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### Original Citation

Deery, Ruth, Hughes, Deborah, Lovatt, Alison and Topping, Annie (1999) "Hearing midwives' views": focus groups on maternity care in Calderdale NHS Trust. Project Report. University of Huddersfield, Huddersfield, UK. (Unpublished)

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# “HEARING MIDWIVES’ VIEWS”: FOCUS GROUPS ON MATERNITY CARE IN CALDERDALE NHS TRUST.

A collaborative qualitative study to ascertain the views of NHS midwives in Calderdale and to explore how these may influence strategic planning of the maternity services in Calderdale.

## **Researchers:**

Ruth Deery, Senior Lecturer, University of Huddersfield

Deborah Hughes, Senior Lecturer, University of Huddersfield

Alison Lovatt, Head of Women’s and Children’s Services, Calderdale NHS Trust

Annie Topping, Senior Lecturer, University of Huddersfield

Autumn 1998

## INTRODUCTION

*The fundamental consultation question, which underpins all the issues raised, is; how can the nursing, midwifery and health visiting contribution be developed and strengthened?*

*[Introduction to "A Consultation on a Strategy for Nursing, Midwifery and Health Visiting", NHS Executive, April 1998.]*

*In developing a strategy to strengthen and develop the nursing, midwifery and health visiting contribution, it will be important to restate the fundamental values which underpin nursing, midwifery and health visiting practice.*

*[ibid. para 4.3.]*

### **The background and rationale of the study.**

NHS strategic planning has rarely been informed by the formal contributions of front line ward based or community based midwives for a wide variety of historical and organisational reasons. This has led the process traditionally to be management led with staff invited to comment on proposals already formulated. The effects of this have been two-fold; firstly, there is a lack of expertise regarding strategic planning of maternity care policies amongst another wise highly skilled workforce; secondly, the lived experience and practical understanding and insight of that workforce has been underused as a resource at a strategic level.

This has meant the majority of midwives are now poorly placed in terms of organisational structure and intellectual orientation to contribute to and influence the reconfiguring of the NHS, both in Calderdale and elsewhere, following publication of "The New NHS: Modern, Dependable" (DOH, 1997). It is, nonetheless, clear that the Department of Health (DOH) wishes to see much greater involvement of frontline midwifery and nursing staff in policy development and planning processes. Effective means of doing this must be developed if the two professions are to be enabled to make their full contribution to health care in the coming decades, as envisaged by the NHS Executive's "Strategy for Nursing, Midwifery and Health Visiting" (NHSE, 1998).

At the same time that these policy developments were taking place nationally there were other issues which needed addressing locally. These were a widely reported loss of morale amongst midwifery staff during 1997 and 1998 and the proposal to introduce Labour/Delivery/Recovery /Postnatal (LDRP) rooms to replace the very traditional maternity unit geography at Halifax General Hospital. In April 1998, a new Head of Midwifery was appointed (AL) and following discussion between her and the link midwife teachers (RD and DH), it was agreed that a systematic and evidence based approach which addressed all three issues should be attempted.

The aims of this study were therefore to inform developments in and understanding of all three phenomena, namely midwifery morale, the introduction of LDRP rooms and how midwifery involvement in strategic planning in Calderdale might be enhanced. This will involve at least one further evaluative study at a later date and more probably two, namely, an evaluation of the impact of LDRP rooms and an evaluation of how the participants view any contribution to strategic planning in Calderdale which results from this stage of the project. The project is multi-professional and collaborative, and in the tradition of action research, meaning that it's exact projectory is unknown at this time. However it is hoped that a material and visible improvement in midwifery morale will result from actions taken as a consequence.

### **Aims of the study**

1. To provide a forum for midwives to explore current service provision, drawing on their lived knowledge and understanding of the issues influencing their clients.
2. To engage participating midwives in discussion, focussing on practice development, and identify possible approaches to the future delivery of maternity services in Calderdale.
3. To identify educational needs which the University and Calderdale NHS Trust might collaborate to meet in the future.
4. To investigate strategies for engaging staff in change management.
5. To establish a "snap-shot" picture of midwifery in Calderdale prior to any introduction of LDRP rooms in order to evaluate their impact on midwives at a later date.
6. To gain an insight into midwifery morale to inform the development of support structures for midwives.

### **Methodology.**

The investigation of ideas and feelings requires a qualitative research design (Hammersley and Atkinson, 1983; Morse and Field, 1996). As the inquiry would focus on important cultural aspects of the maternity service, namely current midwifery morale and, at some point in the future, the impact of LDRP rooms, an ethnographical approach best suited the study. Ethnography is the study of culture and can focus, for example, on the study of institutions or a professional group, both of which are cultural phenomena (Morse and Field, 1996; Grbich, 1999).

Ethnography can itself be sub-divided into various approaches according to research theorists, and critical ethnography best describes the method employed in this project (Grbich, 1999). Critical ethnography focuses on power and how it is distributed within a cultural setting. According to Grbich (1999) it is based on the following assumptions:

*“False consciousness exists among people regarding the hierarchies of power. Society is in a state of crisis and people are dissatisfied. Society is inequitably structured and dominated by powerful hegemonic practices that create and maintain the continuance of a particular world view” (Grbich, 1999, p. 159).*

The purpose of critical ethnography is to understand the origins of the power structures that exist within institutions or social groups. The aim of critical ethnographic research is to *“enhance collective action, improve societies, and foster the emancipation and empowerment of individuals and groups” (ibid. p. 160).* In terms of this project’s aims of understanding the effects of organisational change on midwives and addressing issues of low morale, this approach is apt. It allows for the researcher(s) becoming actively involved in the critical analysis of the cultural hegemony of the maternity unit and its working relationships.

### **Method of data collection.**

Within this broader critical ethnographic approach, a data collecting method needed to be chosen. Due to the then imminent relocation of the maternity unit (since delayed), there were time limits on the project as well as considerations relating to staffing difficulties. Focus groups are time-efficient means of gathering information from a number of people (Morse and Field, 1996; Grbich, 1999). They are also a rich source of data on group dynamics and views on cultural behaviour and enable the degree of consensus on a topic to emerge (Morse and Field, 1996; Grbich, 1999).

Focus groups are a particularly apt method for qualitative data collection for exploring midwifery views and working practices as they mirror the social organisation of midwifery practice that is dependent on a team approach and verbal communication.

RD and DH undertook the facilitation of the focus groups during September and October 1998. RD took the lead in putting the questions to the participants and DH transcribed the sessions by hand. Originally this was planned to be done on lap top computer but this quickly proved to be too cumbersome for the purpose.

The literature on focus groups describes the facilitation of these as more participative than in many other methods of data collection. Whilst there was a list of questions to be explored it is necessary to recognise that these needed to be supplemented by the facilitator(s) in order to maximise response and insight. Grbich (1999) talks about “funnelling” as a means of moving discussion from the general to the specific. This allows probing questions to be asked to explore the answers to the interview schedule in greater depth. Grbich also talks about throwing an exciting or controversial idea or scenario to the group and then exploring the response with the participants. This gives the interviewer a status akin to that of a participant-observer in relation to the focus group (Hammersley and Atkinson, 1983).

This accords well with the paradigm of critical ethnography chosen for this project in which *“the researcher’s position is one of active involvement in the critical, theoretical analysis of inscribed power”* (Grbich, 1999, p. 160). This is crucial to the study’s aim of gaining insight into the midwives’ lived experience of working in Calderdale and the issue of low morale.

The obvious problem with this approach is what Hammersley and Atkinson (1983) refer to as *“the danger of reactivity”* (p. 126). By this they mean that the interview can only give insight by proxy into the culture being studied, and this should always be taken into consideration. The second session held with each focus group (described below) offered an opportunity for the data collected to be amended following its private consideration by participants. Grbich (1999) also points out that the group itself also increases the reliability of the data *“because of the in built checks and balances of a variety of viewpoints”* (p. 114).

### **The sample.**

A stratified sample of thirty midwives was randomly selected from the total population of midwives working in Calderdale NHS Trust. The sample reflected the number of midwives employed on each grade (E, F and G] and the percentage of full and part-time midwives. All three H grade midwives were interviewed using the same interview schedule after the focus groups had ended. Ten midwives were allocated to each of the three focus groups, again in a stratified way to reflect the make-up of the unit in terms of clinical grades. The number ten was chosen as the upper limit of participants for an effective focus group (Morse and Field, 1996). It was agreed not to run any of the groups with fewer than four participants as any consensus reached would not be considered valid.

A semi-structured interview schedule was developed in conjunction with the Head of Midwifery (AL) to address the various aims of the project [Appendix 1]. These questions were put to all three focus groups in the first of the two sessions held with each. These first sessions with each group involved a structured discussion on midwives current feelings about midwifery in Calderdale and their vision for the future of the maternity service. The second session with each group was held 3 weeks after the first, following the distribution of the transcripts of the first sessions to all those who had participated. The purpose of this second session was to allow feedback and comments on the transcript and to agree any deletions from or additions to it. The groups were asked at these second sessions to reach a consensus about what should go forward from the group into the final report to Trust management.

The group sessions were held on University premises, a short distance from the hospital unit. All participants were invited to attend by letter from the Head of Midwifery (AL) and were informed that focus group attendance would be counted as part of the working week. Midwifery managers were asked by AL to ensure that off-duty was arranged accordingly. Refreshments were provided for participants as a

courtesy to indicate that their time and effort to attend was valued. Ground rules were established to emphasise the collaborative, anonymous and equal nature of the focus groups. All first sessions were tape-recorded and contemporaneous notes were taken at all six sessions.

