CHANGING MIDWIFERY: WORKING CONDITIONS AND THE QUALITY OF CARE

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Abstract

Maternity units have been expected to achieve, within constrained resources, significant improvements in the quality and continuity of care as required by government policy. While significant advances have been made, these have been achieved by drawing upon the professionalism and vocational commitment of midwives, and at the expense of their working conditions and sense of wellbeing. While this approach has, in the short term, served the purpose of increasing midwifery output within existing resource constraints, the quality of care has suffered. The increasing problems of recruitment, retention, and falling morale within the profession suggest that it is not sustainable. In the longer term, if the improvements in care achieved thus far are to be sustained, there is a need to reform midwives' working conditions and working environment. This is not to imply that the answer to the ongoing dilemmas facing the maternity services lies solely in improvements in the pay levels or pay structure for midwives. The solution is also dependent on the extent to which midwives are afforded the enhanced status and autonomy recognised as necessary for the improvement of maternity services. Furthermore, strong representation of midwives, alongside improvements in management structures and systems of communication in nhs trusts, are necessary if midwives are to be enabled to participate in decision-making and thereby effectively contribute to improvements in the quality of care.

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Dedication

This paper is dedicated to the midwives and heads of midwifery who took time out of their extraordinarily busy lives to respond to our many questions.

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'Despite their generally positive views, staff surveyed at the trusts visited expressed concern about the demands made upon them: about their workload, skills and responsibilities, and the environment in which they work.'

Audit Commission (1997) *First Class Delivery, Improving Maternity Services in England and Wales.* p. 72. Audit Commission Publications, Abingdon, Oxon.

1. Introduction

The research reported here explored the conditions under which midwives work, and the impact of those conditions on the quality of care provided, from the perspective of heads of midwifery and of midwives themselves. It examined changing work organisation, pay, grading structures, hours of work, job content, midwife involvement and representation, and attitudes to management. And, in turn, it looked at how these changes have affected midwives' work, satisfaction, morale and motivation.

The changes described have taken place against a background of policy initiatives designed to improve quality of service, which have placed additional demands and responsibilities onto midwives. The research suggests that while midwives have responded positively to these reforms, they are dissatisfied with management, with the support they have received in implementing change, with the additional time commitments they are required to make, and with the rewards for their active participation. As a consequence, although their job satisfaction and motivation remains high, morale and satisfaction with their terms and conditions of employment are generally low.

The National Health Service (NHS) operates within continuing resource constraints, meaning that improvements in the quality of care have largely been achieved by drawing upon midwives' vocational commitment. But this commitment is not an inexhaustible resource. In the short run, the physical and psychological cost to midwives of increasing work intensity, and their alienation from management, have had an adverse effect on their ability to provide good quality care. In the longer run, this will damage the NHS' reputation as an employer, making it increasingly difficult to recruit and retain suitably qualified and dedicated people to provide maternity services that meet the needs of women and babies.

2. The Research Project

This research project, commissioned by the Royal College of Midwives (RCM), sought to examine the variety of working practices deployed in maternity units in Great Britain. It aimed to investigate how different forms of work organisation affect the nature and quality both of the maternity care provided, and of midwives' own working lives and well-being.

The first stage of the research project involved a postal survey of maternity unit managers in Great Britain. In early April 1998, questionnaires were sent out to a total of 251 maternity units. The recipients of the questionnaires held a number of different positions within their units, including Director of Midwifery Services, Clinical Services Manager, Senior Midwife and Head of Midwifery, depending on the size and management structure of each unit. However, for the purposes of this report they will all be referred to as 'heads of midwifery'. A total of 121 completed questionnaires were returned, representing a response rate of nearly 50%.

The questionnaires used in the postal survey contained 48 questions, dealing with different aspects of work organisation and industrial relations structures within maternity services. In addition, the questionnaires also addressed the effects of recent national policy

initiatives on midwives' working conditions and the performance of maternity units.

The second stage of the project involved conducting face-to-face interviews in six maternity units in different parts of the UK. The six sites were located in two teaching hospitals, two general hospitals and two community-based maternity units. In each unit, interviews were undertaken with the head of midwifery and with between 12 and 15 midwives, who worked on a range of employment contracts and clinical grades. Each interview lasted approximately one and a quarter hours, during which time the respondents answered questions covering all aspects of their working lives. A total of 80 midwives were interviewed during this stage of the research.

3. The Demand for Improved Quality of Care and the Pressure on Resources

The Government's reform agenda for the NHS in the 1980s and 1990s included a greater emphasis on quality control and consumer choice. This commitment was explicit in policy directives such as *Patients First* (Department of Health, 1982), the *Patient's Charter* (Department of Health, 1991), the *Children Act* (Department of Health, 1989a), the *Health of the Nation* (Department of Health, 1992), and *a Strategy for Nursing* (Department of Health, 1989b). In midwifery, these documents gave rise to three principal changes. The first was the introduction of named midwives with responsibility for co-ordinating the care of clients; the second was the transformation in midwives' work from being task-orientated to being client-centred. The third reform involved the development of accountability and standards, leading to the publication of guidelines by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) which emphasised midwives' personal accountability for the quality of client care. It was in this broader context of pressure for improved quality of care that the provision of maternity services became the subject of widespread debate and reappraisal.[1]

During the post-war period, maternity services in Britain have increasingly operated on a hospital-based and obstetrician-led model, which emphasises the risks of childbirth and results in high levels of medical intervention, even for low-risk pregnancies. Within this system, the role of the midwife has been limited, resembling more the role of an obstetric nurse than that of an autonomous practitioner. However, assumptions about the 'necessity' and 'inevitability' of this trend have come under increasingly heavy challenge from both women and midwives, whose mounting concerns about the impact of high technology obstetrics and growing awareness of consumer rights have helped to initiate widespread debate over the future of maternity care. Even as medical intervention became increasingly normalised within maternity care, it has been countered by a dissenting view - of growing strength - which sees quality of care as involving a shift in emphasis away from clinical procedures, institutional practice and professional convenience and centring it more around the needs and wishes of women. This dissenting view culminated in, and was championed by, the publication of *Changing Childbirth* (Department of Health, 1993a) in England and equivalent documents in Scotland and Wales.[2]

Changing Childbirth identified a number of targets which clinicians, managers and practitioners were expected to meet within five years (Department of Health, 1993b). The indicators of quality of care most relevant to midwifery care were that:

- every woman should know one midwife, who ensures the continuity of her midwifery care: the named midwife;
- at least 30% of women should have **a** midwife as the named professional responsible for their care;
- every woman should know the lead professional responsible for the planning and provision of their care;
- at least 75% of women delivered in a maternity unit should know the person who cares for them during labour;
- midwives should have direct access to some maternity beds in all maternity units (in other words, rights to refer the women in their

care directly to those beds);
- all women should have access to information about the services available in their locality.

The policy changes experienced in maternity services during the 1980s and 1990s took place against a backdrop of widespread NHS reform, culminating in the introduction of the internal market (enshrined in the NHS and Community Care Act 1990). The impact of these institutional changes on the NHS has been well documented (Alaszewski, 1995; Montgomery, 1997; McHale, Hughes & Griffiths, 1997). The introduction of the market mechanism within the NHS was perceived by the government as a means of achieving a number of objectives, including the devolution of responsibility for cost cutting, necessitated by tight fiscal policy; allocation of scarce resources to competing healthcare ends; and *de facto* rationing of services.

Within these straitened circumstances, the recommendations outlined in *Changing Childbirth* had important implications for the deployment of NHS resources.[3] The success of this policy was dependent upon adequate staffing and investment in the professional upgrading and training of midwives. However, both the government and Health Authorities have failed to make available the budgets necessary for effective implementation. Rather, they have expected Trusts to achieve improvements in quality of care within existing resources (House of Commons, Cm 3832, 1998). The requirement is then for greater value for cost in terms of given *tax pounds.* As far as 'value' is concerned, the emphasis is on quality of service, and particularly client satisfaction. As far as cost is concerned, the emphasis is on reducing expenditure *and* improving performance.

Inevitably, the establishment of woman-centred care has had significant implications for service provision and staff organisation within maternity units. Central to its success is the enhancement of the role of midwives. It relies upon midwives fulfilling their role as autonomous practitioners, requiring of them increased knowledge and

a wider range of clinical skills, and taking greater managerial responsibility. Above all, midwives are required to provide more flexible services, particularly with regard to their availability and time. Improvements in quality of care also depend on the establishment of highly co-operative relationships between women, their midwives and other professionals. The necessary diffusion of responsibility, flexibility of provision, and the greater involvement of women associated with these changes, require managerial organisation based on horizontal co-ordination rather than hierarchical control. The successful creation of such a mutually supportive organisational structure is dependent on relationships built on respect, confidence, trust and long-term commitment.

That midwives and Trust managers have a shared interest in delivering improved services is not in question. Midwives have a clearly expressed professional and vocational commitment to the principles of woman-centred care. Understandably, however, this is conditioned by the expectation that higher levels of skills, effort, responsibility and flexibility will be recognised in pay and status. What is in doubt is whether the resource constraints under which the NHS operates allow the staffing levels and investment in human resources necessary for this purpose. Questions must also be asked about whether NHS Trusts have the managerial structures, organisation and procedures capable of creating the trust and co-operation needed for such high quality outcomes.

4. Quality of Care and the Organisation of Caring

There are two dimensions to the quality of care: how it is organised and how, within that organisational structure, caring is carried out. A widespread review of the extent and direction of change in maternity units was undertaken by the Audit Commission, whose report, *First Class Delivery,* was published in 1997 (Audit Commission, 1997). This report found that the range of options for care, and the nature and quality of care provision available to women, varied widely; and that while the majority of women were generally satisfied with the care

provided, a sizeable minority were not. The Commission concluded that there was room for improvement in information provision, in continuity of carer throughout labour and, especially, in the quality of postnatal care.

The Audit Commission also reaffirmed the importance of providing care in the community. Its survey revealed that women generally prefer community-based antenatal and postnatal care on the grounds that it is more personal and informative than care received within a hospital. Moreover, policy makers favour community-based care on the grounds that it is more cost effective than hospital-based care. Nevertheless, the maternity service remains principally a hospital-based service, although in many areas efforts have been made to increase continuity of care by rotating midwives in and out of the community.

The results of our postal survey show that in two-thirds of units, 60% or more of the midwives employed are hospital-based. One fifth of maternity units have 40% or more of their midwives based in the community, a further 46% of units have between 20% and 40% of midwives in the community and about half employ midwives who work both in the hospital and in the community. The survey also revealed that within most Trusts *some* progress had been made in reaching the targets set by *Changing Childbirth,* although the extent of this varied widely (see Table 1). Most progress had been made in the provision of information and in enabling midwives' direct access to beds, with more than 50% of maternity units meeting these targets and most of the rest having made measurable progress towards them. Fewer maternity units had achieved the targets on continuity of care by a named midwife, or on women knowing the lead professional responsible for planning and providing care; less than 40% of the maternity units had met these targets, although a further 50% had made 'measurable progress' towards them.

Least progress had been made towards meeting those performance targets that require a significant reorganisation of staffing or service

delivery. In particular, there has been a notable failure to meet the targets of having a midwife as lead professional and of providing continuous care for women. Less than one-third of the units surveyed had met the target of 30% of women having a midwife as the lead professional, and no attempts had been made or no change had been achieved to meet this target in 24% of maternity units. Furthermore, only 10% of units reported that 75% of women knew the midwife who cared for them during their delivery, and in 38% of units no progress towards this target had been made.

Thus, units differed substantially in their progress in improving quality of care and in centring service provision around women's expressed needs. Further analysis shows that an important link existed between the *location* of maternity services and the quality of care (as defined by national performance targets). Units with the fewest midwives based in the community tended to have the least success in meeting woman-centred care targets, while those with the highest proportion of midwives who were community-based tended to have the highest rate of success in providing women-centred care.

