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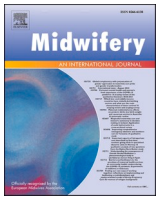

Novel solutions to the midwifery retention crisis in England: an organisational case study of midwives' intentions to leave the profession and the role of retention midwives

Claire Feeley, Tomasina Stacey *

Methodologies division, Florence Nightingale Faculty of Nursing, Midwifery & Palliative Care, Kings College London

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ABSTRACT

Problem/Background: : Midwifery retention is a global issue, but less is known regarding what motivates midwives' intention to stay or leave within individual organisations. In 2021, NHS England funded maternity organisations to employ retention midwives. To date, the impact of these roles has not been evaluated.
Aim: : To explore the views of midwives regarding their intentions to leave or stay within one English organisation and to provide insights into the perceived impact of the role of retention midwives.
Methods: : An instrumental case study was carried out in one organisation. Data a mixed methods survey (n=67/91) and interview data (n=7). Quantitative data was analysed using descriptive and inferential statistics; qualitative data using thematic analysis. All data was synthesised together.
Findings: : The three themes included '*Values-based tensions: The eroding role of the midwife'; 'Discerning differences: Intentions to leave or stay'; 'Retention midwives: Activities and impact'*.
Discussion: : We found that there was a clear link between midwives' intention to leave or stay and their workplace roles; specialist midwives were more likely to stay, report satisfaction, autonomy, and feel a sense of contribution or effectiveness in their role compared to those in other roles. The retention midwives were making a positive difference to midwives' experience of the workplace.
Conclusion: : Midwives working within the same organisation have different experiences of their role and job satisfaction. Future work should consider applying the positive elements of the specialist roles to the wider midwifery workforce to enhance retention. The retention midwife role shows promise, but further evaluation is required.

Statement of significance

Problem/Issue	Retention and attrition of midwives is a global issue
What is already known	Midwifery is a values-based profession, burnout and attrition is associated with a conflict between values and the reality of the work environment.
What this paper adds	Granular insights regarding the differences between midwives working within the same organisation but have different roles showing a strong relationship between a sense of autonomy and contribution to a job satisfaction and a wish to stay in the profession. The first to capture insights of a new 'retention midwife' role.

Introduction

Midwives play a pivotal role in ensuring the well-being of both mothers and infants with strong evidence indicating that midwifery-led care improves over 56 maternal and neonatal outcomes (Renfrew et al., 2014), with projections indicating midwives could save 4.3 million lives per year by 2035 (UNFPA, 2021). Therefore, upscaling the midwifery workforce to provide global universal maternal health care is an international priority (Renfrew and Malata, 2021; UNFPA, 2021). However, there remains a worldwide shortage of midwives, associated with both recruitment and the retention of qualified midwives within the workforce (UNFPA, 2021). While the burden is more significant in low-income countries, particularly in Africa, issues of retention are also problematic in high-income countries (UNFPA, 2021). For example, a

* Corresponding author at: Tomasina Stacey, King's College London, 57 Waterloo Road, London, SE1 8WA, 07580345393.
E-mail address: Tomasina.stacey@kcl.ac.uk (T. Stacey).

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recent survey of over 1500 members of the Royal College of Midwives in the United Kingdom (UK) found that 57% were considering leaving the profession, with over half wishing to do so within a year (RCM, 2022a). With an existing and persistent national shortage of 2500 midwives (RCM, 2022b), the UK is experiencing significant midwifery workforce challenges which needs urgently addressing.

While many studies have identified why midwives leave (or wish to) in the UK, a prevailing issue relates to the inability to practice 'authentic' midwifery or provide 'meaningful' care (Curtis et al., 2006; Hunter et al., 2018; RCM, 2016). Typically, this relates to the midwifery philosophy of relational woman or person-centred care where midwives take an individualised and partnership approach to caregiving (ICM et al., 2014) known to be a source of satisfaction, joy and even resilience (Bloxsome et al., 2019; Crowther et al., 2016; McAra-Couper et al., 2014). Moreover, midwifery is a 'values-based' profession which requires emotionally demanding work (Hunter, 2010). Although this 'emotion work' can be challenging, research suggests this is mitigated by a love of the job, passion for the role, and the reciprocal benefits relational care brings - all motivating factors to join and stay in the profession (Bloxsome et al., 2020; McAra-Couper et al., 2014). However, issues arise when there is an imbalance between the perception of what the role *should* be and the reality, risking moral compromise, distress and/or injury when midwives are unable to provide the care, they feel birthing women and people deserve (Doherty and O'Brien, 2022; Feeley et al., 2021). Moreover, considerable research demonstrates midwives are experiencing increasing levels stress, anxiety and burnout (Cull et al., 2020; Hunter et al., 2018; RCM, 2022b). Thus, suggesting an ongoing tension between midwives' values and expectations of the profession and the actual experience of the role itself.