### **Ethical issues.**

Confidentiality and anonymity were the key ethical considerations identified. It was emphasised by the researchers to the participating midwives that confidentiality was very important but could only be limited due to the nature of the project, that is, what the group said would be written up and presented in other forums. Some of the midwives did ask for certain items to be excluded from the final report as they did not want this data to go outside the confines of the group and their wishes were respected.

The midwives were reassured that all data would be anonymised so that it could not be traced back to any individual or indeed any specific focus group. The transcripts of each first session were distributed to all participants of the relevant group in a sealed envelope marked "private and confidential" and the midwives were asked their permission for the content of the transcript to be included in the final report. Some deletions were made of material which was felt to be too personalised or recognisable.

The data collected from the three focus groups was conflated into one final document so that nothing could be attributed to, or traced back to any single group.

The other major ethical dilemma was the overwhelmingly negative nature of the data which emerged from the groups. Whilst this had been foreseen to some extent it had been hoped that this would be counter balanced by more positive views and opinions in the midwives vision for the future. However despite probing by the facilitator more positive views were not forthcoming. Further discussion therefore took place on how to ensure that the data was not suppressed. At the time of writing it is not entirely clear how this dilemma will resolve.

## **Background information on the maternity service in Calderdale.**

### **Introduction**

The maternity service in Calderdale facilitates the births of approximately 2,400 children per year. These children are born into a wide range of socio-economic, ethnic and geographical situations. Around 98% are born in the Maternity Unit at Halifax General Hospital (HGH) and the remaining 2% at home. About 15% are born on the Midwifery-led unit whilst the remaining 83% are born on Ward E, the labour ward.

### **The midwives**

There were 97 midwives employed by Calderdale NHS Trust at the time of this study. This included 9 midwives employed on the Special Care Baby Unit. These 97 midwives equate to 80 whole time equivalents, comprising 41 full-time and 39 part-time midwives. These midwives are supported by 29 whole time equivalent nursing auxiliaries and 3 whole time equivalent ward clerks although, at the time of the study, staffing levels were below these funded numbers. Nurses and nursery nurses are also employed on SCBU.

Some of the 97 midwives are based in the community working in six geographically based teams. Some work in the hospital unit outside SCBU. The breakdown of clinical grades is as follows:

G grade – 20  
F grade – 29  
E grade – 48

These 97 midwives are managed by three H grades and the Head of Women and Children's Services. Each H grade oversees particular area of practice, namely the wards (E, C and Antenatal Day Care), the Midwifery-led unit, and community and antenatal clinic. In addition to the managerial organisation of midwifery, there is also a statutory system of professional supervision. In Calderdale all Midwifery managers are also Supervisors of Midwives. Two G grade midwives (one community based, one hospital based) are also Supervisors of Midwives.

### **The Maternity Unit**

This comprises of:

An antenatal clinic (including a parent education room)  
An antenatal and postnatal ward (Ward C)  
A labour ward (Ward E)  
A Midwifery-led unit (also known as the GP Unit) which has 8 postnatal beds and 2 birthing rooms.  
A Special Care Baby Unit.  
An Early Pregnancy Assessment Unit (EPAU) and Infertility satellite clinic (linked to Leeds General Infirmary).

Three community midwifery teams are based at HGH with the others being based at Lawson Road Clinic in Brighouse (two teams) and at Hangingroyd Health Centre in Hebden Bridge (one team).

Medical support is provided by four consultant and consultant paediatricians obstetricians and their teams of junior doctors.

### **Midwifery Care**

The midwives provide the bulk of maternity care from the initial consultations in pregnancy (commonly known as “booking” visits) to the 28<sup>th</sup> postnatal day. They are responsible for the care of all women who have a normal pregnancy and childbirth and for midwifery support of women experiencing complications alongside obstetricians. Calderdale, as elsewhere, has experienced a steady increase in the medicalisation of childbirth as reflected in the nationwide increase in the percentage of births by Caesarean section.

The medicalisation of childbirth in recent decades has had a profound effect on the working lives of midwives in Calderdale, as elsewhere. The publication of the Department of Health’s Expert Maternity Committee’s “Changing Childbirth” report in 1993 sought to address this issue and its implications for women, midwives and maternity care. Difficult financial and political forces have restricted the impact of “Changing Childbirth” and, in Calderdale as in many other areas, implementation of its recommendations has been patchy or minimal.

## **STRUCTURE AND LAYOUT OF THE REPORT**

The responses of the groups are presented in a report format. They are not categorised in terms of the questions posed but rather according to emergent themes identified (Morgan, 1995). These were staffing levels and skill mix, organisational issues, working relationships, the working environment and educational needs of midwives. The report begins by addressing staffing levels at the request of the participants in order to reflect their view that this was the key issue and fundamental problem they face.

Quotations from the participants are given in inverted commas and italics. Comments from the researchers are given in bold in bracketed notes to the text. References are given for any specific publication mentioned. All other text (i.e. in regular font) is a narrative account of the midwives views, opinions and feelings, and derives from the transcripts of the focus groups. Within this main body of text certain phrases or words are highlighted in bold. Explanations of these terms can be found in the glossary.

## MIDWIFERY FOCUS GROUPS IN CALDERDALE.

### **1. STAFFING LEVELS AND SKILL MIX.**

#### 1.1. INTRODUCTION

- 1.1.1. Staff shortages are a widespread problem in midwifery (and nursing) as evident from the media. There is unanimous agreement amongst participants that there are nowhere near sufficient midwives in Calderdale. This leads to not only a heavy workload but also to dissatisfaction about the level of care being offered. Midwives report that the spells when they are extremely busy have become longer and more frequent in recent years. They want to provide a greater degree of **continuity of carer** but agree this is impossible with the current staffing level.
- 1.1.2. Understaffing leads to the constant disappointment of not being able to be the midwives they want to be and knowing they are constantly letting women down. For example, giving **informed choice** to women takes time and clients end up not getting the quality of service they should get because midwives are overloaded. A goal should be for each woman to at least have the undivided attention of one midwife when in labour.
- 1.1.3. Some midwives feel management work hard to provide safe staffing levels and also find it frustrating that they can't get more midwives. Others have heard managers claim that staffing levels are adequate and "*up to complement*" but this does not accord with their experience. Midwifery managers are perceived to lack "*clout*". If they had any influence, midwives believe that staffing levels would not be so dire. The pressures put on midwives as a result of inadequate staffing levels is perceived as bullying.
- 1.1.4. Staffing levels are the "*biggest bugbear*" with midwives commonly being unable to take breaks and working many extra hours. Participants cited an example of one midwife who had recently worked ten nights on the trot. The "*general side*" often bleep for cover in order to take a break but the midwifery unit is reported to never do this. Staffing levels should be sufficient to enable meal breaks to be taken. Midwives feel that if they stuck to their contract, the whole system would break down as it runs on goodwill. The midwives have considered "*working to rule*" but feel this would leave women in need.
- 1.1.5. A grievance regarding staffing was pursued some time ago. This was successful, the midwives feel, because of cohesiveness amongst them as well as the fact that they had a good case. However a further grievance pursued by the community midwives, whilst technically successful, is felt to have

resulted in scapegoating over the longer term. The need to unite around these issues is recognised if not acted on.

- 1.1.6. Getting one's payslip is one of the few positive things midwives can identify about their work at the moment despite the fact that most, if not all are inadequately paid for what they do.
- 1.1.7. The Government's "**Super-Nurse**" idea is judged "irrelevant" by participants, as it does not address the needs of the majority of midwives and nurses nor the difficulty of filling empty posts.

## 1.2 GRADING

- 1.2.1. **Clinical grading**, whilst intended to boost the prospects of clinically based midwives and nurses, is seen as having been implemented in ways deleterious to those very staff it was supposed to benefit, and is identified as "*the worst thing that ever happened*".
- 1.2.2. The participants believe all Calderdale midwives should be employed on the same (preferably G, minimally F) grade after twelve months experience following qualification. Equal opportunities are also identified as an associated important issue with regard to training opportunities and promotion prospects. The situation of E grade midwives is felt to be particularly iniquitous, as they are unable to secure the experience necessary to gain promotion, and yet are still put in the ignominious position of being interviewed for posts that they will clearly never be offered. In addition, grading should more clearly reflect the experience that many midwives have and are expected to use even when being paid as an E grade.
- 1.2.3. Midwives felt that their role has expanded in recent years but that as they have developed skills in certain areas (e.g. suturing) rather than being rewarded for these skills, the skills themselves have been devalued.
- 1.2.4. The participants cited the case of two recent midwifery graduates from Halifax who had both obtained F grade posts elsewhere within 6 months of leaving. This contrasts with the current situation in Calderdale where there seems to be no real hope of getting an F grade post in the foreseeable future for most E grades. There is seen to be a particular paucity of F grade posts for hospital-based midwives but working in the community, where there are prospects for improved grading, is not an option for everyone. "*I can't do the on-calls therefore I'll never get an F*".
- 1.2.5. Midwives report a lack of reward for hard work and skill and many describe a sense desperation in facing years without prospects despite developing a huge amount of experience and skill. For example, participants feel that there are lots of highly motivated midwives with degrees working in

Calderdale (reportedly more than in comparable units) but they are disillusioned by the paucity of promotion prospects. Any midwives who are limited to the locality (e.g. because of family commitments) have few options open to them career-wise.