The findings of the six case studies illustrate this variability in the implementation of policy objectives. In five of the six units visited,[4] progress towards woman-centred care had resulted in a significant reorganisation of working arrangements for midwives, usually with the aim of improving continuity of care. Team midwifery had been introduced to promote greater continuity across antenatal, intrapartum and postnatal care. The benefits of this model can be considerable. From the woman's perspective, team midwifery may help secure continuous care from known professionals throughout pregnancy, labour and the postnatal period (providing the teams are small and flexible). For managers, team working provides a flexible method of matching staff to workload. In particular, it ensures that the labour ward is adequately staffed when there is an increase in demand, without taking resources away from other areas. It also increases the skills base and clinical competency of the midwives, who are responsible for all aspects of care.

The findings suggest that staff shortages and limited training resources have prevented the extension of effective team midwifery, which had been implemented in a piecemeal fashion. Many maternity units have initiated team working by pilot schemes, limited to small numbers of women. Only two of the units surveyed had successfully extended team midwifery to all their clients, and in one of these the team midwifery scheme only operated during the day, with night time care being provided by core staff.

Team midwifery was not the only way in which midwives' work had been reorganised. The increased use of *domino* services, the location of more staff in the community, and the rotation of staff from hospital to community, were all being used to improve continuity of care. From the women's perspective, the benefit of these schemes was that they ensured consistency in the care provided, regardless of which professional was caring for them at any time. For managers, domino services and staff rotation allowed more flexibility in staff deployment to meet peaks in demand. This increased flexibility was secured through the additional skills and competencies which midwives gained from working in both hospital and community settings. The introduction of these schemes, as with team midwifery, provided opportunities for midwives to broaden their work experience and skills, to increase job satisfaction through increased work variety and, sometimes, to benefit from upgrading.

In most of the units, team midwifery and other new schemes operated side by side with traditional shift-based maternity services. This 'dual approach' led to disparities in the care offered to women, and to inequities in the quality of care received. It also reduced staffing flexibility and increased the work pressure on remaining core hospital staff, who were required to handle peaks in demand in the labour ward. Lack of resources had also placed additional pressure on postnatal care. Heads of midwifery and midwives from the case study units reported a deterioration in postnatal services. Midwives expressed concern that owing to pressure of work routine visits could not always be made, and others reported that new working

arrangements limited the opportunities for midwives to provide antenatal and postnatal care to individual women. Some midwives also felt that the benefits for clients were not evenly spread and that in some cases improvements for some had been accompanied by deterioration in provision for others. Others reported that woman-centred care had not really got going in their work place, or that that it was still too early to judge its impact.

5. Quality of Care and the Efforts of Carers

Recent research has highlighted concerns about the impact of policy changes on midwives' working lives and on the performance of maternity units. Many midwives have experienced radical changes in their working patterns, with longer shifts and greater responsibilities. These changes have also made it hard for many midwives to balance the demands of the job with the demands of the home (Walton and Hamilton, 1995). This section examines the qualitative aspects of the changes in the maternity units we studied, and the next section considers the impact on the hours and intensity of work.

Developing woman-centred, community-based services requires substantial reorganisation of working arrangements, the success of which relies heavily on midwives' commitment and flexibility. Nonetheless, these changes were generally welcomed by the midwives we interviewed, who recognised the advantages to their clients of the new system of care. Around three-quarters of the midwives thought that the changes had improved client care. They cited general improvements in the quality of service, more continuous and personal care, the empowering of clients to take a more active role in the planning and delivery of their care, and greater client satisfaction.

Midwives also welcomed the opportunities offered by woman-centred care to enhance their own role and status. For 29% of the midwives, woman-centred care meant that they have a more rewarding and satisfying job; a further 18% felt it enabled them to exercise more

skill, autonomy and discretion. This is reflected in midwives' perceptions of how their tasks, skills and responsibilities had expanded (Table 2). Three-quarters or more reported increases in skills used, variety of tasks performed and responsibilities involved in their work, although far fewer reported increased training to match these demands.

Whatever their level of commitment, midwives' *ability* to meet the increasing demands of their work crucially depends on the level and quality of training they receive. Table 3 shows that virtually all the midwives we interviewed recognised the importance of on-going training to enable them to do their job well and for their career development, and a high proportion thought that it was very important. They were also eager to acquire training. The heads of midwifery were equally emphatic about the importance of training for improved performance, and of the keenness of midwives to take it up.

Midwives' enthusiasm for training, and their keenness to undertake it, has to be seen in the context of increasing work intensity, the demands of woman-centred care and the conflicts between these requirements and midwives' family responsibilities. In these circumstances, the willingness and ability of Trusts to deliver effective training is of crucial importance. When the midwives were asked about the training provided, just over half (56%) replied that training was very adequate or adequate, but 41% considered that it was only just about adequate, or inadequate. Moreover, only 31% thought their employers were very willing or willing to provide training, 44% thought they were only fairly willing and 22% thought that that they were not very willing or unwilling (Table 3). The heads of midwifery agreed that training left something to be desired. Of the six interviewed, only one reported that the training provided in their unit was very adequate, one said it was adequate and four said it was only fairly adequate.

6. Quality of Care and the Hours and Intensity of Work of Carers

The midwives we interviewed had generally met the challenge of their expanding role and workload. However, lack of resources and understaffing meant that, in doing so, they had to lengthen their hours and increase the intensity of their work. In all the units visited, team midwifery and other innovations had been accompanied by changes in shift patterns. These invariably involved extended working times and, in many instances, midwives continued to attend women after the end of their shift. These extra demands resulted largely from the resource constraints to which NHS Trusts were, and are, subject. The midwives were well aware of the difficulties facing their employers. Two-thirds of the midwives surveyed said their employers were in financial difficulties, and a further 30% reported that they were at best breaking even. Many midwives (60%) also thought that staffing was inadequate.

Moreover, it is important to note that the major contribution to meeting staff shortages came from the permanent staff in the form of extra hours and greater work intensity. Non-permanent and casual workers were only a small proportion of the workforce and almost all the midwives in the units surveyed by post were on either part-time or full-time permanent contacts. Fixed-term, temporary, seasonal and short-term contracts were used, but these accounted for only 1% of the midwives in the maternity units surveyed. Bank midwives were also employed by more than 90% of maternity units, but this form of casual employment was equivalent to less than 8% of regular employment. Agency midwives were even less important, being used in fewer than 10% of the maternity units, and adding less than 1% to the permanent staff.

There was general agreement amongst midwives and heads of midwifery that overtime was extensively worked, and that it had been increasing over the past five years. The heads of midwifery surveyed by post reported that around one-third (36%) of midwives regularly worked longer hours than their basic working week, and around two-

thirds (62%) occasionally did so. In these maternity units, overtime hours averaged between five and 10 hours for half the midwives and between 10 and 15 hours for more than a third (36%). Of the midwives interviewed, only 7% said they *never* worked extra hours and more than half (56%) said that they always or regularly worked overtime. The extra hours worked were fewer than five hours for 43% of the interviewees, between five and 10 hours for 37%, and between 10 and 20 hours for the remainder. Heads of midwifery confirmed that this pattern of overtime working was typical. They also reported that midwives were increasingly coming into work early and leaving work late voluntarily, showing both their commitment to, and the pressure of, their work.

As well as needing to work longer hours, midwives had also found themselves having to work more intensely. Around two-thirds of the respondents said that the speed of their work and the effort they were required to put in had both increased over the previous five years. This pressure came from the sheer quantity of work rather than from managers or colleagues (Table 4).

The driving forces for this intensified effort are shown in Table 5, which shows what midwives identified as the main determinants of how hard they worked. Virtually all midwives regarded the needs of clients, their own discretion and their fellow workers as important in determining how hard they worked. Their sense of doing something useful and being recognised for it were also major motivating factors. By contrast, less than half of the respondents regarded management reports and appraisals as important in determining how hard they worked, and pay was an important motivator for only 30% of midwives.

In short, midwives' response to the paucity of resources was to increase their working hours and effort. But this was not in response to managerial pressure or increased pay. Rather, it came from the needs of the women in their care, their own professionalism and their loyalty to the team. Importantly, the vocational commitment of the

midwives had protected the quality of the service provided from the effects of shortage of resources, and the midwives felt this commitment had gone unrecognised and unrewarded.

7. Terms and Conditions of Employment

7.1. Local pay bargaining and localised terms and conditions

The principle of local pay bargaining was enshrined in the 1990 Act, which provided the legislative framework for NHS Trusts. Lying behind this initiative was the shifting of the responsibility for the pay bill to Trust level, where it could be contained within the Trust budget. The alacrity with which, in general, Trust managers accepted this responsibility can be judged from a recent survey of local bargaining in the NHS (Thornley, 1998). This found that 'an overwhelming 96% of the Trusts used the ability to pay as their top bargaining criterion, while 71% rely on the argument that "if pay goes up the number of jobs will be cut" as their fall back position' (p. 421). The decentralisation of bargaining was bitterly opposed by the NHS unions and one consequence was the decision of the Royal College of Midwives (RCM) and the Royal College of Nursing (RCN) to rescind the clause in their rule book prohibiting strikes.

However, local pay bargaining has since been judged a failure by both staff and management, and the trend towards localisation has now largely been reversed. In 1997, the Pay Review Body Report reinstated the national pay award, and the new Labour Government committed itself to ending the internal market and restoring a national framework for pay determination. Nevertheless, despite the return to national pay settlements, the decision taken by successive governments to stage pay awards has meant that wage increase for midwives for 1997/98 and 1998/99 have been below the rate of inflation. Thus, a combination of local pay bargaining and staged national pay awards has led to a series of settlements which have failed to compensate midwives for cost-of-living increases.

The introduction of local bargaining has had an even more profound effect on non-pay conditions of employment than it has on pay negotiations. Slightly more than a third (36%) of the maternity units surveyed by post had introduced localised terms and conditions. The most widespread change was the introduction of more flexible working-time arrangements (introduced in 22 units). Less frequent changes included the loss of time off in lieu (five units), longer working time (eight units) and the introduction of flexitime (seven units). Changes in premium times for weekend working (11 units), unsocial hours (10 units) and bank holidays (13 units) had also been introduced, as had changes in holiday pay entitlements (17 units) and sick pay (15 units). Changes in payment systems had included the introduction of performance-related pay (nine units) and job evaluation (14 units).

In most areas, the introduction of localised terms and conditions has been selective. *All* the midwives had been affected in those units where time off in lieu had been withdrawn, and in the 50% of units which had introduced more flexible working time arrangements, job evaluation and longer working time. But where they had introduced performance-related pay or changes in holiday pay, sickness pay, premiums for unsocial hours, weekend and bank holiday working, only a minority of units (35% or less) had applied them to all midwives. Where coverage was not universal, the midwives affected by the local changes to terms and conditions were more usually those on Trust contracts, although in some cases it was only new staff who were affected. Of the maternity units visited, half had introduced localised conditions of employment, including flexible working arrangements, flexitime and longer working hours, and adjustments to premium times for bank holidays, unsocial hours and weekend working. There, as elsewhere, piecemeal change had eroded national terms and conditions, with the consequence that the range of terms and conditions for midwives had widened both within and between maternity units. Nevertheless, the large majority of midwives were still covered by Whitley contracts, or by Trust contracts which mirrored Whitley terms.

The National Association of Health Authorities and Trusts (NAHAT) once claimed that local bargaining would lead to 'more efficient patient care' while giving 'employers greater control over their wage bill, a wide range of improvements for the staff and for the relationships between the staff and their employers' (Thornley, 1998). Table 6, however, shows that heads of midwifery were less than fully convinced that these benefits had been achieved. Fewer than 30% thought that the introduction of localised terms and conditions had had a favourable effect on productivity, costs, quality control or workforce flexibility. They were more optimistic about the benefits for quality of care, midwife training and ability to respond to changing demand, although even for these, less than 40% thought that the effect of local terms and conditions had been favourable or very favourable. However, only a minority of the heads of midwifery thought that local changes to terms and conditions had had an unfavourable impact. Rather, the predominant view was that localised terms and conditions had had neither favourable nor unfavourable effects on the performance of maternity units.