These issues reflect a global problem which has seen attempts to understand and mitigate the attrition of midwives in many parts of the world. In England, numerous research, workforce reports and national policies have focused on this issue; with a novel innovation introduced in 2021 (NHSEI, 2022) where NHS England allocated a one-off lump sum of £50,000 to each maternity organisation to specifically employ 'retention midwives'. Their role was to gather and analyse local data and implement support packages to improve recruitment and retention (NHSEI, 2022). However, it is unclear whether these recent investment and policy efforts are having an effect, as no formal evaluations have been conducted. Additionally, to date, there has been little exploration of whether different workplace roles within the workforce make a difference to intentions to leave or stay. In this context, we report findings from an organisational case study, data that aimed to provide detailed insights into the attrition and retention of midwives within a single maternity service in the South of England - specifically where there were retention midwives in post. Our findings complement and expand the existing literature through examining these issues at a granular level within one organisation while providing novel insights regarding the role and impact of 'retention midwives'. We have reported this paper aligned with the MMARS (Hong et al., 2018) reporting guidelines.

Methods

Design

This research took an instrumental case study approach which seeks to investigate '*phenomena within its real-life context*' (Yin, 2009) and to generate in-depth and multi-faceted understandings of complex issues within a naturalistic context (Crowe et al., 2011); which in this study, related to the attrition and retention of midwives employed within the NHS that included both qualitative and quantitative data to explore the relationships between specific elements as well as more indepth insights into midwives experiences and perceptions. Documentary review of local policy and procedures, Care Quality Commission reports and staffing numbers was also carried out to contextualise the study. While these issues are not unique to this organisation, therefore, this is not an intrinsic case study (Crowe et al., 2011), their willingness to explore these issues means an 'instrumental' case study will facilitate '*a broader appreciation of [the] issue or phenomenon*' (Crowe et al., 2011). The case study 'unit' was one NHS maternity organisation who had employed retention midwives. The research questions were:

'What are the views of midwives, in one NHS organisation, who intend to remain or leave, and why?'

'For those intending to leave, does this relate to organisational specific issues or broader, profession related issues?'

'What work was carried out by the retention midwives, and how was this perceived?'

Setting

The maternity organisation was in South England, relatively small, with a birth rate of <2000 a year. The overall mode of birth was similar to the national average, the homebirth rate of over 3% was slightly higher than the national average of 2.5% in 2020 (ONS et al., 2020). The service encompasses both rural (higher proportion of middle class and wealthier communities) and urban areas (areas of high deprivation with high rates of safeguarding relative to its size of service). A report in 2022, capturing service user views, found all responses were similar or better than average compared to others, suggesting an overall satisfaction with care (CQC, 2022). The organisation had employed two retention lead midwives who had been in post 15-18 months at the time of data collection.

Sample and sampling

At the time of the study, the organisation employed 91 midwives and had 17 student midwives on placement – all of whom were eligible (however, we only included 3rd year student midwives to the interview component). Therefore, the maximum sample size available was 108 participants and we aimed for a 30% survey response rate. Recruitment consisted of purposive and snowball methods via the retention midwife leads, internal social media, internal work emails and workplace adverts. Interview participants self-selected from a trigger at the end of the survey.

Data collection

Data was collected during February 2023 and June 2023 and comprised of; a mixed methods survey (see Supplementary file 1) and in-depth interviews (see Supplementary File 2).

Survey development

The mixed-methods survey included 31 questions (closed and open) to capture basic demographics, perspectives on the role of a midwife, issues of importance, satisfaction, wellbeing, intentions to leave/stay and questions regarding the role and impact of the retention midwives Some of the questions were informed by a survey carried out by the retention midwives at the start of their tenure to determine whether change could be captured. The questions focused on what influenced respondents wish to leave and if there was a difference between those who wished to leave the Trust and those who wished to leave the professional altogether. The results of this initial survey suggested that there was a link between their perception of the role of the midwife, how they felt about their ability to fulfil this role and a wish to leave, this created a starting point for our survey. Additional questions used previous research on midwives' wellbeing, with questions used previously in the WHELM study (Hunter et al., 2018). Each element of the Kings Fund (King's Fund, 2020) ABC Framework were converted into direct questions: to determine to what extent respondents felt that they

experienced each element (autonomy, belonging, contribution). The Kings Fund Framework was developed to help define the core work needs of nurses and midwives in order for them ensure wellbeing and minimise workplace stress, (see Supplementary File 1 for the full survey).

Interviews

Interviews were carried out by CF. An interview schedule was designed to mirror the qualitative questions within the survey to allow for greater exploration and depth regarding; - the midwives' views on midwifery itself, how well they felt able to practice within their preferred approach, what they enjoyed/did not enjoy within their work, intentions to leave/stay and their views on the retention midwives work and role. Interviews last between 35 -90 minutes conducted via Teams which were recorded. Recordings were transcribed ad verbatim with an external transcription company and then anonymised by CF.