- 1.2.6 Hospital-based midwives in general lack any career structure although the situation in SCBU in relation to this is felt to be slightly better than in the rest of the maternity unit. There is, however, some attempt to create a career structure in the community. It is suggested that after one or two years post registration experience, all midwives should be promoted to F. There should be more promotion in the unit in particular. For example, a G grade midwife should be allocated to Ward C.
- 1.2.7. SCBU have retained a more traditional staffing structure which allows a “sister” to over view and manage the ward on each shift.
- 1.2.8. In parts of the hospital unit there is currently a “log-jam of G grades”. There is also, at the same time, concern at the number of G grade midwives due to retire and the fact that there is no-one properly prepared to replace them in terms of development of management skills. The midwives skeptically foresee that it will suddenly become acceptable for F grades to take charge in the future and do the job currently done by the G grades.
- 1.2.9. It is perceived by participants that the Trust has saved a considerable amount of money as a result of downgrading and loss of posts and they believe that this should be used to increase staff and improve grading.
- 1.2.10. Participants express regret that midwifery students they teach, many of whom they perceive as excellent, have not been recruited on qualifying or even given temporary contracts recently.

### 1.3 HOSPITAL MATERNITY CARE

- 1.3.1 Midwives are frequently looking after two or three women in labour when they know that they should only be looking after one, both in terms of effectiveness and safety. This is daunting and stressful for all concerned. The midwife in charge (G grade) often has responsibility for seven or more labouring clients. Only one G is allowed on E at the weekend and if she goes off sick, they have to struggle to find a replacement. This scenario is compounded by the fact that there is frequently only one midwife in the whole of the unit who is able to scrub for Caesarean sections or top up epidurals. There are now only three midwives per shift on labour ward and one of those is carrying the unit bleep. There used to be thirteen per shift. This means many women with problems do not receive sufficient care when in labour. The midwives report feeling lucky if anyone smiles and midwives

are coming on duty looking miserable. *“A bit of joviality, but you just don’t get that anymore.”*

- 1.3.2. Midwives are worried about the safety implications of the conditions in which they work and wonder *“how long will it take before something goes wrong”* on the labour ward. They are aware of the potential legal implications for themselves but they resent being told by others (at the **“Risk Management Day”**) that they are *“the highest risk in Calderdale”* as though they are poor practitioners rather than simply working in a high risk health care area. Midwives used to attend the monthly **perinatal mortality meetings** but there are no longer enough staff to enable them to leave the ward.
- 1.3.3. In order to cover staffing shortages, hospital based midwives have arranged and paid for babysitters but are never thanked for this. Midwives often stay until 10pm or 11pm when on a late shift. One midwife’s partner had even believed a late shift finished at 10pm as she was never off any earlier.
- 1.3.4. The workload of the maternity unit is seen to have increased dramatically over the last 5 – 8 years. Prostin inductions, ever more copious amounts of paperwork, an increasing Caesarean section rate and quicker throughput of clients were identified as the main culprits. The induction rate, in particular, seems to be escalating and this causes an increase in workload. *“We’re killing ourselves at this place and what are we doing it for?” “I’m not the midwife I want to be because of lack of time.”* Other increases in workload are the admission of women to the maternity unit earlier in pregnancy than previously and the development of the high dependency unit on Ward E. There is the constant pressure of knowing there is always something else to be done (examples given include the constant ringing of telephones, buzzers and the demands made by consultants doing rounds). The midwives compare this to working on the community where the contact one has with an individual woman is not subject to such constant interruptions and distractions. *“The consultants would play hell if you prioritised a woman over their round.”*
- 1.3.5. Participants report that they undertake most of the work previously done by junior doctors and that this is having a detrimental effect on important aspects of their midwifery role. An example given is the precedence being given to prostin inductions and intravenous infusions over breastfeeding support. They feel that vital areas such as infant feeding and the facilitation of parenting skills are getting lost. Facilitating the development of parenting skills is seen as an important midwifery task that is being neglected because of lack of staff and time.
- 1.3.6. It is felt that auxiliaries are doing too many important midwifery tasks (bathing/handling babies, breastfeeding support) whilst the midwives are doing paperwork. Midwives report how they used to spend time discussing

health related issues with women and answering their questions, but that this valuable activity is now rare. It is agreed that if a midwife gets caught up in caring for a woman having a prostin induction, it can be hours before she gets to see any of the other women or babies she is meant to be looking after. *"We seem to be losing something somewhere"*.

- 1.3.7. There is a lot of additional record-keeping and computer work now. The midwives are also expected to endlessly clean and restock the ward even when they are busy. *"We want to give time and care, that's why we became midwives, not just to rush in and tick "urine" and "bowels"."*
- 1.3.8. Despite the midwives wanting to do a good job, they are unable to because of poor staffing levels and are totally disheartened. *"There aren't many smiles around on ward C". "Ward C is horrible."*
- 1.3.9. Staff ratios are better on the **Midwife-led unit (GPU)** and the women receive better care because they get more attention. The staff ratios are much worse in the rest of the maternity unit where three women with obstetric problems can be cared for by one midwife.
- 1.3.10. If someone phones in sick, it can also take an hour or more to phone around looking for a replacement. Sometimes there are not even enough staff to enable anyone to call for extra help and this seems to happen with increasing frequency. The midwives report that they are not always able to give basic care to women in labour when they are busy but are *"caught in a bind"*, as staff shortages are no defence for lack of care [note].
- 1.3.11. Staffing is identified as a major problem on Ward C. The lay-out of Ward C is bad and there are only three members of staff on at night despite the size of the ward. Women who have been induced on the ward because of an obstetric problem are then not cared for because of lack of staff, and often arrive on labour ward 15 minutes before their baby is born having received no proper labour care.
- 1.3.12. The **floating staff** set-up is reported to be not working. Midwives are not released from labour ward when it is not busy until the cleaning and stocking has been done. In any event, there are only 6 or 7 midwives in the unit at the weekend and 7 or 8 during the week, which is inadequate.
- 1.3.13. SCBU is also now experiencing staffing shortages and are now receiving complaints as they are no longer able to cover all the rooms with experienced staff and babies are being left supervised by bank staff with no neonatal experience. Traditionally, however, they have always felt able to offer postnatal women with babies on SCBU an excellent level of support.
- 1.3.14. Midwives feel constantly bothered by complaints. They feel personally bothered by them as they cannot give the sort of care they want to give.

Some women say positive things about C but the feeling is that these are women who were on the ward when it was relatively quiet. The participants conclude that this just goes to demonstrate how care can be good when there are enough staff.

- 1.3.15. Midwives want more staff and to be able to provide one-to-one care for women on labour ward. They want extra support staff to answer telephones. They want a lighter workload for the bleep holder at weekends and at night as these midwives can be called away which is difficult if they are in the middle of looking after someone in labour. The H grades should work evening shifts and weekends. More midwives should be trained to scrub in theatre. Staff ratios should also be equal across comparable areas to minimise discrepancies in level of service.

#### 1.4. COMMUNITY MATERNITY CARE

- 1.4.1. The participants identified the knowledge that they could work uninterrupted when in the community as one of the nicest things about it. Although there is a lot more pressure than there used to be for community midwives, they still have the satisfaction of being able to spend time with a woman in her house. The downside of this is ending up working until 6 or 7 pm and getting burnt out in a different way.
- 1.4.2. In addition, community midwives can have 20 antenatal consultations in one morning and they have to do everything from measuring blood pressure to taking blood, from testing urine to filling in records. They can only allow 10 minutes for each appointment which, they feel, is completely inadequate. It is very stressful as clients are kept waiting. *“If you are doing your job properly, it takes time.”*
- 1.4.3. Community workload is also adversely affected by clients failing to keep appointments. In addition, if a client needs admission from the community, the midwife’s work schedule is completely disrupted for the whole day as this takes a lot of time to organise.
- 1.4.4. Community-based midwives have no support workers or technicians available to them e.g. an auxiliary or phlebotomist as there is in the unit. An example was cited of a Rhesus negative woman who was sent to the hospital with a clear request for bloods to be taken but she was sent back to the community midwife to have them taken.
- 1.4.5. Despite the undoubted benefits of **“booking”** women at home, there are not enough link workers for this service to be maintained for Asian women. Frustratingly, “booking” interviews with Asian women have had to revert to being done in clinics where link workers are based. This means a two-tier service and means that the change taking place has been limited.

- 1.4.6. Community-based midwives also report that whilst they used to go into schools twice a year, this has fallen by the wayside because of staff shortages. This is also recognised as being at odds with what the Health of the Nation targets are aiming to achieve. *“I can’t envisage how to do anything more as we can’t do what we’re doing now.”*
- 1.4.7. The community midwives have to spend a period of time each year on labour ward, which is good as it helps maintain skills, but it leaves the community short-staffed. For example, during the following week one team which should have five midwives would only have 2.5 midwives but would still be expected to do the work of five.
- 1.4.8. Community based midwives mentioned the effects of **“Changing Childbirth”** (DOH, 1993) as having had a profound effect on their working practice but it was not seen to have affected hospital care to any extent. Whilst viewing these changes as broadly desirable, they feel that it had not been recognised how they had had *“to turn ourselves inside out”*.
- 1.4.9. Clients’ expectations have also rightly changed. They now expect to have designated appointment times and this has altered the working day for community-based midwives dramatically. They can’t always give the time because someone else is expecting them. *“Everyone wants to be visited within certain times.”*
- 1.4.10. Community midwives also have to cover for and attend women in labour in the “GP Unit”. The community-based teams are constantly losing staff and having them replaced (if at all) with staff of lower grade and less experience.
- 1.4.11. They also want two midwives at every homebirth. Although this is local policy, staffing levels mean that the second midwife is currently only able to attend at the last minute and often misses the birth.

