Review

Midwifery Leadership in a Changing World - Why Is This So Challenging. A Narrative Review

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Midwifery Leadership in a Changing World—Why Is This So Challenging. A Narrative Review

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Abstract

Background Midwifery leadership is recognised as essential to delivering safe, high-quality, and person-centred maternity care. Despite extensive investment in leadership development and governance frameworks, numerous national reviews in the United Kingdom continue to highlight leadership as a persistent weakness in maternity services. Understanding the factors that constrain effective leadership is critical to achieving sustainable improvement. Aim This paper explores why midwifery leadership in the UK remains so challenging. It reflects on national evidence, leadership theory, and the author's professional experience to consider the cultural, structural, and personal dimensions of leadership in maternity services. Methods A reflective approach is adopted, drawing on over 30 years of professional practice across clinical, academic, and national improvement roles. The discussion integrates findings from national inquiries, academic research, and international comparisons, with leadership theories including compassionate, courageous, and adaptive leadership. Findings Midwifery leadership is shaped by complex and competing pressures, including rising clinical complexity, workforce shortages, cultural tensions between midwifery- and medically-led models of care, and punitive governance systems that foster fear. These conditions undermine psychological safety, contribute to attrition, and limit opportunities for succession planning. Evidence suggests that effective leadership behaviours—compassion, courage, adaptability, and systems thinking—can strengthen team resilience and improve outcomes. International models demonstrate how supportive policy environments and greater autonomy enable midwifery leadership to flourish. Conclusion Effective midwifery leadership is both an individual and a structural endeavour. Leaders must demonstrate relational, values-driven behaviours, while systems must dismantle punitive cultures, invest in leadership development, and embed frameworks such as Safety-II. Without cultural and organisational reform, even skilled leaders will struggle to thrive, jeopardising progress towards the ambitions of the NHS Long Term Plan.

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1. Introduction

Midwifery leadership is widely recognised as central to the delivery of high-quality, safe, and compassionate maternity care. Effective leadership empowers maternity staff to reach their full potential and fosters a culture rooted in person-centred values, psychological safety, and professional autonomy. A positive leadership culture is vital for ensuring that midwives feel supported, engaged, and equipped to provide the best possible care to women, birthing people, and families.

Despite this understanding, the UK continues to face significant challenges in embedding strong and effective leadership in maternity services. Numerous national reviews and Care Quality Commission (CQC) inspection reports have identified leadership as a persistent area of concern. In England, the Ockenden (2022) and Kirkup (2022) reviews highlighted failures in leadership as contributory factors to avoidable harm. In Scotland, the 2022 Healthcare Improvement Scotland review of NHS Ayrshire & Arran cited leadership and communication as areas requiring improvement. Wales's review into maternity services at Cwm Taf Morgannwg University Health

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Board (2019) exposed systemic failings in governance and leadership oversight. Similarly, the Regulation and Quality Improvement Authority (RQIA) review in Northern Ireland (2020) called for strengthened maternity leadership and assurance mechanisms.

Leadership in maternity services is complex, multidimensional, and deeply contextual. We know there is a lack of understanding about 'what good midwifery leadership looks like' alongside tensions with professional identity, multi-disciplinary teams, differences between midwife led care and obstetric led care and the agile leadership needed within that. In responding to the challenges outlined in this paper, it is important to acknowledge that leadership and management, while distinct, are interdependent functions that must work in harmony to achieve sustainable improvement. Leadership is associated with vision, influence, and inspiring others to embrace change, whereas management should focus on planning, organising, and delivering services efficiently. Both are essential in healthcare settings, particularly in maternity, where leaders and managers must navigate strategic priorities, operational pressures, and the emotional realities of frontline care. Yet, we see some cultures in maternity services where managers are stigmatised and roles that require agile skills and flexibility to switch from leadership to management in context to what is required are reluctant to acknowledge the importance of both skill sets. Senior staff can be heard saying 'I am not a manager, I am a leader.'

At the same time, leadership development has been a growing priority across the NHS. Programmes such as the NHS Leadership Academy's Edward Jenner and Mary Seacole programmes, the Florence Nightingale Foundation scholarships, have been developed to build leadership capacity within the NHS. Many local trusts also invest in bespoke clinical leadership training for Band 6–8a midwives, in an attempt to supporting succession planning and capability building.

