

The Influence of the Working Environment on Midwifery Staff and Students in Relation to the Newborn and Infant Physical Examination (NIPE)

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Abstract

This qualitative study explores the experiences of practitioners and students in relation to the 'newborn and infant physical examination' (NIPE). Previous research relating to the NIPE has given some insight into practice issues, including why midwives may have refrained from undertaking these examinations and whether it was appropriate to include the NIPE within pre-registration midwifery curricula.

This study examines the views of different practitioner groups including consultant neonatologists, midwifery managers, midwives, practice education midwives and student midwives. The purpose was to gain a detailed perspective of practitioners' experiences; highlighting and comparing themes that were similar and those that were specific to the different participant groups.

Data were collected through student-midwife focus groups and semi-structured interviews with doctors and midwifery staff. The participants self-volunteered across three large NHS Trust sites that were linked to a local university within the South of England.

The main findings indicate that environmental culture and interprofessional collaboration has a major impact on practitioners' experiences and those of the student midwives. There was a notable disparity regarding consistency of training, supervision and assessment processes between junior doctors and midwives. There was a link between this inconsistency and the need for strong managerial leadership and effective collaboration between different professional disciplines. Effective and pro-active leadership was also associated with the provision of equipment, referral guidelines, usefulness of NIPE clinics, knowledge and skill updates and the unnecessary re-assessment of newly qualified NIPE practitioners.

Recommendations for NIPE education, practice and future research are provided in relation to both local and national policies and practices. A key recommendation is to build interdisciplinary respect and collaboration into everyday practice, as this has a significant effect on the quality of NIPE provision.

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Chapter 1: Introduction and Background Information

1.1 Introduction

This study aims to explore the experiences of both midwifery students and qualified 'Newborn & Infant Physical Examination (NIPE) practitioners within clinical practice. At the time this study began, the literature tended to focus either on the location and number of initial midwifery training programmes that included an academic module aimed at achieving the knowledge, understanding and skills to conduct this examination, or conversely, sought to explain why some midwives chose not to continue to conduct this type of examination within practice. These key findings from the literature available at the time when the data collection commenced are explored within the chapter 2 (Review of the Literature).

The dearth of literature relating to individuals involved in NIPE and their cohesive experiences was I felt a missing part of the greater picture regarding why midwives chose to discontinue to conduct NIPES. However, I was also curious if gaining a greater appreciation of the experiences of NIPE practitioners – whether qualified or student - would provide more detailed background information that could be utilised within practice and education settings. As I work within both settings, enabling staff and student development is important if standards of knowledge and skill is to be achieved in the first instance and maintained post successful completion of NIPE training.

The study setting was focused within the three National Health Service (NHS) Trust practice sites affiliated to a local university within the south of England. This study concentrates on staff and student experiences within the hospital environment in relation to the 'physical examination of the newborn' that is conducted within 72 hours of birth. This specific examination may be referred to as the 'physical examination of the newborn', 'examination of the newborn', 'NIPE' and 'newborn or neonatal examination' in-order to maintain context within the text in relation to sources of evidence used and depending on the time-period. In-order to aid clarity and understanding, it is first worth highlighting the historical background relating to the Examination of the Newborn and how this specific examination moved from a 'doctor only' examination into the role and responsibility of other professionals in healthcare such as midwives.

1.2 Historical Background

In England, the term, 'Newborn and Infant Physical Examination (NIPE)' constitutes one of two health screening assessments within the Healthy Child Programme (Department of Health, 2009). An early examination is conducted within 72 hours of birth (newborn examination) and a second examination

is performed at 6 to 8 weeks of age (infant examination) usually within the family doctor's surgery. These two examinations are part of the UK National Screening Committee (2008) antenatal and newborn screening timeline which is updated on a regular basis – the current version retrievable via Public Health England (PHE) (2019). Each examination provides an important link in the chain that identifies abnormality, potential health concerns and acts as a conduit to further inform the baby's parents about acute or future issues on the health and wellbeing of their baby (UK Antenatal and National Screening Committee, 2008).

Historically, this examination was undertaken by a junior paediatrician although a growing discussion during the late 1980's had begun to explore the possibility of midwives undertaking this role. The premise to the rationale for this move was multi-factorial and was partly fuelled by the fact that a) midwives constantly work with parents and their newborn baby and are therefore, well-versed in the signs of the healthy neonate and b) there was a growing debate about the working environment of the junior doctor. Consequently, early 1990 saw the advent of the University within which I worked at the time as a Senior Lecturer in Midwifery, commence their first module designed to train midwives to undertake the examination as part of their normal practice. Eventually, the examination was also integrated into the pre-registration midwifery programme. A small but growing number of other Higher Education Institutions (HEI's) also looked towards developing their own pre-registration courses in a similar manner. Thus as time passed, both midwives and student midwives have been able to complete a 'Physical Examination of the Newborn' module, enabling them to integrate this neonatal examination into their routine care of the 'family' unit thereby strengthening continuity of care (Department of Health, 2009).

The provision of the Healthy Child Programme (Department of Health, 2009), within which the examination of the newborn resides, is also seen in other countries. Australia, New Zealand and the United States of America also have a national service provision in relation to a routine examination of the newborn (Royal Australasian College of Physicians, 2009; Beritz, 2015). A similar approach was taken in Australia and New Zealand, whereby midwives and appropriately trained health care professionals other than doctors can perform the newborn examination (Royal Australasian College of Physicians, 2009) which was then more formerly recognised across Australian districts (Western Australia North Metropolitan Health Service, 2018). Conversely, in America, not all states recognise the midwifery profession and therefore this role provision is non-existent. However, in the UK, recognition of this enhanced role in relation to midwives has over the years become more evident.

In 2013, a Public Health Education meeting took place which was attended by a wide variety of professionals, including paediatricians, junior doctors, midwives and midwifery educators, maternity managers, NHS senior managers and PHE screening team members to name but a few. The meeting sought to discuss the issues surrounding the development of an on-line education module for the examination of the newborn which was aimed at junior doctors. Interestingly, this may have demonstrated that there was already some recognition that the level of training that junior doctors received needed some support and that guidance concerning the consistent process of the examination would be helpful. Also on the agenda, was a presentation by one of the HEI's that incorporated the Examination of the Newborn module into their pre-registration midwifery and post-registration training portfolio. This gave midwifery educators the first opportunity before a diverse audience to explain how they had incorporated the module into year three of their pre-registration midwifery programme. Thus, the importance of midwives being involved in and trained to complete the NIPE, was being made explicitly clear within this inter-disciplinary arena. Increasingly, the need for NIPE practitioners to achieve a consistent standard of practice, record of findings and follow evidenced-based referral processes became an important part of guideline development. This was particularly necessary due to the forthcoming changes aimed at updating and streamlining the nationwide method of recording NIPE findings and failsafe processes that detected babies who had missed out on their NIPE. Thus, this event provided an important discussion venue that eventually led to the first NIPE Handbook that set out the expectations and process of the examination (Public Health England, 2017).

However, at first, the examination of the newborn or NIPE qualification was very much seen as an 'extended role' for the midwife as this examination was not part of the Nursing and Midwifery Council (NMC) standards required of a qualified midwife. Therefore, successful qualification was recognised by the insertion of the NMC code 'N96' on the NMC registrant's statement of entry which was then abandoned in later years as more midwives undertook the training for the newborn examination and the qualification became more widely recognised and accepted across NHS Trust practice sites. Later in 2016, the inaugural 'Newborn and Infant Physical Examination Screening Programme (NIPE) Educators' meeting' was held, at which was presented the first handbook relating to NIPE. Although the NIPE midwife practitioner was recognised as providing evidence-based, cost-effective care as endorsed by the Royal College of Midwives publication – Vision 2000 (RCM, 2000), the examination of the newborn was not included within the Standards of Proficiency for Midwives (pre NMC, 2019b Standards). Even so, as referred to earlier, the European Working Time Directive (Department of Health, 2002) acted as a strong catalytic agent that further motivated NHS Trusts to increase the number of NIPE trained midwives in-order to meet service needs.

With the European Working Time Directive (Department of Health, 2002) coming into effect, the number of hours that doctors in training could work was progressively reduced. As a result, this negatively impacted on the amount of time that a Paediatric Senior House Officer (SHO)/ junior doctor could spend on service delivery and in turn the examination of the newborn. As the number of SHOs available to conduct this traditionally paediatric role did not increase in order to cover the deficit in reduced working hours, this further impacted on meeting service needs. Therefore, in a move to resolve this shortfall, the involvement of midwives was encouraged by both the Royal College of Midwives (RCM, 2000) and the Department of Health (Department of Health, 2000) who declared that this activity should be part of the 'normal' role of the midwife. However, in recent years during the review and eventual publication of the Standards of Proficiency for Midwives (NMC, 2019b), although the NMC did refer to the NIPE in relation to midwives, it was to state (Sutcliff & Renfrew, 2019) that the term 'NIPE' would not be included as a proficiency expected of a qualified midwife in the 2019 standards of proficiency (NMC, 2019b). The rationale for non-inclusion evolved around the differences in relation to the process of the examination itself within the four countries of the United Kingdom (UK) and that training and assessment for NIPE was not yet consistent across the UK (Sutcliff & Renfrew, 2019). Considering the fact that UK pre-registration midwifery programmes have slightly differing formats in terms of content and assessment provision and all UK member countries have guidance that is published and updated as necessary in relation to NIPE, this situation is seen by some as delaying a recognised enhancement to the midwifery role which is viewed by some as a factor discouraging autonomous midwifery practice (Baker, 2013; Blake, 2012 & Council of Deans of Health, 2017). This latter perspective is particularly pertinent as the inclusion of NIPE was endorsed through the publication of the Midwifery 2020 (2010) document that emphasised the expectation that in future all midwives should be competent NIPE practitioners at the point of initial registration.

Although not all Universities have yet incorporated the NIPE module into their programmes of training, such progression has been seen as both innovative and ground-breaking. The concerns that were expressed regarding whether pre-registration students should be completing the examination of the newborn module have abated and it is seen as an appropriate skill for midwifery qualification that has been demonstrated to show a high level of professional competency and skill (Staney & Hopper, 2019).

The integration of NIPE within Pre-Registration Midwifery is a slow process, which in part is because programmes for midwifery training are required to be approved by the Nursing & Midwifery Council (NMC) for set duration after which it is expected that the curriculum will be updated and redesigned before re-approval by the NMC. Re-approval requires the review of the programme to allow for

amendments in-order to demonstrate that the programme remains 'fit for practice'. This term reflects not only the provision of a high standard of teaching and learning both within the University and clinical practice settings, but also the recognition of a changing marketplace and evolving research knowledge base. Therefore, due to the cycle of these events it can take a few years for a programme of training to be updated and new initiatives to be incorporated. Another factor of note is that, within the professional arena of midwifery, there has still been some discord regarding the incorporation of this aspect of training into Pre-Registration Midwifery Programmes. This discord sometimes relates to concerns that students will need to undertake a quantity of extra study therefore necessitating the loss or reduction of teaching in another area of Midwifery (Blake, 2008). However, this does not appear to be the case as a number of midwifery programmes that include examination of the newborn have been approved by the NMC. Whilst this does not by itself argue against extra content within the curriculum, there is a need to recognise the quantity and quality of knowledge and skill that students now need to achieve if they are to practise competently and safely in the current practice environment. In accordance with this, the NMC has a responsibility to ensure that the required content within the curricula enables all students to achieve the required proficiencies of a midwife, including the NIPE, at the time of registration (NMC, 2019e).

However, a key concern in both the practice arena and midwifery education relates to the need for student midwives to have easy access to an adequate number of NIPE trained midwives to supervise them in practice. Unfortunately, as Steele (2007) and Lanlehin et al. (2011) found, for various reasons that not all midwives continued to conduct NIPE's. Indeed McDonald (2008) also argued that a midwife's decision to discontinue conducting neonatal examinations was strongly influenced by a practice environment that offered little support or encouragement. Three years later, Lanlehin et al. (2011) still saw this as primary factor, suggesting that NHS Trust management must work harder to rectify the situation if midwives were not to lose the skills that they had worked so hard to gain. This internal collaboration is also important if Trusts are to fulfil their obligation to conduct and record NIPEs in a timely manner – the implication here, is that you need trained and experienced staff to do this and continue to do so. Clearly, it is also important that the midwives within these Trusts continue to conduct these examinations if they are to fulfil the role of experienced mentor, providing a motivational and effective learning environment for the student midwife.

The findings from the above studies and lack of detailed research into the experiences of NIPE practitioners, motivated me to undertake the research on which this document is focused. As a NIPE practitioner myself and a midwifery educator, it was important to me to try and fill in some of the unanswered questions that were beginning to become apparent within the literature available at the

start of my study. For example, I needed to investigate why availability of equipment was a recurrent issue and what midwives meant when they referred to needing support, respect and training needs. Consequently, as part of my journey towards gaining a better understanding of the issues highlighted, I started to review the literature to see if these issues 'stood alone', related only to NIPE midwives, or if there might be co-related issues associated with interprofessional team working. Therefore, the next chapter discusses the findings of the available literature that initiated my curiosity and provided the impetus to seek further knowledge that could perhaps inform future practice and policy and assisted me to develop my study aims and objectives.

Chapter 2: Review of the Literature

2.1 Introduction

After extensive searching of the available literature prior to even thinking of commencing my own study, I realised that there was a gap in the professional arena of knowledge in relation to the experiences of NIPE practitioners. By the time I commenced my research journey to find answers to the questions that were beginning to form in my mind, there was and continued to be a distinct lack of literature that explored the issues of NIPE practitioners across the disciplines and/or staff grades. Therefore, the impact of the inter-professional working environment and the NIPE process itself on staff and students remained an unexplored terrain.

As this doctoral study extends over a long period of time, I repeated my review of the literature at regular intervals in order to discover if any relevant studies had been undertaken whilst I had been conducting my own data collection. Holloway and Wheeler (2010) propose that the researcher should review the findings of other similar studies, thus encouraging comparison of these findings with the researcher's own study as it advances towards its conclusion. However, such activity is difficult to perform when the context of one's own study has little research with which to compare it. Indeed, it is only recently that Meegan and Martin (2020) and Way et al. (2021) have published their findings on student experiences, which whilst related to my own research, concentrates on the incorporation of the NIPE theory and practice within a curriculum and/or the support that students were able to access in practice. Both studies were conducted from specific viewpoints and due to their much later publication have been discussed within this document alongside my own study findings.

However, there were some studies at the beginning of my research journey which were useful in that their findings posed unanswered questions that partly laid the foundation to the aims and objectives and motivation to conduct my own research. Therefore, this chapter seeks to review the literature in relation to what was available prior to commencing this thesis and discusses some of the issues raised within the studies highlighted and those issues that arose in response to the evolving educational and professional environment of the NIPE. In order to appreciate the contribution of these earlier studies, the aspects central to their core of investigation are highlighted below and include, why midwives were in a prime position to conduct NIPes and why some chose to discontinue to do so.

2.2 Who Should Conduct NIPes & Should Midwifery Training Include NIPE

Initially, the available literature related to the questions such as who should perform the examination of the newborn. Indeed, the findings of some of these studies provided the founding rationale for training NMC registrants, other than paediatricians, to not only conduct the examination but also the

evidence that they did so to a high standard. For example, the findings of Wolke et al. (2002a & 2002b), Tappero and Honeyfield (2009) concluded that midwives were best placed to conduct the newborn examination. Their findings were based on a midwife's standard of competence in comparison with junior doctors in relation to low-risk babies, maternal satisfaction and time wasted waiting for a paediatrician to complete the examination of the newborn before the family could go home. These studies also highlighted that midwives were viewed as being more competent in giving parents higher quality or more research-based information regarding baby care and health promotion, an activity which further endorsed the recommendations within the NHS Plan (Department of Health, 2001).

Other studies by Blake (2012) and Way et al. (2021), amongst others, have discussed whether students should be trained to complete the examination during their initial midwifery training. As not all HEIs included the NIPE module within their curriculum and the fact that many of these courses have only commenced during recent years, this is a more difficult area to gain valid evidence or to access sufficient participant numbers. Nonetheless, even in 2012, Blake was positive about including examination of the newborn within the curriculum and argued that the benefits outweighed the negatives. It will be interesting to explore students' perceptions within my own research to see what their experiences and thoughts are, particularly as the HEI where I am accessing pre-registration students for my research had their first pre-registration students achieving the NIPE practitioner status at the point of initial registration as a midwife, since 2011. Thus, including student perceptions with those of the qualified staff who are participating in my research may give a more rounded and richer overall view of the perspectives of both qualified NIPE practitioners and future practitioners.

2.3 Why Midwives Refrained From Conducting NIPes

As time passed and more midwives became qualified NIPE practitioners, questions began to be asked about why midwives refrained from conducting NIPes. There were three specific studies by Steel (2007), McDonald (2008) and Lanlehin et al. (2011), all based in differing geographical areas within England that investigated the reasons that midwives gave for discontinuing to conduct the NIPE. McDonald's study covered participants within the East of England, whereas the participants for both Steel and Lanlehin were drawn from students on previous cohorts within the locality of the Health Education Institute (HEI) at which the researchers were based.

2.3.1 Study methods

Lanlehin et al. (2011) used postal questionnaires that incorporated open and closed questions as the method of data collection and whilst this method gave room for participant comments, it may have limited the richness of response that could have been collected by other means. For example, face-to-face interviews may have allowed clarification to be sought in relation to participants' answers, or

the participant given the freedom to air the issues they see as pertinent, which may not be covered within the questions set before them. Steele's study (2007) collected data arising from telephone interviews with participants but unfortunately it is unclear as to whether participants were given the opportunity to give their views outside the questions asked. However, it is possible that Steele's data may have been richer due to its more discursive nature, although information gained from certain activities that occur during face-to-face interviews, such as that arising from body language and further clarification of answers, would have been unobtainable. McDonald (2008) used a questionnaire-based audit, which had a similar focus to that of the previous two studies but was also designed to gain information about the training needs of participants with the aim to use information gained to improve local training provision. The audit did enable the views of a greater number of participants to be collected and provide a more informed view. For example, anecdotal evidence existed in relation to the number of midwives choosing not to conduct NIPes although they were trained to do so (Townsend et al., 2004), although McDonald (2008) indicated that the findings of the audit suggested otherwise. However, questions relating to why staff refrain from conducting NIPes, what is meant by support and what staff would deem is 'supportive' are still unanswered. Indeed, I am aware myself, that NIPE midwives will ask a colleague to come and check something if they are unsure either to confirm they are correct or prior to referring to a paediatrician. Thus, peer support may be a necessary factor in encouraging midwives to continue to conduct NIPes. It is recognised that it is difficult to build confidence if you are new to a role which is why student midwives commence their working life as registered midwives by first completing a preceptorship period, allowing their confidence in their knowledge and skill to develop and consolidate (HEE, 2015 and Taylor et al., 2018). Indeed, both Black (2018) and Zwedberg et al. (2020) suggest that those new to the qualified registrant role need staff around them who are experienced and confident in their knowledge and decision-making skills in-order for programmes of preceptorship to work effectively. Perhaps the same support is just as important for newly qualified NIPE practitioners?

2.3.2 Study findings

Nevertheless, the interesting point of all three studies (Steele, 2007; McDonald, 2008 & Lanlehin et al., 2011), is that they all identified similar factors which appeared to affect midwives' inclination to continue or abandon conducting neonatal examinations. Negative factors included a shortage of appropriate equipment, that midwives did not have enough time or opportunity to conduct NIPes, fear of litigation or loss of skill, lack of recognition and respect for role and poor managerial support. Positive factors were voiced as feeling an increased level of job satisfaction which was linked to continuity of care and holistic, autonomous practice, an issue that has been debated in recent years and is also a strategy that has begun to be implemented across various NHS Trust sites (NHS England, 2019a).

Other factors that were highlighted within all three studies included the recognition by participants that further development and updating in relation to NIPE was a necessity and that they needed to feel respected and supported by senior paediatric staff. The latter point about respect and support appeared to link to whether participants were demotivated to continue to conduct the NIPes due a lack of these two elements or motivated and encouraged to do so when they perceived both elements were at a good level that enabled effective interprofessional collaboration.

2.3.3 Present literature - gaps & unanswered questions

Unfortunately, there was little detail given within these studies in relation to what was meant by some of the findings mentioned above, which may have provided information that could have been utilised within the practice arena. For example, what was deemed as 'poor' or 'good' support or why litigation was a particular concern. The lack of detail in relation to some of the findings, results in a need for further exploration as one becomes intrigued to find out the reason behind the themes arising and for example, if the lack of clarity is in part due to the method of data collection or the format of the questions provide little or no room for participants to give extra comments. However, the lack of available detail accompanying participants' comments was also beginning to make me wonder if there was another reason that the full picture was not visible. In the studies mentioned above, participants had commented about managerial and interdisciplinary relationships but due to the very nature of the aims and focus of these studies it may be perceived that the findings can only give a limited perspective – some general aspects of the midwives' side of the story. This therefore led me to question whether exploring the views of other staff involved in the practice and process of NIPE might also give me a greater insight into a much wider and richer view of the practice environment within which NIPE practitioners work.

The other point to note within these studies, is that midwives saw the NIPE role as one that enhanced their practice skills, level of knowledge and understanding which required dedicated time to complete. This could be seen as an 'expected' comment as midwives conducting NIPes was still a very new concept in many practice environments at the time this original data was collected. However, what was interesting was that even in 2008, McDonald's study demonstrated that there were signs that midwives were becoming more open to the idea of the NIPE module being placed within pre-registration midwifery training programmes. As McDonald (2008) suggested, such activity would enable midwives to work more autonomously and holistically in caring for and discharging from care both mother and baby. Indeed, Davies (2008) and McDonald (2018) saw this as an important aspect and gave the view that far more babies and parents would benefit from a midwife's knowledge and experience if midwives conducting NIPes was to become a normal part of midwifery practice. This is a particularly pertinent point when midwives see being able to deliver holistic care without restriction,

as directly impacting on their level of job satisfaction (McGowan & Murray, 2016 and Cramer & Hunter, 2019) and as discussed in more recent years its relationship with the benefits of introducing models of continuity of care (McDonald, 2018 and NHS England, 2017). However, although the above points will be discussed further below, this latter activity is still very much in its infancy in relation to the impact on NIPE practitioners and as such will, in time, require further study to reveal the detail of its influence on the practice environment, practitioners and parents in the context of NIPE.

However, there was a clear lack of detail about other aspects mentioned such as the meaning of 'dedicated time'. This aspect needs to be clarified as this may be a comment that has arisen from staff who do not always have easy access to conduct NIPes and may therefore feel that they are becoming de-skilled, or it could be a more general comment given by participants across the practice arena. Without further discussion with participants, it is difficult to determine if this aspect is solely linked with the finding that some participants voiced about wanting better managerial support, which would assist the practitioner in this area, or if such support was linked to other aspects as well.

The salient point of the themes arising within the three studies above, is that they appear to have a possible, multi-factorial link between a NIPE professional's perception of their role and responsibility. The link arising within the above three studies centres more on how aspects such as recognition and respect can affect professional identity by the very nature of how they impact on a professional's self-image (Sheehy et al. 2019) or in other words, how they see their professional identity. However, Cruess, Cruess & Steinhert (2016) alluded to how developing professional identity is not a linear process but establishes over time during which setbacks may be experienced. This may be one of the reasons that a change in workplace culture or behaviour and perceived professional status may impact both qualified professionals as well as the students who are developing a sense of their professional identity over the three years of their foundation training.

Consequently, these links began to resonate further with me as I began to question the status quo that existed in relation to the environment of interprofessional relationships and collaboration in the context of NIPE. As a NIPE practitioner myself and an educator within the field of midwifery, I knew at first hand the importance of good working relationships with staff no matter their role or status. Even with this knowledge and experience, I was also all too aware that my experience in practice during the time before I commenced my research was through my lecturing role and not as an NHS Trust employee, thus the impact of the day-to-day working environment must for this very reason be partially hidden from me.

Much of the previously available literature in relation to NIPE and within the context of the factors mentioned above has given rationales as to why midwives should conduct NIPes or has indicated some of the factors that influence why midwives discontinued to conduct NIPes. The following sections will review the findings that the participants from earlier studies viewed as enabling or disabling them from carrying out their role autonomously (i.e., supportive or unsupportive), such as poor equipment provision, professional identity and job satisfaction, interprofessional respect, collaboration and autonomy. The next section will also give some indication as to how the above aspects may also influence the career choice of future generations and those students who are already in the process of completing their training.

2.4 Provision of Equipment

Lack of necessary equipment was repeatedly echoed by participants across the studies available. Such circumstances did not allow for a smooth examination process to occur, as time was wasted in hunting for equipment which was clearly a cause of frustration. There is also the possibility that the simple but important issue, such as not having enough equipment to carry-out the role they had been trained for, may further impact on staff who may already perceive that their professional identity and autonomy was being eroded or disrespected. This latter point is difficult to substantiate from previous studies but there is evidence that points to midwives perceiving that being able to discharge **both** mother and baby was very much a part of holistic autonomous practice was seen as a positive part of their role (Kirkham et al., 2006 and Steele, 2007). However, the simple fact of staff not being able to find equipment that they needed, reminded me of an incident in practice and how it might make midwives feel. For example, I did not at first understand why midwives I was working amongst often spoke quite vocally how they and their colleagues frequently had difficulty with finding working equipment, when junior doctors never seemed to experience the same issues. As I brought in my own equipment and therefore the students' I worked with never referred to lack of equipment when they were working with me, I was unaware of this issue. When the next midwife asked if she could borrow my ophthalmoscope when it was not in use, I found out that the ward ophthalmoscope was often missing. She also stated that that she would often find it being used by someone else, was waiting for repair or that the ward only had one for midwives to use even though NIPes would be performed on a frequent basis every day. Lack of equipment has been highlighted in the work of Steele (2007), McDonald (2008) and Lanlehin et al. (2011) which demonstrates the issue has been longstanding. It appears that the lack of such basic equipment that is a fundamental necessity in-order to complete the NIPE was frustrating for the midwives, and I could now appreciate why this was the case.

When such frustrations are experienced by staff, it may impact on their general wellbeing which in turn can reduce levels of job satisfaction (Bandura, 2001). It is possible that the frustration that was

repeatedly voiced was the result of not being able to provide an efficient service to parents when staff had to hunt for equipment, but that it may also have made staff feel undervalued. This may lead them to feel that their role as NIPE practitioners was not seen as an important and necessary part of care provision due to the lack of basic but necessary equipment being a continuing issue, rather than one that was quickly resolved. This may be a tenuous link, but it is a link nonetheless and it is possible that my own research findings may shed light if this or other such events are still an issue for the participants in this research. The link between professional identity and that of a professional's level of job satisfaction has been a subject of discussion over recent years, as will be discussed in the next section.

2.5 Professional Identity & Job Satisfaction

Interprofessional education (IPE) was recognised by the World Health Organisation (2010) as an essential introduction into the training and education of practitioners if they were to be equipped with the skills, knowledge and attitudes to enable different professions to work together and thereby benefit patient care. The perspective was that in understanding the differences between healthcare professions, communication and respect would be enhanced in conjunction with how professionals identified themselves within the healthcare team. However, there is no clear indication within present literature in relation to the positive impact of IPE within student programmes of learning in terms of improved levels of interprofessional communication or patient outcomes. Despite this, IPE continues to be a required feature of both medical and healthcare curricula with the United Kingdom and internationally (NMC, 2008; General Medical Council, 2009 and Wong et al., 2017). However, it can be seen that the image that is portrayed by a professional and how one identifies themselves as a professional was seen as an important factor in how differing healthcare professionals interact with each other. However, perhaps what was not considered at the time was how hierarchical structures within practice also needed to be considered within this interaction and the resulting workplace behaviours that will be an aspect that became a recurring aspect throughout this research. Firstly, it is necessary to explore what a professional views or understands as their professional image or identity.

A well-known recruitment agency defines professional image as how a professional conducts themselves in the working environment and how they are seen by others in terms of communication, behaviour, attitude and attire (Indeed, n.d.). However, due to the nature of the professional image it is influenced by both the professional themselves and 'how they are seen by others', this presents a two-sided approach. One in which a professional image is defined by how oneself behaves as well as how others perceive them, creating two viewpoints that combine within this concept to form professional identity as a whole. Further to this, perceptions of professional image can impact a

professional's own understanding of their self-image. For example, how they behave may correlate to how they expect others to see them and vice versa; they are seen by others in a professional image defined by communication, behaviour attitude and attire and therefore behave in accordance with this. This concept promotes both external and internal understanding of a professional's self-image, influenced by their own perceptions and that of those around them. Furthermore, as mentioned within the previous section, examples such as external treatment and responses such as recognition and respect can affect professional identity by the very nature of how they impact on a professional's self-image (Sheehy et al. 2019). Therefore, one's perception of their self-image and professional identity could be viewed as the interconnected psychological process of 'becoming' a professional (Burford et al. 2020) and the creation and overall understanding of professional identity post-qualification (Caricati et al. 2016).

Professional identity progresses from the concepts of professional image and self-image (how one internally views oneself) as it begins to be defined by more transferable concepts, rather than perceptions. Thus, professional identity may also encompass the relatively stable encompassing of one's attributes, motive and values (Ibarra, 1999). Our professional image, and the self-image this can develop, is intrinsically linked to our professional identity. However, it is important to identify that whilst our professional image remains reasonably fixed to our roles, responsibilities, behaviours and communication to others, our identity is linked more to the individual and their self-perception of their identity as a professional. Within this, I would agree with Shein's (1978) perception that identity is fluid and continually evolves during one's career which was alluded to earlier in relation to the view of Cruess, Cruess and Steinhert (2016). Also, as Blackhouse (2021) points out, our developing identity is not just one aspect of our beliefs or our practice but also how we see ourselves within our work. Therefore, our self-image and professional image becomes an evolving reflection of both our own understanding of the values and motives attributed to our professional identity, as well as being further influenced by an individual's own distinction of their professional identity.

Professionalism is a further concept linked to an individual's understanding of their own professional identity and that of those around them. How we conduct ourselves in a professional environment, upholding behaviours, attributes and values that are commonly associated with professionalism aid us in building our own perception of what our professional identity should be perceived as. Lane and Roberts (2020) suggest that the terms used to describe one's identity, professionalism or perception of oneself can at times appear blurred within current healthcare education, literature and the workplace. Indeed, Blackhouse (2021) recognises that the definition of each of these terms can be interchangeable depending on the context, whether defined by the author of a piece of research or

during discussion with practitioners. For example, Burke (2003) discusses the term 'professionalism' as how others see you and identify you within a professional group which midwives within this study often referred to as professional image. Thus, depending on the context – whether discussing the available literature or the perception of participants within this research, the words are used interchangeably.

A midwife's perception of their professional image appears to have a strong link with their level of job satisfaction. For example, the lack of equipment needed to fulfil their job role may have had an impact on how their professional image as a whole was perceived by others. As this was a continuous issue, it could solidify the midwives' perception that their role and therefore, the professional image they were expecting to present, was not seen as an important and necessary part of care provision. As a result, the frustration experienced could impact the level of job satisfaction experienced. In exploring studies relating to the impact of professional roles within a similar context in teaching and medicine (Bandura, 2001 and Frost, 2006), the need for job satisfaction and a strong sense of professional identity was seen as important factors. A sense of 'belonging' to their profession is an important factor that aids the development of professional identity, whether this be in relation to student midwives or qualified staff (Brailey, 2018 and Capper et al., 2021) as was the ability to provide the level of care for which they were trained (Curtis et al., 2006 and Watson and Brown, 2021). The former of these last two factors relates to a workplace where colleagues were seen as 'inclusive', valued their opinion and willingly shared knowledge, skill and expertise (Fenwick et al., 2012).

More recently, Hunter and Warren (2014) discussed the above aspects further by relating them to the need for midwives to develop confidence and what they termed 'workplace resilience', which they viewed as the ability to cope with stressful situations and the assimilation of new roles. This is particularly pertinent in the face of workplace adversity where staff may feel unsupported or the environment is not a conducive place to work. The impact of such issues can be further compounded by lack of staff, particularly as midwifery is experiencing workforce shortages not just in the UK but globally too (World Health Organisation, 2016). It is possible then that it is not surprising if midwives who qualify as NIPE practitioners and are therefore taking on a new role, are often quoted as using the words 'support' and 'respect' within the studies relating to whether they were still conducting NIPes. Indeed, Hunter and Warren (2014) also argue that midwives, managers and those who work in midwifery education should carefully consider the effect of workplace adversity and the impact on an individual's professional identity. Therefore, it is possible that Hunter and Warren's (2014) conclusions may be viewed as having a stronger correlation with the findings of Bandura (2001), Frost (2006), Steele (2007), McDonald (2008) & Lanlehin et al. (2011), in that it appears that once qualified, the

reality may not always meet the individual's initial expectations. As a result job satisfaction may be reduced which as mentioned previously may in turn increase attrition rates.

Fenwick et al. (2012) agrees with the earlier perceptions of Hunter (2010) in relation to midwives not being able to see themselves as the professional they had wanted to be due to the culture of the working environment. Einion (2016) also referred to the widespread dissatisfaction associated with the culture and practice of midwifery and how resilience to cope with the prevailing culture starts when becoming a student midwife. The emergence of one's professional identity/image is therefore continually developed positively and/or negatively during the transition to qualified midwife status and beyond. Dinmohammadi et al. (2013) reiterate this point, seeing the transition as dynamic and ever changing as their sense of 'belongingness' and perception of their own personal and professional identity develops.

It could be argued that the ongoing development in both professional image and identity continue on into the role of NIPE practitioner. Therefore, supporting practitioner's in this new role should perhaps be an expectation in practice in much the same way that is applied to students who have just qualified who are supported within their newly acquired professional status. This is usually through the provision of a 'preceptorship programme' which aims to guide and support the newly qualified practitioner by developing their confidence in their practice and decision-making abilities. This transitional period is quite important as it is worth bearing in mind that student midwives learn during their training, not only the knowledge and skills they will need on qualification, but that they are also open to the nuances that occur within the practice environment such as the processes, style of communication and common practices that occur. All these factors shape the persona, competence and professional identity of tomorrow's midwives and are factors that need to be considered carefully and in collaborative manner between the HEI and the staff in the practice environment. The preceptorship programme has been recognised as a beneficial development in aiding the transitional process and retaining practitioners in-order to deliver safe and effective care (Health Education England, 2018). However, the influences on student perception regarding future registered practice will be returned to later in this chapter when discussing the student's transition to professional registrant. Indeed, gaining a perception through this doctoral research regarding the impact of the practice environment on student's and how this may influence their professional identity may provide some insightful perceptions for future consideration within the domains of both theory and practice.

2.6 Respect & Collaboration – management and interprofessional factors

Over the years various studies have explored the factors affecting midwives' confidence and behaviour (Kirkham, 1989; Keating & Fleming, 2009 and Bedwell et al., 2015). These studies usually focus on

challenging or urgent situations in midwifery and were not directly related to NIPE. However, the same factors can have a similar impact, reducing emotional wellbeing and ultimately a midwife's sense of clinical autonomy and job satisfaction (Nedvědová et al., 2017 and Cramer & Hunter, 2019). This may be partly due to a midwife's perception that there is a lack of professional respect and collaborative practices in relation to managers which impacted on their ability to be autonomous practitioners (Lanlehin, 2011). Findings in Lanlehin's study related to poor support which ranged from giving midwives protected time to complete examinations during their NIPE course to ongoing issues with access to NIPE's, restrictions relating to Trust processes and non-provision of updating sessions.

Findings from interview data collected by McDonald et al. (2012) have alluded to the quality of midwife and consultant paediatrician partnerships in relation to NIPE. The study participants consisted of ten NIPE qualified and practicing midwives, two midwives who had qualified but were now in managerial positions and therefore no longer conducting NIPes and five heads of midwifery. Part of the study findings suggested that the reason professional partnerships worked well in certain NHS Trust sites and not in others, was due to the perceived level of engagement between midwives and consultant paediatricians. Although from the detail provided it is difficult to ascertain what 'good' may mean, there were indications that power and control played a part in whether the engagement was seen as 'good' or otherwise. Therefore, 'good' could refer to good teamworking but this lack of clarity may again be due to the study being based solely on the perceptions of midwives and heads of midwifery. It did not include paediatric staff and is therefore limited by the lack of available information regarding how the NIPE role and responsibilities in relation to midwives is perceived by paediatricians. Therefore, it is difficult to appreciate how their perception may impact on the level of autonomy that the NIPE midwife can engage in, such as in being able to refer a baby to an appropriate expert or to arrange a specific investigation such as an ultrasound scan of the hips. Yet it was clear within this study that midwives were appropriately trained and valued good working relationships with paediatricians. However, it could be construed that being unable to exercise autonomy is a bone of contention with midwives and impacts on the midwife – paediatric working partnership. Thus to appreciate some of the factors that may enact on the issues above, the following section give an overview of how the cultural environment has been perceived to impact upon or influence the midwife's overall sense of autonomy.

2.7 Autonomous Practitioner

The term 'autonomous practitioner' identifies a practitioner as one who holds 'the authority to make decisions and the freedom to act in accordance with one's professional knowledge base' (Skår, 2010). Both Fleming (1998) and Perdok et al. (2016) further reiterate that the professional role of an autonomous midwife is one in which they are able to control their practice, provide comprehensive

information and make clinical decisions independently with the women in their care. In a profession where the actions of the professional can directly impact the health and safety of those they work with, it is important to acknowledge the autonomy that is linked to this role: where one must act according to the knowledge they possess, utilising it within practice. Therefore, being identified as an autonomous practitioner should reflect that those associated with this concept have the authority to make decisions within their role based on their own evidence-based perception of the information in front of them. In this case, the autonomy of decision-making for midwives is governed by the NMC and the learning they have garnered to perform their role. Thus, utilising this prior understanding, they can make decisions within their role, having been trusted with this autonomy.

The International Confederation of Midwives (ICM, 2018) gives a clear indication that it recognises midwifery as an autonomous profession, a term that just as rightly applies to doctors. Both are experts in their field, but there is a growing indication that the collegial relationship between the two is not as supportive as it could be (Clemens et al. 2021). Clemens et al. (2021) emphasise the issue that autonomy can be experienced differently depending on which practice area the midwife is working, which causes issues when trying to provide a universally accepted definition for professional autonomy in midwifery. Plus, as Zolkefli et al. (2020) points out, throughout literature the terms autonomy, accountability and responsibility in relation to a midwives' autonomous role are often used interchangeably, which may in itself point to the need for the development of an agreed definition for autonomy in the profession of midwifery. However, Clements (2021) and Vermeulen et al. (2022) within their definitions of midwifery autonomy, both perhaps highlight that the specific key need for midwives is to be recognised as having the clear right and responsibility to practice within their code of practice (NMC, 2018) and professional role (NMC, 2018a) in accordance with their professional body and that as prescribed by the International Confederation of Midwives (ICM, 2018).

The NMC gives a clear indication within the Standards of Proficiency for Midwives (NMC, 2019b) which defines the term 'autonomous' as having the knowledge and confidence to exercise professional judgement. However, it is this ability to act as an autonomous practitioner that is sometimes brought into question with the midwifery profession (Wong et al., 2017). Literature examining interprofessional practice and collaboration often focuses on incidents during emergencies and adverse outcomes (Renfrew et al., 2014; Skinner and Maude, 2016; Kirkup, 2015). However, there appear to be few studies that examine how these issues can permeate everyday midwifery practice. However, the impact can be the creation of stress and at times 'burn out' particularly when coupled with staffing shortages and unsupportive working environments (Dixon et al., 2017). The NIPE qualification essentially enables a midwife to work autonomously, holistically and as an advocate, not

only for the parents but also the baby. As previously mentioned, the earlier studies and the discussions above may point to areas of contention that can be hidden in the current literature environment where the focus tends to highlight serious adverse circumstances. Therefore, it is possible that the impact on the NIPE practitioner in relation to being able to work autonomously has not yet been fully explored.

2.7.1 Barriers to autonomy

The Code (NMC, 2018) stipulates that amongst other NMC registrants, midwives are expected to work within the limits of their competence even if these extend beyond the standard of proficiency for midwives at the point of registration. This covers both midwives who undertake the NIPE module post qualification and those students who have successfully completed the NIPE module by the point of NMC registration. Therefore, in the future when all midwives are qualified to perform these specific neonatal examinations, the NIPE should in essence fall under the umbrella of everyday practice. At present, the literature relating to those midwives who choose to discontinue to conduct NIPES provides some reasons as to why this may be the case. However, future research may be able to provide insight and greater detail that could demonstrate that NIPE practitioners can be subject to similar conflicts as those previously mentioned. It may be that these issues are more to do with the environment that midwives work in not enabling or even actively preventing them from working in a manner that they should be able to and for which they were trained - a factor recognised by Hunter & Warren (2014).

The report 'Midwives' Voices – Midwives Realities (WHO, 2016a) expressed that midwives wanted more autonomy and recognition, particularly from obstetricians. It is recognised, as stated previously, that midwifery autonomy is associated with increased job satisfaction (Papoutsis et al., 2014) and positive role model behaviour such as: innovation, sharing of knowledge, supporting colleagues and students, working collegiately with other professionals (NMC, 2018a and Mestdagh et al., 2019). However, both the culture of the working environment and reduced individual responsibility to enacting autonomy can pose barriers to autonomous practice. The NMC (2018a) and Hunter & Warren (2014) both highlight the need for recognition of the barriers that arise within the practice culture of the organisation and those that midwives may impose upon themselves. Zolkefli et al. (2020) also points out that the impact of the infrastructure and culture that exists within the workplace can make considerable impact on a midwife's ability to work autonomously. Indeed, Zolkefli et al. (2020) draws attention to the influence that socio-cultural factors or expectations of the institution and medical profession plus political influences, can either make a positive impact on the level of autonomy or inhibit its existence. For example, Green et al. (2017) perceived the hierarchical structure of the working environment and the prevailing culture that permeated within executive management and

medical perception, was one that favoured medical staff over other professional groups. As such this has been viewed (Jones et al., 2018; Stucky et al., 2022) as leading to conflict in the workplace and the marginalisation and exclusion of other professions from decision-making processes even when trained to do so. Thus, institutional recognition of the positive impact that partnership working can have on staff wellbeing and quality of care, provision of funding for learning development and equipment and the sharing of information and data is to be encouraged (NMC, 2018a). However, this requires that both the organisation and the medical profession need to fully comprehend what midwifery autonomy entails within the provision of midwifery care and the profession. Also, as Perdok et al. (2017) suggested, the challenge lies in finding the balance between maintaining effective collaboration between professional groups whilst maintaining high levels of autonomy, which one could argue is a challenge that remains to be addressed.

As alluded to in the previous paragraph, midwives are known to place their own barriers to practicing autonomously, an issue recognised by the NMC (2018a). The enabling professionalism document (NMC, 2018a) points out how midwives can reduce these barriers through being pro-active in raising concerns, supporting colleagues and students, demonstrating positive role models and behaviour towards others and working collegiately with other professions. However, as Hunter and Warren (2014) emphasised within their research, this type of leadership activity demands a degree of emotional resilience within an arena where shortage of staff causing workplace stress has become a normality and professional autonomy may be reduced. Therefore, the aspect of emotional resilience and its link to coping with workplace stress, increasing job satisfaction and assisting in the maintenance of professional identity and autonomy is discussed in the next section.

2.7.2 Resilience and workplace culture

Resilience has been intrinsically linked to terms such as ‘adversity’, ‘stress’ and ‘workplace resilience’ and the professional’s ability to maintain their emotional state in times of adversity and stress within the workplace that enable us to maintain resilience within the working environment (Gray et al. 2019 and Bozdağ & Ergün, 2021). Within the concept of ‘workplace resilience’, this reflects our capacity to adapt to stress points within the culture of the working environment. Therefore, whilst emotional resilience is a key concept here, ‘workplace resilience’ may also be used to refer to how individuals monitor and adapt their emotions within a working environment. Stress and adverse working conditions, such as restricting the degree of one’s autonomy or practice philosophy can reduce a practitioner’s emotional resilience and job satisfaction which may cause them to leave the profession altogether (Bloxsome, 2020 & Geraghty, 2019). It is these concerns, which are not just limited to the United Kingdom but are also a global issue, has led to studies to reflect the need for change in

workplace culture, the raising of practitioner emotional resilience and the move to raise the level of midwife autonomy in order to reduce attrition rates and increase the level of job satisfaction (Hunter & Warren, 2014 and World Health Organisation, 2019).

It is worth noting, that the concept of 'environmental culture' in this instance refers to the understanding of environmental and organisational factors that can impact the working practices and autonomy of the professional and whether they feel respected and valued by the organisation they work for. Only by acknowledging the impact of these elements within the clinical environment, can the impact on culture that is created and the resilience of those who work within that environment be better understood (Fox et al., 2018).

More recently, the link between the importance of emotional resilience and the need to feel valued and motivated has been discussed in relation to job satisfaction and retention of both midwives and students (McGowan & Murray, 2016; Cramer & Hunter, 2019; Sheehy et al., 2019). Therefore, perhaps for NIPE practitioners, the professional identity and autonomy that they are expected to allude to (NMC, 2018; NMC, 2018a) needs to be **seen** to be respected and supported within the environments in which they work in much the same manner as when conducting everyday midwifery practice. As stated previously, the same feelings and responses as those given by the midwives who had taken on a new role as NIPE practitioners in the studies by Steele (2007), McDonald (2008) & Lanlehin et al, (2011) are not any different to working autonomously during emergency situations. It would be difficult to quantify that for any individual the level of personal impact occurring within an emergency situation is any less or greater than those members of staff or students who are subject to regular or continual workplace adversity. Downe et al. (2010) and Sonmezer (2021) have highlighted poor interprofessional behaviour and communication as some of the factors that reduce a midwife's sense of autonomy. Capper et al. (2021) also suggest that exclusion and bullying behaviours in the workplace, such as disregarding a midwife's knowledge and experience or pressurising them to conform to the workplace hierarchical status quo, had a profound impact on their professional identity.

Therefore, it can be seen that the need for a positive sense of professional identity and autonomy are important aspects to consider in an era where the shortage of midwives is making a significant impact on care provision (Midwifery 2020, 2010; World Health Organisation, 2016). This situation is compounded due to some midwives choosing to retire early or conversely not choosing to continue to work after retirement age, plus some midwives are on sick leave because of stress and lack of job satisfaction (Hunter & Warren, 2014; Stoll & Gallagher, 2018).

How practitioners cope with such workplace adversity has been discussed in some publications. The focus has concentrated on workplace or emotional resilience whereby some midwives have strategies that cope with workplace stress and learning how such strategies can be encouraged, would be useful to disseminate to not only qualified staff but also the midwives of tomorrow (Hunter & Warren, 2014; McGowan & Murray, 2016; Cramer & Hunter, 2019). Such strategies assist midwives not only in urgent, critical situations, but also within everyday practice. The need to address the situation is paramount in relation to qualified midwives and present student midwives if the rate of attrition is to be reduced. However, the impression of midwifery being a stressful environment and that midwives cannot work as they wish or are trained to do, can have a negative impact on how those who may wish to enter the midwifery professions may perceive their career choice which is an important consideration for the survival of the profession, service need and midwifery education.

Unfortunately, a survey of over 20,000 primary school children, found that less than 0.5% wanted to grow-up to be a midwife (Chambers et al., 2018). The impact of Covid-19 is further compounding the issue as 70% of secondary school students do not know what they want to do for a career in a changing marketplace and 78% are worried about making the right career choice (launchyourcareer.uk.com, 2021). Therefore, addressing workplace adversity within all practice arenas including NIPE may not only positively influence interprofessional relationships, but may also have some part to play in how midwifery is presented within the media and encourage the up-and-coming generation to consider midwifery as a valid career choice.

If today's literature continues to highlight the stresses that midwives experience, it is possible that those who are thinking about a career in midwifery may not see it as a viable career that gives them an opportunity to feel a sense of satisfaction and achievement. Likewise, gaining insight into the views of student midwives, albeit in relation to NIPE, may also highlight how the workplace may influence the student's transition towards qualified midwifery status and their future plans and aspirations. Therefore, this doctoral research study may also give student midwives the opportunity to highlight some of the issues they may experience in practice whether these are positive or negative. Thus, the next section details the aim and focus of the research.

2.8 Research Aim - the Wider Focus

The studies mentioned within this literature review may be small in number, but clearly identified similar themes within their findings. They also provoked more questions that deserved further exploration to continue to fill in the gaps and obtain a more in-depth understanding of previous data findings, particularly in relation to, for example, how midwives perceive their professional role and identity in relation to NIPE and the impact on student identity development. Increasing my

understanding of the background to these issues and the workplace influences on both NIPE practitioners and students might give me further insight that could be used to inform the arenas of both practice and education, particularly as previous studies have not included other co-related professionals such as paediatricians. Bringing together the views of NIPE practitioners of different grades and status, would give a wider, richer and more informed picture of the NIPE practice arena, interprofessional relationships and the perceptions that relate to specific professional roles and responsibilities.