## 1.5 MIDWIFERY SKILLS

- 1.5.1. The active facilitation by senior staff of midwives’ professional development is seen as essential. The right skill mix combined with more staff is seen by the participants as a priority. “Scrubbing” for Caesarean sections is the main but not the only skill lack that is identified as causing real problems. There used to be enough staff to enable staff to be “trained up” but now *“because everything is run on such a shoestring”* no-one can be spared to *“train up”*. Staff are unwilling to attend teaching sessions on their days off as they know they will find it difficult to take the time then owing back. Some midwives have this continually on their **IPR** but there is no chance of achieving it. Some midwives were already experienced scrub midwives when they came to work in Calderdale, but they haven’t been able to maintain their skill.

- 1.5.2. Midwives are aware of the irony that one of the reasons they need to learn how to “scrub up” and “top up” epidurals is because they are unable, because of staff shortages, to give clients sufficient support in labour, and the clients consequently require more analgesia and Caesarean sections than research indicates they would if they received better support.[Ref]
- 1.5.3. Midwives feel it is unfair that judgement is passed on them for not having particular skills when they haven’t had the opportunity to acquire those skills. For these midwives, this lack of opportunity is a “double whammy”; not only can they not build up the experience they desire but they are then disadvantaged. Midwives talk of a “culture of blame” in relation to this. They find themselves scorned for having been registered and practising for several years but unable to perform additional midwifery skills. This also affects their ability to obtain a higher grade internally or elsewhere.
- 1.5.4. Whilst hospital based midwives find their lack of development frustrating, community based midwives find that they are expected to maintain a high degree of technical skill associated with hospital based intrapartum care (e.g. epidural “top-ups”, drug administration and recovery from surgery). They are expected to maintain expertise in these areas from six weeks of labour ward placements per year.
- 1.5.5. The recently introduced role of “floating midwife” is also seen to militate further against the possibility of building up experience and skills.
- 1.5.6. Midwives on SCBU describe feeling isolated and would like more opportunity to get involved in antenatal and intrapartum care. Recent rotation of staff from SCBU to the other maternity areas for 4-6 weeks was judged to be very positive.
- 1.5.7. Participants feel that midwifery staff would appreciate more opportunity to work in antenatal clinic and in the community to build up a better overview of the maternity service and improve co-ordination and integration of that service.

## **2. ORGANISATIONAL ISSUES**

### **2.1. COMMUNICATION**

- 2.1.1. The midwives felt that organisational changes were imposed without consultation and not on a trial basis to the detriment of both themselves and their clients. The management style of the unit and Trust was seen as very “top-down” and lacking in consultation. This is stated to be more than an issue of poor communication; it is believed that those imposing change simply believe that staff “do not need to know”.

- 2.1.2. A recent imposition is the “floating midwife”. These midwives can be asked to move around the unit many times in any shift. One participant had just worked in 3 different areas over a six hour shift. As far as clients are concerned, “floating midwives” compound the fragmentary nature of care at a time when efforts should be made to increase continuity. Participants reported having to apologise to clients for having to abruptly terminate an episode of care and this is unsatisfactory for all concerned. It was felt that this would result in an increased number of complaints.
- 2.1.3. Another linked issue is the acupuncture clinic which, whilst supported in principle, has had to be staffed by midwives without any consultation with them even though its use is not confined to maternity clients. The midwives generally want much better representation.
- 2.1.4. Midwives complain that they are often left to “*look complete idiots*” when clients who have read the latest Evening Courier know more about the future of the maternity services in Calderdale than they do. They feel they have been told one thing and then another. They report the worst thing is telling women as this has to change from week to week and others (e.g. GPs) are giving conflicting information. “*You feel absolutely stupid*”. Some women have been told the Midwife/GP unit probably won’t be available but now it looks as though it will be. Some women have decided to “book” elsewhere e.g. because they have been told that waterbirths won’t be available in Calderdale.
- 2.1.5. Managers are seen to have the same problem in ascertaining what is going on. “*They are telling us the truth as they know it but it changes for them as well*”. No-one seems to know what the Senior Management Team are planning. “*I find that absolutely horrendous.*” Midwives complain they find out most by reading the Evening Courier or watching Look North e.g. finding out that Frank Dobson was coming to cut the first sod. “In Touch” is viewed as having hardly anything in it of any significance but a regular newsletter which does inform staff about what’s going on would be welcome. There is nothing in “In Touch” about senior management meetings and these are not open to staff. “*When you have to read the Evening Courier to find out what’s happening to your place of work there’s something wrong with the whole system really.*”
- 2.1.6. The midwives feel it is unacceptable to have so many rumours circulating and simply be told to “*be positive*”. They want to be listened to and not just be invited to “token meetings” when management have already decided what is going to happen anyway. They would also like more inclusive meetings (e.g. unit-based and community-based midwives together) for greater understanding of the service as a whole. Better communication between management and staff is needed.

- 2.1.7. Another example of discontent around policy imposition was the **new breastfeeding policy**. At the present time, they feel women are pressurised into breastfeeding inappropriately by having it *“rammed down their throats”*. It is felt that the breastfeeding policy itself isn't so much a problem as the fact that midwives lack the time to sit with a woman long enough to talk with her meaningfully or help her properly in line with the policy.
- 2.1.8. Participants report that SCBU staff are much more successful in relation to breastfeeding as they are still able to spend sufficient time with women. Breastfeeding is recognised to be a highly personal issue which will consequently always be subject to conflicting advice. The midwives would like a system of peer support for breastfeeding women introduced as the most effective way of building confidence in novice breastfeeding women.
- 2.1.9. Communication problems were highlighted with particular reference to the lack of link workers and interpreters. This is rendering community *“bookings”* ineffective in many cases and midwives feel they are *“muddling along”* to the detriment of the care Asian women are receiving. Interpreters are often promised but don't materialise, leading to many ineffective *“booking”* and **“birthplan”** visits. It is impossible to give informative care when there are no interpreters. In Bradford linkworkers go out with the community midwives but in Halifax these inequalities are not addressed.
- 2.1.10. There are also insufficient interpreters in the Hospital, and not enough hours covered. When the interpreter is called they are often slow to come. The midwives feel they are providing a poor service because of the communication problems for women without English as their first language. Again Bradford was cited as an example of good practice as it had recruited auxiliaries from the Asian community who could double as interpreters. This means there is nearly always someone available and these auxiliaries fulfil an important role. There is a need for more link workers in the community and the hospital and far more leaflets in Asian languages.

## 2.2 WORKING OVERTIME

- 2.2.1 Midwives never get time in lieu and full-time staff are not allowed to claim overtime. However they have been told by the Salary Department that nursing staff are allowed to claim overtime and part-timers are also able to do so. *“It wouldn't happen in industry. It's because we're women.” “It is bullying.”* One midwife wrote the overtime she had worked on her timesheet a few years ago and *“they went ballistic”*. She didn't get paid. Participants believe all midwives should be paid for overtime worked. Some midwives report having been told by personnel that it is midwifery managers who have forbidden the claiming of overtime rather than Trust policy.

2.2.2. Midwives report that they do refuse to work extra shifts but that such refusals often result in managers saying something like *“Oh, I’ll remember this when it comes to the half-term requests.”*

2.2.3. Despite being expected to work without a break midwives complain that they are accused of stealing if they have some toast on the ward.

### 2.3. CHANGE

2.3.1. There are many changes taking place in the NHS and maternity care and the community midwives feel they are in a prime position to make changes. Whilst midwives want these changes to occur, participants feel there is neither the time nor the resources for this to happen effectively at the moment. The **Bradford Pregnancy Bus** is cited as an example of good practice but the funding has been withdrawn and the good effects *“have gone to waste”*.

2.3.2. Participants believe that *“The New NHS”* will lead to the availability of more statistical information and this will show more clearly where inequalities in health lie. The community midwives feel they know where the inequalities are and what they are, and that they should be able to influence the Primary Care Groups (PCGs). *“There may be a chance for once that we can try to improve care and make changes.”*

2.3.3. It is seen by some participants to be an exciting time to work in Calderdale but also an uncertain time. This uncertainty is adversely affecting a lot of staff. People are worried about their job security. Everybody is reported to be looking for other jobs and to *“not want to be bothered with working as a midwife in Calderdale anymore”*.

2.3.4. There are many midwives in Calderdale who have studied at a high level but they are not encouraged to put into practice what they have learned; *“no-one is asked to change anything”*. Midwives learn about the evidence base for practice but they are not asked or encouraged to implement evidence-based change. Change is seen to happen but only very slowly and *“by the by”*.

### 2.4. WORKING EFFECTIVELY

2.4.1 Participants generally want more autonomy in their daily working lives. *“Leave me alone and let me do my job.”*

2.4.2. The design of the records is judged to be unsatisfactory, as they require the same thing to be written many times over in various places within them e.g. time of admission. **[NMR]** This has been recently compounded by the

introduction of the “**red book**” (child health record) which duplicates some of the postnatal records. *“We seem to be making more, not reducing any”*.