When asked to evaluate the effect of the introduction of localised terms and conditions on a range of performance indicators, the views of the heads of midwifery we visited varied, but it does appear that the policies had not been uniformly successful. In one unit, the head of midwifery considered that the changes made to the terms and conditions for midwives on a special project directed at woman-centred care had had a very favourable effect on productivity, continuity and quality of care, quality of training, workforce flexibility and ability to respond fluctuating demand. They had, however, pushed up costs and not improved control over work quality.

In the other two units which had introduced localised terms and conditions, the changes had not proved so successful. One head of midwifery, who had introduced longer working hours, cited a very favourable impact on the ability to control work quality and on the

quality of care offered to women, and a favourable effect on continuity of care and on the quality of midwives' training. Otherwise, the impact was considered neither favourable nor unfavourable. The effects of the changes introduced in the third unit had been neither favourable nor unfavourable in most respects, although a favourable effect had been seen on costs and on the ability of the unit to respond to changes in demand.

Where local changes in terms and conditions formed part of a package designed to improve the quality of care, they seemed to have a favourable impact on performance, if not on costs. When they were targeted at cost cutting, however, beneficial effects on performance were limited.

7.2. Grading

This trade-off between cutting costs and improving performance was an important feature of the grading and regrading of midwives.

The introduction of policies for woman-centred care has placed significant demands - both professional and personal - on midwives. If they are to be sustainable, these demands should be matched by the pay and grading system. However, a common concern expressed by midwives in units using team midwifery was that the existing grading structure did not recognise or accommodate their restructured working arrangements.

In 1995, the Department of Health released an NHS Management Letter (EL(95)77, Department of Health, 1995) which addressed these concerns, and recommended that Trusts implement a minimum F Grade for midwives giving the full range of midwifery care. But only a handful of Trusts have put this policy into practice, and many midwives - despite their considerable responsibility and expertise - remain on Grade E. Moreover, where a minimum F Grade *has* been introduced, it is more likely to be a reflection of tight local labour conditions than of adherence to the spirit of the guidelines.

In some units, the introduction of team midwifery had been accompanied by a downgrading of other posts. While most units have only downgraded posts when vacancies arose, some midwives had been downgraded in post, especially older midwives who had opted to remain in their pre-reform roles. Midwives also complained of what they perceived as unjustified differentials in grading amongst midwives working in teams. Although team midwives all perform the role of autonomous practitioners and hold the same clinical responsibilities for women in their caseloads, in most units they were employed on a mixture of F and G Grades. Many midwives perceived this disparity in grading as being unfair and a potential source of tension within working teams.

There appears to be a relationship between grade structure and quality of performance, with those maternity units with the highest proportion of midwives on the lowest grades being the least successful in meeting targets for woman-centred care. Conversely, those units with the highest proportion of midwives on the highest grades were the most successful. Some of the most interesting differences between units related to the two most difficult targets: that of 30% of women having a midwife as the lead professional, and that of 75% of women knowing the midwife who cares for them during delivery. The units most likely to have met the target or to have made 'measurable improvements towards the target' were those where the largest proportion of midwives were community-based and where, on average, midwives had the highest grades.

It could, of course, be argued that one would expect midwives on higher grades to perform better than those on lower grades. In other words, that the grading structure accurately reflects the relative abilities of different midwives. However, it is clear both from our study and from evidence to the Pay Review Body (Royal College of Midwives, 1998) that many midwives are inappropriately graded, and therefore that a midwife's grading may reflect local market conditions and Trust priorities rather than her abilities and experience. If

midwives are being kept on grades that are not commensurate with their responsibilities and expertise - and there is good evidence that this is the case - then one would expect this to affect their morale. This may be a partial explanation for the impact of grades on performance.

The overall grading pattern of the maternity units included in the study reinforces the argument that the guidance in EL(95)77 has not been implemented. In total, the maternity units surveyed by post employed almost 9,000 midwives. Of these, only 34% were on grade G, 29% were on Grade F and 37% were on Grade E. In the six case study units, the grade structure of employment was 30% employed on Grade E, 38% on Grade F and 32% on Grade G.

7.3. Security, trust and relations with management

It is now widely recognised that high quality work organisation requires a close and trusting relationship between workers and their managers. This is important not only because of the beneficial effects it has on service quality, but also because it creates a climate of confidence in which employees are prepared to work beyond the strict terms of their contract, in the knowledge that their goodwill will not be exploited (Lorenz, 1999). Two important prerequisites for creating trust are long-term security and the quality of relationships between employees and management.

7.3.1. Security and staff reorganisation

There can be little doubt that midwives enjoy a great deal of job security, not only in the sense that there will be a continued need for their service but also because there is a general shortage of midwives. The certainty with which respondents viewed their future job security, valuation of their skills and the likelihood of being laid off, is explored in more detail in Table 8. Most midwives (84%) felt certain about their future career picture. Fewer midwives, although still the majority, felt certain about the use and value of their skills in five

years' time, about their job security with the Trust, about their responsibilities in six months time and over whether they would be laid off in the future. Only 31% felt certain that they would gain promotion, and 69% were uncertain to some degree. This no doubt reflects the delayering of management, which has eliminated or truncated midwifery career paths.

The information in Table 7 suggests that while most midwives feel secure over the prospects of continued employment in midwifery – which is not surprising given the level of staff shortages overall – they feel less secure about their terms of their employment with their current Trust.

These varying certainties are no doubt coloured by midwives' perceptions of their managers' use of redundancy and downgrading in order to achieve reorganisation, lower costs and increased flexibility (Table 8). Whereas more than 60% of the midwives said that management never, or only under extreme circumstances, looked upon redundancy 'as a first solution' to their problems, only 30% felt the same way about managers' use of downgrading. Of the midwives interviewed, 38% thought that their employer would resort to downgrading in order to save money, whereas only 13% thought that redundancies were used in this way. In addition, 10% of the midwives thought that Trusts 'routinely' downgraded their staff. The downgrading of *existing* staff members was mentioned by 18 midwives when elaborating on their response to the downgrading question, and 23 said jobs were downgraded when they became vacant. Furthermore, four midwives said downgrading would have taken place if it had not been resisted, and a further five thought that their Trust would downgrade midwives if the labour market for midwives were not so tight.

Midwives' perceptions of the use of redundancy and downgrading are in some respects matched by evidence of recent experience. Paradoxically, despite endemic staffing shortages, redundancies still feature in the maternity units we surveyed. Between 1991 and 1998,

30 of the 120 maternity units sampled in the postal survey had experienced redundancies, and nine had done so on more than one occasion. The years in which most units made midwives redundant were 1993-4 and 1996-7, with an incidence of 17 and 11 respectively. Generally, the number of midwives affected was small. In more than half the cases, only one midwife had been made redundant and in only two (when 16 and 26 midwives were made redundant) were the numbers of midwives involved greater than six. All the units included in the case study stage of the research had experienced either redundancies or significant reorganisation over the last five years. In the three units experiencing redundancies, all the midwives affected had been employed on management level grades and the redundancies had come about as a result of a total reorganisation of management structures. One other head of midwifery reported that her unit had been restructured through the downgrading of *jobs*, as opposed to individual midwives. She reported that over the last five years most posts, when they became vacant, had been filled with a midwife graded lower than the previous occupant. Another expected her unit to be restructured over the next two years, leading to an overall downgrading of the establishment.

However, security in employment extends beyond concern about losing a job and being able to get a new one. Employees may feel insecure if organisational restructuring and work reorganisation remove the institutional supports individuals rely upon, and valued elements of the work itself (Burchell *et al.,* 1999). Traditionally within the NHS, power and status within the midwifery profession have been concentrated in a hierarchy of midwifery managers. Successive reforms in the 1980s and 1990s led to a significant reduction in the size, power and status of this hierarchy (Harrison, 1998, pp. 146-9), and a devolution of managerial responsibility to ward level. In addition, although the main responsibility for cost control continues to rest with doctors and the professional management, midwives have been increasingly expected to operate as cost controllers. In particular, ward sisters have been expected to take on the role of ward manager. In this capacity, they are provided with

budgets, which indicate the amount of money allocated for staffing and associated expenditure. Indeed, in all the maternity units visited which had experienced redundancies in the last five years, subsequent reorganisation had resulted in a devolution of responsibility, notably onto midwives on Grades H or G. In at least two hospitals, ward sisters (on Grade G) had also been expected to take on greater management and administrative responsibilities. This decimation of midwifery management in recent years had undoubtedly led to a loss of leadership, support and confidence within the profession, and has added to the downward pressure on midwives' grading and promotion prospects.

Furthermore, for several years, NHS Trusts have had to deliver cost-cutting across all areas of service delivery, and maternity care has not been immune. Consequently, areas of maternity care which are not clinically essential (though still important to women, and to the overall quality of care received) have been cut. A good example of this is postnatal care, where the Audit Committee and this survey found clear evidence of substandard care. Reducing staff costs associated with postnatal care - by reducing the care available to women both in hospital and in the community - may not risk lives or litigation, but it does have a significant impact on women's comfort and confidence, on breast-feeding rates and on the transition to parenthood. It also contributes to the decline in job satisfaction and morale that is evident among midwives.

7.3.2. Relations with management

Individual ability to cope with change is strongly influenced by how well that change is managed. If those affected feel uninformed about the change process, or powerless to influence it, they are more likely to become stressed or to react negatively. This is a management responsibility. Unfortunately, the midwives surveyed reported that in many cases the quality of communication and overall relationships with management fell short of that necessary for the development of trusting, co-operative relationships.

Given recent history in the maternity services - with downgrading, low pay, a stressful change process, and the decimation of midwifery career paths - it is perhaps not surprising that many midwives feel somewhat disenchanted with their employers. Nevertheless, it is disquieting that 48% of midwives said they trusted management to look after their best interests ‘only a little’ or ‘not at all’. Only 10% trusted management ‘a lot’. The reasons midwives gave for trusting (or not) management to look after their interests are explored in Table 9. It is significant that a large proportion of those midwives who *did* trust management, said that they only trusted their line manager (who was more likely to be a midwife), not those in higher management.

The advantages to management of looking after their midwives were clearly articulated by several of our respondents:

‘Management look after staff because they need to in order to get the best out of people; it behoves them to be honest and trustworthy themselves; they can’t afford to be too devious’.

‘It is in their [management’s] interest to look after our interests in order to keep staff and maintain morale, but I think more could be done’.

‘At the end of the day, I feel that if management have an interest in staff, they’ll reap rewards because of what the staff gives back’.

However, the midwives perceived little evidence that managers generally understood this logic or made any systematic effort to build trust.

The most popular reason given for not trusting management was that managers were only concerned with their own interests or with those of the Trust. Other ‘non-trusters’ cited negative experiences with disciplinary and grievance procedures and with rules which were regarded as petty and patronising. One-third (36%) of the midwives

felt that they had been let down by management, and 38% said that management had made little or no effort to maintain employment and to ensure the health and safety of their midwives (Table 10). Furthermore, more than half the midwives felt that Trust management made little or no effort to look after midwives' welfare, to encourage employee commitment or to keep staff informed about change; and two-thirds felt that management made little or no effort to develop family-friendly practices.

The result of this was that when we asked the midwives to think of things which might make them *unwilling* to make special efforts for their employers, two-thirds of the respondents suggested unsupportive managerial styles and attitudes. The problems individuals had with management included managers' lack of appreciation, lack of availability, exploitation of their goodwill, subjecting them to excess pressure and demands, nit-picking and unfairness. All these made midwives unwilling to make special efforts. Conversely, when midwives were asked what made them *willing* to make special efforts, 30% returned to the question of managerial style by emphasising the importance of reciprocity, respect, loyalty and appreciation.

