The response rate to the staff survey was 7% of all staff (per the denominators during Phase 2 of the PCLP), with representation from 76% of sites.

**Table 2. Overview of participants in the interviews, quad survey and staff survey**

	Interviews	Quad Survey	Staff Survey
<b>Total Participants</b>	53	289	4011
<b>Total Trusts</b>	18	124	96
<b>Role</b>			
Midwifery	16 (30%)	77 (27%)	2480 (62%)
Obstetrics	13 (25%)	72 (25%)	285 (7%)
Neonates – Medical	9 (17%)	64 (22%)	152 (4%)
Neonates – Nursing	5 (9%)	20 (7%)	416 (10%)
Operational/Management	10 (19%)	51 (18%)	43 (1%)
Medical – Anaesthetics	-	-	35 (1%)
Allied healthcare professionals	N/A	N/A	349 (9%)
Other	-	5 (2%)	251 (6%)
<b>Intake</b>			
1	5 (9%)	49 (17%)	822 (20%)
2	10 (19%)	43 (15%)	1197 (30%)
3	12 (23%)	54 (19%)	670 (17%)
4	11 (21%)	64 (22%)	515 (13%)
5	4 (8%)	65 (22%)	662 (17%)
Split across intakes	11 (21%)	14 (5%)	-
<b>RAG rating</b>			
Red	26 (49%)	68 (24%)	1120 (28%)
Amber	11 (21%)	133 (46%)	1901 (47%)
Green	16 (30%)	88 (30%)	990 (25%)

We conducted 220 hours of rapid focused ethnography over 3-5 days at six sites: two Red; two Amber; and two Green. An overview of site characteristics is presented in Table 3 and a breakdown of staff and activities observed is presented in Table 4.

**Table 3. Overview of rapid ethnography site characteristics**

Site	RAG Rating	No. of Births	Deprivation*	Ethnic diversity**
1	Amber	High	Moderate	Very high
5	Green	High	High	Very high
6	Green	Low	Very low	High
7	Red	Medium	Very high	High
14	Amber	Medium	Moderate	High
17	Red	High	Mixture of moderate and low	Low

\*This measure was determined by ranking every local authority in England by its Index of Multiple Deprivation. The list was divided into quintiles ranging from 'very high' deprivation to 'very low'.

\*\* This measure was determined by ranking every local authority in England by the proportion of residents who did not identify their ethnicity as 'White' in the 2021 census. The list was divided into quintiles ranging from 'very high' diversity to 'very low'.

**Table 4. Overview of staff and activities observed during rapid ethnography across six sites**

	Number
<b>Activity</b>	
Quad/Senior Leadership Meeting	4
Governance Meeting	15
Staff Meeting	22
Handover / Huddle	27
Routine Work	25
Small Group Discussion	22
Individual Conversation / Interview	105
<b>Role</b>	
Midwifery	85
Obstetrics	13
Neonatal – Medical	14
Neonatal – Nursing	18
Operational/Management	15
Allied healthcare professional	9
Other	16
<b>Seniority</b>	
Board	6
Director	16
Head/Lead	19
Mid-level*	36
Lower-level**	93

\*Staff with formalised leadership roles within a discrete area of the service e.g. matrons, advanced clinical practitioners, consultants, registrars, general managers.

\*\*Staff without formalised leadership roles, typically those working at band 7 or below.

## Findings

The evaluation findings are based on a triangulation of data tested across all sources. We identified six findings which are categorised into three sections: establishing and developing the quad as leaders of perinatal services; empowering the quad to change culture; and reflections on the PCLP, including structural factors which affected the PCLP's impact.

### Section 1: Establishing and developing the quad as leaders of perinatal services

#### *Improved relationships within quad teams*

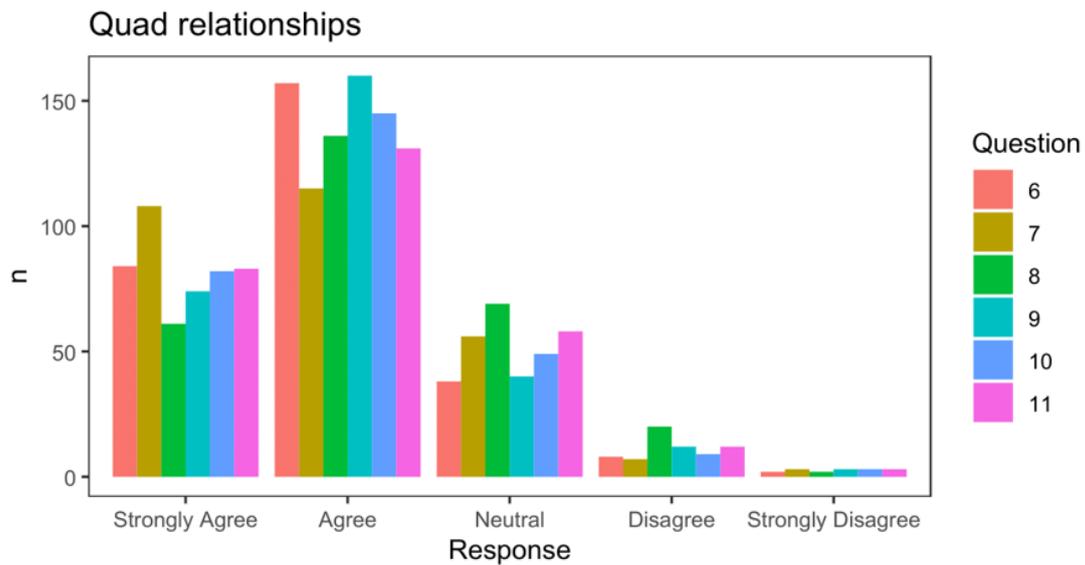
We identified that the PCLP had led to improvements in how members worked together, which was one of the main aims of the programme. This included the quality of the relationships between quad colleagues, the amount they communicated with each other, the methods they used to communicate with each other, their understanding of their respective services and concerns, and the extent to which they saw themselves as having a shared responsibility and vision for their perinatal service.

*'My role bridges everybody, so I'm used to actually dealing with everyone, and it's been nice to actually bring those people together so they can have a conversation that I can be involved in at the same time and not having different conversations [...] Traditionally maternity, obstetrics, neonates, been very, very separate entities [...] working as one combined unit together is actually going to improve on working relationships, it's going to improve on patient safety.'*

Participant 4a (Operational)

**Observation:** *This site has expanded the membership of its quad to respond to local needs. A deputy DoM, with strong skills but relatively little formal leadership training, says that the PCLP and the formation of the quad has enabled the quad colleagues to take 'a strategic view of priorities and forward planning' but, more importantly, that it has created 'a safe space to be honest and just space as a leadership team... and we're developing a relationship with neonatal services.'*

This improvement in relationships within the quad is supported by data from the quad survey. Figure 1 shows that respondents to the survey were more likely than not to report improved relationships with their quad colleagues following the PCLP, with a minimum of 68% agreeing or strongly agreeing with at least one of the questions exploring this.



**Figure 1.** Histogram showing the number of responses for the questions regarding quad relationships:

- 6 = My relationships with my quad colleagues have improved since participating in the PCLP;
- 7 = Getting to know my quad colleagues outside of our regular workplace has enabled us to work better as a team;
- 8 = I communicate more frequently with my quad colleagues;
- 9 = I communicate more frequently with my quad colleagues;
- 10 = I better understand the challenges facing other parts of the perinatal service in my Trust;
- 11 = I can more openly share my thoughts and concerns with my quad.

These improvements were reported as being partly due to the establishment of the quad as a concept and as a new team, along with the protected time away provided during Phase 1. We viewed this quad development in terms of the building of social capital, both as an interprofessional network and as a resource to facilitate social action. Social capital can best be understood within a framework of three intersecting aspects: the structural (a tangible network with access to people and resources), the relational (feelings and quality of connection, belonging and trust), and the cognitive (shared understandings, goals, and values); these together constitute a shared capability for resource exchange and for influencing cultural change within the wider group or organisation (Nahapiet & Ghoshal 1988; Claridge 2018).

The PCLP improved all aspects of social capital within the quads. This was facilitated by the provision of the protected time quads had together away from their day-to-day work in Phase 1 of the programme (structural capital). Many quads told us that getting to know each other informally ‘as people’ rather than just as work colleagues improved their relationships and ways of working together (relational capital). In some cases, this also grew into a feeling of increased psychological safety in which the quad could sense-check concerns, share worries and provide emotional support, and safely challenge each other (relational capital). Some quads said they had found ways to continue this

quality of collective work beyond the duration of the programme, through the establishment of new quad meetings, routines, and communicative habits (structural capital). We consistently heard from quad members that the PCLP had given them a better understanding of other parts of the perinatal service and of the interconnectedness of these parts, along with a clearer collective vision with quad colleagues (cognitive capital).

*'I think it's good to be able to take that time out to do [leadership development], because we don't have time in the normal everyday work. So, I think it is important to be able to step out, take stock, look at ourselves as a group, and how we can work together to improve our service.'*

Participant 11a (Midwifery)

*'Those two [away] days were invaluable from the point of view of that we were able to sit down, go out for dinner, and have conversations that helped those relationships. That was probably just as much value as the actual course content, I'm just being really honest. [...] We are all on a WhatsApp group together, so that gives us the ability to do quick reach or quick response to things if we need to. We did actually say the other day we ought to all go out for dinner again. But that's the informal stuff. I suppose the more formal stuff for us when we meet, we can't always all four of us be at those fortnightly meetings, but wherever we can we do prioritise to attend.'*

Participant 3b (Midwifery)

The protected time quads received during the PCLP also went some way to addressing concerns raised in the ToC about senior leaders feeling 'disempowered and burnt-out'. However, the strengthened relationships between quad members were observed in some sites to impede their relationships with other staff and ability to foster and cascade cultural improvement.

**Observation:** *When interviewed, the quad in one site say they developed strong interpersonal bonds during the programme. They are observed communicating often and freely, in person and online, segueing smoothly between humour and more serious topics; communications and this sense of team belonging are further eased due to the proximity of their offices in the management suite.*

*Their strong bond is also noted by more junior staff. Several staff members view them as a 'clique' or a 'mob'; some comment that the perceived tightness and confidence of the new quad formation makes it even more difficult to escalate concerns or requests for support.*

Some quads also noted that they found it difficult to maintain improvements in social capital beyond the duration of the programme, usually due to ongoing heavy workload impacting their ability to meet regularly or unavoidable turnover in quad membership, which meant new members had not been given the opportunity to build relationships with colleagues outside of their day-to-day work. Staff turnover is generally high in the NHS and some senior clinical posts have short tenures. As a result, personnel churn within the quad created an in-built organisational challenge for many quads, with some finding ways to integrate new quad colleagues and other quads simply ‘fizzling out’. The outcome was determined by the level of engagement with the aims of the programme, openness in approach to new team members, and time and capacity to continue the work.