- 2.4.3. Many of the recordings made are considered to be routine and meaningless rituals (e.g. daily baby examination records) as is some of the care carried out (e.g. postnatal maternal temperatures). It is felt that the time has come to cut back and to let midwives use their common sense and professional judgement more.
- 2.4.4. Midwives would like the opportunity to carry a **caseload** involving the whole spectrum of care from “booking” to postnatal care at home. Any caseload should be realistic (for example a caseload of 55 – 60 women would preclude any chance of achieving continuity of care or of *“having a life”*). *“We can provide holistic care, we are equipped and we can do it if we had the time.”* The introduction of Midwife-led care in Calderdale is recognised as one of the most positive developments of recent years.
- 2.4.5. “Bookings” (initial pregnancy assessments) are now being done in the community and this is seen as *“very, very good, essential”*. The midwives want far fewer antenatal consultations for **multigravid** clients: *“this happens everywhere except Yorkshire”*.
- 2.4.6. Support departments e.g. X-ray and pathology should operate a 24 hour service all year to support the ward staff. Whilst there are staff from these departments on-call, this does not provide a sufficient service. Also the staff who are on-call often do not have the necessary skills for what is required.
- 2.4.7. An extension of their exemption from prescription law to enable them to give paracetamol (as they can already give **pethidine** and other specified drugs) would be welcome. **[note]**
- 2.4.8. Midwives would like to address parenting skills and issues more within parent education sessions. However this is hampered because clients themselves focus almost exclusively on labour issues antenatally and are less inclined to attend sessions which deal more with parenting. Midwives want to organise more parent education and self-help groups in the community. They recognise that parent education doesn’t reach those who would benefit from it the most and would like to have the time and resources to rectify this.

## 2.5. STRESS, MORALE AND JOB SATISFACTION

- 2.5.1. The situation of midwives in Calderdale changes from day to day and is affected by being on call, working nights and difficulties in relationships with managers. Midwives report widespread discontent, colleagues leaving, looking for employment elsewhere, or doing a range of courses in their own time in order to seek employment outside midwifery. There is a great deal

of stress experienced by midwives which manifests itself in time off for sickness, stress related incidents, tears and crying.

- 2.5.2. Morale is unanimously agreed by participants to be low and midwives feel they no longer want to get involved in more than they have to. *“Everyone’s depressive really. People don’t want to come to work and take days sick.”* Midwives report they only go to work for the sake of their colleagues. *“The more apathetic everyone gets, the worse it is going to get. Just when you think morale can’t get worse, it does. Everyone is talking about leaving.”*
- 2.5.3. There is also a lot of uncertainty about the way the service is going to be offered which makes it difficult for individuals to plan their careers and their lives. There is a lot of worry about the mooted merger with Huddersfield. Midwives feel they cannot trust what they read or are told because there have been reassurances in the past but midwives have been let down and now feel wary.
- 2.5.4. Midwives feel vulnerable. They have to make records of everything they do but this is obviously impossible. They might forget to write something down and then they worry about it. Whilst the stress experienced by midwives on Ward E is different to that experienced by community midwives, burn-out is also a problem for community midwives although they are aware that they must continue to provide a service for women. The perception is that managers expect midwives to work despite them having been up all night.
- 2.5.5. In the hospital, midwifery care is very fragmented which can lead to a sense of *“getting nowhere”*. In hospital midwives can feel they are doing the same thing every day and rarely see the women for any length of time.
- 2.5.6. Stress is also experienced by midwives working on the Midwife-led unit as client expectations are high. This can lead to a feeling of being mentally drained. Intimate one-to-one relationships with clients, which continue over many hours, can become very intense and exhausting. The midwives feel that it is right that women have high expectations but this is a cause of stress as there is a sense of never being able to give enough. However some women are perceived as being overly demanding and self-centred. Midwives are trying to do the right things for clients but recognise that it is not always clear what is the right thing.
- 2.5.7. Participants made reference to a work satisfaction survey undertaken 3 or 4 years ago. The midwives feel that no-one would *“dare to or be allowed”* to repeat the same exercise at the present time for fear of the dramatic deterioration in morale it would identify. They were also scornful of the fact that the only material consequence of the previous survey was the *“sop”* of new uniforms.

- 2.5.8. On this note, participants would like to wear something other than nursing uniforms. Polo shirts with a logo together with skirts and trousers would be more appropriate, with the same colour for all grades. However some G grades are believed to be resistant to giving up their *“special dresses”* because they feel they have worked hard for them. They were given the choice of wearing their own clothes or uniform a few years ago and chose uniform rather than having to provide work clothes. There was a uniform committee and apparently a new uniform is being introduced but this is without any consultation with the midwives. Speculation is that midwives will be asked to choose either trousers and tunics or dresses with enormous pleats down the backs, making them *“look like The Incredible Hulk”*. Midwives feel it would be easier and more appropriate to wear leggings especially for homebirths. No-one is seen to be taking a sensible look at uniforms and asking whether these are sensible things for midwives to be wearing. Participants had many complaints about the new corporate uniforms that they expect to be imposed upon them in the near future.
- 2.5.9. The participants agree that they entered midwifery with high expectations but that this becomes lost. One midwife had left a previous job after 6 years because she was unable to provide the sort of midwifery care she wanted to and now found herself in the same situation in Calderdale.
- 2.5.10. A major need is for support, especially from senior staff. The midwives feel they are excessively short-staffed and no-one is available to support them. There is no structure in place for support.
- 2.5.11. Some participants reported feeling comfortable and happy in their work, especially those who work in the community. Community midwives generally feel positive about their career move into the community. They feel they work more autonomously and are able to make decisions which enhances job satisfaction. Job satisfaction also comes from knowing the clients better, and being able to follow them through from the beginning to end of care.
- 2.5.12. *“Booking”* women on the community is seen as a positive development despite the fact that it has added to time pressures. However, the ever increasingly early transfer of postnatal women from hospital is foreseen to have a detrimental effect on community midwives if the issue of resources is not addressed. They would like to see a considerable increase in staffing ratios. This would reduce burn-out, enable greater continuity for women and save on medical budgets (both through reducing use of GPs in maternity care and the need for so many medical staff in hospital).
- 2.5.13. Being on-call is one of the biggest drawbacks of being a community midwife but *“you have to take the rough with the smooth”*. It is difficult to *“have a life”* and be a community midwife and not to get burnt out by **the on-call system**. *“I feel I can’t be doing this in another 10 years time because of the*

*on-call*". There is talk of imposing a rota on community midwives which would include so many weeks of night duty, but this would be impossible for some people. Even if you are called out two nights a week, at least there is a chance to recover.

2.5.14. Community midwives report they work 5 days a week, do parent education two evenings a week and are also on-call for two nights a week. *"No other profession would work like this."*

## 2.6. PAY

2.6.1. Pay is a major problem. Midwives view their pay as ridiculous given their responsibilities for helping bring new life into the world. The midwives report that their £7.37 per hour is laughable given that Aldi till cashiers are paid £7 per hour. *"Is it worth it?"* The monotony of till life would be bearable to some participants *"for the sake of a good night's sleep"*.

2.6.2. Whilst G grades feel they are reasonably paid for what they do, the fact that there is no opportunity to progress financially beyond this is a frustration.

2.6.3. Midwives describe the vastly better working conditions and pay enjoyed by Certified Nurse Midwives in the USA e.g. time off in lieu of on-calls. This is seen as being *"more orientated to life"*. The NHS midwifery on-call payments are viewed as ludicrous (quoted as £5 per night) and compared to what other NHS workers receive for being on-call.**[Note]**

## 2.7 THE BROADER CONTEXT: MIDWIVES' ROLES AND BOUNDARIES

2.7.1. It is felt the Trust have no appreciation of, or interest in, the circumstances of most midwives. *"We give our all and still they want more"*. The major area of concern relates to child care. School holidays are described as *"impossible"* and the need to spend time helping children with schoolwork is also a concern. Midwives also question the acceptability of picking up children from a childminder at 10pm after a late shift even supposing such childminders existed.

2.7.2. Midwives want the off-duty done further in advance because currently they do not know what they are working the next week by the preceding Thursday. They want off-duty at least two weeks in advance in order to organise child-care or preferably a rolling rota which will show what they are working 3 – 4 weeks in advance.

2.7.3. Management need to respect the fact that midwives have young children. On the whole midwives feel they manage spectacularly well with childcare and that they *"do not need unsupportive comments"* from managers about

their domestic commitments. When requests for off-duty are not granted, this has many repercussions for their friends and relatives as they have to reorganise child-care. They find it difficult to organise child care and they end up having to pay for a full-time place when they only use it 2 or 3 times just in case they have to work. This is a huge expense.

- 2.7.4 The Trust nursery is described as “useless” as it doesn’t open for shift hours and is inflexible (it only accepts babies on “fixed shift” terms. When midwives had inquired about placing their children in the nursery, they had been greeted with the response *“Oh, that will be shifts. We can’t possibly accommodate that”*. The nursery is seen as a facility for administrative staff who ironically can place their children in any of the other Halifax nurseries who open during office hours only.
- 2.7.5. If off-duty were done further in advance (four weeks is seen as reasonable), they would be able to organise their lives better. However, because it is done at such short notice, they have to put in more and more requests just to try to organise their domestic lives. Any and every shift can be altered without notice and if they turn up for the wrong shift as a result, they are sent home to come back later. However this does not apply equally to management as an H grade had recently turned up for the wrong shift and then tried to send an E grade home. Participants also feel that they should not have to phone in to obtain off-duty that has been done very late but that they should be phoned at home with it.
- 2.7.6. The participants recall that off-duty used to be done one month in advance but that sickness had often meant that it needed to be re-done. They would nonetheless like to revert to this time frame for off-duty.
- 2.7.7. Some participants report that managers have been helpful regarding childcare but that is often done at the expense of those without children.
- 2.7.8. Midwives suggest that part-time midwives should be paired up to make cover of off-duty easier. More job shares would also help cover the rota better.
- 2.7.9. The participants are supportive of the Trust’s move to offer “family friendly” contracts but emphasise that this must apply equally to staff already employed. So far, the “family friendly” concept has not affected the lives of midwifery staff. The participants point out, however, that more staff will be needed if the desired flexibility over shifts is to be realised.