The intention is that my research would provide new insights that can be used to enrich the present programmes of midwifery education, thereby enhancing the student learning experience but that these insights might also assist in raising the level of understanding within the practice arena in relation to areas of potential improvement or adaptation of service provision or processes. Furthermore, as I work across the boundaries of midwifery education and clinical practice, gaining a greater understanding of the experiences of students and NIPE practitioners within the practice setting may not only serve the interests of students and local NHS Trusts, but also other education providers who already run or are starting to develop NIPE modules within their own Pre-Registration Midwifery Programmes. Knowledge gained may also be shared with the committee that reviews the content of the Newborn and Infant Physical Examination (NIPE) screening programme handbook (Public Health England, 2021).

Consequently, the information derived from the available literature assisted me in developing my research aim as the intention was to explore the area of research in greater depth. Therefore, a qualitative approach was utilised and Interpretive Description was chosen to achieve as much possible depth and detail during the gathering of the data. Semi-structured questions were designed to allow for flexibility of use across all grades and status acting as a trigger to enable discussions to develop which could provide new insights. These 'triggers' were purposely broad so that whilst partly directing participants to think about certain aspects, they also provided the opportunity for participants to voice what they saw as important or co-related issues (greater detail regarding the research design is discussed in chapter 3).

2.8.1 Research aim

This research sought to explore:

***'The influence of the working environment on midwifery staff and students
in relation to the Newborn and Infant Physical Examination (NIPE)'***

The initial broad objectives, sought to discover: -

- What are Midwifery student and NIPE practitioners' perceptions regarding the impact of the integration of the NIPE into theoretical and clinical learning?
- What are the factors affecting NIPE practitioners within the clinical setting?

In relation to the detail of the working environment I was particularly interested in:

- What is the impact of the workplace culture/environment on the ability of NIPE midwives to practice autonomously and on the developing identity of student midwives?
- What are the factors that enabled pro-active working practices and interprofessional working?

These initial objectives were then further broken down into six areas of focus that were used across focus group and interview settings but could also be slightly adapted in relation to the perspective of the participant being interviewed (e.g., consultant or midwife). The areas of focus were:

- What are the expectation and perception of participants relating to how NIPE fits into the professional role of the midwife?
- How participants perceive their professional role links and integrates with other disciplines in relation to NIPE within everyday practice
- The type of 'activities' that participants see as assisting the development of good multi-disciplinary working and learning relationships in relation to NIPE
- What level of input or degree of involvement that both maternity/neonatal staff have in the development of evidence-based guidelines and protocols relating to neonatal health and care practices?
- What type of supportive practices are perceived by all levels of staff involved in NIPE as pro-actively reducing negative impacts on the multi-disciplinary relationship, or promote effective working relationships and/or are perceived as having a positive effect on levels of confidence and competence?
- How useful is the NIPE Forum in encouraging collaboration in the sharing of information and providing an arena where discussion and debate can occur between students, NIPE practitioners, neonatal and University personnel?

Plus, in order to gain an overall and wider picture of the influencing factors within the working environment, participants who were NIPE practitioners from a range of staff of different grades and status were invited to participate. As a result, the participants involved in the study included midwives, midwifery managers, practice education facilitators (PEFs) and consultant neonatologists.

The inclusion of third-year student midwives assisted information to be obtained relating to their specific experiences and view of their practice environment. Their inclusion was important as they complete the NIPE module in the final year of their programme and are also consolidating their skills and transitioning into professionals who would soon be registered with the Nursing and Midwifery Council (NMC). Their perceptions regarding how the workplace culture/environment influenced their developing identity as future NIPE midwives could inform future midwifery programmes and improve the environment and cultural behaviour of the workplace.

The next chapter discusses how the research was designed and undertaken, followed by chapter 4 that reflects on how reflexivity was used within the design and conduct of the research, before leading into the first of three chapters that highlight the findings obtained from the data collected.

Chapter 3: Research Design

3.1 Introduction

This chapter explains the process involved in deciding upon the research design and how the researcher's philosophical stance influenced and shaped the chosen methodological approach and the development of the research aim and objectives within the study. The need to address related ethical considerations and the strategies employed during data collection and management will be explained.

Challenges relating to the role and impact of the researcher relationship with participants will be discussed and evaluated. The discursive thread relating to my thoughts and actions as a reflexive researcher will run throughout this and the next two chapters. At times a more formal 'reflective' section has been used to highlight the activities employed to reduce bias and raise the level of trustworthiness within the research process (Hunt, 2009). Finally, discussion will focus on the process of data analysis and interpretation.

3.2 Research design & methodology

Within the research related literature, regarding the terminology used within research, terms such as *methodology*, *design*, *approach* and *paradigm* - are at times used interchangeably and inconsistently. This can be confusing for both the research student and those who read the completed thesis and therefore, as Carter and Little (2007) suggest, I include at this point a clarification of the main research terms to which I refer. I have used the term '*research design*' as defined by Henn et al. (2006; p.49) as the "*plan or strategy of shaping the research*" which I interpret as the all-encompassing approach (paradigm, approach and methods used) that underpins my research. I have used Harding's (2013) perception of '*methodology*' as the theory and analysis of how research should proceed to provide justification for the research *methods* used. Finally, I adopted Schwandt's (2001; p158) definition of '*methods*' as "the procedures, tools and techniques" of research.

Whilst investigating the literature on research methodology, it also became apparent that often the research design is depicted as a linear process – defining the philosophical stance, identification of the subject foci, clarifying the research aim, data collection methods and analytical frameworks (Mason, 2002; Savin-Baden & Howell-Major, 2013). However, my approach in designing and planning my study emerged as a more spiral process, reflecting Mason's (2002) view who suggested that the degree and direction that the research undertakes may be one that is more fluid and flexible. Indeed, I was first influenced by the studies that explored why midwives chose to discontinue conducting NIPes which

led me to formulate embryonic questions that eventually influenced and informed the design of my study and the exploration of my philosophical stance as a researcher.

3.2.1 Research design

In commencing the research design, the researcher needs to recognise and identify their philosophical stance in relation to their ideas of the world and the nature of knowledge (King & Horrocks, 2010; Savin-Baden & Howell-Major, 2013). Indeed, Opie (2006) discusses the researcher's understanding of their philosophical viewpoint as paramount in reducing their possible impact on the research process which could prejudice the analysis and interpretation of data gathered. Therefore, I recognise that there exists a reality that is subjective, defined by the individual and although the study is independent of me I must recognise my possible influence on both the participants and data analysis - an ontological position that Woods (2011) refers to as subtle realism. Also, I hold the epistemological view that knowledge arises from the experiences of individuals who hold the optimum means to gain information about their perception of reality. This in turn may assist me in understanding more about the chosen focus of my research, through an in-depth exploration of their personal experiences (Henn et al., 2006; O'Leary, 2010; Silverman, 2013). Recognition of the above and my philosophical stance, fundamentally underpins my justification for a specific approach (Marshall and Rossman, 2006; p8) and thus a qualitative rather than quantitative study design appeared to be the logical route to follow.

3.2.2 Choosing qualitative research

Qualitative research engages with the meaning of human experiences to provide further knowledge through accompanying discussion, rather than quantifying and giving a number to the data collected. There is an acknowledgement that the 'truth' aired may be differently perceived or interpreted by different individuals or circumstances (Lo Bindo-Wood & Haber, 2005; Savin-Baden & Howell-Major, 2013). Although the findings may not be replicable, it aims to provide an in-depth discourse of the findings which may resonate with those who read the study analysis when applied to their situation or local population (Kearney, 2005; Hewitt-Taylor, 2011). However, Barbour (2008) asserts that qualitative research can (and should) provide explanations which are more informative than just providing an account of the lived experience. Indeed, Beck (2013) suggests that qualitative methodology enables rigour when exploring new or emerging topics in areas that have had little or no prior exploration, particularly in healthcare. As my aim was to explore practitioner' experiences in relation to the Examination of the Newborn within clinical practice, it was important to me that my research design should enable access to rich data which would enable me to feed back a meaningful interpretation of the findings to service providers.

Both Mason (2002) and Silverman (2013) highlight the necessity within any research design to demonstrate a close link between the approach used and the chosen method of data collection. Their discussion also encourages the researcher not only to formulate a methodological approach to answer the research question or aim but also to acknowledge and justify why other approaches were considered and subsequently rejected. Therefore, I have included my thoughts during this journey towards my chosen methodology in the following section.

3.2.3 *Research Approach*

Qualitative research tends to be dominated by the qualitative methodologies of 'ethnography', 'grounded theory' and 'phenomenology' (Hunt, 2009; Hewitt-Taylor, 2011). Ethnography was considered for this study as it has been described as particularly suited to clinical practice settings (Silverman, 2013 and Newnham, Small & Allen, 2021), as it is essentially a study of the interactions and functions of a cultural group (Hammersley & Atkinson, 1995; O'Leary, 2010). The impact of the behavioural culture of the workplace was referred to in the previous chapter and as this may be a factor within this research (Roper and Shapira, 2000 and Fretterman, 2010), it did appear to be a suitable choice in developing an understanding of how this aspect affected staff experiences.

Ballinger and Payne (2002) used ethnography to rethink policies and working practices within the National Health Service, an issue that may be of interest within my own study. However, I felt that this was incongruent with the aims of my study as the use of participant observation and immersion (of the researcher) in daily practice was inappropriate as I would be unable to witness all practitioner and student experiences first-hand. As my research covered a number of sample groups and NHS Trust sites it was unfeasible considering the time duration it would take. Plus, the possible need to explore other forms of evidence or gain further clarification during data collection would not have been consistent with the ethnographic process.

Similarly, grounded theory would also prove impossible as it is founded on a truly inductive process (Polit and Beck, 2006), in that the researcher has no pre-construed sampling frame and thus data is collected until no new data emerges, or what is termed as 'saturation point'. The methodology of grounded theory was particularly designed for the development of theory to be directly applied within clinical practice (Oktay, 2012). However, the need to utilize an abductive process to incorporate theoretical sampling with constant comparison and theoretical saturation, requires access to return to the sample population in-order to revisit and explore further the emerging theory. This would be difficult within my own research as I wished to explore practitioners' experiences from different sample groups and across three clinical sites which due to the number of participants and time

constraints would not have alluded to the requirements of grounded theory (Glaser & Strauss, 1967 and Okta, 2012). Therefore, this too was deemed to be an inappropriate choice which led to an exploration of the suitability of phenomenology.

3.2.4 Phenomenology - an initial choice

Marshall and Rossman (2006) described phenomenology as a means of focussing on participants' past and present experiences allowing the researcher to gain a better understanding of how these factors may influence the subject matter being studied. On further investigation, Heidegger's philosophical viewpoint (1962) of phenomenology appeared to be a more appropriate choice rather than Husserl's (Dowling, 2007), which requires the researcher to abandon all preconceptions of the area researched if they are to gain a true understanding of the perceptions of the participants. Whereas in contrast, Heidegger (1962) saw the researcher's knowledge and experience as an important element in the research process that should be acknowledged within the interpretation of the data collected. As the research subject is one within which I am involved both from an academic and practice point of view, I would find it difficult to abandon what I think I know and therefore I am more comfortable with Heidegger's hermeneutic (interpretive) view of phenomenology. However, Schutz (1962) and King & Horrocks (2010) both reiterate that caution is required when undertaking interpretive research, if the findings are not to be biased by the researcher's interpretation of the participants' words.

Phenomenology is often used as an acceptable approach within healthcare research. Indeed, some of the earlier studies (e.g., Steele, 2007) that had sparked my curiosity and led me to commence this research, used a phenomenological approach. Ross (2012) views phenomenology as an approach that seeks to establish the stresses and concerns experienced by the participant, whilst recognising that an individual's experience may be different and unique. However, as previously stated, it is this very uniqueness that can prove difficult to clarify and make meaning of within another setting, resulting in the findings not being transferable (Ross, 2012). Indeed, Kuzel (1999) was mindful of the use of this approach in healthcare research and highlighted the inherent need of researchers to utilise reflective clinical reasoning to develop a deeper understanding of a phenomenon if the knowledge gained was to be used effectively to improve clinical practice. Thorne (2008) expands on this viewpoint as she saw what she termed as 'pure' phenomenological description as a constraint within healthcare research where the aim is not ultimately to qualitatively document findings, but to explore the relationships that exist. In addition, Thorne (2008) emphasises that there is a need within the arena of healthcare for findings to be easily accessible to others for reasons of comparison or to inform further investigation. In the current changing world of midwifery education, as an educator and midwife, I often seek information from other institutions and NHS Trusts to inform curricula reviews and

therefore agree with Thorne's perspective. Therefore, the move towards using an 'Interpretive Description' as an approach for my study, appeared to be the most appropriate choice.

3.2.5 Interpretive description

As Thorne et al. (2004) explain, interpretive description draws on some of the values arising within phenomenological research but also allows the researcher to be flexible by utilising other forms or methods of collecting data. This further informs and gives greater strength (or understanding) to the findings derived from one's primary source of data, which as Hunt (2009) points out, can strengthen the 'trustworthiness' of the findings by providing triangulation of the phenomena being studied. For me, this was particularly appealing as I had a growing acknowledgment after conducting the pilot interviews that I might also need to embrace other forms of available data if I was to fully appreciate some of the issues that were coming to light. For example, midwives mentioned specific Trust protocols that governed which babies they could examine in agreement with or in contrast to national guidelines. Thus, further investigation of these protocols allowed for comparison across Trust sites, assisting me to build a picture of how differences between sites may arise and if they had any impact on practitioners within any one specific practice setting. Morse (2012) expressed the view that the use of knowledge gained in this manner assists the researcher to gain a sufficient level of contextual understanding, thus enabling personnel within clinical practice to better appreciate the issues experienced by staff. Thorne (2016) echoes this perception in reiterating that interpretive description provides a means by which the researcher can engage with the data beyond the knowledge gained through the accumulation of clinical wisdom and the available literature in-order to see "what else might be there" (p.40). Indeed, Morse (2012) refers to this in part by pointing out the need for a better understanding of the experiences of those who work within a clinical practice setting. Therefore, within this study, it would be useful to gain an appreciation of how particular aspects of the working environment may affect practitioners, their colleagues and those for whom they provide care. However, it is also important to constantly consider the impact that the researcher may have on the data from its initial collection all the way to the final analysis and recommendations. Thus, the chapter on reflexivity explores these issues and my position and possible impact throughout the research process, particularly where it could be construed that my relationship with participants may not be seen as impartial. However, this important consideration of employing reflexivity and being constantly aware of the need to reduce researcher bias is also alluded to within the rest of the research text.

The final conclusion was that a research design based on interpretive description appeared to be the most appropriate choice for the research aim. Once this decision was made, due consideration was given to sample groups, participant recruitment and the numbers of participants required.

3.3 Participant recruitment & sample size

I wanted to gain a greater understanding of the experiences and perceptions not only of our senior student midwives (who are undertaking their NIPE module) but also those of the NIPE practitioners and the relationships between them. Cooper and Lavender (2013) highlight the debate within qualitative research methodology about whether opportunistic sampling is the only route necessary. My sample groups needed to be representative of their specific group (Bryman, 2004) and in-line with the rationale for conducting the research. Opportunistic sampling would have proved difficult to achieve in the busy clinical environments within three clinical placement sites, plus some participants did not live close to their workplace and consequently this unfeasibility was recognised. As my sample groups of participants all needed to have some level of practice experience or relationship with NIPE, I used purposive sampling as advocated by Palys (2008) and Payne (2008), to enable me to recruit participants from the three local NHS Trusts to which the student midwives were allocated.

3.3.1 Recruitment

Participants within the sample group categories (see Fig 1) were informed by e-mail, posters and word-of-mouth about the rationale for the study and if they wished to participate they were requested to e-mail me for a participant information sheet and consent form. At this point I made them aware that a random number of responders from those who agreed to be included in the research would be contacted to arrange an interview date.

3.3.2 Sample size

There is a considerable difference of opinion within the literature in relation to the number of participants required to enable the collection of enough data from which to gain a credible representation of the findings in relation to the aim of the research (Bloor et al., 2001; Curtis, 2009 and Ellis, 2010). Sandelowski (1995) expresses caution when deciding on sample numbers and strongly advises the researcher not to fall into the trap of 'naïve induction' through a lack of quantity and quality of data. Also, Thorne (2008) warns the researcher to be careful of following the literature relating to 'required' numbers (Morse, 1989; Kuzel, 1999) indicating that this may reduce the opportunity to gain a rich level of data and consequently reduce the chances of making a meaningful contribution within the field of enquiry. Therefore, in recruiting a feasible number of participants from the various sample groups in-order to obtain a rich data source, I set the minimum number required to be flexible enough to cover if anyone decided not to participate or had to drop out of the study.

I also chose the size of each specific sample category to allow for richness of data, whilst allowing for cross comparison to be made across the Trust sites, thereby assisting in raising what Leininger (1994)

terms as the credibility of the research design and resulting data. Kvale (1996) also highlighted this issue by eloquently referring to it as the holy trinity of reliability, validity and generalizability of quantitative research. Whereas Lincoln and Guba (1985) use the term 'trustworthiness' to allow the positioning of a study as "worth paying attention to" (1985, p.290), a view also shared by Thorne (2016). This latter point is discussed further in the section 'reflexive researcher'.

3.3.3 Sample groups

The rationale for choosing my sample groups revolved around the need to gain differing viewpoints from a group of participants that were involved with NIPes but did not share the same professional discipline. I also felt that including the views of senior students would be invaluable as they were living through the process of completing the NIPE module as students and becoming active qualified NIPE midwives during the period of data collection. Therefore, accessing the views of all levels of NIPE practitioner may highlight areas that compare similarly or contrast to those of the other sample groups or with participants in the same sample group but practising within another Trust site. This may therefore reveal issues that participants feel may impact on both student and staff experiences, for example, actions, events or working practices that are considered as having a negative or positive impact.

The only exclusion applied during this study related to Foundation Year 2 (FY2) staff. These junior doctors had just started their neonatal allocation (as part of their second year of training) within the maternity units and therefore had limited knowledge or experience of NIPE at the time of the study. However, it should be borne in mind that midwives views in relation to junior doctors related to their personal experiences with junior paediatric staff prior to the arrival of these new doctors.

Due to the number of sample groups and participants, neither non-NIPE midwives or paediatric registrars were included within the sample groups. The former was due to time and shortage of staff and the latter was due to sickness which had also reduced the available numbers for recruitment.

3.3.4 Sample groups & recruitment numbers

The number of participants contacted the target number and actual number of participants across each sample group can be seen in the following table (Table 1).

Table 1: Sample Groups and Recruitment Numbers

Participant Group	Number contacted	Target number	Actual number
Pre-registration Students - Third year of three-year direct entry programme	60	20	20
Pre-registration Students - short course	18	10	10
Post-registration Midwives - 6-month Postgraduate course	18	8	6
Midwives (NIPE trained)	25	20	26
Midwifery Managers	9	6	6
Practice Education Facilitators (PEF)	4	3	3
Consultant Neonatologists	6	4-6	6

3.3.5 Recruitment issues

Sample sizes achieved for each participant group was close to the identified target number. This may in part have been due to responding promptly to participants and seeking to be as flexible as possible in arranging meetings at times to suit their work schedules with the aim of emphasising that their contribution to the research was valued. However, I did not wish any prospective participant who had expressed interest in taking part in the research, to feel pressurised through over-zealous pursuit in gaining their consent to take part in the study as this could have been interpreted as coercion (Ledward, 2011) or even harassment. Therefore, if no agreement for a date and time to meet was reached after two attempts to contact the individual, I did not pursue the respondent further.

Unfortunately, it was only possible to interview three Practice Education Facilitators (PEF) as one of the NHS Trust sites did not have a PEF in post at the time the research was conducted. However, this did give me the opportunity to gain some perception if this role had an impact in relation to the focus of the study.

The only area of concern that developed during the recruitment process related to the Pre-registration midwifery students. This concern arose as these senior students were already bombarded with requests to complete various university and national education surveys. In conjunction with this, timetabled teaching sessions and summative assessments for this senior year group are quite intense due to the stage in their programme of studies. Therefore, finding space for students to engage with the study as participants required subtle organisation and good levels of communication in-order to maintain their engagement in the study but not make them feel pressurised to do so. As with all other participants, the aim was to engender a perception that their voice was important, but not that they had to participate just because one of their lecturers was the researcher.

3.4 Pilot Study

Ross (2012) discusses the need to make sure that all potential participants are included if the full picture is to be uncovered during one's research. Conducting a pilot study not only assisted me in recognising if the questions I had devised (for both the focus groups and the interviews) provided me with an effective tool, but the data obtained also made me realise that I needed to include PEFs within my participant sample. PEFs are Midwives who have a specific, usually non-management role in practice education in relation to midwives and students. Their non-inclusion could have prevented me from gaining a valuable source of information from a different angle – one that is neither managerial nor part of the ward midwifery team – but who plays an active role in relation to staff training needs and NIPE.

3.5 Ethical Considerations

3.5.1 Ethical approval

As with all academic and clinical practice arenas, ethical approval was sought prior to data collection. Both University and NHS ethical approval was sought and granted (Appendices 1 & 2). Permission was also sought and granted by the Dean of School in relation to access to the student group (Appendix 3). As a matter of courtesy, I also informed the three NHS Trust Heads of Department so that they were aware of the aim, objectives and sample groupings included within the research and received positive reactions from all three.

3.5.2 Participant information & consent

Participant involvement was purely voluntary with all participants who wished to be involved in the data collection being given full written information in the form of a 'Participant Information Sheet' (Appendix 4). This explained the reason for the study and its possible significance to midwifery practice and service provision. Aspects relating to consent, how the data collection was to be conducted, stored and used was clearly defined. Issues relating to confidentiality and publication/dissemination of the findings on study completion were identified. The information was supplied to participants well before the data collection commenced in-order to give them time to reflect on whether (or not) to participate in the study.

All participants were required to complete and return a 'Participant Consent Form' (Appendix 5) prior to data collection commencing. The giving of consent in professional practice in healthcare is always open to revision and/or withdrawal and similarly, the Economic and Social Research Council (2015) views consent to participate in research as an ongoing and open - ended process. Therefore, once the

face-to-face point had been reached at the actual moment of data collection, participants were asked if they had any further questions and if they were still willing to participate.

3.5.3 Anonymity & confidentiality

Prior to signing the consent form, all participants were made aware that any information regarding whether they participated in the study (or not) remained confidential to the researcher and was not divulged to their respective NHS Trust sites or the University. Orb and Eisenauer (2001) highlight that it is important that participants are reassured that the research alludes to the principle of beneficence (preventing harm to others). It was important that participants felt safe when being interviewed so that they did not feel constrained during the interview. Although my research design held negligible risks for the participants, in terms of stress during the interview itself or fear of the data collected being made known or easily accessed by anyone other than myself – certain measures were put in place to reassure the participant and maintain ethical research practices.

All data was stored on a password protected memory stick and a back-up copy of the data was stored on a password protected PC. All consent forms, transcripts, data findings and the memory stick were kept in a locked draw within a locked office. All information was treated with the strictest confidence and was only accessible to the researcher.

Participants were informed that a small 'snapshot' of anonymised quotations may appear in a published report or article. They were assured both verbally and within the content of the research information form, that all data would be stored safely and confidentially (Rees, 2011; Sherlock & Thynne, 2010). All participants were also made aware that I was the only person who would have access to the audio recordings and that I alone would transcribe the recording itself.

Throughout this thesis, codes were used to replace the names of all participants in-order to maintain participant and practice site confidentiality. The use of an individual identifier was the only feature that identified the participant's transcript to the researcher, as this assisted in the collection of relevant contact information such as the status of the participant or NHS Trust site. This later factor facilitated cross comparison between practice sites thereby enabling the identification of themes that may concur as opposed to those that may be perceived as divergent. It also enabled a random selection of transcripts to be identified so that they could be returned to the participant so that they could verify if the content was a true transcription of the interview thus adding to the 'credibility' of the data collected.

3.5.4 Data protection

Participants were made aware that only one record existed which linked individuals to their identifier. This record was stored securely with all other material relating to the data collection and in accordance with the University of Hertfordshire policy on managing personal and confidential data. They were also made aware, that all personal data would only be stored for a set period after the conclusion of the study and then destroyed under secure conditions. The only exception will be for the contact details for those participants who have indicated that they would like a summary of the study findings.

3.5.5 Participant rewards

The act of rewarding participants within research is contentious, as some proponents put forward a case that a reward compensates participation for their contribution, whilst their opponents point out that it may be viewed as bribery or coercion (Barbour, 2008; Rees, 2011). However, as all participants apart from the students were professionals – no awards were offered, apart from articulating my sincere thanks and providing them with my e-mail address in case they wished to have a copy of the transcript of their interview.

At the time of the data collection, the students were in the middle of a very busy assessment period and unfortunately the university was also conducting surveys on programme evaluation. Thus all students were made aware that they could choose whether they wished to remain in the study. As a thank you for giving up their precious time and once the focus groups had reached a natural conclusion, group participants were informed that they could choose a small bag of chocolate/sweets from a box at the side of the room. The students were unaware that the confection would be made available until they were about to leave the area. The students appeared to be genuinely 'touched' by the offer but articulated that they were far more pleased with the fact that their contributions were viewed as an important part of the research being undertaken.

3.6 Method of Data Collection

Carson and Fairburn (2002) perceive that in healthcare research both qualitative and quantitative paradigms need to be evaluated in relation to their ability to make a difference which is the intention of this study. Bowling (2009) adds that the choice of research method depends on the aim of the research itself. However, Ross (2012) although reiterating this point, suggests that debating the most appropriate method is meaningless, highlighting that the important issue is to apply the most appropriate method to the research question or aim. Ross (2012) also points out that the choice of research method can be dependent on one's resources such as time and access to the sample group, which is a factor that the researcher needs take into consideration. To this end, the use of focus groups

for the students and semi-structured interviews for the qualified practitioners was decided upon as the most practical approach that suited the needs of the participants and could be realistically facilitated by the researcher. I also learned that the use of flexibility not only addressed participants needs but doing so did not necessarily need to have a negative impact on my choice of research method. Thus, the Programme of Data Collection and Analysis (Appendix 6) was devised in-order to plan periods of data collection in a timely manner and give an overview of the timings and sample groupings and enable the process to maintain momentum.

The interview questions were developed in response to the data obtained from earlier studies that explored the reasons midwives gave for choosing to refrain from conducting the NIPE (Steele, 2007; McDonald, 2008; Lanlehin, 2011). These questions were further refined in response to data arising from the pilot study.

A methods-based triangulation approach was used to combine the data arising from focus groups and semi-structured interviews, facilitating me to achieve a greater depth of information than with one method alone (Blaxter et. al., 2006; Carey 2013). As stated earlier, this use of different methods of data collection is embraced within Interpretive Description (Thorne, 2016) and is seen as increasing the reliability and validity of the data received by realising a richer, more holistic perception of the situation. However, although my research data mainly arose from focus groups and semi-structured interview responses, I also recognised the importance of incorporating specific information held by the individual NHS Trusts such as the numbers of NIPE trained midwives within the individual Trusts, specific policy documents and guidelines that relate to how the NIPE is conducted or referral pathways. In so doing, I could achieve a deeper level of insight than presently available into the factors that may have an impact on working practices and the individual experiences of the NIPE practitioner.

3.6.1 Focus groups

In relation to focus groups, the advantage of this method is that participants can all be interviewed at the same time (Krueger & Casey, 2000) and thus, the process occurs over a shorter timeframe. Also, midwifery students take part in focus groups for varying reasons across the curriculum and utilising this method will hopefully engender through familiarity with the process, a non-threatening environment and increase the likelihood of participant involvement. However, it was recognised that there may be a participant that is more dominant and therefore may influence (positively or negatively) the other participants particularly in a smaller group (Marshall & Rossman, 2006). Curtis (2009) perceives that three participants is an acceptable number of participants, although Bloor et al (2001) suggest six to ten and Ellis (2010) six to twelve. My intention was to aim for approximately 8

participants per group which may help to temper a dominant presence whilst still giving all participants a chance to contribute. Although a focus group will provide the means to gather certain information, it may be difficult to highlight site specific issues that may arise within the groups of students, unless the researcher is very attentive in noting 'who says what within a group'. To help this latter process, I had planned to draw a quick diagram relating to who was sitting where within the group to help identify who had articulated a site-specific factor and to make notes next to the location of the participant on this diagram to assist me later with transcription and analysis of the data.

Data collection from the midwifery students was arranged first to enable the data to be collected before these senior students completed their programme of training. The data collection from the other highlighted sample groups was then able to commence. As stated earlier, the chosen methods of data collection consisted of focus groups (for midwifery students) and semi-structured interviews (for qualified NIPE practitioners). I originally thought that I might need to conduct interviews with some of the students, but as the data from the focus groups was prolific and detailed, I chose not to do so unless a specific line of enquiry arose that required further clarification.

3.6.2 Focus groups - process

All students completing their NIPE module were asked if they wished to participate in the data collection after being given the information relating to why the research was being conducted. As discussed above, Participant Information Forms were supplied to all participants and Participant Consent Forms were administered and returned prior to the focus group event.

Focus groups were to be used as the primary source of data collection from the student midwives. Interpretive Description allows for diversity in the data collection method in order that the researcher can gain access to information that might otherwise remain undiscovered but, as Silverman (2013) points out the rationale for doing so should be clearly articulated. The sessions were organised to take place within the University itself as this is the usual arena in which focus groups are conducted and should therefore be viewed by the students as familiar ground. The students had indicated that they were happy for the focus group to take place in a classroom that was familiar to them on a set date and time (time parameter was defined as lasting no longer than one hour). They were asked if they were happy for the session to be filmed using a static camera, recorded with a digital audio device or preferred that no such recording was made. It was explained that the recording was only to act as an aide memoir for the researcher but that if they preferred, neither device had to be used – they all opted for the digital audio device.

On the first date set for a focus group, the participating students all attended but appeared somewhat subdued. After sitting and chatting with them, it became evident that although they wanted to be part of the research, they had become fed up with the prospect of yet another focus group. Apparently, the entire senior student groups had been involved in three focus groups over the past week for various impromptu surveys. Naturally, I asked if they wished to continue with the data collection or postpone it. However, the students wanted to continue with the session but asked if it had to be conducted in the same manner as the focus groups they had just completed or if it could be changed. Students were already aware that I had prepared six questions (the same used as for the interviews - Appendix 7) to set off their thinking during the session and after some discussion, the following method was developed with the students and was then adopted for all student cohort groups to maintain consistency.

The focus group consisted of the sample group of student midwives moving into six smaller groups within the classroom. Each group was given a pack of different coloured 'post-it' notes (each colour related to a specific question plus one for miscellaneous comments) on which to make comments or statements relating to the question that they were discussing at the time. Each group discussed one of the questions at a time and when they felt that they had exhausted the generation of any further thoughts and perceptions, they passed their question on to another group and received a new one. Around the room seven flip chart sheets were pinned to the walls – one for each question and a miscellaneous one for statements that a student felt was important to them as an individual or to the whole group (this point being identified on the post-it) but was not necessarily directed to one of the questions posed. The only other identification on the post-it note was the abbreviation for the Trust site in which the student was based. Students were asked to write their comments individually even if other participants in their group were all in agreement or not. This enabled me to appreciate the depth of feeling or frequency of the issue highlighted across Trust sites and within their student cohort. The session came to a natural conclusion approximately 50 minutes after it had commenced, with the students expressing positive comments about being given the opportunity to be involved and to put forward their views.

3.6.3 Reflection – focus groups

If the focus group had been held more formally (recording the discussion whilst the group sat in a circle) I might at times perhaps have heard a more vocal discussion, but in this instance the 'post-it note method' recorded the 'view' of each student. I was able to gain an understanding of the depth of feeling behind a specific issue and the way in which individual students perceived that issue.

As the researcher, I was able to sit away from the groups and observe their interactions without, it appeared, influencing the students' discussions, an event that Mason (2002) likens to being "a fly on the wall" (p92). Therefore, I was able to note when a specific aspect being discussed raised the tone and tempo of one of the sub-groups or produced a flurry of post-it notes and therefore seemed to work well. The students become animated, generated a lot of discussion (even observed in those who are generally known to be quiet/reserved in class) and active (lots of movement towards the flip chart paper to post their comments). Interestingly, the small groups sometimes joined up with other groups for discussion and then broke away again to continue their own small group discussion. During these moments of movement, the issues under discussion appeared to be those to which they all identified with (positively or negatively). Later, perusal of the groups' comments reflected and highlighted these issues particularly those that they deemed were of most significance. Student activity towards posting comments at these points in time was much higher than at any other which tended to indicate their depth of feeling about the specific aspect that was under discussion.

For my part, it was an amazing experience seeing them work in such a pro-active manner, considering how the meeting had first commenced. I also felt that I might not have collected the quantity or richness of data that would have been made available to me by a more conventional or formal focus group method. I had become more aware that not only the more vocal, questioning members of each of the student cohorts had volunteered to take part (who would have given their comments freely), but also those who were naturally more reserved in class. Perhaps it was that all students felt vested in assisting with the research, they were just as noticeably within the focus groups and when posting comments. It is possible that some of these more reserved students may not have been as forward in giving their views within a more formal focus group setting. Also, it may be that although I as one of their own lecturer's facilitated the session, my less obtrusive role may have assisted students to speak through the post-it notes more freely and prolifically. An appreciation of the role and impact of the researcher will be discussed further at the end of the next section.

3.6.4 Semi-structured interviews

Kahn and Cannell (1957) view interviews as, "conversations with a purpose" (p149) which I view as an apt description of the semi-structured interview. A format that enables detail to be obtained whilst following a question process that still allows the participant to add more information as they see fit. Plus, the themes arising from earlier studies can be explored further throughout the duration interviews held. The use of an interview approach within the phenomenological philosophy highlights the participant's perception of a shared phenomenon (Cresswell, 1998) - in this instance the experiences surrounding the examination of the newborn. It appears that my acknowledgement, or

as referred to by Marshall and Rossman (2006) as 'bracketing' my experiences, is an important part of phenomenological interviewing. This is because it links the researcher's perception with that of the participants and focuses on the meaning of experiences for individuals and how these might guide their actions. However, Marshall and Rossman (2006) also highlight that interviewing can be a time-consuming exercise due to the volume of data elicited and this needs to be considered when deciding on the number of individuals to interview within each participant group.

A semi-structured interview approach was utilised for data collection for all qualified NIPE practitioners. This enabled both me and the participant some flexibility to explore new ideas or perceptions as they arose, giving time and freedom for reflection. Denscombe (2010) points out that a semi-structured approach can aid the researcher to remain focused and maintain a sense of direction. Thus, I felt that it was important that I encourage the interviewee to be frank and open rather than express what they thought I wished to hear (Denscombe, 2010 and Drever, 2003). This was particularly important as not all participants may demonstrate a positive view (Sherliker, 1997). For example, they may not agree with the incorporation of the examination of the newborn module into the pre-registration programme. These 'contrary' views as they are sometimes defined, can give just as much insight into the NIPE practitioners lived experience as more positive comments. This reflexive activity is seen as an important factor in phenomenological interviewing (Marshall & Rossman, 1999, p113), as it encourages the revealing of new insights and produces data that is more detailed and comprehensive (Smith, 2009) but this can be affected by the manner, in which the data is collected.

3.6.5 Interview - process

As the relevant points in the data collection were reached, the qualified practitioners were invited to participate within the research and consent obtained. The questions for the semi-structured interviews (Appendix 7) were devised and piloted to enable the interviews to run smoothly but still allow both myself and the participants some flexibility to explore new ideas or perceptions as they arose whilst giving time and freedom for reflection. This type of interview format as Denscombe (2010) points out, aides the researcher to remain focused and maintain a sense of direction. I also made participants aware that the recording would continue until they had physically left the room – an action that has provided me with some very interesting and potentially valuable data which I would otherwise have lost.

I also needed to consider that on the NHS Trust sites utilised for this study, all NIPE practitioners apart from the paediatricians were in regular contact with university lecturers for one-to-one or programme

meetings within practice or University settings. The paediatricians also had contact with NIPE lecturers due to their involvement with NIPE students (both qualified and student midwives), albeit not quite on the same scale. It was important to encourage each participant to be frank and open rather than express what they thought I might wish to hear (Denscombe, 2010 and Drever, 2003) and it was possible that some participants may be reticent in voicing what they consider to be a very negative view (Sherliker, 1997). Therefore, to assist in providing a relaxed environment, all interviews were conducted at a time and venue which suited the participant. This is a point that Bell (2010) clearly sees as an important factor in using interviews as a method of data collection and strongly suggests that the researcher should fit in with the interviewee's plans, thus encouraging and making it easier for them to participate. Thus, conducting my research interviews within the most appropriate and convenient setting for the participant should assist in providing a relaxed environment where the interview could be conducted undisturbed. My involvement and possible impact within the interview itself, is discussed further in later section below on 'Reflection - interviews'.

3.6.6 Interview - audio recording

There are various ways of collecting the data from interviews, but it is important that participants do not feel manipulated or vulnerable (Opie, 2006). Recording the interview could make some participants uncomfortable, particularly in relation to the confidentiality of the material collected (Carey, 2009), such as the name of a member of staff being inadvertently mentioned. When organising the interview meeting and again prior to the recording taking place, participants were reassured that the recording content and transcript would be held confidentially to be heard and used only by the researcher. Unfortunately, it is possible within the practice arena for modern digital equipment to record parts of a conversation that occurs outside the immediate interview venue that may be sensitive to the workplace and patient confidentiality. Therefore, I carefully considered each meeting venue so that this possibility was reduced to a minimum.

3.6.7 Interview – note taking

Note taking or 'field notes' is cited as an alternative method for recording interviews, but Crookes and Davies (2004) describe how these can distance the researcher from the participant at the time of the interview and data can be lost if recorded later. During the interviews I chose to write quick, short notes alongside the audio recording, in order to highlight new information as it arose and particular issues that appeared to be sensitive or produced more emotion. This was useful as at times what was said required further exploration, but it was not always appropriate to interrupt the participant at the time and the notes enabled me to remember to return to the issue for further clarification at a more appropriate point.

The notes made were further enhanced through the observation of both the verbal and non-verbal language demonstrated during the interview. These notes provided me with information in relation to those factors that are not 'visible' on a recording, such as body posture, gestures and eye movement. This type of language can assist the researcher to recognise if the participant is becoming for example, uncomfortable with the interview process or the developing discussion. Equally it can give further indication of the degree of passion demonstrated in relation to a specific issue (Carey, 2013) and therefore the significance attached to it by the participant.

3.6.8 Reflection - interviews

During the pilot interviews I had not only considered if the questions provided an effective tool for data collection, but also to explore if I had inadvertently influenced the participant during the interview. e.g., when I asked for further clarification or when asking them how they felt about a specific issue. Reflecting on what was written in conjunction with listening to the recording aided me to understand if the question was understandable, to detect if my perception of the point being made at the time was accurate and inhibit any views of my own from colouring the spoken view of the participant (Mason, 2002). The use of a digital audio recorder proved to be an unobtrusive method of recording the interviews. Participants had been reminded that an audio recorder was going to be used and that only I have access to the recording and no participant has voiced any concern about its use.

I had been concerned that participants would colour their responses in relation to how they perceived my relationship with them, particularly as Levy (1999) and Rogers (2008) both stress the importance of being mindful of the imbalance of power between the participants and the researcher. Thus, I was conscious that the one-to-one interview situation may not be viewed as a conversation between equal partners (Kvale, 1996). To reduce my impact on the participant(s) I viewed myself as the recipient of their information and the participant(s) as the donor and view the interviews as, "conversations with a purpose" (Kahn and Cannell, 1957: p149).

On reflection, the depth and breadth of data obtained perhaps signposts that *my* concern was not such a focus of attention with the participants. This may be because they saw me as a fellow midwife or colleague who has some understanding of their working environment. Indeed, participants often made comments relating to my understanding of the practice environment or paediatric relationships with midwives, by using phrases such as "*you know what I mean*" or "*you know how it is*". At these moments I did remind them that I was not employed by the Trust and did not work in clinical practice full-time and therefore I wanted to know what it was like for them (the participant). I wanted to make sure that it was their story that I was gathering not one interjected with their assumption of my

understanding. After all, assumption of a person's perspective can work both ways between participant and researcher. Rees (2011) points out that shared understandings can be an advantage within the interview process but, as a researcher, I was cautious in that I did not want to confuse or compromise research principles by not paying attention to the importance of objectivity (Anderson, 2011) – an issue that I needed to be continually mindful of. Therefore, I clarified my current role as a researcher rather than a lecturer or clinician at the beginning of each interview, thereby setting the foundation of our relationship (Holloway & Galvin, 2017).

As participants were already used to working with me as a midwife and a link lecturer, they appeared confident and comfortable that our discussions were confidential and as far as I could tell, were forthcoming, frank and honest in their views. However, it is possible that as I work within their practice setting under the same professional rules in relation to confidentiality (NMC, 2018) but not employed by their Trust, they may have felt more able to voice the negative factors that affect service provision and not feel that they should generally only refer to the positive. In this setting, my 'status' appeared to work to my advantage rather than against me, enabling the participant to trust me with the information that was shared with me.

3.7 Transcription

In-order to capture the essence of the dialogue I transcribed the interview recordings myself. Indeed, Thorne (2016) suggests that this is helpful with analysis as the researcher is more likely to not only hear what is said, but to also take into consideration the silences or changes in tempo or volume, which can be lost when using a transcriber. The short notes taken during the interview have enabled me to highlight and match the recorded interview with the verbal or non-verbal body language that was demonstrated. Furthermore, as Carey (2013) has suggested, this has assisted me in identifying when a participant has become more passionate when following a certain focus in their discussion. These extra notes have also aided my identification of preliminary themes that appear to be replicated during other interviews with midwives and it will be interesting to see – on final analysis - if any of these themes are echoed or conflict with those of participants within the other sample groups.

3.8 Data Management

As previously stated, there is a dearth of available literature exploring the aims and objectives of this study. Therefore, the theory must emerge or be grounded within the data collected, a status referred to by Lincoln and Guba (1985) as being the opposite to '*a priori*', working from something that is already known or self-evident in-order to arrive at a conclusion.

The use of a systematic approach during the organization of the data and whilst searching for and interpreting meaning needed careful consideration if I was as O'Leary states (2010, p260), "to move from raw data to meaningful understanding" and achieve the aim of qualitative data analysis. As I had several sample groups and differing methods of data collection from which to collate the data and gain some 'meaningful' understanding, the following process was utilized.

3.8.1 Focus group data

After the focus groups, the post-it notes were initially placed on several large flip-chart papers, each corresponding to one of the semi-structured interview questions. As each focus group had been given a different colour of post-it notes to use, I could clearly see the perceptions that aligned from one group to another and those that were different or where a new view had been expressed. Gradually, a picture started to emerge relating to the themes that repeatedly presented themselves which could then be compared with those across the sample groups.

3.8.2 Interview data

In-order to check for accuracy, a random sample of interviews were returned to the interviewee, thus checking the validity of my transcriptions for trustworthiness. The transcriptions were also supplemented by the notes made during the interview. In addition, my understanding and insight into the 'story' that was emerging, was at times enhanced by investigating other forms of data, such as particular policies and guidelines to which study participants had referred to that relate to NIPE and neonatal care. This type of data enabled me to explore if, for example, policies were similar and/or accessible on all Trust sites; the evidence on which they were based and gain some idea about how they were used within clinical practice.

Each transcript was repeatedly re-read whilst listening to the audio-recording to check for accuracy of wording, coding, tone of voice etc. (Belafontaine, 2010; Savin-Baden & Howell-Major, 2013). This repetition enabled me to immerse myself in the spoken word and appreciate the nuances that shed light on the deeper perspectives that were being told to me and not just the superficial 'top layer'. In addition, the notes taken during the interview that were added into the transcript also assisted me to deepen my understanding of what the participant was trying to convey (Barbour, 2008). An example of this can be seen in the annotated extract from a midwife's interview transcript (Appendix 8), whereby the participants' annoyance in relation to the 'respect' shown towards her professional standing became quite palpable during the interview process.

3.9 Emergent Themes

Interpretive description requires the researcher to gradually recognise the themes emerging from the data collected. Thus the use of thematic analysis was utilised to enable this process, particularly as King (2004) and Braun and Clarke (2006) see it as a particularly useful approach to data analysis when exploring the similar or different perceptions of various research participants or for uncovering unanticipated themes. Seale (1999) suggests that use of an indexing system during the early stages of data collection establishes useful boundaries but advises against making these so inflexible that creative thought is inhibited. Thorne (2008) also advises the researcher against making premature assumptions about themes that they may perceive to be developing when the data collection is still on-going. Therefore, because I had so many sample groups consider I superficially coded the data collected when 'loose' themes became evident by initially using the interview questions as a 'starting block'. I followed a simple format of coding to identify the sample group and as the process continued the themes and sub-themes as they arose (Crabtree & Miller, 1999). However, both Kearney (2001) and Thorne et al. (2004) warn against clinging to initial findings and encourage a disciplined reflexivity where the researcher is continually questioning the 'links' and 'contrary' information that emerges. Thus, although initial 'themes' did start to emerge with the data from the focus groups and first few interviews, it was necessary within the process of interpretive description to 'stand back' from the growing data until themes started to clearly emerge. I found this a useful exercise as it inhibited me from jumping to conclusions or making precipitous links that may have been difficult to displace from my thinking later and thus reduce my objectivity as a researcher. As it took time to collect all the data from the number of participants involved, this quelling of the urge to 'set' themes within the data, did teach me to be patient and see if the initial themes that had emerged, remained; if other stronger themes became visible or were linked differently than had perhaps first been presented and see more clearly the themes that were more divergent.

Thorne et al. (2004) assert that the use of inductive analytical approaches within Interpretive Description aids researchers to seek out the characteristics, patterns and structure within the lived experiences of the participants. In-order to maintain the process of letting the data 'speak for itself', each sample group was initially scrutinised separately to gain an understanding of the 'voice' of that specific group. Once the information from each group has been repeatedly reviewed, I again stepped back to view the emergent themes. The themes from each of the groups were cross compared (between sample groups within a specific Trust and across Trust sites) to explore if they were in alignment or exclusive to one group or Trust site as displayed diagrammatically in Appendix 9.

Once both the focus group and interview data had been fully collated, the discussion relating to these aspects was commenced. The process of analysis within interpretive description draws inspiration from the techniques derived from various qualitative approaches. Although, the distinction here is that the approach used is not as Thorne (2008, p153) emphasises, “borrowed uncritically or used in a manner that is entirely faithful to the original tradition”. I am aware that I must account for the analytic process used if as Silverman (2013) warns, I am not to devalue the data collected and limit its usefulness within the practice arena. Therefore, during my research, the anthropological and sociological foundations of ethnographic methods were drawn upon as they seek to discover how people make sense of the institutions in which they live and the interactions they experience within them (Feldman, 1995). Nonetheless, I had to be mindful that the data obtained was being filtered through my own personal, interpretive lens (Baker, 2006; Kingdon, 2005) and therefore can never be truly objective. As my research focused on the human context, the acknowledgement of my own influence and biases was just as important to consider as the research journey progressed.

3.10 Data Interpretation

The inductive analytical approach within interpretive description assists the researcher to understand the clinical phenomena that influences staff perceptions within the practice arena. Whilst I initially used loose translations arising from past studies that explored why midwives chose to discontinue to perform NIPE, the evolving data that started to arise developed into a concurrent and reflective relationship between the data collection and analysis across the various sample groups. The initial factors on which I had based my conceptual framework still partly hold a relevancy within the findings. However, the process of standing back, re-reading and re-visiting the data as advocated by Thorne (2016), enabled a process of illumination and interpretation of the data, highlighting areas of limitation and the need for further clarification as the data collection progressed. Self-reflection both personally and reflexive activity within the research process has been central to my eventual analysis of the data. As Savin-Baden & Howell-Major (2013) articulate, data interpretation is a “complex, iterative process, not bound by rules and easily defined strategies” (p.451). Therefore, I acknowledge that the findings may be understood and interpreted differently from another’s standpoint. Even so, the findings represent a “tentative truth claim” (Thorne et al., 2004, p.6) in relation to the phenomena being studied, which is further strengthened via cross sample group comparison highlighting clinically applicable insight.

3.11 Summary of Chapter Three

Within this chapter I have discussed and justified the rationale for my research design and methodological approach, the strategies used to collect the data and presented an exploration of the

ethical issues. My reflexive thinking during the process from designing the research through to clarification of the methods adopted for data management, analysis and interpretation has been an underlying thread throughout the journey. In continuing this thread, the following chapter presents a clearer view of the use of reflexivity in the research process and how it was utilised to develop my research skills and increased my awareness of my impact on the entire research process.

Chapter 4: Researcher Reflexivity & Introduction to Findings

Within the preceding chapter, reflexive thought processes and rationales for decisions made have naturally evolved within the text. This chapter seeks to explain some of my journey to becoming a reflexive researcher and in so doing, how I have worked towards reducing the impact of my beliefs, knowledge and personal experience on the research process and conclusions (Chesney, 2000).