Data analysis

A combination of analytical approaches was used. The quantitative survey data was analysed using descriptive and inferential statistics (SPSS v28.0.1) by TS. As the interview questions were purposefully designed to mirror the qualitative survey questions, we adopted an abductive approach to qualitative analysis (Thompson, 2022). First, CF extracted the qualitative data under each key question (deductive approach) while then using a reflexive thematic approach to coding and theme development (inductive approach)(Braun and Clarke, 2021; Jankowski et al., 2017). This allowed a way to answer the research questions directly while offering the space to generate new insights from the data (Thompson, 2022). Thereafter, the whole triangulated dataset was integrated together. Through aligning the data within a framework that mirrored the order of the survey questions an initial report was generated for the funder. From this, the findings were further synthesised in relation to our core research questions aligned with a case study design as presented in this paper (Crowe et al., 2011).

Ethical statement

Ethical and governance approval was obtained from REC and the HRA (redacted for review). Informed consent for the survey was initiated within the electronic survey and should participants wish to opt out partway through, they could exit the survey and this data was not used. A separate consent form was sought for the in-depth interviews.

Findings

Participant characteristics

For the survey, 70 respondents logged onto the survey and there were 67 valid responses (63 qualified midwives and 4 student midwives, though not all participants completed every relevant question). The overall response rate was 62%, and for qualified midwives, it was 69%, significantly higher than anticipated. See Table 1 for survey participant characteristics. Overall, most of the participants were >35 years old, had >6 years' experience (although 6 participants did not answer), were Band 6 (grade), and had an undergraduate degree. The participants' workplace was spread across the service in relative proportion to typical staffing, although the highest number of participants worked in the community. There were nine specialist midwives within the sample, which are roles at Band 7 (middle management level) typically offering leadership within specialist clinical domains such as mental health or safeguarding. To preserve anonymity, we did not ask what their specific role was. Six bank only midwives participated - those on a 'bank' contract are akin to an organisations' internal agency wherein they have autonomy to choose shifts as/when needed.

For the interview, seven participants participated, all were qualified, employed midwives. To preserve their confidentiality, the following demographics were purposefully kept broad e.g., all were >35 years old; all had >8 years of service with some >20 years. There were two senior midwives and five working at Band 6; four midwives were based in the community, two in hospital settings and one midwife was bank only.

Three core themes were developed answering our research questions – 'Value based tensions: The eroding role of the midwife'; Discerning differences: Intentions to leave or stay'; and Retention midwives: Activities and impact'.

Value based tensions: The eroding role of the midwife

To situate and contextualise the overall findings, we explored participant views of midwifery, their role, and the extent they felt able to fulfil their role. 45/67 survey and all seven interview participants provided insights that revealed complex value-based tensions. Tensions occurred between their love of midwifery and working with women/families and a perception of their role eroding within the current context of maternity care reflecting conflicting and emotional accounts. Fundamentally, participants expressed their love, passion and pride for practising midwifery. Working alongside, advocating for, and looking after women *'at such a special point in their life'* was central to this – which when actualised had a positive reciprocal impact on them. Most reported *'being with-woman'* as central to their care and values – including providing individualised, evidence-based care and supporting women's independent decision-making. This was reiterated throughout and was aligned with the role of *'advocate'* – trusting, respecting and supporting women who make autonomous choices (including 'outside of guidelines') and avoiding coercion to make the *'right'* choices. These strongly held values were felt to serve positive care journeys throughout the whole childbearing continuum to facilitate *'as smooth as possible transition to parenthood'*. Underpinning the midwives' values, they wanted to, and felt they could *'make a difference'* in women and birthing people's lives, observing that the wide reach of their role meant they had many opportunities to accomplish this:

> *'You can really help them out in different ways, whether it be that you help them with breastfeeding, something they've always wanted to do. Or you meet some folks, don't you? And they are in really difficult situations, whether it be domestic violence or safeguarding issues or drug and addiction…There's things you can do to make a big difference to people, to help them as they go through that journey in life.'* RT_Int_02

However, in contrast to these positive responses about their role and values, many midwives reported that the current maternity context did not support the job they loved, feeling that the role of the midwife has been eroded. This was reflected in the survey responses, when asked two questions related to the extent and the frequency of being able to practice midwifery as they saw it, 51 participants responded and the mean score was 5.6 (0 being not at all and 10 being always/fully). While the responses ranged from 0-10 for both, demonstrating mixed responses, only 6 participants (12%) felt that they could practice midwifery as they understood it 'to a large extent' (scoring between 8-10). In part, this related to concerns of midwifery shifting to obstetric nursing, which was raised several times throughout the survey and interviews, with some participants feeling that a wholesale cultural shift seems to have occurred. Moreover, increasing bureaucracy, documentation demands, computer work and excessive guidelines combined with short staffing, busy workloads and the increasing 'risk' profile of women were reported as contributing factors to the negative changes in their role as midwives. Midwives reported significant frustrations regarding bureaucratic demands as taking time away from *'patient care'*, its impact of cultivating a *'defensive'* and *'tick box'* practice; and crucially, that such demands have shifted the skills required of a midwife away from core midwifery toward administrative skills:

'Midwifery practice has become defensive. We have lost the instinct and art of midwifery, and we do lots of testing and ticking boxes in order to improve outcomes which is not always the case. …Key elements of the role [now are] *excellent computer skills, excellent record keeping* [rather] *than excellent listening skills passion for pregnancy birth and beyond, people and communication skills.'* RT_Survey_26

These issues were reported as reflecting broader national issues, where participants perceived an overall declining NHS that had a detrimental impact on the care midwives could provide. Thus, creating tensions between knowing how to provide optimal care but feeling unable to do so. For some, disillusionment had set in as the *'joy as a midwife is lost'* reducing the role to one that is just *'a job that pays the bills, the romance of being there at the beginning of life is long gone.'* Collectively, these values-based tensions were seen as perpetuating a vicious cycle, less time to care, more complaints, more stressful working conditions resulted in reduced work satisfaction and increased sickness rates with five participants reporting moral injury:

'I was feeling so heartbroken by what I was experiencing and seeing in midwifery that I started to look at other career *options… And because I was feeling so heartbroken, I found out about moral injury … I found myself saying I don't believe in what I do. I don't believe in my job….I felt like I was a purveyor of poison. I felt like what I was doing was harmful…'* RT_INT_03

Discerning differences: Intentions to leave or stay

Within the broader context of the first theme, a granular exploration of those intending to leave or stay and why, identified similar issues to previous research but with some novel insights that highlighted the importance of the midwives' area of work, sense of autonomy, belonging and contribution. Of the participants who stated their intentions (n=52), 27 (52%) were considering leaving their job with 11 definitely intending to leave (including one student). Two were thinking of leaving the organisation itself, but staying in midwifery, and three were considering leaving due to retirement. Crucially, there was a significant relationship between area of work and intention to leave, with 85% of hospital ward/clinic midwives indicating some intention to leave, followed by 50% community team midwives but no specialist midwives identifying an intention to leave, see Fig. 1.

For those who identified either a certain or possible intention to leave, the most significant factors influencing their decision were work related stressors and mental/emotional health, and when explored in further detail, the top two factors that were influencing the wish to leave related to a sense of feeling burn out and over medicalisation of birth. A general disillusionment with their role, not feeling valued, administration overload and poor staffing were the next most common reasons. Furthermore, when exploring responses to the King's Fund ABC framework (King's Fund, 2020) we found the participants (n=50) generally did not have a strong sense of autonomy or sense of contribution (with an average score of between 6.14 and 6.2 out of 10 for these 4 questions that related to these elements). Fig. 2.

When the specific elements were examined further, it was found that midwives who had an intention to leave scored significantly lower ($p<0.05$) on all aspects except for the element that captured a sense of feeling 'connected to others around you at work', compared to those that did not wish to leave (see Fig. 3).

For all questions, the specialist midwives and bank midwives scored the highest, suggesting that they may experience greater autonomy and engagement, which is consistent with the fact that no specialist midwives indicated an intention to leave. Conversely, hospital-based midwives scored lowest on almost every measure, again consistent that they represented the group with the highest proportion who identified an intention to leave (Fig. 4).

When asked what would be the most important to factor that would influence them to stay, 46 responded, and the most common response was to be able to do a job that they enjoyed, followed closely by a positive working culture, these were more important than pay and promotional opportunities. For those that could be encouraged to stay, they stated improved (and flexible) shift patterns, better pay, paid overtime, more staff, better skill mix, career development and better streamlined systems (including IT systems) would encourage retention. This sat alongside comments around being heard, feeling valued and the