## 2.8. ORGANISATION OF THE HOSPITAL UNIT.

- 2.8.1. Participants report Ward C to be unsatisfactory with numerous complaints from women and their families. The ward is seen as a staffing pool and women do not get the support they deserve. In their opinion, the

organisation of Ward C needs to be looked at as a priority. Midwives are taken up with too much clerical work which could be done by auxiliaries and this is aggravated by recent cut backs in the number of auxiliaries.

2.8.2. Floating midwives are making the situation on C worse as they tend to “float” upstairs to E. There is a strongly held belief that all **core staff** should be on C with only co-ordinators on E to bring staff up when needed. The midwives reported an incident of only 3 midwives on C the previous week and 5 midwives on an empty E where the “co-ordinator” had them cleaning. This is seen as a complete waste of skilled midwives as auxiliaries can do the cleaning. Also the fact that no midwife felt able to go back and give midwifery care on C rather than clean was deplored. A floating midwife had managed to get to C at 9.30 only to be called back to E. This is opposite in terms of organisation to other hospitals where the majority of staff are based on the wards with only a few core staff on Labour Ward unless women are in labour.

2.8.3. “Floating” midwives are often missing the report on Ward C because they are not being sent there soon enough. The balance of power is seen to lie inappropriately with Ward E, with Ward C becoming its poor relation. Many G graded midwives have been based on Ward E for a long time leading to a nucleus of power. Participants feel that all staff should be rotated in light of this and that a strong leader should be appointed in charge of Ward C.

2.8.4. Antenatal clinic also is the butt of many complaints. *“We need to do something about antenatal clinic. I grovel when I see them sat still waiting for scans at midday when I know they arrived at 9am.”* Many midwives question the need for women to be having so many ultrasound scans which are expensive and take up a lot of time. More emphasis on obtaining, recording and interpreting menstrual histories would reduce the number of women having to come because of uncertain dating of their pregnancy. Many women are waiting 3 hours for a **“booking” scan** despite having been “booked” at home. They then have to wait for the scan result to be seen by a doctor, which causes a lot of delay for the clients.

## 2.9. ORGANISATION OF THE COMMUNITY SERVICE.

2.9.1. The participants believe that all women should have direct access to midwives without going through GPs and cited Mixenden Health Practice as a good example of how this can work. They would like to see more clinics outside GPs’ *“territories”*. They would also like to establish midwives drop-in centres (one is about to start) and the midwifery services better advertised to clients.

2.9.2. Most women are still not offered any choice regarding the sort of care they receive which is still mainly determined by doctors without discussion with the women. Most women are signed up for **GP shared care** and consultant

unit booking. GPs do not offer women Midwife-led care and nor do some midwives as they are fearful of the demands this will make on their time given current staffing levels. Some GP practices give women no options and women are fearful of being struck off if they demand other options. GPs are then paid for care that the midwives actually do. GPs have only done 6 months obstetrics and midwives have far more knowledge and experience so the formers' influence over maternity care is deemed inappropriate.

### **3. WORKING RELATIONSHIPS.**

#### **3.1. INTRODUCTION**

3.1.1. These form the core of many of both the positive and the negative aspects of the midwives working lives. HGH is reported to be a nice hospital to work in because it manages to be professional and friendly. The maternity unit is seen as *"friendly"* and as small enough to allow for mutual support. *"We are there for each other"*.

#### **3.2. RELATIONSHIPS WITH CLIENTS**

3.2.1. Midwives enjoy meeting clients when shopping &c. although they do not always remember who they are which can be difficult. Community midwives see many former clients when out on their visits which they find rewarding. Making a good clinical decision is identified as one of the more rewarding aspects of midwifery e.g. diagnosing a small-for-dates baby or a breech baby. They also get satisfaction from basic clinical skills such as helping a woman to have an intact perineum and successful completion of the third stage of labour. They enjoy getting to know women and building up a rapport and alleviating terror or nerves. They like helping a woman to get settled and relaxed but often lack the time to do this. *"You've got to have the time to do it; there shouldn't be any question really."* They also like to help women feed their babies according to the clients' preferences. The community midwives enjoy continuing care until they feel the client is content and confident.

#### **3.3. RELATIONSHIPS WITH EACH OTHER**

3.3.1. Team spirit is important and is particularly evident on night duty. This is because there are fewer staff who are more closely dependent on each other leading to better rapport and teamwork. There is also less differentiation in working relationships between grades of staff so everyone feels more welcome and valued as part of the team. Although there are still pressures arising from dealing with clients, there is less pressure from medical staff and no elective Caesarean sections. There is more camaraderie and willingness to help each other out. The midwives in charge on nights are more relaxed and supportive and seem to cope with pressures better.

- 3.3.2. On day duty there is a greater sense of caution about whom one is working with, and less ability to choose who to work with. There is more going on during the day leading to a greater degree of agitation in the senior midwives, compounded by greater differentiation between grades. Support is seen as more evident amongst community midwives who take each other's workload to help colleagues called out overnight. This is seen as something which should happen as a matter of course.
- 3.3.3. Participants feel that the hospital staff can be very unsupportive of community based staff. Very few E grade midwives from the unit work in the community and this results in hospital midwives having a misconception about community work and thinking it is easy. Community midwives complain that if they 'phone for advice about a client, they often get sarcastic comments. Community midwives also feel they do not support each other enough.
- 3.3.4. On the other hand, positive feedback from colleagues is highly valued as is any sense of mutual support. However there appears to be less and less time for this. The alteration in shift hours and reduction in staffing levels which has resulted in the loss of a half hour coffee break together off the ward has been highly detrimental to communication and working relationships.
- 3.3.5. On the whole, midwives dislike much about the culture they work in. There is reported to be a lot of professional jealousy within the maternity service. They feel they are expected to do as they are told and that indoctrination takes place along this line. Even a few difficult colleagues can have a seriously adverse effect on morale. *"We've all been with the sisters from hell and hoped they would go, and things get better."* Senior staff are seen as judgmental and midwives feel as if they cannot make the slightest mistake. Midwives want to work in a friendlier environment free from blame and scapegoating.
- 3.3.6. The G grade midwives are understood to have staff support as part of their role but are frequently felt to be unhelpful when approached by more junior staff. One participant gave an example of approaching a senior midwife with the words *"I'm completely out of my depth..."* only to be told *"I haven't got time to deal with this"*. Midwives report being told to look in the Labour Ward protocol book rather than being able to discuss a clinical problem with an experienced colleague. There is a lack of awareness by senior staff of midwives' needs in terms of skills and their level of ability.

#### 3.4. RELATIONSHIPS WITH MEDICAL STAFF

- 3.4.1. Relationships with doctors are seen as problematic especially around areas of clinical decision-making. The midwives want to be more involved e.g. in the decision to give women the choice of delivery by Caesarean section for non-clinical reasons as this has important cost implications for the unit as a whole. They feel it is inappropriate to offer women ever more expensive choices when the midwives themselves have so little choice open to them.
- 3.4.2 Midwives feel consultants make too many decisions about care patterns without consultation or any communication, not even memos. Participants gave the example of women of under 35 years of age having to pay for the triple test. *"We look idiots."* They feel they are having their role extended all the time without any consideration being given as to how this will affect them. *"Telling would be better than nothing. We are looking fools and women will lose confidence in us."*
- 3.4.3 Whilst consultants are generally reported to be easier to work with than registrars, participants point to a tendency amongst the obstetricians in general to treat them as **obstetric nurses**. They feel that more equality is needed and greater recognition of the validity of midwives points of view. *"Just because I wear a light blue dress, it doesn't mean to say I'm an idiot"*.
- 3.4.4 There is always a list of women who need seeing by doctors at the midwives' station but the doctors still expect to be followed around and *"waited upon"* by midwives. The midwives want much more co-operation from doctors generally and specifically want SHOs to have more training so that they know what they should be doing.
- 3.4.5 GP trainees in particular shouldn't be used as SHOs but should be attached to a senior midwife or registrar and work with them. A midwife would be a better teacher of GP trainees as registrars only deal with abnormal childbirth. Junior doctors also lack the ability to act according to their own judgment because they are constrained by the consultants and the protocols.
- 3.4.6. GPs are reported to be often unhelpful and doctors in the unit are unsupportive. Doctors are seen to close ranks and blame midwives when "things go wrong".
- 3.4.7. GPs are seen as already having a lot of power and midwives are concerned about the fact that they are about to be given more in the new PCG set-up. This is compounded by the fact that nurses rather than midwives are also being involved in PCGs. It is feared that the nurses likely to be appointed to PCGs are likely to be exclusively from management. From the point of view of the midwives, it is believed that a nurse with no midwifery knowledge would be preferable to a nurse with a smattering of knowledge as then there would be an obvious need to consult with midwives as the experts. **[NOTE]**

### 3.5. RELATIONSHIPS WITH MANAGERS

- 3.5.1. Managers' lack of practice was seen as compounding their inability to support staff adequately as they lose insight into the realities of the pressures of clinical work. *"If something goes wrong, how many people are going to jump on your back...Everybody"*. The Head of Midwifery's recent spell undertaking clinical practice is positively regarded.
- 3.5.2. There is a culture of protocols being imposed upon the midwives and this is resented. Midwives complain that the four consultants and the senior midwives get together and draw up these protocols. *"We're not children, we're professionals and we should have a say in the protocols we have to work to."* There is a strong sense of being *"treated like naughty children"* and an example was given of a manager requesting a midwife to go to her office with the words *"You, here, now"*. This is thought by them to be particularly inappropriate given the current high requirements for entry to the profession.
- 3.5.3. Midwives dread getting brown envelopes marked "private and confidential" in case it is another request for **a statement**. They are concerned at the number of statements they are asked to write, especially on Ward E. On community there are fewer "incidents" requiring statements as problems are referred to the hospital and generally sorted out before the client is transferred back.
- 3.5.4. Managers are reported to blame midwives, find fault, and never thank midwives for their extra efforts. *"All condemnation and no praise."* One case was cited when a midwife had sought a second opinion from another and her manager had questioned her about her competence in view of this. This was described as bullying. The midwife felt she had acted properly and made the right decision and was very angry to have been questioned over her right to a second opinion.
- 3.5.5. One midwife with many years' experience had recently left because of an incident over which she had been unsupported. Another midwife had gone off sick for a long period because of the same sort of situation. She had lost her confidence and felt unable to practise. *"You are guilty until proven innocent."* Midwives feel as though they are always waiting to see if it will be them next.
- 3.5.6. If a midwife is off sick there is never any card from management to show concern. In previous years managers had always sent cards if staff were ill. *"If managers respect you, you respect them."* Midwives also complain that managers are often moody: *"When you can't go to a manager without looking to see what sort of mood she's in..."* One midwife mentioned an article she had read on "Horizontal violence" [ref] and commented that it perfectly described the working environment of the maternity unit in

Calderdale. Examples were given of managers attributing midwives being off late or feeling stressed to their (the midwives) poor management skills, which is perceived as “victim blaming”.