*‘We did set some objectives for ourselves, but we haven’t done them, and that’s me just being completely honest. We met as a quad for a couple of times after we finished the three-day course, but then junior doctor strikes kicked off again and it just didn’t happen. So [the culture coach] did give us some advice when we met him the first time, just to have check-ins, but there’s been so much movement in our quad it just hasn’t happened.’*

Participant 11b (Operational)

**Observation:** *The quad at one site has formed a solid bond and is spending time together and communicating frequently both inside and outside work. They feel that their quad is working well and that they’ve developed high regard for each other both professionally and personally – ‘we’re friends as much as colleagues’. When one member of the quad is asked to move to a role in another part of the Trust, there’s a ripple of upset across the quad. How will he be replaceable? One colleague notes that ‘Structural cracks appear when you take one key person out of the equation – it all falls down’. The original quad use their remaining meetings together to plan how they may induct an incoming quad colleague who hasn’t directly experienced the PCLP training. They found the programme sufficiently useful that they’re determined to sustain the model despite changes in the quad. One member muses that it would have helped to have a PCLP handbook or other resource that they could use to support the induction process, rather than having to find time to plan it out themselves.*

We found that quads whose members worked in roles with markedly different levels of responsibility – such as a Director of Midwifery (DoM) working at a divisional level grouped with clinical leads working at a departmental level – were less likely to continue working together regularly following the PCLP. This was viewed as primarily due to the constraints

of organisational structures that resulted in limited inter-status contact in meetings, workstreams, and reporting. We heard questions about the rationale for the combinations of personnel chosen by Trusts to attend the PCLP, with some noting that the leaders who 'should' have attended were held back due to workload or immediate pressures. Despite efforts by NHS England to engage with Trusts over who to send on the programme, some participants suggested that there was an early misunderstanding regarding which professionals would constitute an effective quad.

**Observation:** *The Director of Midwifery attended the PCLP along with the Director of Operations but not the Medical Director for obstetrics or neonates; more junior colleagues – the clinical leads – were sent instead. The group who were sent on the PCLP do not meet regularly as the Director of Midwifery feels their work and responsibilities do not demand it.*

### **Summary**

Overall, the PCLP was effective at improving teamworking and shared purpose among perinatal service leaders, as envisioned by the ToC. This was partly due to the establishment of the quad as the key audience for the programme, and the innovative approach of including representation from all four core professional groups within service leadership, with special attention to integrating neonatology. This was facilitated through the time they had together away from day-to-day pressures, which helped them develop social capital.

Maintenance of these relationships after Phase 1 was challenging due to internal and external work pressures, turnover within the quad and attendance from quad members with different levels of responsibility. These challenges impeded the potential longevity of the improved relationships developed by the PCLP and were not sufficiently mitigated. In addition, structural barriers also affected sustainability (see later section).

### **Limited evidence of widespread leadership behaviour change**

The main objective of Phase 1 was to develop the quad as a leadership team but the content – and quad members – also focused on developing individual and collective leadership behaviours. Evidence of widespread changes in leadership behaviour stemming from the PCLP was less apparent, however. This included behaviour change anticipated by the programme, such as: increased visibility and accessibility; compassionate approaches to colleagues and junior staff; listening and openness to others' views and concerns; more inclusive and distributed leadership approaches; challenging incivility and unprofessional behaviour; and active engagement with colleagues and peers both locally and nationally.

We found that some participants reported being more proactively visible to frontline staff and more confident in challenging unprofessional behaviour following their participation in Phase 1. However, they did not always feel this was a transformation of existing practice nor wholly attributable to the PCLP.

*‘The programme was quite useful, it does give you tools. That’s what I was saying about understanding yourself and understanding how another person perceives you, and I did all that, and at some point you did feel maybe the programme was good, but it didn’t actually delve into the next stage [...] another person hasn’t gone to the programme so they respond in the old way, and then that’s it, it stops, and then you haven’t got where do you go next. It’s an ongoing process. It’s not “Oh I’ve gone to this leadership programme so I’ve got all these tools; I’m going to change and everyone else will change along with me.”’*

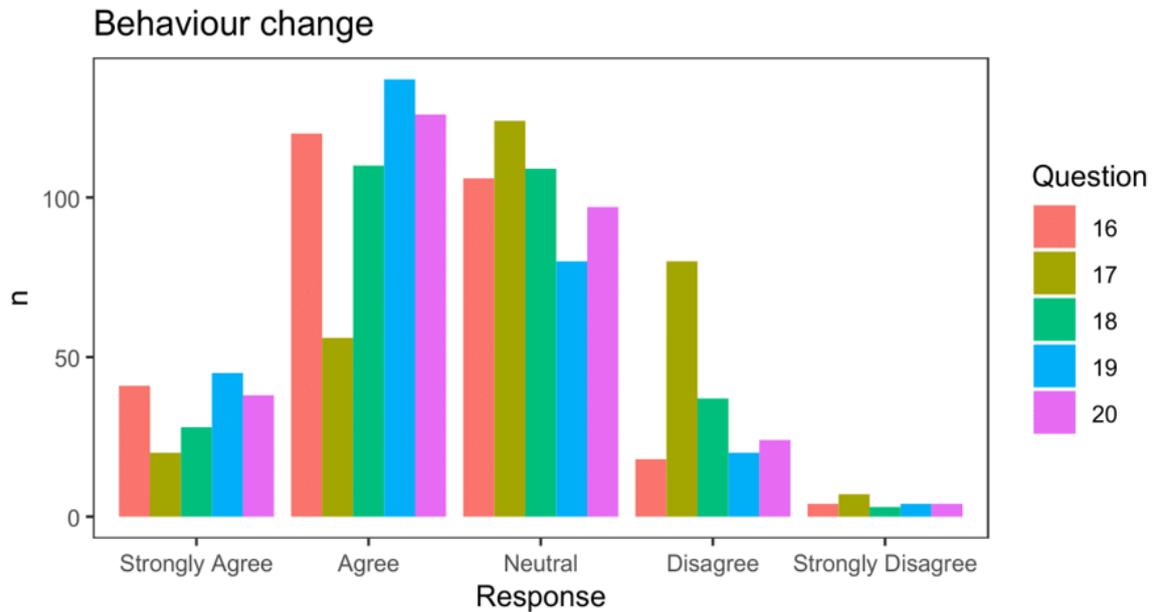
Participant 6c (Obstetrics)

Several participants also felt that they already embodied good leadership behaviours and had therefore gained little new value from the PCLP, while others reported fellow quad members not having improved their leadership behaviours.

*‘We try and do it once every two weeks, to go round and have that chat [...] I think because I have been on lots of these courses that I have done it before [...] I can’t say that was new.’*

Participant 11a (Midwifery)

As shown in figure 2, the quad survey found that respondents were more likely than not to report that they felt better able to lead, and to agree or strongly agree that they were engaging more in several positive leadership behaviours – such as listening more to frontline staff about their ideas for service improvement (64%) and supporting frontline staff to undertake these (57%) – since participating in the PCLP. However, only 27% of respondents agreed or strongly agreed that they were spending more time in clinical areas; it is possible that some felt they were doing this sufficiently before the PCLP.



**Figure 2.** Histogram showing the number of responses for the questions regarding behaviour change:

- 16 = I feel better able to lead since participating in the PCLP;
- 17 = I spend more time in clinical areas since participating in the PCLP;
- 18 = I challenge unprofessional behaviour more often since participating in the PCLP;
- 19 = Since the PCLP I make more effort to listen to frontline staff about their concerns and ideas for improvement;
- 20 = Since the PCLP I support more junior staff to undertake service improvement.

We identified little evidence from frontline staff, particularly at band 7 or below, of widespread awareness of the existence of a perinatal quad, with many saying they only knew or interacted with leaders within their professional group or silo. Although this may have improved in the longer-term, it may also reflect a lack of collective leadership by quads in many Trusts, in that they were not consistently communicating or engaging with staff as a quad and were instead predominantly engaging in their preexisting, siloed leadership behaviours. In many Trusts, rigid divisional structures run counter to efforts to move towards closer perinatal working with joint reporting and shared accountability. Quads found it far easier to function effectively where a Trust had already moved to a clear perinatal pathway underpinned by a corresponding organisational structure.

**Observation:** A small group of community midwives (Band 6s) join the antenatal ward station where two hospital midwives are attending to the day's reporting. I ask them what they know about the PCLP, which they have heard of as 'the quad programme'. None seem to know what the quad is, or who is a quad member. They all know the DoM by name, but only one says she has had direct contact with her. They don't know the others. One midwife points to a poster on the wall behind the station; it displays the management structure. They all laugh, one exclaiming 'I've never seen any

*of these before. No idea'. Another says that she's very occasionally seen the DoM and some of the executive board 'waft through' on a walkaround, but that there is no other contact with senior leaders.*

Staff were also unlikely to report that quad members had changed their individual leadership behaviours. Although during our site visits several staff praised the visibility and empathy of the quad members they knew, they typically felt these behaviours had been evident before the PCLP.

**Observation:** *Several Band 7 midwives offer praise for their longstanding DoM; one says 'She couldn't be more visible.' Others describe the DoM as 'friendly', 'approachable' and operating a genuine open-door policy. One example shared of her efforts to foster a positive culture is a weekly call she started during the COVID-19 pandemic and has continued since, where she recognises the efforts and achievements of staff.*

The staff survey found that respondents were more likely to strongly agree or agree than strongly disagree or disagree that their senior leaders interacted with them (48% vs 30%), as shown in the first histogram in figure 3. However, the second histogram shows that most respondents said their senior leaders' behaviour had not changed in the previous 12-18 months, when the PCLP was running. Staff survey respondents were also equally likely to strongly agree or agree as strongly disagree or disagree that their senior leaders were visible in clinical areas (40% vs 39%).



**Figure 3.** Histogram showing the number of responses for the questions regarding quad leadership behaviour:

2 = I regularly see the senior leadership team in clinical areas;  
 3 = The senior leadership team interact with me.

Many participants found the training useful and well facilitated, particularly quad members in medical roles, who were less likely to have undertaken previous leadership training. However, the training was usually viewed as a refresher of useful leadership principles and techniques; there was less evidence that it led to transformative behavioural change.

*‘You definitely weren’t able to come in and sit at the back and say nothing, she had everybody participating, she had everybody talking to each other, mixed us all up a little bit, made us work together. [Our facilitator] was definitely very good, I did enjoy the sessions.’*

Participant 18a (Operational)

Several participants were more critical of the training and felt it added little value to their leadership capability, as they had already done extensive training.

*'Most of us had already done a lot of cultural work at Master's level or above. So, we were familiar with the intention of the programme and most of the learning really, because we'd done it before.'*

Participant 14a (Midwifery)

Participants often valued engaging with quad members from other Trusts during Phase 1 of the PCLP, learning from and supporting each other, although some noted that it was difficult to sustain attendance at the remote action learning sets due to competing workplace demands. This limited the benefit that participants could draw from this component of the programme.

*'I think the engagement that you get with colleagues from other organisations is really good, because then you can see that you're not alone, everything is very similar. You can then support one another or work your way through things.'*

Participant 19a (Operational)

We did find that respondents to the staff survey who worked in mid-level positions (staff with formalised leadership roles within a discrete area of the service e.g. matrons, advanced clinical practitioners, consultants, registrars, general managers) were significantly more likely respond positively to all questions (Appendix 6) and, in some sites, we saw evidence of quads delegating responsibility to, and increasing the autonomy of, staff at this level. This indicates that the PCLP may have had a positive impact for staff who work in closer proximity to the quad and there were quad members who noted improved cross-disciplinary working in this staff group.

*'I can even see that if I sent communication to the matrons, they are trying to think – well actually, who else from the medical team or the ops team can support them in whatever they're having to do. So, I think it is working; I think it has made a difference.'*

Participant 11a (Midwifery)

One challenge identified in site visits was quad members holding overlapping roles relating to safety and improvement and this creating confusion and conflict, for the quad member and for staff. For example, in one Trust a staff member reported raising staffing concerns in a Safety Champion meeting but the DoM – who also held the Safety Champion role – dismissed it as having been discussed in other meetings she had participated in. We also observed quad members who felt they were visible and accessible to frontline staff, whereas some staff felt concerns were shut down or would only be listened to if they came from certain favoured individuals. There was often a

dissonance between the rhetoric and the practice, the quad member's perception and the reception on the shopfloor.

