WHY DO MIDWIVES STAY?

A mixed-methods study of the factors influencing newly qualified midwives in London to remain in post.

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DECLARATION

I certify that the work contained in this thesis, or any part of it, has not been accepted in substance for any previous degree awarded to me or any other person, and is not concurrently being submitted for any other degree other than that of Professional Doctorate in Education which has been studied at the University of Greenwich, London, UK.

I also declare that the work contained in this thesis is the result of my own investigations, except where otherwise identified and acknowledged by references. I further declare that no aspects of the contents of this thesis are the outcome of any form of research misconduct.

I declare any personal, sensitive or confidential information/data has been removed or participants have been anonymised. I further declare that where any questionnaires, survey answers or other qualitative responses of participants are recorded/included in the appendices, all personal information has been removed or anonymised. Where University forms (such as those from the Research Ethics Committee) have been included in appendices, all handwritten/scanned signatures have been removed.

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ABSTRACT

Background:

Midwives are leaving midwifery in greater numbers than in previous years. Newly qualified midwives (NQMs) are the group most likely to leave. Most research has explored why midwives leave rather than why they stay. This research seeks to understand which factors enable NQMs to stay in midwifery, focusing on London, with the aim of retaining this important group of midwives in the midwifery profession.

Methods:

A pragmatic, mixed-methods approach was used to explore why NQMs choose to stay in midwifery. The research was conducted in two phases. Phase one was a survey, sent to all midwives (n = 1502) in four London Trusts with a 16.3% (n = 248) response rate. Participants were asked to complete two scales, the Connor-Davidson 10-point Resilience Scale and the Bower Midwife Wellbeing Scale, developed for this research. Survey data were analysed using SPSS-27. From the survey, eleven NQMs self-selected to be interviewed (phase two) using the findings from the scales as a basis for questioning. Interviews were recorded and transcribed, and interview data were analysed using Applied Thematic Analysis.

Results:

The survey found that the Bower Midwife Wellbeing Scale demonstrated a significant predictive ability in being able to identify midwives who were more likely to have thought of leaving in the last six months. The higher the mean score of the scale, the less likely the midwives were to have thought of leaving (their post/midwifery), so were more likely to stay.

The interviews identified three themes: head above water, cultural conflicts and professional identity. The factors most likely to enable NQMs to stay were those that improved their professional identity, such as job satisfaction and continuity of care. Factors that were least likely to enable them to stay were a poor workplace culture, such as a bullying culture and lack of staff.

Integrating the results from the survey and the interviews, factors that both improved and diminished personal and professional resilience were identified. NQMs with a higher Bower Midwife Wellbeing score were more likely to stay in midwifery.

Recommendations:

The Bower Midwife Wellbeing Scale, developed for this research, has the potential to predict NQMs who are more likely to stay in midwifery as they score higher on the scale. By predicting those who are more likely to leave, it is proposed that interventions, such targeted support, can prevent attrition. The research also identifies adverse workplace conditions that need to be addressed if NQMs are to stay.

The relevance of the research for education is that high personal resilience enables NQMs to cope better with adverse workplace conditions (improving their professional resilience). Personal resilience can be developed through educational interventions, and it is recommended that this is addressed in pre-registration midwifery education programmes. Further research into testing the Bower Midwife Wellbeing Scale is also recommended, to be able to identify those NQMs who are more likely to stay.

CONTENTS

CHAPTER 1: INTRODUCTION

Midwives in the UK are leaving the profession in greater numbers than ever before (Bonar, 2022a). Newly qualified midwives (NQMs) in the first five years after qualifying are more likely to consider leaving than those who have been qualified for more than five years (Walton, 2021). The literature is abundant about why midwives leave but much less has been written about why they stay, and even less about what motivates NQMs to stay. Yet, if NQMs are more likely to leave midwifery, it is important to find out what the elements are that will encourage them to stay in the profession.

This thesis explores why NQMs in London choose to stay in midwifery during their first two years, providing insights into the factors that facilitate NQMs to remain in post. The aim of this research is to improve the retention of NQMs in London (and beyond) by recommending ways to improve the transition from student to qualified midwife. Through the findings, the thesis recommends areas for improvement in education, research, policy and practice. The recommendations will contribute towards protecting the future midwifery workforce. Although the study was conducted in London, the findings have relevance to NQMs across the United Kingdom and beyond.

1.1 Rationale

As a midwifery educationalist, the transition between student and NQM is of particular interest. I have been a midwife for over 35 years and have worked as a midwifery educator for over 20 years. During this time, I have seen changes in both midwifery education and practice, with the transition between student and NQM appearing to become more problematic. Having successfully supported midwifery students through a three-year midwifery programme, I have witnessed that some graduating students appear able to make the transition to professional practice, whereas others leave the profession within the first two years after qualifying. I am curious about why some graduating students make an effective transition and remain in the profession whilst others, who have also successfully completed a midwifery programme, leave the profession within the first few years. My

interest is particularly around why midwives stay and the factors that enable them to remain within the profession. Whilst retention of students, rather than NQMs, is equally important, there has been much more focus on this area within recent research. By exploring factors that enable NQMs to remain in the profession, I am addressing a gap in current knowledge.

Interest in this transitional period of becoming a NQM also developed my curiosity into the concept of resilience. Exploring the reasons why NQMs choose to stay in midwifery and their levels of resilience is an under-researched area in midwifery. Although resilience is a controversial term because it has many definitions, through the literature, clear concepts have been developed and used for the purposes of this study, which will be explored in the next chapter.

The question my thesis asks is: *Why do midwives stay? A mixed-methods study of the factors influencing newly qualified midwives in London to remain in post.* To understand the context of this thesis, it is important to understand the current context of midwifery practice and education.

1.2 Background to midwifery practice

There is a national shortage of midwives in the UK at the present time. The Royal College of Midwives (RCM) has warned that the shortage is threatening the safety of maternity services (Tyler, 2022). The Nursing and Midwifery Council's most recent registration data report shows that the annual number of midwives joining the register to March 2022 had only increased by 57 from the annual number joining to March 2021 (Nursing and Midwifery Council, 2022b). This is the slowest growth for five years; however, the annual number leaving the register had risen for the first time in three years, from 1,334 in the year to March 2021 to 1,474 in the year to March 2022 (Nursing and Midwifery Council, 2022a). The RCM has reported the greatest year-on-year decrease in midwife numbers to March 2022 since 2009 (Bonar, 2022b). A survey conducted by the RCM at the end of 2021 found that 57% of midwives were considering leaving the profession (Walton, 2021). The group of midwives most likely to consider leaving were those who had been qualified for less than five years. Given that the

UK has a shortage of over 2,600 full-time equivalent midwives, calculated as being the number required to maintain a safe maternity service, these statistics are a cause for concern (Tyler, 2022).

The shortage of midwives and the decline in the number of midwives is of significance because of the consequent threat to safety of maternity services. It has been shown that there is a direct correlation between midwifery-led care and improved maternal and neonatal outcomes (Sutcliffe *et al.*, 2012; Bodner-Adler *et al.*, 2017; Rayment-Jones *et al.*, 2021). To provide safe maternity care, it is therefore necessary to have safe midwifery staffing levels. If midwives are leaving the profession, safe staffing levels cannot be maintained with a resulting risk to the safety of mothers and babies. This has already been demonstrated in recent maternity services reports where poor midwifery staffing levels were identified as one of the factors contributing to unsafe care (Ockenden, 2020; Kirkup, 2022; Independent Maternity Review, 2022).The shortage of midwives has been a concern for several years but the recent decline in the number of midwives is increasingly worrying.

In response to growing concerns, Health Education England, in collaboration with NHS England, published a Maternity Workforce Strategy to ensure the maternity workforce of the future could meet the needs of women and babies (Health Education England and NHS England, 2019). According to the report, there were 22,775 whole time equivalent midwives working in England in 2016 (Health Education England and NHS England, 2019). Adjusting for midwives in managerial and educational posts, this equated to one midwife per 30 births. The recommended ratio to provide a safe service is one midwife to 27 births (Ball and Washbrook, 2010). As part of the strategy to improve this ratio, the report launched a recruitment drive to increase the number of midwifery student places in England by 3,000 by 2023. Recruitment of midwifery students had been negatively impacted by the withdrawal of the NHS bursary for healthcare students in 2017 (Stevenson, 2018). Although student recruitment had started to improve, the report did not predict the COVID pandemic and this has been reported as responsible for many nurses and midwives leaving the profession (Hackett, 2021). It is likely that more students will be required to replace the midwives leaving the profession, but unless

these students stay in the profession once they have qualified, the midwifery staffing shortages will never be resolved.

There are further challenges in practice, which exacerbate the shortage of midwives. One of these challenges is the increased demographic of women with medical risks using the maternity services. Women using the maternity services are increasing in age, obesity, medical and psychological complexity. The average age of childbearing women in the UK was 30.7 years in 2020, increased from an average age of 26.4 years in 1974 (Office of National Statistics, 2022). The age groups where childbearing has increased most significantly in the last few years are in the 35-39 and 40+ year age groups (Office of National Statistics, 2022). Increased maternal age brings its own complexity, as women undergoing childbirth over the age of 40 years are more likely to experience obstetric complications, requiring a more intensive level of care (Cavazos-Rehg *et al.*, 2015). They are also more likely to be obese. A Public Health England report found that 27.4% of women were overweight, 18.3% were obese and 3.3% were severely obese at the beginning of pregnancy, with only 46.5% of women in normal weight range (Public Health England, 2019). Obesity also results in a higher risk of complications during childbirth for the woman and her neonate (Triunfo and Lanzone, 2014). The Public Health England report found that obesity increased with age, with the highest proportion of obesity in those aged 40 years or over (55.4%), increasing the risk yet further for these women (Public Health England, 2019). These figures demonstrate the increased level of risk in maternity care, which in turn requires more midwives to provide safe care.

The shortage of midwives has also been made worse by Brexit. Following the Brexit vote in 2016, just 33 European midwives joined the NMC register in 2017-18, a decrease from 270 in 2015-16 (Nursing and Midwifery Council, 2018b). In contrast, 234 European midwives left the NMC register in 2017-18, up from around 150 in in 2015-16 (Nursing and Midwifery Council, 2018b). This trend is concerning, given that approximately 7.5% of the UK midwifery workforce in 2016 was from the EU (Bonar, 2018). This reflects the nervousness of EU citizens to remain in the UK following the Brexit vote, although now that Brexit has taken place, it might be assumed that the decline in numbers will diminish. However, in the NMC's latest

registration report (Nursing and Midwifery Council, 2022b), although there is no breakdown between nurses and midwives, there have been fewer EU nurses and midwives joining the NMC register year on year since 2017. Given that the highest concentration of EU nurses and midwives is in London, this has had a significant impact on the capital's workforce.

The midwifery workforce in London presents a particular challenge, given that one fifth of all births in England take place in the capital (Office of National Statistics, 2022), therefore all the issues identified are intensified within London. In September 2022, the nursing and midwifery vacancy rate in London stood at 15.2%, the highest in the UK and up from 11.6% six months earlier (NHS Digital, 2022). This is very likely exacerbated by the significant reduction in EU midwives. The workforce in London is also more transient with greater movement between posts and a higher number of bank and agency midwives (NHS Digital, 2022). Challenges to the midwifery workforce in London have been recognised and are being addressed through the Capital Midwife project, which seeks to alleviate issues around recruitment and retention in London (Watts *et al*., 2019; Capital Midwife and Health Education England, 2022). One of the workstreams at Capital Midwife is around supporting preceptorship, usually defined as the first year after qualifying (Capital Midwife, 2019). Preceptorship has been identified as a key period during which newly qualified practitioners are vulnerable to leaving and benefit from additional support (Nursing and Midwifery Council, 2019a). Yet experiences of preceptorship amongst NQMs are known to be variable which further exacerbates attrition (Black, 2018).

Retaining NQMs in post is of great significance to the midwifery profession. They have already completed three years (in some cases, two or four years) of midwifery education and have invested their future career in the profession. It is both personally and professionally detrimental to lose midwives as they have just entered their chosen profession. It suggests that the transition from student to qualified midwife does not match their expectations, despite having spent 50% of their midwifery education in clinical practice (Nursing and Midwifery Council, 2019b). Discovering what makes this transition successful for those NQMs

who stay in the profession could ultimately be beneficial to future NQMs and to the future of the midwifery profession.

1.3 Background to midwifery education

The context of newly qualified practice requires an understanding of the challenges of midwifery education which NQMs have recently experienced. One of these challenges is student attrition, therefore it is important to gain an understanding of the reasons why students leave and why they stay. Health Education England's RePAIR (Reducing Pre-registration Attrition and Improving Retention) project provides some insights into attrition and retention amongst students (Health Education England, 2018). The report includes data of a range of healthcare students (nursing, midwifery and radiography students) and newly qualified practitioners within their first two years of qualifying. It found that between 2013-2015, there was an overall on-time non-completion rate of 30.97% for midwifery students, with the highest level of student attrition occurring during their first year. Whilst some of these students may have re-joined the programme at a later date, some of them left midwifery altogether. The attrition rate for midwifery students in London was higher than for any other region. The report suggests this may be due to several factors. For instance, when asked if they would have done the programme without a bursary (the bursary was about to be withdrawn in England) 70% of students in London said they would not, compared with 50% across the country in total. This suggests cost of living may have been a reason for attrition. London students also reported less support in practice placements, both from mentors and from midwifery tutors. Good support was identified as a key factor in improving retention. A London midwifery student stated: "*Some mentors are the nastiest of bullies*" (p. 44). This suggests the culture of practice may also have been a factor in the increased attrition rates in London. Given the investment by the NHS in educating midwifery students, as well as the personal investment of the individual student, this is of considerable concern.

The other point of high attrition identified by the report was the transition from student to qualified practitioner, a period which was labelled in the report as the '*flaky bridge*' (Health Education England, 2018: 18). Although most of the report focused on students, 25 newly

qualified staff were also interviewed as part of the project. The breakdown of professionals is not given so these were not just midwives. However, their reflections on the '*flaky bridge*' are of relevance to NQMs. Only three of the 25 felt their transition was straight-forward and all three had gained employment at the same Trust where they had been students. Most were concerned about the level of responsibility and the gap between being a student and being qualified as they perceived the gap to be '*vast*' (Health Education England, 2018: 59). This has been identified in the literature as '*transition shock*' and is a recognised feature of newly qualified practice (Duchscher, 2009). Their experience as a newly qualified practitioner was influenced by the quality of the preceptorship programme. A structured, well supported preceptorship programme made a positive difference to their experience. Factors that led them to consider leaving were shortage of staff, being expected to 'step up' too quickly, lack of support and uncertainty in knowing where they were going to work each day (Health Education England, 2018).

The effects of COVID-19 on midwifery education cannot be ignored. A Health Education England report which surveyed healthcare students about their experiences during COVID found that 41% of midwifery students had considered leaving during the pandemic, compared with 37% of nursing students and 27% of AHP students (Health Education England, 2021). Midwifery students were more likely to have considered leaving due to placement concerns (doubting their clinical ability, lack of placement support, high workload, poor placement experience,) but less likely than other healthcare students to have considered leaving for personal and mental health reasons. Given that midwifery students were not on the 'front line' of COVID-19, it is possible that the negativity was because of existing problems being exacerbated during the pandemic. Maternity services were disrupted during the initial stages of the pandemic, which would have had a negative impact on student placements (Silverio *et al.*, 2021). Poor experiences of placement are of concern because they are more likely to make students consider whether they want to continue to become a qualified midwife. Like other healthcare students in the report, midwifery students also reported high levels of feeling overwhelmed and stressed, which is also of concern when they are not yet qualified (Health Education England, 2021).

If the UK is to recruit more midwifery students and ultimately more midwives, it is vital that attention is directed towards their retention (Health Education England and NHS England, 2019). Retention and attrition statistics in the first five years after qualifying are difficult to obtain but a survey conducted by the Royal College of Midwives demonstrated that midwives are most dissatisfied with their work within the first five years and are the most likely group to consider leaving midwifery (Walton, 2021). The reasons for this are not clear and need to be explored. Maternity services need to identify effective strategies to reduce the attrition of NQMs from the profession. Understanding more about the personal and motivational factors that enable NQMs to stay in the profession - and specifically in London - may help to identify these strategies. This in turn may help midwifery educators to implement strategies to minimise student attrition and maximise the transition to newly qualified practice. Improving retention of NQMs is the rationale and basis for my thesis.

1.4 Research questions and rationale

My research aimed to explore the reasons why NQMs in London choose to stay in midwifery. Three research questions were identified and are addressed through the research:

1. What are the internal and external factors that enable midwives in London to remain in post?
2. What are the personal and professional attributes that influence newly qualified midwives in London to remain in post?
3. What is the relationship between personal and professional resilience and the decision of newly qualified midwives to remain in post?

The geographical area in which this study was conducted was carefully considered. As a midwifery lecturer working in South East London, this provided a natural opportunity to locate the research in London. However, there are also specific challenges in London which were of interest when considering why NQMs stay. In 2021, there were over 111,000 births in London, almost 20% of all births in England (Office of National Statistics, 2022). In 66.4% of births, either one or both parents were born outside the UK. There are 18 Trusts providing maternity services and nearly 6,000 midwives working in London, almost one fifth of the

midwives in England (Watts *et al*., 2019). Thus, London provides a significant proportion of maternity services in England, with the challenges inherent in acute Trusts, centres of excellence and a diverse population. London has a more transient workforce than many other areas of the UK, because healthcare professionals often choose to train in London then move to areas outside London (Watts *et al*., 2019). No previous work about leaving and staying has been focused on London and as a busy nucleus of maternity practice with specific challenges, this provides an opportunity to explore issues around retention for NQMs in the capital. As a member of the 'Capital Midwife' steering group, and the 'Capital Midwife' preceptorship task and finish group, I was also particularly interested in what I could do to improve the retention of NQMs in London.

1.5 Outline of thesis including theoretical perspectives

Chapter two of this thesis provides an integrative review of the literature about why midwives stay and why they leave. The reason why midwives stay is not merely the reverse of why they leave although the reasons for both are interwoven. It is therefore important to explore the factors that cause midwives to leave as well as those that enable them to remain in the profession. This assists with a comprehensive understanding of cause and effect. Identifying the factors for leaving and staying in the literature provided an important step in consolidating the research questions and developing the questions posed in the quantitative and qualitative data collection. The literature review also identified the gaps in knowledge which could be addressed by this research.

Chapter two also provides a critique of the literature on resilience, which is one of the theoretical perspectives underpinning this study. There has been much recent interest in (and equally, critique of) theories surrounding resilience (Garcia-Dia *et al.*, 2013). There has also been a growing interest in resilience in the context of healthcare (Huey and Palaganas, 2020). The rationale for selecting resilience as a theoretical basis for the research arose when considering that some NQMs make a successful transition to practice and stay in midwifery whilst others seem unable to cope with the transition to qualified midwife and choose to leave. Given that all NQMs have completed a midwifery education programme successfully,

it was hypothesised that the level of personal resilience may play a part in making this transition. Through the literature review, it became apparent that professional resilience plays an equal part in staying or leaving and this will be defined and explored in Chapter two.

Chapter three outlines the methodology and methods of the study. The second theoretical perspective used to underpin the study was that of pragmatism. This paradigm has been favoured by healthcare researchers in recent years because it provides a practical approach to researching issues in healthcare practice, often providing pragmatic solutions (Tashakkori and Teddlie, 2003b). Pragmatism has been described by Cresswell and Plano Clark (2017: 37) as '*pluralistic and oriented towards "what works" and real-world practice*'. It is grounded in the realities of day-to-day issues, which seemed appropriate when researching the day-to-day experiences of NQMs. Pragmatism and its rationale for my study will be explored in depth in Chapter three.

A mixed-methods study was chosen, enabling firstly quantitative (phase one) then qualitative (phase two) data to be collected. A survey was used to collect quantitative, contextual data from a wide range of midwives working in four London Trusts. From the survey, NQMs self-selected to be interviewed, which provided opportunity to explore how the survey findings related to a smaller number of NQMs in more depth. The perceived benefit of mixed-methods studies for healthcare practice is indicated by the increased number of such studies being undertaken and the preference for mixed-methods approaches by some funding bodies (Creswell and Plano Clark, 2018).

Two scales were used in the first phase of the research to calculate resilience and wellbeing scores according to two different sets of criteria. One of the scales was a previously validated resilience tool (Connor and Davidson, 2003), which has been widely used in healthcare research. For the purposes of this research, this is called the Connor-Davidson resilience scale. The other scale was developed for the purposes of this study, based on previous research into resilience in midwifery (Hunter and Warren 2013). This scale is named the Bower Midwife

Wellbeing Scale as it has not been used in previous research. The rationale and development of the tools will be discussed in depth in Chapter three.

Ethical approval was gained for the study through the University of Greenwich Research Ethics Committee (UREC). The study did not require NHS ethical approval as it did not include data collection from childbearing women and families. However, interviewing NHS staff is viewed as a grey area by some Trusts and because NHS emails were used to access staff, two Trust Research and Development departments withdrew consent to access. One additional Trust was recruited without a requirement for NHS ethical approval therefore data collection took place in four rather than the planned five Trusts. Ethical approval will be discussed in more detail in Chapter three.

Chapter four is a presentation of the results from phase one and phase two of the research (survey and interview data). Survey data were analysed using SPSS (Version 27). This provided descriptive demographic data on the survey respondents. It also calculated resilience and wellbeing scores as outlined above. Using an explanatory sequential design, I was able to use the survey findings to shape the interview questions, which was particularly useful when exploring the concept of resilience. Interview data were analysed using Applied Thematic Analysis, a technique which is particularly suited to mixed-methods research (Guest *et al*., 2012). Applied Thematic Analysis will be further explored in both Chapters three and four.

Chapter five discusses the findings of my study and compares these to the findings in the existing literature. Mixed-methods studies employ a variety of approaches when integrating the different components of the research. This study integrates findings in the discussion stage; therefore, integration is an important element of this chapter. Using the findings from the study, Chapter six provides a conclusion to the work, with recommendations for education, practice, policy and research. This chapter also identifies and discusses the limitations of the study, including reflexivity into the research process and my own positioning within this. The unique contribution of this study to midwifery policy, practice and education is also discussed in this chapter.

1.6 COVID-19 Pandemic

An introduction to any healthcare study undertaken between 2020 and 2021 would be incomplete without acknowledging the context and backdrop of the COVID-19 pandemic. Data collection for my study took place during the pandemic; the survey was distributed in December 2020 prior to the second lockdown in the UK, and the interviews were conducted from March - June 2021 whilst the number of infected people was still high, but the second wave had abated. This was a difficult and demanding time for all health professionals, including midwives, and it cannot be ruled out that this has affected survey and interview responses. Some of the NQMs had qualified during the pandemic, therefore their experience of being both students and NQMs was coloured by the COVID-19 pandemic.

Data collection was delayed by nine months due to the initial outbreak of COVID-19 and the first lockdown, therefore an opportunity was taken to submit an amended ethical application to the University Research Ethics Committee. A COVID-related question was added to the survey and an additional question was included in the interview schedule. Whilst this does not form the focus of the research, the additional questions revealed interesting findings in the context of COVID-19 and these are included in Chapter 4. This opportunity also provides a unique perspective to the work as ethical approval for the study had been obtained prior to COVID-19, so it only required a minor amendment to gather these data.

1.7 Summary

As a midwifery educator, I have a professional responsibility to ensure that midwifery education optimises the transition from student to qualified midwife. Having identified a gap in the research, my study focuses on the reasons why NQMs choose to stay in midwifery during the first two years after qualifying. Recent reports and media coverage have been harsh towards midwives (Ockenden, 2020; Kirkup, 2022; Independent Maternity Review, 2022), therefore this gap in knowledge is of particular concern in the current midwifery climate. The recent COVID-19 pandemic has also made midwives reconsider their career choice and working environment. It cannot be assumed that the reasons why midwives choose to stay in the profession are the opposite of why they choose to leave. Exploring the

reasons why NQMs choose to stay in the profession, therefore, is important when considering how to improve retention of the future midwifery workforce. Although the focus of my study is on London, it is hoped that these findings will also be of relevance to the midwifery workforce in the United Kingdom and beyond.

CHAPTER 2: LITERATURE REVIEW

2.1 Context of review

Chapter one outlined the reasons why there is a shortage of midwives and why the current midwifery workforce in the UK is in decline. According to the most recent NHS Staff Survey, 49.2% of midwives in London were thinking about leaving their organisation in 2021 (NHS England, 2022c). This was an increase from 32.2% in 2020, the largest increase and the second highest percentage of 'thinking about leaving' of any NHS occupational group in London. Why this increase is so much greater than for any other occupational group is unclear, but the report shows that almost half the midwives in London were thinking about leaving their organisation. It is not clear from the report how many were thinking of leaving the profession, but these statistics are of concern for midwifery staffing in London. As identified in the previous chapter, shortage of midwives is a safety issue and results in poorer outcomes for mothers and babies (Independent Maternity Review, 2022; Kirkup, 2022). For this reason, it is important to identify the factors that enable midwives to stay in post. This is particularly important for NQMs, as the NMC data identify that midwives in the first five years after qualifying are the most likely group of midwives to leave after those who are retiring (Nursing and Midwifery Council, 2022a).

To identify the issues around attrition and retention in midwifery, which form the basis for this research, an integrative literature review was undertaken (Whittemore and Knafl, 2005). The purpose of this was to explore factors associated with both attrition and retention as the context for the research and to identify any gaps in the literature relating to the research question. The starting point was based on the overarching question: "*Why do midwives stay*?" However, to explore this question in depth, it is necessary to investigate the factors influencing both retention and attrition in the midwifery workforce. The literature review also explores retention and attrition of NQMs. As previously identified, the literature exploring why midwives leave is more extensive than that relating to why they stay, which was the motivation and rationale for undertaking my research.

A separate review of the resilience literature was conducted, focusing on the concepts and theories of resilience, with emphasis on the difference between personal and professional resilience. The reason for identifying and exploring the resilience literature is that my study hypothesises that more resilient midwives are more likely to stay. The definition and manifestation of resilience, however, are multifactorial and contentious (Richardson, 2002). For this reason, the review explores previous concept analyses of resilience, as well as healthcare studies using the terms 'personal' and 'professional' resilience as these concepts are relevant to my study. This chapter will firstly investigate why midwives leave and why they stay, and will then explore the concept of resilience, drawing mainly from the healthcare literature. The two parts of the review will then be used to justify the rationale for my study.

2.2 Background: Why do midwives stay or leave?

Two parallel and influential reports addressing why midwives stay and why they leave in the UK were published in the early 2000s (Ball *et al*., 2002; Kirkham *et al*., 2006). The '*Why do midwives leave?*' report was funded by the Department of Trade and Industry and the Royal College of Midwives (RCM) in response to a national shortage of midwives (Ball *et al*., 2002). The '*Why do midwives stay?*' report was funded by the Department of Health and conducted as part of the National Midwifery Recruitment and Retention project (Kirkham *et al*., 2006). These reports provide background context for the literature review. However, neither report mentions or addresses resilience, which could be seen as an oversight, and provides the unique perspective of my research. This will be explored in more detail later in the chapter.

The first study to be undertaken was '*Why do midwives leave?*' (Ball *et al*., 2002) and was conducted in two phases. In phase one, a questionnaire was sent to a random sample of 250 midwives who were on the Nursing and Midwifery Council (NMC) register in 1999 but who had not returned an annual Notification of Intention to Practise (NIP) in the year 2000. This provided confirmation that the registrant no longer wished to practise as a midwife that year. The questionnaire aimed to identify their reasons for not returning a NIP. The questionnaire was followed up by interviews with a purposive sample of 28 midwives who consented to be contacted. In phase two of the study a questionnaire was sent to all midwives identified as

leaving the NMC register that year (1975 midwives), of whom 978 (50%) returned a completed questionnaire.

Findings from the study indicated that the largest single category of leavers were those midwives who had become dissatisfied with the midwifery profession (Curtis *et al*., 2006a). Reasons for dissatisfaction included feeling unable to provide the standard of care they aspired to provide. Midwives felt they were not able to provide women with an appropriate standard of care and were unable to develop meaningful relationships with them. Dissatisfaction was higher amongst younger and recently qualified midwives, who worked in different areas within maternity. They felt frustrated with the way in which they were expected to practise midwifery, and with the lack of opportunity to build relationships with women. A significant organisational factor that caused midwives to leave was staff shortages. This resulted in high levels of stress, which in turn created high levels of both physical and mental ill health. Curtis *et al*. (2006b) questioned managers and found they were also frustrated by staff shortages, and a lack of safe skill mix (proportion of senior to junior staff) with too many junior midwives. Consequently, they were managing maternity services at the limits of safety levels and midwives were, therefore, unable to practise woman-centred care.

A further issue of concern was that a significant minority of midwife 'leavers' reported examples of bullying in the workplace (Curtis *et al*., 2006c). This occurred amongst midwives of the same grade but it was also reported that more senior midwives, such as labour ward coordinators, were often the perpetrators. The research identified that NQMs were particularly susceptible to horizontal bullying because of their lack of experience and because they were often younger. One midwife said: *'People were so tired and burnt out, they were dreadful to us newly qualified midwives in particular*' (Curtis *et al*., 2006c: 18). Midwifery managers were aware of bullying behaviour but were more likely to explain this as being a cultural rather than individual behaviour. One manager reported that: '*They [senior midwives] sadly have, I think, ceased in any kind of allegiance with women*' (Curtis *et al.*, 2006c: 20). The researchers appeared to concur with this view and suggested that change should be targeted at a systemic level, rather than singling out individual perpetrators.

Another key issue identified as a reason for midwives leaving the profession was the lack of flexibility of working patterns (Curtis *et al*., 2006d). Lack of control over shifts was cited by 49% of midwives in the study as a reason for leaving midwifery. The need to balance the workforce and to be seen to do this fairly was a reason why flexible working was not favoured by most of the midwifery managers interviewed in the study. Not being flexible, however, was incompatible with the working patterns required of many of the midwives who left, the majority of whom were women, had dependents and therefore wanted part-time or flexible working. Demographically, 40% of those leaving midwifery in the study were under 40 years old, which may also have reflected the different generational requirements of younger midwives. Given the potential number of years they had left to work, this was a finding of great concern for the future of the profession.

The second study, which was titled '*Why do midwives stay?*', was conducted in response to the same concerns around recruitment and retention of midwives (Kirkham *et al*., 2006). It specifically sought information that could be built into a strategy to improve midwifery retention and was also conducted in two phases. There were methodological flaws in the distribution of questionnaires for this study, resulting in it being sent unintentionally to 62 midwives (11%) who had already left. However, the results of the study provide interesting findings and are complementary to findings in the '*Why do midwives leave?*' report *(Ball et al*., 2002). The methodological flaws were acknowledged in the findings.

Phase one comprised sending questionnaires to 300 (5%) midwives who had notified their intention to practise (NIP) midwifery with the NMC for the year 2002/3, confirming their intention to stay in midwifery for the next year. There was a 34% return rate and from this sample, 15 in-depth interviews were then conducted with a random sample of respondents. These interviews generated themes on which the phase two survey was developed. Phase two involved sending 910 postal questionnaires to a wider sample of midwives returning an NIP form. There was a 62% response rate which is an excellent return rate for a postal questionnaire; the average return rate for any survey is only 33% (Lindemann, 2019).

In the phase two survey, midwives were given a range of reasons for staying in midwifery, based on the findings of phase one. The top three reasons for staying, according to the midwives, were related to job satisfaction. They enjoyed the job (94% agreed or strongly agreed), they felt proud to be a midwife (93% agreed or strongly agreed) and they wanted to work in their chosen area of practice (84% agreed or strongly agreed). In the free-text comments, over 20% of respondents wrote '*I love my job*'. Other aspects of job satisfaction related to their relationships with women and feeling they were making a difference. They also identified being an advocate for the women, being able to '*normalise*' midwifery care and being able to give the care they wanted to give (Kirkham *et al*., 2006: 65).

Other reasons for staying in midwifery were having positive relationships with colleagues, feeling valued as a midwife, career development opportunities and being able to provide continuity of care. The latter reason was identified by community midwives, who were more likely to develop meaningful relationships with women throughout their pregnancy than their hospital colleagues. More than half of midwives in the survey, however, reported that their job had become less enjoyable over time. Midwives who had been practising for longer were significantly more likely to report this. In the free-text comments, midwives identified increasing bureaucracy and red tape, poor staffing levels and fear of litigation as factors that made their job less enjoyable. Given the high levels of job satisfaction expressed in the report, it was significant that only two thirds of midwives said they would recommend midwifery as a career to others (Kirkham *et al*., 2006).

These studies provide historical context for the literature review and a rationale for my own study because I wanted to find out whether these conditions have improved in the last twenty years, making it easier to retain NQMs. Both reports were influential in shaping midwifery recruitment and retention strategy at the time of their publication. Because of their significance, the findings of the two studies provide a backdrop for my literature review and were influential in formulating my research focus and questions. It will be noted from the subsequent literature review that many of the themes identified in the two reports recur.

This review will firstly discuss the methodology for an integrative literature review, then explore the literature around why midwives stay and why midwives leave. The reason for including literature about midwives leaving is because such research is far more abundant and provides the other side of the coin as to why midwives stay. In understanding the reasons why they leave, it is possible to identify the factors that need to improve to enable them to stay. This review will also include literature addressing retention and attrition of NQMs. Throughout the literature, it was noted that resilience was rarely mentioned or addressed. The concept of resilience, therefore, provided a unique perspective for my study. For this reason, the review will also examine the 'concept analysis' literature relating to resilience and healthcare, providing a theoretical basis for the concepts of 'personal' and 'professional' resilience, which are used as a framework for my study.

2.3 Literature Review Methodology

A literature review is a systematic and methodical way of critically interrogating, analysing and synthesising a body of literature that already exists on a particular topic or concept (Pautasso, 2013). The purpose of completing a review as part of the research process is to identify gaps in the literature and to ensure that the proposed research is justified by previous research (Hart, 2018).

There are many types of literature review, the choice of which depends on the topic or concept to be reviewed (Hart, 2018). Hart identifies two broad categories of review: interventionist (or systematic) and scholastic (or narrative) reviews. Systematic literature reviews are considered the most rigorous and follow strict methodological guidelines, such as PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) (Page *et al.*, 2021). These are most suited to problems that require the researcher(s) to minimise doubt in a subject area. For this reason, they are best placed to answer scientific or medical questions, or to inform policy makers (Hart, 2018). Systematic reviews usually only include primary sources and are undertaken using a rigorous and systematic approach to identify best available evidence on a focused topic. They provide a synthesis of the available evidence and draw conclusions to enable best policy or practice to be identified. Systematic reviews usually

require at least two researchers who cross-check the appraisal of each study against the inclusion and exclusion criteria so that only those studies meeting strict adherence criteria are included (Nightingale, 2009). Having identified the criteria for a systematic review, it was not considered the most appropriate type of literature review for my study. The purpose of my review was to appraise a wider range of literature to inform the topic and to identify any gaps in knowledge. It was relevant to include literature in this review that does not meet the strict criteria of a systematic review, for instance grey literature (Hart, 2018).

Scholastic or narrative reviews differ from systematic reviews in that a broader range of literature can be accessed, including grey and historical literature (Hart, 2018). They are perceived to be less rigorous and are more suited to identifying relevant concepts and theories to describe and explain a particular term or phenomenon (Sarkar and Bhatia, 2021). By reviewing the current position or thinking on a particular issue, it is then possible to identify any gaps in this subject. To introduce some rigour to the process of a narrative literature review, however, Ferrari (2015) suggests that the quality of narrative reviews may be improved by using some of the methodological rigour derived from systematic reviews. Greenhalgh *et al*. (2018) provide a convincing discussion paper about challenging the assumed 'hierarchy' of systematic reviews over narrative reviews. They suggest that this is due to a misunderstanding of the rigor required for narrative reviews. This aligns with the review methodology chosen for my study, which required a rigorous approach, whilst not claiming to be a full systematic review. Due to the mixed-methods nature of my research, I looked for a specific form of narrative review methodology that was able to integrate both quantitative and qualitative paradigms, as this reflects the nature of my question. For this reason, the methodology chosen for this review was an integrative literature review.

Torraco (2005) discusses integrative literature review methodology, stating that this type of review '*describes a form of research that reviews, critiques, and synthesizes representative literature on a topic in an integrated way such that new frameworks and perspectives on the topic are generated*' (Torraco, 2005: 356). The integrative literature review has been identified as an appropriate method of review for mixed-methods studies because it seeks to

integrate a range of diverse studies (da Silva *et al*., 2020). In fact, Whittemore and Knafl (2005) go so far as to say that integrative reviews are the only approach that can address diverse methodologies such as those found in mixed-methods studies. As my study uses mixed methods, it was appropriate that the literature search to support this work also utilised a mixed-methods approach. For this reason, an integrative literature review was considered the most appropriate narrative review methodology for this review (Hopia *et al*., 2016).

It was then necessary to consider the type of integrative methodology that introduced rigor to the process of searching and analysing the data using a systematic approach. Torraco (2005) suggests that any integrative review should use a structured approach to search, appraise and collate the literature, writing up the review so the writer '*tells the story*' (p. 361) of the literature reviewed. Integrative literature reviews have become increasingly popular as a review methodology in healthcare because of the rigor introduced into the process of non-systematic reviews (da Silva *et al*., 2020). Whittemore and Knafl (2005) propose a five-stage process for the integrative review, based on the work of Cooper (1998). Cooper's model focused on integrating systematic reviews and was adapted by Whittemore and Knafl (2005) to integrate a wider scope of literature, not just systematic reviews. The subject and research questions of my study meant that my review was likely to include a range of quantitative and qualitative literature, also grey literature. For this reason, Whittemore and Knafl's (2005) five-stage integrative review process seemed most appropriate for my review. The five stages of their review method were: (a) problem identification, (b) literature search, (c) data evaluation, (d) data analysis and (e) presentation. This is the format that I have used in my literature review.

2.4 Problem identification

As previously stated, the current level of attrition amongst NQMs is high, therefore it is important to understand why many midwives still choose to remain in the profession. To answer this, the review of the literature asked: *What are the factors that influence midwives to stay in or to leave the midwifery profession?* In keeping with the purpose of a narrative review, this is a broad question, enabling a wide range of literature to be explored (Ferrari,

2015). The benefit of having a research question for the literature review is that it can be used as a focus for the review, answering the question through the findings and discussion of the review (Sarkar and Bhatia, 2021).

2.4.1 Why do midwives stay or leave?

To explore the literature relating to why midwives stay, it was also necessary to explore the factors that cause midwives to leave. Although it cannot be assumed that the same factors have the greatest influence over staying and leaving, it stands to reason that an absence of those factors may cause the opposite response. In other words, an absence of the factors most likely to enable midwives to stay in post may cause them to leave. The influential '*Why do midwives stay?*' and '*Why do midwives leave?*' studies described at the beginning of the chapter were complementary but revealed differences in midwives' motivation to stay and to leave (Ball *et al*., 2002; Kirkham *et al*., 2006). In addition, an initial scoping of the literature revealed that there was much more literature addressing why midwives leave than why they stay. For these reasons, it was decided to explore the literature relating to both staying in and leaving midwifery.