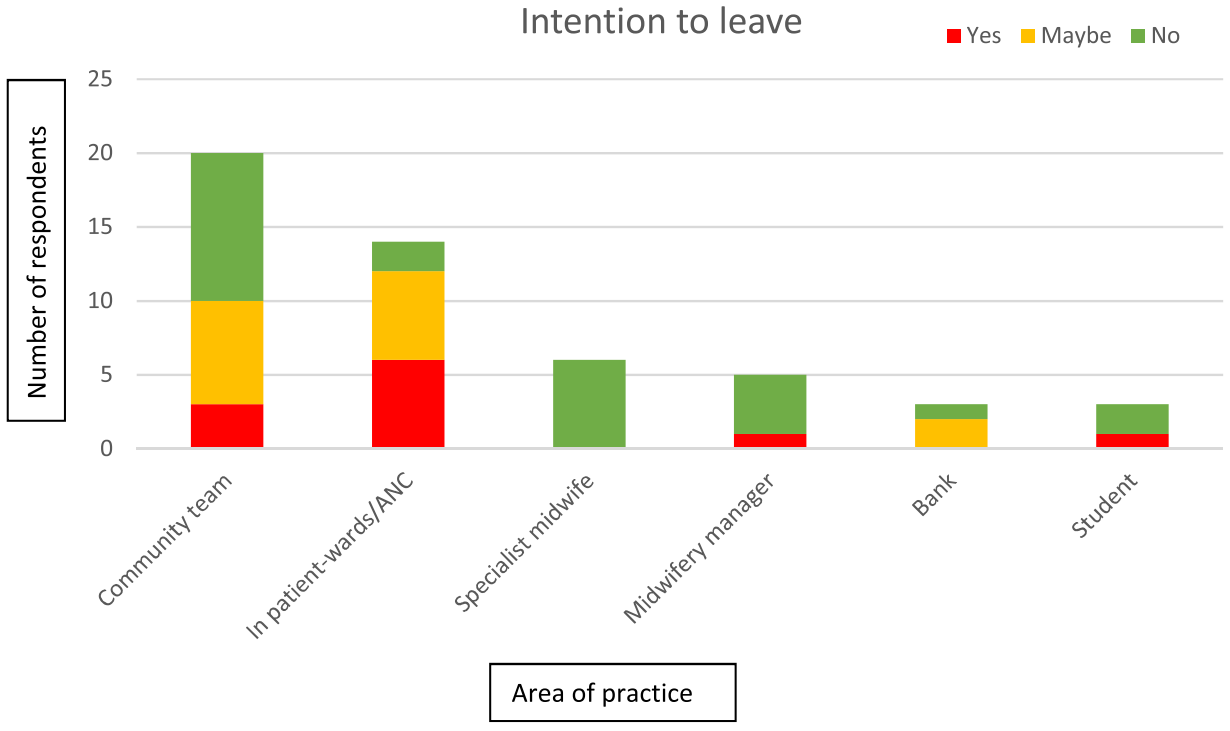

Fig. 1. Intention to leave by place of work.

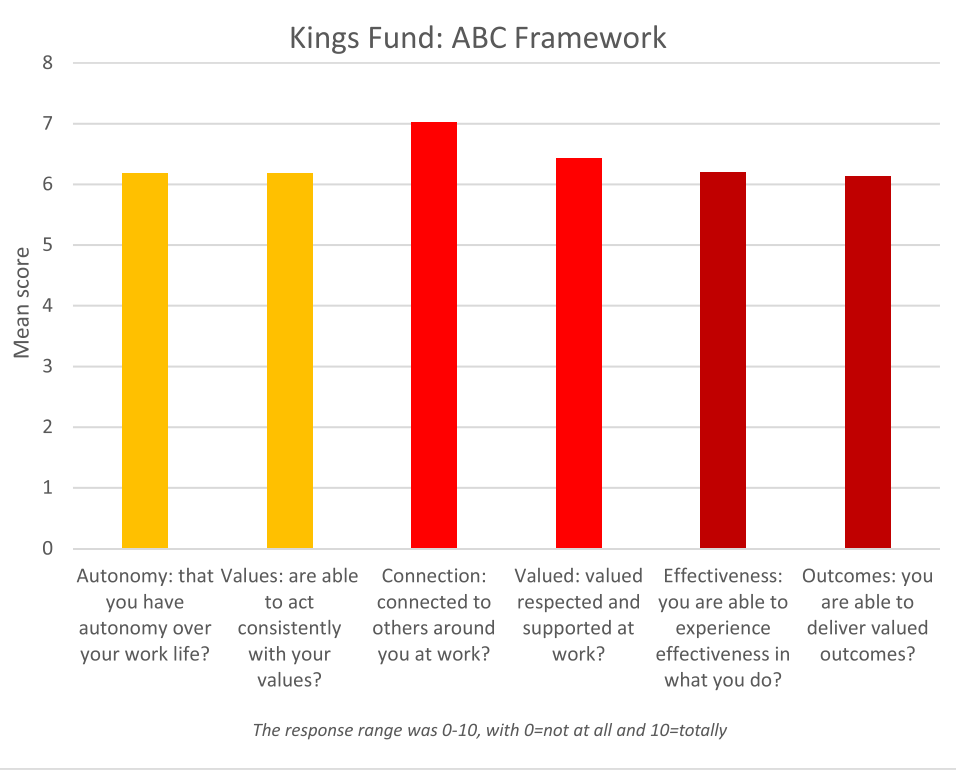

Fig. 2. Response to ABC Framework.