**Observation:** *A quad member shows me how she does her ward rounds, noting that she performs these regularly and has done so even before the PCLP. Staff members respond politely to greetings as she passes and confirm 'all fine' when she asks how things are going. She heads to the offices of a matron she has known for years, where she settles for a more in-depth chat before heading back to the management suite. Her quad colleagues also make efforts to be more visible to the frontline staff, though these tend to be exceptional moments linked to tea-trolleys, charity fundraisers, or other special events involving cake and costumes. Staff say they would value more regular low-key contact, 'mucking-in' and showing genuine curiosity about how things are on the wards. Several mid-level staff report not feeling heard: escalating concerns 'into the void' or being reprimanded for 'negativity' when they share a worry. One matron tells me that 'Sometimes stuff just gets lost in the quad; it disappears into outer space. [...] There's a gap in coming back to teams with outcomes; things might get forgotten or lost because they're so busy. They have to prioritise the big things, but these are all 'big things' for us.'*

### **Summary**

Overall, while the ToC set out broad objectives to improve compassionate, inclusive leadership within perinatal services and change quad behaviours, we found some improvement in leadership behaviours but limited evidence this was achieved consistently across quads. On top of workload and time pressures, this was due to the assumption that 'one approach fits all' would be suitable for the leadership development modules, which did not account for the fact that some quad members – particularly those in non-medical roles – already had extensive leadership training experience, meaning Phase 1 of the PCLP offered them less learning.

Changing behaviour is a complex and challenging goal. A more bespoke approach to the training, and the inclusion of behaviour change theory, may have potentially helped to facilitate more widespread behaviour change.

## Section 2: Empowering the quad to change culture

### ***Limited evidence that conditions were created for wider culture change***

According to the ToC, phases 2 and 3 of the PCLP sought to empower quads to understand the culture within their services and develop an improvement plan. Although achieving culture change was a longer-term goal, we found limited evidence that the conditions had been created to achieve this across Trusts or that there had been cultural change attributable to the PCLP among the wider staff teams beyond the quad. The conditions for culture change set out in the ToC included quads having a better sense of their local culture (usually through use of the SCORE survey) and of their individual and collective roles in improving it, as well as staff being aware of the culture improvement plan and having an opportunity to contribute towards it. The ToC also envisaged that the right people would be involved in local change teams, that the change teams would have agency, that the cultural conversations would be a useful tool, and that local culture coaches would feel able to continue this work with far-reaching impacts.

We heard some criticism of the use and utility of the SCORE survey in Phase 2, for example, which few participants felt revealed new information and compounded the ‘survey fatigue’ experienced by NHS staff. A small number of Trusts opted to use alternative local data and felt equipped to identify and address cultural challenges using these.

*‘I don’t think they told us anything that we didn’t already know. They’ve just essentially quantified how miserable everybody is.’*

Participant 17a (Operational)

There was praise for some of the ‘culture coach’ facilitators in Phase 3, though others noted that their coaches lacked knowledge of the NHS context that quads were working within. This restricted the benefit that some quads could draw from this component of the programme.

*‘[Our culture coach] was lovely, absolutely lovely. But I think that the expectations on how much time people had to do this piece of work, because the meetings with them were over Teams, they wanted to do focus groups with lots and lots of different members of staff, and [it was a] scheduling nightmare, and there wasn’t a great understanding of operationally how maternity services run. So I remember her saying, “Oh, but the obstetrician isn’t here.” I was like, “No, because she’s been called to labour ward because there’s an emergency.” That’s how hospitals run, and there was a real disconnect there.’*

Participant 6a (Midwifery)

*'If we'd had someone slightly different in that coaching role that was maybe a slightly better fit, and understood more of what exists within the NHS, the cultures, the pressures, the framework we were trying to work within, we just felt it perhaps could have been even more valuable [...] some of the coaching sessions we were preparing how to get the work done with that person in addition to getting the work done, so it did take a bit of effort to work out how we were going to get the best out of them to help us.'*

Participant 1c (Neonates)

We also heard that culture coaching sessions were very challenging to schedule within quad members' other commitments, meaning there could be long gaps between them and partial attendance. Some quads felt the culture coaching process was inflexible and overly formulaic, with it focused on organising a certain number of cultural conversations and the presentation of the culture improvement plan to the Trust board. We heard that face-to-face sessions added value over remote sessions.

*'The support from our culture coach, I don't think brought any value to us as a quad. Those sessions just did not feel helpful at all, because it felt like we were being pushed to help them tick a box to say all the quads have achieved this, which is a presentation to board to explain what we're doing with regards to the results from the culture survey. I feel it would have been much better for us to be able to articulate particular challenges that we are faced as a quad, and actually help us find better ways of working together. It just feels that there was a really missed opportunity.'*

Participant 4a (Operational)

*'We had face-to-face sessions with [our culture coach], which were really helpful. Again, we're all coming out of COVID for the last couple of years, so face-to-face was very helpful.'*

Participant 1c (Neonates)

Quads typically found it challenging to engage mid- and lower-level staff to engage in cultural improvement work, even those who had volunteered to participate in 'change teams'. Although some members were offered training to facilitate further cultural conversations, there was insufficient support for the quad and 'change team' relationship, limited development of the leadership skills and cultural awareness within 'change teams', and a lack of protected time offered to 'change teams' in the way it had been offered to the quads. This meant that Phase 3 did not effectively enable the cascading and embedding of cultural improvement beyond the quads.

*'We've really tried hard to cascade the cultural improvement work on the background of the SCORE survey. But I think the whole cascading about ways of working, strategy, that type of stuff, that's been really challenging to cascade down. It might be partly because of the people we've got in those roles. We do have some performance issues [...] I suppose, now I think about it, have we really seen that as one of the desired outcomes of the programme? Maybe we haven't tried hard enough? [...] I don't think that's something that we have really thought about or put emphasis on as an aim of the programme if I'm honest.'*

Participant 1a (Obstetrics)

While NHS England succeeded in getting every Trust executive to release four perinatal leaders to participate in the programme, just two thirds (67%) of quad survey respondents agreed or strongly agreed that leaders in their Trust supported the work of their quad to implement change. At the time of quad survey, only 53% of respondents reported that they had agreed a culture improvement plan, although some had yet to complete Phase 3 when these data were collected. Additionally, only 36% agreed or strongly agreed that Trust leaders had provided sufficient resources to implement the changes identified in their culture improvement plan. This suggests that Trust support could be more engaged with the importance of PCLP and delivering its potential outcomes.

As stated previously, achieving culture change was a long-term objective and we were unable to fully evaluate this within the timeframe of this study and without comparative data from before the PCLP's implementation. The staff survey, as shown in figures 4 and 5, found variation in cultural indicators, with respondents more likely than not to report that they felt psychologically safe at work. However, they reported that this had not changed in the previous 12-18 months. This finding was consistent across intakes and RAG rating, and was also supported by the rapid focused ethnography data.



**Figure 4.** Histogram showing the number of responses for the questions regarding psychological safety

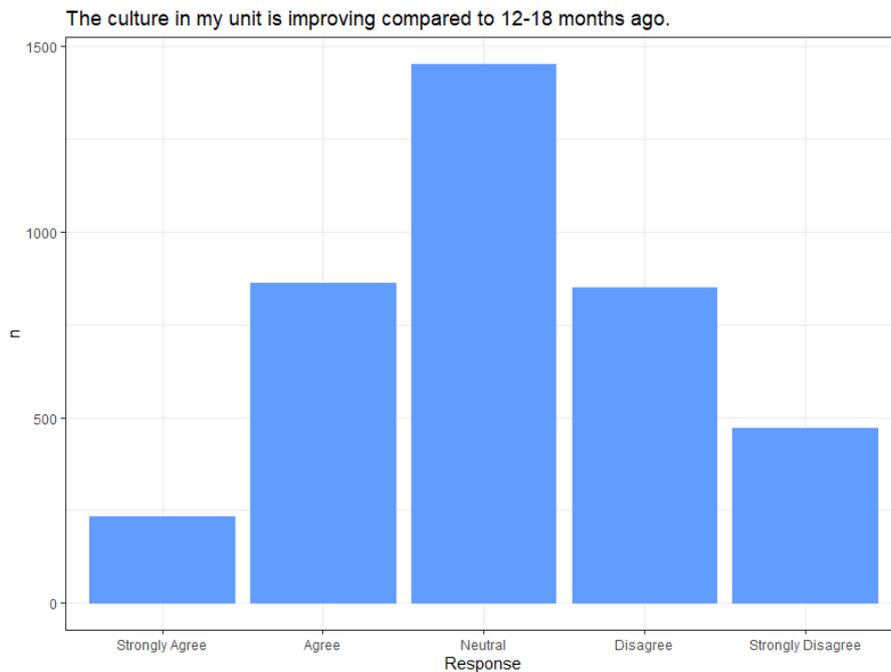
- 4 = I feel listened to and respected when raising concerns;
- 5 = My unique skills and talents are valued and utilised;
- 6 = If I make a mistake, I feel it is held against me

Staff were also slightly more likely than not to report that unprofessional behaviour was challenged (33% agreed or strongly agreed vs 24% strongly disagreed or disagreed), and more likely than not to report that they felt able to suggest changes to improve services (57% agreed or strongly agreed vs 20% strongly disagreed or disagreed). However, most respondents again indicated that these factors had not changed in the previous 12-18 months, and this was also supported by our other data. These findings were consistent across intakes and RAG ratings.



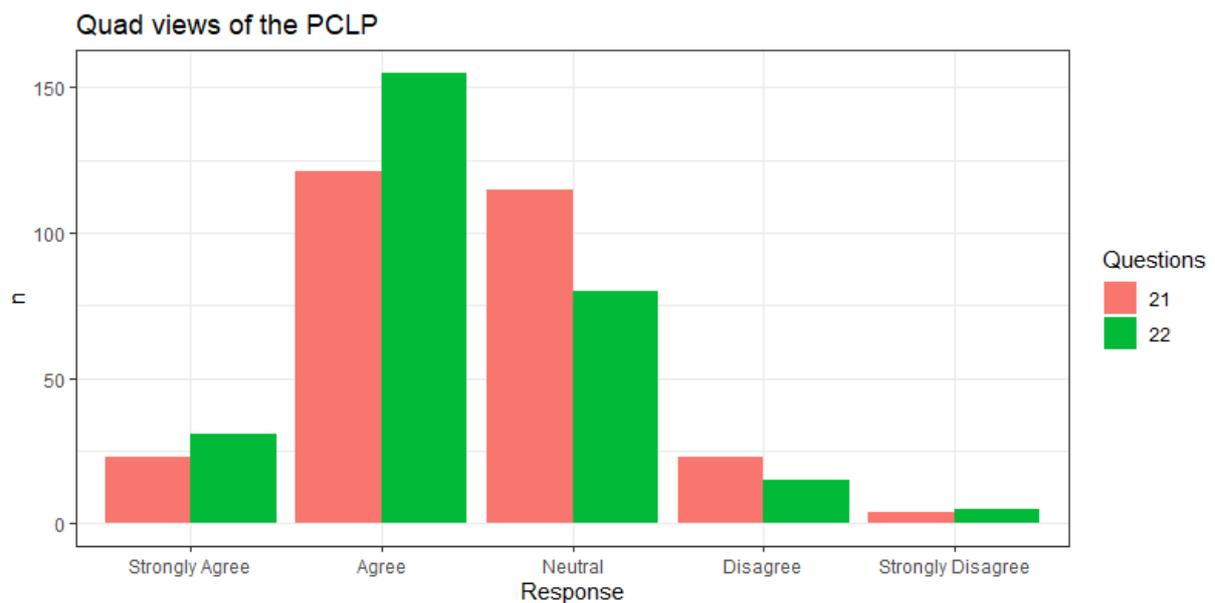
**Figure 5.** Histograms showing the number of responses for questions regarding culture

Respondents to the staff survey were also slightly more likely to disagree or strongly disagree than strongly agree or agree (34% vs 28%) with the statement that the culture in their unit was showing signs of improvement compared to 12-18 months previously, before their senior leaders had participated in the PCLP (Figure 6). The largest grouping reported a neutral response (38%). These findings were consistent across intakes and RAG ratings.