4.1 Reflexive Practice

When I began my research, 'reflexivity' or 'reflexive practice' were terms that I had heard about in relation to research but could not adequately define. As a practising professional midwife and lecturer, I employ reflection both 'on' practice and 'in' practice. The former, with the assistance of a model of reflection for clinical practice (e.g., Benner 1984; Gibbs, 1998; Schön, 1991), supports the retrospective exploration of my actions in clinical practice including the impact of verbal and non-verbal cues on the women and family for whom I am caring within the midwifery setting. The latter is more 'immediately reactive' where reflection is used as a tool (Schön, 1991) throughout the working day to assess how women and their family members with whom I interact with in clinical practice perceive my actions (via verbal and non-verbal cues and feedback). For example, responding to and adjusting my actions in response to a woman's changing needs as labour progressed. Both forms of reflection serve to develop and inform my practice with the aim of becoming an experienced practitioner who practices as a flexible advocate for the woman and her family.

In education, reflection 'on' practice, enables me to review how students responded to a particular format of teaching and facilitate a more effective method of teaching to better assist their differing learning needs. Within the classroom, I may change the intended format of the lesson in-order to raise the level of comprehension. For example, the intended teaching session may have originally been planned as a lecture, but I may change this to a more interactive group format if it helps students to learn or understand the content of the teaching session more easily.

Therefore, with the above in mind and using student midwives as an example, it could be perceived that the dissemination of the 'findings' resulting from my personal reflection 'on' and 'in' practice is more focused on myself and the students that I am working with, either clinically or academically, who will be the midwives of tomorrow. Thus, in this instance, my aim is to aid students to recognise learning opportunities to improve by means of their own personal self-reflection regarding their performance and understanding and in turn be able to identify gaps in their knowledge.

However, this is not the sole role for reflection within clinical practice and education. For instance, within clinical practice it is also paramount to improve working relationships within multi-disciplinary teams through effective reflective practices. The importance and benefits of a clinical workforce in which reflective health and social care practitioners work together for the continual improvement of patient care has been much discussed over recent years (Francis, 2013; NHS, 2016; NHS, 2019a). Indeed, the publication, 'Benefits of becoming a reflective practitioner' (NMC, 2019, p1) highlights and encourages the need for professional teams to "reflect and discuss openly and honestly what has happened when things go wrong". Importantly, this document was issued as a joint statement and supported by the Chief Executives of the statutory regulation of health and care professions such as the Nursing and Midwifery Council and the General Medical Council in recognition of essential need to improve interdisciplinary relationships.

When I commenced the Doctorate in Education, I had an understanding about where I stood as a researcher in relation to the expectations about my professional development, both from a personal viewpoint and that of my employers. I was also aware that as a researching professional, my research might give me insights that I could utilise within both my professional role as a lecturer and that of a registered midwife. However, what I was far more unsure about was whether my role as a lecturer would hinder me in my exploration of the area of practice on which my research was focused. This was due to the fact that the participants who would engage with my research came from the very NHS Trust sites where many staff members and students knew me as both a lecturer and practitioner. These participants were also well-aware that I was exploring a subject area for which I was known to be strongly associated with both in academia and in practice.

My 'personal aim' was to advance my understanding in my field of exploration and "not simply to have lived through the experience", as Thorne (2016, p114) states so eloquently. In doing so, I hoped to not only gain further insight for myself and the students, but also to disseminate information gained within the practice arena if the findings had implications that would enable development in practice standards and care. These key points provided the foundation of my rationale for choosing Interpretive Description on which to base my research design (explored within the previous chapter). Therefore, this chapter focusses on my growing understanding of how the use of reflexivity could assist me in tempering the impact of my personal knowledge, standing and subjectivity on the research process and data analysis, whilst recognising that my professional insight could also be a valuable tool in its own right.

4.2 What is reflexivity?

When first researching the literature in relation to reflexivity, it appeared to suggest that the use of reflexivity assisted the researcher to become absent or neutral within the process of designing the research process and identifying the findings (Mauthner & Doucet, 2003; Jootun et al., 2009). The rationale for this almost 'invisible' researcher was to remove the influence of the researcher (Fontana, 2004). The general theme appeared to be that using reflexivity would remove researcher influence on the entire research process, promoting rigour and raising the level of research validity by reducing the researcher's influence – whether intentional or not – that may affect any part of the process (Primeau, 2003; Fontana, 2004; Parahoo, 2006). Conversely, there are others who view the discussion on the use of reflexivity as being 'open to interpretation'. Mauthner & Doucet (2003) argue that although the use of reflexivity is an important component of quality research, there is unfortunately "an assumption built into many data analysis methods that the researcher, the method and the data are separate entities rather than reflexively interdependent and interconnected" (p414). Thus, the concept of reflexive practice within research was fast becoming a nebulous one as implied by Atkinson and Coffey (2003), who wrote, "Reflexivity is a term that is widely used, with a diverse range of connotations and sometimes with virtually no meaning at all" (Ch.1, p108). Indeed, Carolan (2003) alluded to the difficulty of trying to find a clear definition of what reflexivity means and how it should be employed within one's research design.

With the above in mind, it was therefore difficult for me to differentiate between 'reflection' as used within professional practice and the 'practice of reflexivity' used within research. However, with further exploration of the term, I slowly began to see how reflexivity related to my impact as an individual and professional in the field I was exploring and that this impact was continual and could affect the quality and honesty of the process, the data collected and the data analysis itself. Or, as Rice and Ezzy (1999) suggest which aided my understanding, "An acknowledgement of the role and influence of the researcher on the research project. The role of the researcher is subject to the same critical analysis and scrutiny as the research itself" (p291). Thorne (2016) alludes to the same perception in that she describes how the use of reasoning activities can facilitate the researcher in exploring and rationalising their decisions throughout the research process. In so doing, questions will inevitably arise and adjustment is required so that they are answered. Therefore, although I developed my questions for the semi-structured interviews, I kept the number small to allow for further exploration in relation to the narrative of the participant. Thus, I was able to ask for further information, such as 'how do you feel about ...', 'what would make a difference ...'? However, at the same time I had to be aware of why I was picking up on certain answers – was it my own perception/bias, or because other participants had also talked about the same point? These questions

relating to how, what, why were integral to my research design and data analysis as I recognised that such reflexive strategies would help reflect the integrity of the research itself.

However, I fully appreciated that as Thorne (2016) suggests, the paradox of good research integrity is that you cannot plan for unknown eventualities. Jootun et al. (2009) state very clearly that any qualitative study is prone to a degree of subjectivity, influenced by the researcher's own values, experience and interests. Nevertheless, they also signpost that total detachment is unrealistic and if over analysed, limit and hinder the qualitative process, thus understanding my influence in the research process is important but I need to accept that I will constantly check that it does not bias the data but utilise it to understand it in greater depth. Interestingly, in the same vein as Thorn (2016), they also suggest that acceptance of the researcher's knowledge and experience particularly within the clinical practice setting, can allow a greater level of engagement with participants that can often enrich the quality of the data and can therefore be regarded as a valuable tool to the research process.

Bridges (2014) perceives that the impact of reflexivity is seen through observation, reflection and via the dynamics arising during the interaction with colleagues. This perception was developed further by Attia and Edge (2017, p36) who stated, "we observe in action, we step back to reflect and we step back up again to action". Both perceptions focus on the need to reflect and to be actively self-aware during the whole process of data collection, collation and analysis, which Mann (2016, p16) views as the hallmark of reflexivity.

I was quickly becoming aware of how my relationship with the participants and my prior experience may influence the research process and interpretation of the data. My ongoing analysis of the impact of these influences became an important factor in reducing subjectivity and raising the level of objectivity. This analytical stance was important throughout the research process, such as in recognising what I already knew about working in clinical practice as a NIPE practitioner, how to relax my participants and engender a relationship of Trust, how to effectively transcribe and check the content of the interview narrative and eventually ensure that I examined my own impact on the data collected and how I arrived derived and presented the main themes arising from the data collected. Therefore, to demonstrate some of the reflexive processes employed these issues will be discussed below.

4.3 Prior Knowledge & Experience

As stated previously, my interest in my research area was sparked by my own knowledge and experience as a NIPE practitioner, both as a midwife and midwifery lecturer. Yet, for some years prior

to conducting this research, I had not worked full-time as a midwife within the clinical arena and now when in clinical practice, I teach students who are completing their NIPE module (predominantly qualified midwives and midwifery students).

The current literature that was available at the time, focused on the reasons that midwives gave in relation to stopping to conduct NIPes. The rationale for most of these studies, was that there was a cost factor in training midwives which became an expensive investment especially if some practitioners then chose not to use this qualification when in practice. As I explored this literature, I realised that there was little detail or rationale given for the findings presented as the method of data collection tended to result in factual statements alone. Questionnaires were often used in which questions were asked that related to specific aspects, such as whether a midwife was conducting NIPes and if not, what made them stop doing so. Practitioner responses related to issues such as staffing levels and working with paediatricians. However, due to the method of data collection and questions presented, participants were given little opportunity to give more than bare facts, thus the minutiae were not visible.

I had conducted my own research as part of my master's study to investigate if similar themes as those above were prevalent within local NHS Trusts. I had used similar questions as I wanted to know if any information would come to light that could be used in practice to encourage midwives to continue to conduct NIPes. This knowledge was important to the university that I was working for at the time, as these midwives would be needed to teach the student midwives who would be completing the NIPE module as part of the newly validated BSc Midwifery Programme that would be commencing the following year. Learning from the earlier studies, I chose to use semi-structured interviews to give me more detail and gain insight into why certain factors influenced practitioners choices. The information gained demonstrated similar findings to earlier studies and was shared with the local NHS Trust sites. However, it also made me realise that there were no studies including my own that explored the perceptions of all practitioners' and students who were involved in NIPE. Consequently, I felt that there was not only a gap in the available knowledge that deserved further investigation, but that a more complete picture of the experience of NIPE practitioners' and the students within the practice environment might give a more detailed and cohesive picture than was currently available. Thus, at the point of deciding that I wanted to investigate the situation in more depth, was the point that I realised that:

a) There was little detailed literature relating to NIPE practitioners' experiences per se

- b) My own experience had made me aware that interdisciplinary relationships between midwives and paediatricians could be difficult at times, but what this meant in the reality of the clinical practice arena, I was yet to fully appreciate
- c) NIPE midwives and student midwives saw their NIPE skills as an important component of being a midwife. Thus, being able to give continuity of care, not only to the mother (as has always been within their professional remit) but also the baby was deemed just as important and a necessary part of their role (NMC, 2019b)

Points 'a' and 'c' influenced me as a researcher only so far that these were 'generally known' issues to me and I was very aware of them. Point 'b' was a little different and could have coloured my view regarding the data collected in relation to this area but for the fact that my own experience in practice is different to that of the midwives. What this means, is that because I am a lecturer and have been conducting NIPES and teaching the NIPE module for a long time, my experience when contacting the paediatric team such as when referring a baby for further investigation, usually results in the registrar attending to examine the baby. Conversely, when I am working with students, I expect the student as part of their learning experience to contact and communicate with the paediatrician and follow through with the on-going assessment of the baby and I am aware that often the SHO is sent instead. As a result, I cannot assume that my own experiences of the outcomes of such communications or environmental factors that I experienced in practice were the same for those who worked in practice most of the time. Indeed, I was taught a salient lesson whilst in practice which I have not forgotten, in that I could not understand why the midwives I was talking to stated that they did not have enough equipment. On further investigation I realised that the postnatal ward had two ophthalmoscopes and one was often not working – which is why they did not have enough available equipment when lots of babies required NIPES prior to discharge home. I on the other hand brought in my own equipment and did not need to use the equipment on the ward and therefore, had never thought about what was available. I may have the knowledge and skills to conduct NIPE and can teach it in my sleep, but I knew then never to assume what a situation is like when you are on the periphery. Thus, the use of reflexivity in my research process made me more questioning about how I conducted it in terms of the primary questions used, when using prompts or asking for further information. Additionally, I needed to reflect on whether I was making an assumption about a particular theme that revealed itself or if it actually was viewed as a recurring or common issue by the participants.

In order to gain information from the participants in my study, it was important that in conjunction with acting reflexively, they knew and understood where I stood, both in terms of being a lecturer and practitioner. I wanted to build a trusting relationship between myself and the participant to

demonstrate that I was respectful and appreciative of their time and the information that they shared with me. Therefore, the following section discusses my actions as a researcher towards aiding participants to feel relaxed during the interview and to trust that I would be respectful of the information that they shared with me.

4.4 Building Participant Rapport & Trust

Throughout the data collection process, I was mindful of the pressures that both qualified and unqualified staff may be subject to. Therefore, I made the process as flexible as possible to accommodate the various needs of the different sample groups, for example:

- the student midwives were in the final year of their programme and at a busy point in their year at the point of data collection. There was no way of changing the timing as they needed enough time in clinical practice to be able to give an informed opinion but not for the data collection to interfere with the pressing need to complete any remaining clinical requirements within the practice setting. Thus, the small window of opportunity available, led to a discussion with the students and the use of focus groups – as discussed in the previous chapter - rather than individual interviews
- The midwifery managers, midwives and PEFs were given the opportunity to give dates, times and venues where they would be most comfortable to be interviewed. This worked well with these sample groups with no member of the midwifery staff appearing ill at ease during the interview
- Consultant paediatricians required the most flexibility. This was not due to agreeing to be interviewed and then feeling beholden to doing because there were so few of them within any Trust site, but purely because their working environment did not always make it easy to plan a date and time to meet without a neonate requiring their time and attention. Therefore, to make it easier, I would regularly stop by their offices so that they and their secretaries knew that I was on site and when I was free for them to talk to. This system although seemingly ad hoc worked very well due to the diligent secretarial staff and usually resulted in a time-period in which we were not interrupted during the interview

The above example of building flexibility into the data collection process made it easier for staff to give me time out of their day to be interviewed, for which I was deeply appreciative. Even though I had already stated within the participant information form what would happen to the information they shared with me, I again reiterated this at the time of making the interview appointment and at the beginning of the interview itself. I had no way of knowing at the start of the data collection process what insights or information may be shared with me. However, as I work in healthcare, I am well aware

that staff can find it difficult at times to share their real feelings if they have any concern about what might happen to the information that they divulge. Thus, this area will be discussed in more depth later within this chapter.

4.5 My Stance as a Researching Professional

I felt that if I were to obtain a participant's frank and honest perception, it was important that they knew I was not a threat and respected the views and insights that each participant shared with me during the data collection process. However, prior to commencing data collection, I was aware that achieving 'honesty' may be an unachievable goal. Walsham (2006) highlights this possibility by discussing the disadvantage of close involvement with participants who may not be so open with a researcher that they see as having a vested interest. Conversely, the researcher may be so close to the situation that the participants are in, that they lose their criticality of the situation and the significance and nuances of what participants disclose during the interview process which can then affect the interpretation of the findings (Bradbury-Jones, 2007, Stronach et al., 2007 and Hamzeh & Oliver, 2010). Amongst others, Berger (2013), Drake (2010) and Pillow (2003), also discuss this view in terms of the insider-outsider researcher and the danger of imposing one's own view, beliefs, values and biases on the whole research process, not just the data collection itself.

I was known by staff in all three Trust sites as the lecturer who taught both the pre-registration and post-graduate NIPE modules and, who also completed NIPes in practice across all sites. As I also organised the Newborn Forums, I was well acquainted with the paediatric teams and managerial staff. Therefore, my a priori knowledge needed to be recognised and embraced in a positive manner but not one that impacted on the data. For example, I knew where to obtain further information about Trust guidelines and the teaching of junior doctors, plus I was conversant with the national standards and could use my 'known status' to gain easier access to the Consultants, personal assistant to arrange meetings for interviews.

Another point I had to bear in mind was that I had taught many of the midwifery staff to conduct NIPes. I was aware that they might potentially see me in the position of someone who might judge them for what they disclosed to me, or be concerned that I might identify their views to senior management or paediatricians. It was necessary to be insightful and reflective in appreciating the impact and influence my presence may have on participants and on the decisions I made within the research process. Therefore, to counteract my a priori knowledge or biases I had gained over the years of working in the same practice sites as my participants from influencing my decisions and interpretation of the data collected, I started a journal. Usher (1996) emphasises that the "activity of

the knower influences what is known” (p35) and in recognising this process, it must in turn be possible to temper the researcher’s influence on the research process. Etherington (2004) discusses how the use of a journal can be cathartic in that the writing within its pages is seen only by the researcher. Thoughts can be written in full or be under development, items can be added and removed, links can be made and instructions to oneself written in, crossed through and re-added. Indeed, Johns (1996) refers to students within counselling and psychotherapy who are required to use a journal which is not unlike a reflexive journal, in that it is used to “develop their own internal supervisor” (p90). Thus, the journal becomes a tool, recognising one’s learning and development and is used to expand upon and maintain awareness of the influence of oneself and that of others. Indeed, Etherington (2004) suggests, writing a journal also helps us to see ourselves more clearly in terms of our biases or unacknowledged negative thoughts that may interfere with and influence how we make sense of the data collected, consequently I may be listening but was I actually hearing what was said?

My journal enabled me to not only highlight what I needed to do next and when and how I had completed an action, but also comments made to me by participants throughout the research process and my own thoughts or revelations as they became visible. At the time of starting the journal, I did not know if this would help me maintain my position as a reflexive researcher, but as the study progressed, it helped me understand my position as a researcher and my impact on the process. Most importantly, reflexivity enabled me to not only tell the participants stories but also to begin to unfold and draw the stories from different professional disciplines together. The journal was helping me to scrutinize my choices, actions and interpretation of the data. This constant self-appraisal combined with my unique insider-outsider role created dynamics within the research process which, as Adeagbo (2020) alludes to, appeared to produce a more positive impact on the research process through the richer nuances and detail that participants revealed to me than I had anticipated. This may in part have been due to several factors such as participants feeling that I could be trusted, or that they perceived that with my background I would understand some of the aspects they spoke about. I also recognised, that my viewpoint and how other’s may see me as a researcher (my identity) was itself also changed and moulded by the knowledge and insights gained during the research process and that I in turn may influence them in how they answered a question or read my verbal and non-verbal communications. In recognising this point, I felt more reassured that my a priori knowledge and experience could be moved aside so that I could more clearly hear what others had to say and build a picture that was not my representation of their experiences and perception of the practice arena, but that of the participants. It is worth mentioning at this point, that I kept in mind the words of Jootun et al. (2009) who state that, “Researchers should be aware that total detachment is an unrealistic aspiration that can limit and hinder the qualitative process. By incorporating their social selves it will

allow them to engage with participants and enrich the quality of the research” (p46). Therefore, apart from looking at, for example, the development of the research aim and objectives, I somehow needed to promote an atmosphere where participants trusted me in a manner that encouraged their participation.

4.5.1 Working with participants – the element of trust

One of the decisions I made at an early stage in the study, was based on the possibility that my insider-outsider position could create a negative impact in that participants may only be forthcoming of issues that were pertinent to them if I demonstrated my respect for them and the information that they were willing to give me. Therefore, I reiterated to each participant that what they said as an individual would not be identifiable to Trust staff, which was paramount if I was to obtain as clear a narrative from each individual participant as possible during the data collection process. I also clarified to participants that any publication of the findings would encompass the main points that were highlighted by the sample groups across all three Trust sites. Both during the selection process and just prior to interview commencement, I communicated to all participants who would see the transcripts (which was myself alone and those individuals I returned their personal transcript to for checking). I also made sure that participants were aware that in any publication format, the Trust sites would not be named apart from locating them within the South of England.

I also wanted to make sure that they understood why I was performing the research and what would happen to the recordings (Walsham, 2006). Very few qualified participants needed information about the former but as expected, students often wanted to know more as would be expected during their final year on their programme when they were conducting their own major projects. On the latter point, all participants were informed that the only person who would listen to the recordings and transcribe the content was myself. It was also explained that every second or third transcription would be returned to the related participant for checking and needed to confirm if they were agreeable to this, which none were opposed to. At this time, I found it was a useful point to inform them that I might make some notes to capture information that recording could not, or to highlight specific points as an aide memoir for later. I also informed them that I would only stop recording when they had left the room.

4.6 Interviews – Recording & Transcription

Data collection and analysis of the findings occurred simultaneously in accordance with the process of Interpretive Description (Thorne, 2016). However, for clarity, this section focuses on the interview recordings and transcriptions.

As previously stated, the participants, were always made aware that I would write notes during the interview even though the discussion was being recorded. I also stated that the recording would be paused if we were interrupted and only stopped when they left the room. None of the participants appeared to feel concerned with the fact that they were being recorded and in fact, quite a few of those I sent a transcription of their interview for checking, mentioned that they had forgotten that they were being recorded. This was possibly for two main reasons, firstly the equipment that was obviously visible to them was the microphone, which being small was quite unobtrusive and secondly, the fact that I did not physically move to turn off the recording whilst they were still in the room.

Any notes I made were incorporated into the transcription unless they were already clear within the recording. For example, when the participants appeared to feel strongly about a certain issue, they tended to become more vocal with changes in tone, volume and body language where they often leant forward to emphasise the point they were making. Listening to the interview recording would often allow identification of change of tempo, tone of the speaker and volume, but it was only through the notes taken at the time, that I could appreciate whether the participant was feeling defensive or conversely if they were quite open and assertive about what they were articulating.

I completed all the interview transcriptions rather than using someone else to accomplish this for me, a process that Thorne (2004) views as an important aspect of interpretive description as this allows the researcher to become immersed in the data and not just look at it from the outside. Whilst this was quite an arduous task, it did serve many useful purposes which I only really became aware of and understood as the data collection progressed, as follows:

Firstly, as I was the interviewer, I could cross reference with my notes where there was ambiguity within the recording. For example, the participant might refer to he or she and I could then clearly identify to whom they were referring in terms of staff status.

Secondly, it allowed me to engage with the vocal record on a different level – the words used, tone, emotion expressed – which gave me another window of opportunity to ‘hear’ what the participant was saying and the way it was said which I might otherwise have quite easily missed and the importance of this minutiae would have been lost.

Thirdly, the need to listen to the recording multiple times in-order to faithfully transcribe what was said, enabled me to become immersed in the narrative and put aside my own personal knowledge and experience whilst doing so, aiding me to hear the narrative more clearly.

Lastly, reviewing my notes and listening to the recordings in a reflexive manner enabled me to view my own reactions to the participants narrative. Thus, I could reflect on how I responded to the narrative when the participant became more vocal or where they were discussing areas that I was well acquainted with.

However, I did not rely on my own interpretation of what was said. In order to check that I had faithfully transcribed the interview recording, I sent every second or third transcription back to the interviewee to see if the text was a faithful record of the narrative, if any inferences made such as where the participant had appeared to feel strongly about a particular point was an accurate one. For the sample groups that were naturally smaller such as the consultant sample group, all transcriptions were returned to the participants so that the level of accuracy was similar to other sample groups. This ensured that all sample group recordings were treated in the same manner with no preference being shown to one group over another as I wanted to have the views of all the sample groups and not focus on one more strongly than any other.

All participants who were sent a transcript of their interview returned it within a short time, some with comments or additions and others just stated that they were, “in agreement” with the content. Those who made comments on the content, generally stated that they had not realised how strongly they felt about a certain aspect that they had discussed until they saw the transcript. None of those who commented disagreed with how they felt or stated that they had felt the transcript was unjust and therefore this gave more gravitas to my efforts in transcribing the recording accurately. However, I was still concerned whether the narrative was what I wanted to hear or participants thought should be said and this will be discussed further in the next section – Finding the findings.

Those participants who made additions or gave further information, were usually pointing me to a specific guideline, policy or even a specific member of staff who had access to audit information that related to the point they had discussed. This was really helpful, particularly regarding activities or processes that had been audited as I would not necessarily have known that this had occurred if it was for example, a short, snapshot in time audit that occurred over a short time due to my outsider status. It also gave some indication that the participants themselves were engaging with the research and that perhaps, they saw the value of conducting research in the subject matter. Angen (2000) suggests that participants should see the need to collect data on a specific subject as authentic or in other words they see the value of the research and its place in ‘their world’.

I expected that the information revealed within the transcriptions would give me insight into whether prompts used needed to be adapted or changed. However, on close inspection I found that I used similar prompts where required. For instance, I might ask “can you tell me what you mean by that?” or “what did you feel about that?”. Whilst I was aware I could not necessarily hope to recognise all biases that I might have that would taint the research process and data collection, I did want to temper those values or beliefs that perhaps I was not aware were stronger than I thought. Indeed, Berger (2013) and Buckner (2005), see activities such as strengthening the researcher’s awareness of themselves as part of the world they are studying, as an important reflexive undertaking if the researcher is to give a faithful representation of their findings. My awareness of this ‘world’ was partly instilled in the familiar (I worked in the trust sites as a NIPE practitioner), but I was also experiencing through the participants, perspectives or processes that were unfamiliar to me (day to day practices, paediatrician - midwife communication etc.). Therefore, I needed to constantly ask myself if I was listening and immersing myself in the data relating to the familiar as much as I did with the unfamiliar. In other words, the interest in new information or sights can be much easier than really paying attention to that which is familiar where one can become blinded to the impact of something that is always present and, which over-time, becomes invisible and part of what is considered to be the ‘normal’ or ‘accepted’ landscape. Thus, monitoring for such influences through such reflexive practices enabled me to recognise and counter such influences that as Cutcliffe (2003) alludes to, may reduce the accuracy and credibility of the findings.

4.7 Uncovering Linked Elements During Data Collection

During the process of undertaking interviews, I found that earlier interview data informed later interviews, a process that both King & Horrocks, (2010) and Bazeley (2013) see as a natural process. It did enable me to deepen my understanding particularly in relation to issues that crossed professional boundaries. Although the questions remained the same, information gained during earlier interviews, meant that I could ascertain if staff on one Trust site experienced or perceived the presence of an issue more than on the other Trust sites. This helped me to develop other questions which could be used during the interview process with another sample group. For example, midwives frequently mentioned issues relating to referring a baby to a paediatrician (chapter 6) and therefore, I could then ascertain the consultant paediatrician’s view of the situation which I may not have attained from sticking rigorously to the set questions. This was particularly useful when exploring issues that impact on inter-professional relationships, as this gave me a deeper understanding of matters that may create misconceptions or conversely, may support effective working partnerships to the benefit of the mother, baby and staff morale.

As each interview took considerable time to transcribe, natural breaks between interviewing occurred which enabled me to start to see the emergence of broad themes during the process of transcription. This allowed me to see if the questions being asked were appropriate, if they needed refining or if any prompt used during the interview was useful or could be construed as leading the participant down a particular route or influencing how they gave their answer. As time passed, I realised that the questions needed no amendment as each participant had no hesitation in giving me their answers and that these answers were not just confined to the basic premise of the question. Participants' answers were detailed in such a manner that painted a picture of their experiences (both good and poor), how it made them feel, the impact on themselves as professionals and what they felt should happen and would like to happen.

Perhaps it is the latter two points that made me aware that my 'insider' role did not appear to be negatively influencing how students and staff felt about speaking openly to me. Due to my understanding of the role, I expected that a participant might give me a superficial or generalised description of how an incident or event made them feel, but participants gave clear detail relating to the impact they felt as a person and as a professional. However, knowing my 'insider-self', made me more aware of the need to create some distance between the data emerging and my experienced practitioner role. Therefore, reflecting on such issues, increased my level of awareness to allow as Holloway and Biley (2011) suggest, abstract thinking and theorising of the data to occur unrestricted by personal experience or bias. Although as Fontes (1998) argues, it is possible that a researcher needs to be able to appreciate what it is like to be in certain situation if they are to fully comprehend what the participant is stating. Fawcett and Hearn (2004) allude to Fontes' idea and suggest that the researcher may be disadvantaged by not having direct experience or if they lack immediate points of identification with the subject matter being studied. Smith (2009) and Berger (2013) also express the view that a researcher without personal or secondary experience may influence the aim and objectives of the research and therefore how the participants' experiences are interpreted, thus losing what is actually important to the participants themselves. Berger (2013) does make it clear that the use of reflexivity within research is a necessity if the researcher is to ascertain what they have heard and portray within their writing is to convey what they have been told by their participants rather than what they think or believe to be the case. Consequently, I was conscious during the interviews that any prompt I gave was as open and non-judgemental as possible in-order to hear the detail of the narrative and gain further clarification that what I may have thought I was hearing, was actually what the participant was articulating.

Within my own research journey, I was beginning to feel that my 'insider' or 'familiar' self was allowing me to access and be trusted with information that I might not have been able to achieve as a pure 'outsider' researcher. Indeed, at times staff entrusted me with information about themselves or incidents that they had experienced that I was acutely aware were very personal to them and in some cases felt ashamed or deeply upset about. I felt extremely privileged, not only to be allowed some insight into their world, but also to be trusted not to misuse the information they imparted to me.

Perhaps one essential point I also learned in the process was that in learning about the participants' perspectives, I was also learning more about my own. What I mean by this is that I could appreciate how they felt during events that I had also experienced in practice when working purely as a midwife. Sometimes these events had occurred quite a few years ago, but the feelings they evoked were still similar in context to those presented to me by participants at the time of their interview. Whilst I knew my experiences were my own and not part of the research, what they did make me think about was how particular events were still part of the practice environment some years later! Whether this aspect would become a recurring theme during the progression of the data collection was yet to be seen through the process of transcription and theme evolution. However, I did not wish to bias the data presented to me by purposely looking for one aspect and thereby ignoring others. Thus, the reflective practices as discussed within this chapter were important activities during data collection and interpretation needed to be constantly employed so that all the emerging themes were given due consideration.

4.7.1 Transcription & theme evolution

Each interview was faithfully transcribed in its original format and was not changed to reflect, for example, an improved level of grammar. Bazeley (2013, p148) warns the researcher or transcriber against 'tidying' the recording and thereby inadvertently changing the context or emphasis of the recording if it is to remain as a true record of the interview. As I am a 'touch typist', I completed all the transcriptions myself and was therefore able to maintain the accuracy of each transcription as an accurate version of what was said at the time. In the larger participant groups, every third or fourth transcription was returned to the participant within a few days of the interview to check if they agreed with the transcription. All transcriptions for the smaller groups (< 6 in total) were returned for the same reason. All transcriptions returned to participants were agreed as a faithful record of the interview.

The very act of transcribing the recordings myself allowed me to hear the words of the participant repeatedly several times. This provided an initial opportunity to see broad themes beginning to

appear. At first, I concentrated on exploring each separate sample group for recurring themes but as time passed, it naturally evolved that I could start to cross compare the data from the three Trust sites. Therefore, as more transcripts were completed and checked for accuracy, I started to see the themes that emerged more strongly, unique to a sample group or had a similar context across the groups. I found myself asking more frequently what something meant or how did X occur.

Over time, the data collected from the different sample groups enabled some of these questions to be answered without the need to return to the participant. Answers to other questions were fulfilled by looking at documents such as Trust guidelines and policies and tools of communication used by both midwives and paediatricians. This triangulation incorporating documents as well as participants with different status and roles, enabled me to develop a far greater view of the practice arena for NIPE practitioners than I could have ever achieved concentrating on one group alone.

Thorne's (2016) suggestion of standing back and re-looking at the evidence, not just once but many times as the data is collected, proved invaluable and inhibited me from jumping to conclusions and allowing the 'familiar' (insider researcher) to take precedence. Likewise, Eppley (2006) reminds the 'outsider' researcher that their position within the research may be a fluid one. Therefore, I needed to not only capture the participant's story, but also understand those parts of the story which I am not familiar with (outsider researcher) so that their words and meaning remain a faithful representation of their narrative. Taking time to look at the data as it was collected, assisted me to begin to appreciate some of the themes that were beginning to appear, but also gave me the time to become aware of my own feelings towards what was said during the interviews. Furthermore, both Thorne et al. (2004) and Kearney (2001) warn against formulating themes too early by not taking the time to consider alternative interpretations or directions. The interpretive research process, data collection and analysis should inform one another iteratively, thus allowing the formation and direction of the research inquiry to evolve and, in its new form, be examined for new links and possible interpretations.

My method for viewing the evidence was kept as simple as possible due to the amount of data that arose from all the sample groups. To this end, I wrote the main points that arose onto post-it notes and stuck them to the wall on my stairway. In this manner, the wall became plastered with different coloured post-it notes with each one coded to include the status of the participant and Trust site. The stairs made a good viewing platform to stand back and review the evidence as the collection grew in relation to the number of interviews undertaken and added to with themes that mattered to participants which although not their main issue was very much part of the supporting cast that enabled them to complete their role effectively.

Eventually, the particular themes that emerged were then linked to other themes across sites and disciplines. As these early themes became stronger or weaker, I kept going back to my journal, the recordings and the transcripts to see if I still perceived and interpreted the information in front of me in the same way or if the research process had given me the experience to see nuances, directions to investigate or links that I could not see earlier on in the journey. This reviewing of the data and how I interpreted it was important, as I often referred to the need for the data to speak for itself or the participant's voice to be heard. Although I was mindful that as Morse (1994) highlighted, it is the researcher that drives the interpretation of the research process and ultimately interprets the data. Therefore, my aim as a reflexive researcher was to "faithfully convey an aspect of human life that was not previously expressed or appreciated" (Kearney, 2005, p 147).

As Thorne (2016) points out, the process of Interpretive Description requires the researcher to allow the data to reveal itself through a continuous process of returning to the material collected throughout the period of data collection and beyond, into the emergence of key issues and the analysis of the findings. Thus, throughout the process of data collection and interpretation, I was mindful of the need to remain open to new ideas and reflect on how I heard, read and interpreted the data. Therefore, giving myself space from time-to-time during the data collection and interpretation process, allowed me to appreciate alternative meanings (Northway, 2000). As I gathered more data, I could identify more distinct themes and parallels which eventually could be categorised into clear themes and their related sub themes to aid clarity for the reader.

4.8 Summary & Identifying the Main Themes

The section below gives a summary of the use of reflexivity within my research and then leads into the introduction for the next three chapters which illustrate the collation of the main themes arising from the data collected.

4.8.1 In summary

This chapter has discussed some of the reflexive activities employed during the process of data collection and theme development. Horsburgh (2003) refers to the need to practice reflexivity if the negative impact of the researcher's decisions and actions throughout the research process are to be tempered. My a priori knowledge and experience could have led me to expect certain findings to arise, interpreted a participant's words in a specific manner and ultimately sent me down a route that may have seemed probable but not faithful to the reality of participant's narrative. Allowing space to review recordings more than once, check that participants agreed with the transcript of their recording and to be able to re-read the transcripts, enabled me to see the material through a 'new

lens', as advocated by Alvesson and Skoldberg (2000). In so doing, I could identify if my own experience had influenced my interpretation of the data presented. Ultimately, the use of reflexivity is seen as the criterion for evaluating the quality and validity of qualitative research (Pillow, 2003). However, I also appreciate, as Berger (2013) points out that reflexivity is multi-dimensional and therefore no researcher can hope to produce wholly unbiased research. Therefore, I can only work at reducing and tempering my influence on how the research was developed and the conclusions I have drawn from the data collected by including within my thesis the rationale behind my actions and interpretations of the findings.

4.9 Preface to the Next Three Chapters

The following three chapters present the collective findings of the thematic analysis of the data gathered from the focus groups; interviews; interview notes and other sources of information such as, neonatal policies and Trust documents.

For clarity, each theme has been supported by a quotation(s) that typically arose during the data collection. Some quotations have been truncated for the sake of brevity and where words have been omitted this has been indicated by using: [...], or where it may not be clear as to whom the participant may be referring to this information has been placed within a bracket, for example, ['the paediatrician' or 'the mentor']. Both Harding (2013) and Bazeley (2013) highlight that care must be taken not to alter the original meaning of the quotation or change the context in which the comment was originally made. Therefore, at times, the full quote in relation to the theme identified has been used so as not to distort the original meaning.

As discussed in chapter 3, codes were used to identify the participant's sample group, the number allocated to them within that group and Trust site (see Appendix 6 & 7) and therefore bear no relation to the names of individual participants. Identification of the Trust site enabled cross-comparison in order to identify if a theme was more evident on specific Trust sites and explore possible reasons that may account for the phenomenon. Also, as outlined in this and in chapter 3, the data for each sample group was initially scrutinised separately to gain an understanding of the 'perceptions and experiences' of that specific group, before comparing the themes arising across all groups within a Trust and then across all three Trust sites. In addition, the three student midwife participant groups (Post-registration [qualified midwives] and two Pre-registration groups [three-year direct entry and an 18-month programme]) were also scrutinised across the three groups to see if differences in previous knowledge/training demonstrated any difference in perspective to the data arising from the students.

The main themes and related sub-themes that arose from the data collected across the sample groups are highlighted within chapters 5, 6 and 7 (see Table 2 below).

Table 2. Main Themes & Sub-themes

<i>Chapter</i>	<i>Main Theme</i>	<i>Sub-themes</i>
5	Perceived impact on professional role	<ul style="list-style-type: none"> • Job-satisfaction • Level of knowledge & understanding • Equipment • Supportive factors - general
6	Professional collaboration & communication	<ul style="list-style-type: none"> • Respect for the NIPE practitioner role • Collaborative working • Task orientated working • Referral processes & guidelines • Non-NIPE midwives
7	Bedside manner, consistency of training & university collaboration with the Trust site	<ul style="list-style-type: none"> • Communication – bedside manner • Training & updating • Recognition of NIPE qualification when moving from one Trust site to another Trust • University & Trust site collaboration

Themes that demonstrated a link, whether similar or divergent to other sample groups have been highlighted within the text to provide a cohesive representation of the findings. Similarly, particular aspects that also have a relationship to subject matter in another or across all chapter(s) has been highlighted to aid clarity due to the complexity of the data collected across all sample groups and Trust sites. Due to the number of sample groups, quotes from differing groups have been included to give a perception of how the different groups view similar issues.

The findings (Table 2) arising from the data collected have been presented in chapters 5, 6 and 7. The information presented has enabled identification of the ‘key’ issues that appeared to affect participants experiences in practice and these have been highlighted and more closely analysed in chapters 8, 9, 10 and 11. Again, due to the complexity of the number of sample groups and Trust sites, these key issues have been divided into more manageable chapters for clarity, although some issues inevitably cross over into other chapters within a differing context.

Chapter 5: Perceived Impact on Professional Role

5.1 Introduction

The themes arising from the data that are discussed below are not necessarily exclusive to the chapter title. They also interlink with the content of chapters 6 and 7 which relate to the key issues that became evident within the data findings as existing between the different participant sample groups.

The main issues covered within this chapter are those that relate to how staff talked about the activities that they saw as impacting on their professional role and standard of care. Therefore, the themes highlighted below relate to the following issues: job satisfaction; level of knowledge and training in relation to NIPE practitioners; equipment and the types of activities that practitioners saw as 'supportive' to their role.

5.2 Job Satisfaction

It is useful to note here that activities that engendered a feeling of job satisfaction such as, being within an environment that enables a midwife to practice in a *comprehensive* and *holistic manner*, thereby providing a high standard of care was articulated as important by all midwifery staff. The two elements above were often linked by participants to being able to act autonomously (as discussed in chapter 2). The above would appear to link to how midwives viewed their professional identity and/or how they saw themselves as professionals. Early on in a student midwife's training, the above elements (in italics) become an intrinsic foundation upon which the integrity of their chosen profession is centred.

The word 'midwife' means to be 'with women' (Oxford English Dictionary, 2019) and the available standard midwifery texts that discuss the practice of midwifery that students' access during their training, allude to the elements particularly in relation to the midwife acting as an autonomous practitioner and as a woman's advocate (NMC, 2018). Therefore, some articulation of these elements may have been expected and indeed job satisfaction appeared to be high on the agenda within the data collected for both the students and those midwives who completed the NIPE module. Midwifery staff whether they were a midwife, PEF or manager regularly reiterated they could comprehensively assess the well-being of the neonate in the same professional manner as they already did for the women in their care. The following example was a typical comment relating to the need to be able to carry out their role in a comprehensive manner:

*“It is so good to be able to complete my role and professional responsibilities for **both** mother and baby and not have to wait for a paediatrician as though I am incompetent to know when a baby is well or if it (the baby) has an actual or potential problem.” (MW4 T1)*

However, there is another issue emerging here which has a relationship with the need for midwives to feel confident that they can carry out their role and responsibilities without restriction if they are to comprehensively give the best possible care to women and their babies. This point is reiterated and discussed further in ‘High-Quality Midwifery Care’ (RCM, 2014) which highlights that the delivery of high-quality care is the responsibility of every midwife, identifies the challenges faced by midwives in achieving this goal and discusses possible actions that may have to be taken. This need to provide comprehensive care and how midwives expressed how they felt when they were not able to do so was a recurring theme with midwives, as set out by one participant below:

“I used to have to wait on a paediatrician which was frustrating especially if they got delayed. Here I am giving a woman all this information about their baby, what it could do and what to watch out for but not allowed to complete the NIPE! What must those women have thought? Perhaps they felt that the information I gave them was no good because I couldn’t be trusted to examine their baby.” (MW1 T2)

The point that the above midwife made links the ability to conduct the NIPE examination with how she felt women may have judged her professional ability. This point will be re-visited later in the next chapter on professional collaboration and communication as it links with a similar finding relating to how midwives perceived that the impact of some of the professional behaviour portrayed by paediatric staff might adversely affect their relationship of trust with the woman.

The next clear theme that emerged early on and maintained a steady presence related to participants’ perception of the learning gained during the completion of the NIPE module. Particularly midwives and students clearly saw the NIPE module content as having a positive effect on their ability to undertake their professional role in a comprehensive manner as discussed further below.

5.3 Level of Knowledge & Understanding

The midwives, PEFs and students were the most articulate about how they perceived that completing the NIPE module had impacted on their professional role in terms of knowledge and understanding. The overarching comment made by qualified practitioners related to how they now had a far better understanding of neonatal physiology now than prior to undertaking the NIPE module. Indeed, as a NIPE lecturer, the expected and natural progression in relation to the leap in the level of

understanding (theoretically and practical) becomes evident as the student progresses through the module. However, it was interesting to see how strongly midwives appeared to articulate and reflect on this point, perceiving it as a significant factor in relation to their role as a midwife and their ability to give comprehensive care not only to the mother but also to their baby. For example, the following illustrates the typical comments expressed by midwives:

“my knowledge [about neonates] is far higher now than when I trained. I became quite embarrassed by how little I knew or was aware of prior to doing the NIPE module. Students are so lucky – they are in a much better position than I was when I qualified as a midwife.” (MW2 T1)

Similar responses echoed by other midwives were linked to the fact that they had not wanted to undertake the NIPE module, but had been encouraged to do so such as in the comment made by the midwife below:

“I am glad that I completed the module. I didn’t want to at first, but my manager persuaded me. It worries me that in the past I may not have recognised a serious issue occurring within a baby as I do now. I really did not have a great understanding of neonatal physiology or the depth of knowledge about what was normal or abnormal neonatal behaviour. When you consider that the training for the SHO’s is very little in comparison to what I received – I shudder to think what might have been missed in the past.” (MW14 T3)

The disclosures above were also reiterated by participants in the PEF sample group:

“I don’t think I paid attention to those babies that had risk factors as much. Before the (NIPE) module, I only saw babies who had a mother who was Rhesus Negative (blood group) or had confirmed Strep. B infection as being a problem ... I am really embarrassed to admit that now, but at least I know better now and so do the students thank God, although of course they won’t know that.” (PEF2 T1)

On reflection, as discussed in the previous chapter, I was known to the midwifery staff as both a colleague/lecturer and a researcher. The fact that midwifery staff felt able to express such frank views - which they may have felt could have put them in a vulnerable position - suggests that they felt able and comfortable to express their views to me without fear of censure and that the content of the interview would (as had been stated prior to the interview) remain confidential. The fact that I would

still be working with most of the interviewees within the clinical setting in the future did not appear to cause concern or prevent them from voicing how they felt.

This relationship of trust may have also been the reason for some frank comments arising from the midwives/PEF's when asked why they had not wanted initially to complete the training (e.g., MW14 above). The responses made by all participants who had made the comment centred on the fact that they had all felt that at the time, NIPE training was '*not within their professional responsibility*', that the information given to women (e.g., regarding recognition of poor neonatal health) was '*frightening the women*' and that the module had '*no place in a pre-registration midwifery programme*'. On further investigation, these midwives had all completed their training during the first few years after the post-registration NIPE module had become a validated professional module. However, due to the positive attitude they now held towards the learning gained and the fact that midwifery care in terms of prevention – such as recognition of the signs of ill-health in the neonate had now become a main focus within standard documentation, they did feel that their previously held attitude was no longer prevalent amongst their peers. Indeed, participants who had trained later (approximately 5 years after initial module validation) did not mention that they had not wanted to complete the training or that they had been concerned that midwives and students had access to the module.

The above finding does perhaps point to the changes that have been made in midwifery care which have started to result in heightening standards of care and increasing information sharing with women. A status that both Midwifery 2020 (2010) and the National Maternity Review (NHS England, 2016) promote and work towards with NHS Trust sites. Interestingly, these positive changes also became visible within the following comments made by three of the participants (two midwives and one PEF) when reflecting on when they had completed their pre-registration module:

"My non-NIPE midwife colleagues at the time were really unhelpful and sometime obstructive ... they did not like me doing the module. Now though it is very different, particularly as the students are doing the module." (MW8 T1)

*"I think my colleagues thought I was trying to be superior. They said that I was scaring the women when explaining signs of neonatal ill-health.. Now we **have** to discuss with women the more serious issues, they would not say I was scaring a woman now!"* (MW3 T2)

"When I did my training, they (the midwives and the paediatricians) did not like it. They were a bit antagonistic, you know, saying what did I want to do it [the module] for. That wouldn't happen now, particularly as we have had student midwives on the module for the last six years which I think has helped change attitudes for the better." (MW2 T3)

The student midwives clearly articulated that due to fact that they were completing the NIPE module within their training, they were very aware that they had more knowledge and understanding than some of the midwives they worked with who were non-NIPE trained. This recognition was regularly demonstrated by students through comments such as:

“Sometimes it is a bit embarrassing when I have to say to my mentor [the midwife] that there is something in the maternal notes that needs further assessment by the paediatrician. I have noticed it, because I am doing the module (NIPE), but she hasn’t and so has to check it out – after-all I’m a student she can’t take my word for it! At least they have been nice about it.” (STd20 T3)

“I noticed In the antenatal notes that the baby was identified as being breech from 34 weeks [gestation] although it was a cephalic[(head-first] delivery. I asked my mentor [the midwife] if I should complete a referral form for hip ultrasound ... she [the midwife] asked me why and I explained – she didn’t know, but then she is not NIPE trained so it is not her fault that she did not know the risk factors, but I was worried that she might think that I was just trying ‘look good’ or ‘belittle her’ .. which I really wasn’t, but you do worry about how it might look.” (STp6 T1)

The above comments highlight the student’s awareness about their increased knowledge level, but also illuminated another issue that they appeared to directly relate to their higher level of knowledge. Students often commented (in a similar fashion to those above) about their mentor being ‘nice’; *not appearing concerned by the student showing that they had more knowledge than their mentor* or voicing that *they hoped their midwife would not view them in a negative manner* because they had highlighted an issue. Yet, none of the students interviewed implied that their mentor appeared to act in a defensive manner or displayed that they were annoyed with them and it was difficult to draw any further information about these incidents from the students. It is possible that students may not wish to overtly discuss if they felt that such incidents may have had a negative effect on their progress or assessment within the practice area or their relationship with the midwife with whom they are working but with the present data, this is unverifiable. Findings such as these will be explored further in relation to the available literature within the discussion section of this thesis in-order to see if any further light can be shed on the potential impact of this issue on the student experience.

The concerns voiced by the students above related only to how they were perceived from a professional behaviour point of view and not due to being made to feel that they should not be completing the NIPE module. Therefore, it is possible that the non-NIPE midwife attitude towards

those who complete the module is no longer prevalent. However, the Trust sites involved in this study have been used to qualified staff undergoing NIPE training since the 1990's and the first midwifery students who completed the module as part of their midwifery programme, qualified in 2011. Therefore, this finding may not be generalisable across other Trust sites where the integration of a post-registration module into a pre-registration curriculum has not occurred to the same degree or where only NIPE theory is covered within the student curriculum. Also, as non-NIPE midwives were not included within the research, their views are unknown which needs future investigation if a more complete picture is to be uncovered.

Consultant neonatologists did voice their support for midwives conducting NIPes. However, their comments relating to 'knowledge and understanding' focused more on training issues and are therefore included within Chapter 7 as the data linked strongly with how other NIPE staff expressed their concerns about the training of junior paediatric staff. However, the next theme arose as an area of concern across all sample groups and relates to the issues regarding access to equipment, which are discussed in the next sub-section.

5.4 Equipment

This sub-section highlights the *general issues* experienced by NIPE staff in relation to equipment. The issues raised by staff demonstrated that there was a relationship between the level of accessibility to equipment and how supported or enabled they felt to carry-out their role in an efficient and professional manner. Equipment issues were so consistently expressed by staff, I decided to give this area a sub-section of its own, but it does also link into the next sub-section on supportive activities.

There is very little extra equipment needed when conducting NIPes other than that required by the NIPE practitioner in relation to normal neonatal care and assessing neonatal well-being. Generally, the only equipment that is required by the NIPE practitioner, is an infant stethoscope, an ophthalmoscope and tape measure. However, the quantity of available equipment does not appear to have risen in relation to the greater need for access to available equipment for all NIPE trained staff on all three Trust sites. Despite the number of NIPE midwives within the Trust sites involved in this research has significantly risen over the past six years (approximately now between 60 – 80% of qualified midwives depending on Trust site). Although some practitioners mentioned low availability of equipment, all participants within the sample groups were extremely vocal when sharing their frustration about equipment that did not work, lack of infant sized stethoscopes, issues with equipment going missing and feeling that they had no choice but to supply their own equipment. The following comments give

a good portrayal of how practitioners consistently referred to the above issues and the wish to use the equipment at the best possible time.