In parallel, the academic pathway for midwives has evolved significantly. Alongside, the rising complexity of care—driven by increasing rates of physical and mental health comorbidities, social vulnerabilities, and safeguarding concerns—has prompted a proliferation of specialist midwifery roles across all four nations. For example, National Bereavement Care Pathway supports specialist bereavement midwives; specialist midwives for substance misuse, safeguarding, and public health; expanding continuity of carer models; and perinatal mental health midwifery roles. These roles are frequently embedded within wider leadership and governance structures aimed at driving improvement and assuring quality and involve additional education and knowledge development for aspiring expert clinical leaders.

The transition from diploma to degree-level registration and increasing uptake of postgraduate qualifications—such as MSc Advanced Clinical Practice and MSc Midwifery Leadership—has raised the educational profile of the midwifery workforce. Emerging research suggests that higher education levels in midwifery are associated with increased confidence in leadership roles and improved clinical decision-making (Hunter et al., 2022; Reed & Roberts, 2023). Yet still we are challenged by reports of poor leadership examples, and this adds to the debate: Are leaders born to lead or can leadership be taught?

Governance and assurance frameworks, such as the Maternity Incentive Scheme (England), Maternity and Neonatal Safety Support Programme (England and Wales), and the Perinatal Quality Network (Scotland), have been introduced to support leaders in identifying risk, escalating concerns, and delivering safe care. However, there is growing concern that the increasing bureaucratisation of safety and quality processes may, paradoxically, be undermining leadership. Recent research highlights the risk of a punitive culture developing within maternity governance structures, leading to fear, moral injury, and disempowerment among senior midwives (Kirkup, 2022; Deery & Hunter, 2021). Experienced Midwives are leaving and there is a lack of progression and support for the next generation of leaders to develop.

In this reflective paper, I will reflect on my own experience and explore the current challenges and tensions facing midwifery leaders in the UK. Drawing on national evidence, research, and professional experience, I will consider the impact these challenges may be having on our collective ability to lead maternity services into the future and realise the ambitions of the NHS Long Term

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Plan.) I will attempt to answer the fundamental question: **what does it take to be an effective midwifery leader in these challenging and complex times?**

2. Methodology

A narrative review approach to explore the key characteristics, challenges, and contextual influences shaping midwifery leadership in the UK was adopted. This methodology allowed a broad, interpretive exploration of the evidence and integrates academic literature, policy documents, and reflective professional experience. The review process involved purposive searching of peer-reviewed journals, and policy publications. Key search terms included: "midwifery leadership," "compassionate leadership," "courageous leadership," "safety culture," "maternity care," "professional autonomy," and "workplace culture in midwifery." Literature published between 1990 and 2025 was considered to capture both historical developments and current culture, with a focus on UK-based sources and selected international comparators to contextualise professional autonomy and leadership frameworks. Policy documents from NHS England, the Royal College of Midwives, and key national inquiries (e.g., Ockenden, Kirkup) were included to provide context of current regulatory and strategic frameworks. The reflective component draws on the author's 30-year leadership experience in UK maternity services, integrating experiential insight with evidence to enhance the depth of thematic analysis and practical application.

3. The Changing Context of Maternity Services

The history of midwifery is marked by ongoing struggles for professional autonomy and recognition, and these tensions continue to shape midwifery leadership pathways today. In the UK, while midwifery is protected by statute as an autonomous profession, the legacy of medical dominance in maternity care has led to persistent power imbalances between midwives and obstetricians. The 20th-century institutionalisation of birth shifted maternity care from homes to hospitals, embedding a medically led, risk-averse model that often-marginalised midwifery-led approaches (Donnison, 1988; Tew, 1998). Although significant efforts have been made to reassert midwifery autonomy—most notably through the *Changing Childbirth* (1993) report and more recently *Better Births* (2016)—midwives continue to face barriers to practising fully autonomously within hierarchical NHS structures (Hunter, 2004; Page and McCourt, 2005). Amidst the context of social media campaigns and media reporting of harm caused by maternity services and a widening discourse between midwifery led physiological and medical led high tech ideologies.

These power dynamics not only influence clinical practice but also impact leadership development. Midwifery leaders are often required to act as boundary-spanners, advocating for midwifery philosophy and evidence-based, person-centred care within systems that prioritise performance metrics and biomedical risk management (Kirkham, 2000; Sandall, 1997). The tension between professional values and system expectations can make leadership roles politically and emotionally demanding, contributing to burnout and attrition (Deery and Hunter, 2010). Furthermore, pathways into leadership are shaped by structural limitations—such as lack of access to strategic decision-making forums and limited investment in midwifery-specific leadership development.