2.5. Literature search

Keywords derived from the review's research question (*What are the factors that influence midwives to stay in or to leave the midwifery profession?*) were used as search terms. These keywords were: Midwife/midwives OR midwifery AND retention OR stay AND profession/occupation OR career. A separate search was undertaken replacing retention OR stay with attrition OR leave. Another search was conducted adding AND newly qualified midwives OR early career midwives OR preceptee midwives to each of the previous searches. (Please see Table 2.2 for keyword combinations). Keywords were deliberately kept broad so that all related topics could be captured. The search engines used to conduct the search were EBSCOhost (using the following specific databases within this search engine: Health sciences research databases; Life sciences databases and Psychology/Sociology databases which include Academic Search Premier, MEDLINE, Psychology and Behavioural Sciences Collection, APA PsychInfo, APA Psycharticles, CINAHL full text, Sport Discus and eBook collection), Web

of Science and Google Scholar. Limiters were applied to restrict the search from 2010-2022. The reason for the timeframe was to be able to explore trends in attrition and retention over the last decade and since the findings of the key reports in midwifery: '*Why do midwives leave?*' and '*Why do midwives stay?*' which have already been discussed (Ball *et al*., 2002; Kirkham *et al*., 2006). The literature review was initially conducted in 2020 with a ten-year timeframe. It was then updated in 2022 prior to thesis completion to ensure all relevant literature was included in the final thesis.

Search criteria were restricted to articles in the English language, in academic, peer-reviewed journals and those that were accessible, both within a university library and via inter-library loan, and that were available in full text. Studies were also restricted to those from developed countries with comparable healthcare systems so that parallels could be drawn, although there is wide variation in the organisation of midwifery care within these countries. Literature had either to be directly addressing retention/attrition or staying in/leaving midwifery or include direct questions about these. However, primary data collection was not a necessity; literature reviews, reports and secondary data analysis were included. Boolean operators were used to combine keywords and search terms. (Please see Table 2.1 for search criteria.)

Table 2.1 Search criteria

Search criteria - included	Search criteria - excluded	Rationale
2010 – 2022	Articles pre-2010	To identify retention/attrition trends within the last decade (2010-2020), updated to 2022 for thesis submission.
English language	Papers not translated into English for publication	Time and resource constraints of review, also less relevance of non-English speaking healthcare systems
Peer-reviewed, academic journals, full text available	Non peer-reviewed journals, magazines, media reports	To maintain a level of rigour and academic standard, accessibility of full study

Primary studies, secondary data analysis, literature reviews, professional reports	Opinion articles, personal accounts, case studies	To ensure a wide range of literature was accessed whilst maintaining a level of rigour and academic standard
Developed countries i.e. Europe, North America, Australasia	Resource-poor countries, countries with mixed economies and different healthcare systems	To ensure that whilst midwifery systems may differ, results may be generally comparable to the UK
Literature directly addresses retention/attrition/staying in or leaving midwifery	Indirect findings about stay/leave without direct questioning; nursing and/or student retention/attrition	To ensure purpose or design of study addressed retention/attrition/staying in or leaving midwifery once qualified

Searches were conducted as outlined in Table 2. 2 with the findings notated in the table. The reason for including the terms 'profession, occupation or career' was to eliminate irrelevant literature that included, for instance, hospital stays or being discharged from healthcare services. (Please see Appendix 1. for the PRISMA diagrams relating to each search.)

Table 2.2 Search strategy: Why do midwives stay and leave?

Keywords	Initial hits (academic journals)	Full text/ Scholarly 2010-2022	NOT Nurse OR nurses OR nursing OR student	Abstract	Full text/ not duplicates	Hand search-ing	TOTAL INCLUDED
Midwife/midwives/OR midwifery AND Retention OR stay AND Profession/occupation OR career	755	668	32	12	8	3	6
AND Newly qualified midwives OR early career midwives OR preceptee midwives				4	0 (all duplicates)	0	0
TOTAL for STAY							**6**

Midwife/midwives/OR midwifery AND Attrition OR leave AND Profession/occupation OR career	397	362	29	20	17	8	17
AND Newly qualified midwives OR early career midwives OR preceptee midwives				4	0 (all duplicates)	0	0
TOTAL for LEAVE							**17**
TOTAL				40	25	11	**23**

Once the articles had been identified, inclusion and exclusion criteria were applied (see Table 2.3). Firstly, articles that researched nursing and students were eliminated. Forty papers were identified by titles, and abstracts were then scrutinised. Based on abstracts, 25 papers of relevance in full text were located. Hand searching against reference lists was included, and this revealed a further 11 articles. The 36 full texts were then scrutinized against the inclusion and exclusion criteria and were appraised using the Mixed Methods Appraisal Tool (MMAT) (Hong *et al*., 2018). This appraisal tool was used because it fits the mixed-methods approach of the integrated literature review. Four papers were excluded following appraisal because they were either commentaries, opinion articles or were reporting on a conference paper. A further seven papers were eliminated during appraisal because they did not meet the inclusion/exclusion criteria as they lacked direct relevance to staying in or leaving midwifery. Three papers were only about stress and burnout, which may have resulted in attrition, but this was not explicitly asked about or explored in the research. Four papers were situated in countries with incomparable healthcare systems so did not meet the search criteria. Two additional papers were excluded because they included other health care professionals.

Table 2.3 Inclusion/exclusion criteria

Inclusion criteria	**Exclusion criteria**
Qualified midwives	Student midwives OR nurses
Study directly addresses midwives' intentions to stay or leave	Not addressing staying or leaving directly in the study

Studies using any methodology	Commentary/opinion article/report on a conference
Study conducted in a country with a comparable healthcare system	Study conducted in a resource-poor country or with a dissimilar healthcare system

A total of 23 papers met the study criteria and the inclusion/exclusion criteria, and these papers were then used in the literature review. These included studies from the following countries: Australia (10), Canada (4), Hungary (1), Netherlands (2), New Zealand (2), Sweden (1), Switzerland (1), UK (1) and one was multinational (1). Methodologies found in the studies are included in Table 2.4.

Table 2.4 Methodologies of studies in the review

Methodology of studies	Number of studies	Country of study
Cross-sectional studies/surveys	9	Australia x 4 Canada x 1 Hungary x 1 Sweden x 1 Multi-national x 1 UK x 1
Prospective cohort study	1	Netherlands x 1
Mixed Methods	2	Australia x 1 Netherlands x 1
Secondary data analysis	4	Australia x 1 Canada x 1 New Zealand x 1 Switzerland x 1
Descriptive design	2	Australia x 1 Canada x 1
Phenomenology	1	New Zealand x 1
Grounded theory	3	Australia x 2 Canada x 1
Literature reviews	1	Australia x 1
Total	23	

One literature review was included in the review because the methodology of an integrative review allows for a wide range of studies to be reviewed, including literature reviews (Torraco, 2005). The literature relating to why midwives leave the profession was more abundant than that relating to why midwives stay (see Table 2.2 above). The reason for this can only be surmised but it may be that researchers are more interested in the more clear-cut reasons for attrition than in the less definable factors resulting in retention. If midwives are to be retained in the profession, however, it is important to understand the factors that enable them to remain. This supports the rationale for undertaking my study which focuses on why NQMs choose to stay in midwifery.

2.5.1 Data evaluation, analysis and presentation

The full articles were read and re-read to enable immersion in the findings and to identify overall themes emerging from the findings. A data extraction table of all the studies was produced (Appendix 2) and from this extraction, themes from each of the studies were clarified. Integrating the themes of the studies from both searches, three themes emerged:

(i) Job satisfaction (including professional identity and relationships with women)

(ii) Work-related factors (including stress, burnout and workplace environment)

(iii) Transition to newly qualified practice (including preceptorship)

These themes will be used to structure the review, although it is acknowledged that there is some overlap between the themes, and several studies also reported on both why midwives leave and why they stay.

2.5.2 Job satisfaction and intention to stay or leave

Eight studies addressed the subject of job satisfaction (Cox and Smythe, 2011; Sullivan *et al*., 2011; Versaevel, 2011; Warmelink *et al*., 2015; Jarosova *et al*., 2016; Bloxsome *et al*., 2019; Geraghty *et al*., 2019; Bloxsome *et al*., 2020). Four of the studies focused on why midwives stay (Sullivan *et al*., 2011; Versaevel, 2011; Bloxsome *et al*., 2019; Bloxsome *et al*., 2020) and four discussed lack of job satisfaction in the context of leaving (Cox and Smythe, 2011; Warmelink *et al*., 2015; Jarosova *et al*., 2016; Geraghty *et al*., 2019).

Job satisfaction ('I love midwifery', 'I love my job') emerges from the literature as a key factor explaining why midwives stay. In an integrated literature review addressing the factors associated with job satisfaction and midwives' intention to stay, seven themes were identified that influence why midwives choose to stay (Bloxsome *et al*., 2019). Relationships with both women and colleagues were identified as being important in motivating them to stay. Midwives also stated they enjoyed their job, were proud to be a midwife, and were passionate about midwifery. They felt this got them through the difficult days. They also enjoyed the variety in their work and felt they had autonomy to utilise their skills.

Bloxsome *et al*. (2020) went on to conduct a qualitative study, exploring the reasons why midwives choose to stay in midwifery in Western Australia. The researchers interviewed fourteen midwives practising in Western Australia. As in the integrated review, they found that job satisfaction played a major part in their motivation to stay. Relationships with women and with colleagues were found to be key, also the desire to pass their skills onto the next generation. Midwives unanimously stated that they loved being a midwife and felt that it defined who they were. Some felt that midwifery was their '*calling*' (p. 213) and that once they were a midwife this could not be undone. The authors identified this as an important finding because it suggests that midwifery is more than just a job and that midwives define themselves by their role. They noted that in most theories of job satisfaction, extrinsic factors (such as salary) are identified as being most important. They compared this with their study, where it was the intrinsic factors such as their personal identity as a midwife that motivated them to stay.

In the two other studies addressing why midwives stay, there are commonalities in the themes identified. In a study in Ontario, the three main reasons for staying in midwifery were midwives' satisfaction from working with women, enjoyment of their job and job satisfaction (Versaevel, 2011). The reasons they gave for job satisfaction were feeling they made a difference to their women, being able to interact with women and having autonomy in their practice. Likewise, Sullivan *et al*. (2011) found that the three key reasons for remaining in midwifery were also enjoyment of the job, job satisfaction and identifying with pride as a

midwife. Midwives gained job satisfaction when they felt they made a difference to women, interacted with women and saw women were happy with the care they received (Sullivan *et al*., 2011).

In the literature addressing why midwives stay, job satisfaction was an overriding reason why midwives remain in the profession. The midwives often expressed their motivation to stay as '*I love midwifery*'. They identified their persona as being a midwife, which defined the core of who they are. Relationships with women were central to their job satisfaction, feeling they were making a difference and developing meaningful interactions with the women in their care. Autonomy was also identified as a reason for midwives to feel they have job satisfaction, and this had a bearing on why midwives remained. Although none of the authors defined autonomy within the context of their studies, Bloxsome *et al*. (2020) stated that autonomy is about having control over one's work and not be controlled by others.

The studies that explored job satisfaction and why midwives leave (Cox and Smythe 2011; Warmelink *et al*., 2015; Jarosova *et al*., 2016; Geraghty *et al*., 2019) all discussed job satisfaction in the context of why midwives had made the decision to leave, despite reporting job satisfaction. Cox and Smythe's (2011) study provided case studies of three midwives who had left the profession in New Zealand. All practised as Lead Maternity Carers (LMC), a model of maternity care which is specific to New Zealand, and which provides continuity of carer to women. They had practised between five and eleven years and had left LMC midwifery between 6 months and 3 years prior to the study. An interpretive phenomenological methodology was used to enable the midwives to tell their stories. All three midwives strongly identified with their persona as a midwife; however, their decision to leave midwifery was caused by a disconnect between how they wanted to practise midwifery and the reality of that practice. The midwives felt betrayed by the wider system of care, which failed to support them when they - and their women and babies - required support. Despite the job satisfaction derived from building relationships with women, this study demonstrates very strongly the personal and professional cost of working within a caseload model of midwifery, where responsibility and accountability are high (Cox and Smythe, 2011). The personal detriment to

their own health was eventually too costly to be sustained. Interestingly, none of these three midwives left midwifery entirely; they moved into a different model of midwifery care (Cox and Smythe, 2011).

The study by Jarosova *et al*. (2016) was multi-national, across seven countries - Italy, Poland, Czech Republic, Slovakia, Portugal, Singapore and South Korea - with 1122 midwives completing questionnaires. One in three respondents (37.8%) had considered leaving their organisation, one in four respondents (26.0%) intended leaving the country to practise elsewhere, and one in five respondents (21.6%) intended leaving midwifery altogether. Whilst there were significant differences between the seven countries in intention to leave the workplace and intention to work abroad, there were no significant differences between countries in intention to leave the profession ($p = 0.12$). The strongest correlation was between low job satisfaction and intention to leave, which was demonstrated across all demographic groups and countries, although some groups were less likely to express poor job satisfaction, such as those that worked in hospitals and those with 26-30 years' experience (Jarosova *et al.*, 2016).

Geraghty *et al*. (2019) discussed the stressful working practices of midwives and how this has contributed to midwives seriously thinking about – or actually – leaving the profession. The midwives in this study, however, only worked in a hospital environment. Midwives identified their reasons for contemplating or actually leaving as either a sense of not belonging to the midwifery 'club' or because midwifery practice was not what they wanted it to be. Both these situations generated stress that ultimately affected their health and resulted in their intention or decision to leave.

Lack of job satisfaction was also identified as a strong determining factor in why midwives leave in the study by Warmelink *et al*., (2015) , which explored the career plans of primary care midwives working in the Netherlands. The model of maternity care in the Netherlands is unique in Western countries as it supports a high percentage (85%) of primary care midwives, who are self-employed, and the highest percentage of homebirths anywhere in the

developed world (Warmelink *et al*., 2015). Over the past decade, however, increasing medicalisation of birth is undermining this system of care and changing the way in which midwives practise. More women are being cared for in hospital and more midwives are therefore working as hospital employees (Feijen-de Jong *et al*., 2022). Warmelink *et al*. (2015) purposely sampled primary care midwifery practices and asked midwives in these practices to complete a questionnaire, including career intentions over the next five years. Of the 98 completed returns, 32 midwives (32.7%) expressed an intention to leave primary care practice within the next five years. Only three of these midwives (9.4%) were intending to leave the profession. Significant correlation was found in the characteristics of those who intended to leave; midwives in the age group 30-45yrs were significantly more likely to express an intention to leave than any other age group ($p=0.003$), and those who intended to leave had a significantly lower job satisfaction score (4.25 compared with 4.61, $p < 0.001$).

From these studies, job satisfaction emerges as a significant factor in the retention of midwives. Job satisfaction is both intrinsic (derived from personal and professional identity as a midwife) and extrinsic (derived from developing fulfilling relationships with women and colleagues). Factors creating job satisfaction, such as developing positive relationships with women through providing continuity of care, can also be the factors causing midwives to leave if working practices or conditions prevent midwives from achieving this goal. The midwives in the studies exploring why midwives leave felt job satisfaction was poor when the job did not live up to their ideals for midwifery. They were not experiencing the level of job satisfaction that made the job worth staying for. It is no surprise that lower job satisfaction correlates with intention to leave, but these studies provide evidence that job satisfaction needs to be considered seriously if midwives are to be retained in the profession.

2.5.3 Work related factors and intention to stay or leave

Fourteen out of the twenty-three studies explored the effects of workplace factors on why midwives stay or leave. Of these studies, only one focused on why midwives stay (Gebriné *et al*., 2019). All other studies explored why midwives leave or their intention to leave (Cameron, 2011; Pugh *et al*., 2013; Hildingsson and Fenwick, 2015; Pallant *et al*., 2016; Royal College of

Midwives, 2016; Leinweber *et al*., 2017; Geraghty *et al*., 2019; Harvie *et al*., 2019; Stoll and Gallagher, 2019; Butska and Stoll, 2020; Peter *et al*., 2021; Catling *et al*., 2022; Feijen-de Jong *et al*., 2022). Due to the number of studies in this section, the results will be presented under two headings: burnout and stress and workplace culture.

2.5.3.1 Burnout and Stress

Burnout and stress are discussed as key factors in midwives who considered leaving the profession in six of the studies in the review (Hildingsson *et al*., 2013; Gebriné *et al*., 2019; Geraghty *et al*., 2019; Harvie *et al*., 2019b; Stoll and Gallagher, 2019; Butska and Stoll, 2020). Three of the studies were part of an international study (the {WHELM} study), which explored the relationship between midwives' emotional wellbeing and their intention to leave the profession. These studies all found a correlation between emotional wellbeing and intention to leave (Harvie *et al*., 2019; Stoll and Gallagher, 2019; Butska and Stoll, 2020).

In the initial Australian {WHELM} study, data relating to midwives' intentions to leave the profession were analysed as a subset of the {WHELM} data (Harvie *et al*., 2019). Of the 1037 midwives who completed the survey, 42.8% of midwives had thought of leaving in the last six months. This compares with 67.3% in the Canadian study (Stoll and Gallagher, 2019). The study by Harvie *et al*. (2019) found that the two key reasons midwives gave for considering leaving were dissatisfaction with the organisation of care and with their role as a midwife. Early career midwives (those who had been practising between two and five years) who had considered leaving were the most dissatisfied with their role (68%) compared to any other group. One of the sub-themes for dissatisfaction was '*I am at breaking point*', which strongly related to midwives' feelings of stress, burnout and being overwhelmed by the workload. Stress and burnout in turn, led to intention to leave the profession (Harvie *et al*., 2019).

The Canadian study (Stoll and Gallagher, 2019) was distributed to practising midwives in British Columbia (BC) and Alberta via the Midwives' Association of British Columbia. Over two-thirds of midwives (67.3%) reported that they had thought of leaving midwifery within the last six months (Stoll and Gallagher, 2019), a higher proportion than in Australia, although

only 34.7% stated they had seriously considered leaving the profession. Of those midwives thinking of leaving, 84.8% cited disruption to their personal life of being on-call as the main reason for their intention to leave. The model of midwifery practice is significantly different in Canada, with most Canadian midwives practising caseload midwifery. This model of practice may account for the differences in findings in the Canadian study (Stoll and Gallagher, 2019).

Using the same data as Stoll and Gallagher (2019), the two Canadian states of Alberta and British Columbia (BC) were then compared in more detail because it was noted that levels of burnout were very different between the two states (Butska and Stoll, 2020). Overall burnout score in BC was 49 (where 50 indicates moderate burnout) whereas the average score in Alberta was only 36. In BC, 44% of midwives had seriously considered leaving, compared to only 25% of midwives in Alberta. When asked why they had considered leaving, the impact of being on-call was the most frequently cited reason by both groups (84% for BC and 92% for Alberta). When looking at the reasons for burnout, high workload was the most common reason given by both groups (67% from BC and 54% from Alberta) but the reason for the difference was put down to size of caseload. Midwives in BC had an average caseload of 43 women per year, whereas those in Alberta had an average of 34 women per year. It seems there was a workload tipping point where the satisfaction of being a midwife and providing continuity to women was outweighed by the burnout and stress experienced because of the disruption to personal life by being on-call.

A Swedish study exploring burnout and intention to leave in midwives found that 30.3% of midwives had considered leaving (Hildingsson *et al*., 2013), which although compares favourably to other countries, still represents nearly one-third of midwives surveyed. The most frequent reasons for thinking of leaving were shortage of staff and a stressful working environment (32.5%) and conflicts with colleagues and managers (24.9%). There was a statistically significant correlation between high levels of anxiety, depression, stress and burnout. Although the study looked at length of time since qualifying, this was not a significant factor in intention to leave. As with the study by Harvie *et al*. (2019), however,

levels of work-related burnout were higher in younger midwives and those who had qualified recently.

Stress was identified as a separate concept from burnout in some of the papers (Gebriné *et al*., 2019; Geraghty *et al*., 2019). Whilst acknowledging that the job itself was stressful, midwives identified work-related stressors such as staff shortages, poor management, completing records electronically and acute emergencies as being the factors that stressed them most (Geraghty *et al*., 2019). Once these stressors outweighed their job satisfaction and started impacting their personal life, they considered leaving midwifery. One midwife said '*My kids are saying to me 'you OK Mum'?*' (Geraghty *et al*., 2019: e299). This midwife did not know if she could carry on. A strong sense of coherence, defined as a person's viewpoint on life and capacity to respond to stressful situations, was found to keep midwives in the job (Gebriné *et al*., 2019). Sense of coherence is related to being resilient and it has been shown that a strong sense of coherence is linked to high levels of job satisfaction (Gebriné *et al*., 2019). It has also been linked to having good health, and midwives in the study were 22.4% more likely to stay if they identified as having best health rather than worst health. Sense of coherence, stress and working conditions were all directly and indirectly related to health, which indicates that increasing a sense of coherence, reducing stress and improving working conditions could all reduce the intention to leave.

One of the commonalities from the studies in this theme is that midwives who had thought about leaving had significantly higher levels of burnout, stress, anxiety, and depression than those who had not considered leaving. Work-related burnout was a result of unsustainable patterns of care (such as caseload working), shortage of staff, high workloads, and dissatisfaction with the role. While midwives in all the studies identified with a love of the job, once the impact of the job had a detrimental effect on their personal life or their health (anxiety, depression, stress and burnout), there was a tipping point where the job was no longer sustainable, and they considered leaving. Personal protective factors, such as a sense of coherence (one of the elements of resilience), and good health were important in enabling midwives to cope with these stressors and they were then less likely to consider leaving.

Given that workplace factors were identified as the main cause of stress and burnout in all the above studies, the second theme explores how the environment of the workplace influences midwives' intention to stay and leave. Understanding what these environmental factors are and how to manage them is an important component in understanding how to improve the retention of midwives.

2.5.3.2 Workplace environment

The environment of the workplace in midwifery has received much attention in the literature over several decades. Environment is a broad term that relates to the conditions that affect midwives' working lives, such as staffing levels and workload as well as the relationships between midwives and managers, and between midwives and their peers. The five studies included in this theme are Pugh *et al*., 2013; Pallant *et al*., 2016; Royal College of Midwives, 2016; Catling *et al*., 2022; Feijen-de Jong *et al*., 2022.

The original '*Why do midwives leave*?' study, discussed at the beginning of this chapter, (Ball *et al*., 2002) was revisited by the RCM in 2016 (Royal College of Midwives, 2016). The RCM study targeted its membership and asked any midwife who had left in the previous two years or was intending to leave in the next two years to complete an online survey during a two-week period. Of the 2,719 respondents, 30.8% had left and 69.2% were considering leaving in the next two years. The main reasons for leaving the profession were cited as: inadequate staffing levels; dissatisfaction with the quality of care they were able to give; high workload; lack of support from their manager; and dissatisfaction with working conditions (Royal College of Midwives, 2016). These reasons were little different from the findings of Ball *et al*. (2002) some 14 years earlier.

A similar study in the Netherlands compared community midwives who intended to leave with those who had left (Feijen-de Jong *et al*., 2022). The Netherlands has a specific model of midwifery which means that 72% of midwives work in group practices in the community and are self-employed. They can take on as much work as they want but an average midwife has a caseload of over 100 women per year. This is approximately three times the recommended

number in the UK, although the model of case-loading is different (Ball and Washbrook, 2010). From the sample of midwives who were still in practice in the Netherlands, 33.7% of midwives were intending to leave. The main reasons given for intention to leave were dissatisfaction with the organisation of maternity care (14.2%), family commitments (12%) and dissatisfaction with their role as a midwife (6.1%). Reasons for having left were work-life conflicts, on-call shifts, traumatic work events, work overload and lack of resources. These are all similar themes to other studies, which is perhaps surprising, given that midwives in the Netherlands would appear to have more personal control over their work environment. The study also identified NQMs as a separate group, which will be explored in the next theme.

Two Australian studies explored environment and leaving intentions of midwives who were still in employment, (Pugh *et al*., 2013; Catling *et al*., 2022). Both studies used surveys, and Catling *et al*. (2022) also used the Australian midwifery workplace culture instrument, developed in a previous study (Catling and Rossiter, 2020). Twenty percent of the midwives (excluding those intending to retire) in the study by Pugh *et al*. (2013) compared with 68.3% in the study by Catling *et al*. (2022) expressed intention to leave the profession. Factors most likely to retain staff were identified as working practices such as flexible working arrangements and models of care such as caseload midwifery, adequate staffing and support from managers. This concurs with other studies in the review where more flexible working arrangements and support from management were identified as factors that would enable midwives to stay (Stoll and Gallagher, 2019; Feijen-de Jong *et al*., 2022). Intention to leave was higher for younger midwives in the study by Catling *et al*. (2022), although age did not reach statistical significance.

A New Zealand study that also used a scale to measure workplace factors, adapted the validated Practice Environment Scale (PES), which measures the quality of the workplace environment, and correlated this with wellbeing, job satisfaction and risk of attrition (Pallant *et al*., 2016). The scale assessed quality of management, midwife-doctor relations, resource adequacy and opportunities for development. The study found that a poor experience of all these items was a predictor of attrition. The strongest predictors of midwives considering

leaving were quality of management and resource inadequacy (poor staffing), a similar finding to the previous studies. Developing tools such as the PES may provide an effective way for managers to identify workplace factors that are the greatest cause of attrition.

None of these studies primarily focused on bullying and intention to leave but a bullying culture was identified as one of the reasons for midwives considering leaving in several of the papers. In the RCM study, of those who had already left, 19% had experienced bullying from colleagues and 11% from managers. Of those who were intending to leave, 13% had experienced bullying from managers and 9% from colleagues (Royal College of Midwives, 2016). In Stoll and Gallagher's study (2019), 34.3% of those intending to leave stated this as one of the reasons and the experience of bullying correlated with levels of stress for some of the midwives. In the study by Harvie *et al*. (2019), midwives cited the hierarchical nature of midwifery and consequent bullying as a reason for intention to leave. Even in studies exploring why midwives stay, there are accounts of bullying in those surveyed (Versaevel, 2011), where bullying and negativity by colleagues were identified as workplace concerns. The accounts in these studies represent over a decade of bullying found in midwifery in different countries, appearing as a common thread in many of the studies exploring why midwives leave. Bullying will be explored further within my own study and in the discussion.

2.5.4 Transition to Newly Qualified Practice

The only study in the literature review to explore retention of NQMs and transition to practice directly was a study of the First Year of Practice (FYP) programme in New Zealand (Dixon *et al*., 2015). This is equivalent to the preceptorship year for NQMs in the UK (Nursing and Midwifery Council, 2019a). This retrospective cohort study obtained data from 415 midwives who were registered on the FYP programme over a three-year period (2007-2010). This represented 91% of all midwives graduating in New Zealand during this time. The study followed participants' registration over a five-year period and found that in 2012, up to five years after the midwives had qualified, 86.3% of them still had an active practice certificate, meaning that they were still practising midwifery. By the time the NQMs were followed up, there was a shift towards self-employed practice (from 47.8% to 53.9%) and away from

hospital employment (from 36.9% to 23.3%). Whether this was responsible for the high retention rate was not explored.

The New Zealand study found that the success of the FYP programme in retaining midwives was due to the formal but individualised nature of the programme (Dixon *et al*. 2015). The graduate midwives gained post-qualifying education, professional development and formal mentoring. The success of the programme in retaining NQMs resulted in this becoming a mandatory requirement for all NQMs in New Zealand from 2015. It would be useful to conduct a long-term longitudinal follow-up of midwives undertaking the FYP programme to discover whether it has benefits for retention over a longer period of time.

Whilst not addressing NQMs directly, six studies in the literature review identified results relating to NQMs or younger midwives (Pugh *et al.*, 2013; Hildingsson and Fenwick, 2015; Perry *et al*., 2017a; Harvie *et al*., 2019; Catling *et al*., 2022; Feijen-de Jong *et al*., 2022). These studies identified that younger midwives were more likely to have considered leaving or were intending to leave midwifery (Peter *et al*., 2021; Catling *et al*., 2022), were more susceptible to burnout (Hildingsson and Fenwick, 2015) and had worse mental health scores than either the whole midwifery or the general population (Perry *et al*., 2017). While the younger age group does not necessarily equate to being newly qualified, it is likely that most midwifery graduates are younger than their counterparts. These poorer outcomes are therefore more likely to be found in those midwives who are most recently qualified. This is of relevance to my study, which aims to identify the factors most likely to retain NQMs in midwifery.

2.5.5 Summary

This integrative literature review identified 23 studies which met the criteria for the review, all of which explored why midwives stay and/or why they leave. The key theme identified in the studies about why midwives stay was good job satisfaction ('I love being a midwife'; relationships with women and patterns of working such as continuity of care or caseload schemes). Key factors causing them to consider leaving or to leave midwifery were summarised as workplace factors (stress and burnout, poor staffing levels, high workload,

poor professional relationships and lack of flexible working). For NQMs, the transition to newly qualified practice was strengthened by having a supportive transition programme. From the literature, it was evident that factors which could retain midwives in the profession, such as job satisfaction through caseload midwifery, could also be the factors that caused attrition if the conditions became too stressful. For instance, where midwives had too many women to care for in their caseload, the work impacted on their personal life and became too stressful to continue. This in turn caused them to leave, either the model of care they were working in, or the profession. Retention is dependent on maintaining a good working environment (for instance adequate staffing, flexible working, manageable caseload) to ensure that the job satisfaction of midwives outweighs the factors that cause them to leave.

The literature review revealed a lack of studies specifically addressing retention and attrition of NQMs, which is the focus of my study (why NQMs choose to stay). While there is much written about the benefits and challenges of preceptorship and about the transition of NQMs into their role, there is almost no literature exploring why they stay or leave. There is an abundance of nursing literature on retention and attrition of newly qualified nurses (NQNs), but there are different challenges and stressors in midwifery that cannot be generalised from the nursing literature. Nevertheless, literature relating to NQNs was read for background information. One of the key themes identified in the NQN retention and attrition literature is that of resilience, both personal and work-related resilience (Alshawush *et al*., 2021; Kim and Choi, 2022).

The concept of resilience is missing from the literature exploring retention and attrition of midwives. Whilst resilience was introduced in the paper by Gebriné *et al*., (2019) through the idea of 'sense of coherence', it was not discussed as a separate factor. Given that resilience implies sustainability of a specific or adverse situation, it might be hypothesised that midwives with greater resilience are more likely to stay, even if the working environment is challenging. It is, therefore, surprising that resilience has not appeared in the retention and attrition literature relating to midwives. This provides a gap in the literature which my study has addressed, providing a unique perspective on NQMs, retention and resilience. Prior to

undertaking the study, it was important to identify what the literature reveals about resilience. In the workplace, there are two types of resilience: one relates to the resilience characteristics of the individual person, and one relates to the resilience of a person in withstanding their working environment. For the purposes of this study, these have been given the terms 'personal' and 'professional' resilience. A review of the literature relating to personal and professional resilience using principles of concept analysis is now discussed.

2.6 Resilience

Resilience is a multifaceted and complex concept that has a wide range of definitions. The term 'resilience' is used within a growing number of academic disciplines and the definition of resilience depends upon the context of each discipline (Wiig *et al.*, 2020). There has also been a growing interest in the concept of resilience within healthcare, both at a system and at an individual level (Hollnagel *et al*., 2013). A concept analysis of resilience from the literature found four defining factors: rebounding, determination, social support and self-efficacy (Garcia-Dia *et al*., 2013). Rebounding (described as 'bounce back' in some literature) is the ability to come back from adversity or challenging situations, redefining normality in the face of life-changing events. Determination describes the belief that individuals have in themselves to overcome hurdles that might prevent them from achieving a goal. Social support (defined as at least one important relationship with one significant other person) has been found to be an essential element in individuals who are described – or would describe themselves – as resilient. Self-efficacy is described as the belief in oneself to act in such a way as to reach set goals (Gillespie *et al*., 2007; Garcia-Dia *et al*., 2013).

The relevance of resilience to my study is because it could be hypothesised that midwives with greater resilience are more likely to stay in midwifery. It was decided to include a resilience scale in the research to test this hypothesis. It was therefore important to explore the literature in healthcare relating to resilience and to define the concept of resilience from the healthcare literature. After an initial search, it became clear that two types of resilience dominated the literature in healthcare: 'personal' and 'professional' (or work-related) resilience. It was decided to include a discussion of the literature specifically relating to the

definition and concepts of the terms ‘personal resilience’ and ‘professional resilience’ using principles of concept analysis. This section will critique definitions and concepts of personal and professional resilience through the healthcare literature. It will not address interventions to build resilience, but these will be explored in the discussion chapter in Chapter 5.

Concept analysis is defined as “*a means of identifying characteristics and attributes of abstract or ill-defined concepts with the purpose of achieving clarity*” (Cronin *et al*., 2010: 62). The technique of concept analysis may use either an evolutionary approach, where concepts are revisited through the analysis as more literature is uncovered, or a principles-based approach, which is a more linear approach and follows more rigorous and systematic processes (Smith and Mörelius, 2021). Whilst some of the techniques of concept analysis are used in this discussion, it does not use rigorous principles of either methodology, as this is beyond the scope of the review. Instead, a hybrid model of concept development has been adopted, comprising three phases: theoretical, fieldwork (collecting data) and analytical (Schwartz-Barcott *et al.*, 2002). The theoretical phase will be addressed in this chapter by defining the concepts to be explored and analysing the literature; fieldwork has been addressed through data collection in my research using resilience tools; by combining the literature review and my data collection, analysis in the discussion chapter reaches new conclusions about the concepts of ‘personal’ and ‘professional’ resilience.

A search of the literature for this analysis used the same databases with the same date limiters as for the stay or leave literature (see section 2.5.1 above); however, the parameters for the concept analysis review were broader than for the integrative review of why midwives stay or leave. The findings included primary research, literature reviews, discussion papers, reports and independent publications. It also included literature relating to all healthcare professionals. Please see Table 2.5 for the search strategy, key words and findings.

Table 2.5 Search strategy: Personal and professional resilience

Keywords	Initial hits (academic journals)	Full text/ Scholarly/ 2010-2022	NOT intervention (including COVID)	Abstract	Full text/ not duplicates	Hand searching	TOTAL included
Personal resilience (title) AND healthcare OR nurs* OR midwif*	146	102	36	24	6	1	7
Professional resilience (title) AND healthcare OR nurs* OR midwif*	218	143	33	19	7	3	10
Total							17

After eliminating articles on full text and including sources found by hand searching, a total of 17 sources remained. One of the sources was a management publication on personal resilience and one was a report on a commissioned research project, both from the UK. There were 15 journal articles, including two literature reviews, five discussion papers, and qualitative and quantitative studies. Please see Table 2.6 for a breakdown of studies and countries.

Table 2.6 Methodologies of studies in resilience review

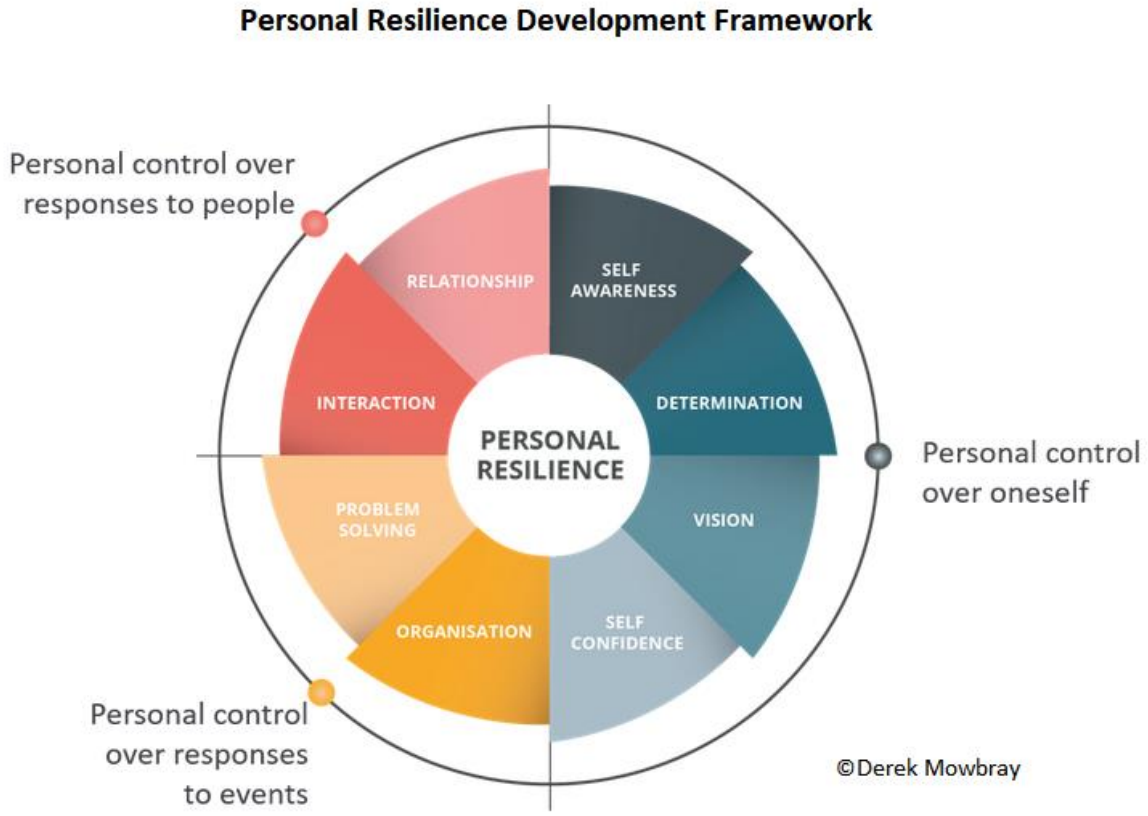
Methodology of studies	Number of studies	Country of study
Scale development	2	Australia x 1 China x 1
Descriptive cross-sectional	1	Israel x 1
Exploratory descriptive	2	UK x 2
Narrative inquiry	1	Australia x 1

Grounded theory	1	USA x 1
Collective case study	1	Australia x 1
Literature reviews	2	Australia x 1 Singapore x 1
Discussion paper	5	Australia x 1 New Zealand x 1 UK x 3
Report	1	UK x 1
Course materials	1	UK x 1
Total	17	17

2.6.1 Personal Resilience and conceptual models

In the literature, there appears to be consensus over the definition of personal resilience. It has been described as '*the ability to recover quickly from illness, change or misfortune*' and '*to bounce back from adversity and difficult circumstances*' (Scammell, 2017: 939). Mowbray (2021: 3) defines resilience as '*having flexible strength of mind to face up to, and overcome, challenges. The more threatening the challenge appears to you, the more you need to be resilient*.' He puts forward a model of personal resilience with eight components (see Figure 2.1). He identifies three areas of personal control: control over responses to people, control over responses to events and control over oneself. The model therefore defines personal resilience as having control over both intrinsic and extrinsic elements or characteristics.