**Figure 6.** Histogram showing the number of responses to the question: *The culture in my unit is improving compared to 12-18 months ago.*

Figure 7 shows that respondents to the quad survey were more likely that not to report that the PCLP was an effective use of their time (65% agreed or strongly agreed) than report that the PCLP had resulted in their service being a better place to work (50% agreed or strongly agreed). This indicates that many participants drew personal benefit from the programme, for example through improved relationships with quad colleagues, but felt that the wider impact or ‘ripple effect’ was more limited. These findings were consistent across intakes and RAG ratings.



**Figure 7.** Histogram showing the number of responses for the questions regarding thoughts on the PCLP:

**21** = Being involved in the PCLP has resulted in the service being a better place to work;  
**22** = The PCLP was an effective use of my time.

We identified some examples of new practices directed at other staff to improve culture, including effort to recognise their achievements and bring key staff together in new meetings to facilitate better working relationships. However, even participants who noted substantive improvements in culture rarely attributed this to the PCLP.

*'I think we have got a change in that culture, but that sort of culture change takes time. It does feel a very different place now than even a year ago. But I suspect much of that had happened before the programme.'*

Participant 8b (Neonates)

## **Summary**

Overall, the objective of creating the conditions for culture change, as set out in the ToC, faced considerable obstacles in many Trusts. We found that the SCORE survey often did not give quads a better sense of their local culture. There appeared to be insufficient support from the culture coaches in many Trusts and insufficient protected time for both quads and staff to focus on culture work. There was a lack of buy-in from Trusts. Staff lacked time to engage so those involved in change teams were not always 'the right people'.

These challenges may have been mitigated if there was more proactive support from the wider Trust to sustain the culture work, such as the provision of protected time and resources, along with board-level and HR oversight of the culture improvement plan, with the quad regularly reporting progress and being accountable for its delivery. The ToC assumed that the PCLP would ideally 'be a high priority' across all phases, but this was not always the case given the multiple competing pressures and responsibilities placed on staff at all levels in the standard course of their work.

Although several quads were yet to complete Phase 3 when we conducted data collection, we found no difference in outcomes between these and quads from earlier intakes which had already completed the programme.

## ***Limited evidence of improved perinatal working***

The PCLP aimed to improve the working relationships between maternity and neonatal staff at all levels, fostering a 'shared vision of their perinatal culture' (ToC) and identity and moving away from maternity and neonates operating independently in silos. We found that the PCLP did lead to improved perinatal working at the quad level in many Trusts, with programme participants reporting better relationships and understanding of their respective services and the ways in which they could work together. However, we found that this was not consistent across all Trusts and it rarely filtered down to other staff beyond the quad.

*'Separate streams and silos still exist, because that's where the buck stops for each lead. But the quad helps and will flex to support each other.'*  
Participant 7b (Operational)

*'So we all get on very nicely thank you until something isn't working in the way we'd like [...] we were talking recently about trying to adjust the footprint of the area that we're working in, and the neonatal team said, "No, this isn't benefitting us." Midwifery team saying, "Well, we want it to benefit us." And we ended up with a stalemate.'*  
Participant 19a (Operational)

Quads and other staff often reported neonates and maternity working in silo, with distinct cultures and a lack of collective communications from the quad. Challenges with perinatal working were often exacerbated by divisional structures which organised maternity and neonatal services separately and hindered interprofessional communication and collaboration.

*'I think the feeling from NHS England is it's a perinatal service team, the neonate sits with maternity, but I think at an organisational level that's not filtered through yet. So, some organisations the neonatal service will be under the Director of Midwifery, whereas in this organisation the neonatal service is lumped in with paediatrics.'*  
Participant 2d (Neonates)

**Observation:** *I ask the neonatal quad member about his service's relationship with the maternity service and examples of collaborative working, such as a neonatal representative attending the maternity safety huddles. He speaks positively about the relationship in general terms but admits that the 11am maternity safety huddle clashes with another meeting in neonates, which prevents anyone attending. Although he is aware of this clash, it has not occurred to him – or anyone else – to try and resolve it.*

Where perinatal collaboration did happen and worked well, staff responded positively and reported feeling appreciated as part of the team, and safer and more effective in improving outcomes for mother and babies. This was seen particularly in certain MDT meetings, and during a number of handovers and huddles. In most cases, however, this positive collaboration was happening before the start of the PCLP, so the programme in such cases served primarily to confirm good practices.

**Observation:** *I am sitting with the nurse in charge in the neonatal unit when she receives a call informing her that the maternity safety huddle will be starting slightly late. She informs me that someone from neonates attends every huddle and has done for several years. After going away to perform another task, she receives another call, informing her the huddle is starting. We walk over to labour ward together – it takes 1-2 minutes. As we walk, she tells me that the relationship with the maternity team has always felt positive and constructive. The huddle is calm and collegiate; the maternity team clearly has friendly relationships, within the team and with the neonatal nurse. She provides an update on the neonatal unit's capacity, and they alert her to labours that may require neonatal input.*

### **Summary**

Overall, our findings suggest that the innovative quad formation, together with protected time away together, was effective at improving collaborative perinatal working among leaders, and a sense of shared vision and responsibility at their level, but that these improvements did not often 'ripple up/across and down' throughout services.

This was due to an entrenched culture of siloed working within different staff groups which the PCLP did not create the conditions to overcome, in large part due to quads and staff not having sufficient time to work on this alongside day-to-day operational pressures and a lack of sustained support for quads – either from the culture coach or wider Trust – to implement their culture improvement plans. These challenges were exacerbated in Trusts where divisional structures did not lend themselves to collective perinatal working.

## Section 3: Reflections on the PCLP

### ***Appraisal of programme design and delivery***

Our findings on the PCLP's impact, alongside views expressed by quad members on their experiences taking part in the programme, enabled us to appraise its design and delivery. We identified several strengths and some weaknesses which limited its overall efficacy across maternity and neonatal services. Previous sections have addressed how the content and delivery of each PCLP phase enabled or hindered its objectives and we build on those findings with a broader assessment of the programme.

We found that most participants had a poor understanding of the PCLP's aims before attending the first module and, even if this later became clearer to them, many also lacked an understanding of the programme's expectations in terms of time commitment. This presented barriers to engagement for many quad members. As noted previously, this lack of clarity is partly explained by PCLP phases and intakes not all having been guaranteed funding at the outset and the ToC having been drafted post hoc.

*'I think we went into it with very, very little information of what we were going to get back out from it. I think that was the problem, we didn't understand. There was no real communication about what we would be needed to do. So I think that's where the apprehension came from. Once we were there and we started doing the sessions it became more apparent how useful this would be bringing it back onsite.'*

Participant 11b (Operational)

*'The biggest challenge though for every organisation is having the time to do this stuff, and what was never conveyed from the outset was the expectation around hours and time, and that has made it incredibly hard I think for sites to be able to commit to this across the board. [...] We had a timeline but it was very loose, it was a very these are the things, but it did not specify it was the expectation of how many hours would need to be released by these staff members, and you're talking about taking an awful lot of resource away from their day to day jobs and roles in order to fulfil the requirements of this programme, that has been a real surprise.'*

Participant 3b (Midwifery)

Participants often reported difficulty isolating any specific impact of the PCLP due to the volume of concurrent improvement programmes they were undertaking, alongside the demands of responding to regulatory scrutiny. They also noted challenges sustaining benefits beyond the programme lifespan. After the initial tranche of formally protected time had passed, quad members reported finding it increasingly difficult to prioritise

PCLP-based culture change work over their day-to-day tasks and shifting strategic priorities.

*'I think we're in a position now where we're having much more transparent conversations about the culture within the maternity service. So, with that [...] we've got a standalone workstream around culture improvement, we've got multiple surveys now that tell us how our staff are feeling. So I feel like we've got the resources there to be able to thematically address certain issues, but as far as it going the whole hog and delivering a completely revitalised culture within the service, I think that there are certain unalienable things that we have to do as an organisation with our members of staff rather than it being left to a programme.'*

Participant 17a (Operational)

These concerns around sustainability were also focused on the inevitability of staff turnover and built-in churn within quads, which the PCLP did not appear to have accounted for sufficiently. During the interviews, many quad members reported either having lost some or most of their fellow quad colleagues since starting the programme; in some cases, new colleagues had attempted to step up into the quad team, while in others the quad had dissolved. Others were conscient that these personnel changes would soon happen and pondered how the learning and relational capital might be sustained.

*'I think there is some inherent challenges... on one side you've got the midwifery side, which is completely 24/7 management; on the other side you've got the clinical side, which is dabbling in management, parachuted in for three years, and potentially parachuted out again. Those practical things... they're not really addressed by the programme [...] I'm the only surviving member of my quad now, I think. So yeah, so the directorate manager has moved on, my neonatal lead moved on, and midwifery has half moved on. So we've got pretty much a new quad.'*

Participant 7a (Obstetrics)

*'I suppose my reflection would be what happens to that opportunity and that learning once I'm no longer in my position? Because it's different for the other parts of the quad, but when you're a doctor in one of these quad positions it is a tenured post [...] how would I make sure that what I've learnt through the programme and what I've learnt about what works, what doesn't work – how would I share that with my successor?'*

Participant 1a (Obstetrics)

We heard from NHS England that the mitigating actions they took to address the impact of quad turnover included encouraging quads to take responsibility for ‘reteaming’, offering flexibility to onboard new quad members as change occurred through the programme, delaying the onboarding of Trusts to the programme where possible when there were significant changes in quad membership occurring, offering ‘reteaming’ support in the culture coaching sessions during Phase 3, providing programme documentation and the offer of a call to new quad members joining mid-programme and encouraging ‘reteaming’ in the final programme communications.

### **Summary**

Overall, the impact of the PCLP was limited by factors that affected how quads were able to engage with the programme, which were not sufficiently mitigated for. We found that the majority of quad members started the PCLP without a clear understanding of its aims or expectations. The PCLP did also not appear to account sufficiently for inevitable quad turnover. The ToC assumed that, in an ideal scenario, ‘there would be no “stuff” getting the way’ of the PCLP and that ‘quads would want to continue this work’ when faced with demands on their time, which was mistaken.

### **Structural factors affect PCLP impact**

Various structural factors can act as facilitators or barriers to effective implementation and the ability to cultivate positive change. Influencing some of these is within the gift of the quad or the Trust board, but many of these factors are determined by national-level or regional-level policy and are outside their immediate control.

The impact of financial constraints, staffing issues, the quad’s relationship with the Trust board, mergers and multi-site Trusts, the impact of separate divisional structures on perinatal working, services with a high number of births and serving a population with complex needs, together with the rigours of regulatory scrutiny were all identified in the quad interviews and during site visits, and they were often reflected in the qualitative responses quad members gave to the survey question about what they expected the long-term impact of the PCLP to be.