International comparisons further illuminate this challenge. In the United States, midwives face significant restrictions on scope of practice in many states due to regulatory and institutional barriers, resulting in limited autonomy and integration within the healthcare system (Kennedy et al., 2010). In contrast, countries such as New Zealand and the Netherlands offer models of care where midwives enjoy high levels of autonomy and professional status, supported by strong governance structures and a policy environment that values physiological birth and continuity of carer (Guilliland and Pairman, 2010; de Jonge et al., 2015). These models demonstrate how greater midwifery autonomy and structural support can enable leadership to flourish, influence service design, and improve outcomes.

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In the UK, midwifery leadership must therefore be understood not only as a function of individual capability but also as a political act: the assertion of professional values within a system that continues to challenge the authority and independence of midwifery. Recognising this context is essential if we are to develop leadership pathways that truly support midwives to lead with authenticity, courage, and influence.

The context in which maternity services are provided is evolving rapidly, shaped by demographic, social, and systemic challenges. There is increasing complexity within the population, with rising levels of obesity, diabetes, mental health conditions, and socio-economic deprivation impacting pregnancy outcomes (NMPA, 2023; Knight et al., 2023). These trends underscore the growing need for multi-disciplinary, cross-boundary collaboration across health, social care, and community sectors to ensure safe and effective care.

Despite these challenges, public and professional expectations remain high. Families increasingly anticipate a risk-free birth experience with positive physical and emotional outcomes (Birthrights, 2022). However, population health indicators, such as maternal obesity and smoking in pregnancy, continue to increase in some areas, and interventions aimed at addressing these trends have achieved only limited success (Office for Health Improvement and Disparities [OHID], 2022).

At the same time, there are significant barriers to providing the very elements of care that are known to improve holistic outcomes. Models such as continuity of carer—which evidence shows reduces preterm birth, improves satisfaction, and enhances safety—have been scaled back or discontinued in many areas due to staffing shortages (Sandall et al., 2016; NHS England, 2022). Similarly, closures of alongside and freestanding birth centres and a reduction in midwifery-led care have reduced choice for families (CQC, 2023). Postnatal care and breastfeeding support remain inconsistent, often compromised by workforce pressures and resource constraints (RCM, 2023). The time for midwives to listen and provide relational care is increasingly replaced with technology-driven processes and bureaucratic documentation requirements (Hunter et al., 2021).

In stark contrast, clinical intervention rates continue to rise. Caesarean section rates in England reached almost 35% in 2022, and induction of labour rates now exceed 40% in many regions (NMPA, 2023). While these interventions can be lifesaving, they are associated with higher short-term risks and long-term implications for maternal health and future pregnancies, which are not yet fully understood (NICE, 2021; RCOG, 2022). This shift demands more technology-dependent services, increased costs, and highly skilled staff—creating additional strain on already stretched resources.

The complexity of cases has driven a need for more specialist midwifery roles, such as safeguarding, perinatal mental health, and continuity leads, often consolidated into fewer sites to maintain expertise and safety (RCM, 2022). Financial pressures exacerbate these challenges, compelling leaders to make difficult decisions about service configuration, including shared commissioning arrangements and group service models (NHS England, 2023). This creates a widening tension between promoting midwifery-led, community-based care and responding to the escalating demands of high-risk, hospital-based care.

4. Reflective Component: Linking Leadership Theory to My Experience

Reflecting on my career, I recognise that many of the leadership qualities identified in current evidence—such as compassionate, courageous, and adaptive leadership—have been central to my practice, often under challenging circumstances. With over 30 years in the NHS, my roles have spanned from integrated midwife to Consultant Midwife, Associate Director of Research, and most recently, National Maternity Improvement Advisor. These experiences have shaped my understanding that leadership in maternity is not only about strategic planning and governance but also about human connection, moral courage, and adaptability in the face of complexity.

Compassionate leadership, as described by West et al. (2021) and supported by evidence in *Compassionomics* (Trzeciak and Mazzarelli, 2019), resonates deeply with my personal philosophy of care. In my role as Consultant Midwife, I led quality improvement initiatives—such as setting up a rural midwife-led day assessment service and introducing digital maternity records—by engaging

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staff through listening, empathy, and shared purpose. I have always prioritised creating environments where midwives feel valued and safe to share ideas, recognising that staff wellbeing directly impacts the experience of women and families.