Figure 2.1 Personal Resilience Development Framework (Mowbray, 2021)



Many of these intrinsic and extrinsic elements are identified through the other papers addressing personal resilience. Wei and Taormina (2014) developed a new scale to assess personal resilience using nurses in two Chinese hospitals. They developed a 10-point scale for each of four subscales: determination, endurance, adaptability and recuperability. The study found that organisational socialisation was key to developing nurses' resilience. If nurses felt well-supported and had good knowledge and education within the organisation, they scored higher on the personal resilience scale (Wei and Taormina, 2014). This was similar to the findings amongst healthcare students in Israel, where it was found that there was a strong correlation between competency, autonomy and personal resilience in nursing students (Avrech Bar *et al*., 2018). Their study used the 10-point version of the Connor-Davidson resilience scale (Campbell-Sills and Stein, 2007) which has been extensively used in healthcare studies and was also used in my study (see Chapter 3 for further discussion). Both scales combine intrinsic and extrinsic personal characteristics.

Both the above studies suggest that resilience increases with experience as knowledge, competency and autonomy are all likely to develop as healthcare professionals gain more experience. A study of the perceptions of personal resilience in intensive care doctors supports this suggestion (Desai, 2021). Desai (2021) found that the doctors identified five themes, one of which was that personal resilience is developed through experience. She also found that certain characteristics of resilience were perceived as important: having resilient attitudes and behaviours, maintaining harmony and cognisance, and understanding the professional environment and challenges to the system. Like the previous studies, the doctors identified both intrinsic and extrinsic elements in their perceptions of personal resilience (Desai, 2021). The doctors in this study were experienced ICU physicians, but the link between experience and resilience would suggest that newly qualified healthcare professionals may have lower personal resilience because they have less experience. Desai (2021) also discussed the sustainability of resilience in areas of high pressure, such as ICU, if trainee doctors are to be retained.

There are two schools of thought about whether individuals are characteristically resilient (personality-oriented) or whether resilience can be developed (process-oriented) (Chmitorz *et al.*, 2018). One study asked nurses and midwives to self-identify themselves as being resilient (Mcdonald *et al.*, 2016). Amongst these self-assessed 'resilient' nurses and midwives, they identified three factors that were perceived by them to foster resilience. These factors included personal characteristics, the most important of which were self-care and self-motivation. These are not the same characteristics identified by Mowbray's (2021) model, which includes self- awareness and self-confidence, but it could be suggested that self-care and self-motivation require the person to be self-confident and self-aware to be able to develop these. Other factors identified in the research by Mcdonald *et al*. (2016) were support networks and organising work for resilience. Whilst these characteristics can be nurtured by the individual, they are also reliant on external factors, again recognising the intrinsic and extrinsic nature of personal resilience.

The authors who support the idea that resilience is or can be developed provide suggestions about building resilience (Scammell, 2017; Thomas, 2018; Mowbray, 2021). Whilst this

chapter focuses on the concepts of personal and professional resilience, the discussion chapter will explore some of the methods identified to develop resilience in both individuals and organisations. Scammell (2017) and Thomas (2018) both agree that while personal resilience can be taught, organisations should not focus on increasing individuals' resilience at the cost of ignoring organisational factors. As stated by Scammell,

> '*…resilience is not simply something for the individual to learn; the workplace context plays a large part in being an enabler or barrier to healthy working practices and this requires commitment in terms of organisational policies'* (Scammell, 2017: 939).

If resilience is only seen as an individual attribute, not being resilient can be seen as a personal failure. But if the organisation is not healthy, no amount of personal resilience may be enough to withstand the workplace adversity. Thomas (2018) reiterates this by suggesting that if personal resilience is a prerequisite to withstanding workplace adversity, the culture of the workplace itself needs to be examined to reduce the level of personal resilience required.

From the literature on personal resilience, it appears there are both intrinsic and extrinsic characteristics that define personal resilience. However, it also appears that personal and professional resilience are highly integrated. If a person has a high level of personal resilience, they may withstand a high level of workplace adversity (Mcdonald *et al.*, 2016). But high levels of workplace adversity may reduce personal resilience, leading to burnout and even attrition from the workplace (Desai, 2021). The definition of professional resilience and what this means for the individual, the workplace and the organisation will be explored in the next section.

2.6.2 Professional Resilience and conceptual models

Professional resilience is a more complex concept to define. The definitions and characteristics of resilience frequently focus on the individual and their response to challenging or adverse situations. There is an increasing awareness, however, of the role of organisations and the characteristics of the workplace in creating an environment where resilience can flourish (van Gorder, 2013; Scammell, 2017). It has been found that workplace

factors such as workload, staffing levels and workplace culture have a significant effect on the resilience and wellbeing of an organisation and of employees within the organisation (Scammell, 2017). Although this is described in the literature as professional, organisational or workplace resilience, there is no clear definition of the meaning of the term 'resilience' in this context (Huey and Palaganas, 2020).

Factors that both increase and decrease professional resilience have been identified, as well as numerous ways to improve professional resilience (these will be explored in the discussion in Chapter 5). In a discussion paper on resilience, Thapa *et al*. (2021) state that leaders and managers have a professional obligation to ensure workplaces are resilient by improving working conditions and developing resilience in the workforce (Thapa *et al.*, 2021). This section will explore the definitions of professional resilience emerging through the literature, then identify what factors increase and decrease professional resilience.

Resilience has, as already stated, been conceptualised from an individualistic perspective, even when it is acknowledged that external or work-related factors may influence an individual's resilience. This was the perspective taken by Huey and Palaganas (2020) in their literature review of factors affecting resilience in health professionals. The influence of individual traits was one of the themes identified in their literature review; however, they also identified environmental and organisational factors as important influences on professional resilience. These factors particularly related to workplace culture. They identified elements that improved workplace culture, thereby improving professional resilience, such as work-life balance, psychologically safe support, positive teamwork and meaningful recognition. These are all factors that are externally determined but can have a positive effect on the individual's ability to be resilient (Huey and Palaganas, 2020).

Another way of conceptualising resilience is at a group or community level. Three papers explore social models of resilience (Sanderson and Brewer, 2017; Winkel *et al.*, 2019; Aburn *et al.*, 2020). They start from the premise that resilience has no definitive meaning and is defined in many ways according to context. Winkel *et al*. (2019) conceptualise resilience using

a socio-environmental model. The authors use the concept of a tree to visualise the effects of resilience on the journey to becoming an obstetrician/gynaecologist. Resilience is identified as the tree itself (roots, branches, leaves), which brings stability to be able to flourish and grow (career aspirations) towards becoming a fully qualified obstetrician and gynaecologist. In a similar way, both Aburn *et al*. (2020) and Sanderson and Brewer (2017) perceive resilience as a social construct, where each group or community constructs resilience according to their social context. Aburn *et al*. (2020) purport that, given the social connectedness of resilience, the phenomenon of resilience cannot be minimised to an individualistic or biomedical level, which is often how resilience is perceived. They suggest that resilience is the inevitable consequence of experiences, environment, cultural context and relationships. They argue for a collective, team approach to developing resilience in nursing staff, which they suggest will ultimately lead to better quality of patient care.

These discussions about the concept of resilience provide differing perspectives on what professional resilience means and how it can be achieved. As identified by Sanderson and Brewer (2017) there is no accepted definition of professional resilience in the healthcare literature, despite the numerous studies. Two factors identified through the literature that positively and negatively influence professional resilience have been selected for further discussion: professional identity which fosters professional resilience, and burnout and stress, which undermine professional resilience. Both factors relate to my study and are therefore worth exploring in more depth.

2.6.2.1 Professional identity

Professional identity is largely developed through professional socialisation within each professional group from early on in a health professional's career (Price *et al*., 2021). Strong professional identity has been recognised in several of the papers as one of the work-related factors that increases resilience (Hunter and Warren, 2013; Hunter and Warren, 2014; Winkel *et al*., 2019). Winkel *et al*. (2019) identified this as one of four factors that promoted work-related resilience. Where junior doctors felt they were making progress or were able to pass on their knowledge to other doctors in training, they had a greater sense of professional

identity and were growing their resilience. Where they felt they had made a mistake, this undermined their professional identity and therefore resilience, unless they were able to see this as a learning opportunity. Professional development was also seen as part of their professional identity and was also an important aspect of professional resilience (Winkel *et al.*, 2019). Another study discussed the importance of professional identity when developing resilience in occupational therapists (Ashby *et al.*, 2013) and reiterated that professional identity was developed through professional socialisation. They define professional socialisation as developing both formal and informal networks within their workplace, resulting in increased professional support. The professional relationships that developed were important in building professional resilience and were also given as the reason why occupational therapists stayed in the job.

There are very few studies exploring resilience in midwives, but one study explored the resilience of midwives who had chosen to stay in midwifery for a considerable length of time (Hunter and Warren, 2013; Hunter and Warren, 2014). This study investigated the concept of resilience in midwives who had more than 15 years of 'hands-on' clinical experience and self-identified as being resilient. One of the themes emerging from the study was 'self-awareness' and under this theme, personal and professional identity and autonomy were important concepts to the midwives. Professional identity related to their love of midwifery and sense of belonging to the midwifery family. Professional identity was strongly integrated with personal identity, for instance one midwife stated: '*A midwife is what I am. It's written through my body like a stick of rock*' (Hunter and Warren, 2013: 32). This strong sense of inter-related personal and professional identity was important for the development of professional resilience. This was an unexpected finding in their work, which the authors suggest may be relevant to other healthcare workers (Hunter and Warren, 2014). The authors' resilience framework for midwifery was used as the basis for developing a resilience framework for my study (see Chapter 3).

2.6.2.2 Burnout and stress

There is an abundance of literature addressing burnout and stress in healthcare practitioners, as already identified, but this section only discusses the papers that directly discuss burnout and stress and resilience. It is interesting that burnout is identified as a significant theme in the 'why midwives leave' literature, as well as in the literature relating to resilience. Most of the papers in this review identify burnout as one of the organisational factors that impact resilience. For instance, in the discussion paper by Thapa *et al*. (2021) , burnout is related to compassion fatigue, which in turn decreases resilience. They suggest compassion fatigue occurs when the physical and psychological needs of patients outstrip the ability and capacity of healthcare professionals to be able to provide care (Thapa *et al.*, 2021). Building team resilience, where the burden of care is shared, may be one way of overcoming compassion fatigue and therefore reducing burnout and stress (Aburn *et al.*, 2020). A collective approach to overcoming workplace adversity not only benefits the practitioners but also has a positive effect on the care provided (Aburn *et al*., 2020).

The literature identifies many factors in the work environment that lead to burnout, such as high workload, low resources, difficult working conditions including workplace trauma and lack of support (Mcgarry *et al.*, 2013; Aburn *et al.*, 2020; Huey and Palaganas, 2020; Thapa *et al.*, 2021). This undermines resilience which ultimately prevents the development of a resilient workforce. Strategies at both personal and organisational level are required to prevent burnout and compassion fatigue and increase professional resilience (Winkel *et al.*, 2019). Being constantly exposed to medical trauma or to intense physical and psychological demands can reduce resilience and result in burnout and stress, ultimately affecting both the practitioner and the quality of care (Mcgarry *et al.*, 2013; Winkel *et al.*, 2019). One study found that burnout and stress resulting from medical trauma in a paediatric setting were higher in those who were under 25 years old (Mcgarry *et al*., 2013). This may also be of relevance to newly qualified practitioners.

Brennan (2017) discusses the relationship between burnout, resilience and wellbeing in nurses. She suggests that by developing resilience in the workplace, through better working

practices, and by taking care of staff wellbeing, burnout and stress can be reduced. She suggests that resilience and wellbeing can be developed through better staff support and training, improving work-life balance, and introducing self-care practices such as mindfulness. A reduction in burnout and stress ultimately results in better patient care and a reduction in staff turnover (Brennan, 2017).

An integrative review by Moran *et al.* (2023) explored what is known about midwives' wellbeing and resilience in the context of workplace stress and adversity. They found that there were risk factors for adversity, such as shortage of staff, high workloads, lack of flexible working and poor workplace culture. There were also protective factors that built midwives' resilience, which were both internal and external. Internal factors included a strong sense of personal and professional autonomy and a sense of coherence. External factors included patterns of working such as continuity of care and control over shift rotas, also having a positive workplace culture. Finally, the review identified sustaining factors for midwives' wellbeing. This included job satisfaction, a strong sense of professional identity and positive relationships with the women.

Moran *et al.* (2023) concluded that rapidly deteriorating conditions in midwifery (particularly during COVID-19) have led to an increase in stress and burnout, with a consequent increase in attrition from the profession. Their review of the literature identified ways in which adverse working conditions can be improved to retain midwives and to increase their wellbeing. They warn against relying on the resilience of individuals, however, and identify the responsibility of organisations in reducing adverse conditions thereby improving the wellbeing and retention of midwives. This reflects the findings of Scammell (2017) in section 2.6.1 above.

2.6.3 Summary of Resilience literature review

The resilience literature suggests that personal and professional resilience are inter-dependent. If a person has greater personal resilience, they may be more able to withstand the adverse factors that affect professional or workplace resilience. Conversely, if workplace conditions are conducive, lower personal resilience is required to withstand the workplace.

Of relevance to my study is that some of the characteristics of personal resilience are developed through experience. Likewise, professional resilience is linked with professional identity, which is developed through a process of professional socialisation over time. For these reasons, it could be suggested that newly qualified practitioners may have lower personal and professional resilience because they have less experience. Although this was not directly addressed in the literature, the relationship between NQMs and resilience will be explored further through my research and through the discussion in Chapter 5.

2.7 Discussion

The literature review has explored why midwives stay and why they leave. In answering the question '*what are the factors that influence midwives to stay in or to leave the midwifery profession*?' it is firstly important to identify what keeps midwives in the profession. From the literature, the review found that being a midwife is more than a job; it is an identity that defines the person and is difficult to discard (Cox and Smythe, 2011; Bloxsome *et al*., 2020). The factors that enable midwives to stay are their love of being a midwife (Bloxsome *et al*., 2020), their professional relationships with women (Catling *et al.*, 2022) and to a lesser extent, with colleagues (Feijen-de Jong *et al*., 2022). This is what provides midwives with high levels of job satisfaction. Models of midwifery that provide continuity of care are more likely to promote a sense of professional identity and, therefore, job satisfaction, which in turn have the potential to retain midwives in the profession (Versaevel, 2011; Stoll and Gallagher, 2019; Butska and Stoll, 2020).

Negative work-related factors, however, can outweigh this strong sense of professional identity and job satisfaction, causing midwives to consider leaving or to leave midwifery (Cox and Smythe, 2011; Royal College of Midwives, 2016; Feijen-de Jong *et al*., 2022). The literature exploring midwives' reasons for actually or intending to leave the profession identified work-related factors that significantly influenced their decision to leave. These included experiencing stress and burnout because of their work. Midwives experiencing higher levels of stress and burnout were more likely to express an intention to leave the profession (Harvie *et al*., 2019; Stoll and Gallagher, 2019). Other work-related factors included

poor resources (such as staffing levels), poor relationships with colleagues, including managers, high workloads (which can in turn lead to stress and burnout) and poor workplace culture such as a culture of bullying (Warmelink *et al*., 2015; Geraghty *et al*., 2019; Aburn *et al*., 2020).

The literature revealed that it is often the factors that retain midwives that also have the potential to cause them to leave. The personal cost of providing continuity of care may result in burnout if the caseload is too heavy, there is lack of support from colleagues or there is poor work-life balance (often a result of being on-call). These factors outweigh the benefits of job satisfaction, which may in turn cause midwives to leave (Cox and Smythe, 2011; Warmelink *et al*., 2015; Feijen-de Jong *et al*., 2022). The Lead Maternity Care midwives in Cox and Smythe's (2011) study, for instance, all expressed a passion and joy for midwifery which was based on their positive relationships with women, even though they had left. The tipping point was the personal and emotional cost of the job, which eventually caused them reluctantly to make the decision to leave. All three midwives were still practising midwifery but were working in a hospital-based model of care where they had less responsibility and better work-life balance, making the job sustainable (Cox and Smythe, 2011).

The literature review also explored the concept of resilience, addressing the question '*how does the literature conceptualise personal and professional resilience*?' by discussing definitions and models of personal and professional resilience. The review found that there is a clearer consensus about the definition of personal resilience as being able to overcome adversity (Mowbray, 2021), but that professional resilience is more difficult to explain. Professional or workplace resilience is dependent on either the absence of workplace adversity or the ability to overcome workplace adversities, such as staff shortages, poor management, poor organisation of care or poor workplace culture such as bullying (Scammell, 2017; Huey and Palaganas, 2020). Professional resilience is also dependent on levels of stress and burnout. To some extent, levels of stress and burnout are dependent on the personal response to workplace adversity (Ashby *et al.*, 2013; Aburn *et al.*, 2020). Where this adversity becomes too great, however, the consequence is that stress and burnout become

unsustainable for all healthcare practitioners, and this is a strong indicator of intention to leave or to actually leave the profession.

There appears to be very limited literature that addresses the intentions of NQMs to stay or to leave or that explores this within the context of personal and professional resilience. Only one study was found that addresses how to retain NQMs and this was in the context of a specific NQM programme (Dixon *et al*., 2015). None of the literature exploring personal or professional resilience specifically looked at NQMs. In summary, it appears that there is very little literature that addresses these three elements together: factors that influence whether midwives stay or leave, resilience and NQMs. This identifies the gap in knowledge that is relevant to my study and will be discussed in the next section.

2.7.1 Summary: Identifying the gap in knowledge

A review of the literature found that studies are abundant around why midwives leave but there is very little recent research around why they stay, specifically in the UK. One influential UK study was conducted nearly twenty years ago which researched why midwives stay (Kirkham *et al*., 2006). This study was commissioned by the Royal College of Midwives (RCM) and received much attention at that time although the methodology was flawed. Studies exploring why midwives stay have mostly been conducted in Australia and Canada rather than in the UK. Studies have found that the factors that enable midwives to stay (such as continuity of carer schemes, which promote job satisfaction and positive relationships with women) are often the same factors that cause midwives to leave (through stress, burnout and inflexible working patterns). Almost none of the literature, however, includes NQMs in these studies.

Most of the literature that relates to NQMs explores their transition to professional practice and evaluates programmes of transition such as preceptorship programmes. There has been minimal work exploring why NQMs leave and only one study from New Zealand exploring why they stay (Dixon *et al.*, 2015). Given that recent data suggest the first two to five years after qualification is a vulnerable period for attrition (Walton, 2021), there appears to be a lack of evidence-based understanding of why NQMs choose to stay in midwifery and the

factors that encourage and support this decision. My research aims to address this gap in knowledge.

Based on the initial research question ('*Why do newly qualified midwives stay*?'), and shaped by the findings of the literature review, the research questions for my study were developed:

1. What are the internal and external factors that enable midwives in London to remain in post?
2. What are the personal and professional attributes that influence newly qualified midwives in London to remain in post?
3. What is the relationship between personal and professional resilience and the decision of newly qualified midwives to remain in post?

The next chapter will explore the methodological approach taken in the study. It will examine other potential methodologies and provide a rationale for the one chosen. It will describe the methods used to conduct the study with justification for their selection. It will outline the data collection and analysis techniques, with discussion of their strengths and limitations. It will outline how the methodology and methods were directed by the research questions.

CHAPTER 3. METHODOLOGY & METHODS

3.1 Background

This chapter outlines the study design (mixed methods) setting out the philosophical position of the study by considering the underpinning paradigm, epistemology, ontology and methodology. It will explore the development of the philosophical approach of pragmatism and why this is particularly relevant to the study. It will also explore the relevance/relationship of pragmatism with mixed methods, both as a concept and as a practical application to the research questions. In choosing a philosophical and methodological approach, other philosophies and methodologies were considered and discarded. These considerations are discussed, justifying the approach taken. It will also explore the positioning of resilience within the study and how this was used as a theoretical framework.

The chapter will then detail the methods adopted for this study and how these were designed to reflect the philosophy and methodology of a pragmatic, mixed-methods study. It will also outline the choice of resilience and wellbeing instruments used to address the third research question and how a new scale was developed. It will discuss how and why the sampling method and population were selected, the study setting and participants, data collection methods and data analysis. There will be a consideration of the approach taken for data analysis and data integration in the spirit of a pragmatic, mixed-methods study.

From the literature review, three themes emerged that influenced midwives' intentions to stay in or leave the profession. These were: job satisfaction, work-related factors and being newly qualified. These themes were evident from the research that explored midwives' reasons for both remaining in and leaving midwifery. It seemed appropriate, therefore, to design a research study that had the potential to address issues of staying in (or leaving) midwifery, whilst also maintaining receptiveness to new findings.

As outlined in Chapter 2, the findings of the literature review led to the development of the following research questions:

1. What are the internal and external factors that enable midwives in London to remain in post?
2. What are the personal and professional attributes that influence newly qualified midwives in London to remain in post?
3. What is the relationship between personal and professional resilience and the decision of newly qualified midwives to remain in post?

These questions provide the potential to research the intrinsic characteristics of the midwives who decide to stay in midwifery as well as the external factors that influence midwives' work intentions. The research questions appear to present a dichotomy in terms of research methodology. On the one hand, external factors lend themselves to large-scale data sets that can identify trends and patterns, suggesting a quantitative methodology; on the other hand, intrinsic factors such as personal and professional attributes and experiences align themselves with a more individualised approach to data collection, which is suggestive of a more qualitative approach. To address the research questions and to give credence to both internal characteristics and external factors that influence staying or leaving, the idea of using a mixed-methods study was investigated. From examination of the literature and from gaining multiple perspectives, this approach appeared to have the potential for addressing all aspects of the research questions and for amalgamating the findings. This led to development of the overall title for the thesis:

> ***Why do midwives stay? A mixed-methods study of the factors influencing newly qualified midwives in London to remain in post.***

3.2 Introduction to Pragmatism

The philosophical approach chosen for this study was that of pragmatism. Ontologically, pragmatists view reality as problem-centred and pluralistic, with their focus on 'what works' in real-world practice (Creswell and Plano Clark, 2018). Epistemologically, pragmatists combine methods (often quantitative and qualitative methods, but sometimes different forms of one of these) to gain wide-ranging knowledge to be able to answer a single question

(Tashakkori and Teddlie, 2003). As the name suggests, pragmatism takes a rational approach, using a diversity of ideas and methods to answer the question or questions. It is suggested that pragmatic research is usually driven by the question(s) themselves, rather than the methodological approach to the question(s) (Biesta, 2010). Pragmatism is particularly suited to mixed-methods studies because of its 'real-world' method, which is one of the factors that informed the choice for this study. Pragmatism was chosen as the philosophical underpinning of the current study, based on careful consideration of alternative worldviews. In justifying my choice and exploring the reasons why this was the best fit for the research questions, it is worth exploring the concept of pragmatism and some of the controversies that surround it.

3.2.1 Pragmatism: a philosophy or a toolkit?

There has been recent exponential interest in pragmatism as a philosophical approach, particularly for mixed-methods research (Long *et al.*, 2018). The proponents of pragmatism as a philosophical construct can be found in the work of several historical philosophers, such as Peirce (1839-1914), William James (1842-1910), John Dewey (1859-1952) and George Herbert Mead (1863–1931) (Biesta, 2010; Elkjaer and Simpson, 2011). Dewey deconstructed the idea of epistemology and proposed instead that the theory of knowledge is based upon interactions or (later in his work) transactions between living persons. The key concept of his theory was based upon the reality of experiences or '*intelligent actions*' (Dewey, 1925: 5). He proposed that knowledge was the consequence of both action and reflection, therefore a transactional arrangement between the process of enquiry and the outcome of this enquiry. This idea breaks down the dualistic nature of knowledge as defined by positivists and constructivists because all knowledge, it was argued by Dewey, is derived from experience (Biesta, 2015).

In response to this worldview of pragmatism, Biesta (2015) argues that pragmatism is not in itself a paradigm because the term 'paradigm' assumes a homogeneous viewpoint that aligns with one set of values and beliefs. The dichotomy of paradigms inherent in pragmatic research creates an uneasy space in research methodology, which is evident in the discussions and debates in the literature about whether pragmatism is a philosophy or just a

methodology (Elkjaer and Simpson, 2011). By drawing on a range of differing viewpoints or worldviews about the problem in question, pragmatism can be viewed more usefully as a philosophical toolkit of ideas and methods that can be combined to provide a range of perspectives or solutions (Glogowska, 2011). To understand the concept of pragmatism further, this idea will be critiqued through the literature on pragmatism and particularly that relating to health and social care.

The philosophical starting point for pragmatism is that its epistemology is empirical not foundational (Scott and Briggs, 2009). The essential premise is that research using a pragmatic methodology can solve problems; the focus is not on whether the process of the research pursues purity, but on the outcome(s) of the research (Rescher, 2005). This starting point can provide a more liberating and flexible approach to research where the focus is on the inquiry itself and not on the underpinning theory. The research itself generates the epistemology, based on the lived experience of that research, rather than being constrained by a single albeit pure epistemological paradigm or philosophy (Scott and Briggs, 2009).

The critique of this approach is that it reduces the philosophical message of pragmatism to 'what works' (Morgan, 2014). Elkjaer and Simpson (2011) suggest that it is the concrete practicality of pragmatism as compared with the more abstract theoretical perspective of other traditions that attracts criticism. Morgan (2014) puts forward the idea that although pragmatism can free the researcher from ontological and epistemological constraints, it is still a philosophical position. Rather than dismissing positivism and constructivism as polarised concepts that are incompatible, he suggests that pragmatism views these two philosophical concepts as two sides of the same coin, thus creating a new, and equally valued, philosophical position. Morgan (2014: 1051) concludes that:

> *'pragmatism points to the importance of joining beliefs and actions in a process of inquiry that underlies any search for knowledge, including the specialised activity that we refer to as research.'*

Conventionally, the positivist or post-positivist paradigms have dominated the field of medical research. In recent years, however, there has been growing interest in using pragmatism and mixed methods for healthcare research (Tariq and Woodman, 2013). Long *et al*. (2018) contend that, within the increasingly complex world of health service research, pragmatism provides an appropriate epistemological foundation for complexity research. They explore the compatibility of pragmatism with complexity theory and surmise that pragmatism provides the flexibility required for complex research methods required by the rapidly changing context of healthcare and health research. This resonates with my own research, which aims to combine methods and approaches to explore the reality of a constantly changing healthcare environment.

One of the reasons I began to explore pragmatism as a philosophical underpinning for this study was because of its ability to provide flexibility in the research process. Since the early academic discussions in this field of research, where pragmatism was described as a 'paradigm war' between two philosophically opposed approaches, there has been much philosophical debate (Griffiths and Norman, 2013). It has been suggested that harmony has been reached in the paradigm battle, albeit an uneasy and multi-faceted harmony for some (Glogowska, 2011; Mollard, 2015). Pragmatism has been embraced, particularly in health and social care, as "*continua of philosophical orientations*" (Teddlie and Tashakkori, 2009: 72) rather than as competing forces that demand a homogeneous resolution. This resonates again with my own work, in which I wanted to provide a pragmatic solution to my research questions, whilst having the flexibility to employ a variety of methodologies to explore these questions. I do not view these ideologies as having boundaries or being mutually exclusive, but more as a continuum of ideas and possibilities, in line with the approach taken by Teddlie and Tashakkori (2009).

The research questions themselves, as stated above, suggest that a diversity of approaches would be useful in exploring the issues they raise. The words 'factors' and 'attributes' provide differing perspectives; 'factors' which might suggest a more quantitative approach and 'attributes' which may suggest a more intimate exploration of the meaning and experience

for individuals. Personal attributes, however, can also be explored through quantitative methodologies, therefore adopting a flexible approach and viewing the data within a continuous dataset seemed the most appropriate direction to take (Teddlie and Tashakkori, 2009). This approach is congruent with a pragmatic philosophy, where the questions demand an eclectic approach to problem-solving. Using this methodology, the research questions themselves direct the philosophy, rather than the philosophy being driven by one particular paradigm and the research questions being shaped by that paradigm. Pragmatism, as suggested by Glogowska (2011), provides a toolkit of methods to explore the research questions, with the potential to reach diverse conclusions.

3.2.2 Why pragmatism?

In reaching this position, it is important to justify why pragmatism was considered the best philosophical solution and why other paradigms were assessed as being less appropriate for the research. Exploring the literature, it was clear that using just one methodological approach would be less effective at addressing both research questions. Positivism or post-positivism is associated with quantitative, reductionist, empirical research that is useful in providing data-driven findings and comparisons (Creswell and Plano Clark, 2018). Such an approach had the potential to reveal trends and explanations that would provide objective factors relating to midwives' intentions to stay (Lincoln *et al*., 2011). In isolation, however, this was not the appropriate method to explore midwives' lived experiences of their early careers. To address the question relating to their personal and professional attributes, a constructivist or interpretivist approach was also appropriate. The constructivist worldview provides socially constructed understandings, based on individually interpreted meanings (Creswell, 2013). The two paradigms used separately would not have provided a clear approach to integrating the data, which is an important element in mixed-methods research (Creswell and Plano Clark, 2018).

Other worldviews were considered which have the potential to integrate mixed-methods data. Critical theory was considered as a possible worldview to underpin the study. Although often associated with a constructivist perspective, many critical theorists operate within both

the quantitative and qualitative paradigms (Teddlie and Tashakkori, 2009). Frega (2014) suggests that critical theory is a strong contender when considering a pragmatic research perspective. Pragmatic, mixed-methods research using a critical theorist perspective includes research into poverty and social stratification as exemplars (Teddlie and Tashakkori, 2009). In considering the critical theory paradigm, Asghar's (2013) work was considered, as he puts forward that a critical theorist perspective should not be bound by either positivism or constructivism; rather, it should use the paradigm best suited for the study. Whilst this view fits my study, critical theory also lends itself best to explaining issues of power or politics (Frega, 2014), which does not fully meet the criteria for this study. Without doubt, there are issues of both power and politics in midwifery practice, and in the experience of NQMs, but it was felt that not constraining the research to these issues would be beneficial in addressing the research questions. The scope of the research potentially covers broader issues, which it was felt required a less constraining and more flexible philosophy, leaving the findings open to wider interpretations.

The transformative (or participatory-social justice) worldview, which is a variation of the critical theory perspective, was also considered. This worldview places emphasis on social justice and human rights, and is often used for research into disability, discrimination and disadvantaged group (Mertens, 2012). Creswell and Plano Clark (2018) suggest that researchers can use a specific lens when taking a transformative approach, such as feminism or critical race theory. Mertens (2012) puts forward a strong case for the use of a transformative approach in mixed-methods research for the same reasons as Asghar (2013), that the paradigm itself does not dictate the methods. Mertens (2012) identifies how the transformative perspective can permeate all parts of the research process, thus providing a theoretical lens through which the perspective of specific (marginalised) groups can be seen. Whilst NQMs could be considered as a marginal group, again this was felt to be presupposing what the research might find and, for this reason, was not considered to be the most flexible worldview to adopt.

In deciding upon pragmatism as the most appropriate worldview for the research, two further factors were considered. These considerations were (a) how to collect the data and (b) how to analyse the data, whilst maintaining a pragmatic perspective. As already stated, pragmatic research often adopts eclectic and multi-faceted methods as these can be supported by such an approach (Creswell and Plano Clark, 2018). These methods may include both qualitative and quantitative data collection and analysis, optimising all available methods to address the research questions. Using both methods was deduced to be the best approach for the study under question, as it was considered important that the initial enquiry should seek information from a larger dataset. It was additionally crucial that individual experiences should be captured to make sense of some of the information from the larger dataset. For this reason, it was decided to use a mixed-methods approach and to create two phases of data collection and analysis.

Pragmatism is most frequently associated with mixed-methods research where a variety of methods may be utilised to explore the research questions from a variety of perspectives (Doyle *et al*., 2009). Doyle *et al*. (2009) assert that mixed-methods research offers not just the opportunity to combine quantitative and qualitative data, but also to integrate the data to reach new conclusions. The rationale for the mixed-methods approach taken in the study and the justification for using this methodology in my research will now be explored.

3.3 Introduction to Mixed Methods

A mixed-methods research study embraces both positivist and interpretivist epistemologies. A combination of approaches was thought to be useful in answering the first two research questions, as outlined above (section 3.1). By combining these approaches, demographic data were gained from the wider population of midwives as well as exploring the meaning of these data in the lived experience of NQMs, who were the focus of the study. It was judged that demographic data were able to provide a broader picture of the midwifery population, whilst qualitative data gave in-depth insight into the experiences and professional lives of the NQMs. This provided an exploration of the research questions from different angles, exploring issues relating to the midwifery population being studied, as well as issues relating to individual

midwives. Saks and Allsop (2012) suggest that combining methods provides a more flexible approach, with the weaknesses of one methodology being offset by the strengths of the other. Conversely, they also state that it provides added complexity to the research process and therefore an additional challenge for the researcher. This will be explored later in the chapter.

There has been a growing interest in the use of mixed-methods research over the past two decades, particularly in health and social care (Turyahikayo, 2014). A Health Research Survey revealed that in 1995 approximately 17% of healthcare research used mixed methodologies, but by 2005 this had risen to 30% (Doyle *et al*., 2009). Since this time, mixed methodologies have been increasingly used in health and social care research (Creswell and Plano Clark, 2018). One of the reasons for this growth in interest is that funding bodies, both government and privately funded, are supporting mixed-methods research as a means of addressing increasingly complex health and social care issues (Hesse-Biber, 2015). Workforce issues, like many healthcare issues, are particularly complex, comprising personal, professional, political and organisational tensions that do not neatly conform to one particular method of research (Denzin, 2010). This applies to my own research questions and is one of the drivers for using mixed methods in this study. Retention issues are complex and an eclectic approach, using both quantitative and qualitative methods, seemed applicable to addressing the research questions and to exploring these from a variety of angles and perspectives.

Mixed methods research most often combines what appear to be diametrically opposed ontological and epistemological approaches, manifested by using both quantitative and qualitative methodologies (Doyle *et al*., 2009). The evolution of mixed-methods research has not been easy and has created both debate and disagreement between methodological camps (Denzin, 2010). In the 1980s, there were ‘paradigm wars’, through the 1990s constructivist disagreements, and more recently politically driven evidence-based or science-based research debates. Throughout these debates, there have been competing and conflicting interpretations of mixed-methods research. As debated above, this has included

variations as to which paradigm is perceived to be dominant and whether any paradigm should be dominant at all (Hesse-Biber, 2015). These debates continue today.

The rationale for using a mixed-methods approach has also been debated and contested. Greene and Caracelli (1997) devised a conceptual framework with five explanations as to why using mixed methods might be useful: for the purposes of triangulation, complementarity, development, initiation and expansion. According to their framework, 'triangulation' is used to check one set of findings against another, to achieve convergence of data, which allows for stronger validity in the findings. 'Complementarity' enables the researcher to gain a more complete understanding of the problem by using different methods to address the same research question(s). Results from one method can then be used to inform another method, which the authors term 'development'. 'Initiation' of a follow-up study may result from the original mixed-methods study. Finally, they refer to 'expansion' as expanding the range and scope of enquiry by using a mixed-methods approach (Greene and Caracelli, 1997).

Bryman (2006) undertook a literature search to determine what the dominant reasons were for researchers choosing mixed-methods research, which methods they chose and why. He searched the sociological literature from 1994-2003 and identified 232 articles, all of which stated they were mixed-methods studies. Of these, 49% were from North America and 27% were from the UK. Using Greene and Caracelli's (1997) classifications, complementarity (28.9%) and expansion (25.4%) were the most frequent types of mixed-methods studies chosen; however, they found that in many of the articles, the method stated by the researchers did not always match the reality of the study. Greene and Caracelli (1997) concluded that either researchers had not properly thought through their justification for mixed-methods studies or alternatively, that results in these studies were unpredictable. Bryman (2006) surmised that mixed-methods researchers need to both understand their methods and maintain flexibility if justification is to be rigorous and new insights are to be gained.

3.3.1 Mixed-Methods Typology

The typology for mixed-methods research has been debated and extended since the work of Greene and Caracelli (1997), most notably by the works of Tashakkori and Teddlie (2003), Morse and Niehaus (2009) and Creswell and Plano Clark (2018). Tashakkori and Teddlie (2003) identified up to 40 different typologies of mixed-methods research, although many of these are variations on a theme. In their most recent work, Creswell and Plano Clark (2018) drew up a table of seven distinct types of mixed-methods designs, from which they distilled three 'core' designs (p. 65). Firstly, there is the convergent design, where two different types of data collection and analysis are conducted in parallel, and the results are compared or even combined. The purpose of this method is to obtain a more complete picture of the problem, to validate one set of data with another. Secondly, there is the explanatory sequential design, which commences with quantitative data collection and analysis. The second phase then collects and analyses qualitative data, with the intention of explaining the results from the first phase. Data collection and analysis, therefore, take place sequentially. Finally, there is the exploratory sequential design. Like the explanatory design, this is also sequential, but in this method, the qualitative data is collected and analysed before the quantitative phase. The researcher uses the qualitative data to build a tool or instrument, which is then tested through the quantitative phase on a larger number of participants (Creswell and Plano Clark, 2018).

The mixed-methods typology selected for this study is the explanatory sequential design (Ivankova *et al*., 2006). As the name suggests, the purpose of the method is to explain the phase one quantitative results in more depth by using the phase two qualitative data to delve into the findings from the quantitative phase (Creswell and Plano Clark, 2018). As outlined by Ivankova *et al*. (2006) and Creswell (2013), the advantage of this method is that it follows a straightforward approach. By using sequencing, phase one data collection and analysis can and should influence the data collection and analysis in phase two; however, there are methodological dilemmas that need to be resolved before the research can take place. Some of these dilemmas include the weighting of both quantitative and qualitative phases, when sequencing should take place and at what point the data should be integrated (Ivankova *et*

al., 2006). Creswell and Plano Clark (2018) emphasise that both forms of data should be integrated so that the discussion provides a fully cohesive interpretation of two data sets. These issues will be more fully addressed in the description of the methods later in this chapter, when considering the research design.

Despite the recent growth in the use of mixed methods as an accepted research methodology, like pragmatism, there has been widespread criticism of its lack of theoretical underpinning (Alavi *et al.*, 2018). Critics have highlighted a lack of ontological and philosophical homogeneity as a flaw in mixed-methods research, stating that it lacks theoretical credibility as a result (Doyle *et al*., 2009; Turyahikayo, 2014). Creswell (2013) states that epistemology should not dictate the methodological approaches and methods that are used. This should be determined by the research problem and how best to investigate the research questions. It is generally accepted that mixed methods are driven by the problem or research question(s) and not by the foundation of its philosophy, which Alavi *et al*. (2018) describe as using a 'cart before horse' approach. Hess-Biber (2010) proposes taking a more comprehensive position towards mixed methods, suggesting that the methodology provides a theoretical bridge linking the research problem to the method.