“It is really annoying when you have to keep going to the other postnatal ward to get an ophthalmoscope because ours is not working ... again! I want to go and get an ophthalmoscope when it is the best time to do the exam for the mother and baby, not have to wait to be able to borrow one and then the baby has just had a feed and gone to sleep!” (MW2 T1)

“I have bought my own equipment (ophthalmoscope and infant stethoscope) so that I can use it when needed ... this isn't right it should be supplied, but I cannot waste time looking for an ophthalmoscope.” (PEF1 T2)

The earlier studies by Steele (2007) and McDonald (2008) had found that midwives were frustrated with poor levels of equipment. However, it would appear that – approximately 11 years on – the cause of the frustration tends to relate less to quantity of available equipment and more to maintenance and ease of access if practitioners are to be able to conduct the NIPE in a timely manner. This fits in with the ethos of providing holistic care for the mother and baby particularly with the steady move towards continuity of care and provision of a high standard of service (NHS England, 2016).

Similarly, participants were annoyed about SHOs who walked off the ward with the ophthalmoscope and the actions that senior staff took appeared to create new problems as demonstrated below in the following comments:

“It is lovely that the managers have put forward a case for more ophthalmoscopes... we only had one before, but the new ones are chained to a stand – you have to bring the baby to the stand to use it [the ophthalmoscope]. Sometimes I forget that it is attached and nearly make the stand fall over – it doesn't look good to the parents, but it was the only way to stop the SHO's from walking off with them.” (MW9 T3)

“It is a real nuisance to be expected to take the baby to a particular area to do the examination – all because senior management thought it was a good idea - often it is far too cold for the babies, but as the ophthalmoscope is chained to the wall we cannot do anything else unless we have bought our own.” (PEF1 T2)

Another point of note is that midwives were voicing the same concerns as in Ward's study (2010), where both nursing students and staff were frustrated when infection control processes were not adhered to and it appears that midwives were voicing the same concerns as seen below:

"I asked my parents to buy me a stethoscope for Christmas so that I can use it on the babies. They don't have them [infant stethoscope] on the ward and I find it hard to listen to the baby's heart with the adult one. We shouldn't be using it (adult stethoscope) on babies anyway due to cross-infection." (STd7 T3)

Midwives on all three Trust sites mentioned the impact that 'senior management' (executive and consultant paediatric level) could have on practice. Often this was voiced in terms that related to the need for 'senior management' to actually listen to what ward managers communicated was required, rather than make decisions that were impractical – as they did not affect paediatric staff or caused further problems such as mentioned earlier by PEF1. Practitioners (apart from the Consultant neonatologist) on another Trust site frequently mentioned a similar issue which was best highlighted by the midwifery manager below:

"We wanted to run a 'NIPE' clinic to cover those days that we are short on NIPE midwives. However, senior management thought that an alcove in the corridor would be a good place and arranged for a curtain to be installed to provide privacy, an ophthalmoscope which is chained to the wall and a neonatal resuscitaire for the baby to lie on. We argued that the area was draughty and cold, but we were told that putting a heater in the area was dangerous. Five months on, the midwives will still not use it as it is far too cold for the babies and now we have expensive equipment that we cannot use stuck in a silly place... what a waste of money" (MM5 T3)

Another issue in relation to equipment that was frequently raised regarded the need for adjustable height cots. The midwives and students were particularly vocal about this issue as they felt that they needed to be able to access cots that could be raised or lowered to suit their height and therefore they could work comfortably without incurring backache. The older midwives mentioned how long it had taken the Trust to provide profiling beds (which could be raised and lowered) to the maternity wards when nursing had been using them for over a year. They felt that maternity was treated as a 'Cinderella service' and that the fact that they had few adjustable height cots (most maternity units only had two or three) added to the evidence that this was the case. Staff made the point that the provision of adjustable height cots would benefit both parents and staff in enabling easier access to the baby.

When practitioners were prompted further, it became apparent that both midwives and students had concerns about new NIPE midwife practitioners being, in their words 'indoctrinated' into using the resuscitaire when completing a NIPE. They often mentioned that this did not enhance or promote holistic care. When asked to explain what they meant by this, the replies were all very similar such as those below:

"The resuscitaire is too high and only a few are adjustable ... it doesn't make it easy to complete the hip examination." (PEF1 T2)

"You have to ask the parents to move to where the resuscitaire is, you cannot just do the NIPE by the bed. You don't ask the mother to move to another room to examine her!" (STp5 T3)

"The parents are not so involved in the examination as they cannot see properly when you use the resuscitaire, nor can they always see your face easily, it puts them off asking questions" (MW4 T1)

"Using the resuscitaire and making parents walk to another room makes it [the NIPE] seem so clinical and medical ... that is not how it should be, we are expecting to find normal progression, we don't often find abnormality or signs of ill health" (STs4 T2)

The practicality regarding equipment was deemed frustrating and practitioners frequently mentioned buying their own equipment in-order to complete NIPes in a timely manner. Additionally, the communication between ward and senior management appears to also be an issue in relation to what many of the midwifery managers and PEFs voiced as the "lack of understanding" shown by senior management when trying to resolve a problem that affected staff at ward level. Midwifery staff often stated that they wanted to provide a holistic and considerate service that met the needs of women and their partners. Yet they often voiced that they could not do so due to the practice environment and the constraints, such as the lack of appropriate equipment, that were seen as obstacles preventing them from doing so. Some of the midwives and students were very clear that having to use the resuscitaire disadvantaged some women and was also inappropriate use of the equipment, as can be seen in the following comments:

"Sometimes a woman cannot stand to watch her baby being examined ... why should she have to adapt to what the doctors or management want, shouldn't we as professionals adapt to their [the woman's] needs?" (STd18 T2)

“Some women after a caesarean section are not ready to walk with their baby to another room so the baby may be taken for its NIPE and then brought back. I think that this disadvantages some women over others ... why should she not be able to see the examination and share in this event. We don’t take women to a different room to do their examination.” (MM6 T1)

“I do not feel that the only resuscitaire on the ward [postnatal] is being used for NIPes. We have already had on incident where the parents and baby had to be turfed out of the room because we needed to use it urgently.” (MM1 T2)

“We get taught to respect our equipment including resuscitaires. The paed’s don’t, they often don’t even cover the bed [of the resuscitaire] when using it and often leave the mask attached to the oxygen dangling or even knock off its protective cover. What would happen if we had to use it in an emergency ... it would be unclean and not ready for an emergency!” (ST3 T1)

Effective communication is a necessity if a high standard of seamless care is to be provided within the maternity setting (NHS England, 2016). However, midwives were also clear about their need to provide holistic, considerate care which resonates with the initial research findings that highlighted such activities as necessary to their role and professional identity. These factors were also identified as a reason given by midwives for wanting to conduct NIPes (Steele, 2007; McDonald, 2008 & Lanlehin et al., 2011) and arose again in relation to how they felt about the use of NIPE clinics which will be discussed further in chapter 6.

As the SHO’s were not included within the research, it is not possible to explore their reasons for taking equipment off the ward. It is possible that as their time is restricted by other responsibilities in other areas of the maternity unit, that they too find that the quantity of available equipment also negatively impacts on their ability to complete their work in a timely manner. However, without their inclusion in the study there is no available data to support this possible rationale.

As mentioned at the beginning of this sub-section, equipment issues also relate to the next sub-theme which arose due to practitioners from all sample groups (except consultant neonatologists) referring to what they found as supportive activities in carrying out their role as NIPE practitioners.

5.5 Supportive Factors - General

This sub-section highlights the general factors that practitioners consistently articulated as necessary in positively supporting them in carrying-out their role in relation to NIPE. Supportive activities were

seen as promoting job satisfaction and feeling valued as a professional, thus improving their perception of their worth and identity as practitioners. These factors tended to fall under the following categories:

- Support shown by managers in terms of maintaining skills, time to complete examinations and provision of equipment in-house and within the community setting
- Access to PEF and university lecturers both in and outside of clinical practice
- Access by all NIPE practitioners across all local NHS Trust sites to Newborn Forum meetings

Although the practitioners talked about Consultant Neonatologist support and how this impacted on their role, this was expressed in terms that related to collaboration and respect between professionals and will therefore be discussed within the next chapter.

5.5.1 Managerial support

Midwifery managers and team leaders who actively worked towards enabling midwifery NIPE practitioners to have enough time within their daily workload and the correct equipment to conduct NIPES, were generally viewed as being pro-active in supporting the practitioner, as portrayed in the following comments:

“I work in the community and need to be able to come and complete NIPES on the postnatal ward as I do not always have enough babies delivering at home in the community to maintain my skills – I discussed this with my line-manager and she arranged for me to come into the unit one morning nearly every month which has really helped otherwise I might have had to stop doing them altogether.” (MW3 T2)

“I started in community last month and my manager made sure that I had the equipment to do NIPES ... if she (the manager) hadn't I would have had to buy my own!” (MW10 T3)

The above examples were typical for those midwives who worked within the community setting or had positions within both community and in-house clinical practice. The provision of equipment to individual community midwives is expensive but necessary as some of these midwives work in areas that are geographically too far to access equipment within the hospital and it would prove inefficient to meet and borrow equipment from each other during completion of the daily workload. Also, the fact that some midwives had their own equipment was appreciated by students, as the comment below is typical of their view of working with a NIPE community midwife, although students in-house also valued the fact that the midwives they were working with possessed their own equipment too:

“The ward was really busy I am glad that my midwife let me borrow her equipment when doing NIPes as one of the ophthalmoscopes was not working and the Paed. [paediatrician] was using the other. We would not have managed to get half our work done otherwise ... babies would have had to go home without the NIPE.” (STp3 T2)

Conversely, managers who were perceived as doing little to assist midwives in completing their NIPE role were not viewed highly and at times related comments ranged from managers being ‘unhelpful’ to ‘obstructive’. For example,

“my team leader doesn’t seem to understand that sometimes I need help to come in from community and just do NIPes ... I need to keep up my skills and work with the students to gain ideas from others (NIPE staff) about what helps them [students] learn.” (MW6 T3)

Midwives, PEFs, midwifery managers and students all voiced concerns about staffing numbers and having the time to complete NIPes, particularly at those times during the year when the birth rate rose considerably. During these periods, there is not always the capacity to bring in extra midwifery staff due to the already low number of qualified midwives available and this can cause a problem with completing NIPes in a timely manner. This can be frustrating to midwives who wish to give the highest standard of care, but who may have to send babies home without the NIPE completed and will have to arrange and emphasise to the parents that the examination will need to be completed within the 72-hour timeline as advocated by Public Health England (2021). The mother will then either need to return to the hospital for the NIPE or it will have to be completed by one of the community midwives which will be extra to her already increased postnatal workload.

In two of the Trust sites, NIPE clinics had been set-up to try and alleviate staffing issues, but midwives stated that this was not an ideal situation, particularly when the midwifery service provision was moving towards continuity of care which seeks to discourage fragmentation of care. Although, the consultant neonatologists were aware of the situation and agreed with the use of NIPE clinics, they did not articulate any further insight into the issue apart from articulating that this provision was in the domain of the midwifery staff and senior Trust staff.

5.5.2 PEF & University Lecturer - support

Students, midwives and midwifery managers were very articulate about how they viewed the role of the PEF and university lecturer (NIPE trained) in practice. They appreciated the time that PEFs and lecturers spent in teaching and supporting those who are undertaking their NIPE module and typical comments included the following:

“They [lecturers] make time to teach and other staff also come and listen, including the SHO’s who have just started in the area [maternity].” (STs6 T1)

“I had just come back from maternity leave and was worried about completing my first NIPE. I asked the PEF if she would come and do one with me and she really helped to restore my confidence.” (MW9 T3)

The collaboration between the lecturers and the Trust site was another area that was often commented on. This collaboration appeared to engender a perception that university lecturers did not just teach the content of the NIPE within the university held sessions but were also more than capable of completing the physical examination of the newborn in practice. This appeared to be an important point for midwives and students alike and they voiced their feelings about this in the following manner:

“Sometimes it can be easy to think that lecturers just teach but don’t know what it is like in practice. With NIPE it’s different. Our lecturer who is based here (site-based lecturer) comes into the practice area and works in practice with us.” (MW8 T1)

“Having a lecturer that can actually conduct NIPes means that my midwives feel that the uni [university] actually understands what it is like to complete NIPes in practice. They really collaborate with us and bring in literature for the NIPE research board and discuss it with the staff... we are really lucky to have this sort of working relationship – I know not all areas of the country are as fortunate.” (MM5 T2)

At times universities can be accused of being out of touch with the practice environment which can lead to disharmony between the university and the NHS Trust site. Different universities have tackled the problem in a variety of ways, but it appears that the method employed between the university and NHS Trusts has been effective within the geographical area in which this research was conducted. This is important if the student experience is to be affected positively and if qualified staff are to be encouraged to undertake future learning within the university such as stand-alone modules that are part of a master’s programme of study.

5.5.3 Multi-Trust site ‘newborn forum’

The university at the centre of this research has made considerable effort in engendering a forum for all NIPE practitioners - irrespective of their status – to be provided with a venue where they can voice concerns and share information within and across the three Trusts. However, it was also deemed

important to use the advent of the NIPE module in the Pre-registration midwifery curriculum as an opportunity to raise the student midwife experience in recognising the professional identity that they will be taking on within their chosen profession, whilst increasing the university – Trust level of collaboration. This research provided a valuable opportunity to obtain information about how NIPE practitioners viewed the newborn forum meetings. Although, a question was devised to this end within the semi-direct questions asked during the interviews, invariably the question remained unasked as practitioners clearly wanted their feelings made known and the following comments give a flavour of the perception of staff.

“Our lecturer started the forums. They are well attended... dates are put out in advance and students get to see one of the ways that inter-professional communication and collaboration really work It sets them [students] up for the future.” (MM6 T1)

“I make an effort to attend the forums as I find out the issues for staff across the other two [Trust] sites near us, I understand better now the issues that midwives can experience and after-all we have to work together if we are to provide good quality care.” (CN1 T2)

“I do wish that our consultant [neonatologist] attended the forums and was as proactive as the other Trust sites ... he never attends which does not help communication between him and us [NIPE midwifery staff] or help us with resolving issues with paediatricians.”
(MW13 T1)

The comments above do tend to support the positive perception for the newborn forums. However, it does also highlight issues relating to inter-professional collaboration and the role it plays in engendering a working environment where mutual respect for professional roles, the sharing of information and supportive, collaborative working practices were seen by staff as an important factor within high-quality care (West et al., 2014; NHS England, 2016). As midwifery staff pointed out, the newborn forums had appeared to positively help the change in relationship with paediatricians.

However, as the comments above indicate, there was also a clear articulation that this professional relationship could still undergo some improvement in the areas of inter-professional collaboration and communication. Considerable data was generated by all sample groups relating to the issues of inter-disciplinary respect, professionalism, collaboration and communication. Due to the quantity of the data collected relating to these contexts, the issues that emerged deserved to be focused on separately. Therefore, within the next chapter, the data findings in relation to professional collaboration and the impact of ‘role’ responsibilities and respect will be highlighted.

Chapter 6: Professional Collaboration and Communication

6.1 Introduction

This chapter focuses on the data findings in relation to professional collaboration and communication. The sub-themes arising from these two main points of foci reflect issues that were consistently voiced across all participant sample groups or where there were areas of dissension.

The sub-themes arising under the umbrella of the chapter title include inter-professional respect and consideration, collaborative practice, referral processes, task orientated working and non-NIPE midwives. Communication between the professional disciplines had an impact within all the sub-themes in terms of how participants perceived that the different professional disciplines communicated with each other and therefore this theme is integrated within each sub-theme.

As stated in the previous chapter, although midwifery staff discussed Consultant Neonatologist support and how this impacted on their role, they also spoke in more detail about what they saw as 'supportive activities' such as '*working collaboratively*' and showing '*mutual respect*' for their role and responsibilities. Both terms appeared to be intertwined within all the sub-themes and therefore the data has been incorporated and contextualised to reflect this.

6.2 Respect for the NIPE Practitioner Role

Midwives work with various professionals whilst caring for mother and baby, such as physiotherapists, pharmacists and sonographers to name but a few. Yet, when using the word 'support' this was always directed towards the paediatric team and usually at registrar and consultant level. This is in part understandable due to the fact that in relation to midwifery, it is mainly the joint consultation between the consultants and midwifery managers who agree the policies and processes they work under in relation to neonatal care, which also cover agreements with other professional fields. This latter point relating to agreed practices will be discussed further within the section on collaboration and communication. Therefore, this section concentrates on the findings in relation to respect between midwifery staff (and student midwives) and consultants with whom they worked.

The importance of paediatric support for midwives per se in relation to the NIPE practitioner role was shown to be an important factor within the earlier studies by McDonald (2008) & Steele (2007). However, it should be noted at this point that the focus of these studies was different in that they were mainly exploring why midwives might refrain from conducting NIPE examinations. Nevertheless, the ways in which midwives articulated 'support' in these past studies does appear to be echoed in

the data within this research in terms of what makes a midwife feel valued as a professional in their field. Similarly, within the findings of this research, the need to feel supported and respected for your professional experience and knowledge was undoubtedly a significant factor in staff feeling valued within their role. Both Nedvědová et al. (2017) and Cramer & Hunter (2019) have alluded to the need for midwives to feel a sense of clinical autonomy which in turn adds to increased job satisfaction.

The number of consultant neonatologists involved in the data collection for this research is understandably small, even with access to three NHS Trust sites, due to most sites employing between 2-4 depending on the size and status of the neonatal service provided. Therefore, the comments below must be viewed in context and cannot be assumed as a view generally outside of the data collection locality. However, it did soon become evident during the data collection, that various aspects that midwives viewed as 'supportive' were clearly linked to those consultant neonatologists who they saw as providing active encouragement and support for their role as NIPE practitioners as opposed to those consultants who did not interact with them in a similar manner.

The advent of midwives becoming NIPE practitioners did appear to be viewed positively by all the consultant neonatologists interviewed bar one, with the following comments typical across all Trust sites:

"I am pleased that more midwives are becoming NIPE practitioners... they work with the babies all the time and are in the best position to notice a deteriorating baby. There are not many babies they cannot examine apart from those who are obviously ill or becoming so. If they can examine and discharge women – why not the baby? After-all, they (midwives) are the experts in normality." (CN3 T1)

"It is good to see more midwives conducting NIPes, they (midwives) are very experienced in their own right ... they can talk to parents in a way that the SHOs still need to learn. My SHOs can learn a lot from them." (CN1 T3)

Midwifery staff and students who felt that their consultants actively supported their role frequently stated that the consultant was 'pro-active', 'ready to listen', 'sought to resolve issues' and 'encouraged sharing of ideas', which enabled them to work as equals albeit with a different focus due to their professional responsibilities and area of expertise. These professional areas of responsibility were often referred to by both midwifery and paediatric staff, as – *the midwife as the expert of 'normal neonatal health'* and the *consultant or registrar as the expert when neonatal health was 'compromised'*.

However, one consultant (who did express that they were happy to be interviewed) when asked for his view about midwives conducting NIPes, responded with the following comment:

"I know that midwives are doing NIPes but that is ... because we do not have enough SHOs. They need to be done ... it is a means to an end." (CN2 T3)

When prompted further to give his views on whether he saw it as a good move to train midwives he declined to say more. However, on asking if he was aware of the content of the training and how the midwives were assessed, he informed me that he left all that side to another consultant neonatologist. Therefore, it was possible that a lack of understanding about the midwife's professional role and training or other factors - which would need investigating further - may be involved in creating the 'tension' that appeared to be present between the midwives and this consultant.

The statements used by staff in relation to those consultants who were not seen as supportive, were often spoken about in a very clear-cut harsher manner. Indeed, as more data was collected it became apparent that the feeling of a lack of support/ respect was more of an issue for midwifery staff on one specific NHS Trust site where midwives consistently referred to one of their two main consultants as 'obstructive', 'inflexible' or 'doesn't consider the mother'. Thus, the following comments were typical of how they felt about the situation, not only in relation to the impact on the standard of care but also to how they felt such behaviour was disrespectful to themselves as trained professionals and was counter-productive to effective collaborative working with the paediatric team:

"If he comes onto the ward he always asks if the NIPes have been completed and if not, why not? He doesn't ask in a nice way, you are made to feel stupid and that you have not done what you should have done which isn't the case, he doesn't care who he says it in front of as it can be other members of staff, the SHOs or the parents ... he just doesn't care!" (MW14 T3)

"Sometimes you feel that there is no point asking about a baby that has been referred and the outcome ... you only get half an answer if you get one at all although I know if I ask the SHO to find out he [the consultant] will tell them the whole story!" (MM4 T3)

"I'm not sure why we have a problem with this consultant but we're all beginning to think he sees us as servants ... he talks to the ANNPs OK who do some of the NIPes in the neonatal unit ... I don't understand it ... they train with us on the same module!" (MW9 T3)

The strength of feeling about behaviour such as that above was often articulated by qualified midwifery staff in terms of being made to feel 'inadequate', 'acutely embarrassed' or 'not being allowed' to do what they are trained to do. Indeed, the student midwives on this site were also quite vocal and expressed their feelings not just in terms of what they had witnessed or experienced but also in relation to their discussions with fellow peers (student midwives) on other Trust sites:

"We have one consultant here who is horrible to the midwives ... he is rude and condescending. The midwives I have worked with are amazing, they know their stuff but they don't deserve the attitude they get from him." (STs T3)

"I was talking to some of the girls in class, they don't have the same problems with their consultants as we do. Oh ... don't get me wrong it's not all of them, just the one. I would not want to work there on qualification if they were all like that, at least the managers are on the case ... they are trying to do something about it." (STd16 T3)

"I went to talk to the manager [midwifery] as I felt really upset for the midwife about the attitude of the consultant as he was really rude to her [the midwife] in front of the mother of the baby we were examining the manager was very supportive ... but it made me wonder how I would have handled it if I had been on my own" (STd20 T3)

"Dealing with rude or aggressive fathers I can do but I should not have to deal with consultants who seem to think that midwives are nothing more than servants who they can boss around, for goodness sake, I'm a qualified nurse, I didn't come into midwifery to be spoken to as a lesser mortal. I am working hard to get my registration as a midwife, just as hard as any doctor in fact it's harder when you have to deal with behaviour like that and short staffing" (ST1 T3)

Conversely, students were just as articulate about the registrars and consultants who organised time in their busy schedules to go to the postnatal ward to teach them or ask them to come up to the neonatal unit so that they could hear a heart murmur on a baby and therefore be aware of the difference to a baby with a normal heart sound. Both student midwives and midwives undertaking the NIPE module were very appreciative of these actions and the time given to them as can be seen in the following comments:

"It is really good to know that the paediatric team is aware that we are on our module and ask us to come with them when they are seeing a baby with an unusual condition. I always check it is OK with the parents, it really helps in recognising some conditions." (MW5 T1)

"I heard a heart murmur yesterday for the first time ... I was so scared that I would miss a murmur because I didn't know what it sounded like and the consultant phoned down from NNU and said would I like to come and listen to it. He [the consultant] explained what was causing it and now I feel more confident." (STs2 T3)

Students were not the only staff members who valued such support as both consultants and NIPE midwives were also appreciative of the time given by others to assist them or their staff and particularly appeared to value the help and support of others as can be seen by the typical comments below:

"The lecturer was working with some of students on the ward today when a new SHO was also meant to be conducting NIPes. He was really worried about it and I said why don't you ask the lecturer to show you a couple as the students she was teaching were also doing their first NIPes. I asked him later how it went and he said that it was great and he felt much better about it now and had told the consultant what had happened who was very happy that someone so experienced had been able to support him." (MM5 T2)

"Last month I examined a baby and found that everything was progressing as it should, but three days later I found out the baby had died – I was devastated, I thought that I had missed something. The consultant was the first to talk to me about it and made me realise that this particular heart condition would not have presented any signs or symptoms at the time I performed the examination – I was so relieved but also so upset for the parents." (PEF2 T1)

The way in which NIPE practitioners spoke about the support they gained from each other in times of need or when someone was aided with their learning, was often spoken of in a respectful manner as in the following statements:

"He [the consultant] has so much to give in terms of knowledge, I really appreciated it as it deepens my own knowledge." (STs8 T2)

"They know so much about the neonate that when they tell me they are concerned – I listen." (CN6 T3)

"I was really concerned with the condition of a baby, the SHO had just examined it and said it was fine ... I contacted the registrar who came down immediately after I explained my concerns, I was so thankful that he trusted my judgement." (PEF1 T2)

The above comments reflect the attitude displayed by all NIPE practitioners when they mentioned action or activities that they valued or that they felt valued their level of knowledge and experience. This sense of value appeared to hold a close relationship with the need to feel respected but was admittedly, a view articulated or referred to mostly by midwifery staff and midwifery students. It was not easy to discern whether consultant neonatologists held the same view in the same manner, and this could be explored further. What did become clear was that this theme of needing to feel valued and respected, reappears within the comments in the next sections on collaborative working and referral processes.

6.3 Collaborative Working

The need for a collaborative and seamless care provision is a concept that 21st Century midwives are introduced to as student midwives and are expected to encompass on qualification in-order to provide high quality care. The NMC (2018) expects professional health-care registrants to recognise signs of deteriorating health and refer to the appropriate professional so that early management, thorough investigation and treatment can all occur in a timely manner. Therefore, midwives must work with and communicate effectively with others if this aim is to be achieved.

Midwives work autonomously within the domains of their registration and accountability, but they are also part of a wider multi-disciplinary team (MDT) which includes sonographers, physiotherapists and consultants within obstetrics, paediatrics and anaesthesia to name but a few. Each is a specialist in their own professional arena but if a patient's health becomes compromised, the best and most timely care can only be given when they work effectively together. The reports published by The King's Fund (2008 and 2014) and NHS England (2016) were aimed at reducing the serious consequences relating to increased morbidity and mortality that have occurred due to environments that do not engender effective communication and patterns of collaborative working between professionals.

Collaborative working within a respectful environment was seen by midwifery staff as necessary if the care given was to be seamless, evidence-based, reassuring to the parents and timely. Their comments appeared to link the level of communication they experienced with words and phrases that related to how it made them feel that they were carrying out their responsibilities properly and that all professionals were working together in a cohesive manner. The comments below are typical examples that reflect the words of staff across all Trust sites. In this case these comments relate to the perceived impact on staff when the working relationship between midwifery staff and the consultants is seen as working well:

“The consultant is great! He is very pro-active and good at passing information on to us in relation to a baby we have referred and who required treatment – it helps us to learn and enforces that what we did in the circumstances was correct as not everything you find is clear-cut and you can doubt yourself.” (MW9 T3)

“Our consultant will always try to make time for you when you are really worried about a baby. This behaviour rubs off on the reg. (paediatric registrar) and the rest of paediatric team, it helps us all work together in a much more productive manner.” (PEF1 T2)

“It is good when a NIPE midwife gives you a picture of what might be happening with a baby as she gives you the detail, the whole picture, it means I can act faster which is better for the baby, better for the parents.” (CN1 T2)

Midwives also spoke about other activities in which they felt included within the paediatric team and how it made them feel their professional status was valued and that *their* contribution to the care of the baby was just as important. Again, the following comments echo the views of midwifery staff across all three sites:

“It is really encouraging when the consultant attends the Newburn forum meeting. He doesn’t take over even when a midwife is presenting an aspect that occurred in practice. He actively seeks the views of the rest of the staff even though they are from all three Trust sites not just our own. When everyone acts in this way, I think it makes us all feel that our role is just as important as any other professional we work with.” (MM3 T2)

“We are invited to attend the neonatal meetings with all the other paediatric team which is great. If a specific subject is going to be discussed he does not forget to let us know ... if we ask questions or put forward points, we are listened to like everyone else, that’s how it should be we learn from each other.” (PEF2 T1)

“We all have to work together if the baby and its parents are to get the best care. Professionally I cannot tell a mother that the reg. [registrar] cannot come to them because one of our consultants has told him not to ... there is no reason he cannot do so! Here we are as students paying attention to national reports about the outcomes of poor communication and where professionals are not working together effectively and this sort of thing happens.” (STp5 T3)

However, perhaps the next comment is the most profound, as it was heard repeatedly – albeit slightly differently from almost every interviewee across all Trust sites. The strength of feeling behind the words came across through the person’s body language, emphasis in terms of tone and tempo and the level of eye contact:

“We are as strong as the weakest link ... it doesn’t matter a jot what your profession is, it is how we work together to care for the baby and the parents that is important ... isn’t it?” (MW1 T2)

These words were intricately linked (either before or after) to the following comments which perhaps gives a flavour of how NIPE practitioners encapsulate the need for good communication and to work collaboratively:

“We need to be kind to each other ... we can say something or request something in a nice way, we are all professionals in our own right ... there is no need to be rude or treat someone as a lesser mortal.” (STp1 T3)

“We are all here to do a job, but it is so nice when the consultant turns round and thanks everyone ... sometimes this cannot happen until much later or in a perinatal audit meeting – but it happens and that is what matters.” (MM6 T1)

“If we don’t work together it doesn’t help anyone, least of all the baby or the parents. It just means going to work is harder ... we all suffer, the baby, the parents, all the staff and the students ... especially the students which is not good if we want them to work with us when qualified. The job can be hard enough as it is without putting them off.” (MW12 T3)

The need for compassion across all staff and positive working environments comes across within the comments above and echoes Oates’ (2014) study. These factors have been mentioned in various reports and publications over the years including the Francis Report (2013), the National Maternity Review (NHS England, 2016) and more recently team working was again mentioned in the Each Baby Counts 2019 Progress Report (RCOG, 2020). Therefore, the findings of this research have some parallel with the content of these publications which seek to highlight, inform and motivate good practices in the areas of inter-disciplinary collaboration, effective communication and pro-active leadership.

However, there was another issue that became more evident as the interviews progressed that related to NIPE clinics. During the early years when courses to train midwives to conduct NIPES had just begun, some Trusts brought in ‘NIPE clinics’ on the postnatal ward where parents could take their baby to

have the NIPE performed. This occurrence tended to occur in high-birth maternity units where the number of NIPE trained staff led to a situation whereby it was difficult to undertake all NIPES prior to the mother being discharged home. However, it became apparent that not all staff are happy that these clinics have remained and the comment below is a typical comment made by one of the midwives:

"We have NIPE clinics and each baby is added to a list and the midwife or ANNP undertakes the examination one after another. Sometimes the babies on the ward are added to the list ... I would much prefer to examine the babies of the women I am caring for myself."

(MW6 T2)

When the midwife above was asked why she thought these clinics were held in her Trust, she stated that they started when there were few NIPE qualified midwives but that this was not the case now and to say that the baby could be kept warm under the heater on the resuscitaire was not a valid rationale. Other staff had also questioned the use of resuscitaire on which to complete the NIPE as unless a baby required emergency care (e.g., resuscitation), most babies did not need direct heat when undressed as the maternity setting is so warm and it makes it difficult for the parent(s) to see what is happening. Additionally, some staff felt it made the hip examination less effective but there is no research available to agree or disagree with this perception. However, it was clear that this particular midwife and other midwives across the Trust sites felt that these clinics were inappropriate and represented a medical image to the parents, obstructing the midwife from providing holistic care to both mother and baby. This perception of being made to follow a medical model seemed to resonate in the comments of the midwives who perceived it as devaluing their professionalism as can be seen in the following comments:

"I want the freedom to work holistically, sensitive to the needs of the mother and baby ... it is not a 'nice' thing to do, it is a professional, caring thing to do." (MW13 T1)

"We should be completing the NIPE when it is best for mother and baby, not because our care is run on a medical conveyer-belt system ... where is the caring in that?" (MW9 T3)

"I could sort of understand it when there were few NIPE midwives, but now it feels like the midwives are having to make it easy for the paediatricians as NIPES are performed within a designated box of time ... the feelings of mothers/parents don't matter and how the midwives feel about this definitely doesn't matter." (PEF 2 T1)

The students were just as articulate in putting forward their views:

“I am not a paediatrician so why should I act like one. I don’t want to hide in a clinical room to conduct the NIPE as though it was some clinical process ... I don’t believe the women want that either.” (STs7 T2)

“When I qualify, I want to be allowed to work as a holistic and caring midwife who can complete a NIPE examination when it is convenient for the parents in just the same way as I do when I complete a postnatal examination on the mother ... what is wrong with that, why do doctors and management think it is appropriate to control our profession ... do they find us threatening? (STd10 T2)

Across the different grades of midwifery staff, the perception of making the NIPE appear as a clinical medical examination that promotes the image of searching for abnormality (medical model of care) rather than ascertaining the presence of normality (midwife model of care) became a recurring theme throughout the midwifery staff and student interviews. Rice and Warland (2013) had previously pointed to this struggle that midwives can experience between providing autonomous midwifery practice and the increasing pressure to follow a medical model of care. Hunter and Warren (2014) and Cramer and Hunter (2019) agree that this is an issue and reiterate why recognition of this ‘power’ struggle needs to be acknowledged and addressed if the level of autonomy and advocacy is not to be further reduced. Spendlove (2018) also warns against the increasing medicalisation of midwifery practice if women are to continue to have a say in their care. The concern is that women will be seen as a pregnancy that needs to be controlled rather than a pregnant woman who needs support and comprehensive information on which to make informed decisions about her care and progress.

The evidence above was echoed by the midwifery staff who often stated that obstetricians saw pregnancy as a problem and that midwifery staff needed to be given explicit instructions to ‘manage’ the pregnancy and that some paediatricians also acted in the same manner. The feedback during the data collection about how midwives felt about the NIPE clinics revealed that many of the staff and students held the same views that have been discussed earlier. However, there was another point that added to what midwives termed as being *undermined* and that was how they perceived paediatricians pushing for the use of an AANP (Advanced Neonatal Nurse Practitioner) to run the NIPE clinics on the post-natal ward which most midwifery staff saw as their role and up to them to ensure NIPEs were completed in the same manner as all areas of their midwifery role. Some typical examples demonstrating their depth of feeling are as follows:

“The paediatricians prefer the AANP to run the clinic ... they don’t trust us which is ridiculous as they (the AANP’s) are trained on the same course as we are but because the AANP’s are under the umbrella of paediatrics they are seen as better than a midwife ... it is quite insulting” (T1 MW2)

“I have had occasions where because the AANP usually is sent down to run the NIPE clinic, if I sneak in a NIPE when I am looking after its mother and I have to refer the baby, the paediatrician will tell the AANP to check my findings. It is so humiliating!” (T2 MW6)

In the three trust sites where the data collection took place, the AANP’s are indeed trained with the midwives on the same NIPE course. They usually complete their NIPE qualification in-order to make sure that babies admitted to the Neonatal Unit (NNU) do not miss out on the NIPE due to other health considerations that may – for good reason - have taken priority. As they work mainly in NNU, there is an expectation that whilst they complete their course, they also conduct supervised NIPES on the postnatal ward. In so doing, they experience the important need to gain evidence regarding pre-disposing factors that may be relevant to the baby in front of them which they can miss out on when a baby’s care on NNU may revolve around the condition for which they have been admitted.

How the AANPs may feel about being asked to run the NIPE clinics and being asked to re-examine a baby due to a midwife referral is not known as AANPs were not included within the data collection. When the consultants on the specific sites that ran NIPE clinics were asked why AANPs ran the clinics, those on one site stated that they did not know they were and that this must have been instigated by their registrar. On the other site one of the consultants stated there was no reason that this should be necessary as the midwives were more than capable and the other consultant stated that he had started this as the AANPs were much quicker at conducting NIPES. Therefore, it would appear that on both sites there is a lack of communication between consultants, registrars and midwifery managers in relation to what action is taking place and who is responsible for that action. Either way, the strength of feeling that arose from the midwifery staff and students was palpable and they clearly felt undermined in their role and that their judgement and decisions taken were not being respected.

The students who are completing their NIPE module are either in their third year of the direct entry programme, in their last eight months of their short programme or are undertaking the six-month NIPE module as qualified midwives. The student midwives are all fast approaching registered practice status and were actively taking on board their professional identity. Therefore, it may not be surprising that they often referred to the professional role but they made it clear that they were aware that midwives

were not always able to fulfil a holistic role as they wished. When asked what they meant, they spoke in terms of:

"The midwife I was working with had to take the baby to the NIPE clinic even though she wanted to do the examination with me by the bedside. The woman asked if there was something wrong with her baby and my midwife had to explain that there was nothing wrong it was just that babies had their NIPES in a room close by. It made me think, why does this happen? There was no reason that we could not have done it and I know the midwife was not happy!" (STd19 T2)

"I missed out on completing a NIPE, because the baby was taken to the NIPE clinic and the room is too small for the midwife, parents and me to be in there at the same time, but I don't understand why we need a clinic. When I qualify, I want to be allowed to work as a midwife ... not as someone who is permitted by the paed [paediatrician] to do this exam [examination] just because I obey the rules and take the baby to a clinic." (STs9 T1)

"Why should we not complete the NIPE in a cot at the bedside when we do the mum's examination on the bed? Going to a 'clinic' is only because the paed [paediatricians] can see that we are doing the NIPES ... they are so regimented, why should they dictate how we [midwives] work. We know what we are doing, we are professionals too." (STd14 T3)

Many of the students who were qualified midwives often made the comment that they did not know why the NIPE clinics existed if midwives were to be allowed to practice autonomously. Some of this student group said they had fallen in-line with what the paediatricians did but had not thought why they were doing so and the following are typical comments from this sample group:

"When I heard a student midwife asking why times had to allocated in the NIPE clinic that I began to wonder at this myself. Okay, the lack of adjustable height cots is an issue and would cause less back ache, but why can't I perform the NIPE when it is a convenient for mum and baby?" (STp1 T3)

"I worked with the midwife in the NIPE clinic and we had a discussion as to why these clinics existed ... I know in the past there were few NIPE midwives, but it is not so bad now. I want to care for both mother and baby, this is task allocation ... I am worth more than that. If you are looking after the mum, she has some knowledge of me and hopefully she will listen more to what I say in relation to what her baby can do and health promotion" (STp6 T1)

Both midwifery staff and students spoke about encouraging and maintaining normality in professional practice. They often spoke of not being 'allowed' or 'permitted' to work in the way that their professional training and standards had prepared them for. They frequently expressed that they wanted to work as a professional in their own right, and used words such as feeling 'dictated to' or 'manipulated' by the medical profession. When asked to explain further it was clear that midwives wanted to work collaboratively with doctors whether they were obstetricians or in relation to NIPE, paediatricians. However, they wanted to be seen as equal partners, not as some stated:

"The consultant paediatrician sees us as a convenience, 'a subordinate' who can fill a service need but if we need to refer a baby due to an anomaly, then sends us a junior doctor ... as if they know more than we do!" (MW13 T1)

"I explained to the paediatricians that we now had enough NIPE trained midwives and therefore did not need to run the clinics anymore. I was shocked at their response, apparently, they think 'we' [midwives] should keep doing them as we are more efficient when doing so. I very firmly told them that midwives were not inefficient as they were implying, that midwives are professionals in their-own-right and did not deserve such disparaging comments when it was apparent that they knew very little about the role and responsibilities of a midwife!" (MM3 T1)

The need to work collaboratively and compassionately came across strongly within the interviews across all Trust sites. However, it would appear that there are certain areas or processes in practice that hinder respectful collaboration by maintaining a level of power disparity within closely working professional groups, such as midwives and doctors. This point was highlighted by Hall (2005) who discussed the disparity of power dynamics that exist in practice which can result in tense interprofessional relationships caused by hierarchical groups or tribes who assume responsibility of decisions for other professional groups as well as their own, discouraging these groups from effectively and respectfully, collaborating with each other in practice. Unfortunately, it would appear that these dynamics were also present within the themes discussed within the next section that more specifically focuses on the issues arising in relation to the process of referral and the access and agreement to Trust neonatal guidelines.

6.4 Referral Processes & Guidelines

6.4.1 Referral issues

Due a midwife's level of expertise and NIPE training, all the NHS Trust sites included within the research have guidelines which require a midwife who finds any anomaly when conducting the NIPE

to refer the baby to the registrar or consultant. It does not mean that the SHO is not involved but it does signpost that a NIPE midwife's professional status and level of knowledge is deemed to be at a standard and whereby direct referral to the registrar or consultant is the appropriate course of action, thereby reducing delay in the need for further investigation and treatment. Most consultants at some point during the interview mentioned the importance of midwives being easily able to access the registrar or themselves in the event of concern about a neonate's health and tended to be very clear on this point, stating:

"I would be very concerned if a midwife did not contact either the reg. (registrar) or myself ASAP is she was concerned about a baby. These newborns can go down so fast and then it is much more difficult to resolve the issue ..." (CN1 T2)

"There is no problem with the midwives referring a baby to the registrar, if there was a problem I would want to know." (CN3 T1)

From the midwifery perspective, staff spoke about their appreciation for the quick response they experienced from senior paediatricians:

"I have never had a problem with getting through to the registrar ... if they're in the middle of something at the time they receive the bleep message, they send someone to give me a call back so that they know if the matter is urgent or can wait until they finish." (MW5 T1)

"I had to call the consultant as the reg. (registrar) had to run to a baby on delivery suite but he was really nice and called back almost immediately and then came down [to the postnatal ward] to see the baby." (STp 3 T2)

However, one consultant gave a comment that did not allude to the guidelines:

"Midwives should complete NIPes if they have undergone the training as my SHO's cannot do all the NIPE's and should not be expected too. They can defer to the SHO if needed" (CN2 T3)

The use of language within this comment, i.e., the word 'defer to' instead of 'refer to' may have been coincidental, but it might also give some credence to why the midwifery staff were so vocal about this specific consultant within earlier comments. After all 'defer' can be defined as submitting to the opinion or desires of another in respect to their judgment or authority (Collins, 2011). It cannot be determined by one comment alone if the above represents the normal language pattern for this

individual and it would be unethical to do so. However, what did become evident during the data collection, is that all midwives interviewed who worked within the same Trust who had contact with this specific consultant articulated that they were well-aware of his views. They spontaneously voiced their thoughts in relation to how it made them feel as professionals. They usually spoke about feeling disrespected at being made to refer a baby to someone who they perceived as having less knowledge about neonates than themselves, or that they felt that they were being treated as someone who was seen as a 'second class citizens' (some staff used the words 'handmaiden' or 'servant') to the doctors.

It is worth appreciating at this point that usually the SHO is completing Foundation Year Two (FY2) of their second year within clinical practice and are therefore required to complete a six-month rotation in the maternity unit. However, many of the midwives have been caring and learning about neonates for many years, even the student midwives have spent two years with hands-on care of neonates prior to commencing their NIPE module within their midwifery training programme. Therefore, to a certain extent, this may be why midwives feel so passionately about, what could be seen as, protecting their status as knowledgeable, experienced professionals. Indeed, this may be the reason for the following comments that were typical of staff working at Trust three when describing various situations that they experienced on a regular basis. These were situations which they felt undermined their professional competence and ignored the level of knowledge and experience they had achieved:

"My midwife had found that the baby's hips that we were examining were bilaterally dislocated. She [the midwife] contacted the registrar to refer the baby for further examination as per the guidelines but was told that the consultant had stated that the SHO should see these babies first before referring the baby to him themselves. My midwife was disgusted and disagreed stating that the SHO could see the baby but needed supervision with the registrar or consultant in-order to learn about the condition and prevent further trauma occurring due to inexperience. In the end, the baby ended up having the hip examination performed by the SHO, the registrar and then eventually the consultant ... the parents were not at all pleased and I don't blame them ... it certainly goes against the research about best practice!" (ST16 T3)

"When I need to refer the baby to the registrar as our guidelines state ... it is really infuriating when he [consultant neonatologist] doesn't like it and sends the SHO! I really feel quite hurt that my expertise is not valued ... I know that I am not the only one who feels like this. We receive a lot of training at the university to reach the standard to complete our NIPE module and the SHO might be shown one if they're lucky! (MW9 T3)

“The midwives know when there is a problem with a baby and are expected to contact the registrar or consultant to come and see the baby but one of our consultants will send the SHO who knows less than the midwives ... it is not good enough! We have had discussions about it and will no doubt have to have more. The other consultant is fine!” (MM2 T3)

Perhaps the most telling comment that arose when midwives divulged these types of incidents, relates to their thoughts that they would not continue to conduct NIPes if the other consultant neonatologist, the PEF and their midwifery manager were not so supportive and pro-active in trying to change the situation. When one considers that these NIPE midwives have completed training to conduct NIPes and are training the student midwives of the future who are already completing the training during their midwifery programme, the impact on maternity service provision in terms of loss of experience and training costs would be considerable, let alone the effect on the individual.

However, as previously mentioned, across all three Trusts midwives work within multi-disciplinary teams and they mentioned other examples of where they felt undermined in relation to their professional knowledge. The most clear and consistent example that was mentioned related to ultrasound investigation of the baby’s hips. Part of the national screening referral recommendations is that a baby who has the presence of NIPE hip risk factors, but a normal clinical NIPE hip examination, should be referred and undergo hip ultrasound by 6 weeks of age (Public Health England, 2019). Within each respective Trust guideline at the time of the data collection, it was written that the head sonographer and the consultant neonatologist had agreed that the NIPE practitioner who performs the NIPE should complete and send to the ultrasound department a referral form for a neonatal hip ultrasound scan. The scan would occur at 6 weeks of age and the practitioner would inform the parents that an appointment letter would be sent to them. As the interviews progressed, it became apparent that although it appeared that all paediatricians could send in the referral form without a problem, this was not always the case for midwifery staff and had become a source of irritation as the following comments illustrate:

“I find it infuriating when whoever receives the ultrasound form decides that because a midwife completed it and referred the baby that it is not acceptable. I have phoned them and said that I am a qualified NIPE practitioner and the guidelines support this action ... they just say that doesn’t matter it has to come from a doctor!” (MW7 T2)

“We have had to discuss with the consultant what to do about 6-week ultrasound referrals as sometimes ultrasound will not accept the referral which is ridiculous.” (MM1 T3)

“Not only is it in our guidelines that we can refer a baby for ultrasound, but if it is not accepted it can delay the baby being seen in a timely manner. It doesn’t reassure the parents that we know what we are doing.” (MM3 T1)

Students and midwives were particularly vocal about incidents where this had occurred. It was not just the fact that the referral form that they had completed was not accepted, they then had to ask the SHO to complete the form and the appointment was then sent out later than it should have been, both factors were clearly not seen as acceptable practice as can be seen below:

“... we have to ask the SHO to complete the form. Sometimes they are very short with us, asking why this was not done at the time. I find it quite insulting” (STp4 T2)

“... this problem tends to happen if there has been a change of staff in the department, usually at administration level. We have to investigate why it has occurred and sort it out. The midwives get quite annoyed, so do I ... it wastes my or the consultants time and all it would take is for new staff to be properly inducted. It’s not their fault and they’re often quite upset that an appointment has not gone out in time.” (MM3 T1)

The comments above also link with the recognition by participants that effective communication and positive action was necessary. Staff were quick to say that they appreciated the involvement of both consultants and managers in investigating the cause of the problem when it occurred and ultimately resolve the situation. Such action reflects the guidance that relates to the need for effective leadership in developing a supportive NHS culture (NHS England, 2016) and for situations to be resolved in a diplomatic and professional manner as advocated by the RCOG in their publication, Each Baby Counts. 2020 Final Progress Report (2020).

6.4.2 Trust Guidelines - issues with access & adherence

Midwifery managers referred to valuing the support of consultants who sought to make themselves available at management meetings when discussing referral processes or new guidelines and protocols. The following comment gives a good account of the views held on two of the Trust sites:

“We do have a good working relationship with our two main consultants. They take turns to come to neonatal management meetings and are very pro-active in their support for the midwives. This is good because it provides a good role model for the [paediatric] registrars and the junior doctors on rotation” (MM3 T1)

It was clear that when senior paediatricians were actively involved in meetings and discussed protocols and guidelines with staff, there was a more positive perception of the interprofessional relationship. However, on Trust sites where this did not generally occur, there was a distinct sense of disappointment when this did not occur across the senior paediatric team, for example:

“We don’t expect all members of the senior paediatric team to turn up to every neonatal meeting, but it is not good when it becomes obvious to the staff that only certain senior paediatricians attend” (MM3 T3)

What did become increasingly evident as the interviews progressed was, apart from attendance at meetings, how much the staff appreciated the pro-activeness of the consultant when there were issues that were causing problems in relation to the guidelines, such as when guidelines were not being followed as in the following comments:

“If a guideline is not being followed, he is more than happy to discuss the situation and try to resolve it,” (MW8 T1)

“He [the consultant] is really good and informs them [SHOs] during their induction that for most things they should check with the midwives first because they have seen it all before and know the guidelines inside-out... which we do of course, but we also follow them because they are evidence-based and the SHOs don’t seem to understand that.” (MM2: T2)

However, this appreciation worked both ways in that consultants also articulated that they were pleased when midwives questioned a guideline or highlighted when a guideline was out-of-date:

“It is great when one of the midwifery team tells one of us that a guideline is out of date so that we can make sure that it is amended. What is worse is when they tell us that we have all agreed a change of action, but the guideline has not been amended – we really cannot have ratified guidance sitting there knowing that what it says for us to do, is not what we are doing. It casts doubt on our practice and leaves us open to legal and ethical scrutiny.” (CN3 T1)

Although new guidelines always have the date of commencement printed on them, they also have a shelf-life – a date by which they must be reviewed. On review, the commencement date then becomes an amended date with a new review date inserted on the ratified document. At times, staff become so used to a guideline that there can be occasions when new evidence point to the need for actions to be changed but the guideline is not amended quickly enough. This then can lead to both

paediatricians and midwifery staff acting on the new evidence but not carrying out the actions signposted in the guideline that has been ratified. The legal and ethical issues that can arise in such situations is one of the reasons why student midwives are taught to check the date on the guideline they are using and explore the available contemporary evidence in-order to discuss the rationale and evidence on which the guideline is based with their supervising midwife. By the time they enter qualified practice, the expectation is that they check the relevant guideline or protocol automatically.