Nevertheless, for most midwives (70%) the primary motivation for making special efforts derived from the needs of the women in their care. A third of these insisted that it was their clients' needs, rather than their employers', that motivated them. In a similar vein, around a quarter of midwives (23%) said that it was their colleagues or their own satisfaction and professional pride that made them make special efforts. Financial reward was cited as important by only 14%.

7.4. Communications

It is generally recognised that good communication is a crucial ingredient in creating the environment for high quality work. Nevertheless, only 23% of the midwives felt well informed about matters which might affect their futures, while one-third thought they were kept 'little' or 'very little' informed of such matters. To explore

in more detail how well midwives felt informed about their futures with the Trust, we asked them to express the strength of their agreement or disagreement[5] with a series of statements relating to communications within their Trust. In response to the statement, '*people feel frustrated because decisions are so often made over their heads'*, 60% agreed (17% strongly) and only 6% disagreed. Responding to the statements, '*the Trust's future direction is clearly communicated*', '*the Trust is quick to tell people about changes taking place'* and '*the Trust explains why changes have to be made',* 50% were neutral (neither agreeing nor disagreeing) and twice as many disagreed as agreed.

The quality of communication varies widely between midwives and other professionals and between midwives and the different levels of management (Table 11). Around three quarters of midwives (74%) rate communication as 'good' or 'very good' with doctors; with line managers, this proportion falls to 64%; and with Trust managers it was as low as 35%. Communication with Trust managers was considered as either 'poor' or 'very poor' by 27% of midwives. Nevertheless, 24% thought that communication was improving, compared with only 6% who thought it was deteriorating.

8. Trade Union Organisation, Representation and Involvement

Notwithstanding the variable quality of their relations with management, midwives are well represented in the determination of pay and conditions and have extensive involvement with management in work organisation. Maternity units have high levels of union density and union membership is overwhelmingly with the Royal College of Midwives (RCM). The RCM had 100% membership in 13% of the maternity units surveyed by post, and between 80% and 99% membership in a further 76%. The RCM is generally recognised for negotiating terms and conditions, and represents its members in disciplinary and grievance procedures and in procedures relating to health and safety and redundancies. The union is less involved with training and pensions, mainly because a sizeable minority of Trusts

(21% for training and 11% for pensions) have no procedures for dealing with these matters.

Joint consultation and involvement were widely practised amongst the maternity units surveyed by post. Workplace Joint Consultation Committees, Higher Level Joint Consultation Committees and Staff Forums existed in 79%, 67% and 76% respectively of the units. In addition, 23 units reported the existence of alternative forms of consultation. Moreover, the RCM is an active participant in consultation processes, with 117 out of 119 units reporting that the trade union had seats on their consultative committees.

In the maternity units visited, almost all midwives were in the RCM and the union was recognised for the purposes of negotiating terms and conditions and for representation in disputes and disciplinary procedures. Trade unions were heavily involved in procedures relating to health and safety, as well as redundancies and pensions, with only one unit not having a procedure for dealing with the latter two issues. On the issue of training, four heads of midwifery reported that their unit had a procedure involving trade unions, whilst two said they did not know whether the Trust had a procedure or not.

Workplace Joint Consultation Committees existed in all the units visited, Staff Forums in four units and Higher Level Joint Consultation Committees in two units (two other heads of midwifery said they did not know whether Higher Level Joint Consultation Committees existed in their Trusts). Trade unions were active participants in these consultation processes, with all heads of midwifery reporting that unions had seats on their consultative committees. In addition, all the case study units reported having alternative forms of consultation: all had regular newsletters, regular team meetings were held in five, and the sixth unit has regular unit and ward meetings. Four of the units had either quality circles or self-managing teams, whilst two of the larger units operate suggestion schemes. Other forms of consultation included regular meetings with union representatives, open directorate meetings and an audit group.

In two of the units, joint working parties had been set up to discuss policy (on the provision of continuity of care in one unit and, in the other, a grading structure and remuneration package designed to reward skill and responsibility).

All the heads of midwifery, in the units visited, reported that relations with trade unions had improved over the last five years. When asked about the value of the formal systems, half of them said that they were important in order to achieve agreement for changes in midwives' working conditions. One stated that it was important to communicate with unions; and one saw these forums as an important channel for information from management to staff and vice versa, as well as a means for keeping staff up to date with the latest developments in national policy and best practice. Similarly, two heads of midwifery viewed alternative forms of consultation as important ways to get policies agreed by consensus, or to help midwives feel they were participating in decision making; two viewed them as a means by which midwives could 'let off steam'. On the other hand, two heads of midwifery reported that the turn-out (in particular for team briefings) was often low owing to pressure of work.

The majority of midwives (58%) felt that disciplinary procedures were fair, 18% considered then unfair and 24% did not know. Of the midwives surveyed, 40% said that increased participation gave them a greater sense of involvement and empowerment (a sense that their views carried weight, that they had more influence, that they could get things done and bring about change). Participation, it was suggested, increased their knowledge of the Trusts' activities and policies and facilitated mutual problem-solving. An important contribution to this was the networking made possible by increased participation, with 20% of midwives suggesting that better contacts (within the teams, between midwives and managers, with other departments and with Trust managers) were important benefits from involvement programmes. Some midwives derived greater satisfaction, motivation and autonomy from being more involved in decision-making. However, other midwives were less engaged and/or were more

negative about involvement programmes: 15% of the midwives said that such programmes did not involve them and a further 10% thought that the joint committees were ‘talking shops’ dominated by managers, or that they did not work effectively because of organisational problems.

The success of involvement/participation programmes clearly depends on how they are organised and the status of the individuals involved, as the following observations by midwives suggest.

‘The unit meetings are very good and you get a good cross section coming. Everything is treated on a confidential basis and you can say what you feel. All grades attend. They are important because they enable things to get done and for the management to be aware of how things are perceived. They also provide an opportunity for managers to make policies clear. And they also provide support for staff.’

‘The Peer Review works because we trust each other in the group. It’s a very open forum, for example we discuss errors, traumatic deliveries. It’s done in a non-threatening way. It’s cathartic to come in and talk through with people you trust. If there’s no trust, you can’t do it.

‘It’s great. On that team, we are all equal and all get a say: managers, midwives, members of the public will say what they want to say.’

But others commented:

‘Ideas are discussed, but not listened to. Management have a hidden agenda. Decisions have already been made’.

‘They are supposed to encourage staff to be involved in decision making. However, I still feel cut off from that process; they ask for staff opinions but don’t listen to them’.

'I'm supposed to be involved in the standards committee but the meetings are often cancelled because staff are short or busy.'

The quality of the organisation and form of representation are clearly important factors influencing the perception of midwives of the benefits of involvement schemes.

The reasons midwives gave for being members of the RCM (summarised in Table 12) also provide important indicators of their needs. More than 90% cited legal services and professional indemnity insurance, reflecting the risk of autonomous professional practice in an increasingly litigious healthcare system. Midwives' professionalism and commitment to practice development is reflected in the fact that 50% of members identified the RCM as serving the professional interests of midwives, and 40% said they were members because of the information and advice provided. In addition, the high proportion of midwives who gave support, security and protection (34%), collective representation (33%), and independent representation (27%) as reasons for belonging to the RCM is a strong indicator of midwives' perceived need for effective independent representation. The reinforcement of this need by recent developments is underlined by the fact that three-quarters of the midwives believed it was more important to belong to a trade union than it had been five years before, while only two midwives said that trade union membership had become less important.

9. Satisfaction, Motivation and Morale

Thus far this report has considered how recent policy changes, which restructured the NHS and the maternity services within it, have affected midwives' terms and conditions and their working environment. Its findings reveal that maternity services have been required to deliver high quality care in resource-constrained circumstances. This has led to an increase in the duration and intensity of midwives work. Over the last few years, midwives have experienced low pay increases, a move towards localised terms and

conditions, and service restructuring. Although midwives have generally welcomed the potential for increased autonomy and status associated with woman-centred care, overall they are distrustful of management and especially of Trust managers. Greater involvement in decision-making over the provision of care was welcomed, if only because it helped overcome communication and other problems midwives had with management. Against this background, this section explores midwives' job satisfaction and morale.

9.1. Satisfaction with pay

The research revealed widespread dissatisfaction with the system of pay determination, and especially with pay itself. When asked how fair the system of pay determination was, 4% of the midwives said very fair, 29% said fair, 30% said only quite fair and 35% said it was unfair. Moreover, only 5% thought pay determination had become fairer since they joined the Trust, compared with the 28% who thought it had become less fair.

Most midwives (70%) thought that their pay was less than they deserved, and for 18% it was much less. The explanation for this widespread dissatisfaction was the perception that their pay had fallen behind that of comparable professions, especially those outside the NHS, and that it had failed to keep up with the cost of living and with their needs. But the most frequently cited reason for pay discontent was the failure of the pay structure to compensate midwives sufficiently for their levels of responsibility, commitment, skill, knowledge and experience. Table 13 shows the extent to which midwives felt that the pay system had failed to reward them for these crucial elements of their work. Over two-thirds of midwives said that the pay structure did not reward their level of training, their commitment to woman-centred care, or their role as autonomous practitioners. Three-quarters of them felt that they received little or no reward for their accountability and additional responsibility. The percentage of midwives who see the pay structure as 'highly' rewarding reaches a maximum of 10% for the level of training and

skill required, and no one thought any of the elements of midwives' work listed in Table 13 were rewarded 'very highly' by the pay structure.

Generally, the heads of midwifery surveyed by post held more positive views of the pay structure. Around 30% thought that the wage structure rewarded midwives highly or very highly for their level of training and skill (30%), for their role as an autonomous practitioners (31%), and for their accountability (33%). However, more of them (39%, 43% and 42% respectively) thought that these aspects of work were rewarded little or not at all. Fewer heads of midwifery thought that the wage structure rewarded highly midwives' additional responsibilities (27%) and commitment to the implementation of women-centred care (22%); more (49% and 50% respectively) thought that they were rewarded little or not at all.

9.2. Job satisfaction

In spite of their dissatisfaction with levels of pay, the midwives we interviewed were generally highly satisfied with their work (Table 14). Midwives also expressed satisfaction with their freedom to use their initiative, with 69% either satisfied or completely satisfied. Around 60% were, to some degree, satisfied with their job security, their relations with line managers and the hours they worked, although 27% were dissatisfied with their working hours. Only 40% of the midwives surveyed were satisfied with their promotion prospects and, unsurprisingly, only 27% said they were satisfied with their pay. Indeed, most midwives were either dissatisfied (39%) or very dissatisfied (16%) with their pay.

The research team compared these satisfaction ratings with the general findings of the annual British Household Panel Survey (BHPS). As shown in Table 15, satisfaction ratings amongst the midwives were significantly lower than those of the women interviewed for the BHPS. This is particularly true with respect to the question on 'satisfaction with pay'; to which only 27% of the

midwives gave a positive response compared to 66% of the women interviewed in the 1995 BHPS survey.[6] Nonetheless, when we asked midwives to describe their satisfaction with 'the work itself', we found little difference between our respondents and other women in the British labour market. In both cases, there was an extremely positive response to this question. In addition to the general indicators of job satisfaction, we also asked the midwives to agree or disagree with the following statement: '*Generally speaking, I am very satisfied with my job'*. The results showed that 70% agreed with this statement, 22% said they neither agreed nor disagreed and just 7% said they disagreed.

9.3. Motivation and morale

The discrepancy between midwives' satisfaction with pay, and their satisfaction with the 'work itself', was mirrored by the contrast between their morale and their motivation. When asked to describe their morale (and that of their colleagues) the results were far from encouraging. Only 35% of the midwives reported that their own morale was good or very good, a proportion which fell to 18% when we asked the respondents to comment on morale in their midwifery unit (Table 16). Morale was poor or very poor for 21% of the midwives, and 46% of them thought that morale in their maternity units was poor or very poor. Moreover, 46% thought that morale was deteriorating, compared to 17% who thought it was improving.