There has been interest in developing a different definition of mixed methods that is not bound by the purist ideology of positivist/post-positivist or constructivist paradigms. Rather, it is proposed that a mixed-methods approach has become a distinct and equally credible methodology that has developed its own theoretical position (Hesse-Biber, 2010). Nonetheless, there is inevitable tension created within mixed methods by using divergent methodologies, which requires resolution at some point in the research process. This resolution is usually achieved through integration, which can occur at any point in the research process (Teddlie and Tashakkori, 2009). Integration within mixed-methods design is a more recently debated subject (Alavi *et al*., 2018; Denzin, 2010) and the ways in which mixed- methods integration can be achieved is a thesis in its own right. According to Creswell and Plano Clark (2018:220), *"integration is the centrepiece of mixed-methods research"*. The point at which integration of data takes place within my study will be discussed and justified

within the methods section and will also be discussed when presenting the findings of the study.

3.3.2 Why Mixed Methods?

A mixed-methods approach for my study can be justified for two reasons. Firstly, as already discussed, mixed-methods research appeared to have the potential to address the research questions most effectively and to fit within a pragmatic paradigm. Secondly, the pilot project, which is detailed below, supported the use of a mixed-methods approach to elicit the variety of data required to address the research questions.

When considering the use of either quantitative or qualitative methods, it might have been possible to elicit information from the participants using either approach; however, the richness of data available from mixed-methods research would not have been achieved. Either it would have been possible to gather data through an instrument such as a survey, but not to understand the depth of meaning of these responses for NQMs or it would have been possible to research the in-depth lived experiences of NQMs, but not to be able to place this in the demographic context of the body of midwives with whom they worked (Doyle *et al*., 2009). By using a mixed-methods design, both results were achievable.

The benefit of mixed-methods research for my own study was to be able to use the findings of the quantitative survey to inform the qualitative interviews. Although a sequential explanatory design is widely used for this reason, there were some methodological issues that needed to be resolved before commencing the study (Ivankova *et al*., 2006). For instance, I needed to decide if one phase of the study was assigned priority, at what point to connect the results and how to integrate the findings. Given that NQMs were the focus of my research questions, it was felt that the qualitative explanation for why NQMs stay should be weighted more heavily than the quantitative survey. In line with sequential explanatory methodology, findings from the resilience and wellbeing scales used in the survey provided the basis for questioning in the interviews. This was the way in which findings were brought together in the study. Integration of results is a complex issue in mixed-methods studies and the stage at which integration takes place needs careful consideration in the design of the study (Johnson

and Onwuegbuzie, 2004). In my own study, it was determined that integration would take place as the results were combined; thus, discussion of the survey findings was integrated with discussion of the themes identified from the interviews. Tariq and Woodman (2013) suggest that if the findings have not been enhanced because of combining quantitative and qualitative findings, then integration has not taken place.

Having arrived at a justification for using a pragmatic, mixed-methods, sequential explanatory study to address the research questions, the next section will describe how these approaches were used within the study. The following section will describe data collection, including the sample and selection criteria, data analysis of both quantitative and qualitative data, and how the study was integrated in the spirit of using a pragmatic, mixed-methods, sequential explanatory design.

3.4 Introduction to Study Methods

The study was conducted in two phases. Phase one comprised the survey, which asked participants about their demographic details and asked questions relating to the first research question: *what are the internal and external factors that enable midwives in London to remain in post?* To identify the internal and external factors, the survey invited participants to complete two scales assessing their personal resilience and midwife workplace wellbeing. It also asked whether they had thought about leaving their post or midwifery in the last six months. Phase two involved interviewing NQMs who had self-selected through the survey. The interviews aimed to address the second research question: *what are the personal and professional attributes that influence newly qualified midwives in London to remain in post?* The interviews explored the components of the scales which received the lowest scores in the survey, to determine how these factors influenced the decisions of NQMs to stay or leave. The main focus of the study was on why NQMs choose to stay in midwifery in London.

3.4.1 Pilot study

Both the survey and the interview questions were piloted on three NQMs to assess whether the tools were (a) easy to comprehend and (b) elicited the information they were aiming to collect. One additional open-ended question was added to the survey because of the pilot,

but overall, the survey was assessed as being easy to complete and took less time than anticipated for all three respondents. The interview questions were tested in a focus group situation and generated a large quantity of data. The focus group was held face-to-face and was recorded for transcription purposes. Midwives identified themselves with a letter ('midwife A') before they spoke so individuals could be differentiated. After a while, this became stilted, and the midwives forgot to 'label' themselves before speaking. In the main study, focus groups were replaced with individual or paired interviews and took place online, because of research regulations around COVID-19 (see below for details), therefore identification of NQMs in the interviews was not an issue. Following the pilot focus group, transcription took several hours, which led me to employ a transcription service for the interviews in the main study. This saved many hours of time and was more accurate than my own transcription.

3.5 Survey – Phase 1

3.5.1 Survey participants

The study survey was sent to all midwives in four London Trusts via their NHS email account using the software Qualtrics. London was chosen as the location because there are specific retention issues in the Capital, with the highest number of midwives currently leaving midwifery working in London (NHS Digital, 2022). The survey was sent out either by the Director of Midwifery or by their representative, which increased authentication of the survey. Survey data were collected during November and December 2020, a delay of nine months from the planned study period due to the COVID-19 pandemic. Two survey reminders were sent to all midwives in three of the Trusts, and one reminder in one Trust, through the same contact as the survey distribution. This elicited further responses in three out of the four Trusts. The survey asked midwives if they had qualified within the last two years. If the answer was 'yes', they were asked if they would be willing to participate in focus groups or interviews. The potential participants then provided contact details and were approached for either a focus group or an interview. A copy of the email to participants and the survey can be found in Appendix 3 and Appendix 4.

3.5.2 Resilience and Wellbeing scales

3.5.2.1 Connor-Davidson Resilience Scale

The resilience scale in the survey was based on that developed by Connor and Davidson (2003) and used a previously validated shorter 10-point scale (Campbell-Sills and Stein, 2007). The purpose of the scale is to demonstrate an individual's level of personal resilience (Campbell-Sills and Stein, 2007). This scale was identified through the literature review as being frequently used in healthcare research investigating the resilience of healthcare professionals. Given its authentication in healthcare research, it was considered applicable to my study. Midwives were asked to respond to ten positive statements relating to elements of resilient behaviour (see Table 3.1). Responses were in the form of a Likert scale, with 5 = strongly agree and 1 = strongly disagree. The higher the overall score, the more personal resilience the individual is likely to have in response to these statements.

Table 3.1 Connor-Davidson Resilience Scale statements

1. I am able to adapt to change
2. I can deal with whatever comes
3. I can see the humorous side of things
4. I believe coping with stress strengthens me
5. I tend to bounce back after illness or hardship
6. I believe I can achieve my goals despite obstacles
7. Under pressure, I can focus and think clearly
8. I am not easily discouraged by failure
9. I think of myself as a strong person
10. I can handle unpleasant feelings

The Cronbach's Alpha coefficient for the Connor-Davidson Resilience Scale in the survey was 0.867, which compares with a Cronbach's Alpha score of 0.85 in the Campbell-Sills and Stein (2007) study, suggesting that this scale had good internal consistency (i.e. over 0.8) (Pallent, 2020). None of the individual items within the scale scored higher than the overall Cronbach's alpha score if deleted and none of the corrected item-total correlation scores were less than

0.3. This indicates that scores for individual statements within the scale were also reliable (Pallant, 2020). Given that this scale has been widely used and tested in studies of healthcare professionals (Campbell-Sills and Stein, 2007; Aloba *et al*., 2016; Madewell and Ponce-Garcia, 2016) my results supported the use of this scale as a reliable tool when measuring individual resilience scores in this study.

3.5.2.2 Bower Midwife Wellbeing Scale

The Bower Midwife Wellbeing Scale was created for the purposes of this survey, based on qualitative research by Hunter and Warren (2013), from which they developed a conceptual model of resilience for midwives. The items for this survey were developed from the Hunter and Warren (2013) conceptual model of resilience by transforming some of their findings into statements. This model identified four themes of resilience: self-awareness, managing/coping, building resilience and challenges to resilience. From the conceptual model, twelve statements were devised which reflected the four themes; three statements were formulated to reflect each theme (see Table 3.2). These themes were selected because they had been identified in the midwifery literature about staying in and leaving midwifery (see Chapter 2).

Although the Bower Midwife Wellbeing Scale is based on the midwifery resilience framework developed by Hunter and Warren (2013) the scale itself measures how positively or negatively midwives assess their workplace conditions to be. For this reason, the scale is a measure of midwives' workplace wellbeing. A high Bower Midwife Wellbeing score correlates with strong workplace or professional resilience, indicating the ability to deal with adverse working conditions (Brennan, 2017; Moran *et al*., 2023). A low Bower Midwife Wellbeing score on the scale indicates that midwives assess their workplace wellbeing to be poor, which is more likely to indicate low professional resilience. The scale comprises work-related conditions relevant to the research questions that Hunter and Warren (2013) identified as building midwives' resilience. Reflecting the workplace wellbeing nature of the statements, the final scale was named the Bower Midwife Wellbeing Scale.

As in the Connor-Davidson Resilience Scale, a Likert scale, with 5 = strongly agree and 1 = strongly disagree, was used, which aimed to demonstrate the wellbeing of midwives through work-related statements. The tool was tested through the initial pilot study for my research, although it is acknowledged that statistical analysis of the model could not be effectively assessed through a pilot study using three participants (Field, 2013). The assessment of reliability of this scale, therefore, was only possible in the main survey when there were enough participants to apply statistical analysis.

Table 3.2 Wellbeing Scale statements based on Hunter and Warren (2013) (used in the survey)

1. The staffing levels are usually safe
2. I have flexibility in my working pattern
3. I am required to work on call shifts
4. I feel valued by my colleagues
5. I feel I am included in the team
6. I have never experienced bullying at work
7. I feel confident while at work
8. I experience a high level of job satisfaction
9. I have a strong sense of identity as a midwife
10. I feel I have good work-life balance
11. I am able to exercise autonomy in my work
12. I can access professional learning and development opportunities

Cronbach's Alpha coefficient for the Wellbeing Scale used in the survey was 0.764, suggesting that the scale had good internal consistency (i.e. above 0.7). When observing the corrected item-total correlation scores, three of the items in the scale scored below 0.3, indicating their inconsistency in the model. Two of these corrected to 0.3 at one decimal place and it was, therefore, decided to leave them in the model. One of the statements, however, scored only 0.062, indicating its unreliability as a measure of wellbeing in the model. The statement was "*I am required to work on calls*". Although shift work in general, including lack of flexibility, was identified in the study by Hunter and Warren (2013) as a workplace stressor, it is

acknowledged that this statement is not values-based. It is a factual statement, where participants either do or do not engage in on-call rotas. In hindsight, a better statement might have related to personal feelings about shift work and work flexibility in a more general way, rather than posing a closed statement regarding on-call requirements. In retrospect, it is unsurprising this item did not fit the model as it is purely factual.

Removing this statement from the scale resulted in a Cronbach's Alpha score of 0.809, indicating greater internal consistency (i.e. above 0.8); however, there were two statements that scored less than 0.3 in the corrected item-total correlation score, but both scored 0.3 if corrected to one decimal place. The 11-point Wellbeing Scale was used for all subsequent analyses and has been labelled the Bower Midwife Wellbeing Scale (Table 3.3).

Table 3.3 Bower Midwife Wellbeing Scale (used for analysis)

1. The staffing levels are usually safe
2. I have flexibility in my working pattern
3. I feel valued by my colleagues
4. I feel I am included in the team
5. I have never experienced bullying at work
6. I feel confident while at work
7. I experience a high level of job satisfaction
8. I have a strong sense of identity as a midwife
9. I feel I have good work-life balance
10. I am able to exercise autonomy in my work
11. I can access professional learning and development opportunities

3.5.3 Survey Data Analysis

Data from the survey were analysed using Statistical Package for Social Scientists (SPSS version 27). After cleaning the data, they were analysed using descriptive statistics and three statistical tests: correlation, independent sample T-test and logistic regression. Principal Component Analysis and Tests of Normality were also used to test the validity of the resilience scales.

Tests of correlation can be either parametric (if assumptions of normality are met) or non-parametric (if assumptions of normality are violated) (Pallant, 2020). The tests are relevant to explore the relationship between a continuous variable (such as the resilience scales) and either another continuous variable or a dichotomous variable (such as the questions in the survey about intention to leave midwifery: yes/no). Tests of correlation were applied to my study when exploring the relationship between the number of years qualified and the resilience and wellbeing scores, also midwives' intention to leave their post/midwifery/ London and the resilience and wellbeing scores.

The independent sample T-test is one of a family of parametric tests used to explore the differences between groups. Rather than exploring the relationship between variables, as in tests of correlation, parametric tests are used to determine significant differences between different data sets or groups (Verma and Abdel-Salem, 2019). The independent sample T-test can be used to explore the differences in the results between one continuous and one ordinal variable. In the case of my study, it was used to explore differences in the scores between those who had qualified less than and more than two years previously.

Regression is a form of statistical prediction but unlike other forms of regression analysis, the purpose of logistic regression is to predict the relationship between continuous and categorical variables (Field, 2013). Logistic regression is a specific test to predict categorical outcomes from a continuous variable. In my study, this test was used to see if it was possible to predict intention to stay or leave post/midwifery/London using either of the two resilience or wellbeing scales. (Please see Chapter 4 for a discussion of the findings.)

3.6 Interviews – Phase 2

3.6.1 Interview participants

The interviews were conducted in March–June 2021 and were therefore still subjected to the University's COVID-19 restrictions for researchers. This meant they had to be conducted online (see section 3.7 Ethical approval) and were mostly held as one-to-one interviews, which were able to accommodate the NQMs' shifts and other commitments. NQMs were

offered the option to be interviewed in pairs with their consent, which some opted to do. The interviews were conducted via Microsoft Teams, which meant we could see one another through the video function. The advantage of online interviews was that a mutual venue was not required, which gave more flexibility in arranging time and location of interviews. The interviews could also be recorded, and with permission, the videos were sent to the professional transcriber. Although Microsoft Teams now has a transcription function, this was not available at the time of the interviews and is also less accurate than professional transcription, which ensures as much of the interview as possible is captured and is accurately annotated.

The disadvantage of online interviews is that the quality of internet connection can be poor, and some participants may not have internet access. This has the potential to prevent inclusivity in the research. One interview was difficult to transcribe due to poor internet connection. Research should be in the control of those being researched as much as those researching, and online interviews could be seen as a good example of participant friendly research (Oates *et al*., 2022).

3.6.2 Interview Data Analysis

Data from the interviews were analysed using applied thematic analysis (Guest *et al*., 2012). Before discussing both thematic analysis and applied thematic analysis, the similarities, differences and the rationale for selecting this method, other methods of qualitative analysis are considered. Each method is explored and the reasons why they were not considered to be the most appropriate method for qualitative analysis in my research are discussed below. There are several interpretive methodologies that might be selected when analysing qualitative interview data (Bernard and Ryan, 2010). Bernard and Ryan (2010) make the distinction between '*the analysis of qualitative data*' and the '*qualitative analysis of data*' (p. 4). They outline three types of qualitative analysis – qualitative analysis of qualitative data, qualitative analysis of quantitative data and quantitative analysis of qualitative data. Depending on the type of analysis required, a suitable methodology and therefore method for analysing the data can be considered.

Analysis of the interview data in this study falls into the category of qualitative analysis of qualitative data. According to Bernard and Ryan's (2010) categorisation, these interview data require some form of interpretive text analysis. It must be acknowledged, however, that the interviews are part of a mixed-methods study, where survey data were used to inform the qualitative arm of data collection. The qualitative data collection does not therefore stand alone and was informed by pragmatism, the paradigm that underpinned the study in its entirety. The analysis of the interview data reflects this and is interpreted through a pragmatic lens (Morgan, 2014). The survey itself elicited qualitative data from the open-ended questions and these data were categorised using quantitative analysis of qualitative data. Analysis of the qualitative data in the survey was undertaken by analysing frequencies of themes and this will be discussed in the results (Chapter 4) and integrated into the discussion (Chapter 5).

A variety of interpretive methods can be used in mixed-methods studies to analyse the qualitative data, depending on the nature and aims of the study (Cotton *et al*., 1999). In my study, qualitative data were part of a sequential exploratory design, therefore a method was required that took account of this design within a pragmatic philosophy. Creswell and Plano Clark (2018) suggest that methods using thematic identification are particularly appropriate for mixed-methods research. This is because they can be aligned to the themes identified in the quantitative arm of the research, allowing effective integration of the data to take place. A range of analytic techniques where thematic identification can be part of the method was considered for the interview phase of this study. These analytical methods will be briefly explored with the rationale for their consideration and with justification as to why they were selected or discarded. The methods of interpretative analysis considered for the qualitative arm of the study were narrative analysis (Cortazzi, 1994), discourse analysis (Burck, 2005) and thematic analysis (Braun and Clarke, 2006). All these methods are appropriate for use in a mixed-methods study, depending on the aim of the study and the type of analysis required (Creswell and Plano Clark, 2018).

Narrative analysis, according to Riessman (1993), does not fit within one paradigm or scholarly field. It can be used in a variety of research contexts as its focus is on the individual

or collective narrative of the story, text or material (Herman and Vervaeck, 2019). Narrative was considered as a method of analysis for this study as it has the potential to tell the midwives' stories of being newly qualified and of illuminating their personal experience of this journey. It also has the potential to link their stories by interpreting the themes that connect them. However, with the focus of narrative analysis being on self-presentation and self-narration (Burck, 2005), it was felt that this would provide a more individualistic focus for data analysis, which may not have fitted well with the philosophy of pragmatism. The primacy of individual voices was not the focus of the findings, and this would have been difficult to align with the principles of narrative analysis (Kelly and Howie, 2007). It was also more difficult to conceptualise data integration within the mixed-methods study using a narrative approach because the individual voices identified within the narrative would have become lost in the combination of findings and the overall distillation of quantitative-qualitative data (Mccance *et al*., 2001).

Discourse analysis was then considered, as this method of analysis has the potential to identify a range of social, political and institutional themes (Burck, 2005). When comparing discourse analysis with narrative analysis, Burck (2005) suggests that the focus of discourse analysis is on the way in which language is used by the participant, rather than on the story being told. Braun and Clark (2021) also compared methods of pattern analysis, concluding that discourse analysis is best used when the context and effects of language are the primary orientation of the research. In considering this form of analysis for my own study, discourse analysis was explored because of its ability to deconstruct the meaning of language, metaphors and stories to understand the context of what the NQMs were experiencing (Johnstone, 2018). This type of analysis might have been useful if it was a purely qualitative study where the focus of the interview data was on eliciting the meaning and understanding of the language used by the midwives within a socio-political context. The interviews, however, did not provide a detailed analysis of the social and political nuances of what was spoken, which is the essence of discourse analysis within a social constructivist paradigm (Burck, 2005). Onwuegbuzie *et al*. (2009) provide justification for different types of analysis in pragmatism but suggest that discourse analysis fits best within a framework of critical

theory. My study fits the more eclectic 'what works' model of pragmatism rather than the study of linguistics and language within a model of critical theory (Johnstone, 2018). For these reasons, it was felt that discourse analysis did not fit within the paradigm of pragmatism defined by my own study.

Thematic analysis was the third approach that was considered for analysis of the interview data and this method of analysis was finally selected as being the most appropriate for the study. Thematic analysis has been described as a '*family of methods*' (Braun and Clarke, 2021: 4) rather than as a methodology, and the justification for this choice, including the thematic analysis technique used, will now be considered in more detail.

3.6.2.1 Thematic Analysis

Thematic analysis has been described as a continuum of methods and techniques that can be applied to a variety of methodologies, rather than being a methodology in its own right (Braun and Clarke, 2019, 2021). At one end of the continuum, thematic analysis techniques use a very structured approach that adopts a more (post) positivist data analysis philosophy, quantifying pre-determined themes and codes during the process of analysis (Boyatzis, 1998). At the other end of the spectrum, Braun and Clarke (2019) propose a more organic and less structured approach to thematic analysis techniques, using a reflexive methodology where the themes arise as the data are analysed (Braun and Clarke, 2019).

There has been much debate in the literature about thematic analysis, with some authors disparaging the method for not having the integrity of a firm methodological background (Levitt *et al*., 2017). Braun and Clarke (2021) suggest there is a lack of understanding about the broad spectrum of methods which comprise thematic analysis, also a lack of appreciation of the theoretical underpinning of each method and how this is positioned within the philosophical framework of the research being undertaken. They identify three generic typologies for thematic analysis which explain how this method is applied within each researcher's own philosophical and methodological perspectives. These three typologies are described as *coding reliability, codebook and reflexive* (Braun and Clarke, 2021: 6).

'Coding reliability' is within a (post) positivist paradigm and 'reflexive' adopts a wholly interpretivist paradigm, with 'codebook' somewhere in between. By adopting one of these typologies, researchers can then adhere to the philosophical and theoretical underpinning from where they position themselves on the thematic analysis continuum. Given this position and acknowledging that Braun and Clarke were the original authors on thematic analysis at its development (Braun & Clarke, 2006), it is important to identify where my study is placed on the continuum of methodological approaches. The philosophical background of this study, as already discussed, is firmly rooted in pragmatism. The study uses a sequential explanatory model (Creswell and Plano Clark, 2018) in which the quantitative element of the study informs the qualitative arm. This is an important practical as well as philosophical starting point for determining the positioning of the qualitative data analysis on the thematic analysis continuum.

Teddlie & Tashakkori (2009) identify that mixed-methods studies can use both inductive and deductive reasoning, depending on the aims of the study and the specific phase that is being researched. When conducting qualitative data analysis, taking a purely deductive approach would limit the potential for unique and unexpected findings as analysis would be focused on a predetermined hypothesis and findings are then structured around these (Boyatzis, 1998). This would give weight to the positivist arm of the study, minimising the interpretive and unexpected potential of the interviews. Conversely, in a mixed-methods study, using a purely inductive approach, where there are no preconceived ideas about the themes, may mean that findings identified in the quantitative phase of the study cannot be used to structure the qualitative data collection (Guest *et al*., 2012). Azungah (2018) emphasises the inter-relatedness of inductive and deductive approaches, suggesting that researchers can combine approaches when using thematic analysis as a method of triangulating the findings. Using both inductive and deductive approaches to thematic analysis fits the purpose and philosophy of this study, which better reflects the mixed-methods approach to data collection. This approach is best described by Braun and Clarke's (2021) *codebook* typology.

Having determined that a codebook approach, using both inductive and deductive methods, was appropriate for the study, it was important to determine a suitable thematic analysis technique on which to base qualitative data analysis. When searching for the most appropriate model to use, I considered that a more structured approach was the best fit for the sequential exploratory model in this mixed-methods study. The use of a pre-determined semi- structured interview schedule informed by the quantitative phase meant that certain ideas were used deductively to address findings from the survey. I felt, however, that too much structure would inhibit the spontaneity of identifying findings in interviews that were unpredictable and unexpected. For this reason, a mixed deductive-inductive approach to data collection and analysis was adopted, in keeping with my pragmatic, mixed- methods study. Specific writers were explored for their more structured approach to thematic analysis.

The work of Boyatzis (1998) was considered, as he proposes a very structured, positivist approach towards code development in the process of analysing qualitative data. Whilst some of his techniques were useful, particularly his ideas around code and theme development, the focus of his work is on quantifying qualitative data, which did not reflect the aim of the interviews. This approach would fall under Braun and Clarke's (2021) *coding reliability* typology which is firmly situated within a (post) positivist paradigm.

Applied thematic analysis, the work of Guest *et al*. (2012) was then considered as this model approaches thematic analysis using both deductive and inductive methods, while also using a qualitative framework. I felt that this combination of using a structured approach for code development, but also with emphasis on letting the data speak during analysis, would most appropriately fit my study (Guest *et al*., 2012). This technique fits best under Braun and Clarke's (2021) *codebook* typology, which bridges the positivist-interpretivist paradigms. This will be explored further in the next section.

3.6.2.2 Applied Thematic Analysis

Applied thematic analysis is detailed by Guest *et al*. (2012) and has since been used in both health and social care research (Mackieson *et al*., 2019; Dickinson *et al*., 2020). The defining

features of applied thematic analysis are in the methodical approach to developing the codebook for analysing the data (Guest *et al*., 2012). Codebook development is comprehensive, and precise meaning is given to the codes identified within the codebook. The codes are then used to develop the themes.

Guest *et al*. (2012) firmly place applied thematic analysis within an inductive qualitative framework, although there are deductive elements within this method. They differentiate between '*structural codes*' (p. 7) and '*content codes*' (p. 19). Structural codes can be created from the interview schedule and are generally predetermined (deductive), whereas content code development is derived from analysis of the interview data using a more iterative process (inductive). The purpose of structural coding is to reflect the aims and objectives of the research (in this case, mixed-methods research) during development of the interview schedule to explore the research question(s). Content coding, on the other hand, is developed from the data themselves so content codes reflect both the expected and unexpected responses of the research participants. Once the codes have been identified, theme development takes place, and may follow a systematic approach (Bernard and Ryan, 2010) or may arise more organically by focusing on the analytic objectives of the study. Bernard and Ryan (2010) outline seven tips for identifying themes, four of which were used in this study. These can be summarised by the recognition of (i) repetition of ideas, (ii) metaphors and analogies, (iii) transitions and (iv) linguistic connectors. All four of these techniques were used when coding the data from my interviews to identify relevant themes.

Qualitative researchers have grappled with ideas about rigour, validity, reliability and bias in thematic analysis (Mackieson *et al*., 2019). Some qualitative researchers have suggested that the terms 'validity' and 'reliability' should be redefined in interpretive research as they have positivist connotations of measurability and quantifiability (Lincoln *et al*., 2011). In their study of naturalistic inquiry, Lincoln and Guba (1985) suggest using the terms 'credibility' and 'dependability' to depict the different approach to rigor in qualitative research. However, Guest *et al.* (2012) hold firm to using the terms 'validity' and 'reliability', arguing that if qualitative research is to be considered mainstream and not marginalised, then it is important

to uphold the legitimacy of accepted terminology. This could be construed as a positivist viewpoint but, given that I have chosen to use applied thematic analysis, I will address issues of validity and reliability as defined by Guest *et al*. (2012). I will also discuss issues of validity and reliability within the results in Chapter 4.

Validity has been defined in many ways but in qualitative research can be summed up as '*confidence in the truth of the findings, including an accurate understanding of the context*' (Ulin *et al*., 2005: 25). Reliability on the other hand is dependent on "*whether the research process is consistent and carried out with careful attention to the rules and conventions of qualitative methodology*" (Ulin *et al*., 2005: 26). In applied thematic analysis, the importance of the codebook is emphasised as a method of ensuring validity and reliability of the findings. Guest *et al*. (2012) suggest that the more descriptive and precise the codebook is, the more consistent are the codes that are developed. Consequently, intercoder validity and reliability will be improved. In my research, I coded the data, but even with one researcher, it is likely to improve the accuracy of coding if the codebook descriptions and codes are detailed and precise. Another method of ensuring validity and reliability, according to Guest *et al*. (2012), is to use a mixed-methods approach, allowing for convergence or divergence of findings. This method either supports findings by triangulation or refutes findings, which means exploring further why there are divergent views and even reviewing the research protocol. Two other methods of ensuring validity and reliability in applied thematic analysis outlined by Guest *et al*. (2012) and employed by my research involve the participants themselves. Firstly, it is important to ask those being interviewed to read the transcript of the interview and to identify any inaccuracies in their understanding of what is transcribed. Secondly, the validity of the work is enhanced by using direct quotes from the interviews so that the voice of the interviewees is represented verbatim in the findings. This also makes the researcher's interpretation of findings from the interviews more transparent (Guest *et al*., 2012).

Applied thematic analysis was chosen for the analysis of my qualitative data because the methodology aligns with both a mixed-methods approach and with a sequential explanatory model. Qualitative data were collected from the survey (open-ended questions) and were used to inform the 'structural' codes within the codebook. These were the broad, expected

codes that were also used to refine the interview schedule. The interview data then elicited both expected and unexpected findings, which were used to inform the 'content' codes. Having a structured approach to coding, codebook development and emerging themes appeared to fit the philosophical approach of pragmatism in my mixed-methods research. This is because both deductive and inductive processes were used in the codebook and subsequent thematic development (Guest *et al*., 2012). I will now outline code development in my study using applied thematic analysis in more detail.

3.6.2.3 Codebook development

The first step in any qualitative data analysis is to immerse oneself in the data (Bernard and Ryan, 2010). Having recorded all interviews, either by means of video or audio recordings, they were transcribed by an external transcription agency. This meant I did not have the benefit of immersing myself in the data at the time of transcription, but once transcribed, I was able to replay the recordings whilst reading the transcripts at the same time. Prior to revisiting the interviews and reading the transcripts, I used the semi-structured interview schedule to identify potential structural codes, in line with the Guest *et al*. (2012) method of codebook development. These codes directly reflected the research questions as well as the interview schedule (see Appendix 8a).

During the first reading, I made notes in the form of words or phrases that related to each of the semi-structured questions per interview, which I then reviewed after the first four interviews. At the first review of these words and phrases, I identified initial content codes that both reflected the structural themes and were in keeping with the data. After listening to, re-reading and making notes on the final four interviews, I revised the content codes, renaming one and splitting one into two new codes. I subdivided the structural codes into the content codes as outlined in Appendix 8b.

I then went back to the transcripts and segmented the text, again in keeping with the methodology of Guest *et al.* (2012), using colour coding for each segment. Where a second or third code appeared in the text segment, I identified this with the relevant coding colour. Guest *et al*. (2012) discuss how to deal with '*fractured structure*' (p. 15) which is an inevitable

consequence of interviewing human participants, regardless of the formality or informality of the interview schedule. Despite being seemingly messy, this is also a point of interest in the data, as unexpected findings allow for code and theme development that might not otherwise have been predicted (Braun and Clarke, 2020).

Having been through each transcript in this way and having developed the codes that were applied to the transcripts, I then considered the overall themes. As outlined above, I used four of Ryan and Bernard's (2003) seven techniques to identify these themes, with particular emphasis on the first three – examination of instances of repetition, metaphors and transitions. By examining and reflecting on the structural and content codes, three distinct themes were identified. These themes will be discussed in detail in the next chapter.

3.7 Data Integration

One criticism of a mixed-methods typology is that many mixed-methods researchers fail to integrate the two or more methods used in their research (Östlund *et al.*, 2011). The process of integration and the thinking behind it has evolved throughout the growth of mixed-methods research (Teddlie and Tashakkori, 2009; Creswell and Plano Clark, 2018). Creswell and Plano Clark (2018) outline the different stages of the research where methods can be integrated. They link this to the research design itself, in the case of my study, a sequential explanatory design. In this type of research, where the quantitative phase precedes the qualitative phase, qualitative data is used to explain quantitative data (Bryman, 2006). Integration takes place by identifying from the statistical data what needs further explanation, then building this into the qualitative data collection tool. Findings from both types of data are represented and interpreted by jointly displaying the data, identifying the value added to the findings by the qualitative explanation (Creswell and Plano Clark, 2018). The overall intent of integration within this design is to drill down into the findings from the quantitative arm by using the qualitative results to explain the initial findings. The qualitative themes should provide insights into the nuances of the quantitative data (Creswell and Plano Clark, 2018).

The term '*inference*' is used to describe conclusions and interpretations that are developed because of research findings (Tashakkori and Teddlie, 2003: 71). Inference is particularly challenging in mixed-methods studies because it needs to take account of the integration of findings. As a result, conclusions and interpretations need to synthesise both quantitative and qualitative results, reaching new conclusions. In mixed-methods research, it is likely that inference will be both objective and subjective, taking account of both statistical data as well as less measurable outcomes such as context and belief. Inferences based on multiple perspectives are likely to be stronger, with greater reliability and validity because they are based on more than one form of evidence (Tashakkori and Teddlie, 2003). The quality of inference also needs to be evaluated. Sound results do not guarantee high-quality inferences; these should be evaluated, and their derivation from the findings should be convincing (Teddlie and Tashakkori, 2009).

In my study, integration took place in the discussion, by combining the findings of the survey and the interviews. Resilience was used as the framework for integration. Findings from the resilience and wellbeing scales in the survey and from subsequent interview questions developed from these scales were merged to reach new conclusions. Inference arising from these conclusions is discussed in Chapter 5 and informs the recommendations in Chapter 6.

3.8 Ethical approval

Ethical approval for my study was obtained in December 2019 through the University of Greenwich Research Ethics Committee (UREC), ethics number UREC/18.3.5.7. The form outlined data collection methods and storage, in line with the Data Protection Act 1998 and the University's research regulations. Data were encrypted and stored under password protection. All data were anonymous (unless contact details were provided for the interviews/focus groups) and identity of the interviewees was only known to me as the researcher. Personal data will be destroyed after two years, as required by the General Data Protection Regulation (GDPR) (European Union, 2016). The information sheets and interview consent form were also approved through UREC. Permission to distribute the survey in each of the four Trusts was obtained through each Trust's Research and Development

departments. NHS ethical approval (IRES) was not required, according to the HRA decision tool (NHS Health Research Authority, 2020). One Trust, however, required IRES approval and was therefore withdrawn from the study and replaced by another Trust (in the same quartile of London) who did not require IRES approval. Please see Appendices 3a, 3b, 6a and 6b for information sheets and consent forms and Appendix 7 for the UREC form.

As the data collection had to be delayed due to the outbreak of COVID-19, I took the opportunity to amend my survey to include two questions about COVID-19 and its impact on midwives' intentions to stay in or to leave midwifery. This was fortuitous because the survey had already received ethical approval; therefore, a minor ethical amendment was all that was required. I also requested that the interviews or focus groups might be conducted online, in line with research recommendations following the COVID-19 pandemic. Amended ethical approval was granted in September 2020 although distribution of the survey was further delayed by the second wave of COVID-19 (see Appendix 4 - survey for details).

One potential ethical issue acknowledged in the ethics application was my dual role as researcher and lecturer at the same university. My ethics form stated:

> *It is acknowledged that I am both a doctoral student and a member of staff and this raises potential ethical concerns. It is possible that participants may be ex-students of the University of Greenwich and, therefore, known to me. However, as qualified midwives, I have no responsibility for them or for their practice. Participants will be advised that they can withdraw from the research at any time and that participation or the lack of it will have no effect on their professional work. If any participants are known to me in either Phase 1 or 2, I will acknowledge this anonymously when writing up.*

The survey was anonymous (unless a respondent gave their email address for interview purposes), but the interviews were face-to-face and, therefore, could not be anonymous. Two of the interviewees were known to me and this was acknowledged at the beginning of their interview. As the interviewees were self-selecting, it was assumed that they would have

chosen not to be interviewed if they had not been comfortable discussing their NQM experiences with me; however, they were informed that the interview could be stopped at any time, and this would not be questioned or judged in any way.

3.9 Summary

Summarising this chapter, I chose to conduct my study using a mixed-methods approach within a pragmatic framework. This methodology was chosen because it fits the intention of the research questions, in other words, to identify the wider context in which the NQMs worked as well as their experience of being a NQM and the factors that enabled them to stay. A sequential explanatory model was used to conduct the mixed-methods study (Creswell and Plano Clark, 2018) because the survey enabled me to gain an understanding of why midwives stay and what might make them consider leaving before exploring this in more detail with NQMs through the interviews.

Two scales were used – one resilience and one wellbeing scale - to explore individual and workplace factors that could explain why midwives might be personally or professionally better equipped to stay in midwifery. The Connor-Davidson Resilience Scale was a previously validated tool (Campbell-Sills and Stein, 2007). The Bower Midwife Wellbeing Scale was developed for this research, using the work of Hunter and Warren (2013). SPSS-version 27 was used to analyse the statistical data in the survey. Qualitative survey questions were analysed using descriptive frequencies. The findings of the survey were then used to shape the semi-structured interview schedule (see Appendix 5). Interview data were analysed using applied thematic analysis (Guest *et al.*, 2012). This method of analysis best suited the deductive-inductive approach used to thematically analyse the qualitative data from the interviews. Chapter 4 will present the results from both quantitative and qualitative phases of the study, illustrating the sequential explanatory approach and how this was used to structure the findings.

CHAPTER 4: RESULTS – SURVEY AND INTERVIEW DATA

4.0 Introduction

This chapter presents the findings from both the survey and the interviews. Findings from the survey were analysed using SPSS (Version 27). Descriptive statistics and statistical tests are presented here, and the findings are used to explain and explore the data. Interview data were analysed using applied thematic analysis (see Chapter 3 for a full description) and the themes arising from the analysis will be explored below.

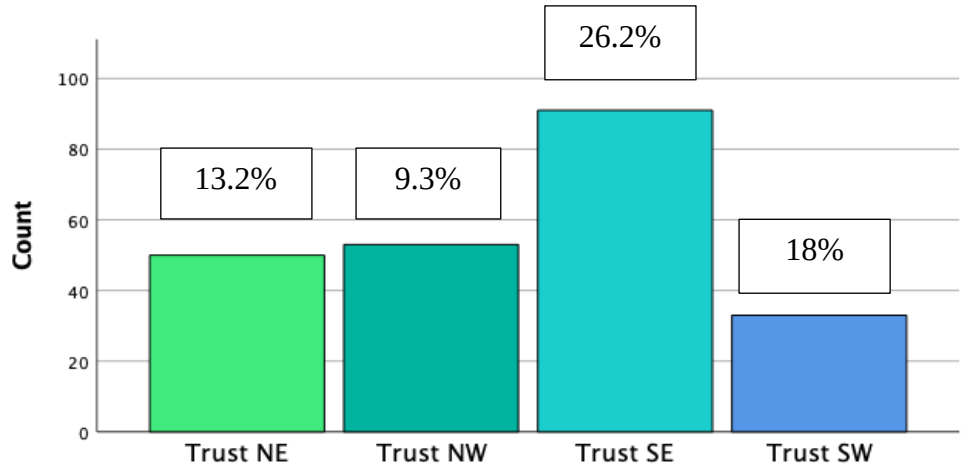
4.1 Survey

The survey was sent to all midwives (n = 1502) in four NHS Trusts situated in each of the four quadrants of London (NW, NE, SW, SE). This sample represented the geographical spread of maternity services across London. The survey was agreed and distributed either by the Director/Head of Midwifery or their representative. The timing was affected by the COVID-19 pandemic: initially distribution was planned for March 2020, but it was postponed as it was not considered ethical to put out a survey when the NHS staff was struggling to keep up with the demands of the pandemic. The survey was therefore deferred for six months, when the situation was reviewed. At this time, COVID-19 cases were once again rising so it was decided to wait until cases started to decrease, which occurred in mid-November 2020. The survey was then released, ahead of the third wave which followed in mid-December. Most of the responses were received by early December, although a reminder was sent out prior to Christmas and the survey was closed in early January 2021. Given this context to the survey (and subsequently the focus groups/interviews), the response rate (16.5%) to the survey was both surprising and heartening.