	KF Score <=3		KF Score 4-7		KF Score >=8		
	Intention to leave (yes or maybe)	No intention to leave	Intention to leave (yes or maybe)	No intention to leave	Intention to leave (yes or maybe)	No intention to leave	Pearson chi sq
A: Autonomy	6	0	16	12	3	11	χ^2= 29.9 p=0.018
A: Values	3	1	21	12	2	11	χ^2= 29.6 p=0.042
B: Connected	3	0	12	9	11	15	χ^2= 20.9 p=0.184
B: Valued	10	1	8	9	7	14	χ^2= 36.8 p=0.006
C: Effectiveness	5	0	20	13	1	11	χ^2= 36.6 p=0.006
C: Outcomes	5	1	19	13	2	10	χ^2= 30.6 p=0.032

Fig. 3. ABC Framework by intention to leave . This represents the number of participants who provided scores for each element of the ABC Framework grouped by whether or not they intended to leave.

stress of the *'shop floor'* being acknowledged by management. Additionally, experienced midwives wanted to feel more valued with greater attention given to their changing needs (e.g., for older midwives with different life circumstances). Other participants shared that they wanted to see a cultural shift towards *'a commitment to a kindness approach amongst colleagues'* and to shift away from a *'blame culture'*. Additional comments related to wanting respect for their professional autonomy, to be supported when supporting women's decision-making and for those in the community, respect for their role *'and not being constantly required to be on delivery suite when community is on its knees'*.

For some participants they grappled with broader issues related to the changing (eroding) role of the midwife discussed earlier but would be encouraged to stay if the organisation attempted to mitigate some of these broader issues; including the concerns that woman-centred care is not authentically supported and the erosion of midwifery autonomous practice:

> *'I think midwives should be trusted to grow and do their own thing, and do their own work, and work their own way because it's such a unique...It's like artistry, isn't it? … And down here it's very tick-boxy. They call guidelines protocols, and every time they mention this, I go, "It's not protocol, it's a guideline. Do you understand the difference between guidelines and protocols?" RT_Int_07*

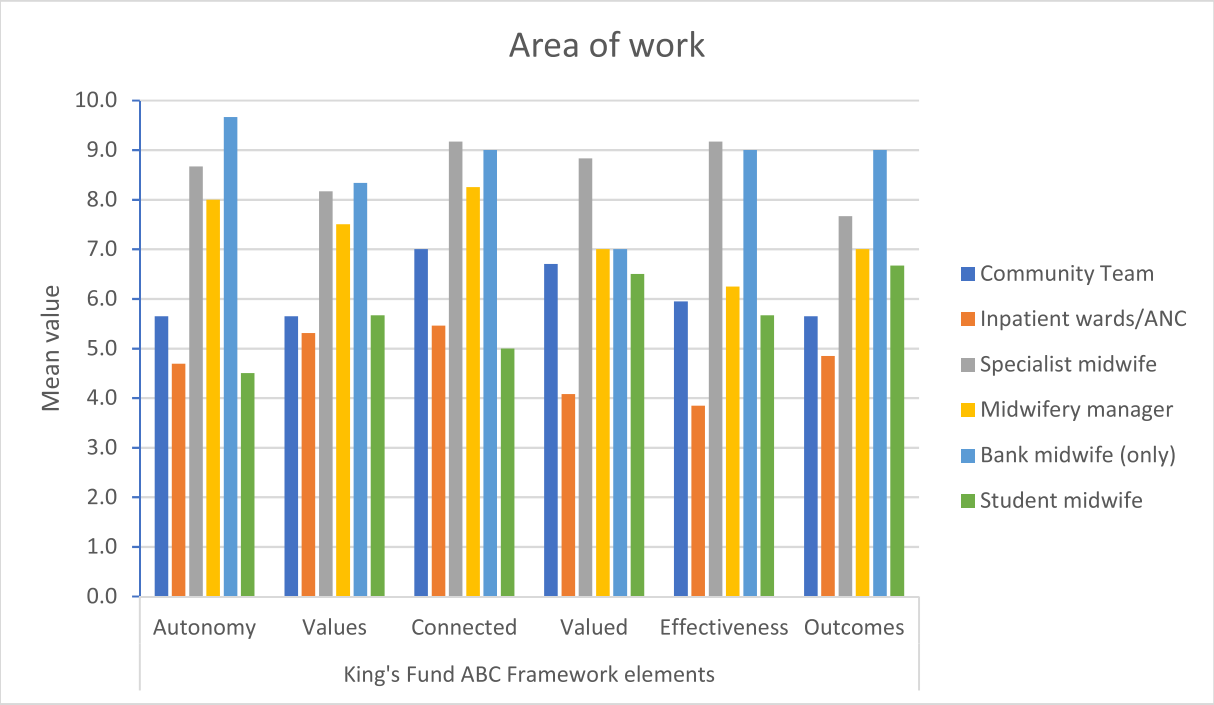

Fig. 4. Mean ABC Framework response score by place of work (n=50).