Another issue highlighted during the interviews, was how staff felt about where the neonatal guidelines were situated on the Trust site electronic system. It became apparent that access to the guidelines was not always easy, for example, student midwives might have to ask the midwife they were working with to access a specific guideline because where it was held on the system was not an area that as students they had access to, or that access was not always available to them. The comments below gave some clarity as to why staff sometimes found accessing the guidelines frustrating if not concerning:

“I got very confused one day as the midwife I was working with opened the paediatric guidelines on the system instead of the midwifery one’s ... I read the guidance ... and then changed to the midwifery one’s – they were not the same, how can that be, why are there separate guidelines I could have done something that I should not have done.” (STp T1)

“We have paediatric and midwife guidelines here, they’re in two different sites on the intranet. It causes confusion if the info. or actions are written differently which could cause a problem. Why one for paed. and one for us ... do they [paediatricians] seriously think that we are not the first to act if a baby becomes unwell? We need easy access to the protocol or guideline.” (MW6 T1)

“When I am working with a student midwife, I expect them to look up the guideline and take the initiative. They are going to be midwives tomorrow – they need to show that they can take responsibility but how can they when they cannot gain access. I know this is changing, but this access should have been available from the time that they gain their Trust ID.” (PEF1 T2)

Not all Trust sites had the same issues relating to access, as in some Trusts the paediatric guidelines and midwifery guidelines are not separate entities. Access to neonatal protocols and guidelines are all in one area within the intranet for all professionals and students to access under the heading *neonatal guidelines*. Indeed, one PEF quite succinctly stated:

“Our neonatal guidelines are for both midwives and paediatricians ... everyone sings from the same song sheet and this way there are no mistakes and no-one gets annoyed with anyone else, but I know not all Trusts are the same.” (PEF2 T1)

6.5 Non-NIPE Midwives

All midwives, particularly those working in the postnatal, community and midwifery led birthing units are aware of which midwives hold the NIPE qualification. As midwives have been able to attend NIPE modules of training since the early 1990's, their presence in any of the above areas is a regular occurrence. The number of midwives becoming NIPE practitioners has steadily risen over recent years and the advent of the NIPE module within the midwifery training programme has caused some concerns as discussed earlier in this thesis.

On the three Trusts within this study, each baby that needs to have a physical examination or a review due to health concerns, is identified for either paediatric review/NIPE or for midwife NIPE in-order to aid quick identification. However, in the past there have been some issues relating to babies that could have been examined by a midwife, being identified as needing to be seen by the paediatrician. Overtime, this issue within the three Trust sites within the study has seen this issue fade only to recur again at a later date. A situation which according to the comments from the NIPE practitioners was a situation that they found frustrating and was reflected in comments such as the one below:

“I thought the issue with babies who could be seen by a midwife ending up being seen by a paediatrician had gone, but it still happens. It is so annoying, you go to do a NIPE and find the SHO has not even bothered to check if a midwife could do it, then they moan that they have too many babies to see.” (MW8 T1)

Staff did allude to the fact that sometimes the situation was due to staff returning to 'NIPE' areas from non-NIPE areas such as the consultant-led delivery suite where few NIPES were performed and therefore forgot which babies midwives could perform NIPES on. Midwifery managers were also aware that at times the causal factor was new staff. Staff who came from midwifery units where NIPE midwives were not so prevalent were also unsure which babies could be seen by which NIPE practitioners and would therefore assume that all babies need to be seen by a paediatrician. The managers were very keen when this occurred to make sure that part of the induction for new midwives should cover the guidelines relating to NIPE. However, they were also aware that if they were not used to student midwives undertaking the NIPE module, they could feel at best uncomfortable and at worst threatened by the fact that these students might know more about the neonate than they did. This factor has been partly discussed earlier, but the full picture in relation to

how non-NIPE midwives feel about not having the NIPE qualification themselves cannot be discussed here as they were not included within the study. Nevertheless, what did appear to be a positive point was that even when staff or students found a situation frustrating, they did not blame the non-NIPE midwife but tried to resolve the situation instead. In trying to resolve the issue clearer guidance was inserted into the NIPE folder next to the list of babies who were to be examined to enable easier identification by both midwives and junior doctors.

All midwifery staff must attend mandatory updating and team meetings, which includes information on which babies a midwife can undertake the NIPE. NIPE midwives themselves in all three Trust sites attend a half-day NIPE update session organised by the university and managers were keen that these events should give NIPE midwives a chance to air any frustrations in a safe environment. These updating sessions and the themes arising from the data relating to training and updating will be discussed in the following chapter.

Chapter 7: Bedside manner, Training, Consistency & Lecturer Involvement

This chapter focuses on issues that arose during the interviews that although relating to the themes covered within the previous two chapters, were considered to deserve a chapter of their own due to the recurrent and animated discussion that arose within all the participant groups.

7.1 Communication - Bedside Manner

One of the issues that arose within all sample groups in relation to SHOs was the general feeling that basic 'people skills' or 'bedside manner', as some of the participants termed it, was 'somewhat lacking'. This was usually related to the fact that although some SHOs were very good at taking on board the need to address the parents during the examination, inform them about their baby's development, health promotion information and the findings of the examination, it was generally voiced that these junior doctors were in the minority. Practitioners often voiced that SHOs said very little with the parents only being told that everything was fine. The following comments give a flavour of the thoughts on this issue across the participant groups:

"How they [SHO] actually perform the NIPE & whether the parents can see what they are doing does not seem to concern them ... I don't think they are aware of the impact on the parents. Some are OK but you would think that they would all be better at talking to people by now." (MM3 T1)

"Quite often the SHO tells parents that their midwife will talk to them about the health promotion stuff! They really should not say things like that it's obvious that they do not think it is important but it is, how else will parents know if their baby is OK in the coming weeks? It really doesn't look good to the parents - you can see it in their faces." (PEF1 T2)

"My midwife told me to go in and observe the SHO performing a NIPE on a baby who was having antibiotic therapy. She [the SHO] did not say anything reassuring to the parents apart from checking that they knew why their baby was having antibiotics ... she then said it was fine and left ... the parents were really upset as they obviously wanted reassurance. I asked my midwife to see them which she did but she also asked the SHO to go back to see them. The SHO did but she was very short with them." (STd14 T3)

Some of the consultants interviewed also mentioned the need for medical students to have more opportunities to practice 'bedside skills' and talking to patients as a 'human being'. On two of the NHS Trust sites, consultants stated that they made a point of discussing the issue during

the induction of junior doctors as they felt that sometimes such basic skills were not evident, for example:

“During their induction [SHO Induction] I chat with them about the need to reassure parents. We discuss the importance of encouraging a two-way conversation, but you know what, I think some of them do not get it. Perhaps it’s because they see it as a task or perhaps the medical school doesn’t emphasise the importance of the ‘bedside manner’ as much as they should ... either way I don’t know what it is.” (CN4 T1)

Wilson (2018) emphasises that student doctors need good role models to learn good patient communication. Perhaps the comments above do point to need for a greater input during medical school where the use of simulated scenarios could be used to assist medical students to become more aware of the impact that their actions and words have on those they are caring for. It is possible then, that the same activity could help junior doctors appreciate how to develop effective people skills not only with patients but also, as Christie and Glew (2017) point out, with the staff they work with in practice.

However, it can also be seen within the data collected, that an SHO’s ability to conduct a comprehensive and effective examination was judged by midwifery staff in terms of knowledge and their communication skills with parents. Although, SHOs do recognise the need to complete a comprehensive NIPE, perhaps it is the interpretation of what comprehensive means that may be the issue. As midwives were very clear that SHOs concentrate on heart, hips, eyes and testes and not necessarily on assessing the baby’s health through investigation of maternal and neonatal records, parental discussion as well as conducting a full clinical assessment of all areas of the body. As the data collection continued, a strong relationship was revealed between the above factors and the need for the training of all NIPE practitioners to be consistent in terms of examination process, parental involvement and assessment. The premise here was that it should raise the level of effectiveness of the examination itself and these aspects will be discussed further in the next section.

7.2 Training & Updating

The midwifery staff across all three Trusts must have successfully completed a university academic Level 6 or Level 7 NIPE module prior to commencing solo examination. They are also expected to attend a NIPE update session every two years. These sessions are run by the university (sponsored by the Trust) and serve a two-fold function. Firstly, staff can be updated on the NIPE module curricula and assessment process used within the module itself and secondly, receive an update in all aspects related to the NIPE and referral outcomes. The session also includes an opportunity to take a skill

check in relation to hip examination as well as review and critique new research findings or proposed guideline changes. All staff are also encouraged to access the NIPE e-learning for health modules available through NHS Health Education England. Yet, although junior doctors receive initial training when commencing their neonatal experience, there appears to be no official expectation to provide evidence of accessing the on-line e-learning provided by the Government national screening committee. As confirmed by the consultants, all SHO's are expected to attend a NIPE lecture/tutorial but there does not appear to be any guidance or documentary evidence of attendance, or that junior doctors have been shown how to perform the examination.

Junior doctors were not included within this study for reasons discussed earlier. However, whilst they spend approximately 6-months within the maternity unit when completing neonatal allocation, they do examine a considerable number of babies and parents. Indeed, as the interviews progressed the increasing volume of concern raised within all the sample groups relating to their involvement in the NIPE, created sub-themes which could not be ignored and might provide some valuable insights to be gained in relation to SHO training in NIPE. Furthermore, exploring how others may perceive them in the light of how they appear to respect the purpose of the examination and the actions of other NIPE practitioners, their conduct of the examination and therefore how they might be judged on their level of knowledge and expertise. It is recognised that the views of the SHOs are a missing voice in this study which may have added an important information regarding their view of the situation and further adding to the body of knowledge that could be utilized within practice. However, the sub-themes arising from the interviews in relation to the above are discussed below.

7.2.1 An important health screening opportunity or a task allocation exercise?

It is usually the Paediatric SHO who conducts the NIPE if there are no NIPE midwives on shift or because there are particular health issues that require a paediatric review as per the NHS Trust guidelines. As already previously discussed, midwifery NIPE practitioners generally appeared to view junior doctors as having less knowledge and experience in relation to NIPE than themselves. During the interviews, the midwifery staff gave more detail as to why they felt as they did, as demonstrated in the following accounts:

“Apart from SHOs who wish to become GP’s, they [SHOs] are not interested in completing the NIPE, they just do it because they have to get the job done.” (PEF2 T1)

“If the registrar is putting on a study session, the SHO is off to it like greased lightning, it doesn’t matter if parents are waiting to go home.” (MW7 T2)

The comments above were echoed by the consultants who alluded to similar sentiments:

“Most of them [SHOs] just see the areas that they need to gain experience in during this second year as a means-to-an-end. The NIPE is just another task to them. I have said the NIPE is a complete process and that includes the health promotion aspect, but I know for a fact they often pass the buck and tell the midwife to do it. If the registrar puts on a teaching session when they [SHOs] should be doing NIPEs, they will be the first in line to attend whereas if they are in delivery suite that is not always the case.” (CN4 T1)

“They [SHOs] see NIPE as a task rather than an important part of neonatal screening and sharing of information with the parents. The fact that apart from the midwife’s initial examination after birth, this is the first screening event that occurs for this baby just seems to pass them by. They don’t even seem capable at times of listening to the parents and giving them information about their baby’s development ... if it wasn’t for the midwife, parents would get very little information about their baby or what to look for in the future as signs of development or illness.” (CN2 T3)

Midwifery staff and students were very clear that most parents not only want the examination performed and know that their baby is healthy, but also want to know more about what their baby can do and what they need to look out for. Some of these concerns are articulated below:

“I think some parents miss out on valuable information when some SHOs perform the NIPE. They [SHOs] don’t listen to the parents or give them time to ask questions. If the [midwives] are busy, then the mother can miss out even though the main aspects are covered during the overall discharge process. Some of the information is really important for parents to understand so the SHO should complete the NIPE with the appropriate information at a time when the parents are highly receptive and focused on their baby.” (MM3 T1)

“You hear some SHOs blatantly stating that the midwife will cover the ‘chatty bits’! I just feel that they don’t understand that these ‘chatty bits’ are ‘facts’ and just as important as the examination itself ... how do parents know what is normal and what they should be concerned about if we don’t do the ‘chatty bits’! I think they either don’t know enough or think it’s not important – both aspects need addressing.” (MW11 T2)

7.2.2 NIPE practitioner training

As stated earlier, how NIPE practitioners learn to complete the examination is not the same across the professional roles. Most of the training for junior doctors takes place in practice and is at times

supplemented with lecture/tutorials from the senior doctors, with no clear indication if their competence is assessed or reviewed. Conversely, the training for midwives and student midwives covers a six-month period of class and practice learning with a clear assessment process which must be successfully completed before conducting solo NIPes.

Midwifery staff were vocal in voicing concerns about junior doctor competency in completing the component aspects of the examination. Although it is interesting to note that this was often linked to the perceived competency of NIPE midwives (a point which will be discussed later). These views tended to relate directly to their perception that a lack of preparation (or training) did not assist SHOs to conduct a comprehensive and effective examination. Midwifery staff were quite emphatic that there was a need to perform the examination in an effective manner otherwise they saw “no point” in conducting the NIPE, as alluded to in the following comments:

“My midwife has been trained and assessed to be competent to perform NIPes, why should the SHO not receive the same training? When I watch some of them (SHOs) I think that if the parents were aware of their level of their experience, they would not be so happy with the care they have received or the information that they have been given.” (STp2 T1)

“I cannot say that I am not worried. My midwives train to do these NIPes, plus they have far more knowledge about normal neonatal behaviour. If the SHO listens to the heart for 30 seconds and finds nothing abnormal even though the midwife has stated that there is a heart murmur... we have a problem. Thankfully, my midwives will go back and listen again and will make sure that the registrar attends if the murmur is still there. I mean, come on ... listening for 30 seconds and does not look for any other aspects is not being thorough and shows a lack of understanding! What would happen if the midwife did not uphold her professional responsibility and the baby had a serious problem.” (MM1 T2)

“You do get some SHOs who do cover all aspects of the examination properly, but there are others who really don't seem to understand how to perform a hip examination for example ... it really makes me cringe at times to watch them.” (MW11 T2)

When asked what she meant by ‘properly’, the midwife’s first response was that some SHOs did not seem to know the difference between a NIPE for a newborn baby and a NIPE at six weeks of age (this differentiation is because the hip examination is performed slightly differently at both time periods to enable the most effective examination to be performed). The midwife’s second point was that she could not see any evidence that the SHO, who had only a week left on the ward, had been taught how to perform the neonatal hip examination. Her thoughts, held a strong similarity to those of other

midwifery staff and students who had also voiced concerns about the standard or effectiveness of the examination in relation to its various component parts or aspects, as in the following examples:

"I know it is not always their fault, but I have watched SHOs performing the NIPE and when you consider all the aspects of this examination are important, you start to wonder what training they get. For example, some complete the red reflex as though you do a quick flash of the light in the baby's eyes and that's it – done, my students perform it better than they do." (MW1 T2)

"I've watched them, they listen to the baby's heart even though it is screaming it's head off because they have just pulled the clothing off without care and attention ... there is no way they can hear the heart sounds properly. I had enough problems listening to the two heart sounds when I first started the module [NIPE] and I have spent two years getting used to a neonates fast heart rate." (STd 9T2)

Concerns about the level of training for junior doctors have been raised in the past as highlighted by both McDonald et al. (2012) and McKinnon (2017), who found that their training was variable and often consisted of a 'see one, do one, teach one' approach. Indeed, when asking the consultants what training the SHO received when commencing their obstetric and neonatal experience, the answer was that they (SHOs) were expected to attend a lecture and demonstration in the classroom, plus they were informed that the NHS England NIPE e-learning (via the NHS HEE portal) was available for them to use. However, the consultants did say that they could not say if every SHO managed to see a real NIPE being performed prior to commencing these examinations on the wards as this type of demonstration was left to the registrar. They also mentioned that there was no formalised process for checking that the e-learning had been accessed and perhaps this was something that they should think about considering the training that midwives received when completing their NIPE module. Of course, without conducting a separate study involving junior doctors to determine if they attend teaching sessions, saw a live demonstration of a NIPE or accessed the NIPE e-learning, one cannot comment further. However, it does perhaps shed light on why midwives may find it a particularly uncomfortable action when their referral is redirected to a junior doctor who they feel may well have less knowledge and skill than they perceive themselves to have.

The aspect of the perceived level of knowledge and understanding of the component parts and issues relating to the NIPE was however, not just associated with the examination itself. Concerns were also raised in association with SHO knowledge about other co-related neonatal health issues, for example:

"It's not just the fact some of them [SHO] don't really understand what they are doing and why, but it is a huge concern that they want an SBR [serum bilirubin rate] on a baby who was nearly three days old just because it looked a 'little yellow' during the NIPE. I had to explain physiological jaundice to him even though he is about to finish his experience here [on the ward]." (PEF2 T1)

"She [SHO] came and said the baby's fine. I asked her if she had completed the scan form for hip scan referral and she said there was no need the hips were fine. I had to explain that the baby had been breech and needed to have a scan in six weeks. She asked me why and I had to explain – this is all basic stuff. We even have a list of risk factors and our Trust NIPE guidelines clearly state all this information and she has been working with us for the last 5 weeks! (MW14 T3)

Student midwives had similar views and related incidents that they had come across as a typical comment demonstrates below:

"SHOs often ask for a blood glucose measurement to be taken. Sometimes this is just based on a parent saying that the baby is not feeding well. They think it is reassuring to immediately go for an invasive test, instead of exploring if the baby has been having wet or dirty nappies first or asking her to call for a midwife the next time the baby feeds so that we can assess how the baby feeds and give her extra support. They have no idea the impact these tests have on parental confidence." (STs T2)

"Most of the time, I don't think they understand the basics. It's not their fault, the senior doctors are often not around and they have to fend for themselves, but what do they have against asking the midwife she would help them learn – although it's not really her job and with short-staffing she doesn't have the time to teach me and the SHO." (STp T1)

The above issues tend to centre on staff (mainly junior doctors) who need a fast introduction to neonatal normality and the variety of anomalies that they may come across in practice. However, the examination itself does demand knowledge, understanding and effective skill application if the NIPE is to constitute a comprehensive well executed examination. The question posed by many of the midwifery staff and students is whether the SHO is the best person to perform this particular examination, if they do not have the support to do so? Another concern that was aired by the midwifery staff and will be discussed next, relates to qualified NIPE midwives and how some are treated when they go to work in a new NHS Trust site.

7.2.3 Recognition of NIPE qualification when moving Trust sites

Midwifery staff on all three sites were extremely vocal about colleagues who had moved to away to new Trust sites not being allowed to complete NIPes unless they were reassessed in their new workplace. This situation has also occurred when a student midwife moved to a different Trust on qualification to commence her first midwifery post. In these instances, I have had to convince the Head of Midwifery that this newly qualified midwife has undertaken the same qualification as the qualified midwives who complete the NIPE module at our university. This is an understandable reaction if the students at the Trust site do not yet have a NIPE module as part of their local university curricula. However, it would appear that some Trust sites expect new staff, even those who have qualified as a NIPE practitioner within the last two years, to conduct supervised NIPes before being permitted to go solo.

Whether these NHS Trust sites are concerned about inconsistency in how students, both pre- and post-registration, are taught to conduct the examination or they wish more conclusive evidence that this module has been successfully achieved – I cannot tell. However, perhaps this issue is significant from another point of view, in that midwives particularly were vocal in stating that if they went to work somewhere new and the same situation occurred for them, they would not continue to do NIPes. They saw no reason as to why they should be reassessed when they have completed a recognised and NMC validated module in the United Kingdom (UK). They were quite happy to be made aware of local guidelines that may be different and understood that this sometimes occurs, but they were not happy for their knowledge and skills to be reassessed as per the following comments:

“Why should I have to be reassessed? I know two colleagues who have gone to different places [Trusts] and they both had to be reassessed, but one almost had to do her entire NIPE module again ... it is not right.” (PEF2 T1)

“If I was told I had to have my skills assessed, they may as well reassess me as a midwife ... what would be the difference? If they would not dream of assessing my midwifery skills, why do they think they have the right to reassess my NIPE skills I wouldn't do it, it's insulting!” (MW10 T3)

It is possible that non-UK midwives may not have been taught to perform the NIPE in the same manner as expected in the England and that this has influenced Trust thinking. For example, there was a drive a few years ago to encourage midwives from other countries who were recognised by the NMC to work in England with some staff having evidence of the NIPE qualification. However, it soon became clear that not all countries perform all parts of the examination as expected of NIPE practitioners in

England such as the auscultation of the heart. As mentioned earlier, midwives who had been trained locally had soon picked up on this fact and the midwifery managers organised further training so that the situation was resolved quickly.

Whatever the rationale, it would appear there is some concern across England in relation to NIPE in terms of consistency of content, teaching and supervision of skills. Both students and midwives have voiced concerns about the lack of supervision that junior doctors receive whilst conducting NIPes compared to the learning and assessment of skill and knowledge that they undertake to be, as some have voiced, 'permitted' to undertake the examination. If this leads to midwives discontinuing from completing NIPes when they move Trust sites, then these midwives may consider their training to be a waste. Conversely, if the new Trust site requires midwives to be reassessed in their NIPE skills when SHO training appears to lack consistency, support or evidence of assessment, then it is unsurprising to hear staff openly state that they see such a requirement as insulting (as seen in the comment MW10 T3 earlier). It is a situation that perhaps requires a greater clarity and uniformity across England and therefore it may be prudent for NHS England to provide greater clarification as to the content, process and training required for NIPE practitioners.

7.2.4 National standards & local guidelines

Being taught a logical flow to the NIPE enables the practitioner to cover the examination elements comprehensively. One issue that was often highlighted by midwifery staff during their interviews, was that depending on the NIPE practitioner, there was at times an inconsistency in covering the elements of the examination and how effectively they were performed. Some examples of this have already been mentioned in earlier comments such as when auscultating the neonatal heart when the baby is crying. However, other issues raised related to the consistency of the examination performed and that changes to the national standards as set by Public Health England (2019) have perhaps caused some degree of confusion. The following represents typical comments that arose within the sample groups:

"... the SHO often sees the NIPE as a task, he doesn't always look at the baby as a whole ... they know the four key areas, but do not always follow through so thoroughly with the general examination such as looking for birth marks, reflexes etc., and reviewing the family history ... well they don't see it as important." (CN3 T1)

"The national standards focus on four areas ... but that is not the entire examination. When the very first standards came out, they did mention more about the general examination but now it's as though the general part doesn't matter, even though the red book [PCHR] was updated to include the general part." (MW9 T3)

“We are trying to get the SHO’s to complete the red book so that they see NIPE as what it is meant to be – a top to toe examination – because we were beginning to feel that they just saw it as four stand-alone elements. I think the national standards need to be clearer on this as it may help consistency in completion of the examination.” (MM5 T2)

All participant groups were aware of the national standards and had knowledge of the recent updated edition that was published by Public Health England in 2019. However, although all midwifery staff and students mentioned that the information relating to the examination had been expanded within the PCHR to include the general examination in more detail, it appeared to be fresh news to the consultants. Apart from one of the consultants, it was clear that the expectation was that whoever performed the NIPE should complete the record and they were surprised to hear that some SHO’s did not complete the general examination part of the book. This may be a reflection on how junior doctors perceive the importance of the examination or their inclination to view NIPes as a task leading them to complete the four key issues of the examination only. Again, this is difficult to assess without the views of the junior doctors who are working in the maternity practice area.

Quite often, concern was voiced in relation to other specific areas of the NIPE such as the hip examination. Again, this was often regarding the lack of supervision of the junior doctors when conducting the hip examination. Midwifery staff and students who conduct the NIPE are expected to be supervised during their training as this aids development of their skills by pin-pointing poor practice and technique. Typical comments in relation to hip examination are as follows:

“SHOs do not get the same training, they are certainly not supervised. When you watch them complete the hip examination on a crying tense baby you know they are not going to get the information that they need. They are fighting with the baby or resort to examining both hips at once which we [midwives] know is not the most effective method at the neonatal stage.” (MM2 T2)

“When I am supervised in my NIPE examinations, the midwife always checks my hip examination technique... the SHOs seem to do what they like. I have seen some really rough and poor practices no wonder research is saying it is a poor test for dysplasia... how can any research tell if it is overall a poor test if the researchers don’t even look at who is performing the examination and what their technique is like. No wonder detection levels have not changed.” (STs8 T1)

One of the consultant neonatologists did acknowledge that it was difficult to supervise the junior doctors and stated that although they were taught how to conduct the examination, they were lucky if they were shown more than one examination. He made the following pertinent comment:

“It is so difficult now with so many demands on the registrars for them to spend quality time with the junior doctors. It is not ideal, but the only way round it is to encourage the junior’s [SHOs] to go and watch the midwives and midwifery lecturers when they are teaching the students... at least I know they are being taught properly.” (CN1 T2)

A consultant on a different Trust site also made the comment that different professions would work much better together if the junior doctors, midwives and student midwives were taught together on the same NIPE module. He also felt that this would greatly enhance the detection rate of Developmental Dysplasia of the Hips (DDH) as the doctors would be supervised in their examinations. Many of the midwifery staff and students had voiced similar perceptions:

“It is about time that some of the barriers were broken down. Research tells us that all NIPE practitioners need to be skilled and well trained to examine a baby’s hips.” (PEF1 T2)

“Why can’t the midwives and junior doctors be trained together? In this instance it would be true inter-professional education.” (MM3 T1)

Another midwifery manager also voiced the concern that if DDH was being missed due to poor technique, then it was possible that greater collaboration between paediatric and midwifery staff would be a pro-active move. She also stated that differing standards of technique and changes brought about by research should be disseminated to and shared by both midwifery staff and paediatricians if local guidelines were to be up to date. However, more than one member of the midwifery staff and students, also perceived that there was a need for the practice environment to become a more conducive place to work collaboratively which they felt would reduce the power of the present hierarchical structure. These words and phrases, such as the use of the word ‘power’, were very clear and represented how these individuals saw their practice environment, for example:

“If an SHO is not doing the hip examination correctly, why not learn from us – a few do and really want to learn, but others make it clear that I am just a midwife. They can be really snobbish about a midwife teaching them. Surely, the consultant could encourage them to take the opportunity to learn, just as we do with our students.” (MW10 T3)

"I should not be made to feel this small [indicating a small gap between finger and thumb] just because I am a student midwife. I have seen more babies than they have during my three years and I know how to do the hip examination, he didn't that was obvious. It won't be any different when I qualify, he will still treat me in the same way." (STd12 T3)

This reference to the impact of the culture of an institution has been referred to earlier in Chapter 2: Review of the literature, where the influence of such an environment can create barriers to professional autonomy and interprofessional collaboration. The impact on qualified staff and student impressions in relation to how they were perceived by junior doctors appeared to be similar. However, not all staff or students spoke about their experiences in this way and were more positive about how they and junior doctors worked together but this may have been due to whose turn it was to conduct the initial teaching and induction of new junior doctors but this is difficult to ascertain.

In relation to local Trust guidelines, midwifery staff had mentioned that it was difficult to act appropriately when the Trust guidelines did not reflect national guidance and/or current literature. The consultants did agree on this aspect and most of them found that the advent of the 'Newborn Forum', that had been put in place by the university NIPE lecturers, had greatly helped in sharing ideas and information and possibly encouraging the move to timely updating of Trust guidelines on those sites who were more reticent or slow moving in making changes. The usefulness of the NIPE midwifery lecturer was deemed by staff as a beneficial collaboration with the local university a theme that is explored in the next section.

7.3 University & NHS Trust Collaboration

Midwifery staff across all three sites spoke about the level and type of input that NIPE lecturers engage in and typical comments include the following:

"I and my colleagues really appreciate being able to access the newborn forums. It is really great we get to share information with anyone that conducts NIPE from the three local Trust sites. The students [midwifery] see midwives and consultants sharing information in a professional manner ... no one has the upper hand, they can see collaboration at work, it sets them up for qualified practice." (MW11 T2)

"When the NIPE lecturer is on-site, she always comes and will do a NIPE with a student. It's really great as when we are really busy or short-staffed, she has more time to explain and help the student develop their skills." (MW4 T1)

Student midwives and PEFs gave similar comments but were also vocal about the interaction between lecturers and junior doctors, for example:

“Because she regularly comes into practice, even the SHOs ... the ones who really want to learn go and ask her advice, it helps to break down doctor versus midwife barriers as she always leaves them with the knowledge that the NIPE midwives can always help them and answer their queries.” (STp5 T3)

“She (the lecturer) will often remind the junior doctors that they can ask any of the midwives about most neonatal issues and that the NIPE midwives are very experienced and a great source of information. I think sometimes they just need to be reminded that the midwives have been working with neonates for years whereas some of them have not even held a baby before.” (STs8 T2)

One aspect that did arise related to what midwives found useful when a lecturer was in practice, for example:

“It is good to see the lecturer in practice in relation to NIPE for both staff and students. We don’t really need support with lecturers working in practice as we have full-time PEFs and we want to keep them, but their (the lecturer’s) support with NIPE is fantastic.” (MW12 T3)

“We had support from the lecturers to make a business case to introduce and utilise PEFs in-house and were very pleased that it was finally agreed. Lecturers coming into practice are so appreciated for their sharing of research, updating and helping us with practice assessment when we need it and the more complex issues relating to NIPE.” (MM5 T2)

“They [PEFs] work full-time in all midwifery practice areas and make a real difference to the development of students when they enter the workplace as qualified midwives as they know all the guidelines and assist in the mandatory training.” (MM1 T1)

The employment within practice of experienced midwives who oversee and work towards staff development has been viewed as a positive influence (Lambert & Glacken, 2005; Scott et al., 2017) within the midwifery practice arena. The above comments constituted a small sample of the appreciation and positive attitude of both staff and students towards the role and the ability to access these midwives when needed. Midwives were also appreciative of the role although they were also mindful that the health education authority and the NMC may wish to encourage the use of dual ‘lecturer-practitioner’ roles. When asked how they felt about the latter, they used words such as ‘it

would be nice if they consulted us first' or 'we know what works for us'. Some staff members and students were very clear in their views in relation to how they felt about lecturers being in practice:

"When we have a lecturer in practice in relation to NIPE for both staff and students, it raises the level of motivation. What I mean is – and it depends on the lecturer – is that the role model they provide is at a high standard, we don't just learn what we need to do but we also see how she (the lecturer) interacts with the parents, the baby and other staff." (STp6 T2)

"Not having the NIPE lecturer coming into practice would be a loss. If there is a member of staff needing re-introduction to NIPE or the staff need updating they are always able to find a way to help. Without this sort of collaboration I and my colleagues would not think that the university valued us as partners. It is not a case they cannot do so they teach, they really know their stuff." (MM2 T1)

The findings of an Australian study suggest that the midwifery academic in practice enables and supports university – clinical practice collaboration and that such activity only optimises clinical learning and collaborative relationships (Griffiths et al., 2021), which in part supports the earlier findings of Frazer et al. (2013) and Griffiths et al. (2019). However, perhaps a 'one size fits all approach' as one midwifery manager stated when discussing the merits of the use of PEFs, academics or lecturer-practitioners in practice may not suit all maternity units and therefore the needs of staff and students in relation to service provision needs to be considered when such decisions are made. Certainly, one PEF gave a clear articulation of her thoughts:

"The more I see of academics in practice, the more I can see the positive influence that they (the academics) have. I don't feel threatened by their presence I see them as being able to strengthen collaboration between us in practice and the university. Working and supporting us with NIPE has really helped this ... I hope this situation does not change just because someone higher-up thinks they know better" (PEF2 T3)

7.4 Summary

These last three chapters have highlighted the main themes arising from the data collected across all sample groups. Comparing these themes across the Trust sites and participant groups led to the recognition of key issues that were clearly influential in relation to staff perception of their workplace environment and how they saw their professional role as NIPE practitioners. Therefore, for ease of understanding, these 'key issues' will be discussed and their implications for professional practice within the next four chapters.

Chapter 8: Identifying the Key Issues for Practitioners and Students

8.1 Introduction

Each of the previous three chapters (5, 6, and 7) were designed to highlight the findings from the data collected in a manner that could be more easily understood due to the number of Trust sites, sample groups and participants involved. There were clear themes that stood out from the findings and chapters 8 -11 discuss these ‘key issues’ (outlined in Table 3) in-order to more thoroughly explore the key aspects that influence midwifery staff and students within the working environment thus aiding comprehension of the significance of the study findings. It has been highlighted within the text where some issues are implicated in more than one key issue.

Table 3: Key Issues Affecting Participants in Practice

Chapter	Key issues	Sub issues
8	Practitioners’ views of the NIPE role in practice & student midwife training	The role of the NIPE midwife Practitioners’ views on integrating NIPE into pre-registration midwifery training Autonomous practice Profession-based control Effective & collaborative leadership
9	Factors that impact on autonomous practice	Consultant neonatologist – support Access to equipment NIPE clinics Role of PEF & Senior Midwifery Lecturers
10	Interprofessional behaviour	Communication & collaboration Impact of hierarchical system on autonomy
11	Co-related factors that influence NIPE practitioner/student identity & autonomy	Guidelines & referral – role of midwifery leadership PEF support & role of Link Lecturer NIPE Training and assessment / National guidance Student experience & transition to qualified practitioner

As a reminder and for further clarity, quotes specific to the issue discussed have been added to aid understanding in relation to the perceived extent of the effect on participants in practice. Therefore, this chapter will focus on practitioners’ views of the NIPE role which will lead into chapter 9 which focuses on the particular factors that midwifery NIPE practitioners perceived as impacting on their ability to practice autonomously. Further chapters explore the issues associated with interprofessional behaviour within the workplace in relation to NIPE (chapter 10) and chapter 11, analyses the co-related factors such as the impact and frustrations regarding national guidance and training and updating. Chapter 12 will conclude the exploration of study findings by discussing the strengths and limitations of the study followed by the recommendations arising from the research.

One point to note, is that one of the themes – interprofessional behaviour – did develop as a strong theme throughout the data collection and therefore will be found as a thread running through

chapters 8, 9 and 11 in-order to give context to how it manifests in practice in relation to the issues discussed. Whilst chapter 10 also explores interprofessional behaviour, the content concentrates more on the general impact within practice.

8.2 Practitioners Views of the NIPE Role

This section focuses on the specific perceptions that NIPE practitioners highlighted regarding their role and responsibilities. It identifies how they view the role of NIPE midwives, the integration of NIPE into pre-registration midwifery courses, the factors that midwives perceive directly impact on their level of autonomy and the co-related influence of management and leadership activities.

8.2.1 The role of the NIPE midwife

Paediatricians and senior management generally see paediatric input into the NIPE as a routine expectation as part of their role. However, as midwives have only been undertaking this role since the early 1990's it was interesting to see how they viewed the role of the midwife NIPE practitioner nearly 30 years later when there still remains the situation that not all midwives are NIPE trained and not all pre-registration midwifery courses have yet embraced and included the NIPE within their curriculum.

Overall, midwifery staff saw the NIPE as a valued part of their midwifery role, which gave them the opportunity to raise their depth and breadth of knowledge of neonatal health and well-being. Both midwives and students gave clear indication that they saw the need for early recognition of the potential risk factors or signs and symptoms that related to abnormality or ill-health in the neonate as a necessary part of midwifery training and their professional role. Indeed, some of the midwives who had been qualified for a longer period of time, even expressed that they should have had a better knowledge base when commencing their midwifery career. They were pleased that students were taught so much more about neonatal care and well-being in their first year than they had themselves as students on a three-year or shortened programme of midwifery training. The overall consensus was the importance of early recognition and the ability to take this recognition forward into decision-making and action – an issue that will be discussed further, later on in this chapter.

Only one of the consultant neonatologists when asked how as he saw the role of midwives in relation to NIPE appeared less than enthusiastic. His perception was that using midwives was a '*means to an end*' and expressed that his junior doctors could not complete all the NIPes and therefore the Trust had no choice but to let midwives '*join in*' if service provision was to be fulfilled. This was not the view held by the other neonatologists, but this was the same consultant who placed tight restrictions on the midwives regarding which babies they could examine or that they should refer a baby that

required paediatric input to the junior doctor - actions which did not follow agreed Trust policy or engender an environment of respect or pro-active collaboration. It became clear as the data collection progressed that this particular consultant's actions were causing frustration amongst the midwives and it would appear that such behaviour was not assisting the development of trusting and respectful relationships between these two disciplines – an issue that will be discussed more fully within chapters 9 and 10.

All other Consultant neonatologists who participated in the study viewed midwives who conducted NIPes to be providing an effective and comprehensive service to both women and babies. Midwives were not only seen as a valuable part of the Trust's neonatal care and screening service, but most of the consultants also perceived that NIPE midwives supported the learning needs of junior doctors when in the clinical arena. However, it is difficult to ascertain the degree of learning support that midwives provide as this was not the purpose of this research. As to whether this provision is appropriate or acceptable in the present climate of short staffing etc. is a subject for debate. What is interesting, is that midwives also mentioned the need for teaching junior doctors but in a different context. There was a strong view that junior doctors should undergo similar NIPE training as midwives, thus ensuring that junior doctors were supervised and assessed in skills, particularly the hip examination and thereby raising standards within the Trust.

Unfortunately, how junior doctors may view this latter point is undetermined as their views have not been included within this study and this will need to be addressed in later research. Of course, the number of consultant neonatologists interviewed, although representing a high number for each of the three Trust sites, cannot represent an overall view that is held across the UK. Even so, it was strongly apparent how the influence of just one consultant could have a negative impact on working relationships. This factor became evident at one specific Trust site where one consultant was viewed by the midwifery staff as being disrespectful by creating barriers that affected their ability to act as autonomous practitioners. In this sample group, staff consistently articulated that this consultant did not agree with midwives conducting NIPes which they asserted caused issues which might subsequently impact on the actions of staff, such as when a baby may require immediate referral and management and timely expert opinion is paramount. Workplace adversities such as this, interlink with other issues relating to professional behaviour and managerial leadership and will therefore be discussed later in more detail in chapter 10.

8.2.2 Practitioner views on integrating NIPE into pre-registration midwifery training

Without dissent, the integration of NIPE into the initial training programmes for future midwives was seen as an important step forward in early recognition of neonatal ill-health, ability to enhance parental knowledge and understanding of their baby and timely referral thereby enabling midwives to fully utilise their role of advocate for both baby and parents. Most of the midwifery staff made a point of highlighting the need to be able to discharge a baby into community care, just as they did for the women in their care. Thus, both midwives and student midwives saw this as a positive activity and a necessary part of their routine care practices.

Interestingly, the very presence of senior students within the practice environment who were undertaking the course and qualifying as registered midwives with NIPE knowledge and skills was seen as a positive, professional step forward. Many of the midwifery staff interviewed, although stating that when they trained as NIPE practitioners they thought such integration would only serve to lose important content from the pre-registration midwifery programme, stated that they did not now hold the same view. Both midwives and consultants generally perceived that these senior students were aiding the acceptance of midwives conducting NIPes by both non-NIPE midwives and paediatricians, as the following midwife emphasised:

“When I did my training, they (the midwives and the paediatricians) did not like it. They were a bit antagonistic, you know, saying what did I want to do it [the module] for. That wouldn’t happen now, particularly as we have had student midwives on the module for the last six years which I think has helped change attitudes for the better.” (MW2 T3)

The midwives who had completed the NIPE module during their training were very clear that they valued the opportunity to complete the module and saw its inclusion within the midwifery role as just as important as all the other aspects of their role if they were to provide holistic, evidence-based care that increased continuity of care for both mother and baby. All NIPE practitioners and students across the sample groups were unequivocal in voicing the view that midwives were the most appropriate practitioners to conduct NIPes having built a relationship with the parent(s) in caring for both mother and child equally.

As stated above, both midwives and students were positive about achieving the NIPE qualification. They appeared to achieve a high sense of satisfaction from being able to give comprehensive care to *both* woman and baby. This sense of ‘satisfaction’ is reflected within the Standards of Proficiency for Midwives (NMC, 2019) and the work of Dove et al. (2017) and Catling et al. (2017) regarding its bond with a midwife’s sense of autonomy as can be seen in the next section.

8.2.3 *Autonomous practice*

Many of the midwifery participants spoke about wanting to practise as an autonomous professional. This was usually voiced in terms of wanting to utilise the knowledge and skills they had achieved on completion of the NIPE course in practice and take necessary action when required. The International Confederation of Midwives (ICM, 2017) produced a position statement that recognised midwifery as an autonomous profession, albeit not yet recognised in all countries across the world. The NMC issued the present Standards of Proficiency for midwives (2019), which highlighted its recognition of the midwife as an autonomous practitioner. Indeed, the NMC clearly point out in this document that the terms '*accountability*', '*autonomy*' and '*professionalism*' were interlinked with the qualified midwife in the UK. How the autonomous midwife is described has been well documented (Fleming, 1998; Bedwell et al., 2015 & Perdok et al., 2016) over the years and the autonomous, professional role of the midwife is seen as one where they can think critically and practice accountably in conjunction with the woman's wishes. The midwife, in a similar manner to a doctor, is a professional who must be accountable for the consequences of decisions made and actions taken.

Unfortunately, it is also well documented (Dove et al., 2017; Catling et al., 2017) that a midwife's sense of autonomy can be eroded within an environment where medical domination pervades Trust practices, guidelines and basic processes. Consequently, the degree of job satisfaction that midwives experience is lowered, midwives can feel demoralised, the quality of midwifery care can be undermined and the attrition of midwives within practice can rise (Davis & Homer, 2016; Hunter & Warren, 2014 and Perdok et al., 2017). Therefore, activities that promote and maintain the level of midwifery autonomy should not only maintain a positive level of job satisfaction in the ability to fully utilise the knowledge and experience gained, but also impact on other medium and long-term aspects. For example, an environmental and organisational culture that positively influences the levels of attrition from the profession, will also work towards supporting and strengthening the quality of midwifery care. Both Davis & Homer (2016) and Perdok et al. (2017) drew attention to the need to work towards supportive activities and warn that adverse organisational culture can only continue to reduce a midwife's sense of self-worth and job satisfaction. It would appear that the data collected from the midwives working within all three Trust sites also reflects the level of impact that Capper et al. (2021) referred to (discussed in chapter 2) in relation to the impact that an adverse organisational culture and medicalisation can have on their role, emotional health and how much they feel restricted and/or unable to carry out their NIPE role as professionals in their own right. It is of grave concern that the negatively viewed issues that arose in the earlier studies that explored why midwives discontinued to conduct NIPes (McDonald, 2008; Steel, 2007 & Lanlehin et al., 2011) are still in existence today and have therefore, not been consistently addressed over the intervening years.

Some issues that create a negative impact are often issues that could be easily resolved such as access to equipment. However, the lack of managerial action on the simple issue of ensuring, for example, adequate availability of ophthalmoscopes, raises the level of dissatisfaction experienced by midwives when other factors were also prevalent. These factors related to the midwifery role and responsibility, appeared to create an intensifying impact whereby many midwives experienced an increasing degree of dissatisfaction and frustration as they felt their professional identity and responsibilities were not considered valuable or an essential part of service provision. Therefore, the presence of factors such as poor interprofessional communication and the presence of a visible and continued paediatric disregard of agreed guidelines and referral processes only added to the frustration expressed by the midwives in this study.

Reports and media coverage tend to focus on the serious outcomes that occur in the face of poor accountability, communication and collaboration (Kirkup, 2015 and Ockenden, 2020). However, the lessons learned in the face of such challenging situations should also be viewed by senior management as knowledge that needs to be taken forward into routine practice. This perception will be discussed further within the following sections of this chapter as the issues arising within the organisational culture need to be addressed at all levels from day-to-day practice to the need to escalate concerns during emerging challenging situations. This is paramount if the current downward trend in relation to job satisfaction and sense of autonomy are not to be eroded further, not just in relation to NIPE but also the wider role of the midwife in terms of accountability and interprofessional comprehension of the depth and breadth of their knowledge and understanding.

8.2.4 Profession biased control

My study was not designed with a feminist and/or gender bias approach as my intention was to uncover what the working environment was like for NIPE practitioners per se. However, the disparity between participants' views regarding interprofessional respect and behaviour, communication and referral issues, are all aspects that have continuously arisen during the data collection. As the male gender remains a dominant feature of the medical profession, particularly at consultant level, it is perhaps not surprising that midwives (a registration still predominantly held by females) may view the increasing medicalisation and control of midwifery as a male orchestrated activity. It was clear that the data collected during this research did not emphasise male gender as an issue but midwives were very forward in pointing out the impact and control held by their medical colleagues. For example, references would typically refer to, '*doctors not following the guidelines*', or that '*the registrar or consultant treats midwives as handmaidens or servants*'. The position and status of male doctors cannot be ignored in any society whereby different professionals should be working together to provide a high standard of care and timely intervention and action when required. Furthermore, it

must be borne in mind that depending on where doctors have trained, learned cultural attitudes may also influence behaviours in the workplace (Kirkup, 2015 and Christie & Glew, 2017). Moreover, as the data for this study was collected and similarities in links between themes became clearer, the very foundations of training within the medical profession and the perceptions that staff hold regarding who holds the power or control in the workplace became more evident - an issue that occurs globally.

The World Health Organisation (WHO) commissioned a survey (2016a) to collect the views of midwives across the globe in relation to the provision of quality midwifery care. Some of the findings highlighted issues that echoed those that exist within the United Kingdom, although it must be borne in mind that the degree of impact depends on the midwife's home country, culture and level of training. Nonetheless, clear areas of contention for midwives related to the extent which both medicalisation and male authority, governed and/or managed midwives' activities, thereby eroding their level of professional autonomy and respect for their role. Some of the comments and terms from those responding to the WHO survey included words such as '*being controlled*', '*disrespected*' and '*looked down on*'. These words are not dissimilar to the views of participants within my own study, as can be seen reflected in the words of the student midwife below:

"When I qualify, I want to be allowed to work as a holistic and caring midwife ... what is wrong with that, why do doctors and management think it is appropriate to control our professionalism ... do they find us threatening?" (STd10 T2)

Midwives spoke in a similar manner and many also added that they '*believed*' that medical training and the behaviour that junior doctors sometimes witnessed in practice, were both important factors in how medical staff behaved towards other professional disciplines in practice. This may then promote a hierarchical, relationship disparity that does little to improve care, the working environment or enable midwives to work as the autonomous professionals that they wanted to be. Often midwifery staff and students spoke about their '*worth*' or '*value*' in relation to how midwives perceived how consultants viewed them as professionals and NIPE practitioners. A phrase most used in this context which best demonstrates how they view the hierarchical nature of medicine was: "*How the consultant views us determines how their staff (registrars and junior doctors) see us and how much they feel that our 'value' is worth*". Some midwives were particularly vocal in stating that they felt that the more '*subservient they appeared, the more the medical staff valued their presence*'. Again, although the midwives alluded to the recognition that they should '*do something about it*', some stated that they were '*tired of trying*' or that managerial leadership needed to '*commit to being supportive of their autonomous role*' rather than superficial gestures which fell by the wayside in the wake of more important requirements relating to the paediatric team.

The link between autonomy and being 'able' or 'allowed' to act as a woman's advocate and make decisions based on sound evidence, has appeared in the literature more frequently over recent years. Autonomy is generally viewed as an essential source of motivation in midwifery care in terms of continuing to practice and effectively advocate for the woman and her family. Indeed, Clemens et al. (2021) stresses that the provision of woman-centred care can only suffer when autonomy is hindered by institutional culture and professional differences. This perspective was also discussed by Rice and Warland (2013) who highlighted how midwives might feel powerless when their feeling of autonomy is reduced and that they are stuck between midwifery and medical based models of care. Furthermore, Hunter and Warren (2014) warn that diminishing autonomy is strongly linked with falling levels of resilience. Thus, the wellbeing of a midwife sits in direct relationship with their level of autonomy, the level of support arising from their colleagues and the processes and environmental culture of the organisation for which they work (Cramer and Hunter, 2019). The data from my study signposts that midwives recognise and are becoming more vocal about the need for effective, pro-active leadership, but in the current working environment are unsure if this will or can occur. What is clear, is that any plan that formulates a process for a considered, leadership activity needs not only to be maintainable and include all professions, but also needs to relook at the principal foundations of initial training. This includes the recognising the need for professional values and collaborative working across all related professions if a change in the practice environment is to enable midwives to work as autonomous, accountable practitioners. As will be seen in a later section that highlights activities in practice that were seen as supportive, when the interprofessional relationships are pro-active and respectful, collaborative working, works!