However, my leadership journey has also demanded courage. During my tenure as National Maternity Improvement Advisor, I worked with trusts rated as "requires improvement" or "inadequate" by the CQC, where cultures of fear and silence were prevalent. Leading improvement in these contexts required challenging entrenched behaviours, addressing resistance, and advocating for transparency even when these conversations were uncomfortable. This aligns with the principles of courageous leadership (Edmonstone, 2022), which stress the importance of moral courage in protecting patient safety and driving change.

Adaptability has been another critical competency in my career. The COVID-19 pandemic exemplified this, when I led a Trust-wide staffing response hub, balancing operational pressures with staff redeployment and wellbeing. Similarly, working internationally with the Florence Nightingale Foundation to review midwifery models of care in New Zealand and Denmark strengthened my ability to think systemically and integrate global best practices into local improvement plans.

These experiences reinforce my belief that effective midwifery leadership is about balancing compassion with courage, and strategic vision with relational care. In a climate of increasing complexity, media scrutiny, and regulatory pressure, my commitment remains to lead in a way that empowers teams, upholds professional values, and keeps women and birthing people at the centre of every decision.

5. The Changing Workforce in Maternity and Leadership Challenges

The maternity workforce is undergoing significant demographic and structural change, presenting unique challenges for leadership. The midwifery profession in the UK is ageing, with almost 50% of midwives aged over 45, creating concerns about retirement-related attrition and loss of expertise (NHS Digital, 2023). At the same time, there has been an influx of newly qualified midwives and international recruits to address persistent workforce shortages (RCM, 2023). This creates a generational gap within teams, often with contrasting expectations, values, and working styles. Younger midwives frequently prioritise work–life balance, flexibility, and career progression, while more experienced staff may emphasise traditional hierarchies and continuity of care (Skills for Care, 2022). Leaders must navigate these differing perspectives while maintaining team cohesion and service quality.

Moreover, the increasing reliance on internationally educated midwives introduces cultural diversity and the need for inclusive leadership practices, particularly in supporting adaptation to UK clinical standards and professional culture (NHS England, 2023). These dynamics occur against a backdrop of chronic workforce shortages—England alone has an estimated shortfall of over 2,500 full-time equivalent midwives (RCM, 2023). The pressure to fill gaps often results in redeployment, loss of continuity models, and reduced professional development opportunities, further challenging morale and retention (NHS England, 2022). For leaders, balancing service delivery with staff wellbeing, professional development, and equitable treatment across diverse workforce groups is an increasingly complex task that requires adaptive, compassionate, and culturally competent leadership (West et al., 2021).

Midwifery leaders find themselves navigating these competing priorities while managing day-to-day operational pressures, workforce shortages, and the need to uphold women's and birthing people's values and choices. Simultaneously, they face intensifying scrutiny from regulatory bodies, escalating assurance and data requirements, and a media landscape often critical of maternity services and the midwifery profession (Kirkup, 2022; Ockenden, 2022). These dynamics raise a fundamental question: **what does it take to be an effective midwifery leader in these challenging and complex times?**

6. A Culture of Fear in Maternity Leadership:

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The culture within maternity services has shifted significantly in recent years, and for many in the workforce, fear has become a dominant influence on how they lead and practice. Fear of getting things wrong, fear of blame, fear of referral to the Nursing and Midwifery Council (NMC), and fear of losing employment now shape day-to-day decision-making for midwifery leaders (Kirkup, 2022; Ockenden, 2022). This fear is compounded by the increasing prevalence of media scrutiny and public naming and shaming when adverse events occur (Birthrights, 2022). Leaders often describe the emotional toll of carrying responsibility for both patient safety and organisational reputation while trying to protect their teams (Hunter & Warren, 2014).

Underlying this is the very real fear of causing harm to women, birthing people, and babies—the fundamental drivers for why midwives enter the profession. However, this moral responsibility, when combined with punitive regulatory systems and the constant demand for compliance with assurance processes, can create an overwhelming sense of vulnerability among senior staff (Deery & Hunter, 2021). Reports such as the East Kent Inquiry (Kirkup, 2022) have highlighted how a blame-focused culture can become embedded, leading to defensive practice and diminished psychological safety within teams.