- 3.5.7. It is felt that the records of and care given to women having homebirths and Midwife-led care are scrutinised much more than those of women delivering in the Consultant unit. Midwives feel they cannot use their midwifery skills and knowledge enough but that they have to follow protocols too much without being able to be flexible and use their own skills and judgement. *“Protocols are rules not guidelines and we need guidelines”*. They are seen as symptomatic of the way in which managers relate to them.
- 3.5.8. In hospital, support is seen as helping each other through a difficult time especially with regard to what is seen a culture of blame amongst managers. Lack of support from managers is a major disappointment and the loading of more and more work onto midwives in the search for a better service is a problem.
- 3.5.9. Midwives feel they have to be manipulative to get anywhere. *“There’s no chance of being assertive with the current management structure.”* They desire a change of management. The participants believe that the majority of midwives are frightened to do anything and feel that *“there is a strong pecking order”*.

#### **4. THE WORKING ENVIRONMENT.**

##### **4.1. INTRODUCTION**

- 4.1.1. The physical environment of the maternity unit is considered to be more important for both clients and staff than currently seems to be recognised. Both groups are affected by *“the feel of the place”*.

##### **4.2 THE HOSPITAL ENVIRONMENT**

- 4.2.1. The “GP Unit” is seen as a pleasant working and birthing environment but not the rest of the unit. *“A nice, good working environment with light and space is good for everyone.”* It is also important to have equity of environment with all areas being decorated, furnished and maintained to an equally pleasant standard.
- 4.2.2. The layout of ward C is described as “atrocious” and should be improved as a priority, including the installation of an emergency bell. The planned Labour/Delivery/Recovery/Postnatal (LDRP) rooms could compound the lack of support midwives are able to give women as the women will be isolated in their rooms and no longer be able to give each other help and support, especially around breastfeeding. The help that clients give each other is

seen as important and it is frustrating to many of the midwives that putting breastfeeding women together in one room is frowned upon. It would be nice to know what women prefer regarding this. LDRP rooms will have some advantages for midwives i.e. they will be able to give more focussed attention to clients by shutting the door.

#### 4.3. THE COMMUNITY ENVIRONMENT

- 4.3.1. Personal safety is a major issue for community midwives. They often have to park their cars and walk to *"God knows where"*. Social changes such as the rise in gangs affect them. Their lack of communication equipment is potentially dangerous; *"you can't use a pager to call for help"*.
- 4.3.2. Hospital taxis should be used to take community midwives to homebirths so that, if the woman is transferred, midwives don't have to leave their cars *"in the back of beyond"*. For unexpected births at home, midwives should be able to go out with the ambulance crew directly from the unit as it is dangerous to be looking around for a strange house at night. Safety should over-rule cost but midwives feel that they will have to wait for a midwife to be attacked before management will do anything.
- 4.3.3. There are areas in which midwives do not want to venture after schools come out because of the predominance of gangs. They are aware they can call the police but they have nothing to call them with. When they are in a client's house which has no telephone, they have to wander round the streets trying to find a call-box which hasn't been vandalised. This also means they have to leave a woman with a problem unattended while they call for help.
- 4.3.4. Mobile phones should be provided for all community midwives so that they do not have to keep going back to the unit to pick up the only one. They also want a portable **Sonicaid** and **Entonox apparatus** for every team (currently sharing this vital equipment between three teams). The Entonox equipment has been on order for 4 years. There is insufficient equipment for homebirths as this is being shared between teams
- 4.3.5. The Trust is reported not to pay for the 'phone rental of all community midwives despite Whitley Council agreements and this dispute has apparently been going on for years. Management refuses to endorse payment and this is seen as another example of bullying. Some midwives have bought their own mobile phones but the Trust make no contribution to these. When these and other issues are raised, managers are reported to cry and this is perceived as *"emotional blackmail"*.

## 5. EDUCATIONAL NEEDS OF MIDWIVES.

### 5.1. INTRODUCTION

5.1.1. It is perceived that there is insufficient educational opportunity and that whatever opportunity does exist is not distributed fairly. Continuous programmes for development should be available. It is felt that currently *“everything is channelled into one miraculous day at Northowram and the CTG half day. It’s a miracle if you can manage that”*. This **Clinical Risk Management Day** is described by some participants as *“a waste of time”* or *“interesting but irrelevant”*. The midwives want more educational support.

5.1.2. Money is identified as a major constraint to educational development. Midwives are having to prove their need to undertake a course and are then only allowed a small amount. Meetings are reported to be held fortnightly by senior staff to decide *“who is worthy of what”* and it is perceived that the higher grades get the most and that study leave is granted to the same few people rather than equally shared out.

5.1.3. Midwives have got *“the sorts of qualifications”* management asked them to get but now they are stipulating more specifically what courses they can do and *“only one person a year gets to do a course”*. Comparisons are made with educational opportunities open to those working at the Infirmary where nurses are thought to get a lot more in terms of study leave and opportunities. The overall view is that management does not want to support study leave and there are not enough staff to allow study leave now anyway. Any study day they do attend should have **ENB approval** if possible. **[note]**

5.1.4. Extra qualifications and expertise should be recognised and those who have attained these should be better encouraged and facilitated to use them and share them. Participants gave examples of aromatherapy and breastfeeding qualifications that they thought were underused and not capitalised on.

### 5.2. EDUCATIONAL PRIORITIES

5.2.1. Perineal suturing and **CTG** Interpretation workshops run at the University of Huddersfield are popular as are any study days on *“basic midwifery”* subjects. The personnel-run sessions on time-management and team management were also judged helpful. The drug awareness day is particularly highly praised.

5.2.2. Community midwives want an informal gathering to discuss cases and homebirths. They report having asked for this many times but it has never materialised. They feel it would help build their knowledge and confidence. Midwives want in-service training for waterbirths. They resent *“feeling*

*pests*” for asking for these things. Whilst it would be good to have more education about empowering women and providing continuity of care, at the moment the midwives have no time to give that sort of care.

- 5.2.3. The midwives would like a practice development midwife or a lecturer-practitioner **[note]** in post. They stated that this should be a full time post and at least an F, preferably a G grade. They would also like a **Journal Club** and the time to attend a Journal Club. **[note]** There a Journal Club planned but this has fallen by the wayside, as the organisers had no time to get it established. The midwifery forum is poorly attended because it is difficult to find time for it. *“Management couldn’t give a monkey’s.”* More shared learning with doctors would be welcome and the Advanced Life Support in Obstetrics (ALSO) course was cited as a successful example of this.
- 5.2.4. There is unanimous agreement on the need for more assertiveness training so that the midwives can more effectively negotiate with management. On the other hand, this is also seen as a waste of time, as they believe that no notice will be taken of them. Midwives want more education for managers so that they do not bully so much.
- 5.2.5. A more structured programme of **preceptorship** needs to be developed urgently for new staff. Midwives would like education opportunities for cannulation **[note]**, Caesarean section and community midwifery. Also more education around the parameters of normal labour to enable fewer transfers from midwife-led care would be beneficial.
- 5.2.6. The participants also think that an educational strategy for midwifery in Calderdale should form part of the business plan so that it is properly funded in terms of staffing, leave and payment. This would prevent the common scenario of midwives being unable to get to any sessions currently organised.

## GLOSSARY

- 1.1.1. **Continuity of Carer:** When care is provided throughout pregnancy, labour and the postnatal period by a single midwife or a small group/team of midwives.
- 1.1.2. **Informed Choice:** A decision made by a client based on unbiased and evidence-based information.
- 1.1.7. **“Super-Nurse”:** A recent idea mooted by the Department of Health of creating a consultant-type post for nurses and opposed by the Royal College of Midwives with regard to midwifery.

**1.2.1. Clinical grading:** Introduced in 1988 for midwives and nurses working in the clinical area. Midwives in Calderdale are currently graded on E, F and G. The Department of Health has recommended a minimum of F for all midwives carrying a caseload. G was described in the original grading criteria as “the minimum level for.....midwives working in the community”.

**1.3.2. Risk Management Day:** A mandatory annual study day for qualified staff (half day for health care assistants) covering the topics of health and safety, fire, food hygiene, tissue viability, record keeping and resuscitation.

**Perinatal Mortality meetings:** Open forum (usually held monthly) in which obstetricians, midwives and paediatricians discuss the care given to those women whose babies have died or been born in a very poor condition.