Financial constraints, due to national and Trust-level funding priorities, can limit the amount of cultural improvement work that can take place and the level at which it can be sustained. Although there was variation between sites, some quads and other staff suggested that the workload demands from additional interventions and initiatives in the current funding climate added further strain to an already stretched workforce.

*‘I have a seat on the board, and I have mentioned [needing more support], but there’s no money. [...] I think from my perspective it just feels like firefighting all the time and being reactive to things all the time. You just go*

*from one thing to another. We've done a lot of good work, don't get me wrong, but it's exhausting.'*

Participant 9c (Midwifery)

**Observation:** *One site had a group of Band 7 specialist midwives designated as Professional Midwifery Advocates (PMAs), but they described having no team leader or clear guidance in place, nor time allocated to perform the role. Posters on the backs of toilet doors offered assurance and signposted staff to share their worries with the PMAs, but the PMAs themselves reported feeling distressed and insufficiently supported from above.*

Adequate staffing, both in terms of sufficient numbers and appropriate mix of skill and experience, was reported to be essential to cultivating a positive workplace culture and a safe service for women and babies. Where services were not felt to be adequately staffed, or where there was a high turnover of staff, quads and more junior staff alike found it harder to find time and space to engage in cultural work. Some frontline staff, particularly in midwifery, reported instances of poor behaviour, burn-out, or bullying when staff were redeployed to cover shifts in other parts of the service, usually delivery suite. Sometimes quads and other senior leaders stated that they had achieved full staffing levels for a service but acknowledged that this was not yet palpable by the frontline staff, particularly where recruits were newly qualified or otherwise in need of mentoring and additional training. Poor culture was also cited as one of the factors driving poor retention of more experienced staff.

*'It goes hand in hand with services being appropriately staffed and led. Because you can be happy doing your job as a midwife, but if you come to work every day and you haven't got the right numbers of staff, it doesn't matter how nice your senior leadership team are, you are not going to feel happy coming to work. And if you believe that nobody is doing anything about it and you're stuck in that perpetual cycle of coming onto shift and it is short staffed, then however much work we put in place they're not going to feel any better.'*

Participant 17b (Midwifery)

*'It's difficult to try to improve culture while everybody is under so much pressure. Virtually every hospital is understaffed, there's always empty midwife shifts, so as soon as you try to make cultural conversations people will always turn round and say, "Well, it would be easier if we had more people working here, and we didn't have to cover so many shifts."'*

Participant 4d (Obstetrics)

Another factor that made it more difficult for quads to benefit or embed learning from the PCLP was where they worked in multi-site Trusts. Sometimes the staff at these sites had residual tensions following mergers, focused on inequity of resource or imbalances in leadership contact and attention.

**Observation:** *One of the Trusts we visited is split across two sites in neighbouring conurbations. The management offices are situated in the larger, newer hospital, so the Trust board, the quad, and the mid-level staff are all based at that site. The small team of mid-level staff running the smaller site attend management meetings remotely and feel their concerns are not heard: ‘We’re vocal about challenging the inequality between sites, but it doesn’t make much difference. We feel like an afterthought.’ Staff report feeling neglected and ignored, noting that the quad used only the larger site’s data to set training objectives, KPIs, and improvement strategy, even where the smaller site is performing well; staff are frustrated at the apparent lack of curiosity or acknowledgement of local achievements and approaches. One Band 7 tells me it was ‘Less a merger than a takeover; we’re two different sites but, in the end, we just get swallowed up.’*

Sometimes Trusts in this position struggled to identify who to send to the PCLP, particularly whether they should establish a larger strategic quad or multiple site-based quads. This led to difficulties engaging with and sustaining the work back on-site as quad members working in different local sites were unlikely to meet or work together regularly but those working at a strategic level were removed from the day-to-day culture in some or all of their sites.

*‘You’ve got two hospitals therefore you need to send two teams, but actually our plan was always to create one team. So, because we’ve got two heads of midwifery we couldn’t have sent both of them along in our four that were invited to attend, so we ended up with two groups of people going. But you’re then not sending along people who are working together.’*

Participant 19a (Operational)

Another factor that determined how effectively the PCLP aims and objectives could be achieved was the quality of the quad’s relationship with the Trust board. Where quads had a positive and supportive pre-existing relationship with the board, they were more likely to receive enthusiastic buy-in to support participation in the PCLP. This took the form of formally protected time, increased interest in and time for discussion of cultural and leadership matters, and increased openness to requests or business cases for resources. Where the relationship was dysfunctional, it was more difficult for the quad to

leverage resources and influence change. In some cases, we found that the PCLP had helped empower quads to improve relationships and engage more assertively with their Trust board and to ‘speak with one voice’. This could be viewed as an example of the social capital developed by quads during Phase 1.

*‘I think this helped us [...in terms of] how do we manage up? How do we manage an exec team that are quite new, that are all grappling for their own positions? [...] It’s kept me awake at night, and also blood, sweat and tears, but we’re getting there. So, we’re doing a real good upward reporting structure so that we’ve got really good oversight at all levels within the division and within this pathway. I think all of those elements seem to be coming together now, but... the PCLP definitely gave us tools as a new quad in terms of how to manage some of the stuff that we were undergoing at the time.’*

Participant 17c (Neonates)

*‘I go to Board every other month... They’re aware of the cultural pressures that we have here. They’re aware of the physical pressures in terms of staffing. They’re aware of the estate challenges and the impact. I share feedback on morale, on culture, on outcomes, on KPIs, on the good, the bad and the indifferent really with the board. They receive the whole package, and they’re supportive of me as a leader, and obviously support me with investment, with time, with mentorship if needed.’*

Participant 14a (Midwifery)

We found the PCLP helped nudge some quads towards developing a perinatal model. However, where maternity and neonatal services remained in separate divisions, with distinct governance and reporting structures, effective perinatal working was hindered, even with the best efforts of the quad and wider staff teams to act collectively.

*‘We are trying our best to bring it under one umbrella. So, we as a leadership team are calling it “perinatal services”, but teams on the shopfloor would still call it “maternity”... So yeah, that’s something that we’re working on, but it is still at the moment separate, and that’s epitomised I guess by the fact that the operational manager for NICU is the manager for paediatrics currently, so I don’t manage NICU, I just cover maternity services, which in an ideal world would contain NICU, but it currently still sits under paediatrics.’*

Participant 13c (Operational)

*'Part of the difficulty here is that maternity and neonates sit in two different divisions, and that is a very difficult structure to try and navigate, and that's something that I am working on from a strategic perspective at the moment, and the conversations I'm having about we need to be in the same division with the same... because also the line management, the leadership all gets a little bit of a mess. I think we are having a lot more coming together because even outside of the divisional structures I'm aligning our meetings so that everybody is presenting in the same place, the same thing. We're aligning the reporting processes so that we've had oversight of everything we need.'*

Participant 19b (Midwifery)

The ability of quads to create the conditions for a positive culture was also influenced by local context. Where Trusts were providing services for a high number of births, particularly in populations with complex health and social needs, there were heavier demands on staff. In relatively affluent areas with mothers who generally experienced fewer complications, quads and frontline staff appeared not only to have a more positive work culture but also had the time and resource to nurture and sustain this. This positive was amplified in Trusts servicing a smaller number of births and where the smaller staff teams knew each other better and therefore shared greater and more widely distributed social capital.

**Observation:** *During an informal conversation, a Band 7 midwife is relaying how positive she finds the culture in the service: 'It's just lovely [...] the people are so friendly.' She says the benefits of this culture extend beyond staff to the quality of care patients receive: 'Staff just care [...] everyone wants to be better.' She notes that part of the driver for this culture is that service users tend to be relatively affluent and educated; they have high expectations and hold you to a high standard.*

Regulatory scrutiny – whether in terms of internal governance requirements or external interventions, such as the CQC inspection process or the Maternity Incentive Scheme – is recognised as both essential and demanding. During the timeframe of the PCLP the CQC was undertaking its National Review of Maternity Services in England 2022-2024, which was also launched in response to the Ockenden and Kirkup reports and resulted in heightened levels of scrutiny. Quad members had mixed views on the approach taken by inspectors, and on the reports and ratings they received. Where services were found to be inadequate or requiring improvement, we found that this had an immediate impact on staff morale.

*'I'd love to be able to say at the end of this programme it's been wonderful, it's really enhanced. The sad reality is we entered this programme actually very, very positive on the [hospital] site, and we've ended up in a place and a position where there's probably things that have come out of that [recent CQC] report, but also through our cultural conversations that we're in the midst of right now as well, about they're important and we need to hear these things, and we need to take them on-board and we need to think about our steps moving forward. I wish I could sit here and say it feels like we've got the right resource, and the right response, and that we're able to move this forward, but I now feel like that battle is on my hands in terms of trying to stick in the right support, trying to keep the teams motivated. It feels like a really hard space right now.'*

Participant 4c (Midwifery)

*'There are other national regulations that we have to meet even just to be a maternity service, never mind one that is currently under the spotlight with the CQC... I think it's ticking the boxes we need to, but to be honest I think it's actually inhibiting progress around culture. Because I think the more time that you invest in doing returns and things like that to various different regulators is time that you could be spending with the team in trying to better unpick and come up with a solution to workplace culture issues.'*

Participant 17a (Operational)

While critical reports and reduced ratings could have a negative impact on local culture, in some cases we also saw quads and staff teams rally to the challenge of responding to CQC requirements. Some quads told us that the PCLP had helped them develop the confidence and skills to better manage these challenges.

**Observation:** *In response to concerns raised during an unannounced CQC visit, three of four members of the quad at one site called a meeting of all mid-level maternity staff, along with some neonatal staff, to discuss the outcome of the visit and to ensure that staff pulled together to ensure that all the assurances and updates requested by the investigators were provided to deadline. The issues were discussed with openness and an acknowledgement of the potential emotional impact of further scrutiny following a poor outcome, despite all their hard work. Affirming collective responsibility and experience, the quad acknowledged the toll it was taking on 'all of us' and asked for further, defined, support with the list of specific requirements. Through a combination of volunteering and polite requests, all the tasks were quickly allocated with clear parameters, communication*

*routes and deadlines – delivered with empathy and thanks, and a reminder that the ‘door is always open if anyone needs to talk’.*

### **Summary**

The impact of these structural factors, both those that help and those that hinder the aims and outcomes of the PCLP and related improvement initiatives, cannot be underestimated. Perennial issues like funding, staffing, mergers and multi-site working, and access to resources via the Trust board underpin or undermine efforts to improve culture throughout the workplace. The PCLP did not sufficiently account for or mitigate these barriers.

## Conclusions

Our evaluation of the PCLP found that the 'Leadership' components of the programme were the most successful. The PCLP ToC highlighted several key objectives for Phase 1, including improved interpersonal relationships between quad colleagues, the establishment of new ways of working together, a greater sense of belonging and psychological safety, and a shared interprofessional perinatal identity. This was partly due to the establishment of the quad as the key audience for the programme and the innovative approach of including representation from all four core professional groups within service leadership, with special attention to integrating neonatology. This was facilitated through the time they had together away from day-to-day pressures, which helped them develop social capital. We also found evidence that some quads had developed more effective relationships with their Trust boards. However, we also identified challenges in maintaining these benefits beyond the duration of the PCLP, which had not been anticipated by the ToC. These included quad turnover, attendance from quad members with different levels of responsibility and heavy workload. Additionally, structural barriers affected sustainability.