4.1.2 Survey: demographic data

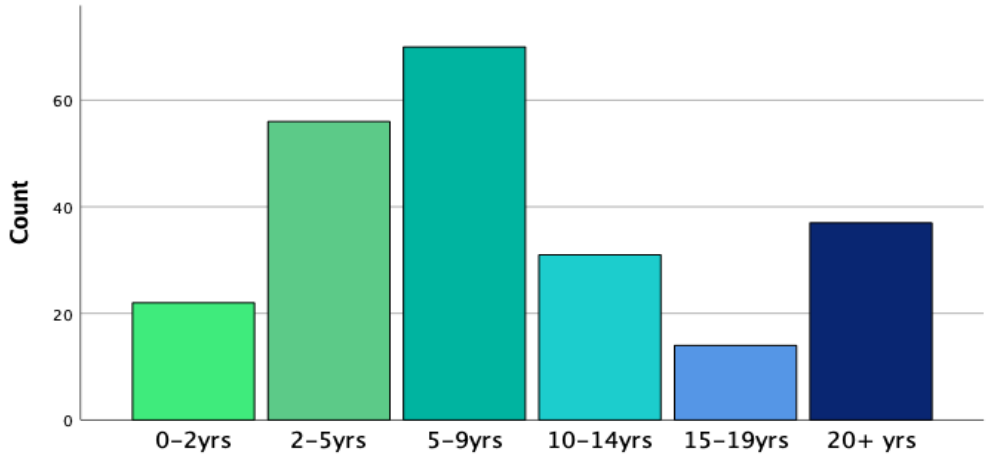
There were 248 responses to the survey (16.5%); 11 responses were incomplete and were discarded. This left 237 full respondents from all four Trusts, a completion rate of 15.8%. Figure 4.1 provides the response rate by Trust/area.

Figure 4.1: Distribution of survey participants by Trust



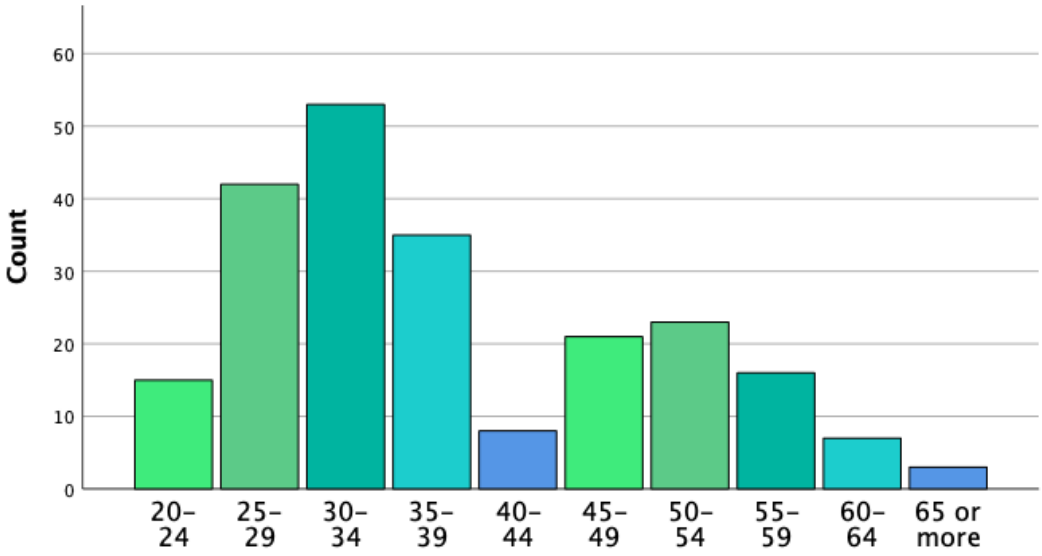
Midwives who had qualified in the previous two years accounted for 9.6% (n= 22) of the responses, whereas those who had been qualified for more than 2 years accounted for 90.4% (n =215). Given that phase 2 of the research invited NQMs (within 2 years of qualifying) to be interviewed, this was appropriate to enable the research questions to be addressed. A breakdown of length of time qualified can be seen in Figure 4.2.

Figure 4.2. Length of time qualified



The age distribution amongst respondents demonstrated that 65% of respondents were under 40 years old (n = 145) suggesting a younger midwifery workforce, as demonstrated in Figure 4.3.

Figure 4.3. Distribution of survey participants by age



More than two-thirds of midwives stated that they had qualified in London (66.7%, n = 158). Over one-fifth had qualified elsewhere in the UK (n = 52). Midwives who had qualified in Europe accounted for 10.5% of respondents (n = 25) but less than 1% of midwives had qualified internationally (outside Europe and the UK, n = 2). Over one-third of the midwives (36.3%; n = 86) had worked in London for less than 5 years. This would suggest that a significant number of those who qualified in London were more likely to stay in London.

Ten midwives (4.2%) stated that they were on Band 5, identifying them as having qualified within the last 12 months. As already stated, 22 midwives (9.6%) had qualified within the past two years, defining them as NQMs for the purpose of my study. Over half the midwives (58.6%) were on Band 6, which indicates the midwife has passed her (Band 5) preceptorship period. Approximately one-third of midwives were on a higher band (27.8% on Band 7 and 5.9% on Band 8). Band 7 and 8 midwives are mostly on specialist/management grades, with Band 7 midwives being either community midwives, specialist midwives or ward managers. Band 8 is reserved for matrons and higher positions, such as consultant midwives.

Responses to the questions 'have you thought of leaving your post/midwifery/London in the last 6 months' and 'has your experience of COVID-19 influenced your intentions?' resulted in the following data (see Table 4.1).

Table 4.1 Have you thought of leaving?

In the last six months, have you thought of leaving:	Post?	Midwifery?	London?	Has COVID-19 influenced your decision
YES	41.5% n = 98	62.9% n = 149	48.1% n = 114	73.4% n = 174
NO	56.5% n = 133	34.6% n = 82	48.9% n = 116	23.6% n = 56
Missing data	2.5% n = 6	2.5% n = 6	3% n = 7	3% n = 7

Whilst over 40% had considered leaving their post in the last six months, nearly two-thirds of all midwives had considered leaving midwifery, which was a noteworthy finding. Equal numbers had or had not considered leaving London and three-quarters of all respondents cited COVID-19 as influencing their decisions. Given that the survey was distributed during the pandemic, it provided an opportunity to question midwives about their response to COVID-19. These questions were also explored with NQMs in the interviews.

4.3 Preliminary data analysis

Before commencing the analysis of the data, the reliability of the resilience and wellbeing scales used was assessed. In total, there were 224 respondents who answered all questions in both scales (94.5% of respondents included in the survey). This was therefore the total number used for all scale calculations. For detailed discussion of the validity and reliability of the scales used in the survey, please see Chapter 3.

4.3.1 Descriptive statistics: Resilience and Wellbeing scales

As discussed in Chapter 3, the Connor-Davidson Resilience Scale was used as a measure of personal resilience. In the survey, the actual range of scores was 17-50 (out of a potential range of 10-50), giving a mean score of 39.7 and a median score of 40.0. This would suggest

a higher level of agreement than disagreement with the statements. The Bower Midwife Wellbeing Scale was used as a measure of midwife workplace wellbeing, an indicator of their level of professional resilience. In the survey, the actual range of scores was 15-55 (out of a potential range of 11-55). The mean score was 40.2 with the median score being 41.0. Again, this would suggest a higher level of agreement with the statements than disagreement.

4.3.2 Tests of Normality

Figure 4.4 Test of normality for Connor-Davidson Resilience Scale

			Statistic	Std. Error
Sum of Connor Davidson	Mean		39.7455	.37401
	95% Confidence Interval for Mean	Lower Bound	39.0083	
		Upper Bound	40.4826	
	5% Trimmed Mean		39.8737	
	Median		40.0000	
	Variance		30.775	
	Std. Deviation		5.54753	
	Minimum		17.00	
	Maximum		50.00	
	Range		33.00	
	Interquartile Range		7.75	
	Skewness		-.476	.164
	Kurtosis		.737	.327

Figure 4.5 Test of normality for Bower Midwife Wellbeing Scale

			Statistic	Std. Error
Sum of Bower	Mean		40.1855	.45851
	95% Confidence Interval for Mean	Lower Bound	39.2819	
		Upper Bound	41.0892	
	5% Trimmed Mean		40.4882	
	Median		41.0000	
	Variance		46.461	
	Std. Deviation		6.81622	
	Minimum		15.00	
	Maximum		55.00	
	Range		40.00	
	Interquartile Range		9.00	
	Skewness		-.719	.164
	Kurtosis		.958	.326

The two scales were then subjected to tests of normality to see whether they followed a normal distribution curve (Pallant, 2020). As can be seen from Figure 4.4, the mean and the 5% trimmed mean (which removes the extremes and outliers from the data) are very similar (mean = 39.7, 5% trimmed mean = 39.9) for the Connor-Davidson Resilience Scale. This suggests that the outliers have not had a strong influence on the data. Likewise, for the Bower Midwife Wellbeing Scale (Figure 4.5), the data suggest that there is not much difference (mean = 40.2, 5% trimmed mean = 40.5), therefore, it is likely that the outliers have not had a corruptive influence on the scale.

The skewness and kurtosis scores are important in assessing the distribution of the data (Pallant, 2020). Both scales have negative skewness, indicating that there is skewness towards the higher end of the scale, particularly with the Bower Midwife Wellbeing Scale (Connor-Davidson = -0.48, Bower = -0.72). This would suggest there is greater agreement with the statements in the scales than disagreement. However, as Field (2013) acknowledges, this is not so relevant in large data sets (defined as more than 100 samples or participants) where it is more important to examine the visual distribution of the associated histogram. These can be seen in Figure 4.6 and 4.7.

Figure 4.6 Normal distribution histogram – Connor Davidson Resilience Scale

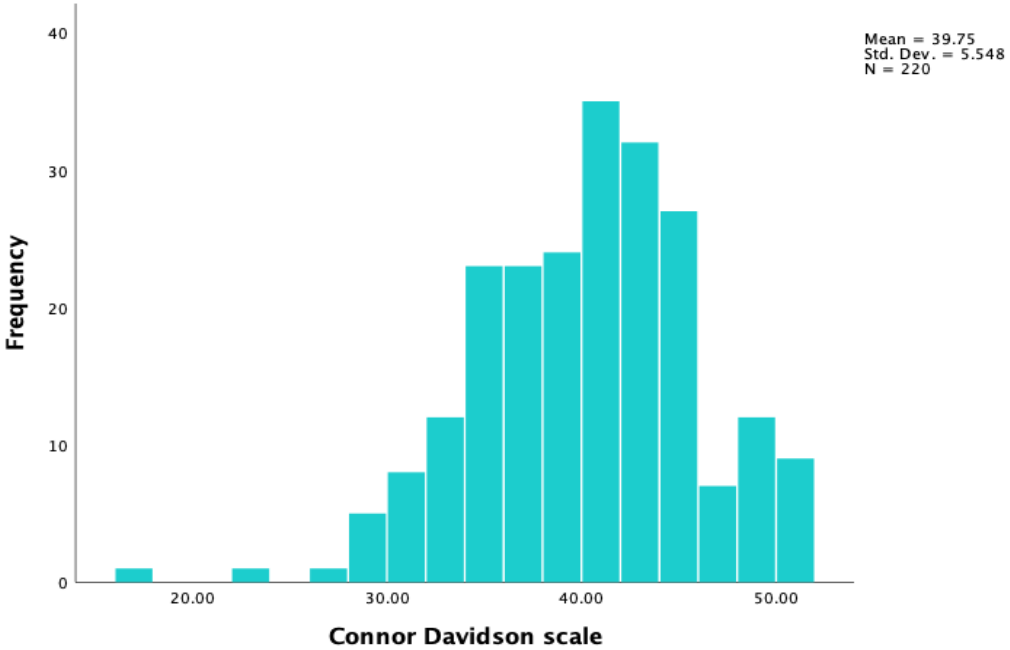
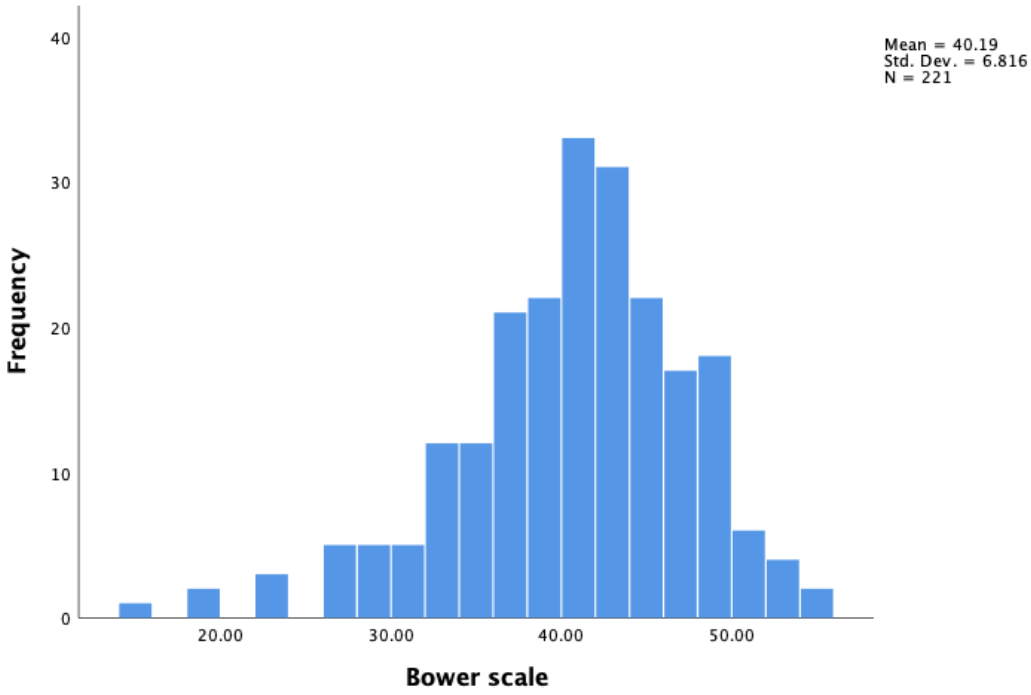


Figure 4.7 Normal distribution histogram – Bower Midwife Wellbeing Scale



It can be seen from the histograms that the Bower Midwife Wellbeing scale distribution, although skewed to the higher end, is more normally distributed than the Connor-Davidson Resilience Scale. The general pattern of the graphs, however, would indicate that there is a relatively normal distribution pattern for both scales. Field (2003) goes so far as to say that tests of normality can almost be ignored for larger samples (greater than 100) because the size of the sample ensures that the sampling distribution is normal regardless of what the data look like.

Another indication of normality is to identify the values for the Kolmogorov-Smirnov and Shapiro-Wilk tests. In both the resilience and wellbeing scales, the test results are significant (Connor-Davidson score: <.004, Bower score: <.001). As for the skewness and kurtosis scores, however, as the sample size gets larger, the assumption of normality is less important as the size of the sample itself ensures normality (Field, 2013).

The final test for normality is to look at the boxplot of the distribution of scores (Figures 4.8 and 4.9). This also identifies the extremes and outliers, which have the potential to skew the results of the tests discussed above. As already indicated by the 5% trimmed mean scores, the outliers appear not to have had a significant impact on the normality scores, but the boxplot identifies individual cases that can then be individually assessed. In the boxplot for the Connor-Davidson Resilience Scale, only two outliers are identified; neither of these are extreme values. The boxplot indicates a symmetrical spread of values, with the two outliers lower than the 50% box. In the Bower Midwife Wellbeing Scale boxplot, there are five outliers, again all lower than the 50% box, but none of these are identified as extreme values.

Figure 4.8 Box plot for normality – Connor Davidson Resilience Scale

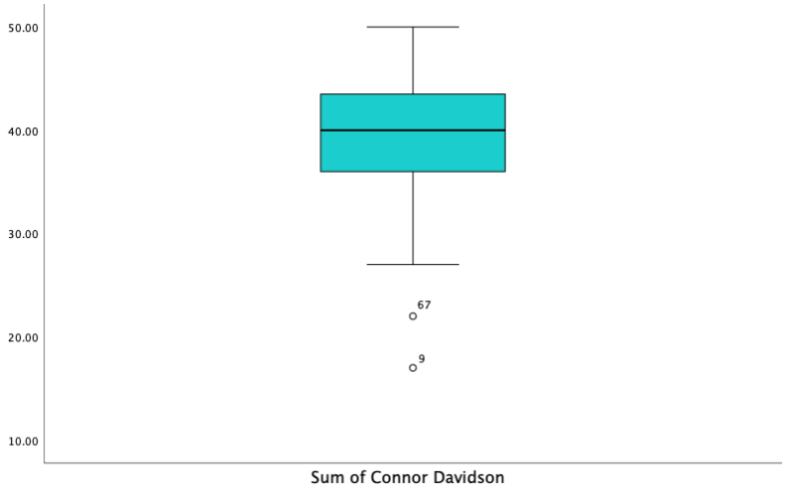
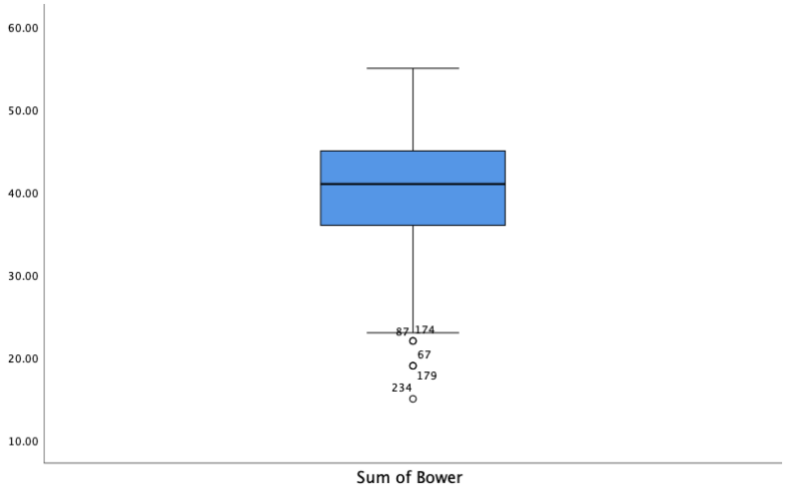


Figure 4.9 Box plot for normality – Bower Midwife Wellbeing Scale



In summary, having assessed both scales using tests of assumption of normality, it can be concluded that most of these tests are less relevant to the survey data than observing the visual distribution of normality using the histograms. This is because the data set is large enough to offset the violation of normality tests, which are only significant if the data set is small. On visual observation, both scales approximately follow a normality distribution curve, although the data appear to be skewed to the higher end of both scales. Given the large data set (n = 224), this is less important than in small data sets and statistical tests are unlikely to be affected by the outcome of individual tests (Pallant, 2020).

4.4 Correlation

A test of correlation (Pearson's r parametric test) was applied when exploring the relationship between the number of years qualified and the resilience and wellbeing scores, also midwives' intention to leave their post/midwifery/London and the resilience and wellbeing scores. This test was appropriate because the tests of normality demonstrated normal distribution.

The first question under consideration was: is there a relationship between the number of years qualified and the resilience/wellbeing scores? The hypothesis might be that as the number of years since qualification increased, so did the resilience/wellbeing scores for that midwife. To decide whether this was an appropriate test, preliminary analysis was carried out by looking at the scatter plots of the variables under analysis (Pallant, 2020) to see whether there appeared to be a visual relationship between the continuous variables (see Figures 4.10 and 4.11).

As can be seen from these scatter graphs, there is no obvious relationship between the number of years qualified and either the resilience or wellbeing scores. If a relationship had been detected, the scatter dots would have been situated around an imaginary diagonal line, the direction of the line indicating whether this was a positive or negative correlation. As no relationship was detected, it was not appropriate to undertake correlational analysis on these specific questions.

Figure 4.10 Scatter plot for correlation – Connor-Davidson Resilience Scale

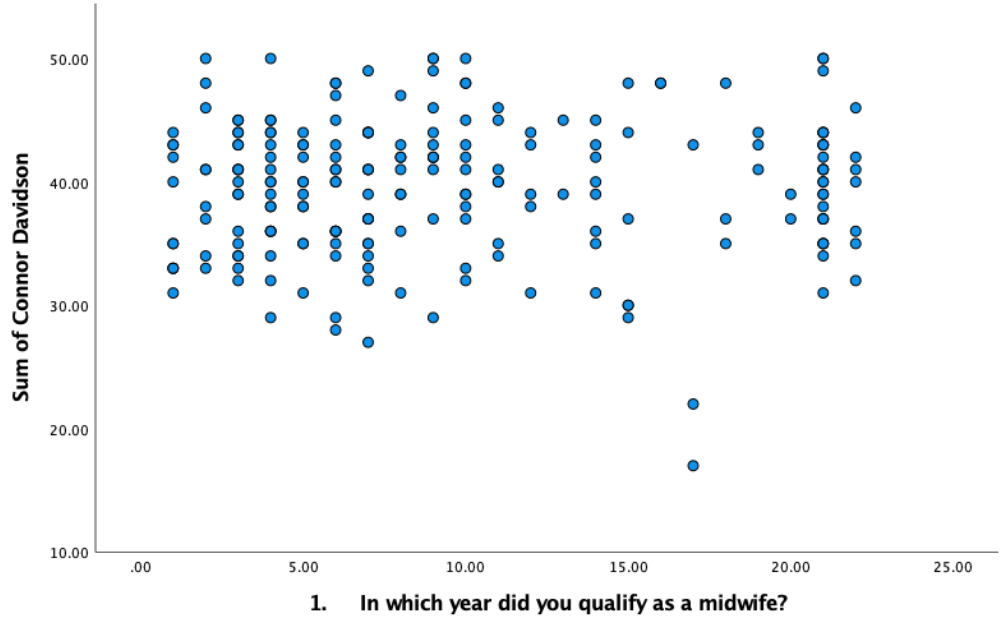
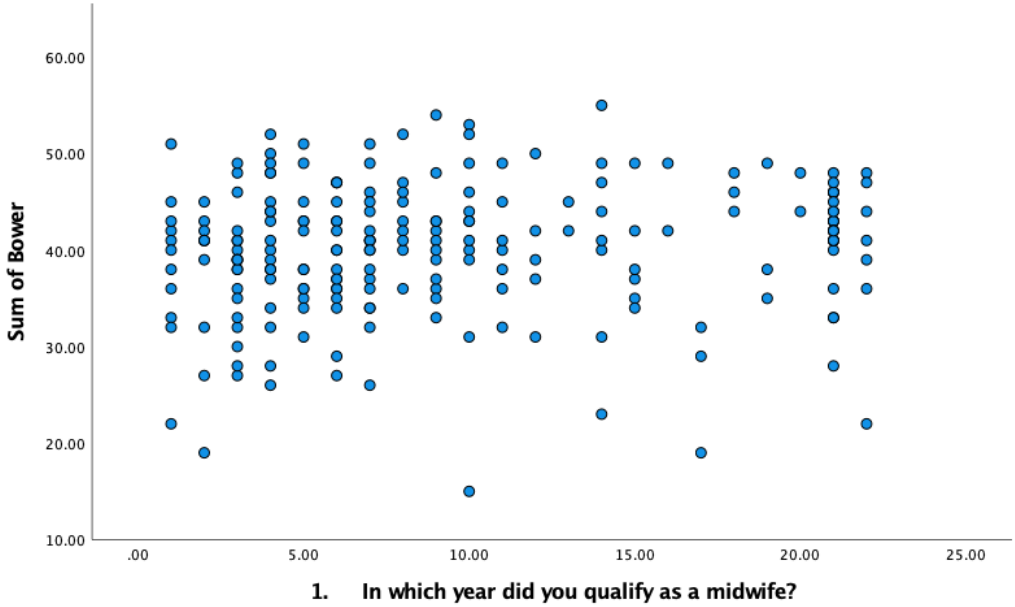


Figure 4.11 Scatter plot for correlation – Bower Midwife Wellbeing Scale



Secondly, the three questions relating to intention to leave the post/midwifery/London in the last six months were correlated with the resilience and wellbeing scales (see Figures 4.12 and 4.13). The statistical calculation of the correlation between dichotomous variables and a

continuous variable uses the Pearson's correlation parametric test (Field, 2013). This is applicable to the questions in the survey about intention to leave.

Figure 4.12 Correlation of Connor-Davidson Resilience Scale with intention to leave post/midwifery/London

		Sum of Connor Davidson	CurrentPost	Midwifery	London
Sum of Connor Davidson	Pearson Correlation	1	-.029	-.042	-.026
	Sig. (2-tailed)		.673	.535	.701
	N	220	220	220	219
CurrentPost	Pearson Correlation	-.029	1	.472**	.377**
	Sig. (2-tailed)	.673		<.001	<.001
	N	220	231	231	230
Midwifery	Pearson Correlation	-.042	.472**	1	.203**
	Sig. (2-tailed)	.535	<.001		.002
	N	220	231	231	230
London	Pearson Correlation	-.026	.377**	.203**	1
	Sig. (2-tailed)	.701	<.001	.002	
	N	219	230	230	230

**. Correlation is significant at the 0.01 level (2-tailed).

Figure 4.13 Correlation of Bower Midwife Wellbeing Scale with intention to leave post/midwifery/London

		Sum of Bower	CurrentPost	Midwifery	London
Sum of Bower	Pearson Correlation	1	-.312**	-.438**	-.147*
	Sig. (2-tailed)		<.001	<.001	.028
	N	221	221	221	221
CurrentPost	Pearson Correlation	-.312**	1	.472**	.377**
	Sig. (2-tailed)	<.001		<.001	<.001
	N	221	231	231	230
Midwifery	Pearson Correlation	-.438**	.472**	1	.203**
	Sig. (2-tailed)	<.001	<.001		.002
	N	221	231	231	230
London	Pearson Correlation	-.147*	.377**	.203**	1
	Sig. (2-tailed)	.028	<.001	.002	
	N	221	230	230	230

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

The relationship between the Connor-Davidson Resilience Scale (measuring personal resilience) and intention to leave (post/midwifery/London) was investigated using a Pearson correlation coefficient. This test found that there is no correlation between personal resilience and intention to leave (post/midwifery/London) because all r values were below 0.1 (Pallant, 2020).

The relationship between the Bower Midwife Wellbeing Scale and intention to leave (post/midwifery/London) was also investigated using a Pearson correlation coefficient. There was a negative correlation between midwife wellbeing and intention to leave (post: r = -.312, N = 221, p = <.001; midwifery: r = -.438, N = 221, p = <.001; London: r = -.142, N = 221, p = .028), demonstrating an inverse relationship. There was a moderate negative correlation between midwife wellbeing and intention to leave midwifery, which indicated that a higher wellbeing score correlated with less intention to leave. This was statistically significant, indicating confidence in the results. The other questions only had weak correlation with the scale, as r values were .3 or less (Pallant, 2020).

In summary, the Bower Midwife Wellbeing Scale was demonstrated to have a moderately strong inverse correlation with the question '*Have you thought of leaving midwifery in the last six months?*' A higher score suggests that midwives are less likely to have thought of leaving midwifery in the last six months. This could be useful in identifying those who are more likely to stay in midwifery, also those with low wellbeing scores who are more likely to have thought of leaving. This will be explored further in Chapter 5 (discussion chapter).

4.6 Independent sample T-test

The independent sample T-test was used to address the following questions:

1. Is there a difference in Connor-Davidson Resilience scores between those who qualified in the last 2 years and those who qualified more than two years ago?
2. Is there a difference in Bower Midwife Wellbeing scores between those who qualified in the last 2 years and those who qualified more than two years ago?

Before this test could be performed, it was necessary to collapse Question 1 of the survey into two groups: those who had qualified up to two years ago and those who had qualified two years ago or more. Two years was chosen to mirror the NQMs who were invited to interview in phase 2 of the study. See Figures 4.14 and 4.15 for results.

Figure 4.14 Independent T-tests for Connor-Davidson Resilience Scale

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Sum of Connor Davidson	Equal variances assumed	.345	.558	-.503	211	.615	-.65285	1.29795	-3.21145	1.90575
	Equal variances not assumed			-.497	22.991	.624	-.65285	1.31384	-3.37079	2.06509

Figure 4.15 Independent T-tests for Bower Midwife Wellbeing Scale

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Sum of Bower	Equal variances assumed	.726	.395	-1.664	212	.098	-2.61115	1.56890	-5.70379	.48148
	Equal variances not assumed			-1.470	23.308	.155	-2.61115	1.77677	-6.28400	1.06170

The first test compared the Connor-Davidson Resilience scores for those who had qualified < 2 years ago and those who had qualified ≥ 2 years ago. There was no significant difference in scores for <2yrs (M = 39.00, SD = 5.60) and ≥2 yrs (M = 39.65, SD = 5.52); t (N = 213) = -0.50, p = 0.62 (2-tailed). The difference in the means (mean difference = -0.65, 95% CI [-3.21, 1.91]) was very small (eta ^{2} = 0.005).

The second test compared the Bower Midwife Wellbeing scores for those who had qualified < 2 years ago and those who had qualified ≥ 2 years ago. There was no significant difference in scores for <2yrs (M = 37.76, SD = 7.84) and ≥2 yrs (M = 40.37, SD = 6.71). t (N = 214) = -1.66, p = 0.1 (2-tailed). The difference in the means (mean difference = -2.61, 95% CI [-5.70, 0.48]) was very small (eta ^{2} = 0.016).

The fact that there was no difference between the groups is an interesting finding. Even though midwives who had been qualified < 2 years appeared to have a slightly lower mean Bower Midwife Wellbeing score than those who had qualified ≥2 yrs (37.76 compared with 40.37), this was not a statistically significant finding. It can be concluded that the measures of resilience and wellbeing used in the survey did not demonstrate a significant difference in personal resilience or midwife wellbeing between NQMs in their first two years compared with those who had been qualified for longer.

4.7 Logistic Regression

Correlational analysis has already identified that there is a lack of correlation between the resilience or wellbeing scales and any of the independent variables (except for the Bower Midwife Wellbeing scale and intention to leave midwifery). Binary logistic regression was used to see whether it is possible to predict intention to stay or leave (post/midwifery/ London) using either of the scores and the two categorical outcomes – intention to stay or to leave.

Each of the questions asking about intention to leave (post/midwifery/London) was included in the regression model with both resilience and wellbeing scales and number of years since qualification, to see if either or both scores and length of time since qualification might predict whether midwives had considered leaving. The findings from logistic analysis are presented below by considering each question in turn.

4.7.1 Question 12: Have you considered leaving your post in the last six months?

Direct logistic progression was performed to assess the predictor values of both resilience and wellbeing scales on the likelihood of midwives having thought of leaving their post in the last six months. The model contained three independent variables (Connor-Davidson Resilience score, Bower Midwife Wellbeing score, years qualified). The full model containing all predictors was statistically significant χ^2 (3, N = 211) = 23.37, p<.001, indicating that the model was able to distinguish between respondents who had and had not thought of leaving their post in the last six months. The model correctly classified 60.7% of cases.

Only one independent variable, the Bower Midwife Wellbeing score, made a statistically significant contribution to the model, as shown in Figure 4.16. This variable had an odds ratio of 0.89 which is less than one, demonstrating an inverse relationship. This indicated that for every increase of one point on the wellbeing scale, the odds were 0.89 lower of thinking of leaving their post in the last six months. Stated another way, the higher the wellbeing score, the less likely they were to have considered leaving their post.

Figure 4.16 Logistic regression predicting likelihood of thinking of leaving post in last 6 months

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B) Lower	Upper
Step 1[a]	Sum of Connor Davidson	.029	.029	1.042	1	.307	1.030	.973	1.089
	Sum of Bower	-.112	.027	17.905	1	<.001	.894	.848	.941
	1. In which year did you qualify as a midwife?	-.016	.023	.500	1	.480	.984	.942	1.029
	Constant	3.910	1.336	8.562	1	.003	49.889		

a. Variable(s) entered on step 1: Sum of Connor Davidson, Sum of Bower, In which year did you qualify as a midwife?.

4.7.2 Question 13: Have you considered leaving midwifery in the last six months?

Direct logistic progression was again performed to assess the predictor values of both resilience and wellbeing scales on midwives' likelihood to have thought of leaving midwifery in the last six months. The model contained the same three independent variables (Connor-Davidson Resilience score, Bower Midwife Wellbeing score, years qualified). The full model containing all predictors was statistically significant χ^2 (3, N = 211) = 47.37, p<.001, indicating that the model was able to distinguish between respondents who had and had not thought of leaving midwifery in the last six months. The model correctly classified 73.5% of cases. As shown in Figure 4.17, again only one independent variable, the Bower Midwife Wellbeing score, made a statistically significant contribution to the model. This variable had an odds ratio of 0.84 which is less than one, demonstrating an inverse relationship. This indicated that for every increase of one point on the wellbeing scale, the odds were 0.84 lower of thinking of leaving midwifery in the last six months. As in the previous model, the higher the wellbeing score, the less likely they were to have considered leaving midwifery in the last six months.

Figure 4.17 Logistic regression predicting likelihood of thinking of leaving midwifery in last 6 months

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B) Lower	Upper
Step 1[a]	Sum of Connor Davidson	.056	.031	3.206	1	.073	1.058	.995	1.125
	Sum of Bower	-.180	.031	33.030	1	<.001	.835	.786	.888
	1. In which year did you qualify as a midwife?	.017	.025	.497	1	.481	1.018	.969	1.068
	Constant	4.212	1.410	8.927	1	.003	67.489		

a. Variable(s) entered on step 1: Sum of Connor Davidson, Sum of Bower, In which year did you qualify as a midwife?.

4.7.3 Question 14: Have you considered leaving London in the last six months?

Finally, direct logistic progression was performed to assess the predictor values of both resilience and wellbeing scales on midwives' likelihood to have thought of leaving London in the last six months. Again, the model contained the same three independent variables (Connor-Davidson Resilience score, Bower Midwife Wellbeing score, years qualified). The full model containing all predictors was not statistically significant χ^2 (3, N = 211) = 5.09, p=.167, indicating that the model was unable to distinguish between respondents who had and had not thought of leaving London in the last six months. The model only correctly classified 54.0% of cases, which is only just above 50%. As shown in figure 4.18, none of the independent variables made a statistically significant contribution to the model.

Figure 4.18 Logistic regression predicting likelihood of thinking of leaving London in last 6 months

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B) Lower	Upper
Step 1[a]	Sum of Connor Davidson	.008	.026	.099	1	.753	1.008	.957	1.062
	Sum of Bower	-.037	.022	2.882	1	.090	.963	.923	1.006
	1. In which year did you qualify as a midwife?	-.026	.022	1.483	1	.223	.974	.934	1.016
	Constant	1.520	1.167	1.696	1	.193	4.573		

a. Variable(s) entered on step 1: Sum of Connor Davidson, Sum of Bower, In which year did you qualify as a midwife?.

4.7.4 Summary of resilience/wellbeing findings in survey

In summary of logistic regression analysis on the three survey questions, it can be shown that only the Bower Midwife Wellbeing Scale has a predictive ability in relation to the questions: *have you thought of leaving your post/midwifery in the last six months*? The Bower scale demonstrates a statistically significant ability to predict whether midwives are more likely to have considered leaving their post or midwifery. The higher the wellbeing score, the less likely the midwife is to have thought about leaving her post or midwifery. In other words, greater wellbeing is more likely to predict that a midwife will stay. The Bower Midwife Wellbeing scale's ability to predict whether midwives intend to leave or stay in midwifery, however, is stronger than its ability to predict whether they intend to leave or stay in their post (73.5% accuracy for thinking of leaving midwifery, and 60.7% accuracy for thinking of leaving post). None of the results were statistically significant if length since qualification was put into the regression model. This demonstrates that the model was not able to predict whether NQMs as a separate group are more likely to stay in or to leave their post/midwifery.

These findings have implications for midwifery practice. The Bower Midwife Wellbeing Scale developed from the work of Hunter and Warren (2013) predicts that those with a lower wellbeing score are more likely to have considered leaving their post or midwifery. The scale could be used to identify those midwives, regardless of length of qualification, who require further support, therefore improving retention of midwives who might otherwise pursue their intention to leave. Although no significant difference was demonstrated by length of qualification, this finding is still important for those NQMs who have a lower Bower Midwife Wellbeing score and are therefore more likely to consider leaving. The wellbeing score findings relating to NQMs and their experience of making the transition to midwifery practice will be further explored through the qualitative findings (below). Chapter 5 will explore the relationship between resilience, wellbeing and NQMs in the discussion.

4.8 Interviews with NQMs

From the survey, 22 NQMs (who had been qualified for less than two years) were identified as meeting the criteria for interview, 13 of whom offered their email addresses for further contact. From these 13 volunteers, 11 NQMs (50% of those eligible) were interviewed. Midwives were interviewed either individually or in pairs, which resulted in eight interviews in total, representing three of the four Trusts.

Interviews followed a semi-structured format (see Appendix 5), using mostly pre-determined questions, which had been approved through the University of Greenwich Research Ethics Committee (UREC) (see Appendix 7). In keeping with the sequential exploratory methodology, the two statements in the resilience and wellbeing scales that received the lowest overall mean scores were also included for further exploration in the interviews. These statements were: *coping with stress strengthens me, I am not easily discouraged by failure, staffing levels are usually safe,* and *I have not experienced bullying at work.*

4.8.1 Qualitative Data Analysis

Table 4.2 provides a summary of the demographics of the NQMs who were interviewed.

Table 4.2 NQM interviewees

Interview	Interviewee	Trust	Trust where trained	Length of time since graduation	Length of time working as NQM	Comments
1	NQM 1	NW	NW	2 ½ years	2 ½ years	Working part-time clinically
1	NQM 2	NW	NW	2 ½ years	2 ½ years	Working part-time clinically
2	NQM 3	NE	Another London Trust	2 years	1 ½ years	About to leave post to take a career break
3	NQM 4	SE	SE	1 ½ years	1 ½ years	About to move to another Trust
4	NQM 5	NE	NE	1 ¾ years	1 ¾ years	Full-time

4	NQM 6	NE	SE	1 ¾ years	1 ¾ years	Moved Trust for 1st job
5	NQM 7	SE	Trust outside London	3 years	2 years	Moved to London for 1st job; about to leave midwifery for medicine
6	NQM 8	SE	SE	9 months	9 months	Part-time
7	NQM 9	NW	NW	9 months	8 months	Full-time
7	NQM 10	NE	NE	8 months	7 months	Full-time
8	NQM 11	SE	SE	1 year	9 months	Full-time

4.8.2 Codebook

Once all the interviews were recorded, either by video or audio recordings, they were transcribed by an external transcription agency (please see Chapter 3 for details). This meant I did not have the benefit of immersing myself in the data at the time of transcription. Once transcribed, however, I replayed the recordings while reading the transcripts at the same time, thus immersing myself in the interview data. Prior to this, I used the semi-structured interview schedule to identify potential structural codes, in line with the method of codebook development outlined by Guest *et al*. (2012). The structural codes identified were 'NQMs' experience', 'resilience', 'remain' and 'leave' (see Appendix 8a). After going through the first four interviews and identifying the initial content codes, I then went through the remaining interviews and revised the structural and content codes, as described in section 3.6.2.3.(see Appendix 8b). The content codes are summarised below in Table 4.3.