**1.3.8. Midwife-led Unit (GPU):** This unit started as a pilot project in 1995 and has since become a fully operational service. Midwife-led care refers to that maternity care which is provided totally by midwives without either obstetric or GP involvement. The unit provides labour and postnatal in-patient facilities as part of the broader and community-based midwife-led service. About 14 – 16% of Calderdale maternity clients give birth in the unit. The unit also provides hospital intranatal care to women whose GP’s wish to be involved in their labour care. As this service pre-dates the development of Midwife-led care, the unit is commonly called the GP Unit. [See also entry for **Changing Childbirth (1.4.8.)**]

**1.3.11. Floating staff:** All staff other than core staff (see 2.8.2. below) who are designated as maternity unit staff rather than ward staff, and who work wherever they are needed in the unit.

**1.4.5. “Booking”:** The initial health assessment interview and examination in a client’s antenatal care. The name is obsolete and derives from the time when there were insufficient hospital beds for all women to opt for hospital birth. Women had to “book” a bed until the 1970s.

**1.4.8. Changing Childbirth:** A Department of Health Report published under the auspices of its Expert Maternity Group in 1993 and based upon the findings of the House of Commons Health Select Committee’s 1992 inquiry into the Maternity Services (Winterton Report). The central themes of Changing Childbirth are Choice, Continuity and Control for women in their maternity care, especially in terms of the place of birth and the lead carer. Amongst other recommendations, Changing Childbirth states that within 5 years, 30% of women should be cared for under the auspices of a midwife, that 75% of women should be cared for in labour by a midwife known to them antenatally and that all women should carry their own case-notes. Changing Childbirth remains government policy. [See also entry for **Midwife-led Unit (1.3.8.)**]

**2.1.7. New breastfeeding policy:** An updated policy issued to all staff in October 1998 after a lengthy consultation process. It forms the basis of the maternity unit’s work towards the UK Baby Friendly Award (an internationally recognised award for excellence in infant feeding practice).

- 2.1.9. Birthplan:** A written plan for labour outlining the client's wishes and preferences for her care. It is currently done in consultation with a community midwife in late pregnancy in the client's house.
- 2.3.1. Bradford Pregnancy Bus:**
- 2.4.2. Red Book:** A parent-held child health record previously distributed by health visitors. As it now starts from birth, it has been given out by midwives on Ward E since summer 1998.
- 2.4.4. Caseload:** A designated number of women allocated to a small group/team of midwives for the whole of their maternity care.
- 2.4.5. Multiparous:** A woman who has had one or more babies. Research has demonstrated that the majority of multiparous women have a good outcome to pregnancy with far fewer antenatal consultations than traditionally offered (Hall, 1989).
- 2.4.6. Pethidine:** a synthetic narcotic drug used for analgesia in labour as it has less adverse effects on the baby's respiratory system than other systemic analgesics.
- 2.5.13 On call system:** Three midwives are on-call each night from 16.30hrs to 08.30 hrs to cover for homebirths, midwife-led deliveries, and unplanned births at home. These midwives can also be asked to come in and work on Ward E if it gets very busy. The on-call midwives cover the whole of Calderdale and not just those parts with which they are familiar.
- 2.8.2. Core staff:** Staff permanently or semi-permanently allocated to a specific ward area.
- 2.8.4. "Booking" scan:** an ultrasound scan done at approximately 15 weeks gestation to estimate the Expected Date of Delivery. This can also be done by adding three months and deducting seven days from the first date of the last period prior to conception but an irregular menstrual cycle renders the calculation more problematic.
- 2.9.2. GP shared care:** Maternity care offered to clients which involves GPs and community midwives. Care takes place in the GP's practice and normally only relates to the antenatal period. There is a system of remuneration for GPs for any maternity care given by them or by the community midwives linked to their practice which is a recurring theme of complaint from midwives nationally.
- 3.4.3. Obstetric nurses:** Nurses who undertake intranatal care under medical guidance in some countries e.g. the USA, Chile and parts of Canada. Obstetric nurses only undertake deliveries if the obstetrician does not turn up in time. This form of care is associated with high levels of intervention and poor health outcomes for mother and baby (Wagner, ).
- 3.5.3. Statement:** A written account of an incident which is or may be the subject of a complaint or investigation.

**4.3.4 Sonicaid:** A small hand held ultrasonic device which enables the fetal heart to be heard externally.

**Entonox apparatus:** A gas with analgesic properties often used in late labour, self-administered by the client via a mask or mouthpiece.

**5.1.1. Risk Management Day (see 1.3.2. above).**

**5.2.1 CTG:** Cardiotocograph (a paper tracing of the fetal heart rate and uterine activity).

**5.2.3. Journal Club:** An informal forum where journal articles are presented and discussed by midwives and doctors.

**5.2.5. Preceptorship:** A period of non-hierarchical supervision and support for newly qualified staff .

## **RECOMMENDATIONS**

A goal should be for each woman to at least have the undivided attention of one midwife when in labour. (1.1.2.)

Grading should more clearly reflect the experience that many midwives have and are expected to use. (1.2.2.)

After one or two years post registration experience, all midwives should be promoted to F. There should be more promotion in the unit in particular. (???)

Midwives want more staff and to be able to provide one-to-one care for women on labour ward. They want extra support staff to answer telephones. They want a lighter workload for the bleep holder at weekends and at night as these midwives can be called away which is difficult if they are in the middle of looking after someone in labour. The H grades should work evening shifts and weekends. More midwives should be trained to scrub in theatre. Staff ratios should also be equal across comparable areas to minimise discrepancies in level of service. (1.3.14)

They want two midwives at every homebirth. (1.4.11)

Midwives on SCBU describe feeling isolated and would like more opportunity to get involved in antenatal and intrapartum care. (1.5.6.)

Participants feel that midwifery staff would appreciate more opportunity to work in antenatal clinic and in the community to build up a better overview of the maternity service and improve co-ordination and integration of that service. (1.5.7.)

The midwives generally want much better representation. (2.1.3.)

They would like more inclusive meetings (e.g. unit-based and community-based midwives together) for greater understanding of the service as a whole. Better communication between management and staff is needed. (2.1.6.)

The midwives would like a system of peer support for breastfeeding women introduced as the most effective way of building confidence in novice breastfeeding women. (2.1.9.)

There is a need for more link workers in the community and the hospital and far more leaflets in Asian languages. (2.1.10)

Participants believe all midwives should be paid for overtime worked. (2.2.1.)

The community midwives feel they know where the inequalities are and what they are, and that they should be able to influence the Primary Care Groups (PCGs). (2.3.2.)

Participants generally want more autonomy in their daily working lives. (2.4.1.)

Midwives would like the opportunity to carry a **caseload** involving the whole spectrum of care from “booking” to postnatal care at home. (2.4.4.)

The midwives want far fewer antenatal consultations for **multigravid** clients (2.4.5.)

Midwives would like to address parenting skills and issues more within parent education sessions. (2.4.8.)

Participants would like to wear something other than nursing uniforms. Polo shirts with a logo together with skirts and trousers would be more appropriate, with the same colour for all grades. (2.5.8.)

A major need is for support, especially from senior staff. (2.5.10)

They would like to see a considerable increase in staffing ratios. (2.5.12)

They want off-duty at least two weeks in advance in order to organise child-care or preferably a rolling rota which will show what they are working 3 – 4 weeks in advance. (2.7.3.)

Midwives suggest that part-time midwives should be paired up to make cover of off-duty easier. More job shares would also help cover the rota better. (2.7.8.)

The Trust’s move to offer “family friendly” contracts but emphasise that this must apply equally to staff already employed. (2.7.9.)

The organisation of Ward C needs to be looked at as a priority. (2.8.1.)

All core staff should be on C with only co-ordinators on E to bring staff up when needed. (2.8.2.)

Participants feel that all staff should be rotated in light of this and that a strong leader should be appointed in charge of Ward C. (2.8.4.)

The participants believe that all women should have direct access to midwives without going through GPs They would also like to establish midwives drop-in centres and the midwifery services better advertised to clients.  
(2.9.1.)

Midwives want to work in a friendlier environment free from blame and scapegoating. (3.3.5.)

They feel that more equality is needed and greater recognition of the validity of midwives points of view. (3.4.3.)

The midwives want much more co-operation from doctors generally and specifically want SHOs to have more training. (3.4.4.)

GP trainees in particular shouldn't be used as SHOs but should be attached to a senior midwife or registrar and work with them. (3.4.5.)

It is also important to have equity of environment with all areas being decorated, furnished and maintained to an equally pleasant standard. (4.2.1.)

The layout of ward C is described as "atrocious" and should be improved as a priority, including the installation of an emergency bell. (4.2.2.)

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Mobile phones should be provided for all community midwives so that they do not have to keep going back to the unit to pick up the only one. They also want a portable Sonicaid and Entonox apparatus for every team. (4.3.4.)

Continuous programmes for development should be available. The midwives want more educational support. (5.1.1.)

Extra qualifications and expertise should be recognised and those who have attained these should be better encouraged and facilitated to use them and share them. (5.1.4.)

Community midwives want an informal gathering to discuss cases and homebirths. (5.2.2.)

They would also like a Journal Club and the time to attend a Journal Club. (5.2.3.)

There is unanimous agreement on the need for more assertiveness training Midwives want more education for managers. (5.2.5.)

A more structured programme of preceptorship needs to be developed urgently for new staff. Midwives would like education opportunities for cannulation **[note]**, Caesarean section and community midwifery. Also more education around the parameters of normal labour to enable fewer transfers from midwife-led care would be beneficial. (5.2.5.)

An educational strategy for midwifery in Calderdale should form part of the business plan so that it is properly funded in terms of staffing, leave and payment. (5.2.6.)

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