Retention midwives: Activities and impact

Unique to this study was capturing the new 'retention midwife' role where we collated their activities in the first 15 months of being in post along with gathering staff perspectives within the survey/interviews. Funding for the role was originally for 12 months but during data collection, NHS England approved funding for another year (and to date, funding has been extended again). Table 2 highlights the retention midwives core activities which included a baseline staff satisfaction survey exploring intentions to leave, introducing a buddy support system (initially to high risk attrition groups and then expanded), introducing monthly restorative clinical supervision sessions, orchestrating 15 off site wellbeing away days for each midwifery team, launching a formal method of acknowledging clinical excellence, incorporating an onsite reflexologist and access to a psychologist to promote wellbeing and actioning responses to staff feedback collated across these initial activities. The retention midwives collated the midwives' core areas of concerns generating a core action plan, documenting those achieved or continued works in progress. The core areas they sought to address were working patterns, staff recognition, support and wellbeing, staff development, staffing levels and addressing skill-mix issues, environment, management support/visibility, culture and communication, specialist roles, presence of doctors, equipment, improving services for women, and financial issues such as paid overtime.

Considering these activities, we explored the views of the midwifery staff of the retention midwives' role. First, we found a slight reduction in the number of participants who were considering leaving since the retention midwives' original baseline survey (63% vs 52%) which, within a national climate of a continued retention crisis suggests that their role has been successful. The majority (88%, n=49) of participants were aware of retention midwives' role (12 % were 'unsure'). 37 survey and all seven interview participants shared positive insights - they highly valued the activities the retention midwives put on including the away day, commencement of a maternity research council, specialist directed training, wellbeing sessions (psychologist, complementary therapies, and Professional Midwifery Advocate sessions) and introducing 'Greatix' (opposite of Datix where staff can report positive feedback rather than an incident). Crucially, many participants positively evaluated their proactive listening, consulting and actioning approach to which visible outcomes were observed e.g. *'implementing the staff recommendations from the away days'*. That discussions turned into actions was viewed favourably and some reported an improved culture through their *'inject*[ing] *positivity into the workforce'*. They were also viewed as positive role models influencing positive change and visibly escalated staff concerns to management, which was valued and made some staff feel cared for:

> *'Being amazing mediators between managers and staff, showing compassion and care for us and the women we care for.'* RT_Survey_38

Responses to what the retention midwives could either do better generally related to wanting more of what they already do and for them to have greater influence within higher management. Some staff were not clear on what actions/activities the retention leads had carried out and several suggested better communications regarding these activities. For some, toxic cultures and/or staff struggles were noted specifically on the wards and suggestions for the retention midwives to focus activities here. This mirrored other concerns the retention midwives tended to focus on newly qualified midwives and less so on older and/or more experienced midwives – an area for improvement. Moreover, for those who were aware of retention lead activities, accessibility of attending them was a concern, again, particularly for ward staff:

> *'Maybe there are quite a lot of benefits and things that are sent out to us Trust* [organisation]*-wide. And I suppose for a lot of midwives we don't feel like we've got the time to make use of a lot of those. So maybe looking more at how can you actually free people's time up to do those…Because I think as midwives, we look at all that stuff and we look at the [other] staff that have the time to go and have a meal in the restaurant in their break and everything, and we think, "Oh well that's just a joke. It's just a joke." You can have these lists of benefits, can't you, but if you are not actually saying, "Okay this month this team's turn to have lunch hour and we'll find some cover for them for their morning clinic", or whatever it is. And they did do that for our away days…'* RT_Int_05

Discussion

This case study research explored the views of midwives within one NHS organisation regarding their intent to stay/leave while also providing novel insights regarding the introduction of 'retention lead' midwives. Overall, our findings indicated key interrelated areas impacting the midwives' wellbeing and desire to leave/stay: the changing role of the midwife, workplace stressors and subsequent poor mental health, undue bureaucracy and perceived restrictions to their autonomy. Unique to this study, we found strong indicators of dis/satisfaction related to the midwives' job role and area of work which significantly influenced experiences of autonomy, belonging and contribution (King's Fund, 2020). Furthermore, this study is the first to explore the new 'retention lead' midwife role and found substantial activities were carried out to enhance the workplace environment..

The Royal College of Midwives (RCM, 2022b) suggest that the increased rate of attrition is due to shift patterns, lack of support for professional development and local workplace cultures, however it appears that there may be a more fundamental issue at play. We found an erosion of the midwives' role was reported as increasing bureaucratic demands - excessive (and duplicate) paperwork, and/or, computer work and/or, poor IT systems -shifting the nature of midwifery into a 'administrator' rather than clinical role. Moreover, meaningfulness in practice is associated with job satisfaction (King's Fund, 2020). The findings from this study support the argument that there is, often, an incompatibility between midwifery principles and the current structures and processes of work (Spence, 2023). The participants reported passion, commitment and motivation to make a difference. However, most reported concerns that midwifery was shifting towards 'obstetric nursing' that is more aligned with a task orientated medical support role (Walker, 1976). Such values-based tensions are difficult to overcome without structural change and can lead to moral compromise, distress or even injury (Feeley et al., 2021; Foster et al., 2022; Pollard, 2011) with far reaching consequences such as burn out, poor mental, physical and emotional health(Cull et al., 2020; Feeley et al., 2021; Hunter et al., 2018; RCM, 2016). These concerns run deep, particularly when midwives feel they are causing more harm than good when their practice is confined to a task-based, institutional-centric approach (Cooper, 2011; Feeley et al., 2021; Hunter, 2004).