8.2.5 Need for strong, effective & collaborative leadership

The encouragement to recognise workplace adversity and engender a working environment with strong pro-active leadership is not new (The King's Fund, 2014; Jefford et al., 2016 and Cramer and Hunter, 2019). However, this situation needs to be explored at all levels, not just within acute or emergency situations as tends to be publicised at present, as highlighted within the recommendations and guidance issued after investigating extreme adverse incidents such as the public inquiry that focused on the Mid Staffordshire NHS Foundation Trust (Francis, 2013). To reiterate, whilst these publications are extremely important to explore why such incidents occur and demonstrate that lessons have been learnt that can be carried forward into future practice, it is also paramount that across all levels of staff, the issues that affect everyday practices and staff well-being are also investigated. In so doing, this may help find some common ground that would assist in reducing the challenges of the workplace environment with the aim of promoting respectful, encouraging and supportive interprofessional relationships. An effective team-working environment across all areas of

midwifery practice results in timely care and communication. Those practitioners who conduct NIPES require the same supportive team when a baby needs to be referred to paediatric care. This should not be an event that demoralises and/or reduces the autonomy of a midwife when for many they are carrying-out an everyday health assessment which, at times, requires immediate action and referral in-order to improve neonatal outcome.

Kirkup (2015) pointed out within the Morecambe Bay investigation that effective teamwork is an essential element within midwifery care. The report highlighted that a loss of mutual trust between professional groups was made worse as adverse clinical events started to arise. Once again, although the above reported the outcome of investigatory findings in relation to adverse maternal and neonatal outcomes, the lessons learned can still be applied to everyday practices including NIPE. The behaviour of staff towards each other, whether within the same discipline or between disciplines is important at all times. Actions and levels of respectful communication should be of the same standard whether referring a baby to the senior paediatrician or in an emergency situation. The Department of Health (2015) published an independent report focusing on improved leadership within the NHS to address the issues raised by Kirkup. Later, in 2019, The Royal College of Midwives (2019a) produced a manifesto detailing the need to strengthen midwifery leadership which was also reiterated by Read (2019). More recently, the new NHS England Maternity Leadership Training programme (Department of Health & Social Care, 2021) has been set-up which may enable the presence of unprofessional behaviours to be addressed and organisational culture to change to a more pro-active and positive environment.

The need for pro-active support from midwifery managers was a subject that arose frequently during the interviews with both midwives, PEFs and student midwives. Again, it is important to reiterate here, that midwifery staff and students clearly recognised that they need to be an active part of the process of changing the culture of their practice environment. However, one factor that arose strongly, was that they needed a leadership team that held a strong midwifery voice that was valued and respected by paediatric staff. When questioned further, the general consensus was that such a position had not yet been achieved, although both midwives and consultants stated that they appreciated the efforts of midwifery managers to try and bridge the void between the professions. Nonetheless, it was apparent, that many midwives and student midwives saw such activity as an uphill struggle and that without mutual, collaborative activity from the paediatric team that the end goal may never be achieved.

The above perception was linked by some participants to the fact that some of the issues that influence activity to enhance interprofessional collaboration are restricted by external forces. Midwifery staff were quick to highlight that the perception of one's identity that commenced in medical school was one of the issues that they saw as directly perpetuating the present climate. This relates to the difference in mindset between doctors and midwives, whereby doctors often learn to see themselves as ultimately responsible and accountable for the outcome of care given. As a result, they tend to take precedence and have the most input into Trust guidelines and protocols, even to the point that they agree to and sign-off those that lie within the professional midwife's remit (Hansson et al., 2019). Midwifery staff participants were well aware of the impact that this can have on the manner in which they practice. For example, which babies they are '*allowed*' to examine to whether or not they can refer a baby directly for a hip ultrasound. Such actions were seen as undermining their professional knowledge and experience, particularly when being told to '*defer*' to a junior doctor for a baby's hip ultrasound, which they could often do themselves without the accompanying delay in waiting for a paediatrician.

Midwifery staff also made it clear that the situation above was further compounded by ultrasound staff refusing to accept referrals from midwives even when this was agreed within Trust guidelines. One Trust ultrasound department had stated that this occurred as midwives would refer too many babies and the cost implication would be too great. However, no evidence at this Trust could be found to support this view and as both midwifery and paediatric staff worked under the same national guidelines relating to referral for ultrasound, it is highly unlikely that such a situation would occur. As the situation was on-going it would suggest that a collective agreement between the ultrasound department, paediatricians and midwives needed to be reached based on the available evidence. Again, such inactivity begs the question as to why paediatricians and midwifery managers are not working to address the situation which would only serve to increase parental satisfaction and neonatal health outcomes through initiation of an investigation in a timely and professional manner.

It would appear that without strong, effective and collaborative leadership, in which all professional disciplines are listened to and issues resolved, many of the issues that midwifery staff and students are experiencing at present will continue. The tangible frustration that staff experience is already a contributor to staff and student attrition (HEE, 2018 & RCM, 2019) and just as importantly, they often experience first-hand parental dissatisfaction. These instances most commonly arose when parents were waiting for appointments to be made for future investigations or when junior doctors, especially at the start of the maternity rotation, are unable to adequately inform parents about what is happening and why, or when they were unwilling to ask the midwife because she was '*just a midwife*'.

Effective interprofessional collaboration in relation to NIPE requires that all professional disciplines involved, show respect for each other and value the dearth of knowledge and expertise that is available on which to draw from.

The discussion within this chapter reflects the literature highlighted earlier within chapter 2 in relation to resilience and the impact of adverse workplace cultures (Gray et al, 2019; Bozdağ & Ergün, 2021; Bloxsome, 2020; Geraghty, 2019; Mestdagh et al., 2019 and Zolkefli et al., 2020). It would appear that there is a link between resilience and being able to act as an autonomous professional wherein one's professional identity, role and responsibility is accepted and respected by other professionals within one's field of work exists hand-in-hand. Therefore, leadership strategies within the workplace need to take this into account if the behavioural culture of the workplace environment is to improve and attrition rates reduced. The collegiate working together of professionals can only be viewed as a positive step forward. However, all professionals and staff in senior leadership roles will need to take individual responsibility for their behaviour and actions if this change in culture is to be nurtured in a more pro-active manner and become sustainable.

The following chapter explores another key issue as identified by study participants as exemplifying the interprofessional activities they found demeaning and/or demoralising or disrespectful as well as those activities they felt supported them in their autonomous role and enabled them to give comprehensive care of both mother and baby, thereby making a difference to their positive well-being and professional identity.

Chapter 9: Specific Factors Impacting on Autonomous Practice

9.1 Introduction

This chapter focuses on the factors that NIPE practitioners regularly articulated as ones that either supported or assisted them in their NIPE role, conversely caused frustration, or at times hindered them from carrying out their role in a comprehensive and autonomous manner. Therefore, the factors most cited were related to consultant support, access to equipment and the use of NIPE clinics. Another factor that quickly arose during the data collection and continued to demonstrate considerable depth of feeling from practitioners will be discussed within the next chapter – Chapter 10: Interprofessional behaviour and respect.

9.2 Consultant Neonatologist - Support

It is worth reiterating at this point, that the consultant related data collected during the study arises from only a small number of consultant neonatologist interviews across three Trust sites. This was not because the consultants were reluctant to be part of the study, but because there are only a small number of consultant neonatologists at any one Trust. Therefore, to appreciate their views and the working culture more comprehensively, it would be useful to conduct a more far-reaching study in the future that could cover a wider area of the UK in-order to appreciate if other consultants and midwifery staff had similar perspectives.

Within the three Trust sites, consultants who were perceived by midwifery staff to be supportive of their role in relation to NIPE, were clear in their views that the midwives knew far more about neonatal well-being than most of the junior doctors. Without exception, these particular consultants even expressed the view that perhaps it would be better if the midwives taught these junior doctors the process and skills of the NIPE. When this point was explored further, their rationale was that it would not only serve to develop their skill and communication abilities but would also aid them in gaining a better understanding of the midwife's role, the importance of providing adequate information regarding examination findings to the parents, community staff (midwife, health visitor and GP) and ensure they understood the parental need for timely information including health education/promotion. In part, this view arose due to consultant concerns, that at times junior doctors demonstrated a lack of appreciation of the importance of gaining informed consent from parents and comprehensive record keeping. For example, occasionally they appeared to expect that as they were a 'doctor', gaining parental consent was a discretionary act and not a mandatory one. In relation to record keeping, midwifery staff had witnessed instances where junior doctors did not complete the Personal Child Health Record book and left it for the midwives to do or did not listen to parental

concerns and address them with accompanying explanation. All consultants apart from one, were clear that they expected more professional, considerate behaviour from their junior staff, thereby demonstrating that they were capable of not just giving parents the care and information that they needed, but also what they wanted, even if the junior doctor felt the subject matter was unimportant or trivial. For example, some parents are unaware that issues they raise may well be transient or common during the first few weeks of neonatal life, but the point here is that issue is important to them and therefore needs to be addressed through clear explanation and a professional manner.

It is also interesting to note, that these same consultants were also much more assertive at stating that they wanted midwives and not just managers to inform them when agreed procedures were not followed so that they could reiterate correct process with their paediatric team soon after the event had occurred. This may indicate that either lines of communication for such incidents are expected to either progress through midwifery management to be discussed during midwifery-paediatric managerial meetings or that the midwives are unsure or do not feel that they can pass the information onto the registrars and consultants themselves. Perhaps once again, such issues may point to the impact of hierarchical practices and expectations held by midwives that need to be eroded by encouraging pro-active communication and action by both midwife and paediatrician. Conversely, it is possible that senior management has also been negatively influential at times, such as when choosing to budget for equipment solely for junior doctors rather than for all NIPE practitioners to use. Such decisions may appear inconsequential within the wider scale of concerns, nonetheless similar repeated actions can have a considerable and long-lasting impact on staff. To illustrate, midwives often quoted such activities as being frustrating and making them feel disrespected and unrecognised for their knowledge and skill. As midwifery staff and students talked about these issues, they often referred to feeling not listened to which did not point to a working environment that aided and supported collaborative activity.

A close relation to the previous issue, was the fact that all Trusts had a policy stipulating that all guidelines - including those relating purely to midwifery care - must be agreed and signed by a doctor. This does not imply that doctors should not know about or look at the available guidelines, but it re-emphasises to midwifery staff and students who holds the power over their profession's guidance and procedures even though these are based on contemporary evidence. In relation to NIPE guidance, both midwives and students were vocal in their views that collaboration is required about which babies they can examine and the disparity between Trusts:

"I see no reason for the difference in the list stating which babies I can examine and the list my sister (working at a different Trust) practises by, it's just silly it should be universal." (MW7 T2)

“We are so restricted here in which baby I am ‘allowed’ to examine, but apart from obvious ill-health or abnormality, we should be able to examine a much wider range ... they are all still ‘normal’ and there is no evidence as to why we could not do so, why don’t paediatricians and midwives agree this together.” (MW3 T1)

“Our paediatrician (consultant) says there is no reason we cannot conduct NIPes on most babies, but I know this is not the same in all Trust sites ... why not? It doesn’t make sense.” (STd18 T3)

Midwifery staff were very vocal about the fact that they felt the national screening programme did not go far enough within their programme handbook to clarify or give some indication as to which babies they could examine or allude to the training of ‘all’ NIPE practitioners and the need for supervision and development of skills for all. The programme handbook does not give a comprehensive view of the training content, although it does allude to the need for training and updating, albeit directed at some practitioners only. Midwifery staff did refer to their perception that this was not good enough when they had to complete a course that supervised and developed their skills when junior doctors were, at times, very lucky if they were shown an examination and watched doing one by the registrar or consultant.

In such instances as those above, midwifery staff often appeared to feel that they were not trusted to recognise signs of ill-health and yet when they did refer a baby, they were told to inform the junior doctor which negatively reinforced and compounded how they felt, again doing little to engender a collaborative working relationship. Midwifery staff often expressed that such experiences, *“left them feeling like a servant”* or, made them feel that they *“lacked knowledge or experience”*. These types of attitude link with the earlier work relating to the introduction of IPE (Reid et al., 2018) and hierarchical structures that favoured medics above other professions (Green et al., 2017). However, senior paediatricians who also asked the midwife about her findings and views about the baby’s health were viewed as a good example of different professional disciplines working together. The midwifery staff and students interviewed clearly preferred the latter scenario, stating that they felt a ‘valued’ part of the ‘professional team’ and their knowledge and experience was being respected. This echoes the findings of Mammen et al. 2023) in relating to how such examples of civility and respect in practice can raise the self-esteem of newly qualified staff and graduating students (Kuliukas et al., 2021) strengthening their professional identity and resilience.

Again, as previously referred to, this might suggest that what could be deemed as insignificant actions, may prove more effective and sustainable in enabling the building of a positive workplace culture as

advocated within the NHS Long Term Plan (NHS England, 2019). Even so, such behaviour should be encouraged through effective, compassionate leadership that encourages, promotes and actively supports good practices such as in the latter scenario, thereby reducing what may feel for some midwives an insurmountable, interprofessional void.

Although midwifery staff and students were very willing to voice similar, positive comments in relation to pro-actively collaborate consultants, they were also clear on behaviour they deemed unacceptable. Consultants whose actions were seen as frustrating, rude, or prevented them from acting autonomously, were seen as *'disrespectful'* and *'unprofessional'*. Incidents that caused the most frustration included repeatedly being told to contact a junior doctor, even though they were following national NIPE guidance (Public Health England, 2019) which was even echoed within the Trust's own guideline, requiring them to *'refer to a senior paediatrician'*. Midwives spoke of such actions as eroding their autonomy and being disrespectful of the level of knowledge and skill that they had achieved in order to undertake NIPes. They also said that junior doctors working under such consultants often picked up similar behaviours and that asking midwifery managers and senior management to intervene was not a course of action that all participants felt able to take. Again, this links with the earlier views made by midwives in that they want a stronger managerial leadership that engenders an atmosphere of approachability, listens to staff issues without repercussions and actively and collectively seeks to address interprofessional behaviour – an aspect that will be discussed more fully in chapter 10.

Although the quality of consultant support was deemed an important factor, two other key issues were also seen as unsupportive, restrictive or as many voiced, particularly frustrating when conducting NIPes. These issues included access to equipment and the continued use of NIPE clinics, which will be discussed below.

9.3 Access to Equipment

Midwifery staff and students were very vocal about the issues relating to availability of equipment. The equipment required to conduct a comprehensive NIPE is not extensive – a good quality infant stethoscope and an ophthalmoscope are generally all that is required. There is minimal cost outlay when compared to a transcutaneous bilirubinometer which a midwife may not use so often, although when used is a vital instrument in investigating the level of neonatal jaundice. However, whilst most midwives and students expressed that they had purchased their own stethoscope for personal ear hygiene reasons, they did not see any reason why they should have to purchase the more expensive ophthalmoscope. The need to 'find' the ward ophthalmoscope, either due to junior doctors pocketing

the equipment and then not returning it to the ward or because it was borrowed for use elsewhere and similarly not returned, was frequently voiced as frustrating. However, it appeared that equipment that was not working or had not been replaced when damaged, caused a greater level of irritation especially when managers were informed but the issue was seen as being slow to resolve or was not addressed. Midwives often stated that the lack of action meant that for want of a small but necessary piece of equipment they were unable to do their job without spending time looking for working equipment and therefore they felt they were seen as unimportant by some midwifery managers.

Midwives in one Trust site spoke about how managers had tried to address the above issues but often perceived that the measures put in place, such as attaching the ophthalmoscope to a wall or the resuscitaire were ill-conceived or caused more issues and inconvenience than they were meant to resolve. Additionally, the fact that they were expected to stop what they were doing and find stethoscopes and ophthalmoscopes for junior paediatric staff or, as in some Trust sites, this equipment was actually supplied to junior doctors but not to the NIPE midwives who would be frequently using the equipment, was seen by many of the midwifery staff as particularly demeaning. Those midwives who worked within the community setting often spoke of having to collect and return ophthalmoscopes as they were not permitted one as part of their equipment. Often the terms *'handmaiden'* or *'second-class citizen'* were used to express how the lack of or needing to find equipment for others made midwives feel. Such comments expose the perception, already referred to in the work of Gergerich et al., (2019), that hierarchy is one of the primary sources of conflict within the workplace and that bureaucratic barriers within executive management can prevent pro-active change in the workplace by enforcing and maintaining the power held by doctors. In the last few weeks of the data collection, one of the Trust sites was rolling out ophthalmoscopes to community midwives which was seen as a positive move and line-managers were praised for continuing to fight for the provision of such equipment. Community midwives were well-aware of equipment budgets but found it difficult to accept that senior management could not see the need for such equipment even though the Trust had targets to reach relating to NIPE and having appropriate equipment enabled this.

It is disheartening that issues regarding access to equipment are still occurring some years on from the earliest mention of this issue in Steele's (2007) study. Admittedly, the issue in Steele's study (2007) appeared to be more to do with quantity of equipment rather than equipment that was in good working order. Nevertheless, such incidents appear to add to a midwife's overall perception of their professional role in terms of how other disciplines demonstrate (or not) respect for their knowledge and competency to conduct NIPes. Some staff even likened the situation to a bricklayer who had the knowledge and skill to competently build a wall but was not allowed access to the equipment to check

the wall was straight and remain standing! In this case, lack of an ophthalmoscope wasted valuable time and the outcome could result in delaying a timely referral for a baby.

Midwifery staff participants frequently linked such frustrations as lack of access to equipment, to how they viewed their '*place*' or '*status*' in the workplace in relation to their NIPE role. They spoke with passion about how they perceived that the level of autonomy that they were permitted within their Trust was directly related to how the paediatric team and management valued their knowledge and skill. In turn, this impacted on the level and quality of communication and collaboration they experienced with the paediatric team. Midwives felt they were not listened to when asking for more or working equipment and this disheartening feeling of not being listened to was also applied to the use of NIPE clinics.

9.4 NIPE 'Clinics' – The Antithetical Approach to Holistic Care?

The use of NIPE 'clinics' where parents are given a time to take their baby to a specific room for the NIPE to be conducted, was also seen by many of the midwifery staff and students to be counterproductive. They saw these '*clinics*' as preventing them from conducting NIPes at a time and in a manner that was conducive to the parent(s), enabling holistic care of both mother and baby. Only two of the Trust sites held NIPE 'clinics', both being in a room where the equipment for the examination was stored. Midwifery staff within these two Trust sites had worked alongside this concept for quite some time since the reduction in junior doctors' hours had been introduced (Department of Health, 2002) and the numbers of NIPE trained midwives were still low. Midwifery staff views related to how '*useful or not*' the concept was and/or how they felt it caused disruption and gave the impression to the parents that the NIPE was a '*medical*' examination under the control of doctors. Most parents want to know that their baby is '*okay*' and this is the case in the majority of term babies that are examined at the time of the NIPE. Therefore, there is no need to '*medicalise*' the examination setting and increase parental stress when they may already be tired and anxious about the findings of the examination. Part of a midwife's interaction with parents when any contact or care is given to their baby, should be to raise parental knowledge and confidence in their ability to care for their baby – the NIPE should be no different.

Midwives stated that paediatricians and midwifery management had put forward two main points for maintaining the provision of NIPE clinics, even though the number of NIPE trained midwives had risen considerably within their Trust sites. The first point that had been put forward was that NIPE clinics were useful when babies need to be reviewed the following day by a paediatrician or if born at home and there was not a NIPE midwife in the area that the parents lived, although apparently this was a

rare occurrence at both Trusts. Staff were quick to state that neither provided a really good reason for the use of NIPE clinics as in both circumstances babies could easily be seen on the ward when necessary. The second point that had been raised, was that it was beneficial for student midwives to be allocated to the 'NIPE Clinic' where they could accomplish several NIPES in a relatively short time. However, midwives were very aware that this did not allow students the time to reflect on the examinations performed, which is an activity that is recognised in aiding student learning and the development of their decision-making skills as required by informed, expert practitioners. The need for students to develop reflection, both as an individual and within the interdisciplinary team, is a theme that runs through both Part 1: Standards Framework for Nursing and Midwifery Education (NMC, 2018b) and the Standards of Proficiency for Midwives (NMC, 2019b). The midwifery curriculum at the time of the data collection sought to develop a student's ability to reflect and learn from both positive and adverse outcomes and/or experiences and was an activity incorporated into their NIPE practice assessment document.

The overall view of both midwives and students was the perception that the clinics were inappropriate and represented a medical image to the parents and obstructed the midwife from providing holistic care to both mother and baby. Thus, midwives perceived that they were not listened to and what the paediatric staff wanted is what was enforced rather than being given the opportunity to have a collaborative discussion on the subject and recognition of the midwives role and responsibility. This situation was clearly seen by some midwives as dictating what they could do as professionals and was seen as a show of power which appeared to lead to resentment on the part of the midwives and students. The NIPE was often seen as comparable to the discharge examination of the mother that the midwife performs at the bedside and therefore often the phrases such as the following were heard:

"We don't treat mothers in a medical manner, why should we do this for her baby ... it gives the wrong image, almost as though we expect to find a problem which then starts parents worrying." (PEF2 T1)

"Aren't we demeaning the mother by treating her baby as a medical case, when we don't do this to her at discharge ... are we saying she does not matter – she can be left to the midwife? What must she think?" (STp5 T3)

When participants were asked for further information regarding the maintenance for these clinics, the midwives were very passionate in relation to how doctors treated them and therefore how it made them feel:

“We have to use the clinic room because the doctor prefers us to do it in one place ... why? They often have an AANP in the room at the same time ... they are trained by the paed’s [paediatrician] so it feels as though they are watching your every move!” (Std8 T1)

“We are not obstetric nurses ... I am not employed to bring the baby to a junior doctor. I am not there just to fetch and carry for them or clean the baby when it has a poo in the middle of the examination! Who do they think they are?” (MW6 T3)

Rice and Warland (2013) refer to the power struggle that can occur between medicine and midwifery and how midwives saw it as undermining their autonomy. Here, it is seen in relation to their concerns about the continued presence of NIPE clinics, even though they were not needed for the same reasons as when originally set-up. There is also an element perhaps that their views are not being heard and that the continuation of these clinics is because it is perceived by both paediatricians and senior management that they provide a more effective service. Midwives frequently stated that the clinics did not provide greater ‘patient satisfaction’ or increased ‘service effectivity’ and that their presence should not be used as a blanket approach. The number of NIPE trained midwives has risen considerably in the intervening years within the Trust sites where the data was collected for this study. It was tangibly evident in the manner in which these midwives talked about their NIPE qualification that they were proud of the level of knowledge and ability that they had achieved. It is possible then, that using AANPs (chapter 6) has also added to midwives’ frustration, which may be why such strong words such as ‘insulting’ and ‘they are seen as better than a midwife’ were mentioned and spoken with much strength of feeling. Midwives did not appear to have negative comments about AANPs per se, but the regular use of AANPs on the postnatal wards on two of the Trust sites to complete NIPes, tended to be negatively received by the midwives and seen as another demonstration that they were not trusted to complete NIPes. The root of their annoyance arose as the result of being told by the registrar or consultant to refer to the AANP on the ward when the midwife wanted a senior paediatrician to see a baby. Therefore, it could be construed that the reactions of midwives to such events were understandable and again did little to raise the levels of interdisciplinary respect let alone an individual’s self-confidence in her abilities.

In the remaining Trust site where NIPE clinics were not used anymore, midwives did appear to be happy to conduct the NIPE at the bedside. The only occasion at this Trust where parents needed to take their baby to another room, were those babies that needed specific paediatric attention. In fact, midwives at this Trust generally only mentioned that they needed more height-adjustable cots in order to provide a better working environment in terms of manual handling as they would not have

to stoop over the cot when examining the baby. These midwives spoke about being able to give holistic care and providing parents with a service that not only included the NIPE but informed them about their baby's abilities, care needs and where to seek help if required, all in an environment that, as more than one midwife stated, *"was more relaxed and similar to being at home where a resuscitaire is not a scary part of the furniture"*.

As stated earlier, most of the babies that midwives examine are less likely to have any conditions that need paediatric intervention due to the uptake of screening (via maternal blood and ultrasound investigation) their gestational age and maturity. Therefore, all three Trust sites have agreed policies on whether a baby is reviewed and/or NIPE performed by a paediatrician. In reality, midwives can complete the NIPE for most of the babies who are born at term and have no serious pre-disposing conditions, such as those that are life-threatening or require immediate referral at birth for serious abnormalities. As midwives have been trained through the means of an NMC recognised midwifery programme and possess the NIPE qualification, then it should follow that they have the knowledge, skill and understanding to carry-out their work to the standard required whilst alluding to the parent(s) needs and wishes. Whether the NIPE is performed at home or within the hospital setting there should be no difference, apart from the logistics of the environment itself, that there is an expectation to complete the NIPE in a specific area or at a specific time. This therefore begs the question why there is a stronger influence in some Trust sites that dictates what midwives can do (e.g., conduct a NIPE clinic), where they are permitted to do it (specified room or place), which babies they are allowed to examine and to whom a midwife should refer a baby in the event of an anomaly. It is therefore possible that the level of interprofessional behaviour, respect and environmental culture are factors that managers need to focus on more strongly, if midwives are to feel that their knowledge, skill and understanding in relation to NIPE is valued and respected.

It is evident from those interviewed, that positive working environments with effective levels of communication and co-working are valued highly by staff. Some staff were quick to point out that managers and paediatricians who listened to their concerns and more importantly made a point of attending the ward areas on a regular basis, were seen as good role models who dealt with issues quickly and efficiently. For example, one Trust had issues due to building works creating noise that caused problems when trying to listen for neonatal heart murmurs. Midwives, managers and paediatricians worked together with the project managers to ensure that noise was kept to a minimum at certain times during the day to avoid disruption, not only so that the above action could be conducted but also so that mealtimes and quiet times were respected. Another example related to access to the consultant paediatrician after action had been taken due to a baby being recognised as

becoming seriously unwell during a NIPE. The consultant made specific visits to the ward to update staff on the baby's progress (even when the baby was transferred to another neonatal unit) which aided the staff and students to debrief and discuss the case to enhance learning which could be taken forward into future practice. The midwifery staff were quick to voice their appreciation which was noted within ward and shared meetings with the paediatric team.

Conversely, environments when staff felt that they were not heard or valued and that their level of knowledge and experience was disrespected, were more likely to not only mention discontinuing to conduct NIPes but also gave an indication that they were wondering if they wished to leave the profession altogether. During the interviews, there was consistent, albeit quietly restrained comments relating to how midwives and even some students were viewing their professional futures:

"I love being a midwife ... but why does it have to be such a battle. It seems women have needs that doctors' don't want to address. Women sometimes have to fight to be seen and heard, how will that happen if even I as her advocate am not even listened to?" (MW14 T3)

"I want to be the sort of midwife that gives excellent care and advocacy, don't get me wrong if something is not right, I know when to refer ... but why don't doctors listen? I will be qualified in three months ... I see how they treat the midwives and the women ... it's not right!" (Std7 T3)

"The thought of qualifying is scary but I know I can do it. What worries me is how to deal with the doctors ... some of them are so rude and they put you down in front of the parent(s) and other staff which puts everyone on edge. I am not sure if I'll cope." (STs9 T2)

The impact of negative working environments cannot be denied and will need constant activity using various strategies if change is to occur as ultimately, they do not enhance the experiences of staff, which may lead to a further decrease in the level of job satisfaction and increase the present rate of attrition. The impact of such environments will be discussed in more detail in chapter 11 as students need support and strategies in place to enable them to manage adverse situations in a professional and calm manner if they are not to leave the profession soon after qualification. In relation to parent(s) such environments could cause delay in treatment which may in turn affect health outcomes. Therefore, the next chapter takes a closer look at the impact of interprofessional behaviour in a more general context in-order to highlight some of the subliminal or underlying behaviours that cause staff to feel frustrated and devalued.

Chapter 10: Interprofessional Behaviour & Respect

10.1 Introduction

This chapter concentrates on the findings that relate to how negative or positive interprofessional behaviour can reduce or raise the perceived level of respect communicated to the recipient. Both midwives and students spoke strongly about wanting to be allowed to work as autonomous practitioners, not because it was a case of trying to '*achieve normality at all costs*' but because they are trained to recognise ill-health, problem solve and make valid, evidence-based decisions. They felt strongly that they should be recognised for their expertise and trusted by paediatricians to take decisions and refer babies as and when appropriate, rather than - as many midwifery staff voiced - being made to feel that '*they were not capable of doing so*'. When this last point was highlighted to the consultants, most appeared surprised and were quick to say that any midwife or student who felt upset, humiliated or processes were not followed by one of their team, must let them know as this was unacceptable behaviour. Only one consultant responded by stating: "*Such behaviour doesn't happen here, I am sure the managers (midwifery) will tell me if it does, but it doesn't*". The comment was worrying due to the fact there was no room for movement or allowance that there could be an issue even when faced with the knowledge that some of the midwives had vocalised that negative behaviour was at times a problem. Whether the consultants are aware of such behaviours or not, it would still be apparent that knowledge of such events is still not being regularly communicated or discussed as openly as it should be within and between the professions. If this is the case, then issues may not always be addressed in a timely manner and possibly not resolved. However, in order for the extent of such incidents to be understood, their very occurrence needs to be acknowledged by both midwives and paediatricians.

Only half of the midwives interviewed stated that they would inform the paediatrician if his/her manner was unacceptable. The remaining interviewees in the sample group said that they would find this difficult and wanted more pro-active managerial support or a process that they could state their feelings without worrying about having done so. When asked what would worry them, answers were generally related to being seen as a *troublemaker*, or even more concerning, that they were worried that the senior paediatrician would send a junior doctor when they had an urgent need for an expert opinion. Both are of grave concern when there are two professional disciplines that need to work collaboratively not only for the health and well-being of a newborn but in doing so, they also provide the parent(s) with effective support at what is often an anxious and sometimes frightening time in their lives. Therefore, as much of the data collected linked to or directly pin-pointed interprofessional relationships as directly influencing the working environment, it is important to discuss the culture

and processes that have influenced the education of health professionals as well as those that may occur in the working environment.

10.2 The Art of Communication & Collaboration

Addressing interprofessional collaboration is not a new concept in nursing and midwifery. During the early 1970's, the need to address interprofessional culture and behaviours within professional health education curricula were starting to be formulated (Bernstein, 1971). In 1986, 14 years after the initial recommendation of the need for significant changes to nurse education (Briggs, 1972), the then nursing and midwifery governing body – the United Kingdom Central Council – introduced the concept of Project 2000 (1986) which was then implemented in 1989. Project 2000 aimed to move students to supernumerary status and raise the standard of research in nursing and midwifery education in-order to instil and raise the awareness that evidence-based care was paramount. However, another aspect was that nursing and midwifery students would engage in a period of shared learning in relation to foundation knowledge and skills for the first 18-months of their training. After this period students then completed their training within their chosen specialism. This period of shared learning gave students the opportunity to mix with students studying midwifery and all branches of nursing, giving them a wider perception of role differences and responsibilities, albeit only within these professions.

In 1999, the document *Making a Difference* (Department of Health) took nursing and midwifery education one step further. This document sought to address the negative aspects of Project 2000 relating to new registrants being perceived as less skilled and lacking in confidence. Therefore, it aimed to raise, amongst other aspects, the students' level of knowledge and skill so that newly qualified professionals would not only be able to provide comprehensive, evidence-based care but also, be well on their way to becoming confident in their ability to make sound decisions. This was further strengthened through the publication of *Fitness for Practice* (UKCC, 1999) as one aspect of this was the recognition that students also required experienced, effective support whilst in practice and for a designated period-of-time after qualification, known as 'preceptorship' (Peach, 1999). The implication here is that nurses and midwives should be equipped to act and be seen as a professional capable of carrying out an autonomous role, but it is recognised that even the most competent and confident student can find commencing registered practice a daunting prospect. Unfortunately, at the time that this change occurred, staff shortages were a growing concern, thus it could be argued that student preparation and transition to professional practice was more in consideration of staff shortages than actively working towards enabling students to take on the autonomous professional role (Lord, 2002).

The initiatives above are not highlighted here to review the reasons why they did not achieve or match the expectations and views of qualified professionals, students, or those who use NHS services. They are used to highlight some of the progressive changes that have occurred in nursing and midwifery education that have worked towards raising the standard of these professions and it could be argued the autonomy and resilience of the individual. However, perhaps what is even more interesting, is that the evolving picture above does not give a clear mention of interprofessional collaboration that includes medical staff in any of the earlier documents. It was not until 2010, that the WHO issued a document that quite clearly emphasised the importance of interprofessional learning if professionals were to work together for the greater benefit of those for whom they were caring. Examples are given of good practices in other countries and strategic changes to how both doctors, nurses and midwives are trained that enables collaborative learning and working.

Since the publication of the WHO (2010) document above, more research has been published which explores how interprofessional learning can aid the building of supportive and respectful professional relationships within healthcare (Lawlis et al. 2016; Housley et al., 2018; Grace, 2021). However, whilst many universities integrate interprofessional learning within their professional healthcare courses, there are few that can enable students within medicine and other healthcare professionals to learn together – or as WHO (2010) more refers to, ‘train together’. The aim was to enable respectful, collaborative working within the practice environment. I would therefore argue, that enabling an education system that pro-actively seeks to enable such learning experiences, may be one of the most necessary if not most challenging actions that needs to take place before any real change in medical – nursing/midwifery relationships is to occur. The paramount point here is that the foundations of collaborative working and opportunities to engage with other disciplines that collaborate with one’s own future discipline, must occur within both NMC and GMC foundation programmes of learning.

10.3 Communication & Leadership Equals Positive Working Environments

Reports such as Francis (2013) and Kirkup (2015) describe the outcome of poor healthcare culture and some of the specific practices and processes that lead towards poor interprofessional teamwork. These reports are published in response to the investigation of serious events occurring within the practice environment. Nonetheless, some of the issues highlighting the need for better relationships and communication between midwives and paediatricians is also a regular feature within the studies mentioned earlier in relation to why midwives discontinued to conduct NIPes. Indeed, the art of reflecting on what you say and do in practice in conjunction with effective interprofessional communication and collaboration, can have considerable positive impact on staff within the

workplace and on those for whom they are caring (West et al., 2011, Armstrong, 2018 and Sonmezer, 2020).

A theme that was frequently highlighted within my research as the data collection progressed related to interdisciplinary respect, highlighted by phrases such as:

“They [paediatric registrar] don’t listen to you, they still send the SHO instead of coming themselves, then the SHO calls them and the Reg.[registrar] comes straight away... apparently, I am incapable of knowing if a baby is becoming unwell – I obviously know nothing whereas the SHO know it all!” (PEF2 T1)

“The guidelines state that I can refer a baby for a hip ultrasound for risk factors but the sonographer will not accept the referral because I am a midwife – when I asked why I was told that I do not have appropriate knowledge to do so although they will accept a referral from a junior doctor who knows less than me, what am I supposed to do?” (MM10 T3)

Such behaviours from senior members of staff did not appear to instil a collegiate feeling of partnership working where there is a mutual respect for the knowledge and expertise of other professionals. However, neither does it point to a managerial presence that is supportive towards the midwives or demonstrates a high leadership standard as advocated by the NMC (2018a), RCM (2019) and the RCOG (2020). Just as importantly, when midwives recognised their responsibility in changing their environmental culture, their inability or cautious approach in doing so may highlight the strength of the present hierarchical system. This may impact on leadership initiatives which either become ineffectual, are given low priority or lack support from management at both line-manager and executive levels. Indeed, Adcock et al. (2022) explored the need, not only for leaders to possess core leadership skills and the motivation and commitment to implementing evidence-based care, but also the ability to create and sustain strategic collaborative relationships. However, this also requires commitment and effective support at the Trust executive level, which may prove problematic as often midwifery is not represented at executive board level as highlighted further in chapter 11.

10.4 The Impact of a Hierarchical System

Both Brydges et al. (2021) and Sonmezer (2020) discuss the implications in midwifery of the historical impact of continuing a profession centred education with little integration between disciplines. The increasing medicalisation of midwifery, which is particularly prevalent on the labour ward, leads to frustration and a reduction in midwife autonomy (Wong et al., 2017; Newnham et al., 2017 & Sonmezer, 2021). The influence of such factors on midwifery staff in relation to NIPE appears to be

similar, creating an environment where staff experience the same level of frustration and feel that their knowledge and skill is discounted by paediatric staff.

However, activities that promote positive working behaviours in practice, also need to permeate the content and activities within publications that are linked to NHS reforms to promote positive behaviours and yet some appear to unwittingly reinforce the negative aspects instead. For example, the Royal College of Physicians published a series of documents aimed at improving team working in healthcare. The third resource in this series was entitled 'Team Communication' (RCOP, 2017) within which it explores barriers to communication and highlights 'good' practice. Part of this document related to 'call-out' and 'check-back', a system often employed in critical situations and an example of a typical 'positive' conversation between doctors and nurses, presented as a learning activity. Although the process of 'call-out' and 'check-back' is effectively demonstrated, the doctor refers to another doctor by name and the nursing staff are addressed as nurse. One must bear in mind that this publication's aim is to promote effective communication and discusses the benefits of this as improving job satisfaction, staff retention and facilitating a culture of support and teamwork. It could be construed that this document portrays that the respectful act of using someone's name is permissible in relation to a doctor but not a member of the nursing staff, which gives a subliminal but powerful message that relates more to who is in control and the prevailing hierarchy, than the key issue which is to promote effective communication and teamwork.

Using someone's name demonstrates respect and support for the person who is being addressed no matter if that person is the one you are giving care/information to, or a member of staff in a clinical area whatever your profession or status, thus reducing the power that a hierarchical structure of working can have on staff. Indeed, the use of first names has been recognised as a key factor in improving communication and equality between staff members in other working environments such as the airline industry (Gladwell, 2008), where they have worked to flatten the level of a hierarchical power structure and its related negative outcomes. Brailey (2018) described the impact that occurred within this industry where staff were so subservient to the captain that they were unable to challenge decisions made which sometimes led to serious and fatal consequences. Similarly, in maternity care, Kirkup (2015) also demonstrated that all levels of staff must feel able to question decisions or actions taken if the serious outcomes that occurred in Morecambe Bay are to be avoided in the future. Thus, we could learn much from those who work in environments other than healthcare that would enable healthcare professionals to find strategies that would work to positive effect for both staff and patients.

Within the maternity environment, the term multi-disciplinary team (MDT) is applied to a collaborative group of disciplines that is usually led by the highest-ranking team member – usually the physician. In midwifery, use of the term MDT is usually used in potential or actual emergency circumstances and will be found in much of the literature relating to such events. In the wider context, an *Interprofessional team* is one that is often required in the event of expertise from other professionals such as endocrinology or diabetic specialists, social care, safeguarding issues. In these instances, multiple different professional disciplines may come together to agree goals or plan care in-order to improve health outcomes and patient satisfaction. It could be suggested that the latter term has time to investigate the available evidence and discuss possible actions, whereas emergency situations can be time precious requiring fast decision making. However, the professionals involved are all qualified in their respective disciplines and therefore, all team members should be able to feel that they can challenge decisions made if based on sound evidence, even if it is the consultant who has made the decision! Admittedly, using team members names is not an overall solution, but it has been found to reduce status associated hierarchical impediment and embraces the respect conferred by the ‘*Hello my name is*’ philosophy.

10.5 Embracing Value & Respect

The importance of a professional introducing themselves to a patient, was poignantly highlighted through the campaign, ‘Hello my name is ...’ (hellomynameis, 2017) when a doctor became a patient herself and felt the impact of professionals not stating their name at the start of any interaction with her or asking what name she wished to be called by. The negative influence this had on her sense of maintaining any control in an extremely uncomfortable and anxious time in her life, was so profound she started to write about the impact on her and how this needed to change in practice. Some medical schools have now taken this simple act on board and instigated medical student learning aimed at facilitating good professional behaviours (Grother et al., 2019). Whether this action permeates across all medical schools and to what extent, remains to be seen. If a change occurs in relation to positive communication towards staff as well as patients, it is possible that such activities could lead to better relationships within practice.

Brailey (2018) referred to the “mynameis” ... campaign when she discussed how hierarchies and the way professionals address each other within practice can have a major impact on team communication and its ability to work together collaboratively. She also points out that the wider influence of tribalism that Weller et al. (2014) referred to as accompanying a hierarchical environment can negatively impact on patient care and safety (Kirkup, 2015). Unfortunately, examples of poor information sharing or where someone perceived as lower in the hierarchy finds it difficult to debate

or question a decision even though they have the knowledge to do so, remains a prevalent factor within workplace culture (Ockenden Report, 2020 & 2022). Such incidents continue to reflect the work of Taran (2011) and the Department of Health (2013), who alluded to the '*them and us*' culture that can exist within poor working relationships between midwives, obstetricians and paediatricians. Therefore, reducing some of what may even appear to be insignificant hierarchical activities can have a greater impact on how professionals interact with one another, but this needs to be commenced during initial training and continued within the practice environment. In the context of NIPE, the above aspects link strongly with an earlier comment that was often voiced during interviews:

"If they [registrar and consultant] value us their junior staff tend to do the same." (MW2 T1)

Midwifery staff and students who voiced similar sentiments to the above statement, clearly linked the quality of the conversations and communications with paediatric registrars and consultants with how valued they felt and whether their concerns would be taken seriously, and timely and appropriate referral would be actioned. Midwifery staff in one of the Trust sites often identified the issues they were having in relation to behaviour and expectations with one of the neonatal consultants. They vocalised that the consultant had stated that midwives should do what they were '*told*' to do. For example, not expect a senior paediatrician to turn up in response to a referral being made and take a baby to the area where the junior doctor was working. As a consequence, his attitude was reflected in the behaviour of his junior doctors, who would not attend the birthing unit when asked or would question or belittle the midwife's need for a senior paediatrician when challenged. Such behaviour may echo the work of Downe et al. (2010) who refer to the *fractal* phenomenon derived from complexity theory, whereby responses or antagonisms learned as junior doctors become self-perpetuating as their careers progress, otherwise known as the 'feedback loop'. Thus, the junior doctors these midwives were referring to in this study were already gaining a learned response toward midwives, which without some form of intervention could be perpetuated, or fed-back into more senior roles. In turn, midwives faced with such behaviour, voiced their dislike and sometimes found themselves acting hesitantly or expecting doctors to be confrontational. The concern is not only that the junior doctors are learning such behaviours but so are the student midwives and thereby it is possible that until this cycle or feedback loop is broken, a whole new workforce who are in the mode of learning their craft will continue to demonstrate such behaviours in the workplace.

The consultant referred to above appeared to be unaware that such responses were seen as disrespectful to midwifery staff, or at least gave no indication that this might be how he was perceived. In terms of not listening to the rationale for the referral, was often viewed by midwives as making an experienced NIPE practitioner refer the baby to a junior doctor who would need to refer to a senior

paediatrician in due course, resulting in delayed management and actioning further investigations. It did not go unnoticed by the midwifery staff or parent(s) that making the mother move to another area with her baby was also inappropriate, particularly for those whose mobility may make this difficult. Such incidents were often termed by midwives as *'unreasonable to ask of mother and baby'*, as the parent(s) often felt *'pushed from pillar to post'* and would often become more upset due to having to wait to gain 'expert' information from a senior paediatrician. In such incidences any staff member whatever their perceived status must be able or be supported in engaging a calm, professional conversation to try and resolve the issue before the need for further escalation is required.

As referred to previously, both Kirkup (2015) and the Ockenden Reports (2020 & 2022) have highlighted the issues that impact on care. For example, both poor communication and incivility in the workplace have led to professionals feeling undermined, unconfident and feeling unable to challenge decisions. To reiterate, although these reports are the result of investigations into serious issues relating to care management and Trust processes, there is an echo of these issues within the data collected from midwifery staff and students that sheds light on how similar issues and behaviours are permeated throughout all aspects of practice, including NIPE. The Each Baby Counts (RCOG, 2019 & 2021) reports also recognise the risks to patient care in relation to poor behaviours and hierarchy in the workplace. These reports have given due recognition to the findings that staffing shortages played a part in negatively influencing care management, resulting in poor outcomes regarding morbidity and mortality. However, they also highlighted the need for strong collaborative leadership between midwives and doctors to address negative workplace behaviours and reduce the negative influence of inbuilt hierarchies – an issue already discussed in Chapter 8.

Although alluded to earlier, the need to work towards respectful interprofessional collaboration is not just a necessity for midwife – paediatrician teamworking. Student midwives and junior doctors see and hear how different professions interact with one another within the practice arena. Therefore, it is important that interactions between disciplines are professional at all times, not just for these junior doctors and student midwives but also for those for whom they are caring. The title of *'healthcare professional'* holds a particular representation whether in medicine or midwifery for both those in the profession or training towards qualification, women and their partners. Therefore, this professional status is often defined for example, as 'qualified', 'competent', 'caring' or 'skilled' in their respective discipline. In relation to NIPE, parents also possess a similar image and an inherent trust in a professional's knowledge that they will understand and inform them in the event that their baby displays an anomaly or shows signs that their health is deteriorating.

However, as previously alluded to, a good role model also teaches professionals and learners those skills that are sometimes more difficult to put into practice, such as effective 'communication', 'courage' (to speak up when there are concerns) and 'respect' (for those one is working with and caring for). Indeed, Wilson (2018), reflects on the need for medical students to be taught how to improve their bedside manner and that good role models in practice would help this process. Such learning may assist junior doctors to gain these skills and the understanding of their significance in promoting higher patient led care (The King's Fund, 1999), satisfaction and reduce safety risks through better doctor-patient communication. In so doing, not only a greater appreciation may be gained of the intricacies of these skills but may also present other learning opportunities. For example, midwives mentioned that junior doctors needed to improve their skill to effectively recording the findings of the NIPE and just as importantly discuss them with the parents – or as one midwife eloquently phrased "*they [junior doctors] are not good at the chatty bits ... it is what parents need, not just what they want*". Therefore, providing the opportunity to observe an experienced communicator in action would improve their 'bedside skills' not only in relation to NIPE but also in other areas of practice.

10.6 Raising the Standard of Interprofessional Communication

It is regrettable, that even though a UK consensus statement (Von Fragstein et al., 2008) and the World Health Organisation (WHO, 2010) both alluded to the need for communication skills in medical student training, issues with communication and team-working which in turn influence professional behaviour are still prevalent today. Conversely, midwifery curricula has contained content on the skills and practice of communication as laid out in the standards set by the Nursing and Midwifery Council (NMC, 2019a) that informs pre-registration midwifery education and training and reflects the Standards of Proficiency for Midwives (NMC, 2019b). It is interesting to note, that even with this content and the inclusion of reflection as a learning tool, both the midwives and students interviewed stated that it was difficult at times to communicate effectively with the paediatricians. In part this may be due to the paediatricians perceived status in the hierarchical structure that is part of their practice environment and to a degree some of the role-models in midwifery may, not unlike medicine, not be as positive as they could be. However, what may be missing from midwifery curricula is the process and skill of how you challenge decisions or how you assist the professional in front of you to 'listen' to what you are saying, or even propose another way to resolve the issue, particularly when there is a baby that needs more timely escalation or expert opinion. The points made above may also relate to the fact that although Interprofessional Education (IPE) within healthcare may encourage a mixing of professionals and raise their level of understanding about each other's roles, it often does not touch on the subject of hierarchical structures and their impact on interprofessional communication. Indeed, Gergerich et al., (2019) discusses how not addressing this aspect within IPE can result in unresolved

tensions between professional groups in relation to who is perceived as holding ultimate decision-making power. Both Paradis et al. (2017) and Reid et al. (2018) note the need for flatter hierarchical structures which echoes the work of Gladwell (2008) and Brailey (2018) - referred to in section 10.4 above - as a move towards reducing interprofessional tension and poor collaborative working practices. However, Elmqvist et al. (2016) highlighted that this was the result of a strong hierarchical structure accompanied by blame culture that had been prevalent in the past but that this was not so evident in recent years. Conversely, Reid et al., (2018) found that students when reflecting on their interprofessional working experiences during IPE, still perceived that a power imbalance was prevalent and portrayed some resentment towards the higher status that institutions automatically placed on doctors which was echoed by the students in this research. This would therefore point to the need for IPE to be permeated throughout the layers of staffing – student to senior executive management – if there are to be any significant changes to how the importance of the differing professional roles are to be perceived by other professional groups and as a consequence encourage and promote a change in cultural behaviour in the workplace. Reid et al. (2018) also issued a caution in that not addressing this important point may result in enforcing rather than challenging negative behaviour within practice such as disrespecting or not valuing another professionals knowledge or understanding. This would enact a similar consequence to that discussed below in relation to the influence of role-modelling on both staff and students. This last point is particularly poignant when one considers the latest General Medical Council report (2022) that in part reviewed junior doctors' impressions of working with other disciplines. In this report, junior doctors tended to perceive that working relationships with other professionals was valuable and demonstrated good teamwork. However, most of those interviewed were in their first year as a junior doctor and therefore this begs the question if there is something different occurring within the first year when they mostly work in nursing areas as opposed to year 2 when they also encounter more acute areas such as obstetrics and need to collaborate with midwives. Although, this is an area yet to be studied I would argue that in the meantime, strategies to improve the cultural behaviours of the working environment must not only start during student training in all disciplines, but must also progress and be maintained within the working environment for qualified staff.