By examining and reflecting on the structural and content codes, three distinct themes were identified:

(i) Head above water

(ii) Professional conflicts

(iii) Professional identity

Table 4.3 Summary of Structural and Content codes

Structural Code	Content code 1	Content code 2	Content code 3
Head above water	Transition	Sink or swim	Support
Professional conflicts	Stress and burnout	Culture of bullying	Staffing
Professional Identity	'I love midwifery'	Work/life balance	Fitting in
London	Reasons to remain	Reasons to leave	

These themes arose from the structural codes above, evolving from the factors identified in the content codes that reflected newly qualified midwife status, and contributed to leaving or staying in midwifery. The theme '*head above water*' includes the findings relating to the original structural code of 'newly qualified midwives' (transition, survival – renamed 'sink or swim' to reflect the use of water metaphors - and support). The theme '*professional conflicts*' incorporates the organisational factors relating to leaving, as well as questions in the Bower Midwife Wellbeing Scale (culture of bullying, stress and burnout, staffing levels). Finally, '*professional identity*' recognises the personal and professional factors relating to staying, including questions from the Bower Midwife Wellbeing Scale; if these factors are positive, they make the job worthwhile (job satisfaction, work-life balance, fitting in).

London was developed as an additional theme in response to the question about whether they had thought of leaving London in the last six months. This was also related to the question about whether COVID-19 had influenced their decision, and the data about the effect COVID-19 had had on the NQMs' preceptorship arising from the interviews. However, closer examination determined that these were not distinct themes, but a contextual component of each of the main themes. Discussions about London and COVID-19 will therefore be presented as a separate part of the data analysis. The structural and content codes and their relationship with the themes are summarised in Table 4.4 below.

Table 4.4 Relationship between codes and themes

Original Structural Codes	Content codes	Theme related to codes
Newly Qualified Midwives' Experience	Transition	Head above water
	Sink or swim	
	Support	
Culture and resilience	Stress and burnout	Professional conflicts
	Culture of bullying	
	[Failure – not used]	
	Leaving London	London
Remain	Job satisfaction	Professional identity
	[Prof development – not used]	
	[Fitting in – new code]	
	Remaining in London	London
Leave	Staffing	Professional conflicts
	Work/life balance	Professional identity
	Leaving London	London

4.9 Themes

4.9.1 Head above water

The first theme to emerge from the interview data was that of the NQMs keeping their heads above water. This theme arose from the structural code relating to NQMs' experience in their first year of practice and encompassed the content codes (sub-themes) of transition, survival (renamed 'sink or swim' as above) and support (or lack of support). Head above water brought together the findings that the period from being a student to becoming a NQM is one to be survived. NQMs reported that this is often a difficult time, and their descriptions of this transition related to the step-up between being a student and being qualified and their abilities to negotiate this step. Whilst some took this step in their stride, many NQMs used water-based metaphors to depict the success or struggle of their transition, for instance, their ability to 'sink' or 'swim'. The level of support they received was often the determining factor in how well they negotiated the first year of practice. These three sub-themes will be explored within the overarching theme of 'head above water'.

4.9.1.1 Transition

'Transition' is the term used to reflect the interface between being a student and being a NQM. In the interviews, the midwives talked about this as being both a positive and a challenging time. Unanimously, NQMs described the enormous learning curve they had been through and how much they had developed during their preceptorship period. One midwife said:

> *'Although it was really hard, the rate of learning was so intense that you very quickly think "oh gosh I was so worried about that only a month or two months ago and now it feels really familiar.' (NQM 1)*

They talked about the 'mental adjustment' and the 'shift in mindset' from being a student to becoming a NQM. One midwife talked about the shift from being dependent on others for decision-making to making decisions alone:

> *'…"do I need to ask anyone if that's okay?" or even examining and stuff; you're like "do I need to double-check that I should do it right now or wait or like…?" It's a complete mental shift.' (NQM 5)*

While this learning was viewed positively by the majority of the NQMs, it was also felt to be overwhelming and intense. Despite the term 'preceptorship', they felt there was an expectation by the maternity services that NQMs would immediately make the switch to qualified practice without the need for a transition period. For the midwives themselves, however, there was a perceived deficit between their experience as a student and the responsibility of becoming a NQM. One midwife explained:

> *'It was very much an expectation of "well you've qualified now so you need to be able to deal with this situation". If you were like "I'm not really feeling that I'm coping very well, could I maybe have some support?" You would kind of be met with "well you need to be able to cope with this because this is what is required of a midwife", which I think can be unrealistic.' (NQM 2)*

The workload was one of the main challenges for most of the NQMs, particularly if they had been placed on the ante/postnatal ward as their first rotation. They described how there was no distinction made between themselves and the workload of more experienced midwives. On the contrary, more experienced midwives often gave the NQMs the tougher workload including the women that were seen to be 'hard work' (often because they had high-risk factors) so that they could have an easier time on shift. For instance, one NQM described how she was given the side rooms on one of her first shifts, where the 'high-risk' women and/or sick babies were situated, requiring a lot more effort to care for them. She perceived that this was because none of the other midwives wanted to care for them because they presented as a more intense workload, but that her newly qualified level of knowledge and experience was not enough to care for them safely on her own. She felt she was put in a risky situation and that there was a lack of support from her colleagues, who then got annoyed at her if she did not complete her tasks on time. She felt undermined and unsupported by this behaviour.

The period of transition also raised issues of professional boundaries and professional status. Midwives described how they had to relearn where their professional boundaries lay and when to escalate situations, either to other midwives or to the multi-professional team. This correlated with developing their confidence, which for some NQMs, had been their biggest challenge. Some midwives described extremely difficult clinical care, such as obstetric emergencies and maternal cardiac arrest, which they had been involved with early in their preceptorship period. This had often been the turning point in their confidence levels, when they realised that what they had learnt as a student had in fact equipped them to deal with these difficult situations. One midwife described how, because of her experience, she had learnt to wait longer before escalating a situation as she now felt more confident to manage it herself before requesting help.

> *'…so I feel like whereas before it would be 30 seconds when I first started and I'd be like "oh help!" So with things like that I think I wait a little bit longer. Shoulder dystocia I would go in now for the manoeuvres. I would, yeah.' (NQM 6)*

4.9.1.2 Sink or swim

The sub-theme of 'sink or swim' came through the NQMs' accounts of surviving the first six months of being qualified. It included descriptions of how NQMs felt overwhelmed as if they were sinking. Words such as exhausting, gruelling, overwhelming, terrifying, scary, frightening and traumatic were used to describe this period, with one midwife saying: '*I think it's just so exhausting when you are inexperienced*' (NQM 1). Their experiences of survival strategies were often expressed through metaphors, such as 'baptism of fire', getting 'thrown in', keeping 'your head above water', 'sink or swim', developing a 'tougher skin' and 'paddling like mad'. Many of the metaphors used by the NQMs involved water and expressed the idea of not going under or trying not to drown. Although most of the NQMs used these metaphors as part of a longer explanation, one midwife summed it up in a sentence:

> *'I think when you first start, you're such a small fish in a big pond, now I'm really kind of, you just kind of get on with it and you're so busy trying to float rather than sink that you don't really know what's going on…'(NQM 4)*

Two of the NQMs spoke about blocking out experiences as a way of surviving or swimming. One talked about letting things go over her head, particularly when confronted with difficult people. Another made several references during the interview to her brain shutting things out, her mind freezing or putting difficult experiences into a metaphorical box. It appears that this was the way in which some NQMs were able to continue without being paralysed by previous traumatic experiences to the extent that they were too scared to continue to practise.

One NQM talked about surviving her first traumatic experience and how this had made her realise that she was able to practise as a midwife. She talked about how this would enable her to survive a similar situation in the future, even though it was traumatic, and stated:

> *'It makes me think actually, you know, now when I have like a prolonged bradycardia or something like that you think "oh, you'll be fine". It's made me feel very alert, but a little bit less frantic maybe, because you think well actually, I've seen something that*

was so horrendous and you do just, you get through it, it's awful but you do.' (NQM 11)

It was acknowledged by several of the midwives that some NQMs did not survive this transitional period. The stress of the job, lack of support or level of responsibility was overwhelming, and they were not able to sustain being a midwife within this environment. One NQM talked about survival of the fittest and how preceptorship could become a cycle of survival, reaching breaking point and then leaving:

'I know a lot of midwives leave the profession, and it kind of seems to be this cycle where it's like, survival of the … strongest or something, … I have seen many newly qualified midwives look like they are close to breaking point and telling their manager or their, the matron or whoever that they are close to breaking point.' (NQM 1)

This section identifies factors that both facilitated and inhibited the transition period for NQMs, enabling them to sink or swim. Whether NQMs were able to survive this transition appeared to depend to a great extent on the level and quality of support they experienced. This will be explored in the next sub-theme.

4.9.1.3 Support

The midwives' accounts of the level of support they received varied both between and within Trusts. Some of the NQMs appeared to be very well supported while others had very poor support, and in two cases, this had been one of the deciding factors in planning to leave midwifery. Midwives identified the change in support levels from being a student to being a NQM, and most felt that the level of support they required initially was not there. Some NQMs felt more supported by their peers than by more senior midwives. Most NQMs related the level of support to the personalities of individuals, with individuals identified as having a reputation for being supportive or unsupportive. Talking about her greatest challenge being newly qualified, one NQM said:

'I got to a point on labour ward, I was there for a good few months and I was really happy, felt really supported, and then I went through a little time period where I was

on with certain people who just weren't very supportive people, and didn't really play as a team … and those were kind of my worst shifts, my most challenging shifts.' (NQM 9)

Several of the NQMs made specific reference to the preceptorship midwives in their interviews. The role of these midwives is to support both the NQMs (preceptees) and the preceptorship training programme within the Trusts. Again, the NQMs' experience of this role was mixed, with some feeling very well supported: '*She was exceptional, and she was extremely supportive and when she was on …it was amazing*' (NQM 2). However, others felt this role was less than supportive. One NQM described how the preceptorship midwife had made her feel guilty for asking for support in her first theatre case since qualifying. Most of the NQMs, however, recognised that although the preceptorship midwives tried to offer support, they only worked during the daytime Monday-Friday, which was unhelpful if the NQMs needed support during night shifts or at the weekends. The preceptorship midwives also had a lot of NQMs to manage if they worked in a busy Trust. One NQM said:

'...and she's a lovely, lovely lady. She had something like forty or fifty [NQMs] that she was managing, and she tried really, really hard, but I think as long as we weren't causing any issues, or we weren't receiving any criticism she basically had to prioritise the people that were really in need and didn't really come in to check in on me very much…' (NQM 3)

NQMs were asked what would have improved their preceptorship period. One midwife spoke about how she felt the university should have a role in the first year of qualifying and felt that a more 'formal' model of preceptorship would have provided the additional support she needed:

'I think it's a shame that there isn't like a way for the university to still be involved in that first year. If there was some way of having that more like formal mentorship involved, I think that would be amazing, but I know that's pie in the sky.' (NQM 3)

What the role of the university would be in this situation was not really clear. However, this midwife was requesting that the transition between student and NQM be made more formal and that this might include a role for the university in providing support.

Summarising the theme 'head above water', being able to survive the transitional period from being a student to becoming a NQM was dependent on how the midwives negotiated this transitional period. This depended on how they managed to 'sink or swim' and the level of support they received. A successful transition period depended on the NQM being able to 'step up' from being a student to being a qualified practitioner. In many cases, this meant rapid learning which had the ability to either increase or decrease the NQM's confidence.

In different ways, all the NQMs talked about sinking or swimming during this period. Many directly referred to water, using metaphors such as keeping one's head above water, being thrown in or paddling like mad. In some cases, their survival appeared to be tested by those in a more senior position to see if the NQM would 'sink or swim'. Being able to keep their head above water depended on the level of support they received. Although they all described structures of support in their Trusts available for NQMs, it appeared that these support strategies (such as the preceptorship midwives) did not always meet the reality of their support needs. One midwife talked about the resilience required for this transition period being at the expense of the NQMs' own wellbeing (NQM 11). The concept of resilience will be explored in further detail in the second theme.

4.9.2 Professional conflicts

The theme of professional conflicts emerged from statements in the Connor-Davidson Resilience Scale (Campbell Sills, 2012) and Bower Midwife Wellbeing Scale, which were used in the survey. Within these scales, the statements most negatively rated (i.e. those with the lowest mean scores) were identified for further exploration in the interviews to elicit why they were generally disagreed with and what they meant to NQMs. These statements prompted some enlightening responses about the nature of their practice and their initiation into the culture of the organisation. The statements selected for questioning can be found in

Table 4.5. The three sub-themes in this section are responses to stress and burnout, bullying and staffing levels. The statement around failure was discussed but did not add to the discussion and this will be reflected on at the end of the section.

Table 4.5 Resilience/Wellbeing statements used in the interviews

Statement (Scale)	Mean score	Code
I believe coping with stress strengthens me (C-D)	3.7 / 5	Stress and burnout
I am not easily discouraged by failure (C-D)	3.5 / 5	Sense of failure
The staffing levels are usually safe (Bower)	2.6 / 5	Staffing levels
I have never experienced bullying at work (Bower)	2.8 / 5	Cultural of bullying

4.9.2.1 Stress and burnout

The first sub-theme is about the NQMs' response to stress and consequential burnout. Although the NQMs may have worked in the same area as a student, they were now expected to make their own decisions and be accountable for the care they provided. This was a stressful change of culture for most of the NQMs interviewed. When discussing the statement '*I believe coping with stress strengthens me*', some of the NQMs agreed with this statement, although almost all agreed that too much stress was a trigger for not coping. Some midwives felt that stress was a motivator for learning, because only through learning to manage challenging situations in midwifery were they able to develop their skills and confidence as a midwife. Some midwives did not think stress was a positive factor in their work because it was exhausting and could be potentially dangerous. However, most midwives felt that there was a tipping point, where too much stress had only negative consequences. One midwife stated: '*If you get too stressed, you implode*…' (NQM 4). Another midwife stated: '…*you should never just have to cope with stress*…' (NQM 8).

NQMs expressed ideas of fear and terror when talking about stress, with one midwife saying: '*I just find that all the newly qualified staff as well, a lot of them are just terrified*' (NQM 7).

This was seen to contribute to a stressful working environment, in addition to which many midwives perceived that they were working in a situation without the necessary support, as discussed in the previous theme. One pair of midwives talked about the persistence of feelings of fear and terror, with statements such as '*I still feel just as terrified, honestly*' (NQM 6) and '*I don't really feel like the fear goes*' (NQM 5). They had both witnessed and been involved with acute clinical emergencies, which may have reinforced this fear during their preceptorship period. Two NQMs referred to burnout being a consequence of stress and that this was an unhealthy response to stress. One of the midwives talked about how she now only worked part-time in clinical practice and stated: '*I think that helps a lot with burnout for me personally*' (NQM 2).

The idea of coping was prevalent in many of the interviews when talking about stress. Some midwives felt there was an expectation of being able to cope because this demonstrated you were a 'good' midwife. In one of the paired interviews, two of the midwives debated what coping actually meant:

> *'I guess that kind of goes back to what (NQM 2) was saying earlier, like there is an expectation that if you cope you are good, and actually I'm not sure that I really agree with that at all, in that it's so much more multifaceted than that and it's not about coping in adverse situations; that's fine if you're talking about not getting stressed … but that's not so fine if you're talking about [caring for] fourteen women on the postnatal ward. Well, how do you define coping there? Like, you know, yes you may feel okay, maybe someone might, but there's going to be a woman that you haven't seen in nine hours and that's always, you know, is that coping? I don't know. It's like up for debate, I guess. (NQM 1)*

The midwives were reflexively debating with themselves whether coping meant just being able to get through the workload, albeit an impossible workload, regardless of the quality of the care provided, or whether that was a negative definition of coping. They suggested that whilst some midwives might see this as coping because they got through the day, they themselves viewed coping as being able to provide the care they wanted to provide. Not being

able to provide the quality of care they would have expected of themselves was by its very nature a stressful situation.

Three of the midwives perceived that London was more stressful to work in than other areas of the country, due to the high turnover of midwives, and high risk and complex nature of childbirth in the London population. One midwife expressed this by saying:

> *'There have been a few [names university] students who have trained in London and like "no, I'm going back to Suffolk" or "no, I'm going out [of London] because I can't cope with the workload that's expected"…. Imagine you train in like a really stressful environment and then go like for a cakewalk somewhere else (laughs)…' (NQM 8)*

Whether London was in reality more stressful than other areas could not be tested because 10 out of the 11 NQMs interviewed had not experienced working anywhere outside London. This idea of London being more stressful than elsewhere in the country will be revisited when discussing the NQMs' plans to stay or to leave London later in this section.

4.9.2.2 Culture of bullying

The second subtheme identified in the theme about professional conflict is a 'culture of bullying'. The statement about never having experienced bullying at work was identified through the survey as being the second most negatively scored statement in either of the scales (see Table 4.5). The NQMs spoke openly and frankly about their own experiences and those of others they had witnessed. All NQMs interviewed strongly supported the view that bullying was prevalent in the maternity services in which they worked. They had all either witnessed bullying of another NQM or experienced bullying for themselves. Even if not all behaviour was labelled as bullying, most participants referred to a hierarchical culture within the maternity services which was detrimental to the NQMs' experience of their first two years in practice.

The bullying that occurred in their preceptorship period was perceived by the NQMs as a negative 'rite of passage' into the midwifery workforce. Several of the NQMs interviewed

stated that NQMs were given the heaviest workloads and that there was a lack of help and support, even if the rest of the unit was not busy. This appeared to be a cultural 'norm' for NQMs and was seen by the midwives themselves as an initiation test to see how and whether they coped. If they were unable to meet the expectations of their more senior colleagues, for instance the arbitrary timeframes expected in which to complete tasks, NQMs would then be criticised by these midwives for not passing the 'test'. For instance, one NQM stated:

> *'And to make matters worse, after you've eventually done everything, you go back and you transfer the lady and then somebody will say "Oh, why were you taking longer in theatre?"…but then you'd think like, I'm junior, [so] I'm taking longer in theatre, why hasn't someone come to ask me do I need help, do I need something?' (NQM 10)*

In some of the examples given, NQMs were unsupported to the point where the care of the woman and/or baby was compromised. This was often a consequence of senior midwives not responding when NQMs were seeking help in their room. In the worst case that was cited, a woman had a postpartum haemorrhage (PPH) of 2.3 litres of blood and the baby ended up in the neonatal intensive care unit (NICU) which the NQM felt sure could have been prevented if someone had answered her call bell on the first attempt. She described it as follows:

> *'…the doctor then left me in the room by myself, the coordinator left me in the room by myself, with a flappy episiotomy. The baby started grunting… and they just, she just left, and the doctor said, "oh just call me when you need me to suture," and I was like, I've only got one pair of hands, the coordinator was nowhere to be seen, despite no [other woman] being on the board, and this lady ended up losing 2.3 litres, having a manual removal, and the baby went to NICU for a screen and treat……. the coordinator came [back] in and said, "oh, this baby's grunting," I said, "yes I know, I've been trying to call you for ten minutes to come in and to review this baby. I can't leave a woman that's bleeding," … and finally everyone decided to come in and do the PPH protocol….'(NQM 4)*

This NQM appeared to have coped with the situation, but she was angry about not being supported and not having her request for help responded to in a timely manner. She was

particularly angry about the consequences to the mother and her baby, which she felt was a direct consequence of her call for help being ignored as a NQM. The workload of the delivery suite at the time was not excessive and she felt she was being 'tested' as a new midwife.

The NQMs who appeared to cope with this 'testing' and come through the preceptorship period intact, spoke about how they had learnt to fit in (see next theme for further discussion on 'fitting in'). One NQM was told to use the right 'buzzwords' and learn how to play the game to prevent herself from being bullied. This NQM had also been told she had a 'likeable personality' so she would be fine although she was very condemning of this judgement. In other cases, not being bullied meant keeping your head down and not speaking out, which left some NQMs feeling guilty for not protecting those who were experiencing bullying. They knew that speaking out, however, would make their life more difficult because they would be seen to be going against the prevalent culture. One mature NQM talked about how she did speak out about bullying behaviour against her, despite knowing there would be consequences.

> *'But definitely I've experienced bullying at work. I've had like the coordinators take me on…and I was absolutely livid and went straight to the matron and was like "I'm not being treated like this" … and the matron just said to me "oh well, you know when so-and-so and so-and-so get together you know what they can be like" and that was the response. And … I wrote a formal complaint and I said "if anything of this bullying culture ever occurs again" I said "I will be taking it as high as I can take it because it is completely unacceptable"… I was livid. I still am! Because why are people treated like that? It's so unacceptable.' (NQM 6)*

This response, however, was unique in the interview data and the NQM concerned had had other jobs in responsible positions before coming into midwifery. She was not prepared to accept behaviour that she had not previously experienced and which she considered would be unacceptable in other work contexts. The experience of other NQMs was that they felt unable to challenge such behaviour and some NQMs felt belittled by the behaviour of their

more senior colleagues. One NQM said she was made to feel that she was stupid if there was something she didn't know, so she stopped asking for help.

> *'…there are still certain midwives, if I have a question, I won't go to them for help because they're …either really rude or unapproachable or they won't give you a straight answer, they'll tell you to go somewhere else or they don't have time … so I won't go to them, ever.' (*NQM 7)

Two of the midwives interviewed, although still working in midwifery when interviewed, had already made the decision to leave midwifery and have subsequently left their posts. In both cases, their decision to leave was a direct result of the bullying they had experienced. One of the midwives was taking time out and hoping to return to midwifery after a break but was unlikely to return to London. She said: '*if I had been treated more kindly, then I probably would have stayed*' (NQM 3). Although she was still passionate about midwifery work and caring for women and their families, she said she could not stay in a profession that treated NQMs in this way.

Listening to the accounts of the NQMs being interviewed, it became clear that there were two ways in which the culture of bullying was acted out. Firstly, there were more experienced individual midwives who were renowned for their behaviour and who appeared to give all NQMs a difficult start. Secondly, the midwives described a generic culture of bullying that pervaded maternity services. This culture appeared to be unchallenged, therefore allowing poor behaviour to be perpetuated. Most of the NQMs interviewed described the poor behaviour of individual midwives, using words which included rude, unhelpful, lazy, unkind, nasty, hostile, passive-aggressive, unapproachable, not playing as a team. It was acknowledged that not all midwives were like this, but those that were made the NQMs' lives very much more difficult. In fact, some of the NQMs had chosen to stay in the Trust where they had trained because they knew who would help them and who to avoid. They were 'insiders' and had already learnt how to play the game as students. When talking about the challenges of the preceptorship period, one midwife said: '*…but then you learn pretty quickly who you can and can't go to*' (NQM 6).

Nearly all the NQMs talked about how the system accepted the behaviour of these individuals, with other midwives (including managers and matrons) dismissing poor behaviour as just part of their character. One midwife reported:

> *'But the ones that I've come across … they're still doing it because at no point has anyone said "sorry, this behaviour is not okay" and been pulled up on it. …I've been to management and said, "this is what I've witnessed" and they've gone "oh [sighs] I mean that's just her isn't it?' (NQM 5)*

The reaction '*that's just her…*' was viewed as a very common response by management to the NQMs who reported or attempted to challenge such behaviour. There was a long-standing acceptance of the behaviour of certain midwives who had a history of behaving in this way. For some reason, they became 'untouchable'; their behaviour was excused as just part of who they were, as in the quote above. In some cases, even the NQMs attempted to normalise this behaviour because it was routine and therefore, they did not perceive this as being personal to them:

> *'I think the reason why I wouldn't label it as particularly bullying when it's ever been done to me, or someone has ever said something, is that the person who has been nasty or spiteful is routinely nasty and spiteful to most people, so it's not that their behaviour is particularly different towards me…'(NQM 2)*

There was an acceptance or excusing of such behaviour because she didn't feel singled out. Several NQMs made comments about the acceptance of bad behaviour of certain midwives. In some interviews, other excuses were given for this behaviour, such as the highly stressful environment in which they were working, particularly on labour ward, where there appeared to be a specific issue with poor behaviour. However, some of the NQMs were clear that this did not excuse poor behaviour and that everyone was working in a stressful environment, yet most midwives did not behave in this way. Several of the NQMs suggested that some of this was due to midwifery being staffed almost exclusively by women. One midwife stated: '*I don't know if maternity is worse because we are all women*' (NQM 1), and another stated, '*It's because we are a bunch of women*' (NQM 6). Other NQMs talked about midwives being

'*bitchy*' (NQM 7) or having a '*bitch fest*' (NQM 11), again with the implication in their interview that this is because midwives are predominantly women. Whether this is an accurate perception or not, there is without doubt a cultural element to the persistent behaviour around bullying of NQMs by other more experienced midwives and the lack of challenge to this behaviour from midwifery managers.

Bullying behaviour as a systemic institutional practice was referred to in nearly all the interviews with NQMs, with frequent comments such as '*I think bullying is rife in the NHS*' (NQM 1) and '*It's cultural, absolutely*' (NQM 3). One NQM stated:

> *'We just accept bad behaviours, we accept laziness, we accept bullying, and it's just…part of our culture. And like I mean I'm sitting here quite comfortably saying this to you and I have had this discussion with multiple people who feel the same and nothing is ever done because…I can't do it by myself.' (NQM 8)*

Many of the NQMs expressed frustration that this behaviour is culturally accepted and that nothing changes or is done about it. Most NQMs felt that this was not just about hierarchy, although this may have contributed, but that it was due to longevity in that the perpetrator midwives had been there for a long period of time and had actually become part of the culture. One NQM described them as 'old fossils' (NQM 4):

> *'…and some of the midwives that do work there have, I'm sure have been there since the dawn of time and are very set in their ways and it doesn't make for a nice work environment… and it's all of the old fossils who are an absolute nightmare to work with because you end up doing all the work…'* (NQM 4)

The NQMs who had worked in other industries before coming into midwifery were adamant that this behaviour would not have been acceptable outside the NHS. Several NQMs mentioned the NHS or maternity culture as being 'behind the times'. One NQM expressed the view that: '*…the NHS, just like our computer system, is 20 years behind; so is our outlook*' (NQM 2). They considered that one of the reasons why cultural bullying was not challenged within the system was because it had been an accepted part of it for so long.

When discussing bullying behaviour, there were conflicting views as to whether this was a London-based culture or whether the culture of bullying was widespread. One NQM said: '*If you do speak to midwives out of London, they say it's not as bad*' (NQM 6); however, the NQM who had trained outside London, when discussing bullying behaviour, stated: '*Yeah, it happened in (name of place) all the time*' (NQM 7).

In summary, the bullying issues raised by the NQMs in the interviews were not related to one Trust or midwives of any specific background; they were universal and widespread. The interviews supported the findings from the survey by the lack of agreement with the statement '*I have not experienced bullying at work*'. This confirmed that there is a pervasive culture of bullying within maternity services in London. The interviews further demonstrated that this behaviour appears to be targeted towards NQMs. Those who found strategies to survive this behaviour appeared to demonstrate resilience, as evidenced by taking on the perpetrators or by acknowledging that this was not personal. Given that most of the NQMs interviewed were planning to stay in midwifery, it can be concluded that the majority demonstrated personal and professional resilience, regardless of what they had experienced. One of the various reasons given to explain such poor behaviour was the lack of staff and this will be explored in the next sub-theme.

4.9.2.3 Staffing

In the interviews, NQMs were asked about the effect of staffing levels on their transition to qualified practice, because the statement '*the staffing levels are usually safe*' was the most negatively rated statement in the Bower Midwife Wellbeing Scale (see Table 4.5). When participants were asked to respond to the statement about staffing levels usually being safe, there was unanimous disagreement with the statement amongst all NQMs interviewed. Many midwives stated that it was unsafe, that staffing levels have never been as bad and that staffing has '*just gotten worse and worse and worse*' (NQM 7). This quote came from one of the two midwives who were planning to leave midwifery and when asked what might have kept her there, she replied '*better staffing, better staffing*'.

Poor staffing levels were identified in all interviews as contributing to NQMs' dissatisfaction with the job, which all midwives talked about, regardless of which Trust they were working for. This was particularly difficult when they were first qualified and from the interviews, staffing levels appeared to be at their worst on the postnatal ward:

> *'I was two weeks into my job and I came in and I was the only midwife on the Postnatal Ward and we had twenty women, twenty babies and I was straight on the phone to the midwife in charge and I was like "I am not qualified for this, like I need help". But she's like "oh well, you know, we're going to send someone up from Birth Centre, blah, blah, blah" and I was like "no, you need to send them now, like I'm not taking handover, like this isn't safe" and it's like there's no way in this world, like I'm finding my feet, I can barely cope with my caseload by myself, let alone…managing the ward and looking after, like giving safe care, like there's absolutely no way that's possible.' (NQM 8)*

This NQM took a stand against the situation but in other Trusts, there appeared to be an issue with the high number of Band 5 (preceptee) midwives, as there were often no midwives higher than a Band 5 on a postnatal shift. One NQM stated that she was the shift coordinator for the ward, having been qualified for only 11 months. Normally, Band 5 midwives would not take charge of a shift until they had completed their first year of preceptorship and become a Band 6 midwife. This NQM was on shift with three other NQMs, all of whom had started working within the last month and were still being orientated, therefore required a higher level of supervision, which she was not experienced enough to provide. Another NQM stated:

> *'…in the Trust that I worked at [they] often would staff very junior, as in like first year of midwifery staff, together with no other Band 6s, and I remember them once trying to do that in the triage area and I was just like, this is a bad idea…' (NQM 3)*

The number of women and babies allocated to NQMs resulting from staff shortages was often considered to be unsafe, with the NQMs frequently reporting having to care for ten postnatal women and ten babies in one shift. One of the NQMs reported that her NQM friends in a neighbouring Trust (not included in this study), were frequently required to care for 15

women and babies on their own. NQMs who had moved out of the hospital, at least part-time, expressed their relief at having got away from the postnatal ward in particular:

> *'I'm glad to be out of kind of the wards. Well, I do still work in them, I do two on-calls a week, so I dip back in and out so I'm not losing my skillset but I'm glad I'm not there constantly. It's a draining environment that's for sure.' (NQM 6)*

4.9.2.4 Failure

The fourth most negatively rated statement from the scales (Connor-Davidson scale: Campbell Sills, 2012) was around failure and whether this resulted in discouragement. In this research, when NQMs were asked about failure, two types of related responses emerged. Failure was seen either as being a personal failure or it was seen as a failure in care. Some of the midwives brought up the concept of failure, recognising that how they dealt with it was a personality trait. One NQM stated that '*failing…has never been an option, I think it's just the sort of person I am*' (NQM 7). The NQMs demonstrated sensitive, reflective practice and would question themselves about what else they could have done to improve their care. Most NQMs saw failure as something that's inevitable when you are new to midwifery and that this was a great opportunity to learn. One midwife stated:

> *'I feel like in midwifery you fail, if you want to use the word, you learn, but you will fail a lot, like you get things wrong, and you make mistakes, and you miss things and you do things maybe you shouldn't have done, hopefully with the best intentions but still, and I feel like it's by doing that that you learn, and don't make the same mistake.' (NQM 11)*

One NQM acknowledged that failure was discouraging but that so much was invested in becoming a midwife, it was such a big life choice, that midwives just keep going, despite the failures. Two of the NQMs reflected on what the failure might be (personal or clinical), and how discouragement depends upon the type and magnitude of the failure. It was also acknowledged that what one person considered to be a failure, another person might not.

The question about whether failure is discouraging was not particularly well answered by the respondents and during the process of analysis, caused me to reflect. From the transcripts, it was evident that I had initially asked both questions relating to the Connor-Davidson Resilience Scale at the same time (the questions about stress and failure). This necessitated repeating the questions for the midwives. In doing this, I inadvertently missed repeating the second question, that is the question about failure in the first two interviews. I amended this for the next six interviews. I also became aware from working with the transcripts that I had failed to probe when listening to the answers to this question. This was not the case for the other questions relating to the resilience and wellbeing scales. These omissions resulted in poorer quality of responses to this question. On reflection, the question would have been more focused if I had asked for a specific example of when the midwives perceived that they had 'failed' and what this meant to them. This would have made their interpretation of the concept of failure clearer, and the term 'failure' in itself, as outlined by the NQM above, may be unhelpful. There may be reluctance to admit to failure for fear of repercussions.

In summary, the theme of professional conflict discusses the sub-themes of bullying, stress and burnout and poor staffing levels, all of which had the potential to cause NQMs to leave. These factors were identified from the resilience and wellbeing scales in the survey, as the statements relating to these factors had the most negative scores. However, the findings from the interviews demonstrate that most of the NQMs found ways of negotiating negative culture, as nine of the eleven NQMs who were interviewed had decided to stay in midwifery. This suggests that the NQMs had either personal or professional resilience, or both, which enabled them to overcome the professional conflicts inherent in newly qualified practice. The concepts of resilience and wellbeing and comparison of these findings with the existing literature will be revisited in the next chapter. The findings from this theme also suggest that the factors motivating them to stay in midwifery were stronger than those which may have caused them to leave. The next theme explores the factors identified by the NQMs that enabled them to stay in midwifery and what strategies they used to make this sustainable. The factors enabling them to stay were all related to their professional identity, which is the next theme.

4.9.3 Professional identity

The final theme discusses the factors that positively influenced NQMs to remain in midwifery. Even though most of the NQMs interviewed chose to stay, some of the influencing factors they identified meant staying in midwifery was challenging. This theme covers factors that either positively influenced them to remain or had the potential to influence them, even though there were some barriers to these that NQMs had to overcome. The positive influences on staying in midwifery were '*I love midwifery*' (including continuity of care), work-life balance and fitting in. This theme will also discuss conversations around whether they would choose to remain in London in the future.

4.9.3.1 'I love midwifery'

Job satisfaction, summarised by the statement '*I love midwifery*', emerged as a strong reason why the NQMs interviewed were still in post and in most cases, why they felt they would always stay in midwifery. As one NMQ expressed it:

> *'…to be paid to do the job I want to do feels amazing, and I feel, like, tremendously proud just being a midwife and I can't imagine doing anything else…' (NQM 11)*

Several of the NQMs talked about midwifery as a '*lifestyle*' (NQM 9) or a '*profession*' (NQM 5) with one midwife stating: '*my job is going to be my life*' (NQM 4). Most of the NQMs said that they love their job, and even with the bad days and the poor outcomes, the overriding articulation was that they love midwifery. One NQM talked about her passion for midwifery, and she felt that when that passion has gone, midwives should no longer practise midwifery. Several of the NQMs had been mature students and had worked in other jobs and industries before entering midwifery education. These midwives felt they had found a profession that was not just a job, and which was more rewarding and fulfilling than their previous roles. They felt that they were able to make a difference for women and their families.

> *'I don't think any job I've had previously has had the same level of satisfaction. ..the bond with women is amazing, ... I just think there's nothing quite like it. But yeah, so I don't think I will leave midwifery in answer to your question.' (NQM 1)*

Case-loading was one of the elements of midwifery that strongly attracted the NQMs to the profession. Three of them were already working in a case-loading team and another three were planning to do so in the near future. Getting to know the women and their families provided a high level of job satisfaction for the NQMs as it was often the ability to develop meaningful relationships with women that had attracted them into midwifery in the first place. Two of the NQMs identified case-loading as the reason they had stayed. One NQM described her recent experience of case-loading, as she had just joined a case-loading team after her preceptorship period:

> *'Why am I still here? …I carry thirty-five women on my caseload and I really like them, so I feel passionate about the continuity of care pathway and the benefits that they're getting from it and how you can see the outcomes are so much different to what they would have been otherwise.' (NQM 6)*

The other NQM, who had also started in a caseload team after her preceptorship period, compared being in the team with being on the wards:

> *"…I finished my preceptorship and then I've now gone out to be a continuity of care midwife, which I enjoy a lot more. I'm glad to be out of kind of the wards. Well, I do still work in them…but I'm glad I'm not there constantly. It's a draining environment that's for sure.*" NQM 5

She felt that working in a continuity team, even though she was on-call twice a week, gave her more job satisfaction, more meaningful relationships with the women and a better quality of life compared to working in the hospital all the time.

In addition to their passion for case-loading, several of the NQMs who were working in or planning to work in continuity teams expressed a passion for caring for vulnerable women. This included women with mental health issues or those who were asylum seekers or had poor socioeconomic backgrounds. For the one NQM who trained outside London, this was the reason she had moved to London to take up her first post. She acknowledged that there was a lack of diversity where she had qualified and that the increased diversity had attracted her to move to London and to work with more vulnerable women, which she really enjoyed.

A significant number of the NQMs could not see themselves in full-time clinical midwifery for the remaining future. Two of the midwives already had dual roles in both clinical practice and research. This was within two years of qualifying and both felt that this was the reason they were still able to sustain their practice because the dual roles offered them greater variety and job satisfaction. Two other NQMs interviewed were aiming to become midwifery lecturers in the future and '*go down the academic route*' (NQM 2). One midwife was exploring becoming an antenatal sonographer. Whatever their plans for the future, however, ten out of the eleven NQMs interviewed (including one who was taking a break) were planning to stay in midwifery long-term, even if this was not in full-time clinical midwifery.