Being a senior leader in maternity today can feel like a no-win situation, with high expectations and limited resources creating the perfect conditions for stress and burnout. Research indicates that midwifery leaders experience higher rates of stress compared to many other health professionals, with workload, fear of litigation, and responsibility for serious incidents frequently cited as primary stressors (Sheen et al., 2020). These pressures contribute to experienced leaders leaving the profession after short tenures in senior roles, resulting in a loss of expertise at a time when it is most needed (Royal College of Midwives [RCM], 2023). In turn, younger and less experienced midwives are often placed in leadership roles with limited preparation, mentorship, or organisational support, leaving them vulnerable to the same cycle of stress and attrition (RCM, 2023).

The consequence is a system where fear becomes normalised and "leading through fear" starts to feel inevitable. This environment undermines the principles of compassionate and transformational leadership advocated in NHS policy (NHS Leadership Academy, 2019) and erodes the psychological safety that is essential for learning and improvement (West et al., 2021). If this trajectory continues, the profession risks perpetuating a culture that prioritises compliance over curiosity and fear over innovation—conditions that are incompatible with sustainable improvement in maternity care.

7. What Makes a Good Midwifery Leader in These Challenging Times?

Compassionate leadership remains central to creating positive cultures in healthcare. West et al. (2021) emphasise that compassionate leadership—defined by attentiveness, understanding, empathic response, and helpful action—is essential for improving staff wellbeing and patient outcomes. This is strongly supported by emerging evidence from *Compassionomics*, which demonstrates that compassion in healthcare is not only a moral imperative but also improves clinical outcomes, reduces costs, and enhances staff engagement (Trzeciak and Mazzarelli, 2019). In maternity services, where relational care and emotional labour underpin practice, compassionate leadership provides a crucial buffer against stress, moral injury, and the fear-based behaviours associated with punitive or compliance-driven cultures. Leaders who listen deeply to staff concerns, respond with empathy, and take meaningful action foster trust, psychological safety, and resilience within their teams—conditions that ultimately translate into safer, more respectful care for women and birthing people.

However, compassion alone is not enough. Good midwifery leaders must also demonstrate courageous leadership, which involves speaking truth to power, challenging behaviours, and dismantling systems that perpetuate harm, bias, or inequity (Szczygiel et al., 2020). Courageous leadership requires moral courage—the ability to act ethically and advocate for what is right, even in the face of personal or professional risk. Evidence suggests that leaders who demonstrate courage foster greater trust, transparency, and team resilience, particularly in high-stakes environments such as maternity services (Edmonstone, 2022). Recent inquiries, including Ockenden (2022) and Kirkup

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(2022), have highlighted the devastating consequences of cultures where staff feel silenced and unable to escalate concerns. Both reports recommend the creation of psychologically safe environments, where leaders actively encourage speaking up and ensure staff are protected from blame or retaliation. Such leadership behaviours are essential for preventing failures and promoting a culture of learning and accountability.

Brené Brown (2018) argues that true leadership requires vulnerability, courage, and the willingness to step into uncertainty despite the risk of criticism or failure. For maternity leaders, this is particularly critical in the current climate, where political, financial, and media pressures often drive priorities that may conflict with what is right for women and birthing people. Brown emphasises that "courage is contagious" and that leaders who model brave decision-making create cultures of integrity and trust. In maternity care, this means advocating for person-centred models, such as continuity of carer and midwifery-led services, even when these approaches face resource constraints or policy challenges. Courageous leadership in this context is about resisting the temptation to comply passively with top-down demands and instead holding firm to evidence-based principles that improve safety, choice, and experience. Such bravery is not about avoiding fear but about "choosing courage over comfort" (Brown, 2018), a stance that is essential if maternity services are to fulfil their purpose of safeguarding the wellbeing of women, birthing people, and families.

Adaptability and systems thinking are also critical. The complexity of modern maternity care—with rising intervention rates, workforce shortages, and increasing specialisation—demands leaders who can navigate ambiguity, respond to rapid change, and integrate perspectives across professional and organisational boundaries. This includes using data intelligently to inform decisions, while avoiding the trap of prioritising metrics over meaning. In this context, the shift towards a *Safety-II* approach offers a valuable framework for rethinking safety and improvement. Unlike traditional *Safety-I* thinking, which focuses on what goes wrong and preventing errors, *Safety-II* encourages leaders to understand and reinforce what goes right in everyday practice by examining how healthcare professionals adapt successfully to variability and complexity (Hollnagel et al., 2015). Applying Safety-II principles in maternity settings promotes a more holistic understanding of quality and resilience—focusing not only on avoiding harm but also on fostering the conditions under which safe and effective care routinely occurs. This systems-oriented perspective aligns closely with adaptive leadership, empowering midwifery leaders to move beyond compliance-driven models and instead cultivate learning cultures that value professional judgement, reflection, and innovation.