Nonetheless, when we asked our respondents to describe their motivation levels, 47% said they were 'very motivated', 29% said they were 'motivated' and 23% said they were 'quite motivated'. Indeed, of the 79 midwives who responded to the question on motivation, only one respondent supplied us with a negative description of her level of motivation (Table 17).

We investigated further to find out whether there were particular factors that influence levels of midwives' morale and motivation. In particular, we examined whether midwives' morale and motivation

were affected by the type of maternity unit in which they work or by the models of care which they provide. We found that motivation levels amongst midwives were uniformly high regardless of the type of unit they worked in or the mode of care provided. In contrast, levels of morale did vary between units. There was, however, no general correlation between levels of morale and category of unit, with the exception that morale was uniformly low in large teaching hospitals where the turnover of staff is high.[7] Similarly, there is no clear relationship between morale and the mode of care provided by midwives – although significantly, morale appeared to be highest amongst midwives who were employed in the one unit which had *not* made significant progress towards introducing woman-centred care and therefore had not undergone significant restructuring in recent years. One factor which does appear to influence levels of morale amongst midwives, however, is the level of staffing. Amongst midwives who perceived staffing levels as 'inadequate', 64% described the morale within their unit as poor; this was true of only 17% of midwives who described staffing levels as 'adequate'.

The simplest explanation for the paradoxical coexistence of low pay satisfaction with high 'work' satisfaction, and of low morale with high motivation, is that midwifery is not just a job: it is a vocation. In other words, midwives feel called to perform to the best of their abilities, regardless of poor morale and/or deep dissatisfaction with pay and conditions. This explanation was strongly supported by the statements of the midwives themselves, when we asked them what made them make special efforts. Overwhelmingly, they replied that their primary sense of obligation was to their clients, i.e. women and babies. It remains an open question, however, as to how long the NHS can continue to rely on midwives voluntarily making special efforts in the face of low morale and deep dissatisfaction with pay and conditions. This leads us back to the important question of the relationship between the terms and conditions of employment of midwives and the quality of their performance.

10. The Impact of Terms and Conditions on the Quality of Care

There was strong consensus between the heads of midwifery and their staff that midwives have responded positively to the drive to improve quality of care, and that this vocational commitment has helped overcome the obstacles to improved care posed by the resource constraints under which the reforms laboured. The survey also supports the view that many midwives benefited from the opportunity to acquire extra skills and responsibilities, and to operate more fully as autonomous practitioners.

It is clear, nonetheless, that the pay and conditions associated with midwifery, as well as the under-staffing and extra stress that result from them, have a marked impact on midwives' quality of working life. One-third of the respondents reported that working conditions had deteriorated as a result of the introduction of woman-centred care, compared with the 30% who thought that their working conditions had improved. More than a quarter (27%) of midwives felt that unreasonable demands were sometimes made of them by management, and 40% thought management were unreasonable about the hours they were expected to work. The costs to midwives included more intensive work, less favourable hours and more psychological pressure (as reported by 25%, 22% and 19% of midwives respectively). Others reported more disruptions to their family and social lives and more physical risk, in particular through increased community visiting.

The findings of this research also reveal that midwives' description of the impact of woman-centred care initiatives on their working conditions is strongly correlated with the number of extra-contractual hours they work, and with their perception of the adequacy of staffing levels. Amongst midwives who work less than five hours of overtime per week, 52% think the introduction of women-centred care has led to an improvement in their working conditions. By contrast, this is true of only 20% of those who work more than five hours of overtime per week. Likewise, amongst midwives who perceive the staffing

levels in their unit to be adequate, 67% suggest that woman-centred care has improved their working conditions, whereas this is true of only 15% of those midwives who perceive staffing levels as inadequate.

But even more importantly, this research makes clear that midwives' pay and conditions affect the quality of care provided to women and babies. The Government's own indicators of quality in maternity care - the *Changing Childbirth* indicators - have been only patchily realised. This is in itself not surprising, given that an ambitious programme of reform was demanded within existing resource constraints. However, closer examination of the indicators reveals that those which have been achieved least often were those with the most significant staffing and resource implications - continuity of carer and midwife-led care. Even the most dedicated midwife cannot overcome staffing shortages and structural deficiencies through individual effort of will.

The importance of these difficulties should not be under-estimated. The Audit Commission found that two-thirds (68%) of women said they were left without professional support at some time during labour, and one in four of these (24%) said that this happened at a time when it worried them to be alone. Similarly, while more than two thirds of women (71%) said it was important to them to have previously met the community midwives who provided their postnatal care, only one in three (32%) of them had done so. Many women were concerned about staff shortages, and a number cited low morale as having been evident among the staff providing their care. The reform of maternity services set out in *Changing Childbirth* has achieved a remarkable degree of consensus from service providers and users alike; it remains Government policy. The most significant obstacle to its realisation lies in staffing and resource issues, and how these affect both the organisation of maternity care and the working lives of those who provide it.

Our research found that the *location* of maternity care was associated with significant differences in the achievement of *Changing Childbirth* targets. Within a primary care-led NHS, it makes sense to provide mainstream maternity services in community settings, close to the communities which they serve. *Changing Childbirth's* policy of improving the choices available to women over the care they receive also implied a development of community-based alternatives to hospital care. And, according to the Audit Commission, women themselves prefer maternity services that are provided in the community. Indeed, our research found that maternity units with a high proportion of midwives working in the community were more successful in achieving *Changing Childbirth* targets. Yet shifting maternity care into community settings carries cost implications (not least because community midwives are on a higher clinical grading than hospital-based midwives) and so maternity services continue to be primarily hospital-based.

Midwives' pay and conditions affect the quality of care they can provide both directly and indirectly. Midwives are working harder and for longer hours; the pressure of work means they have less time available for those areas of work which are less essential from a strictly medical viewpoint, but which are nonetheless clinically significant - for example, postnatal care, which already enjoys less resource allocation and less consumer satisfaction, but which is an easy target for cuts. It also seriously limits their ability to provide extra support to those women who need it, for example very young women and women who are isolated or unsupported in the community. Indirectly, the quality of care midwives provide is worsened by the growing recruitment and retention crisis in midwifery - resulting from a combination of work intensification, inappropriate grading, inadequate support for training, lack of promotion prospects, and low pay. The evidence from our survey suggests that midwives do everything possible to absorb these difficulties, in order to continue providing high quality care to women and babies; however, their ability to continue doing so should not be taken for granted.

Moreover, many of the midwives felt that they were paying a heavy price for filling the gap between demands and resources, contributions which had a direct affect on their performance by undermining their physical and psychological capabilities. Fully half of the midwives felt that working longer hours was having a detrimental effect on the quality of their work. The intensification of work also adds to its risks. There are significant dangers of back and other injuries associated with midwifery and over half the midwives we interviewed (53%) expressed the view that this danger had increased over the previous five years, compared with fewer than 10% who thought it had not. Midwifery is also a stressful occupation. Almost half (48%) of the midwives were coping well or very well with the stress of their job and a further 46% said they were coping fairly well. Nevertheless, almost half the sample suffered with symptoms of stress from their working environment and for more than half of these, their stress symptoms had become worse over the past five years. 38% had taken time off work as a result of stress at work.

It is possible to measure individual psychological well-being and how it is influenced by working conditions by using the 'General Health Questionnaire' (GHQ). This is widely used in organisational psychology to detect harmful levels of stress. It is a good predictor, not only of a wide range of physical illnesses, but also of rates of premature mortality.

The GHQ scores constructed for the midwives in our survey provide evidence of lower levels of midwives' psychological health associated with important determinants of worsening work conditions: increasing work pressure and inadequacies of staffing. This is shown in Figures 1 to 3, which relate mean GHQ scores to, respectively, pressure from managers and supervisors, pressure from the sheer quantity of work, and staffing shortages. A clear relationship is established between generators of stress and lower psychological health. This, combined with the evidence from midwives that they have taken time off because of stress, strongly suggests a direct relationship between deteriorating working conditions and performance.

The stress induced by high pressure work environments can damage care because it reduces the **coverage** provided by midwifery units (as more midwives are forced to take time off work or leave the profession altogether). But the results from our survey also show that midwives clearly feel that the greater the pressures they have to contend with, the harder it becomes for them to maintain the **quality** of care which they provide. For example, when we asked them whether or not working longer hours affected the quality of their care, more than 60% of those who said they experienced 'a great deal' or 'quite a bit' of pressure from 'the sheer quantity of work' said, '*Yes, working longer hours does affect the quality of my work'*. By contrast, this was true of only 39% of those who were experiencing less pressure from the sheer quantity of work (Figure 4). Likewise, midwives who said that staffing levels were inadequate were much more likely to perceive a negative relationship between long hours and quality of care than those who felt that the staffing levels were adequate (Figure 5). In short, the midwives we spoke to all displayed an extraordinary level of commitment to the women in their care but those who suffered the most pressures - in terms of inadequate staffing and stressful work environments - had been forced to recognise that the quality of their care was not always immune to such pressures.

Midwives' low levels of satisfaction with many aspects of their work, their low morale and their negative attitudes to management are clear signs that they feel that their employers have broken the **psychological contract** with them. The notion of the psychological contract captures the *implicit* commitments made between people and their employers. It draws out the kinds of informal dynamics which employers may affect as they change the organisation and the terms and condition of work. An important role of the psychological contract is that of helping to secure co-operation at work. The operation of this contract may be demonstrated by individuals staying with their organisation when there are opportunities elsewhere, and by their willingness to be adaptable to changing performance

requirements. In return for their loyalty, hard work, co-operation and commitment, the employee expects to be 'looked after' through the course of their employment. In other words, the employee expects the employers to fulfill their side of the 'bargain'. But where these expectations are not met, the results may be a withdrawal of co-operation, negative work attitudes and an increase in labour turnover.[8] On the other hand, midwives' high motivation and continued commitment to the women and babies in their care is clear evidence that they are absorbing rather than passing on to their clients, the negative consequences of breaching the psychological contract.

Although the quality of maternity care may be protected in the short term from the adverse effects of its cost cutting and industrial relations strategy by midwives' vocational commitment, this cannot be guaranteed for the longer term. It is getting increasingly difficult to recruit and retain midwives as the decline in their terms of employment becomes intolerable and the service's declining reputation makes it increasingly unattractive to new recruits. We asked the midwives whether if anyone in their maternity unit had left because of something they could not tolerate. We followed this up by asking whether if something had been so intolerable that they themselves had been tempted to leave. Two-thirds of the respondents knew of fellow midwives who had quit in these circumstances and around one-third had contemplated leaving because of something they could not tolerate. In both cases, half gave reasons associated with workplace conditions and pressure. One respondent said one of her colleagues had quit because:

She could not stand not being listened to, not cared for, the care wasn't good because the workload was too high.

Reporting more generally on quits from a unit which had gone a long way towards meeting the requirement of woman-centred care, one respondent said:

It is usually a combination of things, for example, style of practice and they get so tired they leave.

The reasons individuals themselves found their working conditions intolerable also reflected these pressures:

Hours. You are expected to work, including night work, sometimes up to 22 hours. Providing continuous care is not always safe. Women have high expectations of delivery of service irrespective of the time.

Stress caused by the lack of staff and the fact that my grading was discussed but not solved.

Inflexibility of work, causing difficulty with childcare. Can't afford full-time child care, and childminders don't let you use them different days each week. Shifts totally unpredictable.

In short, midwives are subject to mutually contradictory pressures: the demand for higher quality of care and the need to cut costs. The resource deficit is made up in part by drawing on the vocational commitment of midwives. The damage this causes to the midwives' psychological and physical health, and the ill-will it engenders, inevitably affect the quality of care - a damage compounded in the longer period by the loss of experienced midwives and the difficulties in replacing them.