While numerous studies have explored midwifery retention/attrition issues, they have largely been national based studies with less focus upon specific workplaces or job roles. Our findings have captured two key novel findings. First, in the UK, the midwifery workforce reflects the increased complexity of maternity service delivery (triage, antenatal clinic, antenatal day assessment, community teams operating multiple patterns of work etc.) and the rise in specialised roles/departments (diabetes clinics, preterm birth clinics, birth choices clinics etc.). Such complex service configurations have seen a rise in Band 7 (middle management) midwifery specialist roles who lead specific services across organisations (e.g., mental health, safeguarding, infant feeding etc.). They combine managerial/leadership and governance activities with teaching/education while managing caseloads (RCM, n.d). These roles appear to fulfil the midwives core needs for autonomy and contribution (King's Fund, 2020), workplace satisfaction and in this study, none intended to leave. However, we also found some negative implications for the wider midwifery team who raised concerns these roles were reducing the skill-mix and availability of experienced 'general' midwives.

Second, our findings indicated a worrying trend that hospital midwives were struggling the most, had the least amount of autonomy and greatest levels of dissatisfaction and subsequent intention to leave. The polarisation of our findings between groups of midwives within the same organisation are significant, but rarely discussed in the literature. A recent study of 2347 national UK midwives which sought to explore the association of individual characteristics, work-related factors and working practices on emotional wellbeing outcomes of UK midwives also found that hospital midwives, (specifically those working on the postnatal/antenatal wards) had increased odds of work-related burnout and reduced job satisfaction (Dent et al., 2024). Together, both studies demonstrate a need to explore more closely differences between groups of midwives within the same organisation e.g., workplace culture is frequently cited as stressor (Frith et al., 2014), but 'workplace culture' may be more nuanced and specific to an area, rather than necessarily reflecting the wider organisation. The roles and responsibilities within the different workplace areas appear to radically influence the degree of autonomy and contribution midwives have or feel (King's Fund, 2020) and must be explored further.

This study is the first to capture insights regarding the activities and perceptions of the role of retention midwives. We noted exemplary activities with the retention midwives committing to emotional wellbeing and psychological safety in novel ways. Their proactive listening and actioning appeared to make a positive difference to workplace culture and crucially, the midwives' feelings of being valued – thus, fulfilling a core human need (King's Fund, 2020). While there were some important positives, we also found there were limitations to their role. Namely, they were attempting to mitigate wide-scale national and societal issues ever present in the UK; hyper-medicalised and institutionalised agendas, and negative media portrayals are situated against a backdrop of persistent poor staffing, reduced NHS funding, pandemic recovery and a cost-of-living crisis. Within this context, it is laudable any positive differences were made but it is unsurprising they are yet to resolve all the core issues within the workplace. Further research in different sites and longer-term evaluations are required to add to this under researched area.

Strengths and limitations

A strength of this study was the use of a case study design which generated different types of data that were triangulated, thus enhancing the trustworthiness of the findings. That the study was in one organisation is both a strength and limitation – a strength as it provided the opportunity to generate in-depth insights and granular findings and served as an opportunity to explore the new retention midwives role. Conversely, with only one organisation within the study as a 'case study unit' some findings may be specific to this organisation and not transferrable elsewhere. However, this was mitigated by exploring the wide evidence base where our findings echoed others, while also providing newer, novel insights.

Conclusion

The retention of midwives is a global priority and while the burden of understaffing is most profound in low-income countries, high-income countries such as England are also facing retention challenges. This organisational case study captured insights from the midwifery workforce in one unit to explore their views regarding intent to leave/stay and to explore, for the first time, the role and perceived impact of retention midwives. While we found similar persistent negative issues found elsewhere (erosion of midwifery, workplace stressors, poor mental/emotional health, undue bureaucracy etc.) we also found that the specific workplace and job roles were significant factors for dis/satisfaction and intents to leave/stay – either facilitative or prohibitory of autonomous working. Furthermore, we uniquely captured the role and perceived impact of retention midwives which while early days, we found they had a positive impact on emotional wellbeing and psychological safety but were limited to the extent they could impact broader, national issues and concerns.

Author agreement

We confirm this article is our original work and has been published prior or under consideration elsewhere.

Both authors have seen and approved the manuscript submitted.

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CRediT authorship contribution statement

Claire Feeley: Writing – original draft, Project administration, Methodology, Formal analysis, Conceptualization. **Tomasina Stacey:** Writing – review & editing, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Declaration of competing interest

None.

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Ethical statement

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2024.104152.

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