What is clear, is that all professional courses need to aid students to understand the importance of respectful teamwork and the impact that healthcare culture can have on patient safety and the student's developing professional identity. Indeed, there has been a move in certain parts of the country to improve communication skills within medical schools (Wilson, 2018) but this will take some time to permeate into the workplace. The rationale for encouraging the integration of Interprofessional Education (IPE) into healthcare curricula (nursing and midwifery) is a positive one.

Perhaps the issue may also lie with working towards related disciplines coming together, rather than putting together all of the foundation courses that a university runs as tends to occur now. Unfortunately, not all universities have a medical school which would lend itself to blending interprofessional learning between medicine, midwifery and nursing curricula. The introduction of IPE within foundation learning is a positive move but what also needs to occur is a change within the practice environment. Students need to see good role models who communicate with other professions in a respectful manner and sees each professional discipline as important as each other in providing comprehensive timely care for the baby and its parents whether this relates to NIPE or not.

The issues with learning communication skills may also lie in the practice environment that junior doctors are exposed to. This view had been highlighted in an earlier study by Baxter and Brumfitt (2008), which although small and unrelated to maternity care demonstrated that professional differences in terms of knowledge, skill, power and status were highly influential factors in relation to interprofessional communication and professional identity. A later study by Wilson (2018) still reiterates the view, that junior doctors need good role models and effective supervision in-order to learn good patient communication, not just the knowledge, skill and expertise that their role requires. This is reflected in the comments of midwives in this study who reported that junior doctors were shown one NIPE and then their skill ability was not supervised or assessed. This may mean that they are missing out not only on the intricacies of the skill itself, but also the information gathering before the examination, the discussion with the parents during and after the examination and correct recording and referral processes. Also, as highlighted by the midwives, they are not being given opportunities to observe effective communication between professionals or gain an appreciation of other professional roles, knowledge or skill level.

As Christie and Glew (2017) point out, there may be a need for the more senior clinicians in practice to also access training in good communication, as otherwise junior staff will not necessarily be learning from good role models. As previously reiterated, the reports looking at good practice to improve communication generally arise out of stressful situations where mortality has occurred. Perhaps what needs a greater focus, is the day-to-day art of communication between disciplines and mindful working practices that temper and resolve the behaviours between doctors and midwives that are counter-productive to effective team-working (World Alliance for Patient Safety, 2009). Just as importantly, a change to openly praising practices that promote compassionate collaboration should become the 'norm' – an activity that is starting to become more obvious within maternity units through the use of display boards and digital communications with staff.

Changes to the culture of the practice environment need to be maintained and become 'normal' behavioural practices, during foundation training and also within the workplace which requires on-going collaborative work by all professional groups. In so doing, it would benefit qualified practitioners and the students of today who will be the registrants of tomorrow whatever professional route they are following. Therefore, the next section reviews some of the issues that may influence a midwifery student's transition towards qualified midwife status and their view of autonomous professional practice.

Chapter 11: Co-related Factors Influencing Identity & Autonomy

11.1 Introduction

Although this section is termed 'co-related factors' that does not mean that they have any less impact than those issues already discussed within previous chapters. As the data was collected, it became distinctly noticeable that these factors had a recurring relationship to previous issues discussed. Some of the issues were highlighted by NIPE practitioners and students as causing strong feelings of frustration and demoralisation, whereas others were seen as supportive and pro-active. In other words, their presence appeared to be interwoven into the influences and impacts that occur within the working environment of NIPE practitioners. Therefore, this section commences with how midwives view their professional autonomy and then moves on to focus on the influence of the PEF and link lecturer role, NIPE training and assessment. It also includes the issues that may influence a midwifery student's transition towards qualified midwife status by impacting on their developing professional identity and autonomous practice.

11.2 The Professional Midwife - Pro-active or Passive

The use of clinical guidelines within healthcare practice is primarily to provide practitioners with a systematically developed evidence-based guide to specific clinical circumstances, thus encouraging appropriate care and informed contemporary practice. The requirement for practitioners to follow the guideline written for a particular circumstance should reduce inappropriate variations in practice and lead to higher standards of care (Thomas, 1999 & Maxwell, 2022). It should be noted that as Berg et al. (2000) and Symon (2006) point out, a guideline sets out a guide that is aligned with the utilitarian foundation of achieving the best outcome for most people. Therefore, this can at times be challenging, as it is also important to recognise that patients need to be provided with the evidence to aid them in making their own decisions which must be valued and respected (NMC, 2018, NHS England 2019b & 2021b) even if their decision does not align to the Trust guideline.

In relation to NIPE, there are many guidelines that link to this particular examination, such as those that focus on neonatal jaundice or hypoglycaemia. All three Trust sites included in this study also have a clinical guideline that details the issues relating to the examination itself, such as why the examination is performed, who should conduct the examination, how it should be conducted and recorded and the referral processes in relation to anomalies found. An important point to note with this latter guideline is that on all three Trust sites it is for the use of all NIPE practitioners, irrespective of their professional discipline as it reflects the national NIPE standards (Public Health England, 2019b).

The aspect that was regularly articulated as a source of frustration for both midwifery and student midwife sample groups related to the referral processes that need to be actioned when finding an anomaly during the NIPE. Whilst preceding chapters have already alluded to this issue in relation to 1, this section gives further insight into how staff articulated their feelings when discussing this aspect and whether they saw this situation as resolvable.

Generally, midwifery staff were very appreciative of the actions of senior paediatricians who responded in a timely manner when requested and often spoke about feeling valued for their knowledge and skill, for example:

“I called the registrar (paediatric) to come and see a baby I had examined ... he arrived in 5 minutes ... I was shocked as the others usually send the FY2, but he said I obviously knew what I was talking about ... and the baby needed to be seen quickly. I was so chuffed that he valued my knowledge and acted on it, but that should be the norm, shouldn't it?” (MW14 T3)

Comments such as those above were not uncommon occurrences during the midwifery staff and student interviews. Consultants also appeared to value midwives who recognised adverse neonatal conditions and acted swiftly whilst ensuring parents understood the reason for the referral. One of the essential factors that they appreciated most, was that the midwives gave them detailed information at the time of the call that enabled them to understand those instances when immediate action was required. When the collaboration between midwifery and paediatric staff worked well it appeared that there was a clear level of mutual respect for an individual's expertise notwithstanding their professional discipline. However, there were issues that were repeatedly aired by midwifery NIPE practitioners relating to doctors not following the Trust NIPE guidelines particularly in association with completion of the PCHR and referral processes.

As the interviews progressed, it became clear that midwifery staff viewed this type of behaviour and the action of disregarding the guidelines by paediatric staff as uncooperative or demeaning – a mental attitude that appeared to further reduce the level of their belief that both disciplines were actively working together for the benefit of the baby. Previous chapters have reiterated midwifery staff and students' feelings towards being told by junior paediatric staff to complete the PCHR for them, or when contacting a senior paediatrician they are told to refer a baby to a junior doctor, even though the need to refer to a senior paediatrician is clearly stated within their Trust and national guidelines (Public Health England, 2019b). In these events, there was a strong consistency across all midwifery staff and student sample groups about how this made them feel in relation to their professional role and identity, for example:

“When I first started conducting NIPES I thought the registrar was having a grumpy day and did as he asked and referred the baby to the junior doctor. Later, I realised they [senior paediatricians] often did this even though the guideline is clear ... it isn't right, they [junior doctors] have less experience than me. I feel I am being checked up on.” (MW2 T2)

“I am getting really fed-up. Often, when I refer a baby to the senior paediatrician, he sends the SHO ... if I need to refer a baby for hip ultrasound because of the presence of risk factors I can't as I am not allowed to do so. I have to get the SHO to complete the referral ... it is so ridiculous when both can conduct NIPES but I am the one not allowed to send the referral!” (MW4 T1)

“Does he [consultant] not trust us [midwives] to take appropriate action on our examination findings, why does he let us do them, I know the senior paed's [paediatricians] are busy, but I don't refer a baby for trivialities ... it makes me feel worthless? (MW6 T3)

NIPE midwives and their managers were very clear that they understood senior paediatricians were busy and that there were not enough of them even though their midwifery units covered 6-7000 births per year. They also wanted easier access to senior paediatricians when required and saw this as integral to the provision of timely care for the baby that they were referring. The NIPE midwifery team recognised that junior doctors had to learn, but they did not want this learning to be at the expense of timely treatment and/or resulting in the baby being repeatedly examined, firstly by the NIPE midwife then the junior doctor and eventually a senior paediatrician. The presence of neonatal/NIPE guidelines that reflect effective interdisciplinary collaboration, contemporary research and national guidance was something that they welcomed. The perception was that this may aid changes in other processes such as enabling midwives to refer a baby with defined risk factors for a hip ultrasound instead of waiting for a junior doctor to complete the referral. However, this would also need the inclusion of a senior ultrasonographer during guideline development if all disciplines are to appreciate the underpinning rationale.

There was also a strong expectation that referral guidelines should be adhered to by all who use them whatever the professional discipline, albeit in consideration of parental consultation, understanding and agreement. Considering the rationale given earlier regarding the purpose of the presence of a clinical guideline, it is possible that in relation to the general NIPE guideline discussed above, it is possible that it is not wholly fit-for-purpose. What I mean by this, is that when staff choose not to follow what the guidance states, or service processes regularly and consistently create an issue with following guidance, it appears to become accepted practice. It is possible that the reasons for this may

be due to a lack of senior paediatricians in practice or other factors that impinge on putting measures in place to investigate and address issues, such as unnecessarily repeating a neonatal examination or delayed treatment/action. However, when one bears in mind the findings of both Kirkup (2015) and the Ockenden Report (2022), it is concerning that such circumstances can continue with seemingly little activity to resolve the situation. As previously reiterated, the two reports above were in relation to serious incidents in practice, even so, it is just or even more important to resolve the issues within the foundations of everyday practice. This is particularly paramount when neonatal referrals are made by a NIPE practitioner as they frequently need timely consideration by a senior paediatrician. Plus, in the presence of risk factors for hip ultrasound in the example used above, a midwife referral can also reduce costs incurred by using a doctor's time or waiting for a doctor to be present. The attitude of senior paediatric staff who view a junior doctor being sent to see a baby as acceptable practice when the baby has been referred by a midwife, may appear to be a small issue in the context of the findings relating to serious incidents. Although, as Ederer et al. (2019) point out, legal provisions on who is responsible for what, cannot replace effective communication and action in critical situations, which in-itself necessitates an interdisciplinary collaboration where each discipline holds an equal level of respect. The point here is that if collaboration does not work effectively and becomes part of normal behaviour in everyday practice, it could be construed that there is a long way to progress towards the development of effective interdisciplinary collaboration when more serious incidents start to emerge.

A perception often aired by midwifery staff, is that although they share concerns with their senior managers, they did not feel that these concerns are fully discussed at managerial or interdisciplinary level. There was a strong feeling that collaborative work should occur as an expectation, not only in practice but also those areas associated with practice such as guideline development. In so doing, it was perceived by these staff members that issues such as, not being able to refer a baby to ultrasound for hip risk factors could be resolved and their level of understanding and skill would be more valued and respected. Both midwifery staff (in all sample groups) and consultants felt that more collegiate interaction regarding team working and guideline development was viewed as not only a positive step forward, but also that interdisciplinary understanding in relation to professional knowledge and responsibility would be increased and disseminated to other co-workers. This in turn could raise awareness of the knowledge, role and responsibilities of all disciplines, which when lacking is a known factor in creating a disharmonious culture within practice that lowers morale (Hunter & Warren, 2014). However most participants no matter their discipline were unsure as to how and when they could debate ideas to enable better working relationships, which may be part of the issue in making changes to the working environment.

Another aspect that midwives and managers did articulate, was that sometimes doctors made them feel that they do not appreciate or at times understand that a strong safety culture is paramount. This aspect perception arose during discussions between midwives and paediatricians and reflects and enforces the differing professional philosophical differences between doctors and midwives as highlighted in chapters 6 and 8. Midwifery staff were often quick to dispute their lack of perception and, similar to international (Sinni et al., 2014 & Ederer et al., 2019) and national research (Currie & Richens, 2009), articulated the importance of reflection, feedback, ongoing learning and effective interdisciplinary communication as particularly influential in reducing maternal and neonatal morbidity and mortality. Both midwifery staff and student participants within this research, also strongly vocalised the importance of clinical governance and the need to be able to work holistically in-order to be in possession of all the available information necessary for effective decision making. Both points allude to the recent UK Government publication, Safer Maternity Care (Department of Health, 2021b) which recognises the link between the prevailing culture within practice and clinical quality. It is possible that strong leadership (see Chapter 8) and the presence of Directors of Midwifery on executive boards, would greatly assist individual Trusts and medical staff to appreciate that midwives do take this part of their role seriously (RCM, 2003). Perhaps just as importantly, members of professional disciplines need to be given the time and encouragement to set transparent interdisciplinary foundations that enable a culture of collaborative everyday working, rather than working on misunderstanding and incorrect assumption in relation to role responsibility. Therefore, midwives may need to become more pro-active in taking the initiative and voicing their ideas or activities that could promote collegiate working.

In one of the quotes near the beginning of this chapter, a midwife used the words '*feeling worthless*' when discussing her perception that the consultant was not taking her examination findings seriously by sending a junior doctor to review a baby that she had referred to a senior paediatrician as per Trust and National guidance. The terms of feeling '*worthless*' and being '*incapable of making valid decisions*' were often how midwives in particular, articulated how it made them feel. Interestingly, when midwives talked about their ideas such as more collaborative working on guidelines during the interviews, they were asked if they had discussed this course of action with their managers or the senior paediatricians. The replies given demonstrated that the midwives appeared to be reticent about being so assertive by usually referring to themselves as being their '*own worst enemy*' even though they were well aware and articulated that such inactivity '*did not sit with the ethical expectations of their own profession's standard of accountability*' (NMC, 2018). A similar perception was discussed in the previous chapter which may point towards midwifery staff wanting or being more prepared to take firmer hold on their role and responsibilities than they feel they have at present.

This recognition of needing to take pro-active responsibility and not solely expect senior midwives or management to do so was clearly apparent but the ability to take this forward was either blocked by service needs, lack of staff or unsupported by time or management. As referred to earlier, this can only add strength to the argument for a senior midwife presence at every Trust executive board as advocated by the RCM (2003). This would ensure that the evidence to support strategic change in maternity settings is not hidden or over-written due to lack of insight or, as eloquently stated by Lord Hunt in the House of Lords, "*We know that midwives are subsumed under nursing leadership and that has consequences when it comes to priorities and resources*" (Hansard, Vol.779, Col.788-789, 2017). Some years have passed since this debate and changes are taking place but perhaps this is at too slow a pace for some of the NIPE midwives interviewed, who spoke about becoming '*handmaidens*' to the doctors which was not what they 'signed-up' for considering the level of experience and knowledge they have achieved. Perhaps herein lies the danger that the specific professional remit of the midwife may become invisible.

The Professional Midwifery Advocate (PMA) role was developed at the time that 'supervision' of midwives was changed to a more reflective model of peer and self-assessment of practice competency, accountability and advocacy in England (NMC, 2018c). However, at the time the research was conducted, PMAs were still not a visible entity within every Trust site. The support and encouragement of PMAs, PEFs, innovative midwifery leadership and the prevailing NHS maternity policy that promotes cultural change will hopefully continue to encourage collegiate working (NHS England, 2019 & NHS England, 2021c) and continuity of carer (Department of Health & Social Care, 2021b). In so doing, staff may feel supported which may enable them to take a more assertive stance within their professional role, thereby gaining a higher appreciation and respect for their professional knowledge. The impact may work towards increasing their level of resilience and ability to work autonomously, which may lower the rate of attrition. Indeed, the influence of such changes may not just affect qualified staff, but how students view the profession and their future professional identity which needs serious consideration as they will be the midwives of tomorrow and the future of the profession. Midwifery staff appeared to have a clear perception that they are an integral part of maternity services and were also aware that they should be a pro-active part of the cultural change and not just a passive bystander to the process. With this in mind, the next section takes a closer look in relation to how midwifery staff and students view the value of PEFs and link lectures in supporting their NIPE role as this was repeatedly linked to the above throughout the interviews.

11.3 PEF Support & Role of Link lecturer

11.3.1 PEF Support

During the time of the research, one Trust site had a PEF in post for a number of years, the second site had appointed a PEF two years prior to the study commencement and the third had not yet made an appointment to the role. The above PEFs had worked within their Trust site for a number of years, were solely employed for the purpose of aiding the learning experience of student midwives and were all NIPE trained. There were other PEFs employed within the Trust sites but their remit was either nursing students or qualified staff, therefore the focus here relates to those linked with student midwives.

Although research has indicated that the PEF role is valued by both students and staff, the research tends to focus on the value of this role within nursing (Leigh, 2014 and Scott et al., 2017). However, even within nursing research there is an indication that this is an undefined role title (Conway & Elwin, 2007) and that clear criteria in relation to role and responsibilities is lacking (Coates & Fraser, 2014). If in these circumstances the post-holder is also insufficiently supported in their role, it may lead to a feeling of being overwhelmed and isolated (Kelly et al., 2002 and Cangelosi et al., 2009). Indeed, for very similar reasons, link lecturers within the Trusts affiliated to this research, had facilitated the sharing of contacts between PEFs on other Trust sites in-order to aid the growth of a supportive PEF community. It was felt at the time that if we as lecturers expected PEFs to be fully involved with the lecturers and student midwives, then we also needed to give them our full support.

Although the findings from nursing studies may have similarities with midwifery, it is difficult to state this for certain. Unfortunately, the role and responsibilities of the PEF is an under-researched area in relation to midwifery and thus the evidence evaluating the impact of this role in practice is limited. However, the students interviewed within this study on two of the Trust sites were without exception, very positive about the presence of PEFs and the support they provided in partnership with midwife NIPE practitioners and link lecturers. When students on the third Trust site were asked whether they had spoken to the students on the other two sites, they were adamant that they wanted a PEF to be employed at their Trust too and were envious of the other students who had access to them. However, they were also very positive about how the university had addressed this issue and provided more NIPE lecturer support whilst the number of NIPE midwife practitioners gradually increased.

Oates et al. (2020) support the students' perception above, suggesting that the importance of these roles within midwifery practice are invaluable due to their close working proximity with students in the practice setting. Oates et al., (2020) also proposes that their consistent presence enabled students

to feel more supported particularly in relation to the emotional aspects of their training. Egan et al. (2019) also highlights the need for compassion in the workplace, which also links into emotional well-being for staff and students. Furthermore, as the PEF was a constant presence in practice, they were in a position that they could be flexible in aiding those students who were low on NIPE examinations or just needed to become more confident in their NIPE knowledge and skills. In conjunction with the NIPE link lecturers, students spoke highly of the level of support that they could access and consequently on qualification, tended to continue conducting NIPes and maintained their skills all the way through their preceptorship period and beyond. Also, the university in conjunction with their three affiliated Trust partners, had already agreed when the first NIPE module was offered in the early 1990's that any student who achieved their NIPE qualification should be enabled to complete NIPes on a regular basis, whether they were newly qualified, worked in community settings or in-house. Therefore, the positive responses that NIPE practitioners and students gave during their interviews may be testament to the collective input provided between NIPE midwives, PEFs and NIPE link lecturers that aimed to develop confident, competent NIPE practitioners who did not emerge from the preceptorship period lacking the confidence to conduct NIPes.

11.3.2 NIPE link lecturer – a positive influence for NIPE practitioners & students?

Within the three Trust sites where this research was conducted, link lecturers had a regular rota that enabled them to visit the site and were therefore, a visible presence. When NIPE link lecturer input changed in-order to assist the students and midwifery staff while the number of NIPE midwives increased, it had become noticeable that the attitude of staff towards the university also started to change. For example, there had been far fewer comments similar to *'well, the university teaches you this way, but this is what you need to do'*. There may have been a number of reasons for this type of comment at the time, but this is difficult to ascertain some years on without some clear evidence. However, what did appear to gradually change, was that better relationships between university and midwifery staff were starting to emerge. Therefore, it was interesting to gain insight into how the staff in all sample groups felt about the current relationship and whether the NIPE lecturer role still had a place in practice.

Students within each of the respective Trust site sample groups were particularly vocal about the positive influence created by having access to link lecturers who were NIPE trained, not only on themselves but also the practice environment. This, they articulated, was firstly due to the fact that completing a NIPE with one of their lecturers made them feel that not just the lecturer in front of them, but others within the university, did *'actually know what they were talking about'*. Also, they greatly appreciated the fact that lecturers would challenge them during the examination not only in relation

to their knowledge base, but also if a referral was required. The student was expected to initiate and discuss it with the paediatrician. Admittedly, lecturers had more time to discuss and explore issues with students than the qualified staff which may well have influenced their perceptions and responses. Nonetheless, comments tended to be favourable and when staff were asked what they got out of having a lecturer on-site, their answers ranged from using the lecturer as a resource and to share knowledge with, that they felt more motivated and the lecturers gave them the opportunity to reflect on their level of practice and the feedback received on their interactions with other disciplines.

The initial aspect of using the lecturer as a resource and to share knowledge with worked both ways. If new literature had been published, this was brought to the attention of the PEFs to disseminate to the Trust staff. Likewise, changes to practice, care or processes were passed on to the lecturers for dissemination amongst the link team for the site and to see how the information could be integrated into present or future theory or skills sessions. Thus, this aspect may be viewed as an expected product of the collaborative relationship between the Trust sites and the university, as alluded to in the work of Fraser et al. (2013) and Griffiths et al. (2019 and 2021). However, there was also clear indication that the link lecturers conducting NIPes with staff and students, did also facilitate and motivate staff and students to reflect and become more pro-active in their contact with paediatric staff. It appeared that this was not due to one specific activity over another, rather it was a multi-factorial approach through observing conversations between paediatricians and NIPE lecturers, encouraging staff and students to give a full concise picture to paediatricians when referring a baby (for example, for a heart murmur or hip dislocation) and encouraging all NIPE staff to attend the inter-Trust newborn forums. Those staff who had only recently achieved the NIPE qualification were appreciative that lecturers actively sought contact with them in practice, which in partnership with the PEFs made them feel supported and motivated to continue to conduct NIPes. Experienced NIPE practitioners also appreciated that they had not been forgotten and that both lecturers and PEFs actively sought to ensure that they were able to access sessions aimed at updating their knowledge and skill, particularly if they had been away from practice for a while. Spending time with these returning members of staff facilitated their transition back into conducting NIPes which also assisted in reducing the loss of a member of staff from conducting NIPes due to fear or apprehension, ensuring that future students would be able to access their knowledge and expertise.

Students particularly referred to the learning they achieved through looking at strategies in relation to communicating with midwives, other disciplines and parent(s) that enabled them to discover how to raise their level of self-esteem and cope with the thought of new or challenging situations that were occurring or they were expecting when they attained registered midwife status. Of all the sample

groups, they were the most vocal in stating how the newborn forums demonstrated to them that paediatricians and midwives could discuss issues relating to referral, new literature etc., as equal partners in the care provided to both neonate and parent(s). This equality was reflected in the fact that apart from a main facilitator, no one discipline oversaw the meeting as issues relating to practice or new research etc., could be brought to the meeting by anyone attending. The only rules were that the meeting should be accessible, all attendees had an equal say no matter their discipline or status and that there was tea and cake! However, maintaining these forums and enabling staff to attend in an environment that was short-staffed, is not an easy process, particularly when Trust staff were encouraged to take on its organisation and ensure that all NIPE practitioners were aware of the meetings. It would appear that these forums took on another role in enabling specific care practices at the different Trust sites to be explored and a typical example was recounted by both midwives and consultants as follows:

“When the forums started, I thought the lecturer was just a bit mad ... what I mean is how would it work, would it change anything ... now I can see where she was going with it ... we said we were never listened to but she listened and now we [paediatricians and midwives] talk, we actually talk!” (MM5 T1)

“We had an issue with whether midwives could complete a NIPE on a baby born via caesarean section. It was silly really; one Trust site did not allow it but ours Trust did. At the forum it was discussed – quite animated at times ... the end result was that there was no reason for not doing so ... problem solved!” (CN6 T3)

It would appear that issues or care practices that had no founding evidence for their presence could be quickly debated and resolved to the benefit of all concerned. According to the midwifery managers, some of these issues caused ‘most delay for parents’ or conversely ‘raised parental anxiety’ and one of the consultants stated, ‘I don’t understand why we cannot resolve these issues sooner’. Perhaps it is this latter point that highlights a key issue, in that it is not that midwives and paediatricians do not seek the same aim – the health and wellbeing of the baby but that opportunities to debate issues need to be a regular occurrence. Issues that are counter-productive, lower parental satisfaction or where there is no benefit in maintaining their existence, need to be resolved. It is possible that the wider issues of government and national agendas, Trust resourcing and the culture of the practice environment tend to take centre stage and leave little time of what may be construed as less important. However, it could be argued that the very discussions that would aid some of the small changes to occur could also assist a gradual change in practice culture. Enabling staff to discuss the available evidence and listen to each other’s views, may be one of the most powerful tools in encouraging and facilitating interdisciplinary

team working. Such concepts are not new. Over the years, Bronstein (2003), D'Amour et al. (2005) and Downe et al. (2010) have all discussed the need for effective interdisciplinary collaboration to have a shared ownership and to encourage trusting relationships to develop. In so doing, the negative feedback loop that can exist (Chapter 10) that prevents effective collaborative practices to develop could be broken and replaced with better working relationships which can only be of benefit to all concerned.

11.4 NIPE Training & Assessment – A Bone of Contention

The NIPE Handbook (Public Health England, 2021) highlights that a doctor can undertake all elements of the 6 to 8-week NIPE examination, but also recognises that not all trainee GPs undertake formal paediatric training. The onus here is that the learning acquired through recognised training is a necessity as is the personal responsibility to maintain competence in this valuable skill. This also applies to those GPs who have not undertaken the examination for some time and all NIPE practitioners. However, it is worrying to note that Public Health England (2021) refers to midwives needing to complete a university accredited examination of the newborn course and yet gives no indication as to what training junior doctors need to undertake or the expectations of how they are trained when they are conducting NIPes. This stance appears inconsistent, particularly considering the fact that in 2017 the initial rationale for the proposed development of the NIPE e-learning modules (NHS HEE, n.d.) arose due to the recognition that the understanding and skills of junior doctors needed to be improved. However, as referred to earlier, it is worrying that midwives often query the knowledge and training of junior doctors, such as in the following quote:

“Other than a lecture I don’t see the SHO getting any further training, don’t get me wrong, some SHO’s are very good ... they actually give the impression that they have had more than just one teaching session on NIPE.” (MW9 T3)

As similar perceptions as that above were regularly articulated by midwifery staff, perhaps an evaluation of whether these modules are used, who uses it and for what reason. Also, a review focusing on individual Trust policies in relation to NIPE teaching, learning and skill maintenance, may be overdue. The outcome of such research may add to the findings of McDonald et al. (2012), McKinnon (2017) and Lee et al. (2001) and therefore gain a better understanding that enables future planning and development if the quality of the NIPE is to be consistent and effective in recognising abnormalities.

One of the issues that midwife NIPE practitioners regularly voiced, related to the discrepancy between the training they undertook to become NIPE practitioners and that of the junior doctors. As stated

earlier in chapter 7, qualified midwives and student midwives (across all Trust sites within this study) undertake a module that contains theoretical sessions and practical supervision. Students then need to achieve successful completion of a theoretical and practical assessment before they can conduct solo NIPes. Conversely, junior doctor training to conduct NIPes was found to be varied across all three Trust sites. It was clear that in all Trusts junior doctors received theory sessions but in relation to the practical application, some Trusts only provided a 'see one, do one' approach. More importantly, there appeared to be little supervision as to how their skills were developing or if their technique – particularly in relation to the hip examination – was performed correctly and effectively. This reflects the findings of McDonald et al. (2012) and McKinnon (2017) who had similar concerns relating to the fact that the screening element of the examination – particularly of the hip – will only be effective if the practitioner has gained the necessary technical ability. Therefore, one could question why junior doctors are conducting solo NIPes with what appears to be little supervision and support. Indeed, in an earlier study by Lee et al. (2001), it was found that ANNs were significantly more effective in recognising abnormalities during the NIPE than the junior doctors. Again, using hip examination as an example, effective training and execution of the clinical examination process was found to prevent babies from presenting with the condition late due to non-recognition at the neonatal examination stage. Over the years, ANNs have increasingly completed the same NIPE module as midwives in-order to demonstrate knowledge and competence, echoing the earlier view of Walker (1999) that practitioners other than doctors can ensure a higher quality of recognition and care.

On further exploration, there are some Trusts across England who do not appear to have a clear NIPE teaching strategy or an assessment of competence (McKinnon, 2017; University Hospitals of Leicester, 2021), whereas others demonstrate clear expectations in these areas (Norfolk and Norwich University Hospital, 2019; Royal Cornwall Hospitals, 2017). A greater level of transparency in relation to how junior doctor are taught, learn and are supervised in connection with NIPE might assist in reducing some of the frustration expressed by both midwifery staff and students concerning the knowledge and skill level of junior doctors. It may also lead to an increase in the level of discussion in regard to expectations for **all** NIPE practitioners, no matter their status, not just in how they are taught and supervised during initial learning, but also their responsibility for maintaining their level of competence and thereby their timely recognition of anomalies.

Midwifery staff commented that junior doctors will specifically migrate to an experienced NIPE midwife to ask for guidance or just to watch the examination be performed – a request that I too have experienced in practice. The reason FY2s usually give is that they want to learn, for example, how to communicate effectively and sensitively with parents, how to discuss the health promotion aspects or

because they want to perfect their examination skills. However, this begs the question if the lack of ongoing supervision or some other reason is the initiator for this action. Although it also has to be noted that such interaction between midwives and junior doctors does appear to improve interprofessional relationships, even if only in a small way, as the quotes below typically demonstrate:

“It is so nice when they [SHOs] come and ask to watch the examination. They are really interested in watching the hip examination and often find the health promotion aspects eye opening ... it seems they do not often discuss these areas in their teaching session with the registrar ... the focus is on the four areas highlighted in the NIPE handbook.” (MW3 T2)

“My midwife was demonstrating to me the two manoeuvres for the hip examination. The SHO came over to watch. Afterwards when we were completing the record, he came over to say thank you, apparently, he was shown how to perform the examination once and was worried that he was not doing it properly.” (Std6 T1)

Most of the consultants indicated that they knew that some of their junior paediatric doctors would learn from the midwives and expressed that this was a good thing as they knew their registrars could not give more time to teach and supervise the SHOs. However, as McKinnon (2017) highlighted, most SHOs learnt best from a combination of e-learning (such as the NIPE e-learning modules) and bedside teaching so that they could learn from more senior clinicians. However, if paediatric teams are relying on SHOs to choose to observe midwives performing NIPes this may not constitute ethical practice. Such activity will inevitably be subject to whether the junior doctor chooses to seek such knowledge and guidance on their own volition and if not, then a lack of such involvement may possibly result in a NIPE that is not performed as comprehensively and effectively as it could be. However, without gaining the views of the junior doctors within this study and their performance at conducting NIPes during their maternity experience, a true picture of how they perceive their level of learning and support, cannot be ascertained at this time.

It is possible, that Trust sites could provide more skills supervision to enable junior doctors to carry out a comprehensive and competent NIPE. Alternatively, perhaps they could pro-actively engage in more interprofessional collaboration whereby the midwives teach and work in collaboration with the junior doctors. However, the funding for the extra workload for the midwives may be the obstacle here especially considering the present climate in relation to the fact that as yet, not all midwives are NIPE trained, staff shortages are prevalent and the present culture can cause some midwives to refrain from conducting NIPes altogether. On the plus side, it would not only assist and support the acquisition of knowledge and skills but might also enable junior doctors to be more aware of the role and

responsibilities of the midwife. In turn, this may reduce some of the behavioural and cultural issues that are experienced by staff within the practice environment (as discussed in chapter 10) by inhibiting the opportunities for SHOs to learn behaviours that can continue and become embedded as their career progresses (Wood & Gray, 1991; Downe et al., 2010). As Clark (2022) has alluded to, hierarchy can stifle innovation and therefore, even small but consistently maintained activities that gradually reduce hierarchical barriers can work toward better interdisciplinary working and communication. Consequently, the standard of teamworking may be raised to a level where no matter the discipline, every voice counts and is respected for that professional's contribution to the comprehensive and sensitive care of the individual's involved.

11.4.1 Inconsistency in examination process

The difference in how the NIPE was viewed in terms of screening and the actual examination performed was clearly evident within the data collected. Midwifery staff and students often mentioned that FY2s mainly focused on the heart (auscultation and pulses), eyes, hips and testes and often commented "*that parents were not informed fully about the findings*" or, that some continued with conducting bilateral hip examination at the initial NIPE stage when good practice is to conduct the examination on one hip at a time.

Consultants were well aware that their junior doctors saw NIPE as a task to be completed and did not view issues such as health promotion or re-viewing cardiac function as the baby became more active, as part of the examination process. They also appeared to be aware that the FY2s did not always read the family and obstetric history as thoroughly as the midwives, who review the records to ascertain if there are any specific risk factors relating to the baby to be examined. As the consultant interviews progressed, most consultants revealed that they had concerns with the lack of time to supervise the junior doctors, but they also voiced that the NIPE midwives would recognise anything untoward. This last point is concerning for a number of issues, firstly a baby is often discharged from hospital soon after their NIPE is performed and the fact that the NIPE may have been completed by a junior doctor who has apparently found nothing untoward gives little time for a midwife to recognise if this is not the case. Secondly, this is in total contrast to those Trust sites where midwives where midwives are heavily restricted by paediatric guidelines as to which babies they can examine and only under certain conditions. Therefore, such comments could imply that a midwife is now deemed capable to examine any baby due to her level of competency and yet on other Trust sites this would not be the case. It could be construed that Trust guidelines relating to the babies a midwife can complete a NIPE, may no longer be in-line with what is occurring in practice, do not align with national guidance or that there is inconsistency across and within Trust sites. As midwives are deemed competent in conducting NIPE

perhaps the guidelines need to be reviewed and this could also be reflected and strengthened within national guidelines. For example, a midwife could undertake a NIPE on any term baby who does not need an automatic referral to the paediatric registrar or consultant due to obstetric or family history or urgent need as occurs in many Trust sites but not all. Thirdly and more importantly, a baby may not have been discharged home if a more experienced NIPE practitioner had completed the examination. One must also bear in mind a co-related factor in that junior doctors have often not been in contact with a neonate before and some are open to the midwives about this fact and voice their concerns about their knowledge level. Consequently, some individuals find that they have to adjust to the fact that they are not examining a miniature adult, but a fetus that is transitioning into neonatal or extra-uterine life and as a result, they often find the quantity of information that they need to take on board is considerable, if not at times overwhelming. Although consultants strive to ensure timely recognition and management of neonatal conditions, they are also trying to manage FY2 learning with only a small team of staff. Again, perhaps this calls for a radical review of how junior doctors are taught and supervised during their foundation years within the maternity arena and the number of senior paediatricians available to teach within a Trust site.

11.4.2 Maintenance of knowledge & skills

The NIPE Handbook (Public Health England, 2021) clearly sets out the intention that a local mandatory competency assessment process should be in place. Plus, an annual update on NIPE screening pathways and local referral processes should be provided for all NIPE practitioners, including midwives, nurses, doctors and health visitors. Midwifery staff across all three Trust sites had varied guidance relating to maintenance of NIPE knowledge and skills. Two Trust sites require both midwives and ANNPs to complete the NIPE e-learning modules and to attend a NIPE update (theory and Practical skills for midwives) on a 2-yearly basis. Midwives in the third Trust site were required to complete the e-learning but were not offered a NIPE update and if midwives wanted to attend a NIPE update/conference they had to organise this themselves. Therefore, it would appear that Public Health England Guidance is not always followed in relation to provision of mandatory learning, nor does it link update sessions with all NIPE practitioners, including the doctors. Once again, the message that midwives appeared to deduce from this, is that doctors are either not adhering to this guidance or that their updating in relation to NIPE either does not review these issues or is non-existent. Indeed, the midwifery managers did not feel that the doctors were actively encouraged by the Trust to attend even though they had all the information relating to the session dates, time and content. Those midwives who worked within the Trust that did not offer or provide updates, articulated that they regularly asked management for these sessions. However, the managers clearly articulated that they were equally frustrated, as they were constantly informed that there was no financial provision for such activities

even though part of the medical training budget was often unused. In the current cultural climate, including and enabling access to interprofessional NIPE updating sessions for all NIPE practitioners within the Trust, would work towards the sharing of consistency of examination, knowledge and care practices which might facilitate better teamworking and enhance collegiate relationships which can only benefit staff and service users.

Overall, those midwives who were provided the opportunity to attend update sessions were very appreciative of being enabled to do so, as they provided an opportunity to review technique, discuss new evidence in relation to neonates and the NIPE. It also provided an opportunity for staff to discuss the rationale(s) for changes to both national and local referral processes. Midwifery staff were particularly positive towards the continuation of the collaborative content organised between the Trust and the local university. This in part appeared to arise resulting from the perceived improvement of interprofessional relationships during their attendance at the newborn forums, as discussed in chapter 7.

The other guidance that PHE issued in relation to maintenance of knowledge and skill, is that competency should be assessed. However, competency has two foci, one being the experience a practitioner achieves when conducting regular NIPES and secondly the assessment of their knowledge and skill. PHE was clear that experience arises out of the quality of examinations and not on the number of examinations that were performed within a set time period, for example a month or during a year. Although PHE does state that local providers could specify numbers of NIPES to complete per year if they so wished. In regard to the second foci, none of the midwives on any of the three sites had been assessed on the quality of their NIPE since initial qualification, apart from those who had attended update sessions and reviewed their hip examination technique. Midwives were also very clear and consistently stated that if they had a query they would ask a colleague or the paediatric registrar to review their findings, which is considered good practice as in all aspects of midwifery. However, the vital point in relation to newly qualified NIPE practitioners is slightly different as they need to consolidate their learning, particularly when embedding hip examination technique. Therefore, it may have been useful for recognition of this need within national guidance to encourage Trust sites to be pro-active in enabling staff development through the completion of NIPES on a regular basis during their first year as a NIPE practitioner. The more newly qualified midwives and student midwives who participated in this study frequently mentioned that the hip examination and cardiovascular assessment were the areas that they were most worried about on qualification and if they had been away from practice for a period of time. Therefore, there is a need to make sure that these practitioners are well supported and given opportunities to work in those practice areas that enable

them to conduct NIPES. As a result, this could reduce the risk of staff becoming deskilled and abstaining from conducting the examination altogether, which would lead to a loss of both self-esteem and also a loss to service provision.

Midwifery managers who were themselves NIPE practitioners appeared to understand that newly qualified staff or those who have been out of practice for a while due illness or maternity leave, require extra support on qualification or returning to practice. These managers openly stated how they enabled newly qualified staff to access practice areas where they could complete NIPES even during their preceptorship period. However, not all midwifery managers are NIPE practitioners and in one Trust site in particular, midwifery staff were frustrated and concerned that their skills were not being maintained which for some staff caused undue stress. Most midwives were aware of colleagues who had been NIPE qualified for a while, but because they were not enabled to maintain their skill were now so anxious that they had chosen to refrain from conducting NIPES, which again is a loss to continuity for mother and baby and a financial loss to the Trust who paid for the midwife to undertake her NIPE training.

11.4.3 Re-assessment of midwives on qualification

To reiterate an earlier point of an unexpected aspect revealed during midwife participant interview, staff who had newly gained their NIPE practitioner status were expected to undergo further assessment in practice on qualification. It was unexpected due to the fact that this was not a requirement for any member of staff within the three Trust sites if they had undertaken a NIPE module that was validated and recognised by the NMC. There appeared to be no rationale for this activity, as after-all, a newly qualified midwife's knowledge and skill is not reassessed on registration within the Trust site she has gained employment. Neither was the activity confined to bringing the new member of staff up to date on local policy which would be an expected course of action. In some of the cases that midwifery staff recounted, the assessment was similar to the practical assessment undertaken at the end of an accredited NIPE module and for some colleagues they had to undertake a number of NIPES before they were allowed to conduct a solo NIPE. Interview participants were very vocal about this requirement and were indignant to hear that it should be occurring but were also pleased that no such initiative was going to occur at their own Trust site.

It is understandable and good practice to assess the knowledge, skill and understanding of the process of the NIPE in relation to practitioners who have completed an examination of the newborn course overseas. This is solely due to the fact that some international-based courses do not include for example, auscultation of the heart or examination of the hips. Therefore, some practitioners need to

learn and understand about cardiovascular assessment and become competent and confident in the skill before conducting solo NIPes. However, as stated earlier, the NIPE Handbook refers to 'assessment' in the section relating to maintenance of knowledge and skill, which may cause confusion in relation to newly qualified practitioners. It is possible that the Trust guidance may have misinterpreted this reference to assessment too literally, perhaps not recognising that the assessment should have been linked far more clearly to the context of reviewing knowledge and skill at a future parameter of time. Additionally, why the Trust has focused this guideline solely on qualified midwives within the Trust is perplexing and concerning as it may give conflicting messages to midwives about how the Trust really views their level of knowledge and competence.

Even though the midwives and students that I interviewed were not going to be reassessed with the Trust sites encompassed by my research, their reaction made it acutely obvious that such an activity was not positively received. It is possible that this could make them wonder why they had undertaken the module in the first place and secondly as stated by some of the midwives, why they and not doctors were being singled out in this manner. Unfortunately, such news did have an impact on the student midwives who were undertaking the NIPE module and many linked this incident to how they viewed their future registration and the worth placed on their professional role, which will be explored in the following section.

11.5 Impact on Student Experience – Transition to Registered Professional

An aspect that did become clear during the progression of the data collection, was that whatever has an impact on midwives will also change the practice experience for student midwives and may even have an ever-increasing negative or positive impact on the student as their course progresses. Students such as those in Carolan's study (2013) that explored student perception of a midwife's role, were found to have similar expectations to midwives about their professional role prior to commencing their midwifery programme of study. Indeed, Carolan's study (2013) explored the importance of professional socialisation where the student needs and expects to adapt and take on the persona of a practicing midwife albeit in an environment that has its own hierarchy and practice guidelines. Consequently, Carolan (2013) suggests that when expectations were not met students were more likely to feel disappointed by the experience or even discontinue their training altogether. However, professional socialisation has an impact on both student and qualified staff. The cost of student attrition from a professional course is considerable as is the cost to the NHS when a midwife chooses not to use the skills that she has attained after attending a course paid for by her employers or leaves the profession altogether. Therefore, in exploring the impact on the student and NIPE practitioners, it was with a view to finding possible strategies that could assist in reducing the influence

of negative factors in practice, on students during the completion of their NIPE module in their third year. The findings that arose, albeit linked to NIPE, were aspects that could also be applied to qualified staff and not just student midwives during this period of time in which they are making a transition to registered professional.

Whether exploring the experiences of students in relation to NIPE would have resulted in similar findings to exploring the experiences of third year students per se it is difficult to determine. Nevertheless, what is apparent is that the students viewed NIPE as an important part of their programme and they related their narrative to both registering as professional midwives and as NIPE practitioners – they saw little difference between the two. For these students, being a NIPE practitioner was an embedded part of their role and responsibility as a midwife. Likewise, student perception of their growing professional identity was often influenced by their experience of midwife – paediatrician interaction which clearly had an impact on their perception as to how they saw themselves as future autonomous midwives. Some students expressed that in their experience that, although there was an obvious hierarchy when working with junior doctors in obstetrics, it was often easier to discuss care with the FY2 because they felt they had the support of both the woman and the midwife, plus the FY2 had to report back to senior members of the obstetric team. However, in relation to NIPE, the perception was more acute, in that they mainly had to communicate with FY2s whose neonatal knowledge level was less than their own. Students often witnessed negative communication which they found upsetting on behalf of the midwife they were working with, the parent(s) of the baby and the baby who has as yet, no voice of its own. As Gunther (2011) and O'Mara et al. (2014) highlight, students can find it difficult to cope with such challenging situations which can make them question their career choice. Such experiences can make a major impact on attrition rates, not just on the student who is thinking about developing their own autonomous practice but it also aligns with a factor that manifests in midwives who discontinue to conduct NIPes or who choose to leave the profession as they are unable to work in a professionally autonomous manner (Curtis et al., 2006; Watson & Brown, 2021).

11.5.1 Supporting & enabling students & staff in practice

Education practices in midwifery work towards closing what Lange and Kennedy (2000) term as the 'theory-practice gap' (t-p gap) in-order to achieve the purpose of midwifery education which is to prepare students to enter the profession as competent, skilled practitioners. The t-p gap is generally used to denote where classroom education does not always match what the student sees in practice. Therefore, midwifery lecturers have to work hard to maintain strong links with practice in-order to be aware of changes to care practices or techniques so that these are discussed in classroom skills

sessions. Sometimes these links involve lecturers frequently being on-site and providing an obvious presence for both staff and students. In relation to NIPE, site visits are aimed at working with qualified and unqualified students in-order to conduct NIPES.

In the university where I worked during my data collection, in-order to support practice during a time when not all midwives were NIPE practitioners, the university NIPE lecturers needed to provide much needed support by conducting NIPES in practice. This activity not only assisted the students but also the midwives during a period of transition where the Trust sites were in the process of increasing NIPE midwife numbers. This supportive activity also encouraged positive and strong university – practice site relationships to develop where lecturers were not just seen as teachers, but also as knowledgeable and skilful practitioners in their-own-right. This activity strengthened the collaborative relationship to such an extent that it was recognised and commented on favourably by the NMC reviewers that attended for the programme re-approval event when the curriculum was updated and renewed in-line with latest research and market forces. It soon became clear that research participants of all statuses were greatly in favour of this provision and wanted the collaboration to continue. The midwifery teaching team had made a conscious and agreed decision to train more staff to conduct NIPES, plus time spent in practice by lecturers was not onerous as it was shared between the link team of lecturers for that particular Trust site. However, it is acknowledged that not all HEIs are able to commit to such an undertaking.

Carolan (2013) argues that although fulfilling the requirements of both the University and the NMC bridges the t-p gap in part, the main issue may be more about what is missing in terms of support and strategies to comprehensively prepare students for their new social world of registered practice. Carolan's (2013) perception of professional socialisation is underpinned by the work of Clouder (2003) and Arndt et al. (2009) on the process of how a student gradually forms a professional identity. Carolan (2013) suggests that the essential element as to whether the student achieves this identity rests on the student's ability to reconcile her expectations with her perception of the reality of professional midwifery – a point also echoed within Hunter's and Warren's (2014) study.

It is possible that an important consideration within any educational programme is not only to assist students who are already progressing through their training but instigate strategies that raise realistic images of professional midwifery practice and start to develop resilience from the very beginning of the student journey. In so doing, students may be more prepared to be pro-active in seeking opportunities to advance their skills in an increasingly busy environment. This is particularly important in those Trust sites in which not all midwives are qualified NIPE professionals and students may have

to work harder to access those members of staff who are. Therefore, a curriculum that works towards equipping and enabling students to take on autonomous practice in a professional manner with other related professionals, may be one factor in a complicated and multifaceted practice environment.

However, there are useful tools that can aid a deeper level of learning and understanding (Dunne et al., 2016; Bass et al., 2017 and Edwards, 2017) such as reflection in and on practice. It can also aid students – particularly if different year groups come together – to see how different strategies can be employed within the workplace in-order to share skills relating to advocacy and professional behaviour which can help when coming across challenging situations within the workplace. This was an aspect that student participants referred to as showing them strategies to communicate differently or act more pro-actively in the situations that they came across or when they were upset with how the FY2 spoke to the midwife that they were working with, for example:

“I had to do the SBAR for a baby with a heart murmur to the registrar ... I was really scared as he can be quite off-hand with us ... but I remembered something we had discussed in our group reflection session ... I did it and it worked, what I mean is, he was actually silent for a moment, examined the baby and just said, the student is right it is a transitional murmur.”

(STs T3)

The quote above epitomises how students were understanding the lessons learnt during mandatory reflection sessions which they could also utilise within their preceptorship period when they first practise as qualified midwives.

Preceptorship is when the newly qualified midwife is provided with extra support in all areas of midwifery. It is designed to improve confidence and develop their present quality of practice as they are emersed into their registrant status. For student midwives who qualify with the NIPE qualification, this can be a period where their technical skill and confidence can decrease unless they are given regular opportunities to engage in completion of NIPes. Therefore, discussions between the university and the Trust sites who ultimately control the content and format of their preceptorship programmes was important. Midwifery management on all three Trust sites embraced the opportunity to ensure that newly qualified midwives continued to conduct NIPes, not just during the preceptorship period but also when more experienced. As a result, midwifery participants in the study were very positive about the support that they had received from the PEFs, managers and more experienced NIPE midwives and felt confident in conducting NIPes. What was also interesting to note, was that it was also important to these midwives to know that they could still access NIPE lecturers on the ward areas, as they had been worried that they might not be able to engage with university lecturers anymore.