We found more limited evidence of the PCLP leading to improvements in leadership behaviours among quad members. Although many participants – particularly those working in medical roles – found elements of the leadership training useful, they often saw it as a 'refresher' rather than new learning. Although some quad members self-reported that they were exhibiting better leadership behaviours – and we found some evidence of the distribution of responsibilities and increased autonomy to mid-level staff – this was not consistent. There was also limited evidence that frontline staff knew of the existence of the quad or of the senior leaders outside their professional group, indicating a lack of collective leadership. On top of workload and time pressures, the limited evidence of behaviour change was due to the assumption that 'one approach fits all' would be suitable for the leadership development modules, which did not account for the fact that some quad members already had extensive leadership training experience, meaning Phase 1 of the PCLP offered them less learning. Changing behaviour is a complex and challenging goal; a more bespoke approach to the training, and the inclusion of behaviour change theory, may have helped to facilitate more widespread behaviour change.

According to the ToC, phases 2 and 3 of the PCLP sought to empower quads to understand the culture within their services (by undertaking the SCORE survey) and develop an improvement plan, with support from external facilitators. Although achieving culture change was a longer-term goal, the objective of creating the conditions for culture change, as set out in the ToC, faced considerable obstacles in many Trusts. The SCORE survey often did not give quads a better sense of their local culture. There appeared to be

insufficient support from the culture coaches in many Trusts and insufficient protected time for both quads and staff to focus on culture work. Trusts mostly did not offer active support or oversight of culture improvement work. Staff lacked time to engage so those involved in change teams were not always ‘the right people’. The ToC assumed that the PCLP would ‘be a high priority’ across all phases, but this was not always the case given the multiple competing pressures and responsibilities placed on staff at all levels in the standard course of their work.

The PCLP also sought to improve the working relationships between maternity and neonatal staff at all levels, fostering a perinatal culture and identity rather than a culture where maternity and neonates operated independently. Although there was evidence of some quad members having a better understanding of their perinatal service as a whole, beyond their own specialism, this was not consistent across Trusts and there was limited evidence of this approach being filtered down to frontline staff. Quads and other staff often reported neonates and maternity working in silo, with distinct cultures; challenges with perinatal working were exacerbated where divisional structures organised maternity and neonatal services separately.

We heard that many quad members had little initial understanding of the PCLP’s aims, content or duration. NHS England told us that they attempted to communicate these in various ways, including through emails, FAQ documents, virtual welcome sessions and virtual face-to-face meetings with most quad members at various stages in the programme.

We identified a number of structural factors affecting certain types of sites which affected how, and to what extent, the PCLP or similar interventions are likely to have the most positive impact:

- Multi-site Trusts, which often:
  - saw tension between different site teams – especially following a merger
  - created quads which were either too localised or too senior to engage with staff across all sites
- Trusts with maternity and neonates in separate divisions, which impeded perinatal working
- Trusts with dysfunctional or disengaged relationships between the Board and perinatal quads
- Trusts servicing a high number of births and a population with complex health and social needs

Sites such as these are likely to need the most intensive engagement and work, but they may also have the greatest potential for positive change.

We did not identify any differences in impact among quads themselves or in wider staff teams based on the length of time since the programme had been completed (by intake), by RAG rating, or by professional role or seniority.

### **Strengths and limitations**

We used an exploratory, iterative mixed methods approach, which saw each phase of data collection inform the subsequent phases and generated substantial amounts of data. Reflexivity, multiple researchers undertaking in-depth analysis, triangulation of data from multiple sources, and seeking external feedback from experts within the team meant we were able to mitigate potential researcher bias and develop robust findings.

Our inclusive sampling strategy ensured we captured perspectives from a diverse range of NHS Trusts, with variation in the number of births, the region, CQC leadership assessment and whether they were single- or multi-site Trusts. We achieved a relatively high response rate to the interviews and survey carried out amongst the quads from a good range of participants, intakes, and RAG ratings.

Our use of rapid focused ethnography enabled insight into service culture beyond the perspectives of quad members. This approach resulted in detailed and nuanced accounts of interprofessional and interpersonal behaviours, interactions, and dynamics in context, producing a more holistic account of the local culture than what is simply reported by individuals.

Our interview data, despite sampling to ensure diverse representation across Trusts by RAG rating, were based on a higher level of participation from quad members based in Red-rated Trusts (49%). This was due in part to the Red-rated Trusts being more likely to have multiple sites, meaning there were multiple quads to recruit from, but this group were not overrepresented in either the quad or staff surveys.

This low response rate together with the duration of the evaluation and the slow, complex process of cultural change in organisations, meant we were unable to assess the longer-term impact of the programme. The response rate to the staff survey, while we heard from 4011 members of staff across 96 different sites, reflects only 7% of potential responses and demonstrates the issue of 'survey fatigue' reported by the quads and others.

We were not able within the constraints of both funding and timeline to undertake any data collection before the PCLP started to establish a clear baseline or to undertake ethnography in more than six sites. However, the timing of the evaluation meant we were

able to capture data from Trusts at various stages of the Phases 2 and 3, with the first intake having completed the programme at least six months ago, while others were still completing Phase Three. All had completed the leadership components.

## **Conclusions**

The PCLP made an innovative attempt to start addressing poor workplace culture – a notoriously difficult phenomenon to change – and the intensive work with the quads reaped clear benefits to the relationship between members. This was one of the main aims of the programme. While the culture improved at quad-level, the programme did not adequately address the inevitability of quad turnover or internal and external work pressures. The relatively short-term support offered by PCLP did not appear to facilitate the creation the conditions for wider culture change: this may have been helped if the quads had been accountable to Trust boards in order to sustain culture improvement work.

Furthermore, by taking a uniform approach across heterogenous Trusts and professionals, the programme did not account for the level of previous training quad members had received (which offered less learning for many) or sufficiently navigate structural barriers, such as where Trusts had maternity and neonatal services organised into separate divisions.

There would have been value in involving specialist academics in the programme and its evaluation. The evidence – both from our evaluation and in other previous studies – suggests that taking a whole-system approach is needed to successfully change culture.

## **Considerations for future culture and leadership work**

We identified 8 considerations to guide future culture and leadership initiatives seeking to build on the PCLP, which could improve their efficacy and impact:

1. Establish clear aims and objectives, programme content, and funding before starting the programme, which is currently challenging due to the continuously changing landscape, reactive nature of national policy work and funding constraints of NHS England.
2. Include academics and evidence in the development of the programme and its evaluation at the outset, alongside drawing on existing NHS resources to develop effective and sustainable leadership and management practices. This is not currently how programmes of this nature are developed and evaluated.
3. Secure increased buy-in at Trust-level at the outset of the programme to ensure that executives and Human Resources are fully, actively supportive and accountable for the PCLP aims and activities, immediately and in the longer term. This should include protected time for quad members.

4. Ensure quad members who attend each have equivalent levels of responsibility within their organisation, which was problematic despite multiple attempts using numerous methods by NHS England.
5. Undertake an individual leadership training needs assessment with quad members and provide appropriate training options to complement participants' experience and needs. This could be done using existing training courses.
6. Increase the face-to-face culture coaching for quad members and train mid-level staff to develop their leadership skills and empower them to play a more active role in the development and implementation of the culture improvement plan, with provision of sufficient protected time by the Trust.
7. Develop a short programme to ensure quads with new members can quickly access the PCLP's benefits to working relationships, until Trusts are able to sustain this themselves.
8. Consider adopting a more focused approach, targeting sites which have greatest need due to structural or other pre-identified problems.
  - a. This may be done by creating a tool to regularly monitor which Trusts would benefit most from support, based on the identified barriers (see previous section) and other metrics such as staff retention and birth outcome data.

We are mindful of the organisational constraints within which NHS England works, particularly regarding phased or unpredictable funding. These factors act as barriers to clear and successful planning and programme implementation. The PCLP was an ambitious and much-needed initiative rolled out during a period of particularly intense scrutiny and public criticism of maternity and neonatal services; it is important to build on successes and to learn from what did not work, in order to enhance the impact of future culture and leadership programmes.

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## Appendix 1: PCLP Theory of Change

<p><b>What is the problem you are trying to solve?</b> Flawed teamworking, pulling in different directions with a lack of shared purpose</p> <p>Lack of compassionate and inclusive leadership and care in maternity and neonatal services</p> <p>Incivility and a lack of compassion in the workplace</p> <p>Work doesn't feel a positive place to be- low moral</p> <p>Disempowered and burnt-out leaders</p>	<p><b>Who is your key audience?</b></p> <p>All phases it is the senior perinatal leadership teams 'Quads' at every Trust with a maternity and neonatal service in England</p> <p>Includes midwifery, obstetric, neonatal and operational representation</p> <p>Phase 2 &amp; 3 also includes survey lead and change team</p>	<p><b>What is your entry point to reaching your audience?</b></p> <p>Pre-programme co-design with quads</p> <p>Regional perinatal teams utilised to agree sequencing of Trusts and provide contact details</p> <p>Entry to DoM pre-prog via NHSE Culture and Leadership Team (email)</p>	<p><b>What steps are needed to bring about change?</b></p> <p>3 steps (phases) of the programme; 1) Team development; 2) diagnostic / chance to hear staff voices; 3) space to re-team and plan for improvement Change in mindset and then behaviours of quads</p> <p>Participants need to engage / show up</p> <p>People feel they have permission and agency</p> <p>Active engagement with local teams</p> <p>Quads being curious about culture post programme</p>	<p><b>What is the measurable effect of your work?</b></p> <p><b>Phase 1</b></p> <p>Quad identifies as a team</p> <p>Quad working together, not in silo's</p> <p>Individually and collectively the quads have <b>shifted their thinking (and ? separately their behaviours)</b></p> <p>The quad recognise the importance of relationships and that how they 'show up' matters</p> <p><b>Improved leadership practices</b></p> <p>The quads make space to develop as a team &amp; meet more often</p> <p>Quads have a shared vision for their perinatal culture</p> <p><b>Quads feel valued as part of the programme</b></p> <p>Quads feel inspired and motivated</p> <p>Increased connection across the country – peer support</p> <p>Quads understand the importance of self-compassion and kindness</p> <p><b>More inclusive culture within quad</b></p> <p>Quads have hope for the future</p>	<p><b>What are the wider benefits of your work?</b></p> <p><b>Phase 1, 2 &amp; 3</b></p> <p>Improved relationships between national, regional and local teams</p> <p>Improved understanding of the importance of relationships- beyond the quad</p> <p>More attention paid to team health as an early warning signal</p> <p>Understanding of how actions at every level help or hinder the creation of the conditions to support local culture</p>	<p><b>What is the long-term change you see as your goal?</b></p> <p>Empowered, compassionate and inclusive perinatal leaders, working together across the country</p> <p>Improved cultures work experience / increased moral / less sickness / improved attrition for staff within matneo</p> <p>Reduction in avoidable hard due to team working / communication failures / breakdown</p> <p>Improved coordination of support offers</p> <p>Improved experience and outcomes for service users</p> <p>Improved coordination of support offers</p>
<p><b>Key Assumptions</b></p> <p>Compassionate, inclusive leaders with a shared common purpose and vision = positive cultures = happier staff and improved experience and outcomes for those using service</p> <p>One approach fits all</p> <p>Culture is a dynamic social construct</p>	<p><b>Key Assumptions</b></p> <p>Quads will participate</p> <p>NHSE will approach it the right way (relational)</p> <p>PCLP will be supportive</p> <p>Our definition of quads is right</p> <p>Quads participating are the right people</p> <p>how we do things matters</p> <p>Our sequencing is right</p>	<p><b>Key Assumptions</b></p> <p>Be open to it, have time to engage</p> <p>There would be no 'stuff' getting in the way – strikes, CQC</p> <p>Participants would be the 'right' people locally</p> <p>Quad stability</p> <p>They would read emails and respond</p>	<p><b>Key Assumptions</b></p> <p>Approach of suppliers will align</p> <p>Quads will be reflective</p> <p>People show up, and want to develop (all phases)</p> <p>Quads would be in better place come phase 2</p> <p>Quads have wider Trust support</p> <p>Adequate survey response</p>	<p><b>Key Assumptions</b></p> <p>Quads have better relationships within organisation &amp; MNVPs</p> <p>Quad impact will ripple up/across and down</p>	<p><b>Key Assumptions</b></p> <p>Quads have better relationships within organisation &amp; MNVPs</p> <p>Quad impact will ripple up/across and down</p>	<p><b>Stakeholders</b></p> <p>Wider NHSE</p> <p>Regional teams</p> <p>Trust Boards</p> <p>LMNSs / ODNs</p> <p>Suppliers</p> <p>Royal Colleges</p> <p>DHSC (funding)</p> <p>All mat neo staff</p> <p>Matneo service users</p>

What is the measurable effect of your work?