4.9.3.2 Work-life balance

Good work-life balance and flexible working were mentioned by several NQMs as a factor that would keep them in midwifery. One of the research midwives identified in the previous section stated: '*I am also part-time clinical now and have found that has really given me a better work-life balance as well*' (NQM 2). Another NQM thought that preceptees could be given greater shift flexibility, particularly at the beginning of their preceptorship:

> '*And it would make a massive difference when you've got ten preceptees starting, what is the harm in giving them all fixed shifts? So that they have a work-life balance because, like we said, at the very beginning going from student to qualified is like day and night, it's two completely different worlds.' (NQM 8)*

Poor rotas were one of the factors that NQMs cited as negatively affecting their preceptorship experience. NQMs felt they were often given the most uncompromising shifts, seen as another part of the initiation process for NQMs. One midwife in particular felt that midwives who were well established always got the set shifts they requested, which felt unfair. Of her own rota, she stated:

> *'I think also just the, even silly things like the rota, you know, like it would just be so cruel and, you know, often I was going to the sister being like "I've got five [12 hour] nights in a row, like I just don't think that I will know my name by the end of it, let alone be able to deliver a baby.' (NQM 1)*

As in the quote above, some of the NQMs interviewed felt giving them the worst shift patterns was unacceptable and took action, while others went part-time to prevent having to work such difficult rotas. Part-time hours or split roles were seen to improve work-life balance and to make an otherwise unsustainable job possible to endure. One of the NQMs who had taken a part-time research post stated of her future practice:

> *'But I also have to be realistic with what I will feel is a good balance in my life, which I don't think will ever be full-time clinical work again.' (NQM 2)*

Another NQM spoke about the lack of flexibility in her work-life balance and the difficulty of having unpredictable rotas when trying to manage her children. She had therefore negotiated flexible working after her preceptorship period, which had been accommodated and had made a big difference. Nevertheless, to negotiate flexible working, she had to go part-time. Flexible working was the only way in which she could maintain a midwifery post and fulfil her childcare obligations. In making her decision, she stated:

> *'I mean one week I had two nights, a day and a half off, two days, a day off, two nights, a day and a half off, two nights… It's exhausting and it's exhausting for people with children, it's exhausting for people with any expectation of having a life, like just being able to like see people, things like that…. You go into another world where you're just like "I don't know what day I'm in any more". Suddenly a month has gone past, and I haven't seen daylight. I went for three weeks without seeing my children for more than an hour at a time.' (NQM 8)*

Her suggestion was that flexible working should be offered to all NQMs on the basis that different midwives prefer different shifts, and it is likely that rotas can be worked out if midwives are given fixed days and shifts. She suggested that this would remove one of the difficult issues when first starting work, which was never knowing which shift they would be working. The lack of predictability of working patterns was an issue mentioned by several NQMs during interview. From the NQMs interviewed, providing flexibility of rotas and working patterns could make a difference to the retention of NQMs.

4.9.3.3 Fitting in

The final sub-theme in this section can be described as 'fitting in'. NQMs explained how they had to adapt their behaviour to fit the midwifery culture, so they were accepted. Sometimes this involved keeping themselves out of the way to ensure they did not have to encounter the difficult culture. One NQM talked about '*navigating the politics*' and said: *'And I was just like, you know what, …I'll stick in my room and, you know, it'll all be fine' (NQM 4)*. Keeping out of the way was a commonly expressed strategy for avoiding the culture, and was taken to an extreme level by one NQM, who denied herself basic needs on shift, so she did not have to engage with those who perpetuated the culture:

> *'I will stay in the room, all night and I barely come out. Like I make sure that I don't need to go to the toilet, that I don't need to have a drink, I don't need to do anything because I don't want to interact with them.' (NQM 7)*

Other NQMs also tried to avoid getting drawn into the culture by disengaging with it: *'I tend to ignore people a lot if I don't approve of what they're saying to me' (NQM 6)*. In the same vein, another NQM said:

> '*and I suppose I've kind of, sounds terrible, but I suppose I've more thought "well, you know, like I'll just not get involved".' (NQM 1)*

Some of the NQMs felt they were able to fit the culture, either because they didn't really notice it *('…but maybe I have been [bullied], and I've just been oblivious to it!' NQM 4)*, or because they felt they had been accepted into the clique. One NQM talked about whether your 'face fit' or not. Talking about other NQMs, she said:

> *'if your face doesn't fit on that shift, it's not like part of the 'in' crowd, you're not part of the clique, or at least if you're not accepted by the clique you just have the worst time..'* (NQM 8)

She described the behaviour towards one NQM in particular who appeared to be singled out for poor treatment by more experienced midwives, and in the end had decided to leave the Trust. But of herself, she was told:

'"(NQM 8,) you've got a likeable personality, you're going to be fine". That should never have been said…'(NQM 8)

She did not agree with this behaviour, as evidenced by her final comment, but accepted that for whatever reason, she was one of the 'in' crowd, which made her life bearable. In the interviews, one NQM who was part-time talked about not being accepted into the clique for this reason, because she was not a full-time midwife.

In an attempt to 'fit in' and accept the culture, some NQMs tried to make allowances for poor behaviour because of the stressfulness of the job. One NQM said:

'I keep reminding myself, when it comes to like other people being rude or being difficult, I'll keep reminding myself that no one goes into midwifery to be nasty and no one goes into a job where their responsibility is to care for people and to bring life into the world and to help people become mothers, no one who has got nastiness in them would go into that out of choice, so it's just the constantly reminding myself that the likelihood of these clashes is actually because of the pressures of a system that none of the people on the floor are responsible for and trying to be a little bit more forgiving of when people do things that are frustrating by telling ourselves that' (NQM 2).

Whilst there is no doubt that midwifery is a stressful occupation, and that sustained stress may result in poor behaviour, not all midwives described by the NQMs behaved in this way. It could be argued that acceptance of poor behaviour through making allowances is merely perpetuating the situation. It is understandable, however, that this NQM (and other NQMs interviewed) used compensation as a form of self-protection.

NQMs also described active behaviours they adopted themselves, which enabled them to fit in. For instance, one NQM said '*it's learning the personalities of the team that you're going into' (NQM 7).* Rather than challenging poor behaviour, there was an acknowledgement that she had to learn how to behave herself, to fit round this behaviour and to be accepted. Another NQM actively forged friendships that she knew would enable her to fit in:

'…you need to be friends with the right people; if you're friends with the right people, you will be fine' (NQM 8).

The idea that there are 'right' people suggests these are the midwives who control the culture or at least are the midwives who can make the lives of NQMs difficult if they don't behave like them and fit in.

From this sub-theme, it appears that learning to 'fit in' is faced by the NQMs in different ways but is essentially about learning to become one of the 'clique'. This avoids the NQM being singled out and experiencing poor behaviour directed at them. This sub-theme demonstrates that fitting in is a response to the culture of bullying and enables NQMs to find strategies to cope with this so they can stay in midwifery. Whether this perpetuates poor culture for future generations of midwives would be an interesting study in itself.

Summarising the theme of professional identity, job satisfaction ('*I love midwifery*') was an important factor in retaining NQMs within the profession. Despite the elements which made their working environment difficult, such as poor rotas and lack of flexible working, NQMs were clear about their love of midwifery, and this enabled most NQMs to choose to stay in the job. Having the potential to develop meaningful relationships with women, such as working in case-loading teams, was a strong determinant of job satisfaction. NQMs, however, were often given rotas that were inflexible and fragmented, making their work-life balance unsustainable. This had already caused four of the eleven midwives interviewed to go part-time, just to be able to sustain their working life. The NQMs also learnt to adapt themselves to the culture of midwifery by adopting different strategies to 'fit in'. This included activities of avoidance, acceptance and adaptation. If they were able to do this, they were more likely to be able to negotiate the culture so they could stay in the job. They identified that having job satisfaction in their work, particularly through continuity models, better work-life balance, better shift patterns and more sympathetic rotas, would make the difference in enabling them to stay in midwifery long-term.

4.10 London – staying or leaving?

During the interviews, NQMs were asked whether it was their intention to stay in London for the foreseeable future. The five NQMs who were originally from London were more able to see themselves in London for the rest of their career than those who had moved to the capital to undertake their training or their first job. Several NQMs identified the expense of London as being the factor that might drive them from London, just to be able to afford the cost of buying their own house. One NQM, when asked whether she would leave London, stated:

> *'I grew up in London and my family are in London, all my friends have stayed in London from school, so I don't think [I will leave]. And I think if I did it probably wouldn't be work driven, it would just be more, being able to buy a house would be lovely and it's never going to happen on a midwife's wage in London, so that would definitely be a pull. But personally, if money were no problem, I would stay in London.' (NQM 1)*

Six of the NQMs were originally from outside London and thought they were likely to return to their roots at some point for family reasons. They also cited the cost of living in London, although they acknowledged that this was offset to some extent by the London weighting payment. However, none of the NQMs interviewed, apart from those who had already decided to leave midwifery, had plans to leave London for the next few years. One NQM was planning to work for a non-government organisation (NGO) which would necessitate going abroad to work for periods of time but she saw her base as being in London. Another NQM summed up what kept her in London: '*for now I'm kind of very career driven, and I'm enjoying my friends, and the culture of London, the excitement of London, the opportunities of London' (NQM 9).* Several NQMs referred to the opportunities in London as a reason to stay. One discussed the 'currency' of training in London:

> *'I feel as though if you can train in London and then stay qualified, do your preceptorship in London and then carry on after that, then you can nail your midwifery career in London forever.' (NQM 2)*

There was also a perception that London was busier than anywhere else, even though ten of the eleven NQMs had not known anywhere else. One NQM said:

'*It's just London and it's wild, it's a jungle…Imagine you train in, like, a really stressful environment and then go like for a cakewalk somewhere else*.' (NQM 8)

Whether this was founded on hearsay or imagination is not clear, but one of the NQMs who had spoken to other NQMs outside London reported that they said it was not as bad as in London. Another NQM spoke about the job being less stressful outside of London because there was a better ratio of midwives to women. The NQM who had moved to London to take up her first job said she had found that women in London had greater vulnerability, and this came with an increased workload:

'… when I moved to London, I mean especially [Trust], we see a lot of vulnerable women, a lot of disadvantaged women, a lot of people that you just think you wouldn't come across in [name of place] because I trained in [name of place].' (NQM 7)

Summarising the question '*do you think you will leave London?*', most of the NQMs planned to stay in London in the immediate future. However, the majority did not come from London and planned to move back to their roots, or to move out of London once they had a few years' experience in the Capital. The reasons given for thinking about moving were mostly due to the cost of living and to access affordable housing, even though some of them acknowledged the assistance from the extra London weighting payments. The NQMs also perceived that workload and stressful working conditions were greater in London, although ten of the eleven NQMs interviewed did not have experience anywhere outside of London.

4.11 Summary of findings

The interviews provided rich data from eleven NQMs in three of the four quartiles of London. The interviews expanded on the findings in the survey and explained these findings in the context of newly qualified practice. Although NQMs were asked about what keeps them in midwifery, their answers and anecdotes also identified the factors that may cause them to leave. In response to why they chose to stay in midwifery, their overwhelming response related to their professional identity as a midwife and their love of midwifery. They described midwifery as not just a job, and spoke about being 'once a midwife, always a midwife'. Their

job satisfaction and love of midwifery was largely due to their ability to develop relationships with women and families, particularly where they were able to work within continuity of carer schemes such as caseload teams. The reasons why they chose to stay, however, were contingent upon their working conditions being manageable, even if these were adverse. The NQMs in the interviews identified the most difficult adverse conditions as being the culture of bullying and inadequate staffing levels, which resulted in poor support during their transition to becoming a NQM. Where adverse conditions outweighed the reasons why they chose to stay, NQMs in the interviews considered leaving or had made the decision to leave.

The survey endeavoured to answer the research question*: what are the internal and external factors that enable midwives in London to stay in post*? The interviews, on the other hand, addressed the research question: *what are the personal and professional attributes that influence newly qualified midwives in London to stay in post?* The concept of resilience is relevant to both questions and provides a framework for integrating the results. In the survey, resilience and wellbeing scales were used to measure both internal and external characteristics of resilience and how these related to midwives' intentions to stay in or to leave their post or midwifery. The factors in the scales that were rated most negatively in the survey were used to formulate questions about personal and professional attributes and experiences in the interviews. As already described, factors that enabled NQMs to stay in midwifery needed to outweigh the factors that caused them to contemplate leaving or to leave. The tipping point for individuals appeared to be dependent on both personal and professional factors and attributes. Some NQMs were able to challenge poor culture and remain in midwifery whereas for others, this was the reason they gave for intending to leave.

In the following discussion chapter, the interrelationship between the survey and interview data is explored, comparing my findings with the existing literature. The concepts of personal and professional resilience are used to integrate the data. The relevance of the findings for NQMs is debated, using the research questions to frame the debate. Finally, a model of resilience is proposed that integrates the findings and the overarching question: *why do newly qualified midwives stay*?

CHAPTER 5: DISCUSSION

5.0 Introduction

In this chapter, the research questions are discussed through integration of the research findings, exploration of the relevant supporting literature and interpretation of what this means for NQMs, specifically for those working in London. Firstly, I will summarise the findings from both phases of the research: the survey (quantitative) and the interviews (qualitative), presented in Chapter 4. As a pragmatic, explanatory sequential study, the findings from the survey and interviews will then be integrated to answer the research questions (Creswell and Plano Clark, 2018). The integrated findings will be contextualised by comparing the findings in my study with research findings in other literature, both from midwifery studies and, where appropriate, from other disciplines. Following this, definitions of personal and professional resilience will be explored through the results of my study and through existing literature. Concepts of personal and professional resilience will be used to structure the discussion and to address the research questions. Finally, a retention model for NQMs will be proposed. The model aims to identify those aspects of personal and professional resilience that are more likely to predict that NQMs will remain in the profession. The issues around staying and leaving are complex, however, and this will be explored through the discussion. The unique contribution of this study to the retention of NQMs will also be explored. The discussion chapter will link to the recommendations and conclusions in the final chapter.

5.1 Summary of the findings

The survey addressed the research question: '*what are the internal and external factors that enable midwives in London to stay in post*?' The interviews addressed the research question: '*what are the personal and professional attributes that influence newly qualified midwives in London to stay in post?*' When combining these results, the concept of resilience is used to explain the findings and to answer the third research question: '*what is the relationship between personal and professional resilience and the decision of NQMs in London to remain in post?*' Figure 5.1 demonstrates the relationship between the research questions and the methods used in the research.

Figure 5.1 Relationship between research questions

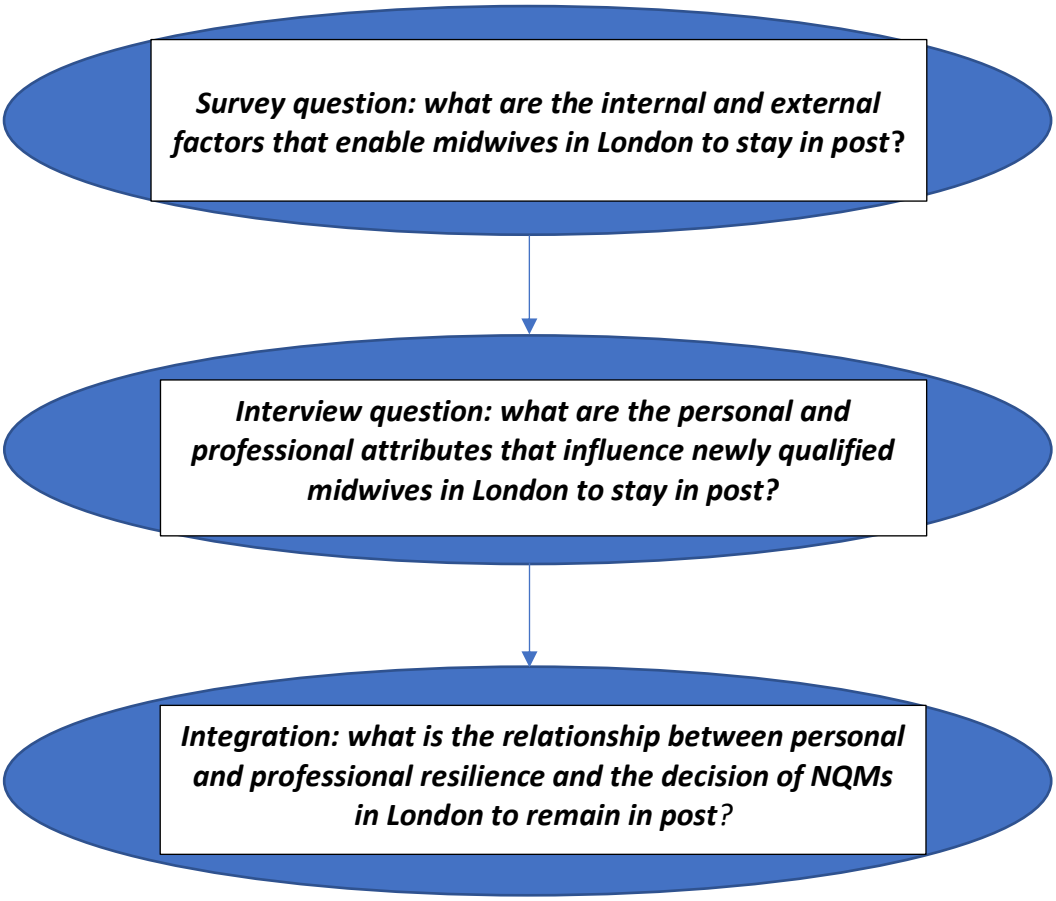
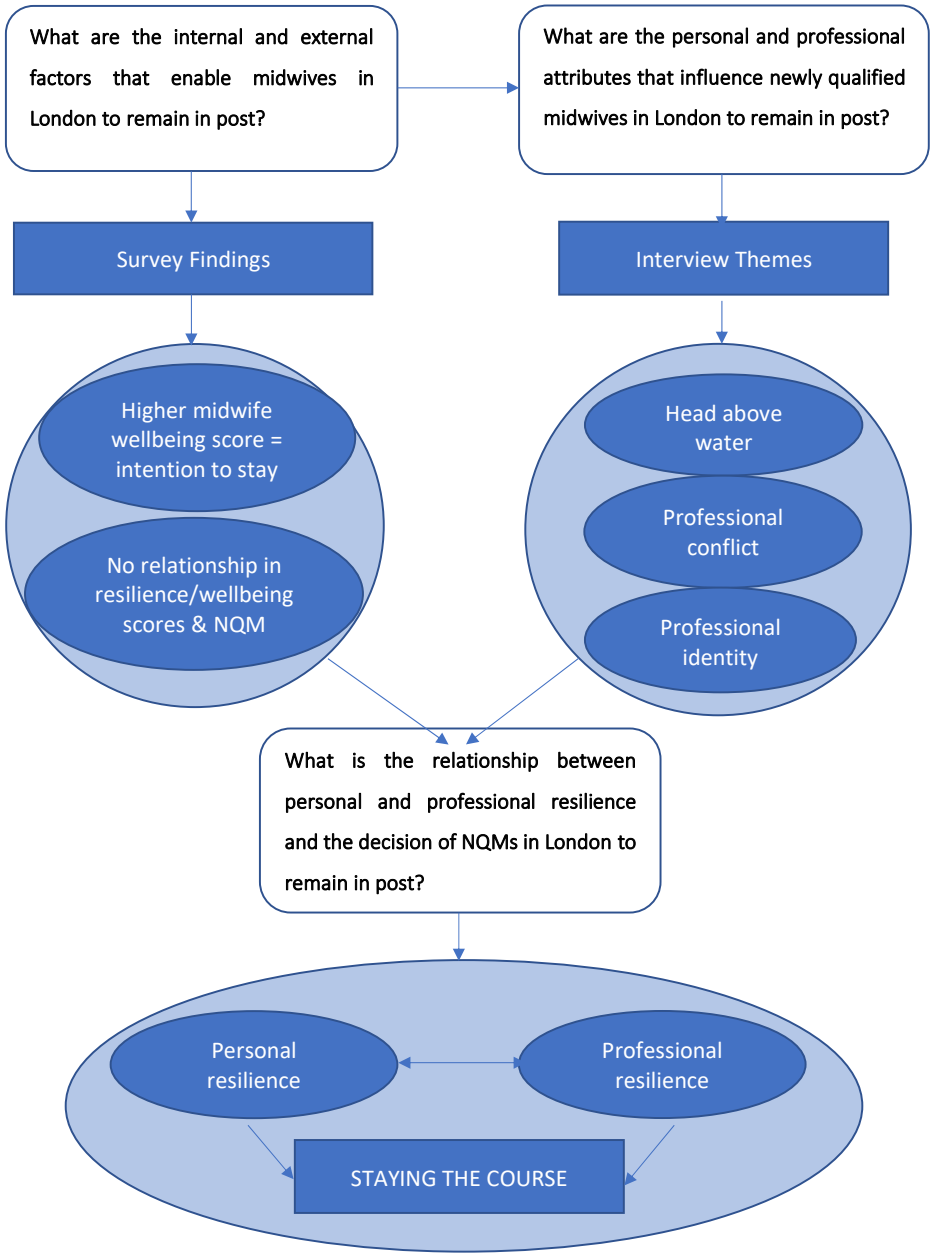


Figure 5.1 demonstrates the relationship between the research questions; integration of the results was conceptualised using a methodological diagram (see Figure 5.2). By integrating the quantitative (survey) and qualitative (interviews) data, Figure 5.2 illustrates new insights into why NQMs choose to stay in post in London. This diagram demonstrates the relationship between the themes from the research and personal and professional resilience.

Definitions of personal and professional resilience are explored through the literature review in section 2.6. These definitions are further discussed in section 5.2 of this chapter and are used to explore the findings and themes of both parts of the mixed-methods research.

Figure 5.2 Methodological Diagram: integration of findings



5.2 Integration and resilience

In this mixed-methods study, an explanatory sequential design was used, meaning that the quantitative survey took place first and informed development of the interview questions (Ivankova *et al*., 2006). Chapter 3 outlines further detail about the methods used. The survey used resilience and wellbeing scales, identified as being relevant to the research question. The first scale, the 10-point Connor-Davidson Resilience Scale was validated in previous healthcare research (Campbell-Sills and Stein, 2007), having been adapted from a 25-point resilience scale devised by Connor and Davidson (Connor and Davidson, 2003). The second scale, the Bower Midwife Wellbeing Scale, was developed from the work of Hunter and Warren (2013) on resilience in midwifery and was created for the purposes of this research. It was adapted from the resilience model that was developed from their qualitative research (Hunter and Warren, 2013) as a measure of midwife wellbeing. Both the Connor-Davidson and Bower scales were checked for reliability following factor analysis, with the Bower Midwife Wellbeing Scale being adapted from a 12-point scale to an 11-point scale because of reliability testing, a process detailed in Chapter 4 section 4.2.

It was clear from the statements in the scales that they assessed different information about the participants. The Connor-Davidson Resilience Scale used statements about a personal response to situations and events, whereas the Bower Midwife Wellbeing Scale used statements which required responses about work situations and the work environment. For this reason, the two scales have been conceptualised as broadly addressing 'personal resilience' (Connor-Davidson scale) and 'midwife wellbeing' (Bower scale). The concepts of wellbeing and resilience, whilst not the same are nevertheless related (Mguni *et al.,* 2012). According to the work of the Young Foundation, wellbeing '*captures a psychological state at a point in time*', whereas resilience is a more dynamic process, that enables individuals to build on previous experiences of coping to '*future proof wellbeing*' (Mguni *et al.,* 2012:3).

The Bower Midwife Wellbeing scale only measures midwives' wellbeing at one point in time, but in the interviews, the NQMs were referring to their wellbeing in an ongoing professional context. According to the definitions put forward by Mguni *et al*. (2012) the dynamic ongoing

state of midwives' workplace wellbeing could be interpreted as professional resilience. It is worth noting from the Young Foundation research that an individual may have a high wellbeing score but be low in resilience and vice versa. Their research was looking specifically at personal wellbeing and resilience, so the application of their findings to workplace wellbeing and resilience needs further work. For the purposes of this discussion, midwives' wellbeing as captured by the Bower Midwife Wellbeing Scale is used as an indication of their ongoing professional resilience.

In the context of this research, personal resilience is defined as the personal ability to negotiate transition to newly qualified practice. Professional resilience, on the other hand, is defined as the professional or organisational factors that help or hinder the transition to newly qualified practice. These two concepts of resilience will be used to synthesise the findings of the research, compare the findings with existing literature and address the research questions.

The concepts of personal and professional resilience are defined in the literature review (section 2.6), but it is worth acknowledging that these concepts are interrelated and complex. If the factors affecting professional resilience are adverse, such as poor staffing levels or poor workplace culture, this affects personal resilience, such as self-confidence and self-efficacy. Conversely, if an individual's personal resilience is low (due to poor mental health, for instance) it is likely that they will also have low professional resilience. Scammell (2017) suggests that organisations often use personal resilience as a concept to blame individuals for not being able to cope with workplace factors that are in fact the responsibility of the organisation. The burden of blame for poor resilience is therefore placed on the individual practitioner in situations where the organisation should be addressing systemic problems.

In support of the interrelationship between personal and professional resilience, McAllister and McKinnon (2009) state that resilience involves the interaction between three factors: personal characteristics, the context and the stressor. My research addresses all three of these interactions. It identifies personal characteristics through the survey and the way in

which midwives responded to the Connor-Davidson Resilience Scale; it explores the professional context and factors affecting professional resilience through responses to the Bower Midwife Wellbeing Scale; and it studies how NQMs respond to the stressors of their transition to newly qualified practice by questioning them in more detail at interview.

In the section on personal resilience (section 5.3), I discuss the findings relating to the transition to newly qualified practice and how NQMs survive this transition. In the next section about professional resilience (section 5.4), I discuss findings relating to the culture of practice, including bullying, staffing levels and burnout. I then explore the inter-relatedness of personal and professional resilience in the final section (section 5.5) through the context of professional identity and how this can influence NQMs to stay. This section integrates the findings from the survey and the interviews, applying these to NQMs by addressing the final research question: *what is the relationship between personal and professional resilience and the decision of NQMs in London to remain in post?* Firstly, the findings of the survey and interviews will be related to personal and professional resilience.

5.2.1 Summary of survey findings

As outlined in Chapter 3, the survey was sent to all midwives within four Trusts in London in December 2020, with 237 usable responses. The survey sought to address the research question: *What are the internal and external factors that enable midwives in London to remain in post?* The survey found no correlation between length of time qualified and either the resilience or wellbeing scores when comparing NQMs with those who had been qualified for more than two or five years. This seems counter-intuitive as there is evidence that health professionals demonstrate more resilience with increasing age and length of experience (Yoruk, 2022). Garcia-Dia *et al*. (2013), however, undertook a concept analysis of resilience, which identified defining attributes such as rebounding, determination and self-efficacy. They found that these were influenced by both intrinsic and extrinsic factors but not necessarily defined by age or experience (Garcia-Dia *et al*., 2013). Their analysis found that these attributes are more related to personal characteristics, which supports my research findings.

My survey also found that the higher the Bower Midwife Wellbeing score, the less likely that the midwife had thought of leaving her post and/or of leaving midwifery in the last six months. This is not a surprising finding, as it could be assumed that positive wellbeing would result in more determination to stay. If it is assumed that demonstrating wellbeing equates to having resilience, the literature supports this finding: in a meta-synthesis of systematic reviews, Huey and Palaganas (2020) identified that 'positive adaptation' is a consequence of having resilience. The authors questioned whether coping skills are a characteristic of having more resilience or whether using coping skills makes one more resilient. Their analysis found that use of coping strategies appears to improve resilience and that higher resilience is a characteristic of being more able to adapt to one's situation (Huey and Palaganas, 2020). As already identified in the literature review in Chapter 2, this suggests that resilience can be developed, which is encouraging if this can be channelled towards NQMs staying rather than leaving. The factors relating to resilience identified from the survey will be discussed in more detail in sections 5.3. and 5.4 through the discussion on personal and professional resilience.

5.2.2 Summary of interview findings

Eight interviews were conducted with eleven NQMs who had qualified in the last two years: five interviews were conducted individually, and three interviews with pairs of NQMs. The interviews sought to address the research question: *What are the personal and professional attributes that influence newly qualified midwives in London to remain in post?* The interview data were analysed using applied thematic analysis, a variation of thematic analysis, which was developed by Guest *et al*. (2014). This technique, detailed in Chapter 3, provides a structured way of coding thematic material that is particularly suited to mixed-methods research because it uses both structural and content codes to analyse the findings (Guest *et al*., 2014). Structural codes were derived from the survey data, therefore pre-empting the interview findings. Content codes then built on the structural codes but were derived from the interview findings and provided more detailed coding (see Appendices 8a and 8b). This was the first stage in integrating the data, a crucial component of mixed-methods research (Teddlie and Tashakkori, 2009).

Figure 5.2 (above) summarises the findings from the interviews, which found three key themes. The first, 'head above water', comprised three sub-themes: transition, sink or swim and support. These themes addressed the process of becoming a NQM in practice and the factors that contributed to making this process easier or more difficult. As discussed in Chapter 4, there were many references to water metaphors, which resonates with the literature (Hughes and Fraser, 2011; Fenwick *et al*., 2012). This will be discussed in further detail in section 5.3 when discussing personal resilience.

The second theme, 'professional conflicts', also comprised three sub-themes: stress and burnout, culture of bullying, and staffing. These themes revealed the extent of bullying towards NQMs and their responses to this culture, which included learning how to fit in. Discovering that all the NQMs interviewed had either witnessed or experienced bullying was unexpected. The themes of bullying and stress and burnout will be explored further in section 5.4 when discussing professional resilience.

The third theme identified in the interviews was professional identity, which describes how NQMs took on and related to their professional persona as a NQM. Working practices were important in developing professional identity which resulted in three further sub-themes: 'I love midwifery', work-life balance and fitting in. Taking on their professional identity appeared to be a strong attribute in determining their future trajectory in the profession. These sub-themes will be explored in the final section (section 5.5) addressing the overarching research question: *Why do newly qualified midwives stay in London*?

5.3 Personal resilience

This theme brings together findings from the survey and the interviews relating to individual attributes and characteristics of resilience. These attributes were explored in the literature review (see section 2.6.1). In my survey, the 10-item Connor-Davidson Resilience Scale was used to assess personal resilience in all midwives, regardless of length of time since qualification. Collecting demographic data made it possible to correlate personal resilience scores with some of the attributes that have been suggested in previous studies to affect

resilience, such as age, length of experience and cultural background (Burns and Anstey, 2010). The results of my survey found that age, length of experience or ethnicity did not appear to influence participants' resilience scores. This is an interesting finding when related to NQMs, as it could be hypothesised that lack of experience would equate to lower personal resilience. However, my findings would appear to support other studies which found that resilience was not dependent on demographic characteristics such as age and length of experience (Alharbi *et al*., 2020). These results were further explored through the interviews.

From my interview findings, the transition to newly qualified practice and the ability to survive this transition was influenced by the attributes that relate to personal resilience. Personal characteristics that were intrinsic to each NQM, such as their ability to bounce back after hardship, influenced how they made the transition to newly qualified practice. The interview data suggested that those who had higher personal resilience were more able to make changes to their situation and therefore more likely to experience a successful transition. This will be explored below in further depth, comparing my findings with the relevant literature where appropriate. The elements of personal resilience that reinforce the decision of NQMs to stay will also be drawn out in the discussion. This is discussed under three themes: 'transition', 'support' and 'surviving transition'; the discussion integrates findings from both the survey and the interviews.

5.3.1 Transition

The first two years of practice were identified through the interviews as being a period of 'transition' from student to qualified midwife. This transition time encompassed the learning that took place from being a student to taking on qualified status. Some midwives described their learning as a positive period in their transition, whereas others struggled to gain the support they needed to develop their learning.

During the first year of practice, NQMs (and other health professionals) undertake their 'preceptorship' period, which is formally recognised as the transitional period from student to qualified practitioner (Nursing and Midwifery Council, 2020; Royal College of Midwives,

2022; NHS England, 2023). Most of the NQMs interviewed had navigated their preceptorship period, despite adversities, and made a successful transition to become a Band 6 midwife. They spoke of being 'thrown in', and of the 'culture shock' of being qualified in comparison with being a student. It appeared they had the personal resilience to withstand the adversities and to negotiate the transition period. The idea of being 'thrown in' and the transitional needs of NQMs not being fully recognised also resonates in the literature. Norris (2019) used action research to explore the experiences of NQMs making the transition to qualified practice and likened this to being in the wilderness. Using Bridges' (2011) model of transition, she identified that transition was a three-stage process for the NQMs who had to let go of being a student and enter a period of loss, before reaching the '*neutral zone*' (p. 131) where they learnt to become NQMs. This stage of transition was described in her study as being 'thrown in' and required the NQMs to develop inner strength and confidence to make a successful transition to newly qualified practice. These characteristics of inner strength and confidence are indicative of personal resilience as already described in Chapter 2 (Mowbray, 2014).

Another study that identified confidence as a key attribute in the transition from student to qualified status explored transition in the context of transcending barriers (Barry *et al*., 2013). The authors found that during the transition period, the initial anxieties of the NQMs gave way to increased confidence in both their competence and their ability to provide woman-centred care. According to Mowbray (2012), both self-confidence and relationships are important components of personal resilience. In a study of the transition of newly qualified nurses (NQNs), Whitehead *et al*. (2016) identified the importance of 'confidence and resilience' from their interviews with NQNs. They did not define resilience but NQNs identified that what made them more confident also made them more resilient. This suggests that the NQNs were referring to personal resilience.

One of the midwives interviewed in my research found the transitional period too difficult to navigate and she had already made the decision to leave. She felt the concept of being protected as a NQM during preceptorship was not recognised by the Trust, partly because there were too many Band 5 midwives needing support and not enough more experienced

staff to support them. Whether this was because she lacked personal resilience or whether it was because work-related factors outweighed her personal resilience is difficult to determine. Day-Calder (2017) outlines how work-related factors can be overcome by building one's personal resilience, thus highlighting the link between the two. If NQMs are enabled to build their personal resilience, this could be a factor in retaining them in midwifery. This will be discussed in more detail during the recommendations in the next chapter.

5.3.2 Support

In the survey, a lack of support was given as a reason for considering leaving by over 7% of all midwives. The context of COVID-19 at the time of the survey, however, must be acknowledged. Interview data also indicated that a successful transition to newly qualified practice was dependent on good support. Similarly, Griffiths *et al*. (2019) found that where NQMs had good support, they were more able to make this transition and remain in the profession, but as expressed by many of the NQMs in my study, support was largely dependent on individual midwives who were on shift. Preceptorship midwives, whose role is dedicated to supporting new preceptees, were generally viewed positively by the NQMs in my study, but it was acknowledged that they were spread too thinly and could not be there at critical times. The NQMs reported that most preceptorship midwives only worked Monday to Friday so were not able to support them during night or weekend shifts, for instance. This was seen to be a limitation in the overall support received by the NQMs in my study and had a significant impact, as they were often rostered for nights and weekend shifts.

Preceptorship has been identified as an important mechanism for a successful transition to newly qualified practice (Mason and Davies, 2013; Feltham, 2014; Kitson-Reynolds *et al*., 2015). It has been supported by policy, with NHS England recommending a preceptorship period for all nurses and midwives and recently developing a framework for midwifery preceptorship programmes (NHS England, 2023). The Royal College of Midwives sets out a position statement on preceptorship for midwives, identifying principles of good practice (Royal College of Midwives, 2022). The NMC also supports the principles of preceptorship,

although it does not set standards for UK-wide preceptorship programmes (Nursing and Midwifery Council, 2020). The NMC (2020: 3) states that the purpose of preceptorship is to:

> "*welcome and integrate the newly registered nurse, midwife and nursing associate into the team and place of work, help them grow in confidence, and begin their lifelong journey as an accountable, independent, knowledgeable and skilled practitioner*."

One of the principles of preceptorship, according to the NMC, is that the preceptee should be empowered (NMC, 2020: 10). The principle elaborates that preceptees should be supported by a named preceptor and should have their individual learning needs supported. The word 'support' appears 25 times in the document, reinforcing this as a key requirement for preceptorship programmes. As in my study, previous research has identified that support is an important component of a successful preceptorship programme (Mason and Davies, 2013) but that this is often variable due to staff shortages, workload pressures and limited support from dedicated preceptorship staff (Wain, 2017). As in other studies, such as Wain (2017), the NQMs in my study identified that some staff were known to be helpful towards NQMs but there were also those who were known to be avoided because they had a reputation for being unsupportive. One midwife said of her preceptorship experience: '*you just kind of get forgotten in your room, you get spoken to like crap and they're really unsupportive*' (NQM 8).

A lack of support perceived by many of the NQMs in my study could be accounted for by the discrepancy between expectations and realities of qualified practice. As students, the NMC standards require that they work with a named practice supervisor, even if this supervision is indirect (Nursing and Midwifery Council, 2018a). As NQMs or preceptees, although there is an expectation that they will work alongside a preceptor midwife, at least in the first few weeks, this was rarely a reality. Most of the NQMs felt unsupported at certain points, even if this was not all the time. The level of support appeared to be a crucial factor in keeping their head above water and in whether they made the decision to stay in their post. One of the two midwives who had made the decision to leave midwifery, at least for the immediate future, cited lack of support as one of the reasons for making this decision.

Previous research also reveals an unrealistic expectation of the support available, which appears to be a key component in NQMs' perceptions of lack of support (Griffiths *et al*., 2019). In one study called '*Fairytale Midwifery*', which explored the lived experiences of NQMs, the findings indicate that newly qualified practice is a 'reality shock' (Kitson Reynolds *et al*., 2014: p.660). This 'reality shock' was first described by Kramer (1974) in nursing and has been found in many studies since (Newton and McKenna, 2007; Dyess, 2009). It is explained by the authors of '*Fairytale Midwifery*' that NQMs are still in student mode and are therefore not actively seeking support for themselves (Kitson Reynolds *et al*., 2014). The authors conducted a literature review ten years after the original study and found that this was still the case (Ashforth and Kitson-Reynolds, 2019).

Several studies suggest support mechanisms that should be in place for NQMs to ease the transition (Mason and Davies, 2013; Feltham, 2014; Black, 2018; Norris, 2019). Norris (2019) suggests that third-year students should be placed in the area where they are going to be newly qualified for their last placement and that as preceptees, they should be buddied with a Band 6 midwife. Individualised preceptorship programmes are identified as being important, with the emphasis on skills development (Mason and Davies, 2013). None of these suggestions are new; however, the support received by many of the NQMs in my research was lacking, which suggests that there is still a need to implement the recommendations of previous research. Given that one of the key attributes of personal resilience is confidence (Mowbray, 2021), it is important that NQMs are given the right amount of support to develop their confidence so that they can make a successful transition to professional practice.

5.3.3 Surviving transition and personal resilience

Ten out of eleven NQMs interviewed in my research were planning to remain in midwifery with one NQM planning to leave the profession (although a second NQM was also leaving to take time out). This means that they had successfully negotiated their preceptorship year and had survived their transition to qualified practice. Throughout the interviews, NQMs used different expressions relating to 'survival' to describe their experience of being newly qualified (see section 4.9.1 – theme 'head above water'). Several midwives articulated their experiences using metaphors relating to water, for instance being 'thrown in' (NQM 2 and 8),

learning to 'float rather than sink' (NQM 4), describing their experience as 'sink or swim' and 'paddling like mad' (NQM 6) and 'keeping my head above water' (NQM 4). This was also reflected by other NQMs as feeling 'out of my depth' (NQM 5) or in 'over my head' (NQM 9). This language is interesting because the analogies and metaphors of water have been found in other studies relating to NQMs (Hughes and Fraser, 2011; Fenwick *et al*., 2012), as well as NQNs (Horsburgh and Ross, 2013; Eklund *et al*., 2021). Hughes and Fraser's study (2011) of NQMs used the metaphor of 'sink or swim'. What enabled NQMs to 'swim' in Hughes and Fraser's (2011) study was having a named preceptor midwife and being able to work alongside them; having good support during the first year after qualifying, including support from a specific role, such as from a practice development midwife; and being given a personalised programme during preceptorship, rather than using a 'one size fits all' approach. The findings of Hughes and Fraser's (2011) study are also reflected in those of nursing studies into preceptorship (Hollywood, 2011; Lim *et al*., 2013; Whitehead *et al*., 2016).