Newly qualified participants frequently used the words, *"I was worried I would be 'dropped' by the university"*. It appeared that maintaining a link with the university, even if they did not physically need it, influenced their level of confidence particularly when they saw a link lecturer in practice. Whether it is because lecturers have been such a strong mainstay during their journey to become a midwife, that it is needed for a little longer while they find their feet in the next chapter of their career progression is unknown and deserves exploring. All universities incorporate sessions during a student's final year that aim to support their development as they approach qualified status and the reality of what this means to them. However, perhaps what has been missed here is that link lecturer input may be more important for new midwives than has previously been recognised within practice or midwifery education.

11.6 Summary

This chapter has reviewed the key issues relating to how midwives view the influences on their professional activity, the impact in practice of the PEF and link lecturer role, NIPE training and assessment and the issues that may influence a midwifery student's growing professional identity and transition towards registrant status and autonomous professional practice. Collectively, chapters 8 – 11 constitute the discussion relating to the key issues that affect practitioners and students in practice due the impact they have on their professional role and identity.

In the next chapter the author reflects on her journey, highlights the limitations and strengths of the of the research findings and puts forward some key recommendations that should be considered within the practice environment, national guidance and training and within the programmes of education in relation to student midwives.

Chapter 12 Research Limitations, Strengths & Recommendations

As a final reflection on the research process, I knew I was taking on a challenge by interviewing so many participants across a range of sample groups. I explored various research designs that would enable me to achieve the depth and breadth of data that would assist me in gaining a richer, more detailed understanding of the influence of the working environment on NIPE midwives and students. Eventually I used a research design, whereby I transcribed each and every participant interview, which was as exhausting as it was illuminating. Following Thorne's (2016) guidance to return to the findings as more data was collected, enabled me to identify the main themes that emerged. Links between the themes that started as being barely tangible on first scrutiny, were gradually unveiled as the data from other participant groups added a different dimension by revealing how different disciplines viewed similar aspects. This gradually enabled a more detailed understanding of the impact on the participants' perception of their practice/cultural environment to become exposed, albeit one that was multifaceted and linked with interwoven factors as highlighted in the preceding chapter.

The aim of this study was to gain a greater insight into the influence of the working environment on midwifery practitioners and students within clinical practice in relation to the Newborn and Infant Physical Examination (NIPE). Although this research provides a much more detailed picture of the issues impacting on NIPE practitioners and students, I am aware that it has also presented the need for further exploration particularly in the areas where this research was limited in its design. However, no other research has been conducted that allows for cross-comparison of the data arising from the various roles within two professional disciplines, thus giving a more detailed insight into practitioners' experiences across three large NHS Trust maternity units. Whilst the data has enabled the gaining of a better understanding of the influence of the workplace environment on practitioners, it has also highlighted aspects in relation to the student perspective, both regarding NIPE and the impact on their developing professional identity.

12.1 Limitations

I did consider at the beginning of the data collection that excluding junior doctors and non-NIPE midwives as participants would limit the impact of the findings. The former would have filled in the gaps in relation to their views regarding training and support needs during the time they are within the maternity and neonatal areas. In particular, it would have been valuable to gain a better appreciation of how their knowledge of the midwife's role and quality of their interaction/communication may link with the feedback loop, discussed earlier in chapter 10. Also, it would be good to investigate if those junior doctors who accessed midwives to learn more about the process and skill involved in the examination, felt more supported due to the one-to-one learning that they

experienced, similar to those participants in McKinnon's work (2017). However, due to staffing levels of junior doctors, it was considered that taking staff out of practice for an interview would cause unnecessary impact on service provision during the time of the data collection. Therefore, it must be borne in mind that the findings, discussion and final recommendations within this research, can only represent the perspective of midwifery staff, students and consultants, albeit the latter in small numbers.

Similarly, interviewing non-NIPE midwives may have clarified aspects such as how they felt about working with NIPE qualified midwives, how they saw the role working in practice and what would influence their decision to complete the NIPE module themselves. It would also have been interesting to gain some understanding of how they experienced the quality of their relationship with paediatric staff and if this differed from the views of all other non-medical NIPE practitioners. Similarly, it may have been useful to gain a more informed appreciation of their relationship with the student midwives who were undertaking their NIPE module. Particularly, as student neonatal knowledge will rise as their NIPE module progresses enabling them to recognise signs of neonatal anomalies more quickly perhaps than the non-NIPE midwife with whom they be working at the time.

I recognise that inclusion of the two groups above may have provided even richer and more detailed data, perhaps revealing the possibility of other concepts and factors that affect NIPE practitioners within the practice environment. Therefore, future research, including these two specific professional groups may prove beneficial in the future, in relation to how two professions can teach and learn together and if in so doing, the impact of the aforementioned feedback loop may be lessened. Plus, such research may also give further insight into the level of support a student may require in practice.

12.2 Strengths

One factor that may be perceived to limit the impact of this research, is that the findings may not be generalisable across England or the United Kingdom. However, I would argue that due to the wide diversity of sample groups and the research covering three large Trust sites, these findings give a good indication of the experiences of NIPE practitioners that could be utilised in other geographical regions of the country. The strength of this research lies in the fact that the three NHS Trusts from which the participants were recruited, were not affiliated to each other (not part of the same NHS Trust), were of similar status in terms of number of births per year, staffing numbers across the professional groups and the service users in all the Trust sites were varied in terms of diversity. Also, returning transcripts to participants for agreement of the transcription and the ability to cross-reference themes across a variety of sample groups involving both qualified and student status all added to the validity of the

data. Plus, another important factor lay in an aspect that I was most concerned about when designing the research - my own involvement as the researcher. Therefore, reflexivity was constantly employed to question my stance and decision making as a researcher, which was particularly important as I was known across all three Trust sites as a midwifery lecturer involved in the NIPE module and was an active NIPE practitioner within my lecturing role. This fact made me even more particular in maintaining objectivity and taking care with the words used when a participant made a specific point on which I needed further information in-order to clearly understand their meaning. However, the reality of the situation was surprising, in that it appeared to encourage staff to volunteer to participate and be open and detailed in their answers. Whether this was due to the fact that as they trusted me in my role as lecturer, they now did so as researcher, or because the timing of the data collection was one where staff were ready to share their perceptions and wanted them to be heard, I cannot tell. However, participants vocalised that they appreciated the chance to take part in this research and were positive about being given their transcripts for critique and validation of their words in terms of meaning, emphasis and emotion. Although, I deemed it important to return scripts for participant validation of the transcription of their words, this and the opportunity to participate was voiced by many of the participants as demonstrating that their input was really valued and above all, respected.

12.3 Recommendations

In relation to some of the following recommendations, actions can and should be instigated in a timely manner. The only barriers may be lack of managerial and/or executive level support or reluctance to appreciate how even small measures may make a positive impact in practice on the cultural environment and thereby staff wellbeing and interprofessional communication. Other recommendations relate to NIPE national screening committee guidance and junior doctor training in relation to neonatal care and screening. This latter point in particular arises from the midwives perspective and the literature relating to the impact of the workplace culture. However, there is a clear need to improve relationships between paediatricians and midwives whilst developing resilient midwives and those of the future. This is paramount if both students and midwives are to see themselves as a professional in their own right and a leader of change rather than a bystander.

12.4 Consistency of Examination Content & Process

The NIPE Programme Standards Handbook (2021) needs to reflect and emphasise the importance of the entire examination in-order to dissuade junior doctors from following a task centred examination approach. This would encourage doctors to discuss with parents the information they need to know about their developing child in terms of their abilities and health promotion aspects. At present, many junior doctors give limited information or none at all, expecting midwives to provide the information.

This can lead to inconsistency and possibly a parent not receiving the requisite information at all if the midwife is unaware that the information has not been provided at the time of the examination. It should be expected that whoever performs the NIPE, also needs to provide developmental and health promotion aspects if the parents are to receive a comprehensive and informative service. After-all, the Personal Child Health Record book updated the record within it relating to NIPE to include all aspects of the examination, including general examination aspects. This action was to ensure that information was passed onto the parents and that all professionals involved in the care of the baby were aware that the information had been given. This type of change needs to occur in all national documentation related to NIPE, as this will help prevent parents from being excluded from or their need for information being missed.

The NSC needs to provide a greater level of transparency in the NIPE Programme Standards Handbook (2021) in relation to the training and maintenance of skills for all NIPE practitioners. This would give a clear message regarding the teaching and learning of doctors as well as all other NIPE practitioners. NSC also needs to communicate with the NMC, so that there are clearer expectations for the content, assessment and duration within HEI NIPE modules and this also needs to be considered within junior doctor (FY2) training. However, this latter point needs to be taken on board by the medical schools and led by effective leadership within Trust sites.

In conjunction with the above, there has been increasing discussion at present about the lack of clarity in relation to the NIPE which can lead to confusion. This lack of clarity has heightened due to national inconsistencies across the United Kingdom in terms of who uses the term NIPE, differences in module content and how many babies need to be examined to achieve competency during training. At present most HEI's that offer NIPE within the direct entry curriculum require students to complete the module over a six-month period, which is reasonable in terms of current numbers of NIPE practitioners in practice and the time it takes to learn the accompanying theory and practice skills. However, this can be more problematic to achieve within current Return to Practice, midwifery courses as some only run over three months which then need to be extended a further three months to accommodate the required NIPE module as now required by the NMC. This results in students not being able to regain NMC midwifery registration until their NIPE learning and assessment is complete. This illogical situation needs to be addressed by the NMC and both Health Education England and employers depending on who is sponsoring the student at the time, otherwise they could choose not to continue to fund these students for the extra duration of time possibly leading to a loss of midwives returning into practice. Considering the present midwifery staffing shortages, these issues require collaborative working between the NMC, HEIs, NSC, HEE and NHS Trust sites if such situations are to be resolved

and training provision and staff entering practice have been enabled to do so in an appropriate manner that does not entail extra stress due to delayed NMC registration.

12.5 Impact of the NMC Standards in Relation to Perceived Competency

Presently, the NMC includes 'systematic examination of the newborn' within course standards relating to foundation midwifery training, return to practice midwifery courses and international midwifery courses. This has caused great discussion to occur within Trust environments, HEIs and for LMEs. The confusion for future employees (the student) and employers (NHS Trusts) arises due to the fact that usually the inclusion of the above term directly reflects the content of the NIPE. Therefore, as any HEI has to reflect the standards within its curriculum whatever route the student arrives e.g., as a newly qualified midwife or achieves re-registration as a midwife, it is difficult for Trusts to know if the student has actually completed a recognised NIPE course. This of course has implications for clinical practice if wrongly assumed that the new member of staff is also a NIPE practitioner. The situation creates an issue for HEIs, such as an HEI that does not provide NIPE within its direct entry midwifery courses must ensure that students are made aware that they must inform their new NHS Trust/employer that they are not NIPE practitioners in-order to prevent assumption and miscommunication of the facts. Inadvertent expectations of employers due this inappropriate wording could lead to risky actions being undertaken and this need to be addressed. Either the wording needs to be improved for clarity of meaning, or clear expectation given that HEI's must make it clear to the student's future employer that their course did not include NIPE within the curriculum.

12.6 Managerial Support & Pro-active Midwifery Leadership

Although there are paediatric meetings to which midwifery staff are invited, these tend to focus on specific cases or provide a showcase of junior doctor research. Therefore, provision of opportunities to debate issues in a non-hierarchical forum would be pro-active in providing a venue where all staff concerns can be voiced, listened to and valued, similar to that demonstrated within the newborn forums. Therefore, organising in-house newborn forums could not only provide a forum for staff to debate issues, recent research etc., but could also commence a shift in interdisciplinary relationships.

Both midwifery managers and paediatricians need to encourage NIPE practitioners, paediatricians, junior doctors and students to attend NIPE update sessions. This would enable staff to update NIPE knowledge and review of examination techniques together. Importantly it could also encourage the sharing of ideas and information whilst providing students with a sense of what interdisciplinary collaboration and communication should '*look like*'. However, it is recognised that this requires the facilitator of the session to have innovative and effective leadership skills if they are to foster an

environment that promotes and encourages collaborative working that is continued to be supported and encouraged in everyday practice.

Trust executive management needs to recognise that strong midwifery leadership requires nurturing and support that is clearly evident to all maternity unit staff. Inflexible policies affecting working practices need to be reviewed if parental satisfaction is to be improved and a blanket medical model of care is not to suffocate holistic, autonomous care practices in low-risk situations. Similarly, there is also a need for senior management to understand the PMA role and the role of the Professional Development Midwife so that the integration of their role in midwifery and student practice is not hindered by lack of commitment from the Trust.

Furthermore, senior management needs to show clear commitment of their support to staff via the two roles above. In so doing midwives may feel supported and thereby more motivated and encouraged to become part of the solution rather than acting as a bystander to the issues within the environment of practice that can cause increasing frustration, stress and disillusionment of their professional role. In turn students will develop a greater level of resilience and learn strategies that enable them to take on their professional identity with a clear perception of their value to parents, the baby and the paediatric team – an aspect further highlighted in point 12.10.

12.7 Neonatal Inclusion & Exclusion Criteria

The support of pro-active collaboration particularly in relation to reviewing guidelines and feasibility of the Trust referral processes is a necessity if the frustrations created related to following Trust guidelines are to be reduced. This may assist midwives to feel more valued and respected for their professional knowledge and skill. Similarly, the list of babies that midwives can examine needs to be reviewed as there is little justification for particular babies to be excluded from those a midwife can examine. However, this is a factor that should also be considered by the national screening committee and national agreement sought as this would help to uncover out-of-date practices based on old, unsound or at times, little contemporary evidence. Updating local and national guidance would reflect the knowledge, understanding and experience of those who have completed the NIPE module, thus reducing one of the factors that lead to a perception that midwives are not valued and respected for the training that they have undertaken. Encouraging Trusts to support leadership activities that work towards aiding positive collaboration relationships between paediatric and midwifery staff can also raise the level of mutual respect for their expertise within their differing roles. Just as importantly this would enable the needs of babies and their parents to be met in a timelier manner and not leave parents waiting. For example, for a junior doctor to complete an ultrasound referral for risk factors in

relation to neonatal hips, when a midwife has already recognised the need but is restricted in doing so due to a local Trust protocol or lack of agreement with related disciplines such as ultrasonography. Ensuring that practitioners are afforded the same rights in such circumstances and all disciplines agree on appropriate processes would support the recognition of expertise and knowledge gained.

12.8 Equipment Provision & Use of NIPE Clinics

It is evident that to complete a NIPE, appropriate equipment must be available and in working order. It is inexcusable that staff either need to provide their own equipment (unless they wish to do so) or have to waste time hunting for an ophthalmoscope. There also needs to be a move away from the use of ophthalmoscopes attached to trolleys which can create a safety hazard or restrict the easy use of the equipment. Any staff member who uses the equipment who are not solely based in that particular area such as junior doctors must be made aware that they should not walk off the ward with the equipment as this not only prevents other staff from access but also raises the infection risk from cross-contamination.

NIPE clinics do serve a purpose for those babies who need to return to the hospital either for completion of the NIPE, or because they need a follow-up review for a particular aspect of the examination. However, conducting the NIPE by the bedside where the parents can easily see the process, allows for a timely examination in relation to both the baby's and mother's needs. Plus, it enables completion of the neonatal daily examination record at the same time. This makes it more comfortable for the parents and instils the normality of the examination similar to when the mother's discharge post-natal examination is performed.

12.9 Training

The teaching and supervision of NIPE for junior doctors requires reviewing if the standard of the examination is to be consistent and the quality of information giving and examination findings is to be high, sensitively approached and timely action taken if required. There is evidence that the present disparity in skill-supervision demonstrates that junior doctors, new to the neonatal area, deserve and need supervision to improve if they are to be adequately equipped to recognise anomalies and appreciate the importance of each component part of the entire examination. At present, both midwives and consultants are aware that junior doctors see the NIPE as a 'task' to be performed and tend to concentrate on the heart, hips, eyes and testes, rather than acknowledging that the entire examination gives clues as to the health status of the baby and that they are therefore just as important when making decisions about care choices.

It is known that some junior doctors have sought time with midwives and ANNPs in-order to learn about the process and understand the skills required, particularly regarding the hip examination. Therefore, a change needs to occur in relation to their teaching and learning and this also needs to be reflected within national guidance where very little information compared to that of midwives is highlighted on the training of doctors, which may be making an assumption at the level of training and supervision junior doctors receive. All Trust sites need greater collaboration to occur between NIPE practitioners and paediatricians in order to address this situation. The activity whereby junior doctors are taught by midwives or ANNPs would allow for supervision of both their practical and communication skills. Particularly in relation to the hip examination, poor technique needs to be corrected if the two manoeuvres used are to be performed correctly and safely, which cannot occur when supervision is lacking. Also, working with midwives and ANNPs may again work toward reducing the feedback loop effect as discussed in chapter 10 where negative behaviours are perpetuated within practice without intervention breaking the 'loop'. Such negative behaviours may appear to be insignificant but tempering these through effective leadership and practitioners themselves making others aware of the impact on staff may assist in raising the level of interdisciplinary respect for each other's professional role and responsibility and in so doing provide a positive feedback loop in its place.

12.10 NIPE Updating Sessions & Review

Updating sessions are not a luxury for any practitioner as they are a necessary part of reviewing knowledge and skill in the arena of a national screening process. Therefore, these sessions should be a mandatory requirement for all NIPE practitioners, no matter their status, in conjunction with completion of the NSC e-learning that is easily available to healthcare professionals.

Incorporating the opportunity to review skills particularly in relation to the hip examination would reduce the formation of poor techniques and enable support to be arranged for those newly returning to their NIPE role after time away. Enabling skill development in this manner with further support in practice if required allows learning and time for staff to practice within a safe environment and lead to raise the quality of their NIPE skills. Such activity would also partly reflect the NIPE handbook requirement for 'assessment'. However, I would argue that the word review is a better term for this activity, as there is a need to appreciate if the practitioner is able to access areas where NIPes are performed and if not, how this could be organised so the practitioners are empowered to maintain their confidence and competence.

12.11 Unnecessary Re-assessment of Newly Qualified NIPE Practitioners

No practitioner who has recently undertaken a recognised NIPE module should be required to undertake further assessment of their knowledge and skill before being permitted to conduct solo NIPes. There is no evidence for this course of action which only results in delaying the practitioner from completing NIPes to consolidate her learning and development and this activity only appears to apply to those practitioners in nursing and midwifery, further creating a disparity amongst medical and non-medical practitioners. The irony of this activity is that these latter practitioners have successfully passed a theoretical and practical summative assessment which has often been conducted by the very same practitioners who are re-assessing their skills. Post qualification should be a time to concentrate on supporting these newly qualified NIPE practitioners in their new role through peer support, in much the same manner as the preceptorship programme was instigated for newly qualified midwives. The only exceptions are for those staff whose knowledge and skill needs to be reviewed as they may need further information, support and/or teaching in relation to the following situations:

- Staff working at a new NHS Trust site in-order for the NIPE practitioner to become conversant of local policy and differences in referral patterns and processes
- NIPE practitioners who have been out of practice for some time (e.g., illness or maternity leave) will require support and updating on their return, including time to re-evaluate their skill competency
- Internationally qualified midwives - may have a NIPE qualification but on closer investigation certain aspects may not be included such as cardiac examination or hip assessment. Therefore, a review of the content of their course and skill competency should be reviewed prior to undertaking solo NIPes and similarly to the point above they will also need to become conversant with national and local policy

Some of the above practitioners will require an update session, need to complete the NIPE e-learning and/or physical support in conducting NIPes until they feel confident to complete solo NIPes. Supporting these practitioners is just as important as teaching and supporting any midwife or student in practice to complete the requirements of the NIPE module if all midwives are to achieve NIPE practitioner status and more easily provide support to their colleagues in times of need.

12.12 Positively Raising Student Experiences

It is evident that students experience the same negative behaviours in practice as qualified midwives. Indeed, their frustration and at times, anger, indicate how the cultural experience can impact on their growing professional image. HEIs need to review how students can be better prepared for future

professional practice if the rate of attrition and low morale within the profession is to be reduced. However, this is not a process for the HEI to deal with on their own. It is paramount that the HEI, Trust management, midwifery staff and doctors make a determined and mutually agreed plan to facilitate change within the practice environment. Only then can real change become consistently maintained and evident within everyday practice through better policy and referral, comprehensive communication, interdisciplinary respect for the differences in professional responsibilities and the raising of staff well-being and morale. All of these factors are important for effective, sensitive and comprehensive care that is not only of a high standard but enable staff to raise and be confident that their concerns are listened to in the event of the early stages of neonatal ill-health. In so doing, the learning environment for the student midwife becomes one that is innovative and pro-actively promotes inquisitiveness, the motivation to learn and the resilience that enables pride in one's own profession and stimulates autonomous practice.

One of the simplest measures that HEIs can take on board is the effective use of reflection on and in practice within current curricula, as it enables students to view situations from different perspectives and hear others' views on management or why the situation may have occurred, thus increasing their knowledge and understanding on a deeper level. The manner that reflection is utilised needs to be reviewed so that it not only assists student development as they gain a professional identity but also assists them in the future when as qualified practitioners, they complete a reflective component as required for revalidation as a midwife. Students need to see a greater level of transparency within the Trust, that issues of concern that have been raised have been actively listened to and discussion has occurred to pro-actively achieve a resolution.

Students had expressed that they had found the midwifery forums useful as this type of activity was seen as positive when staff whatever their status discussed issues in a respectful and open manner. Therefore, this type of activity combined with reflection, as mentioned above, would enable students to build a more positive view of how professionals should work together for the benefit of those for whom they are caring. However, HEI's also need to aid students to develop strategies that they can utilise in practice to assist the progression of their developing skill in acting as an autonomous professional. With this in mind, a firm thread within the midwifery curricula that utilises conflict resolution strategies, could be a way forward to enabling students to build their resilience and fully appreciate and practice their role as advocate for both parents and babies.

12.13 Summary

The provision of good role models is paramount for both student midwives and junior doctors if the current environmental culture in clinical practice is to improve. In enabling them to learn behaviours and strategies which aid the development of resilience and support the utilization of their professional knowledge and skills is not a luxury but a necessity. The professions must be empowered to work together in an attitude of mutual respect, demonstrate professional behaviour and where all practitioners work together in the provision of high standards of care.

The recommendations proposed are indicative of those which have the most pressing need to be addressed if present frustrations and inconsistencies are to be reduced. Future research as discussed earlier, will enable further information to be obtained that enables the root causes of some of the negative issues discussed in this document to be viewed in finer detail so that they can eventually be resolved. For example:

- Investigating in greater depth the experiences of junior doctors across the UK in relation to NIPE teaching and supervision, would assist in appreciating their experiences and level of knowledge and skill and how this might impact on care practices
- Exploring the perceptions of non-NIPE midwives may shed light on their view of the NIPE qualification, supervising students who are undertaking the module and their rationale for choosing to undertake (or not) the NIPE module
- Reviewing the extent of any support that newly qualified NIPE practitioners receive and whether their perception of their role as NIPE practitioners is the same or different to their expectations as students

The Maternity Transformation Programme (NHS, 2017), the RCMs (2019a) Manifesto for Better Maternity Care and the document Each Baby Counts (RCOG, 2021), all work towards the redesigning of maternity services for the benefit of parents, their baby and the practitioners involved in their care. However, if senior midwifery managers are not supported in developing effective leadership abilities or are not enabled to represent the midwifery profession at Trust executive level, the frustrations and inconsistencies within the present practice environment may be slow to change. Reduced numbers of midwives within practice and present cultural behaviours may have caused an impact that midwives may neither have the incentive, or motivation to become actively involved in being part of the solution to cultural change, but may remain as bystanders who contribute to the issues in practice rather than becoming part of the solution. Such an outcome can only create situations where neonates may not receive timely care or where the standard of NIPE continues to demonstrate inconsistencies which may be detrimental to the health of the neonate, the emotional well-being of the parents and that of

the practitioners involved. Thus, the results of this research co-relate to the findings of reports such as Ockenden (2022) and pin-point areas where change needs to be actioned. Furthermore, the simple, feasible and practical measures described within these recommendations can have a positive impact on staff in terms of their emotional well-being, not just in that they can complete an examination that they have been trained to do but also that they may feel listened to and appropriate action has been taken in a timely manner for both the baby and its parents. In time, all staff may see a cultural change that enables more effective and compassionate collaboration and communication which will inspire midwifery students about their role in midwifery care when they graduate as registered midwives.

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Appendices
(1-11)

Appendix 1: University of Hertfordshire Ethical Approval – Confirmation



UNIVERSITY OF HERTFORDSHIRE
SOCIAL SCIENCES, ARTS AND HUMANITIES

ETHICS APPROVAL NOTIFICATION

TO Evelyn Dolby

CC Professor Joy Jarvis/Dr. Lynn Todd

FROM Dr Timothy H Parke, Social Sciences, Arts and Humanities ECDA Chairman
DATE 25/09/14

Protocol number: cEDU/PG/UH/00708

Title of study: Exploring the integration of the post-registration physical examination of the newborn module into pre-registration midwifery programmes.

Your application for ethical approval has been accepted and approved with the following conditions by the ECDA for your school.

Approval Conditions:

- The supervisor must see and approve the questionnaire and the interview schedule prior to recruitment and data collection.
- The supervisor must see and approve the permission received to conduct the interviews prior to recruitment and data collection.

This approval is valid:

From: 09/10/14
To: 27/02/16

Please note:

Your application has been conditionally approved. You must ensure that you comply with the conditions noted above as you undertake your research.

Failure to comply with the conditions will be considered a breach of protocol and may result in disciplinary action which could include academic penalties. Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.



Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

Appendix 2: NHS REC Approval



Do I need NHS REC approval?

You have answered 'No' to the following questions, which would indicate that you do not need NHS REC approval for the sites in England. However you may need other approvals.

[GLOSSARY](#)

Question Set 1

- Is your study a clinical trial of an investigational medicinal product?
- Is your study one or more of the following: A non-CE marked medical device, or a device which has been modified or is being used outside of its CE mark intended purpose, and the study is conducted by or with the support of the manufacturer or another commercial company (including university spin-out company) to provide data for CE marking purposes?
- Does your study involve exposure to any ionising radiation?
- Does your study involve the processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers, without consent?
- Is your study a clinical trial involving the participation of practising midwives?

Question Set 2

- Will your study involve research participants identified from, or because of their past or present use of services (adult and children's healthcare within the NHS and adult social care), for which the UK health departments are responsible (including services provided under contract with the private or voluntary sectors), including participants recruited through these services as healthy controls?
- Will your research involve collection of tissue or information from any users of these services (adult and children's healthcare within the NHS and adult social care)? This may include users who have died within the last 100 years.
- Will your research involve the use of previously collected tissue or information from which the research team could identify individual past or present users of these services (adult and children's healthcare within the NHS and adult social care), either directly from that tissue or information, or from its combination with other tissue or information or likely to be come into their possession?
- Will your research involve research participants identified because of their status as relatives or carers of past or present users of these services (adult and children's healthcare within the NHS and adult social care)?

Question Set 3

- Will your research involve the storage of relevant material from the living or deceased on premises in the UK, but not Scotland, without an appropriate licence from the Human Tissue Authority (HTA)? This includes storage of imported material.
- Will your research involve storage or use of relevant material from the living, collected on or after 1st September 2006, and the research is not within the terms of consent from the donors, and the research does not come under another NHS REC approval?
- Will your research involve the analysis of DNA from bodily material, collected on or after 1st September 2006, and this analysis is not within the terms of consent for research from the donor?

Question Set 4

- Will your research involve at any stage intrusive procedures with adults who lack capacity to consent for themselves, including participants retained in study following the loss of capacity?
- Is your research health-related and involving prisoners?
- Does your research involve xenotransplantation?
- Is your research a social care project funded by the Department of Health?

If your research extends beyond England find out if you need NHS REC approval by clicking the 'OTHER UK COUNTRIES' button opposite.

[OTHER UK COUNTRIES](#)

If, after visiting all relevant UK countries, this decision tree suggests that you do not require NHS REC approval click here.

[Print This Page](#) [Print This Page](#)

[Click here to start again](#)

This tool was developed by the Medical Research Council (MRC) Regulatory Support Centre on behalf of the Health Research Authority (HRA).

Appendix 3: Dean's Approval to Conduct Research Involving Midwifery Students



Received: 28 August 2015

To: Dolby, Lyn

Dear Lyn

Thank you for your request.

I am very happy to give permission to enable me to conduct focus groups and interviews with the students on our midwifery programmes. This is of course subject to you receiving the appropriate ethical approval for your study.

Good luck with the research.

Regards,

██████████

Professor ██████████,

Dean of School of Health and Social Work

T: ██████████
M: ██████████
E: ██████████

Appendix 4: Participant Information Form

UNIVERSITY OF HERTFORDSHIRE

**ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
(‘ETHICS COMMITTEE’)**

FORM EC6: PARTICIPANT INFORMATION SHEET

Title of Research

*‘The Influence of the Working Environment on Midwifery Staff and Students
in Relation to the Newborn and Infant Physical Examination (NIPE)’*

Introduction

You are being invited to take part in a research study. Before you decide whether to do so, it is important that you understand why the research that is being conducted and what your involvement will include. Please take the time to read the following information carefully and ask me if there is anything that is unclear or if you require any further information. Please take your time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of this study?

This study aims to explore the experiences of students and NIPE practitioners within clinical practice in relation to the Examination of the Newborn. It seeks to investigate individual experiences; inter-professional relationships and if/how differences between sites may arise and if they have a particular impact within the practice and academic settings

Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part I have enclosed a consent form which I would be grateful if you could complete and return to me by the date stated within the covering letter, indicating whether or not you agree to participate in the research. If you choose not to take part or to withdraw from the study at any time, you can do so without giving a reason. If you are a student at the University, your decision will not affect your progress on your module.

How long will my part in the study take?

Focus group sessions (student participants) should not last any longer than an hour and interviews will be of approximately 45 minutes duration.

What will happen to me if I take part?

Students

If you decide to take part in this study, you will be involved in a focus group discussion. You will be given a date, time and venue for the focus group session. It is possible that focus group participants will be given the opportunity, if they wish to participate in a one-to-one interview with the researcher. Mutually convenient dates, times and venues will be agreed with those students who agree to participate further in the study.

NIPE Practitioners (Midwives; Neonatologists; Past Students from previous academic year)

If you decide to take part in this study, you will be invited to attend an interview at a mutually convenient time, date and venue.

Midwifery Managers

Midwifery managers will be asked to attend for interview at a mutually convenient time, date and venue.

What are the possible disadvantages, risks or side effects of taking part?

There are no disadvantages, risks or side effects to taking part in this study.

What are the possible benefits of taking part?

As the integration of the 'Examination of the Newborn' module into pre-registration midwifery is a new initiative, it is hoped that the study findings will be used to improve the administration of the module and seek to ascertain if the strategies being employed are effective and/or useful. The study may also help to provide useful insights into how both the student midwife and the NHS Trust practitioner could be better supported in practice.

How will my taking part in this study be kept confidential?

All data will be stored on a password protected memory stick. A back up copy will be stored on a password protected PC. All information will be treated with the strictest confidence and your details will be known only to the researcher. Any information used in the dissemination of the results will in no way identify you.

What will happen to the results of the research study?

The findings will be utilized to improve the current training. Some information may be disseminated to the NHS Trust practice areas, but this will be generalized across all three NHS Trust sites within the remit of this research and no one individual or Trust site will be identifiable. If you wish to see the summary of the study findings these can be sent to you.

Who has reviewed this study?

University of Hertfordshire, Ethics Committee for Studies Involving the use of Human Participants

Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me, in writing, by phone or by email:

Lyn Dolby: University of Hertfordshire, Hatfield Campus, College Lane, Hatfield, AL10 9AB

L.Dolby@herts.ac.uk Tel: [REDACTED]

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University Secretary and Registrar.

Thank you very much for reading this information and considering taking part in this study.

Appendix 5 : Participant Consent Form

Participant Consent Form

Dear Participant,

As explained in the research meeting and Participant Information Sheet, please complete the following *Consent Form* for the study highlighted below and return to Lyn Dolby as directed at the end of this form.

I, the undersigned [*please give your name here, in BLOCK CAPITALS*]

.....
of [*please give contact details here, sufficient to enable the investigator to get in touch with you, such as an email address or telephone contact number*]

.....
hereby freely agree to take part in the study entitled:

*'The Influence of the Working Environment on Midwifery Staff and Students
in Relation to the Newborn and Infant Physical Examination (NIPE)'*

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits. I have been given details of my involvement in the study.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

4. I have been given the opportunity to ask questions of the researcher and have had a satisfactory answer to my queries.

Signature of participant.....Date.....

[Name in BLOCK CAPITALS].....

Signature of (principal) investigator.....Date.....

Name of (principal) investigator [*BLOCK CAPITALS*].....

Please return this form as a **hard copy** to the administration office who will keep it safe for my collection.

'Thank you for agreeing to participate in this study it is most appreciated'

Appendix 6: Timetable of Data Collection & Analysis

Phased programme of Data Collection and Analysis 2015 - 2020						
Participant group	2015	2016			2017	2018 - 2020
	Oct - Dec	Jan -	June	Oct.	April	Cross comparison analysis
Students Midwives	Recruit students for interviews	Commence interviews	Data analysis			
Midwives	Recruit first phase of interviews	Commence first phase of interviews	Recruit 2nd phase of interviews	Conduct 2 nd phase of interviews	Data analysis	
			First analysis			
Managers & PEFs	Recruit managers for interviews	Commence interviews			Data analysis	
Neonatologists			Recruit for interview	Conduct interviews	Data analysis	

Appendix 7: Foundation Questions Used for Focus Group & Semi-structured Interviews

- What are the expectation and perception of participants relating to how NIPE fits into the professional role of the midwife?
- How participants perceive their professional role links and integrates with other disciplines in relation to NIPE within everyday practice
- The type of 'activities' that participants see as assisting the development of good multi-disciplinary working and learning relationships in relation to NIPE
- What level of input or degree of involvement that both maternity/neonatal staff have in the development of evidence-based guidelines and protocols relating to neonatal health and care practices?
- What type of supportive practices are perceived by all levels of staff involved in NIPE as pro-actively reducing negative impacts on the multi-disciplinary relationship, or promote effective working relationships and/or are perceived as having a positive effect on levels of confidence and competence
- How useful is the NIPE Forum in encouraging collaboration in the sharing of information and providing an arena where discussion and debate can occur between students, NIPE practitioners, neonatal and University personnel.

Appendix 8: Sample Interview Transcript Demonstrating Initial Coding

(R = Researcher and P = Participant)

Coding: **bold** = higher voice or greater animation

Red highlight = passion

= laughter

R: Q1

P: I think that it was a good idea because being a NIPE practitioner myself for three or four years? em... I have always taught student midwives doing initial examinations --pretty much NIPE -- with the exception of the heart and the hips so for me I didn't think it was a massive step from what they were getting anyway. Err Initially I thought that having NIPE as part of your midwifery skills would increase continuity of care, which is what came out when I did my 'stuff' (participant had conducted on-site research as part of her Master's programme in relation to NIPE). It didn't quite work that way # within the Trust #

R: Why was that?

P: Because eh, we have so few midwives at the moment who 'do' NIPE so we are pulled through to the post-natal ward, so we are meeting 'mums' for the first time and doing the NIPE's so there is no continuity of care there. Em.. but obviously the vision is – when everybody (midwives) is trained (NIPE) it will become part of our discharge and continuity of care which I think is a **fantastic idea** and I want to **convince other staff** that it is a good idea – we can do what we are trained for.

R: Do other staff need convincing?

P: Initially there was a **lot** of resistance, a lot of resistance – the classics (midwives in conversation) were “they (the University) get rid of high-risk midwifery module, the paed's can do that (the NIPE examination) they (the student midwives) need to know about high-risk midwifery” so yes there was a lot of resistance.

R: Do they understand why (removing high risk midwifery from the curriculum) that occurred?

P: No! They think it is the fault of the University and not the NMC (Nursing & Midwifery Council), that the University has taken away high-risk midwifery. I think they are only just starting to realise.

The other reason that I think that it is absolutely brilliant to do the course is that the er.. students are **so much more** aware of the newborn now which I can see because I have mentored them (the student midwives) now since they have started it (the NIPE module within the pre-reg curriculum) and the comments I get a lot even when we are doing the initial or daily examination, not necessarily the newborn examination is “your so much more thorough than when someone else is doing them” – generally that 'someone' is not a NIPE practitioner! So that for me is a bonus.

R: Q2

Well, yes, the ideal goal is that it becomes part of the normal midwifery discharge. So em! The midwife is looking after mum and baby – it doesn't take long. Well when I am doing the baby (NIPE) it doesn't take me that long although some (midwives) might say that they are not given enough time to do the NIPE! I know I am going against that but it doesn't take me that much longer to fit a NIPE into a discharge examination when you discharge the baby as fit to go home. When you become quite efficient at it, it (the NIPE) does not take you that much longer...I don't quite see why it would take longer than 20 minutes for a straightforward baby. Some students say that midwives say it takes an hour – I tell them that maybe when they first start it will take them longer but we (the midwives) are not going to throw them into clinics (this Trust holds NIPE clinics) where as a Trust we had that whole appointment system where you had half an hour – that was not just to do the examination (NIPE) but to do everything, review the notes, perform the examination and write your notes up and then you start the next one (next NIPE). So I tell them (the students) that it eventually won't take them that long. Having been through that 'clinic' system I know you become so efficient that it will not take that long with practice. They (the students) do have the luxury of time to become gradually proficient and speed up which is a natural progression when you are learning.

I'm sorry I have probably gone off at a tangent and I have forgotten the question #####

R: ## No please don't be sorry it is all valuable information for me ##

P: Oh, I remember So... I do see it all as **a natural progression of individualised postnatal care that provides continuity which is as it should be**. The research points to continuity of care and the same person giving that care as being important. **It shouldn't be as it sometimes is at present a task to be completed...** the **benefit of integrating it within the midwife's normal practice is evident in her satisfaction and leads to a higher level of maternal satisfaction**.

R: Q3

P: Em.. I think for me when I am assessing students, the skill – as I said – is not much more than when you are doing a normal initial/daily examination, so I have no problem with the skill. I think for me, even more than knowing all the ins and outs of conditions I er.. I need the student to know every single pathway (care and referral pathways) so again with the student I saw yesterday who was listening to the heart... I told her 'you know what? I don't need you to tell me all the different conditions – I know you need to know them to pass your course, but if you hear something I don't need you to tell me what that is, all you need to tell me is what you are going to do about it. So I think that as long as they get that and don't have this overwhelming feeling that they have to prove to me that they know what it is that is all that matters.

I know some of the third years (student midwives) who are near the end and maybe haven't quite got it together yet and I show them it [the NIPE] all the way through, they don't find it as daunting. I even make sure that they take the action required in the event of a referral – it's important for them to do this otherwise what are they going to do when qualified. They make up the baby notes; put together the letter for the GP ... **they need to know the whole process**. Again, **for me, this is important** ... when one of the clerks used to do all this type of paperwork and then left, everything was in a bit of a mess as no one knew what to do. it

was a bit of a blaze of fire, but now I know all the pathways because I have now had to see it all the way through, I think it is important and gives confidence to the student if they know ... they will not be in such a panic if they find something and don't know what to do next. So knowing the process is more important and I am not so bothered if they don't necessarily know what is causing it (the problem) as long as they know what is **not normal** and know what action to take – **that** is what is important.

Students' have to realise that we do not diagnose, we refer. If a baby is jaundiced and symptomatic it needs a proper blood test – not a flash test (use of bilirubinometer) – and correct referral is required.

Every student I have worked with is doing **really well**, their foundation knowledge is **much higher** when they start doing NIPE – much higher than students before NIPE was part of their course. **It makes them much better at basic neonatal care.**

R: Q 4

P: Personally I have no problem with either my managers or the paediatricians and I have no problem with working with anyone. Actually....since we have been going to the ward – and the SHO's (paediatric) have been down there at the same time **it has got better** for everyone. I think because **of the way it is run**, we do all the babies on the ward and they [the SHO's] do all the babies in the nursery – the ones that are coming back in (after going home) – that it is quite nice that sometimes they [SHO's] come to find you to ask **your opinion** of something or to come and **check something for them**. At first you think 'but you're the paediatric SHO' but **we know our stuff and they are still learning**.. often they have only been shown one examination and then have to go off and do it themselves. So I get along well with the SHO's but it is because we have been **forced** into working together... that wasn't there before and as we are **visibly teaching the student's we are more obvious to them and I think ...** our knowledge is more obvious?

It also used to be that **you are the midwife so you do the normal** and the **paeds do the abnormal**, but all that is scrapped now since our new neonatologist decided that there should not be a divide – he is clear that it is a screening test and any midwife can do any baby – if **you** find something - **you refer**. I think that (the change to NIPE inclusion and exclusions) this has **changed the perception that you (Midwife) are less important so you do the normal babies and you (SHO) are more important** so you do the abnormal babies. **I think this has made a massive difference** and I **talk to the registrar's (paediatric) a lot as well and they quite literally... quite often will be like "can the SHO come and do this or that with you" .. it aids their learning and so I think it has made a massive impact.**

When I refer for a problem I refer directly to the registrar [paediatrician] which is how it should be. I have worked with babies and know a lot more about them than the SHO who is just completing his turn in neonatal care. The registrars now recognise that if I find an issue that I am referring to them for, what is the point of sending the SHO to check it when they will need to refer to their senior anyway – it is not good for the baby as it delays action being taken and it is not good for the parents. The only problem with this is the SHO does have to learn as well

Appendix 9: Diagrammatic Representation of Trust Site Data Collection Process & Participant Sample Groups

Diagrammatic Representation of Trust Site Data Collection Process



Participant Sample Groups

Participant sample group	Total Number of
Student midwives	36
Midwives	26
Midwifery managers	6
PEFs	3
Consultant neonatologists	6

Appendix 10: Coding Used in Text to Denote Participant Group & Trust Site

Participant Group	Code used in text to denote participant
Student	ST
Midwife	M
Midwifery Manager	MM
Practice Education Facilitator or equivalent role	PEF
Neonatologist	CP

Trust Site	Code used in text to denote Trust site
1	T1
2	T2
3	T3

Appendix 11: Glossary of Terms & Acronyms

ANNP (Advanced Neonatal Nurse Practitioner)

A neonatal special care nurse. ANNPs usually completed the NIPE module in-order to conduct NIPES

Director of Midwifery (DoM)

A senior midwife appointed within a leadership role who manages the strategic and operational delivery of maternity care within a Trust setting. They are advocates for both women and are the expert voice of the profession, whilst accountable for the managing the strategic planning of the maternity services, provision of midwifery care and professional leadership

Discipline, Specialism

The area in which the individual has studied and qualified to enter into a professional registration.

General Medical Council (GMC)

The professional regulatory body of the medical profession

Guideline

A guideline in clinical practice, reflect best practice as based on the available, contemporary local and National evidence. They are used for both emergency situations and to provide a level of consistency in general care practices.

Health Education Institution (HEI)

An institution of learning where individuals can learn about and train for their chosen profession in healthcare, for example, midwifery, nursing, physiotherapy etc. Learning is provided at academic level 6 and/or 7 and is provided within both a university and a practice site setting.

Head of Midwifery (HoM)

A registered senior midwife appointed to focus on the operational delivery of maternity care within a Trust setting. They usually report to the to a director of nursing/health board as they do not have direct access to strategic Trust executive board decision-making

Health Education England – eLearning for health (HEE elfh)

This site provides e-learning modules across a broad span of health care issues. It is also the site where practitioners can access e-learning in relation to NIPE

Multi-disciplinary and Interprofessional/Interdisciplinary Team

Multi-disciplinary team (MDT) is the term applied to a team that is usually led by the highest-ranking team member – usually the physician. In midwifery, use of the term MDT is usually used in potential or actual emergency circumstances and will be found in much of the literature relating to such events.

Interprofessional/Interdisciplinary teams are where different professional disciplines come together to agree goals or plan care in non-emergency situations. Recently, the literature in relation to healthcare has been using these two terms far more in-order to encourage the promotion of a greater level of respect and collaboration between professional disciplines with the aim of improving levels of communication and the care given in-order to improve health outcomes and patient satisfaction.

Midwifery Led Birthing Unit

This is an area either external to, or within the maternity unit which is staffed by midwives. Women who book to birth in these units are usually considered to be a low risk for complications.

National Health Service (NHS)

The Government-funded medical and health care service within the United Kingdom

National Screening Committee (NSC)

The NSC is part of the Department of Health & Social Care. It engages with population screening across all age groups and initiates and develops present and new screening programmes

NIPE (Newborn & Infant Physical Examination)

A complete 'head to toe' physical examination of the newborn baby, often referred to as the NIPE.

NIPE / Examination of the Newborn / Newborn or Neonatal Examination

The terms 'examination of the newborn', NIPE and 'newborn or neonatal examination' are used across various practice sites by staff (for the NIPE), geographical locations and literature publication dates. Therefore, for the purpose of this thesis these terms are interchangeable.

The NIPE does not relate to the 'initial examination' of the newborn that is conducted soon after birth, or the 'daily examination' of the newborn that is conducted each day if seen by a midwife.

NIPE E-learning modules

These are a set of modules that enable NIPE practitioners to up-date their knowledge in all areas of the examination process and recording of the findings. It was originally designed in 2017 in-order to raise the knowledge and competence of junior doctors and is supplied on-line via NHS Health Education England

Neonate

A term given to the newborn baby until six weeks of life post-birth

Neonatologist

Usually, a consultant paediatrician who is a specialist in neonatal care. For ease of use within the text, the word consultant has also been used.

NIPE Practitioner

A qualified professional who is registered with an appropriate professional body (e.g. Nursing & Midwifery Council [NMC] or General Medical Council [GMC]) who has successfully undertaken training in Examination of the Newborn

Nursing and Midwifery Council (NMC)

The professional regulatory body for Nursing and Midwifery

Paediatrician

Paediatricians are doctors who manage medical conditions affecting infants, children and young people (up to the age of 18).

PCHR (Personal Child Health Record)

The PCHR is a national standard health and development record given to parents/carers at a child's birth. Sometimes it is referred to as the 'red book' due to its red cover. The information recorded, includes the examination and immunisation history, weight and information about child development and health promotion.

PHE (Public Health England) / National Institute for Health Protection / UK Health Security Agency
An executive agency of the Department of Health & Social Care that was set-up in April 2013 to protect and improve the nation's health and wellbeing and reduce health inequalities.
PHE was superseded on October 2021 by the National Institute for Health Protection and the UK Health Security Agency

Practice Education Facilitator (PEF)

A specific non-management role in Nursing or Midwifery in which the post holder is responsible for the educational development of a designated group of qualified NHS Trust staff. They are also involved in the facilitation of learning for pre-registration students within clinical practice.

Practice – Environment, Culture, Behaviour

The above terms are used interchangeably within this thesis depending on the term used by staff members. The onus relates to individual perception about how the different professionals co-exist with each other.

Protocol, Guideline

A protocol in clinical practice offers information that is adapted to local contexts and reflects the agreed-upon approach for a specific situation or health condition. A protocol is usually the term used for the agreed practice for emergency situations but sometimes the terms, protocol and guideline are used interchangeably.

Pre-Registration Midwifery Programme

A university programme of training that has been approved by the NMC. The programme may be offered at academic level 6 (degree) or level 7 (masters). Two programmes of training are available across the UK:

3-year Direct Entry programme - for those who have no nursing qualification

18-month programme for those who have gained an NMC qualification as Adult Nurses

Professional Midwifery Advocate (PMA)

The role of the PMA is to support midwives in their advocacy role, build personal and professional resilience and assist the midwife to develop professionally to enable the provision of high-quality care.

Professional Identity / Image

Both words are used interchangeably within this thesis as the meaning for staff appears to be similar and yet fluid throughout their career.

Resuscitaire

A highly technical piece of equipment that combines a platform on which a baby can be placed for ease of access with an overhead heater and all the components you need for clinical emergency and resuscitation, such as oxygen, drugs etc.

Senior Paediatrician

A senior paediatrician is defined as a paediatric registrar or consultant neonatologist.

They are the person to whom a NIPE practitioner should refer a baby when an anomaly is recognised. At times the senior paediatrician may also be a paediatrician with specialist skills, for example, a paediatric cardiologist.

Senior House Officer (SHO) / Junior Doctor / FY2

SHO, FY2 and junior doctor are terms that are interchangeable and are terms used in relation to the same grade of doctor within the maternity units. Within this research, participants mainly used the terms SHO or junior doctor.

A medical graduate who has completed 4-5 years in Medical School and Foundation Year 1 (FY1) and is now completing Foundation year 2 (FY2) of the medical training programme in the United Kingdom. This part of training requires that they complete 4 monthly rotations across different disciplines, including Accident and Emergency and a specialist area.

Post August 2005, doctors in Foundation year 2 were previously officially referred to as SHO's and this term is still prevalent in clinical practice today.

Transcutaneous bilirubinometer

A hand-held device that is sometimes used as a non-invasive method for measuring serum bilirubin levels in relation to neonatal jaundice