**Phase 2**

Quads have data/insight into current cultures within their teams to support planning for improvement  
Quads/survey leads have been supported to demonstrate compassionate leadership through listening / curiosity and staff have had the opportunity to have their say on how it feels to be at work (measurable by uptake of survey / completion rates  
NHSE role modelling of positive cultures through compassionate support Local conversations about culture were promoted  
Staff felt valued and listened to- that they have a voice  
The survey give staff an opportunity to say the things they wanted to say (or was it not helpful)?  
The culture survey was a positive experience?

What is the measurable effect of your work?

**Phase 3**

The quads have a better sense of their local culture  
The Quads have a better sense of their values and the culture they are aiming for / trying to nurture  
The Quads have a better understanding of the importance of how they show up  
The Quads understand the need to be constantly curious about culture  
The Quads see themselves as 'one team', not a separate mat and neo team?  
The Quads better understand their roles in improving culture  
The Quads better understand what they could do to nurture local cultures?  
The Quads feel able to support cultural conversations (cc) with their teams  
The cultural conversations were a positive experience and helpful?  
The right people involved in the change teams  
The change teams feel they had agency  
This methodology (cc) felt a useful tool to use in the future  
Quads were left with a sense of hope?  
Local culture coaches feel they had the capability and capacity to continue the conversations  
Staff (on the ground) had an understanding of their local culture  
Staff (on the ground) were aware of the improvement plans and have an opportunity to contribute to them?  
Quads are having more conversations with their board safety champions?  
Quads have a better relationship with their board safety champions?  
Has the programme learning filtered to other parts of the organisation?  
Quads are influencing more broadly?  
Phase 3 was a positive experience

Assumptions for measurable effects (all phases)

Safety culture surveys are a positive intervention  
That quads would be in a better place come phase 2 and 3  
Quads and teams had time to engage throughout  
That there would be a good SCORE response rate  
This programme would be a high priority  
Quads would get support from their Board  
Quads would know who the right people were to participate  
Quads would speak with and support their survey lead  
Quads would be open to challenge, reflection and change  
Quads would want to continue this work  
Quads would continue to meet outside of the programme  
Quads would draw on learning from the programme once back in the day job  
Other surveys wouldn't get in the way of SCORE  
The process of doing SCORE and the conversations will shape the future recruitment and retention – word gets out that some units are good places to be and others aren't?  
Short term sickness? change

## Appendix 2: Interview topic guide

### Reminders:

- Thank interviewee for attending
  - Introduce yourself
  - Reminder about study aim
  - Read PIL
  - Audio recording/anonymity/confidentiality/data usage
  - Withdrawal of consent/don't have to answer questions
- 
1. Can you briefly introduce yourself – where you work, role, how long you have been there, type of unit, demographics of women
  2. What has been your experience of the Perinatal Culture & Leadership Programme (so far)? What have been the benefits, aspects have you enjoyed? What aspects could be different, any disadvantages?
  3. What did you think the PCLP was aiming to do? What were your expectations and have they been met? Ask why/why not
  4. What has been the biggest impact of participating in the PCLP on you/your leadership style? Any specific aspects of the programme that have led to this?
  5. Have you noticed any changes in your quad colleagues?
  6. Tell me about your quadrumvirate colleagues. What were your interactions and relationships like before the programme? *Prompt: how often did you meet, meet, how familiar were you with each other, did you feel part of a team? Could you easily turn to a colleague for support? Did you raise concerns with each other?*
  7. What are your interactions and relationships like now with your quad colleagues? Have they changed in any way since you started the programme? *Prompt: do you feel part of a team, can you easily turn to each other for support, can you easily raise concerns with each other?*
  8. Are there any colleagues within the quad you feel you don't have much interaction or connection with? Has that changed in any way since commencing the programme?
  9. How are your interactions with other colleagues e.g. board safety champions, board members, immediate reports, frontline staff? Have these changed in any way since commencing the programme?

10. How would you describe the culture in your unit? How do you think staff would describe the culture?
11. Where do you see your role in contributing to the culture of your organisation? How does that fit with your quad colleagues?
12. Have you identified any areas for improvement with regards to culture? Have you made any plans/implemented anything to address these?
13. What would be the tipping point/help facilitate the changes you are hoping for? Who are the key people you need to engage with?
14. Have there been/(could there be) any challenges in implementing any improvement initiatives/learning from the PCLP? How could these be overcome?
15. Finally, how do you plan to work with your quad colleagues once the programme ends?
16. Anything else you would like to mention about the PCLP?

## Appendix 3: Survey questionnaires

### **Quad survey**

**We appreciate how busy you are, and that you may have completed a lot of surveys, but this one is really important.**

It is part of an independent evaluation by the University of Birmingham of the NHS England Perinatal Culture and Leadership Programme (PCLP), and without your response we will not know the impact of the programme or be able to inform similar initiatives which NHS England may deliver in the future. Even if you haven't completed the PCLP, or joined it partway through, it is still important we hear from you.

**The survey will take approximately 5 minutes to complete.** It asks about your background and your views and experiences of the PCLP. There are no right or wrong answers.

**Everything you share will remain completely confidential.** The information you tell us will be used in our evaluation and in reports and publications, including any quotes, but you will not be identifiable. This questionnaire is for your Trust only, so we will know where you work, but we will not attribute any of your responses to your Trust. Although this was sent to you by NHS England, your response will come directly back to the University of Birmingham and **NHS England will not have sight of any responses.** You will receive periodic emails reminding you to complete it, as we cannot identify individual responses.

More information is available on our website. If you have any questions about the survey or the wider evaluation, please email [pclpevaluation.birmingham@contacts.bham.ac.uk](mailto:pclpevaluation.birmingham@contacts.bham.ac.uk)

Thank you in anticipation of your time in completing this questionnaire.

### **A) About Me**

1. What is your professional background?
  - a. Midwifery
  - b. Nursing – Neonatal
  - c. Medical – Obstetrics & Gynaecology
  - d. Medical – Neonatal
  - e. Operations management
  - f. Other (please specify)
  
2. How many years have you been working in your current role?
  - a. ≤1 year
  - b. 2-4 years
  - c. 5-9 years
  - d. 10-19
  - e. 20+

3. Which sections of the PCLP did you take part in?
  - a. All phases
  - b. Face-to-face modules (Phase 1)
  - c. Action learning sets (Phase 1)
  - d. SCORE survey process (Phase 2)
  - e. SCORE survey debriefing and cultural coaching (Phase 3)
  - f. None of the above

**B) Before the PCLP**

4. Before the PCLP I already worked well with (please select all which apply):
  - a. All members of my quad
  - b. Director/Head of Midwifery
  - c. Obstetric clinical lead
  - d. Neonatal clinical lead
  - e. Operational Manager
  - f. Other (please specify)
  
5. Before the PCLP, my service was a safe and positive place to work
 

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*

**C) Working with my quad colleagues since participating in the PCLP**

6. My relationships with my quad colleagues have improved since participating in the PCLP
 

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*
  
7. Getting to know my quad colleagues outside of our regular workplace has enabled us to work better as a team
 

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*
  
8. I communicate more frequently with my quad colleagues
 

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*
  
9. I better understand the challenges facing other parts of the perinatal service in my Trust
 

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*
  
10. I can more openly share my thoughts and concerns with my quad
 

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*
  
11. My quad colleagues work effectively as 'equal partners' with no clear hierarchy
 

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*
  
12. My quad have agreed shared goals for improving our culture
 

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*
  
13. My quad have agreed an improvement/action plan for culture change
 

*Yes      No      Partially*

**D) My organisation's support for the PCLP process**

14. Trust leaders support the work of my quad to implement change

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*

15. Trust leaders have provided sufficient resources to implement the changes identified in our PCLP action plan

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*

**E) My leadership style since the PCLP**

16. I feel better able to lead since participating in the PCLP

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*

17. I spend more time in clinical areas since participating in the PCLP

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*

18. I challenge unprofessional behaviour more often since participating in the PCLP

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*

19. Since the PCLP, I make more effort to listen to frontline staff about their concerns and ideas for improvement

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*

20. Since the PCLP, I support more junior staff to undertake service improvement

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*

**F) My thoughts about the PCLP**

*This is the last section. We really appreciate the time you have given to completing this questionnaire.*

21. Being involved in the PCLP has resulted in the service being a better place to work

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*

22. The PCLP was an effective use of my time

*Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree*

23. What do you think will be the longer-term impact of the PCLP on your service?

*FREE TEXT*

24. Please tell us what could have been done differently to maximise the impact of the PCLP

*FREE TEXT*

***Thank you very much for completing the survey.***

## **Staff survey**

**We appreciate how busy you are, and that you may have completed a lot of surveys, but this one is really important.**

This survey is part of an independent evaluation by the University of Birmingham of the NHS England Perinatal Culture and Leadership Programme (PCLP), which was an intensive programme that ran over 12-18 months for your senior leadership team to improve leadership and culture. The team who took part are known as the quad and typically included your Head/Director of Midwifery, Obstetric and Neonatal Clinical Leads and Service Manager, although some Trusts sent other senior staff.

This survey is for staff at all other levels and will help us understand whether the programme has had any impact on your work. We have been given permission by your senior leadership team to contact you.

**The survey will only take 3 minutes to complete.** There are no right or wrong answers, as we are interested in your views and experiences of your service.

**Everything you share will remain completely confidential.** The information you tell us will be used in our evaluation and in reports and publications, including any quotes, but you will not be identifiable. This questionnaire is for your service only, so we will know where you work, but we will not attribute any of your responses to your Trust. Although this was sent to you by NHS England, your response will come directly back to the University of Birmingham. **No one in your Trust or NHS England will see your responses.**

More information is available on our website. If you have any questions about the survey or the wider evaluation, please email [pclpevaluation.birmingham@contacts.bham.ac.uk](mailto:pclpevaluation.birmingham@contacts.bham.ac.uk)

Thank you in advance for your support and time in completing this questionnaire.

### **About You**

We are asking these questions to help us understand the results.