These are the problems that midwives and heads of midwifery live with daily, so perhaps they should have the last word. We asked them what could be done to prevent the NHS from losing its midwives. Their responses are summarised in Table 18, and they reveal a large measure of agreement about what needs to be done. The most popular solution, attracting half the midwives and even more heads of midwifery, was an improvement in pay. But pay is by no means the only problem. Improved working conditions were suggested by 21% of midwives and 14% of heads of midwifery. In addition, many heads of midwifery put special emphasis on the need to enrich midwives'

jobs and improve their status (47%) and the need to provide better training, career development and promotion prospects (27%) - measures which were recommended by fewer midwives (20% and 12% respectively). On the other hand, more midwives than heads of midwifery (36% compared with 23%) thought that improved management and organisation would help retain midwives in the NHS. A high proportion of both midwives and heads of midwifery (30% or more) recommended increased staffing or, more generally, better funding and more resources. Family-friendly policies and more flexible hours to accommodate domestic demands and social needs were proposed by around a quarter of midwives (23%) and rather more (30%) heads of midwifery.

11. Conclusions

Over recent years, the policy agenda in maternity services has been the subject of substantial review and reform. The resulting Government policy - for woman-centred care - has been implemented patchily, restricted by costcutting and competing priorities. It has also been contested, despite its popularity with women and with midwives, by intransigent professional territories, service structures and workplace cultures. So, despite the emphasis on community-based care, maternity services remain primarily hospital-based. Despite the emphasis on midwife-led care, midwifery management and midwives' career pathways have been decimated. And, despite the emphasis on reducing unnecessary medical intervention in childbirth, resources continue to be diverted away from postnatal care and one-to-one care in labour in order to finance the rising caesarean rate and new obstetric technologies. In short, the maternity services are caught in policy and cultural cross-currents. The implications of this are now coming to the fore, with the outcomes producing paradoxes which pose important challenges for the future of the service. The first of these centres on the degree to which expanding the range of options and choices for women and their families, and improving the quality of service, are compatible with finite resources and the constant requirements of cost cutting (Audit Commission, 1997). The second

dilemma is whether providing greater autonomy for midwives, through the establishment of self-managing teams responsible for their own caseloads, is compatible with management styles and structures within NHS Trusts.

Whilst policy-makers have consistently recognised that the success of woman-centred services depends on the provision of adequate resources as well as on improvements in midwives' working conditions (House of Commons, Cm 3832, 1988; Department of Health, 1993), limited action has been taken on either front. Progress towards the introduction of woman-centred care in maternity units has been varied, both in terms of the different systems of work organisation used, and of the success of the units in meeting national performance targets. Progress has been slowest in those aspects of the service relating directly to the provision of continuity of care. These include continuity of care by a known midwife, women knowing the lead professional responsible for planning and providing care and, in particular, the targets requiring that 30% of women have a midwife as the lead professional and that 75% of women know the midwife who cares for them during their delivery. As a result, it is clear that, to date, the central objectives underpinning *Changing Childbirth*, i.e. improved quality of service and choice for women, have not been achieved. The underlying problem is the lack of resources available to meet the inevitably higher costs involved in providing woman-centred services.

The research reveals that moves towards woman-centred care have been largely welcomed by midwives. Midwives are whole-heartedly committed to the provision of improved care, and fully recognise that woman-centred policies can help to achieve this. They also recognise the potential improvement to their own jobs arising from models of care which resist unnecessary medicalisation of pregnancy and birth. However, midwives see themselves as having been called upon to bear considerably increased responsibility and autonomy without adequate recompense, in both pecuniary and non-pecuniary terms. They consider that the existing pay and grading structure offers little

or no reward for the level of training they require, their role as autonomous practitioners, their level of accountability, and their additional responsibilities and commitment to the implementation of woman-centred care - a view which is shared by a substantial proportion of their managers. Although measures such as the EL(95)77 letter have recognised that midwives' increased autonomy and responsibility (as called for in *Changing Childbirth*) need to be rewarded, Trusts have displayed a widespread failure to comply with this guidance.

In addition, a substantial proportion of midwives have suffered deteriorating working conditions. Over recent years, midwives' responsibilities, levels of skill, task variety, effort and autonomy have all expanded, whilst their work has intensified, particularly in those units where a high proportion of midwives work in the community. Midwives have been called upon to work longer hours that intrude into their family and social time. This is the result not only of the introduction of 'woman-centred care', but also of inadequate staffing. Indeed, our research reveals that the greater the number of extra-contractual hours worked, and the more they perceive staffing to be inadequate, the greater is the tendency for midwives to feel that woman-centred care has had an adverse impact on their working conditions.

Paradoxically, while midwives are highly dissatisfied with pay and other aspects of their jobs (much more so than women workers generally) they are highly satisfied with 'the work itself'. Likewise, although midwives suffer from low levels of morale, they still display high levels of motivation and retain a strong commitment to providing the best possible care for 'their' women and babies. As noted earlier, the simplest explanation for the coexistence of low pay satisfaction with high 'work' satisfaction, and of low morale with high motivation, is that midwifery is not just a job. It is a vocation. Hence, introducing improved levels of service whilst constraining resources can be seen as taking in the *vocational slack,* a process by which the additional resource cost is substantially borne by midwives without a

commensurate adverse effect on the quality of their service.

But this can only be a short-term expedient. The widespread feeling amongst midwives is that excessive hours and more intensive work are causing stress and having detrimental effects on both the quality of their work, and on their families. Significantly, midwives are leaving the service in ever greater numbers, whilst new recruits are proving more difficult to attract and retain.

The other major dilemma facing maternity services stems from systems of management. Whilst recent policy changes have stressed the importance of (a) increasing the autonomy and responsibility of midwives, (b) encouraging self-management through team midwifery, and (c) creating midwives' own caseloads, the widespread dissatisfaction midwives have with management suggest that it is incapable of delivering the co-operative and high trust relationships necessary to make the new forms of work organisation a success.

The effects of this dissatisfaction are, to an important degree, ameliorated by trade union representation and by joint consultation. The importance of joint consultation in the day-to-day running and management of change is widely recognised by both midwives and heads of midwifery. The benefits of increased participation for midwives are the greater sense of involvement and empowerment it gives them. Its role in improving communication and providing an opportunity to share information and knowledge is also recognised. Importantly, midwives perceive trade union and individual involvement as helpful in overcoming the shortcomings of management, but have negative attitudes to participation when the participatory institutions have no effective power, are dominated by management, and fail to generate the trust relations which midwives see as important.

In conclusion, it is clear that, to date, both the Government and NHS management have expected maternity units to achieve significant improvements in the quality and continuity of care for women in the

context of severely constrained resources. Significant advances have been made, but these have been achieved by drawing upon the professionalism and vocational commitment of midwives, and at the expense of their working conditions and sense of well-being. While this approach has, in the short term, served the purpose of increasing midwifery output within existing resource constraints, the damage it inflicts on midwives' psychological and physical health and domestic and social well-being, and the increasing problems of recruitment and retention and falling morale within the profession, suggest that it is not sustainable. In the longer term, if the improvements in care achieved thus far are to be maintained, the Government and NHS management need to revisit and reform midwives' working conditions and working environment. This is not to imply that the answer to the on-going dilemmas facing maternity services lies solely in improvements in midwives' pay levels or pay structure - although these would make a significant difference. The solution is also dependent on the ability of NHS Trusts to give effect to *Changing Childbirth's* promise of enhanced status and autonomy for midwives. Furthermore, strong representation of midwives alongside improvements in management structures and systems of communication in NHS Trusts are necessary, if midwives are to be enabled to participate in decision making and thereby contribute effectively to improvements in quality of care.

Notes

1. House of Commons Health Committee (1992) *Second Report – Maternity Services: Volume 1.* London: HMSO; RCOG, RCM, and RCGP (1992) *Maternity Care in the New NHS: A Joint Approach,* Report from the Presidents of the RCOG and RCM, and Chairman of RCGP, London; Government Response (1992) to the Second Report of the Health Committee: Maternity Services, Session 1991-92, Cmnd 2018, London: HMSO; Department of Health (1993a), *Changing Childbirth,* Report of the Expert Maternity Group, London: HMSO; and Audit Commission (1997) *First Class Delivery: Improving Maternity Services in England and Wales*. London: Audit Commission.

2. Department of Health (1993a) *Changing Childbirth,* Report of the Expert Maternity Group, London: HMSO; Scottish Office Home and Health Department (1993) *Provision of Maternity Services in Scotland: A Policy Review,* Edinburgh: HMSO; Welsh Office (1992) *Protocol for Investment in Health Gain: Maternal and Early Child Health.,* Cardiff: HMSO; a document – *Delivering Choice* (Department of Health and Social Services (1994) Belfast) that purports to be an equivalent to *Changing Childbirth* in fact conforms more closely to a more obstetric model of maternity care and is resistant to the more radical ideas associated with woman-centred care.

3. Audit Commission (1997) *First Class Delivery: Improving Maternity Services in England and Wales*. London: Audit Commission.

4. The sixth unit was in the process of launching a review of service delivery and working practices.

5. On a five-point scale: agree strongly, agree, neither agree or disagree, disagree and strongly disagree.

6. Six waves of the BHPS have now been released. At the time of writing, we only had access to the data drawn from waves 1-5 (which correspond to the years 1990 to 1995).

7. In the case of community units, morale was higher in one of the units, with 53% of midwives reporting morale as being satisfactory. This compared with only 19% of midwives in the second community unit reporting that morale was satisfactory, and a further 75% saying that it was poor. A similar pattern (or lack of one) emerged between the two general hospitals.

8. See Rosenblatt & Ruvio (1996).

Table 1. Percentage of units meeting indicators of quality of care most relevant to midwifery care

Targets	No attempt has been made	No change has been achieved	Measureable improvements towards targets	Target has been met	No. of units
Every woman should know one midwife who is responsible for continuity of maternity care	0	8	55	36	121
30% of women have the midwife as the named professional	9	15	45	31	117
Every woman should know the lead professional responsible for the planning and provision of care	3	7	51	40	119
75% of women should know the person who cares for them during their delivery	8	30	53	10	120
Midwives should have direct access to some beds in the maternity unit	5	9	25	62	117
All women should have access to information about the services available in their locality	0	4	40	56	120

Table 2. Change in job content over the previous five years (% of midwives).