Tom Peters, a leading voice in leadership theory, advocates for the principle of "humanising leadership", emphasising that effective leaders must recognise the humanity of those they serve and those they lead (Peters, 2018). His argument centres on the belief that leadership is fundamentally about relationships, empathy, and valuing human behaviour over systems or metrics. For maternity leaders, this philosophy is critical. The current climate, shaped by political pressure, media scrutiny, and financial constraints, often prioritises compliance and cost-efficiency over person-centred care. Yet maternity care is, by its very nature, relational and deeply personal. Leaders who adopt a humanising approach focus on what truly matters for women and birthing people—their safety, dignity, and experience—rather than simply responding to external demands. By creating compassionate, psychologically safe environments for staff and resisting a culture driven solely by performance targets, maternity leaders can align care with core professional values and uphold the principles of respectful, individualised maternity care. In essence, embracing Peters' vision means re-centering leadership on humanity, enabling leaders to balance organisational pressures with the moral imperative to do what is right for families.

Finally, effective midwifery leaders must be committed to developing others. The NHS People Plan and Maternity Transformation Programme emphasise the importance of talent development and succession planning. Investing in structured leadership development programmes ensures that future leaders are equipped to handle the demands of contemporary maternity care.

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8. Limitations

As a narrative review, this paper does not aim to provide a comprehensive or systematic synthesis of all available evidence on midwifery leadership. The selection of literature was purposive and interpretive, guided by relevance to the UK context and alignment with the author's professional experiences. This may introduce selection bias and limit generalisability. The integration of reflective analysis adds depth and authenticity but also introduces subjectivity, as insights are shaped by the author's individual leadership journey. While the inclusion of policy documents strengthens the practical relevance of the review, it may lack the methodological rigour associated with formal empirical research. Future research using systematic methods or empirical inquiry could build on this work to further test and expand the themes identified.

9. Conclusions

In a climate of increasing complexity, scrutiny, and organisational pressure, the question of what constitutes good leadership in maternity services has never been more urgent. Traditional command-and-control models are no longer sufficient; instead, effective midwifery leadership today requires adaptability, emotional intelligence, and a commitment to fostering cultures of compassion and psychological safety.

The NHS Leadership Academy (2019) defines effective leadership through nine behavioural dimensions, including inspiring shared purpose, engaging others, leading with care, and evaluating information to make evidence-informed decisions. These principles provide a framework for leadership that is values-based, inclusive, and focused on collective responsibility rather than hierarchical control. Midwifery leaders who embody these behaviours can create environments where staff feel empowered to speak up, innovate, and provide person-centred care, even under significant pressure.

In conclusion, my personal leadership journey affirms that the qualities of compassion, courage, adaptability, and strategic vision are not theoretical ideals—they are essential, lived competencies that I have drawn upon time and again across my career in midwifery leadership. From leading service improvement projects in rural settings to navigating national-level quality improvement in struggling services, I have seen first-hand how these leadership behaviours can inspire change, foster team resilience, and improve care. Yet I have also witnessed how frequently the cultures within maternity services work against this type of leadership. Environments shaped by fear, scrutiny, and rigid compliance structures leave little space for relational leadership, reflection, or learning.

Although national strategies, such as the NHS Long Term Plan, call for compassionate and inclusive leadership, the reality for many midwifery leaders is one of relentless operational pressure, limited support, and insufficient authority to drive meaningful change. During my time as a National Maternity Improvement Advisor, I worked with services where experienced leaders felt disempowered and emerging leaders were forced to step up without adequate preparation or psychological safety. These experiences make it clear: without cultural and structural shifts across the system, even the most skilled and values-driven leaders will struggle to flourish.

To truly support high-quality maternity care, we must go beyond articulating what good leadership looks like and actively create the conditions in which it can thrive. This includes dismantling punitive cultures, investing in leadership development, embedding systems-thinking approaches like Safety-II, and recognising that supporting those who lead is a strategic imperative—not a luxury. Only then will midwifery leaders be empowered to deliver the compassionate, courageous, and adaptive leadership that women, birthing people, and maternity teams so urgently need.

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