25. What is your professional background?
- a. Midwifery
  - b. Nursing – Neonatal
  - c. Medical - Obstetrics & Gynaecology
  - d. Medical – Neonatal/Paediatrics
  - e. Medical – Anaesthetics
  - f. Operations management
  - g. Support staff (e.g. HCA/Maternity support worker/Nursery nurse)
  - h. Other (please specify)

26. Please select the category that best describes your professional role? *[Options will be filtered according to Q1 response.]*

- a. Matron
- b. Consultant midwife
- c. Advanced clinical practitioner
- d. Labour ward coordinator
- e. Band 7 midwife
- f. Band 6 midwife
- g. Band 5 midwife
- h. Maternity support worker
- i. Band 7 neonatal nurse
- j. Band 6 neonatal nurse
- k. Band 5 neonatal nurse
- l. Nursery nurse/Healthcare support worker
- m. Foundation doctor
- n. Speciality trainee ST1 - ST2
- o. Speciality trainee ST3 - ST7
- p. SAS doctor
- q. Consultant
- r. Other (please specify)

27. What is your ethnicity?

*Please select the relevant Census category.*

Asian or Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background

Black, Black British, Caribbean or African

Caribbean

African

Any other Black, Black British, or Caribbean background

Mixed or multiple ethnic groups

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed or multiple ethnic background

White

- English, Welsh, Scottish, Northern Irish or British
- Irish
- Gypsy or Irish Traveller
- Roma
- Any other White background
- Other ethnic group
  - Arab
  - Any other ethnic group
- Prefer not to say

### About Your Workplace

1. I can identify the senior leadership team in my service:
 

a. Director/Head of Midwifery	Yes	No	Unsure
b. Obstetrics Clinical Lead/Director	Yes	No	Unsure
c. Neonatal Clinical Lead/Director	Yes	No	Unsure
d. Operations/General Manager	Yes	No	Unsure
  
2. I regularly see the senior leadership team in clinical areas.
 

<i>Strongly Agree</i>	<i>Agree</i>	<i>Neutral</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	N/A
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Has this changed in the last 12-18 months

<i>More</i>	<i>About the same</i>	<i>Less</i>
-------------	-----------------------	-------------
  
3. The senior leadership team interact with me.
 

<i>Strongly Agree</i>	<i>Agree</i>	<i>Neutral</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	N/A
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Has this changed in the last 12-18 months

<i>More</i>	<i>About the same</i>	<i>Less</i>
-------------	-----------------------	-------------
  
4. I feel listened to and respected when raising concerns
 

<i>Strongly Agree</i>	<i>Agree</i>	<i>Neutral</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	N/A
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Has this changed in the last 12-18 months

<i>More</i>	<i>About the same</i>	<i>Less</i>
-------------	-----------------------	-------------
  
5. My unique skills and talents are valued and utilised
 

<i>Strongly Agree</i>	<i>Agree</i>	<i>Neutral</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	N/A
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Has this changed in the last 12-18 months

<i>More</i>	<i>About the same</i>	<i>Less</i>
-------------	-----------------------	-------------
  
6. If I make a mistake, I feel it is held against me
 

<i>Strongly Agree</i>	<i>Agree</i>	<i>Neutral</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	N/A
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Has this changed in the last 12-18 months

*More About the same Less*

7. Unprofessional behaviour is challenged in my unit

*Always Often Sometimes Rarely Never N/A*

Has this changed in the last 12-18 months

*More About the same Less*

8. I feel able to suggest changes to improve services

*Strongly Agree Agree Neutral Disagree Strongly Disagree N/A*

Has this changed in the last 12-18 months

*More About the same Less*

9. The culture in my unit is improving compared to 12-18 months ago

*Strongly Agree Agree Neutral Disagree Strongly Disagree N/A*

10. Is there anything else you want to tell us about working in your unit?

*Free text*

**Thank you for your time and effort in completing this questionnaire.  
It will help us evaluate the impact of the Perinatal Culture and Leadership  
Programme and inform future NHS England work on this topic.**

#### Appendix 4: Sample RAP sheets for rapid ethnographic data collection

<b>Researcher</b>		
<b>Date + visit no X of 6</b>		
<b>Site ID</b>		
<b>RAG rating</b>		
<b>CQC maternity leadership rating + date</b>		
<b>PCLP intake + completion status</b>		
<b>Topics</b>	<b>Main findings</b>	<b>What we observed that supports this finding</b>
<b>Team capital &amp; belonging</b>		
How is the Quad working as a team? e.g. civility, ways of meeting as a Quad, mutual support, means of communicating, shared understanding & goals	Cognitive: Relational: Structural:	
Obstacles to effective perinatal working/implementing PCLP aims		
What has changed since PCLP/since evaluation interview?		
What are the Quad's shared goals/plans?		
Quad membership & belonging: professional hierarchies, boundaries, power		
<b>Leadership behaviours</b>		
Distributive/collective/inclusive/siloed/solo actions & their impacts		
Leadership perspectives from <b>Quad</b> colleagues – visibility, support, psychological safety, openness to new ideas, role modelling, civility, compassion, empathy + has it changed?		
Leadership perspectives from <b>middle management</b> – visibility, support, psychological safety, openness to new ideas, role modelling, civility, compassion, empathy + capability building; role in improvement work + has it changed?		
Leadership perspectives from <b>frontline staff</b> – visibility, support, psychological safety, openness to new ideas, role modelling, civility, compassion, empathy + has it changed?		

Addressing challenging relationships/poor behaviours – views from <b>Quad colleagues</b>		
Addressing challenging relationships/poor behaviours – views from <b>middle management</b>		
Addressing challenging relationships/poor behaviours – views from <b>frontline staff</b> (note roles)		
<b>Culture</b>		
Quality of interactions – at handovers, in huddles, in general, civility, ‘Hot-spots’ and triggers of conflict, intra- & inter-professional dynamics, power dynamics		
Perspectives from <b>Quad</b> colleagues – on culture, how mistakes & serious incidents are handled, blame & learning opportunities? Barriers & enablers of change?		
Perspectives from <b>middle management</b> on culture, how mistakes & serious incidents are handled, blame & learning opportunities? Barriers & enablers of change?		
Perspectives from <b>frontline staff</b> on culture, how mistakes & serious incidents are handled, blame & learning opportunities? Barriers & enablers of change?		
Ongoing culture work/QI, whether PCLP related or not – learning opportunities, listening sessions		
How staff view staffing levels – respective views of <b>Quad</b> (control of staff allocation); <b>middle management</b> (decision-making; level of autonomy); <b>frontline staff</b> (experience of teamworking/capacity/safety) + impact on culture & morale		
Structural: HR practices around recruitment, retention, induction, training, socialisation, performance management, job design		
<b>Organisational structure</b>		
Aspects supportive of perinatal working		

Aspects impeding perinatal working		
Engagement & relationship with Trust/Board/maternity safety champions/NEDs - does middle management/shopfloor know who these people are & feel able to access them?		
Engagement & relationship with Maternity Improvement Advisors and other external stakeholders, where applicable		
All staff experiences of working in transitional care and other setting where maternity and neonatal staff interact		
<b>Resonance of observations with interview data (initial triangulation)</b>		

## **Appendix 5: Data management**

All electronic data were stored on University of Birmingham computers within a secure network, restricted access, site firewalls, and antivirus software. The data were held in shared drives, only accessible to the evaluation team. Computers used by the staff involved comply with University regulations for safe storage including password protected access.

### **Interviews**

Audio recordings were securely transferred through the University of Birmingham transfer service portal to an approved and contracted health specialist transcription service, adhering to GDPR guidance and with a data sharing agreement in place. They were transcribed intelligent verbatim and anonymised by deleting individual and Trust names, and other identifiable information.

Interview recordings were deleted once the transcript has been completed and anonymised. Following completion of the study, transcripts will be stored in archive for 10 years before being destroyed in accordance with the University's data retention and disposal policy.

### **Ethnography**

Data collected during site visits used anonyms and/or coded identifiers to capture professional role/grade while protecting the identities of participants and the Trust. Researchers used paper notebooks to record anonymised observations. We used encrypted voice recorders to securely capture further interviews and focus group discussions undertaken on-site. These recordings and resultant data were treated in the same manner as those discussed above.

### **Surveys**

Survey responses were entered into the University's preferred provider, JISC Online Surveys. This is an online survey tool designed for academic research, education and public sector organisations. It is GDPR compliant and certified to ISO 27001 standard. The data were downloaded from the survey platform and managed in a Microsoft Excel database.

We used Microsoft Copilot to synthesise qualitative data collected via the survey tool, to support our analysis. Copilot is the University-approved generative AI software; the license ensures that all data remain encrypted and are not visible to Microsoft, so are not used to train any of its underlying language models.

## Appendix 6: Comparison of survey responses between mid-level and other staff

We specify statistical models to estimate the association between the response to the questions and whether staff are working in mid-level positions. The models are ordinal logistic regression models with adjustment for intake and RAG rating and including site random effects to capture unexplained site-level variation.

The interpretation of the odds ratios is the proportionate change in the odds of being in a higher category (where “higher” means towards the “Strongly Disagree” end of the scale). An odds ratio greater than one indicates that that group has a higher odds of disagreeing with the question.

### Difference in staff survey responses from mid-level staff

Estimate	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
<b>Intake</b>								
1	1.00 (reference)							
2	1.17 (0.81, 1.67)	1.08 (0.81, 1.44)	1.07 (0.82, 1.39)	1.07 (0.83, 1.36)	1.03 (0.83, 1.28)	1.14 (0.90, 1.45)	1.1 (0.86, 1.41)	0.99 (0.73, 1.33)
3	1.25 (0.86, 1.8)	1.13 (0.85, 1.5)	1.28 (0.97, 1.67)	1.14 (0.89, 1.46)	0.99 (0.79, 1.24)	1.12 (0.88, 1.44)	1.13 (0.88, 1.46)	1.24 (0.92, 1.67)
4	1.24 (0.89, 1.74)	1.19 (0.91, 1.57)	1.09 (0.85, 1.42)	1.05 (0.84, 1.32)	1.11 (0.90, 1.37)	0.91 (0.73, 1.14)	1.02 (0.81, 1.3)	1.00 (0.75, 1.35)
5	1.02 (0.72, 1.46)	0.95 (0.71, 1.28)	1.08 (0.82, 1.42)	0.9 (0.69, 1.15)	1.1 (0.88, 1.38)	1.05 (0.82, 1.36)	0.92 (0.71, 1.17)	1.11 (0.81, 1.52)
<b>RAG</b>								
Green	1.00 (reference)							
Amber	1.34 (0.97, 1.82)	1.46 (1.12, 1.89)	1.41 (1.11, 1.78)	1.25 (1, 1.57)	0.83 (0.69, 1.01)	1.35 (1.1, 1.68)	1.45 (1.15, 1.82)	1.22 (0.92, 1.59)
Red	0.98 (0.75, 1.29)	1.03 (0.83, 1.27)	0.91 (0.75, 1.13)	0.95 (0.78, 1.15)	1.02 (0.86, 1.22)	1.03 (0.86, 1.24)	1.11 (0.92, 1.33)	0.95 (0.75, 1.2)
<b>Mid-level staff</b>	0.42 (0.36, 0.50)	0.32 (0.27, 0.38)	0.36 (0.30, 0.43)	0.37 (0.31, 0.44)	1.95 (1.65, 2.32)	0.47 (0.4, 0.55)	0.33 (0.28, 0.39)	0.41 (0.34, 0.49)

Posterior mean and 95% credible intervals for the ordinal regression parameters of outcomes Q1 – Q8, Q1: I regularly see the senior leadership team in clinical areas; Q2: The senior leadership team interact with me; Q3: I feel listened to and respected when raising concerns; Q4: My unique skills and talents are valued and utilized; Q5: If I make a mistake, I feel it is held against me; Q6: Unprofessional behaviour is challenged in my unit; Q7: I feel able to suggest changes to improve services; Q8: The culture in my unit is improving compared to 12-18 months ago.