Change in:	Increase	No change	Decrease	No. of midwives
Variety of tasks performed	87	9	4	76
Level of skill used in job	83	15	3	75
Responsibilities involved in job	75	23	3	75
Training provided	40	49	9	75

Table 3. Importance of ongoing training, keenness to acquire training and willingness of employer to provide training, (% of midwives)

Would you say that . . .	1	2	3	4	5	No. of midwives
Training is important to continue doing job well.	59	30	10	1	0	71
Training is important for my future career.	42	32	18	4	3	71
I am keen to acquire training.	37	31	27	4	1	71
My employer is willing to help me acquire training.	13	18	44	16	6	71

Key:
1 = very important, very keen or very willing
2 = important, keen or willing
3 = fairly important, fairly keen or fairly willing
4 = not very important, not very keen or not very willing
5 = not important at all, not keen at all or not willing at all

Table 4. Pressure to work (% of midwives)

Pressure from:	A great deal of pressure	Quite a bit of pressure	Some pressure	Very little pressure	No pressure	No. of midwives
Sheer quantity of work	9	37	43	8	4	79
Line managers	3	14	34	29	20	79
Work-mates or colleagues	4	6	32	41	18	79

Table 5. Determinants of how hard midwives work (% of midwives)

Determinants:	Very important	Important	Fairly important	Not very important	Not important at all	No. of midwives
Client or customer	69	29	0	0	0	72
Your own discretion	63	35	1	1	0	72
Feeling you are doing something useful	47	38	15	0	0	72
Your fellow midwives or colleagues	42	50	7	1	0	72
Having your achievements recognised	28	44	21	6	1	72
Supervisor or manager	10	36	31	21	3	72
Reports and appraisals	7	37	36	13	6	72
Pay incentives	11	19	43	15	7	72

Table 6. Effect of the introduction of localised terms and conditions (% of units)

Effects on:	Favourable or very favourable	Neither favourable nor unfavourable	Unfavourable	Don't know	No. of units
Productivity	27	59	2	12	41
Costs	29	52	14	5	42
Quality control	34	61	7	7	41
Quality of service to women	38	52	5	5	42
Quality of midwife training	34	57	4	5	42
Flexibility of work force	29	63	2	5	41
Response to changing demand	36	49	7	7	41

Table 7. Certainties of the future (% of midwives)

	Certain	Uncertain	No. of midwives
Certainty of:			
Future career picture	84	17	72
Use and value of skills in five years' time	71	29	71
Job security with the Trust	68	32	72
Responsibilities in six months' time	67	33	72
You will not be laid off in the future	60	40	71
Promotion & advancement in next few years	31	69	68

Table 8: Redundancy and downgrading as ways in which Trusts solve their problems

(% of midwives)		
	Redundancy	Downgrading
Never	28	18
Only under extreme circumstances	35	22
Only when it could save money	13	38
Routinely	1	10
Don't know	23	12
No. of midwives	79	77

Table 9. Reasons why midwives trust or do not trust managers to look after the best interests of midwives

	No. of Responses	% of midwives responding
Reasons for not trusting:		
They only look after their own interests	32	42
Management is not to be trusted	5	7
They do not support or protect	2	3
Negative personal experience	14	18
I look after my own interests	6	8
Reasons for trusting:		
Trust line managers but not those higher up	9	12
They look at our interest for strategic purposes	3	4
Positive personal experience	3	4
Managers are to be trusted	10	13
No. of midwives		76

Table 10. Efforts made by management (% of midwives)

Efforts to:	Every effort	Some effort	Little effort	No Effort	Don't know	No. of midwives
Maintain employment for its midwives	22	44	21	6	7	72
Ensure the health and safety of midwives	8	53	31	7	1	72
Look after the welfare of midwives	6	36	40	17	1	72
Encourage employee commitment to the trust	6	38	40	14	3	72
Keep midwives informed about plans for changes in the Trust	3	39	44	11	3	72
Develop family-friendly practices; e.g. crèche facilities, career breaks, job sharing	6	24	39	28	3	72

Figure 1. Mean GHQ scores by how much pressure midwives felt from managers or supervisors

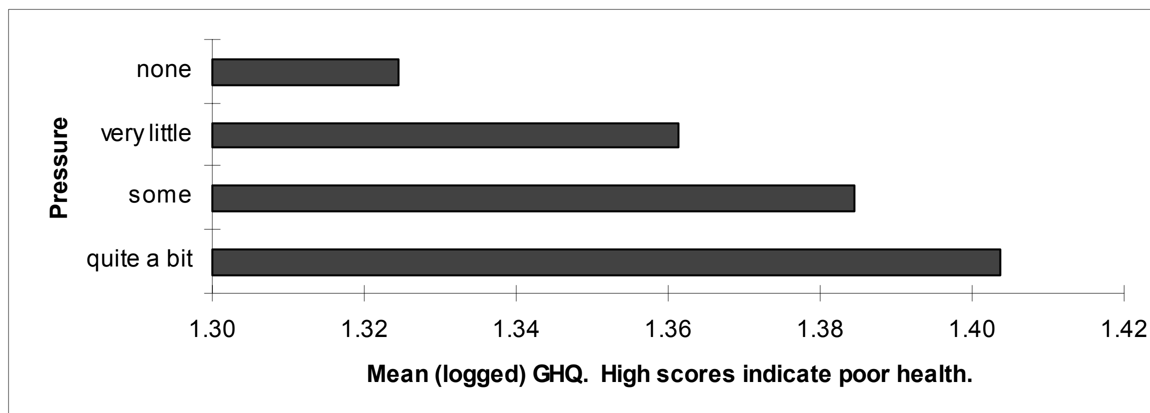


Figure 2. Mean GHQ scores by how much pressure midwives felt from the 'sheer quantity of work'

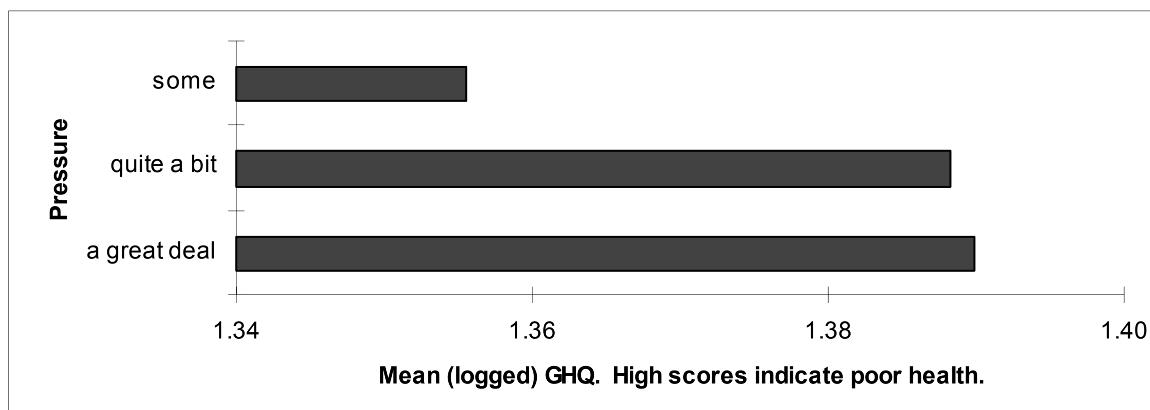


Figure 3. Mean GHQ scores by midwives' description of the adequacy of staffing levels

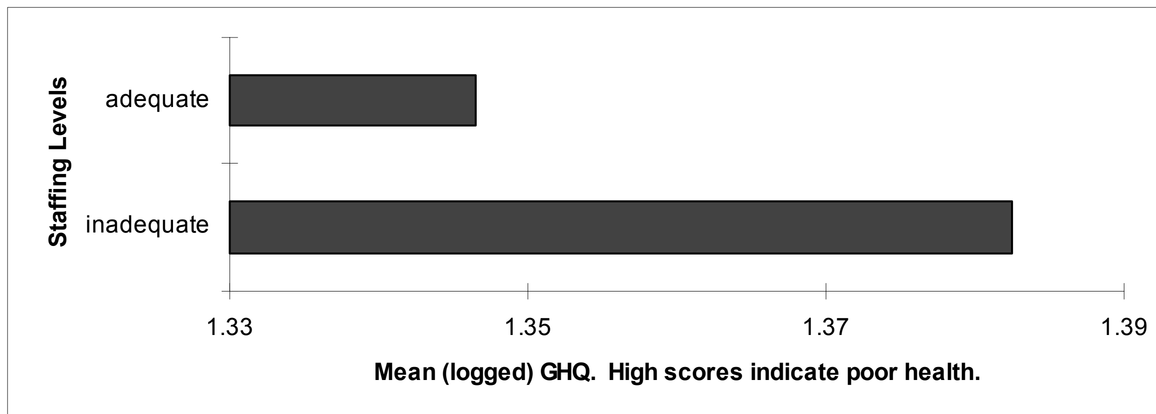


Figure 4. Percentage of midwives who said that working hours affected the quality of their care – according to how much pressure they felt from the sheer quantity of work

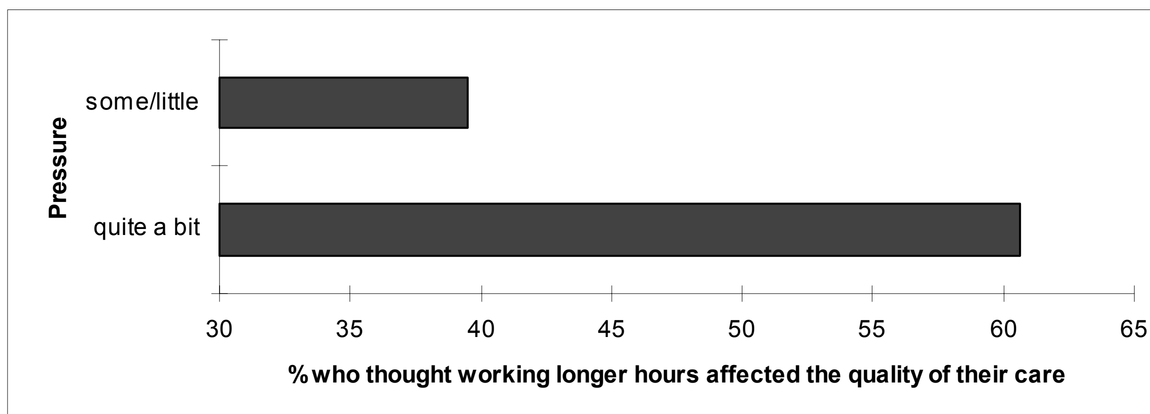
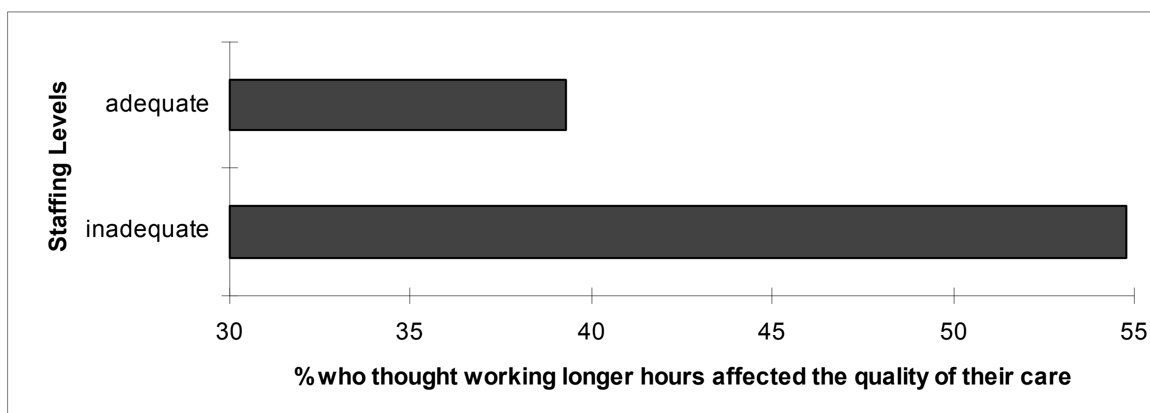


Figure 5. Percentage of midwives who said that working hours affected the quality of their care – according to their description of the adequacy of staffing in their work area.



Bibliography

Alaszewski, (1995) 'Restructuring health and welfare professions in the United Kingdom' in T. Johnson *et al.* (eds) *Health Profession and the State in Europe* London and New York:. Routledge.

Audit Commission (1997) *First Class Delivery: Improving Maternity Services in England and Wales*. London: Audit Commission.

Burchell, B, Day, D, Hudson, M, Ladipo, L, Mankelow R, Nolan, J, Reed, H, Wichert, I, Wilkinson, F. (1999) *Job Insecurity and Work Intensification:Flexibility and the Changing Boundaries of Work*. Report for the Joseph Rowntree Foundation (f*orthcoming).*

Department of Health (1982) *Patients First.* London: HMSO.

Department of Health (1989a) *The Children Act.* London: HMSO.

Department of Health (1989b) *A Strategy for Nursing.* London: HMSO.

Department of Health (1991) *The Patient's Charter.* London: HMSO.

Department of Health (1992) *The Health of the Nation.* London: HMSO.

Department of Health (1993a) *Changing Childbirth: The Report of the Expert Maternity Group.* London: HMSO.

Department of Health (1995) NHS Management Executive Letter EL(95)77. London: DOH.

Department of Health and Social Services (1994) *Delivering Choice* Belfast: DOH.

Government Response (1992) to the Second Report of the Health Committee: Maternity Services, Session 1991-92, Cmnd 2018, London: HMSO.

Harrison (1998) ‘The Workforce and the New Managerialism’, in R. Maxwell (ed.), *Reshaping the National Health Service*, Hermitage, Berks: Policy Journals.

House of Commons (1991-1992) *Health Committee, Second Report, Maternity Services.* Chairman: Winterton, N. London: HMSO.

House of Commons (1998) *Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine, Fifteenth Report on Nursing Staff, Midwives and Health Visitors 1998 (*cm 3832). London: HMSO.

Lorenz, Edward (1999) ‘Trust, contract and economic co-operation’,*Cambridge Journal of Economics,* volume 23, number 3 May 1999.

McHale, Hughes & Griffiths, (1997) Conceptualising Contractual Disputes in the National Health Service Internal Market’ in Deakin and Michie (ed.) *Contract, Co-operation, and Competition: Studies in Economics, Management and Law*. OUP.

Montgomery, (1997) ‘Control and Restraint in National Health Service Contracting’ in Deakin and Michie (ed.) *Contract, Co-operation, and Competition: Studies in Economics, Management and Law*. OUP: Oxford.

RCOG, RCM, and RCGP (1992) *Maternity Care in the New NHS: A Joint Approach,* Report from the Presidents of the RCOG and RCM, and Chairman of RCGP, London.

Rosenblatt & Ruvio (1996) 'A test of a multi-dimensional model of job insecurity: the care of Israeli Teachers' *Journal of Organisational Behaviour,* vol. 17, pp.587-605.

Royal College of Midwives (1998) *Evidence to the Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine for 1999*, RCM; London.

Scottish Office Home and Health Department (1993) *Provision of Maternity Services in Scotland: A Policy Review,* Edinburgh: HMSO.

Thornley, C (1998) 'Contesting Local Pay: The Decentralization of Collective Bargaining in the NHS' *British Journal of Industrial Relations* 36:3 September 1998, pp 413-434.

Welsh Office (1992) *Protocol for Investment in Health Gain: Maternal and Early Child Health,* Cardiff: HMSO.

Walton and Hamilton (1995) *Midwives and Changing Childbirth*. London: Books for Midwives Press.

Executive summary

The research project

- The aim of the research was to examine the effects of midwives' terms and conditions of employment on the quality of maternity care.

- The research project involved a postal survey of all maternity units in Britain (with a response rate of 50%) and detailed case studies of six maternity units, where midwives and heads of midwifery were interviewed.

Quality of care and the organisation of caring

- Recent reforms in the maternity services have aimed to provide woman-centred care; that is, care which is more responsive to women's needs and choices, which is guided by informed user involvement, and which provides continuity of care from a small number of known professionals.

- The research revealed that the successful implementation of the programme of reform requires:

    - additional staffing
    - investment in the professional upgrading and training of midwives
    - a revision of midwives' pay and grading to reflect their greater responsibilities and contribution.

- Although these preconditions have been officially recognised, the Government and Health Authorities have failed to make available adequate funding.

- Consequently, reforms have been implemented in a piecemeal fashion.

- Notable advancements have been made by Trusts in improving information for maternity service users. However, there has been much less success in improving those aspects of service provision which rely on adequate staffing and resourcing: continuity of carer, one-to-one care in labour, postnatal care, and midwife-led care.

Quality of care and the efforts of carers

- New models of maternity care, such as caseload midwifery, require a substantial reorganisation of working arrangements, the success of which relies heavily on midwives' commitment and flexibility.

- Midwives have demonstrated a clear commitment to woman-centred care and have accommodated the required increase in autonomy, the need for higher levels and a wider variety of skills, and the additional responsibilities associated with these changes. Training provision, however, has failed to keep up with these requirements.

- The increasing demands of midwives' work have been accompanied by a lengthening of working hours and an intensification of work.

- The pressure of work had increased in all maternity units, but particularly so in the units with high proportions of midwives working in the community.

- Midwives were more likely to feel that their working conditions had worsened the greater the number of extra-contractual hours they worked, and the more they perceived staffing to be inadequate.

Terms and conditions of employment

- A combination of local pay bargaining and staged national pay awards has led to a series of pay settlements which failed to compensate midwives for increases in the cost of living.

- Where local changes in terms and conditions of service formed part of a package designed to cut costs, they had little positive effect on performance. When they had been linked to improvements in the quality of care, they appeared to have had a favourable effect on performance, if not on costs.

- Only a handful of Trusts have implemented the officially recommended minimum F Grade for midwives giving the full range of midwifery care.

- Many midwives remain on Grade E despite their considerable responsibility and expertise.

- The maternity units where the midwives had the highest grades tended to be community-based. These units had made most progress in improving quality of care.

- Team midwives in most units tended to be employed on a mixture of F and G Grades, regardless of their similar caseloads and clinical responsibilities. Midwives perceive this disparity in grading as being unfair and a potential source of tensions within working teams.

- It is clear that many midwives are inappropriately graded, and that a midwife's grading appears to reflect local market conditions and Trust priorities rather than her abilities and experience.

Security, trust and relations with management

- Key requirements of high quality work organisation are a sense of security, close and trusting relations between midwives and their managers, and good communication.

- Despite endemic staff shortages, many Trusts had made midwives redundant.

- Redundancies have been concentrated in managerial grades, and this had resulted in a decline in leadership, support and confidence within the profession, adding to the downward pressure on midwives' grading and promotion prospects.

- Units had also used downgrading to reduce costs. While most downgrading took place when posts fell vacant, some units had downgraded midwives in post.

- Most midwives feel secure over their prospects in midwifery, but they feel less secure about their prospects in the Trusts where they are currently employed.

- Relationships between midwives and management lack the closeness and trust necessary to support co-operative work relations.

- The most important motivator for midwives was the needs of the women and babies in their care. Midwives were also motivated to make a special effort to support their colleagues, for their own job satisfaction, and to demonstrate their professionalism.

- Management style and attitudes were the main reason why most midwives would not be prepared to make a special effort for their employers; inadequate pay was much less important as a demotivator.

- Half the midwives had little or no trust in management to look after their interests. A large proportion of those with trust in management reserved it for their immediate managers (who are usually midwives), but not for senior Trust management.

- The antipathy many midwives felt towards management resulted from their feeling of having excessive demands made of them, and from being treated unfairly. They also felt that management made little or no effort to look after their welfare, to encourage their commitment to the Trust, to keep them informed about plans for changes, or to develop family friendly practices.

- Communication was good with doctors, but not so good with line managers and poor with Trust managers.

- Most midwives were ill-informed about what went on in their Trust and about issues that might affect their futures. They also felt frustrated because decisions were often made over their heads.

Representation and involvement

- The Royal College of Midwives (RCM) represents a very high proportion of midwives in collective bargaining over terms and conditions of employment, disputes and disciplinary procedures.

- Heads of midwifery reported that relations with trade unions had been improving, and that these were important for securing agreement for change, communicating information to staff, and in keeping staff updated on national policy and best practice.

- Most midwives were members of the RCM because it provides legal and insurance services, serves their professional needs, provides information, and offers support, security, protection and individual and collective representation.

- A large majority of midwives felt that it had become more important to belong to a trade union in recent years.

- Joint consultation and joint involvement were widely practised in maternity units, and trade unions were active participants.

- Heads of midwifery felt that joint consultation was important for reaching consensus on policy, to involve midwives in decision-making and to allow them to 'let off steam'.

- Midwives welcomed participation because it gave them a greater sense of involvement, led to better communication, and provided the opportunity to share information and knowledge, and to network.

- A minority of midwives did not feel involved in joint committees and other participation schemes. They thought they were badly organised talking shops, dominated by the managers.

Satisfaction, morale and motivation

- Midwives are highly satisfied with 'the work itself', but are much less satisfied with career prospects, relations with management, security, working hours, and especially with pay.

- Midwives were highly dissatisfied with their pay, which they felt failed to reward the levels of responsibility, commitment, skill, knowledge and experience required in their work.

- They also thought that their pay compared badly with pay of other professionals, especially those outside the NHS, and had failed to keep up with the cost of living.

- Midwives had low levels of morale but high levels of motivation.

The impact of terms and conditions on the quality of care

- There was a large measure of agreement between the heads of midwifery and their staff that midwives have responded positively to the drive to improve quality of care, and that their vocational commitment had helped overcome the resource constraints under which the reforms laboured.

- Nevertheless, pay and conditions and under-staffing adversely affected the quality of midwives' working life and the care they provided.

- An Audit Commission survey showed that whilst women were generally satisfied with the maternity service they received, many were not.

- Women prefer antenatal care in the community rather than in hospital; they did not receive continuous care, especially during labour, and were disappointed with the quality of postnatal care.

- The most significant obstacle to overcoming these problems lies in inadequate staffing and resources, and the effect this has had on the organisation of maternity care and the working lives of those who provide it.

- Midwives' pay and conditions affect the quality of care they can provide, both directly and indirectly.

- Pressure of work means that midwives have less time available for those areas of work which are less essential from a strictly medical viewpoint, but which are nonetheless clinically significant.

- In particular, postnatal care is inadequately resourced and an easy target for cuts. This limits midwives' ability to provide extra support for very young mothers, women who are isolated or unsupported in the community, and others in special need.

- Midwives' low levels of satisfaction with many aspects of their work, low morale and negative attitudes to management are indicators of their alienation. On the other hand, midwives' high motivation and continued commitment to the women and babies in their care is clear evidence that they are absorbing rather than passing on to their clients, the negative consequences of this breaching of their *psychological contract.*

- The pressure on midwives to fill the gap between demands and resources threatens the quality of their work and reduces their capabilities by undermining their physical and psychological health.

- Over half the midwives felt that working longer hours was having a detrimental effect on the quality of their work. This was more strongly felt when midwives were under greatest pressure from the sheer quantity of work and when they saw staffing levels as inadequate.

- The intensification of work adds to its risks. A large proportion of the midwives thought they were at greater risk of injury, and that the symptoms of stress had become worse over the past five years. As many as 40% had taken time off work as a result of stress at work.

- Our research establishes a clear relationship between generators of stress and lower psychological health. This, combined with the evidence from midwives that they have taken time off because of stress, strongly suggests a direct relationship between deteriorating working conditions and performance.

- Indirectly, the quality of care midwives provide is worsened by the growing recruitment and retention crisis in midwifery - resulting from a combination of work intensification, inappropriate grading, inadequate support for training, lack of promotion prospects, and low pay.

- Midwives and heads of midwifery said that these problems could be solved by:

    - improving pay and working conditions

    - enriching midwives' jobs and improving their status

    - improving training, career development and promotion prospects

    - improving management and organisation

    - increasing staffing and funding and more resources

    - adopting family-friendly policies and more flexible hours to accommodate midwives' domestic demands and social needs.

Conclusion

- To date, both the Government and NHS management have expected maternity units to achieve significant improvements in the quality and continuity of care within finite and shrinking resources.

- While significant advances have been made, these have been achieved by drawing upon the professionalism and vocational commitment of midwives, and at the expense of their working conditions and sense of wellbeing.

- While this approach has, in the short term, served the purpose of increasing midwifery output within existing resource constraints, the quality of care has suffered. The increasing problems of recruitment, retention, and falling morale within the profession suggest that it is not sustainable.

- In the longer term, if the improvements in care achieved thus far are to be sustained, the Government and NHS management need to reform midwives' working conditions and working environment.

- This is not to imply that the answer to the ongoing dilemmas facing the maternity services lies solely in improvements in the pay levels or pay structure for midwives.

- The solution is also dependent on the extent to which midwives are afforded the enhanced status and autonomy promised to them in *Changing Childbirth*.

- Furthermore, strong representation of midwives, alongside improvements in management structures and systems of communication in NHS Trusts, are necessary if midwives are to be enabled to participate in decision-making and thereby effectively contribute to improvements in the quality of care.