The other midwifery study, which used different metaphors relating to water (Fenwick *et al*., 2012), applied the concept of a pond to describe the experiences of 16 NQMs making the transition to practice. The authors describe the pond as a toxic environment that has many layers and can be '*both clear and peaceful or murky and infested*' (Fenwick *et al*., 2012: 2054). As in Hughes and Fraser's (2011) study, they also identified the concepts of 'sinking' (poor relationships with midwives and a difficult working environment) and 'swimming' (good relationships and a supportive working environment). This study took place in one area of Australia, where NQMs could work in hospitals or in case-loading practices. The midwives who worked in case-loading practices and were able to provide continuity of care to their women were generally more positive about their transition and more able to 'swim' than those working in hospital environments where there was more likely to be a shortage of staff and an overburdened workload. The pros and cons of working in a continuity model of care during preceptorship are further explored in section 5.5 below.

To some extent, the idea of sinking or drowning might be expected, as newly qualified practitioners need to learn to make the transition from being a student, where their practice

is continuously monitored by a practice supervisor (Nursing and Midwifery Council, 2018a). Although the midwifery studies identified above took place over ten years ago, it would seem from my research that NQMs still use language depicting sinking, swimming or drowning when making this transition to newly qualified practice. Even though NQMs are supported within preceptorship programmes, as described by the studies (Hughes and Fraser, 2011; Fenwick *et al*., 2012), this support is not one-to-one as it would have been when they had student status. It would appear from my research that developing elements of personal resilience, such as self-confidence, relationships and self-determination, to overcome drowning are also important to surviving transition.

This section addresses the research question '*what are the personal and professional attributes that influence newly qualified midwives in London to stay in post?*' My research demonstrates that whether NQMs can survive the transition to qualified midwifery practice appears to rely on their personal resilience and on the support they receive. Thomas (2018) suggests that the resilience of an organisation is dependent upon the personal resilience of the workforce. It follows that by increasing personal resilience in individuals, there will be a consequential increase in the resilience of the organisation. It would, therefore, seem beneficial to the retention of NQMs in the maternity services that the personal resilience of individual midwives be strengthened and developed. As will be explored when discussing professional resilience in the next section, however, personal resilience is also dependent on factors affecting the resilience of the organisation, so the relationship between personal and professional resilience is symbiotic and complex.

5.4 Professional resilience

This theme integrates findings from the survey and the interviews relating to professional resilience, which refers to the relationship between wellbeing, resilience and workplace factors. The concept of wellbeing in the Bower Midwife Wellbeing scale illustrates a snapshot of the midwives' workplace wellbeing at the moment in time when the scale was completed. Workplace wellbeing – or lack of wellbeing – correlates with the concept of professional resilience as a dynamic and ongoing response to the state of wellbeing (Mguni *et al*., 2012).

It is acknowledged that the term 'professional resilience' is used interchangeably with organisational and/or workplace resilience as described in the literature review (see section 2.6.2 for further discussion).

In my survey, the Bower Midwife Wellbeing Scale was used as an assessment of midwife wellbeing within the midwifery workplace. As previously described, this is not a validated tool and was developed for the purposes of this research, using the work of Hunter and Warren (2013). As detailed in the methodology chapter (section 3.6.2), this scale had high reliability suggesting it is a valid tool in the context of this study. Analysis of the Bower Midwife Wellbeing scores suggested that midwives in the survey had a relatively high level of workplace wellbeing overall, with a mean score of 40.2 out of a possible score of 55 (73.1%). This compares with a mean score of 39.7 out of a possible score of 50 (79.4%) for the Connor-Davidson Resilience Scale. This suggests that the majority of midwives in the survey had both high personal resilience and high workplace wellbeing. The percentage of midwives with high or very high personal resilience, however, was greater than the percentage of midwives with high or very high workplace wellbeing, as indicated by these findings. Being qualified for two years or less was not a significant factor in either scale.

The two statements in the Bower Midwife Wellbeing Scale that midwives least agreed with were '*I have never experienced bullying at work*' (2.8/5) and '*Staffing levels are always safe*' (2.6/5). In the literature, workplace culture and workload (which is dependent on staffing levels) are identified as key elements affecting professional resilience (Hunter and Warren, 2014; Cusack *et al*., 2016; Scammell, 2017). In the interviews in this study, NQMs were asked about these elements of the Bower Midwife Wellbeing scale to ascertain their experiences of workplace culture and workload. Their responses revealed how most of the NQMs had poor experiences with both yet had remained in midwifery. These responses are discussed below under the themes of a culture of bullying and staffing levels, workload and burnout. These themes are compared with the literature as well as being discussed in the context of professional resilience.

5.4.1 Newly Qualified Midwives' experiences of a culture of bullying

The negative response to never having experienced bullying found in the survey (as described above) was corroborated by the interview results. Without exception, all eleven NQMs interviewed in my study had either seen NQM colleagues being bullied or had experienced it themselves. One NQM summed this up by saying: "*I think that maternity is quite, unfortunately, infamous for bullies actually*" (NQM 9). The culture of bullying within maternity was referred to by another NQM: "*There's actually quite a lot going on at the moment which I've called out as being workplace bullying to specific people*" (NQM 5).

In one extreme case, where the NQM was left on her own to deal with a difficult situation, despite calling for help, the NQM stated "*Their entire culture… it needs to change if they want to retain their staff*" (NQM 7). This NQM was angry about her experience but able to recover from it and was planning to stay in midwifery. However, she recognised the effect this behaviour could have on retention. Another NQM, who had decided to leave midwifery, felt that the culture of bullying within her unit was intolerable and did not feel that she had the personal resources necessary to sustain practising as a midwife within such a culture. It appears from the interviews that there was a tipping point where midwives either felt that the culture was unacceptable but that there were other reasons to keep them in midwifery, or that the culture was too damaging to endure, and they could no longer tolerate working as a midwife. This was often despite the fact that they loved being a midwife. It is difficult to determine whether this tipping point is dependent on the severity of the bullying experienced (i.e. erosion of professional resilience) or on the personal resilience of the individual but is likely to occur when there is an imbalance between the two. My data suggest different factors are involved for each person and that there is a pivotal point for NQMs where the ability to remain in midwifery is outweighed by the poor culture of practice. At this point, professional resilience breaks down and the NQM, as in my example, may decide to leave midwifery.

The culture of bullying in midwifery is abundant in the literature and has been researched in many different contexts over several decades (Hadikin, 2000; Newman, 2019; Ohadike, 2019). In a Royal College of Midwives' (RCM) survey in 2002 about why midwives leave, bullying and

horizontal violence were given as major reasons for midwives leaving the profession (Ball *et al*., 2002). In a RCM follow-up survey, nearly fifteen years later, the findings were no different (Leversidge, 2016). Whilst bullying is apparent in other health professions, including medicine and nursing (Samsudin *et al*., 2018; Darbyshire *et al*., 2019), and even at a Trust-wide level, (Gent, 2018) there appears to have been a long-standing and specific issue with bullying in midwifery.

Bullying in midwifery has been made more apparent by recent investigations into maternity services where poor maternal and neonatal outcomes have been attributed to poor culture within maternity units (Kirkup, 2015; Kirkup, 2022; Independent Maternity Review, 2022). In the Kirkup Report (2015), which investigated poor maternity care at Morecambe Bay Hospitals NHS Trust over a prolonged period of time, the report found '*incidents that exposed a bullying culture within the unit*' (Kirkup, 2015:129). The report identified a dysfunctional culture between medical staff and midwives, also a poor culture within these groups. The report recommended many actions relating to multi-disciplinary working, accountability and governance to prevent a repetition of such poor culture developing in maternity units in the future.

Despite recommendations such as this, the most recent reports to investigate maternity services and poor outcomes revealed almost identical outcomes to those in Morecambe Bay (Kirkup, 2022; Independent Maternity Review, 2022). The Ockenden Report (Independent Maternity Review, 2022) into services at Shrewsbury and Telford NHS Trust was the most in-depth and lengthy investigation of any maternity service, spanning over 20 years and including the experiences of 1,486 families. The culture of bullying is a significant theme throughout the report, with the word 'bully' or 'bullying' appearing 20 times in the report. The word 'culture' appears 91 times, mostly relating to a poor culture within the unit. In response to a staff survey which was conducted as part of the investigation, 65.5% of staff (mostly midwives and obstetricians) said that they had personally witnessed or experienced bullying in the unit. In an interview with the review team, one midwife stated: '*There is a culture of bullying on labour ward. Staff don't always feel supported by the shift co-ordinators*'

(Ockenden, 2022: 66). The investigation found that bullying and unkindness had permeated into the care being given to women. The recommendations are far-reaching and openly address the generalised bullying culture within the unit, with one recommendation stating:

> '*The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service*' (p. 191).

In the Ockenden Report (Independent Maternity Review, 2022), as in the original *Why do Midwives Leave?* study (Ball *et al*., 2002), perpetrators of bullying were both managers and midwives' own peers. However, certain factors made victims more vulnerable to this behaviour, such as being a student or being a newly qualified midwife.

Midwifery students have been found to be in a particularly vulnerable position regarding bullying (Capper *et al*, 2021a; Capper *et al*., 2021b). In the latest National Education and Training Survey, 32.5% of midwifery students reported that they had experienced bullying or harassment. This compares with 15% of the overall healthcare student population (Health Education England, 2023). The work of Capper *et al*. (2021a and b) exploring the experiences of students found there was a culture of acceptance, which was so ingrained that bullying took place in front of both other midwives and women in their care. This study reinforces the findings of Gillen *et al*. (2009) from over a decade earlier. The other group of midwives identified as being more vulnerable are newly qualified and inexperienced midwives (Curtis *et al*., 2006d). Other researchers have also found this to be the case, such as Cull *et al*. (2020), who found that bullying was just one of the reasons why NQMs felt overwhelmed and unsupported and were more likely to consider leaving midwifery. One explanation for this is that it relates to the generalised and status-specific culture of treating NQMs badly, part of their 'rite of passage', as found in my research.

Several of the NQMs in my interviews discussed the behaviour of individuals who perpetuated the culture of bullying. These were 'known' individuals whom the NQMs knew to avoid. One NQM said "*but then you learn pretty quickly who you can and can't go to*" (NQM 6). When

asked who these individual midwives were and whether they were midwifery managers, the NQMs responded that it was most often those with longevity rather than seniority, thus midwives who were ingrained into the culture of the unit. This finding was shared by NQMs in different hospitals, so was not specific to any one hospital or Trust. The NQMs had also experienced supportive and facilitative colleagues, but this often depended on whether they were accepted into the culture by those who held power. Knowing the individuals who were supportive or unsupportive was seen to be one of the advantages of remaining in the unit where they had trained because they were already aware of which midwives they could turn to and which ones they should avoid. This finding resonates with that of Feltham (2014) who found that preceptees felt more confident when undertaking their preceptorship in a hospital already known to them, where they knew the players.

My study uncovered a widespread practice within the maternity units of not challenging 'known' individuals who perpetuated poor culture. One NQM, when reporting such behaviour, said "*the matron just said to me 'oh well, you know when so-and-so and so-and-so get together you know what they can be like' and that was the response*" (NQM 6). The idea 'that's just her' or 'you know what they are like' was commonly quoted in the NQM interviews as the justification given for individuals' behaviours. None of the NQMs thought this was acceptable and there was perplexity as to why this was allowed to continue, especially when the NHS purports to support a zero-tolerance culture towards bullying (NHS England, 2019). Furthermore, these NQMs did not feel able to challenge this culture themselves for fear of retribution. The fact that this culture is allowed to continue and has been perpetuated over many years suggests that it becomes a learned behaviour (Lester, 2021). If the NQMs in my study were followed for several years, it is likely that some of them will become the perpetrators of the future, even though none of them thought this was appropriate behaviour as a NQM.

The concept of peer-to-peer bullying has been labelled as 'horizontal violence' in healthcare literature, mainly relating to nursing (Armmer and Ball, 2015; Tedone, 2020; Krut *et al.*, 2021). In an analysis of the situation in nursing, Tedone (2020) suggests that early-career nurses are

at particular risk. She suggests this is because preceptor nurses (nurses who act as mentor to NQNs) are not given additional time within an already busy workload to support their preceptee (the NQN). This leads to resentment about supporting the new nurse before they have even started. Due to work pressures, this resentment can progress to become horizontal violence, with preceptors criticising, berating or undermining the confidence of NQNs, resulting in higher attrition of new nurses (Tedone, 2020). The same situation relates to the NQM in my interviews who reported there were too many preceptees in her Trust. She perceived this as being responsible for the stress of her more experienced colleagues and subsequent bullying culture, which ultimately caused her to resign. This chain of events helps to explain the interconnectedness of work-related factors that lead to bullying, ultimately undermining professional resilience and potentially causing NQMs to leave.

Several NQMs in my study suggested that one of the factors contributing to a bullying culture is that midwifery is an almost all-female profession. Comments were made such as "*it's because we're a bunch of women, you put that much oestrogen in a room, you're going to have troubles*" (NMQ 6) and "*especially because I work with so many women... It's just so difficult to not feel like people are being bitchy when they... I mean, they are*" (NQM 5). It is difficult to compare this perspective with any other profession because midwifery is more predominantly female than almost any other occupation, including nursing. There is much literature about bullying of females in predominantly male occupations, such as law (Khan and Daniyal, 2018) and politics (Sorrentino *et al*., 2022), which is explained by the misogynous culture and perceived subservience of women in these domains. There appears to be no specific research into female-female bullying amongst professionals, and specifically health professionals. The literature only explores female-female bullying between school and college students and adolescents, which does not directly relate to professionals and the healthcare context. The reasons for female-female bullying in a midwifery context, and in fact, a wider context, would be an interesting perspective to explore in a future study. Women are often regarded as the 'victim' in literature about bullying, rather than being seen as the perpetrator (Khan and Daniyal, 2018; Sorrentino *et al*., 2022).

In summary of this section, my findings support the existing literature, that the experience of bullying is widespread in midwifery. All NQMs in my study had either experienced bullying themselves or had witnessed it occurring to other NQMs. As supported by the literature, my findings would suggest this is a form of 'rite of passage' which is multifactorial. Hierarchy and status, a female-dominated profession and the extra workload required to support NQMs were all identified as factors perpetuating this behaviour. Most of the NQMs in my study learnt to negotiate this culture and stayed in midwifery, demonstrating professional resilience. Where the negative workplace culture outweighed their professional resilience, NQMs decided to leave.

5.4.2 Staffing levels, workload and burnout

Excessively high workloads are often the result of poor staffing levels, another significant factor reported in the literature that decreases professional resilience (Scammell, 2017). Poor staffing was undoubtedly a factor in my own research. In the survey, the statement '*staffing levels are usually safe*' in the Bower Midwife Wellbeing Scale received the lowest mean score (2.6/5) of any of the ten statements. This means that a large majority of midwives in the survey either disagreed or strongly disagreed with this statement, suggesting that the staffing levels were usually unsafe. This is of particular concern for NQMs, given that they require additional support during their preceptorship period (Nursing and Midwifery Council, 2020). In the interviews, this statement was explored further and NQMs were asked about the impact of staffing levels on their preceptorship support.

In the interviews with NQMs, they described the ante/postnatal wards as having the worst staffing ratios. One midwife said: '*Postnatal ward was horrendous … they worked their staff to the bones there and consistently like, they're consistently one staff short*…'(NQM 4). The impact on the NQMs was that they were often left in charge when they did not feel ready for this. One NQM said: '*And I was the senior on the ward because we had…myself and three midwives, one of which had been a midwife for a month and then one for two weeks and one for one week and they were both still orientating'* (NQM 2). This midwife had been qualified for only eleven months and had just gained her Band 6 promotion. She did not feel ready to

manage the very busy ante/postnatal ward and to supervise three very junior midwives, two of whom should still have been supernumerary because they were in their first two weeks.

In the community, NQMs also experienced poor staffing levels. One midwife said: '*We've had two midwives hand in their notice and then a third one this week and so … from that team of where there was probably about twelve midwives full time, there's now two…and it's so unsafe*…'(NQM 5). The impact of staff leaving and not being replaced was a recurring theme in the interviews. Whether this was because the interviews were conducted a year into the COVID-19 pandemic is difficult to confirm but the impact of the pandemic on staffing was also discussed. One midwife was sceptical about this being the main reason for poor staffing levels and said: '*They keep saying that it's COVID related, that we've got long-term sickness because of COVID…. It's not just COVID and long-term sickness, there is something else going on there*…' (NQM 7). This midwife recounted that staffing levels had been poor before the pandemic, but COVID-19 was now being used as an excuse for continuing poor staffing levels.

In the investigatory reports of maternity services already discussed, staffing levels were identified as a major factor in poor outcomes and poor culture in the units (Kirkup, 2015; Kirkup, 2022; Independent Maternity Review, 2022). In the Ockenden Report (Independent Maternity Review, 2022), it was noted that suboptimal and unsafe staffing levels in the hospital resulted in staff feeling stressed and fearful at work. This was particularly acute on the postnatal ward and in community because midwives were taken away from these areas to staff the labour ward as the labour ward was seen to be the priority area. This impacted on staff morale, resulting in a culture of fear and anxiety. Ultimately, the Ockenden Report stated that if staff felt unsafe, they would leave, causing further attrition from the midwifery workforce. This, in turn, led to a further decline in staffing levels, thus perpetuating the cycle (Independent Maternity Review, 2022). The report noted that the staffing concerns were found in the obstetric as well as midwifery teams. One of the recommendations of the report was for the government to initiate a workforce plan for all maternity services to prevent attrition:

> '*…this workforce plan must also focus on significantly reducing the attrition of midwives and doctors since increases in workforce numbers are of limited use if those already within the maternity workforce continue to leave*.' (p. xi).

The relationship between staffing levels and attrition is well established. A Royal College of Midwives (RCM) survey undertaken in August 2021 revealed that 84% of RCM members were not happy with staffing levels (Walton, 2021). The survey also identified that 57% of midwives and maternity support workers were considering leaving the NHS, and one of the reasons given was because of poor staffing levels. Of those midwives who had qualified in the past five years, 50% were considering leaving the profession and nearly 50% of those were planning to leave within the next 12 months. If carried out, this would result in a 25% attrition rate of NQMs, which is a significant loss to the NHS. It is also a loss to the economy, given the cost of educating midwives over three years if students are not recruited into the workforce. The number of midwives in the NHS is decreasing, whereas in most professional groups, the numbers are increasing (NHS Digital, 2022). This is despite Health Education England's Maternity Workforce Strategy to increase the number of midwifery student places by 25% by 2023-2024 and to increase the number of whole-time equivalent midwives by 750-800 (Health Education England, 2019). According to the latest analysis by the Royal College of Midwives, the number of midwives has decreased over this period (Bonar, 2023), contradictory to the targets set by the Maternity Workforce Strategy.

When investigating 'workplace adversity' for midwives, researchers have found a shortage of midwives is a global contributory factor to adverse conditions (Cramer and Hunter, 2019; Geraghty *et al*., 2019; Matlala and Lumadi, 2019). This has been found in countries as diverse as the UK, South Africa and Australia. In their '*What Women Want*' survey, completed by over 1.2 million women worldwide, the White Ribbon Alliance found that the highest request from women globally was for more midwives and nurses (White Ribbon Alliance, 2019). In their equivalent survey for midwives and midwifery students (*Midwives Voices, Midwives Demands*), over one third of midwives worldwide called for more or better-supported midwives (20,783 out of 56,105 respondents) (White Ribbon Alliance, 2022). Of the 1061 UK respondents, over three quarters (772) of midwives and midwifery students called for more

or better-supported midwives, and the free text responses reiterated the call for safer staffing levels, more staff and better support from management (White Ribbon Alliance, 2022).

From the literature, the relationship between poor staffing levels and attrition appears to be clear. According to Scammell (2017), poor staffing levels are one of the major factors undermining professional resilience. The impact of staff shortages on NQMs, therefore, is to decrease their professional resilience, resulting in higher rates of attrition (Scammell, 2017). This is supported in my own research as the two NQMs who had decided to leave gave staff shortages and workplace culture as the main reasons for making this decision.

Stress and burnout, due to poor staffing levels and high workload, are also factors affecting professional resilience. Burnout is described by the World Health Organisation (WHO) in the 11th revision of the International Classification of Disease (ICD-11) as '*a health issue resulting from chronic workplace stress not successfully managed*' (WHO, 2022: online). In the literature, stress and burnout are often described as a measure of poor wellbeing. In a study of radiologists by Rekabi *et al.* (2023), burnout from low staffing and high workload resulted in poor wellbeing. They assessed burnout using scores measuring emotional exhaustion, depersonalisation and lack of personal accomplishment (Rekabi *et al*., 2023). High levels of burnout, they concluded, equated to poor levels of workplace wellbeing. In a similar study, a survey of Indian medical students revealed there were very high levels of burnout, measured by exhaustion (81% of students) and disengagement (88%). This correlated with poor wellbeing scores as assessed by the General Health Questionnaire, where it was found that 62% of all medical students were assessed as having poor wellbeing (Farrell *et al*., 2019).

An integrative literature review explored the relationship between midwives' wellbeing, resilience, stress and adverse workplace conditions (Moran *et al*., 2023). The review found that burnout could be prevented by creating sustainable working conditions by addressing adverse conditions such as poor workplace culture, high workload and lack of continuity of care models. This was found to increase both the midwives' resilience and retention in the

profession. The authors warned against relying on midwives' personal resilience as a substitute for addressing adverse workplace conditions which were the cause of the burnout.

Burnout was described by midwives in my own research, and was demonstrated through the interviews, with one part-time NQM stating, '*I think that [part-time] helps a lot with burnout for me personally*' (NQM 2). This was because the full-time workload was so stressful and emotionally exhausting for her that she had decided to work part-time to enable her to continue working in midwifery. Stress was mentioned by several NQMs in the interviews with one NQM stating: '*If you get too stressed, you implode*…' (NQM 4). Again, this was said in relation to staffing levels and workload. Although the Bower Midwife Wellbeing Scale did not specifically ask about burnout, by implication those who described being stressed or burnt out were demonstrating poor midwife wellbeing. According to Cleary *et al*. (2020), looking after the needs of the workforce can prevent stress and burnout, thereby enhancing workplace wellbeing.

In summary of this theme on professional resilience, my study echoes the literature, identifying that poor workplace culture, specifically a bullying culture, pervades midwifery practice and is frequently targeted at NQMs. This conflicts with the ideal of providing extra support for NQMs that is necessary for a successful transition to qualified practice; yet it appears that bullying is wide-ranging and has become an accepted behaviour towards NQMs, which has been in evidence for many decades. This culture of bullying is exacerbated by the poor working conditions midwives are currently experiencing, with poor staffing levels and high attrition within the profession (Bonar, 2022b). Adverse working conditions, such as a bullying culture, poor staffing levels and high workload, have been identified as factors that cause stress and burnout, undermining workplace wellbeing, which in turn diminishes professional resilience. This cyclical chain of events had a negative impact on the NQMs interviewed in my study, with two of the eleven already planning to leave midwifery. Nine of the eleven, however, had stayed and the reasons found in both the survey and the interviews for remaining in midwifery will now be explored. These reasons will also be discussed in the context of both personal and professional resilience.

5.5 Staying the course: Why do midwives stay?

This section addresses the final research question: *what is the relationship between personal and professional resilience and the decision of NQMs in London to remain in post?* The reasons for remaining in midwifery from both the survey and the interviews will be discussed under the overarching theme of professional identity. They include job satisfaction ('*I love midwifery*'), relationships with women (continuity of carer) and fitting in. Flexible working and work-life balance will also be discussed in this section. Given that this research focused on midwives in London, the survey responses to '*have you considered leaving London?*' and the interview responses to '*what keeps you in London?*' will also be considered. Finally, the interconnectedness between personal and professional resilience, and whether these can meaningfully be separated, will be debated. This will be discussed in the context of NQMs staying, both in midwifery and in London.

5.5.1 Professional identity and job satisfaction

In both the survey and the interviews, when midwives were asked what kept them in midwifery, they overwhelmingly stated that they loved their job. In response to the open text survey question '*what is the main reason you are still practising as a midwife*?', 43.6% of midwives (n = 99) stated that they stayed in midwifery because of job satisfaction and 14.5% (n = 33) because of their relationship with women and families, although it is acknowledged that there may be overlap between these two categories. Remarkably, 26.6% (n = 61) used the word '*love*', referring to either their job, the women, their colleagues or the profession. Fifteen used the word '*passion*' or '*passionate*'.

In the interviews, NQMs were asked '*what has kept you in midwifery*?' Responses reflected the themes in the survey, such as loving the job, finding value in their work, feeling passionate about midwifery, and seeing midwifery as a way of life, not just a job. One NQM said: "*I love my job! … I can't imagine doing a job that you just go to because it's a job….*" (NQM 4). In the interviews, NQMs also talked about the relationships with the women in their care. One midwife stated: '*the entire point of becoming a midwife is to be with the women*' (NQM 8). Two NQMs talked about the benefits of continuity of carer as unusually, they had been placed

in continuity teams during or directly after their preceptorship period. When asked why she was still in midwifery, one of the two midwives said: "*I feel passionate about the continuity of care pathway and the benefits that [women] are getting from it*" (NQM 5). Both midwives described this model of care as a fundamental reason for remaining in midwifery.

This 'love of midwifery' is also found in the literature relating to midwifery job satisfaction (Bloxsome *et al*., 2020; Evans *et al*., 2020). The relationship developed with women is unique in midwifery, especially when midwives are working in continuity of carer models (Fenwick *et al.*, 2018). Studies from Australia, where this model of care is more widespread, have identified that working in continuity of carer models as an NQM is more likely to result in the midwife staying in midwifery (Griffiths *et al.*, 2019b; Evans *et al.*, 2020). It is well documented that a continuity of carer model provides midwives with high levels of job satisfaction (Fenwick *et al*., 2018; Hanley *et al*., 2021). Hobbs (2012) identifies that NQMs in the UK, working in models of care that support being 'with woman' such as caseload midwifery, make the transition to newly qualified practice more easily. The opposite situation prevails in Australia, where midwifery education is predominantly organised within case-loading teams. Griffiths *et al*. (2019) explored the transition to qualified practice, where there is little opportunity to gain employment within such teams. Those NQMs who were unable to gain employment in a continuity model of care, in which they had trained, were much less satisfied with their transition and felt much less confident to make this transition. Such findings resonate with my own research, where the NQMs who were already working in caseload settings felt this was one of the reasons they were still practising.

Continuity of carer models are strongly supported by recent UK maternity policy (NHS England, 2016; Welsh Government, 2019). The NMC identifies continuity of care and carer as one of the five domains of proficiencies for midwives and students (Nursing and Midwifery Council, 2019b). In response to the policy drivers, targets were set for continuity of carer models to be implemented across England, with a target of 35% of women to be on a continuity of carer pathway by March 2020 (NHS England, 2020). However, this ambition has been partially derailed by the pandemic. There is also a mismatch between the ambition and

the reality in practice, due to staffing shortages, flexible working requirements, and organisational barriers (Dharni *et al.*, 2021).

There is strong evidence, however, of the benefit of continuity of carer models for pregnancy outcomes and for women's satisfaction (Sandall *et al.*, 2016). There is also strong evidence that continuity of carer models improve job satisfaction for NQMs (Fenwick *et al.*, 2012; Griffiths *et al.*, 2019; Evans *et al.*, 2020; Wilson *et al.*, 2020). Given that Domain 2 of the NMC Standards of proficiency for midwives is dedicated to proficiencies based on providing continuity of care and carer to women (Nursing and Midwifery Council, 2019b), NQMs should be competent to provide this type of care when they qualify. There is a reluctance, however, to place NQMs in continuity or caseload settings during their preceptorship period because the responsibility is perceived to be greater. The evidence, particularly from Australia, suggests that doing so may be a cornerstone to improving retention of NQMs.

For some midwives, the concept of being on-call and of working irregular hours to fit a caseload of women is not compatible with demands on their personal lives which makes working in a continuity model very difficult. In my survey, midwives were asked whether they were required to be on-call. Only 31.2% were required to be on-call at least some of the time, with 55.7% never having to be on-call. This reflects the need for many midwives to have flexible working hours to accommodate dependents or other aspects of personal life (Prowse and Prowse, 2015). Many of the NQMs in the interviews would have appreciated more flexible working and this is discussed in the next section.

5.5.2 Flexible working

The ability to have control over their working patterns was another important factor that determined NQMs' ability to remain in midwifery. In the survey (free text question), some midwives identified flexibility of their role as one of the reasons that kept them in midwifery. These respondents were mostly part-time midwives. Flexible working was discussed by several of the NQMs in the interviews. Four NQMs stated they had gone part-time to keep them in midwifery, two of them having gone into research so they could '*avoid irregular shifts*' (NQM 2) and '*manage my stress*' (NQM 1). One midwife had gone part-time and said she

'*would have left completely otherwise*' (NQM 8). This highlights the need for part-time working for many midwives and provides evidence that more flexibility enables them to stay in midwifery.

In the interviews, one NQM said: '*I am also part-time clinical now and have found that has really given me a better work-life balance*' (NQM 2). Another NQM had requested flexible working because of childcare which she could not organise with irregular shifts. She stated '*it would make a massive difference to attainment if for your first year, you had flexible working*', (NQM 8). By this she meant that it would be easier to achieve the requirements for preceptorship if NQMs had more control over their working patterns, which was a source of stress for many NQMs. Another NQM gave stress as the reason for going part-time, saying: '*I have to do this part-time, I'll have to do community, I can't do hospital, I find it too stressful*' (NQM 3). In her case, stress was due to the hospital environment, and she felt that working in a community setting would reduce her stress.

Flexible working is a way of giving newly qualified practitioners some element of control, thereby improving their work-life balance, which is one way of ensuring the job is sustainable. Flexibility is particularly important to the younger generation because they are more likely to demand flexible working (International Workplace Group, 2019). Flexibility is well documented in the literature as a means to improve work-life balance and therefore reduce attrition in health professionals, particularly in newly qualified professionals (Kool *et al*., 2019; Ho *et al*., 2021). Ho *et al*. (2021) explored factors influencing retention of NQNs in Scotland and found that work-life balance was one of the three key reasons given for remaining in post. Work-life balance is also an important element for other newly qualified professionals prone to burnout and attrition, such as teachers (Powell, 2016).

Despite the evidence supporting flexibility in the workplace, it seems from the interviews and from the literature that flexible working is not forthcoming for midwives and that the only way NQMs in my study were able to negotiate this was to work part-time. The question arises as to whether NQMs should have to work part-time just to be able to remain in the profession.

This is a form of attrition because a midwife who works part-time is not maintaining the whole-time equivalent workforce as this fractional post is often left vacant (RCM, 2022). Part-time working also has a financial effect on the midwives who feel forced into reducing their hours. Working part-time, however, as illustrated by the survey and the interviews, might make the difference between the midwife staying in midwifery and leaving altogether. In my study, four NQMs had opted to work part-time and two had made the decision to leave midwifery. This represents a high rate of attrition in just eleven NQMs within their first two years of qualifying.

5.5.3 Professional Identity and fitting in

The final theme in the section on professional identity relates to the ability of NQMs to 'fit in' or to integrate successfully into their professional environment. In the interviews, NQMs talked about learning to fit into the system to negotiate a successful transition. One NQM said: "*if your face doesn't fit, [you're] not, like, part of the 'in' crowd, you're not part of the clique, or at least if you're not accepted by the clique you just have the worst time"* (NQM 8). This midwife felt that she had learnt to fit in and be accepted, even though she felt that was wrong. The midwife recounted her experience as a student, saying: *'there was a particular midwife who was just absolutely disgusting to me… [as a student]'* but "*as soon as my uniform changed from grey to blue [as an NQM] like she's a gem*" (NQM 8). This midwife felt that suddenly her 'face fitted', although she was aware that this was not the same for other NQMs in her unit.

Being accepted by qualified midwives was not the experience of many of the NQMs. They felt that there was an attitude of 'testing NQMs out', to see whether they were going to fit in or not. This caused them a great deal of stress, leaving them feeling unsupported and alone. As already discussed in Chapter 4, this was sometimes at the cost of safe care for the woman and her baby. One NQM talked about a lack of support from the labour ward coordinator as a form of initiation. The NQM responded, saying "*so when you come to me and say, oh why have you left the room, the placenta's not out? I'm trying to tell you that I need help …and you've decided not to answer the buzzer*" (NQM 5). Several NQMs talked about having to wait

for staff to answer the buzzer or having to call several times before there was a response, even in emergency situations. The NQMs perceived this as being 'tested out', to see if they could deal with an emergency now that they were qualified.

Concepts of NQMs 'fitting in' and being 'tested out' are also found in the literature. In their article about the 'reality shock' of being newly qualified, Kitson Reynolds *et al*. (2014: 665) talk about '*being part of the club*'. NQMs were at the mercy of more senior midwives' idiosyncrasies and were expected to read the mood of these midwives to avoid feeling intimidated by them. This was often stressful and led to low morale. Conversely, Cull *et al*. (2020) identified that feeling part of the team was one of the most important aspects of making a successful transition to newly qualified practice. Where this did not happen, it was seen as a strong element of dissatisfaction in the workplace and one that hindered transition. In their study, one midwife described: "*feeling too intimidated to ask for help"* because she and other NQMs had repeatedly been humiliated in front of other staff (Cull *et al*., 2020: 554). This resonates with experiences of not fitting in and of being humiliated described by some of the NQMs in my own study.

In the interviews for this research, NQMs also described how they had learnt to fit in to make their transition easier. One NQM described how she had been told she was a 'likeable person' so she would fit in. However, she did not support this, saying: '*That should never be a thing, …like no-one should be telling someone "you're a likeable person so you're going to be okay"*' (NQM 8). Another NQM in my study talked about the hierarchy in midwifery, which depended on how experienced you were. She described students as '*the bottom of the food chain'* and said that as one's career progressed, there was greater acceptance and recognition of one's status as a midwife (NQM 11). This resonates with work by Hobbs (2012), who found that NQMs had to fit into the culture of midwifery by adopting the '*habitus*' (defined as 'cultural field': 396) of each practice area. The habitus encompassed entrenched viewpoints, usually of the 'old school' midwives; shared dispositions which included '*fitting into the culture'* (p.391); and new ways of thinking, which was described as NQMs wanting to make a difference (Hobbs, 2012). Although this was an ethnographic study, which included observation of NQMs in practice, the findings around 'fitting in' are very similar to my own.

'Fitting in' was identified as an important element of professional identity as the NQMs in my study then considered themselves (as did their colleagues) to be part of the midwifery workforce. In this sense, preceptorship can be seen as potentially problematic as there is still a 'learner' label attached to NQMs which suggests they are not fully-fledged midwives. From my findings and the literature, it appears they are still vulnerable to being treated differently and to being ostracised by the more experienced midwifery workforce (Hobbs, 2012). Where preceptorship is embraced and viewed positively, however, as part of a midwife's career trajectory, it seems that NQMs are more likely to be accepted and fit in with the existing midwifery staff (Feltham, 2014).

In summary of the theme 'staying the course', the reasons NQMs gave for staying in midwifery are not just the reverse of the difficulties they encountered, which made them consider leaving. The NQMs in my study strongly identified with being a midwife, not just as a job but as a way of life. The theme '*I love midwifery*' encompassed their midwifery work, their relationships with women as well as with colleagues. This was the overriding reason that NQMs chose to stay in midwifery. If they were able to provide continuity of care to women, this appeared to strengthen their commitment and give them even more job satisfaction. Work-related factors also determined their resolve to stay, primarily their ability to work flexibly and their acceptance within the midwifery workforce, which influenced their ability to fit in. If they were given flexible working patterns and if they were seen as fitting in, they were more likely to stay. How these factors are related to personal and professional resilience will be explored in section 6 below. Firstly, the context of London and what midwives said about staying in London will be discussed.

5.5.4 Staying in London

The research for this thesis was focused on four acute Trusts in London, which has undoubtedly influenced the findings. All four Trusts operate busy teaching hospitals; one Trust alone has five maternity units – three consultant units and two stand-alone midwife-led units. There is perhaps more chance of being 'thrown in' as a NQM in inner city teaching hospitals, due to the higher turnover of staff and the complexity of care required for diverse

populations. Both the survey and the interviews asked why midwives chose to stay in London and these findings specific to London will be examined here in the context of resilience.

The survey findings of those who responded to the question '*what is the main reason you choose to stay in London*' identified seven main reasons: I am a Londoner/I love London (17.6%), this is where I live (22%), this is where I work (11%), family and friends (20.3%), diversity of London (6.2%), more career opportunities (8.4%) and financial reasons (10.6%). Reflecting on Mowbray's model of personal resilience in Chapter 2 (Mowbray, 2014), many of these reasons fit the concept of having personal control over oneself or having personal control over responses to others, for instance, self-determination and relationships. Except for career opportunities, the reasons given for staying relate to definitions of personal resilience rather than those of professional resilience.

In the interviews, the NQMs were asked about their reasons for staying in London and their future plans for staying in London. The reasons they gave were the same as those in the survey: either because they were Londoners, their family and friends were here, or because they felt this was where they would gain the best experience. Two NQMs also mentioned that they would be financially worse off if they were to move out of London (due to the additional London weighting payment). Several NQMs, however, said they may move in the next few years, either back to where they or their families were from, or to be able to afford to buy a house or start a family. The only two NQMs who had immediate plans to leave London were those who had already made the decision to leave midwifery. They both had plans to move away from London, one because she was changing career and one for a better quality of life. These midwives had not made the decision to move away from London based on attributes affecting their personal resilience, but based on work-related factors which reduced their professional resilience.

One NQM who was planning to stay talked about the work-related pressures in London and how several NQMs she had worked with had already moved away from London because of the stress of working in a busy, understaffed Trust. Talking about the work-related pressures

of being a midwife in London, she said: '*it's just an absolute onslaught…it's not any particular Trust…it's just London and it's wild, it's a jungle*' (NQM 8). From the interviews, it is difficult to say that the reasons for staying in (or leaving) London were different from any other busy, inner-city maternity unit, but one financial difference was mentioned: London weighting. From the survey and the interviews, it became clear that this is an important incentive for many of the midwives to stay in London.

This section addressing 'why do midwives stay?' has discussed the reasons midwives gave, in both the survey and the interviews, for staying in midwifery. These reasons related to their professional identity and working arrangements. This section has also addressed their reasons for staying in London. The decision to stay relies on factors affecting both personal and professional resilience, with job satisfaction being dependent on positive working relationships and a conducive working environment. It appears that the reasons why midwives decide to stay are determined by the balance between their personal and professional resilience and this will be explored further in the next section.

5.6 Integrating personal and professional resilience

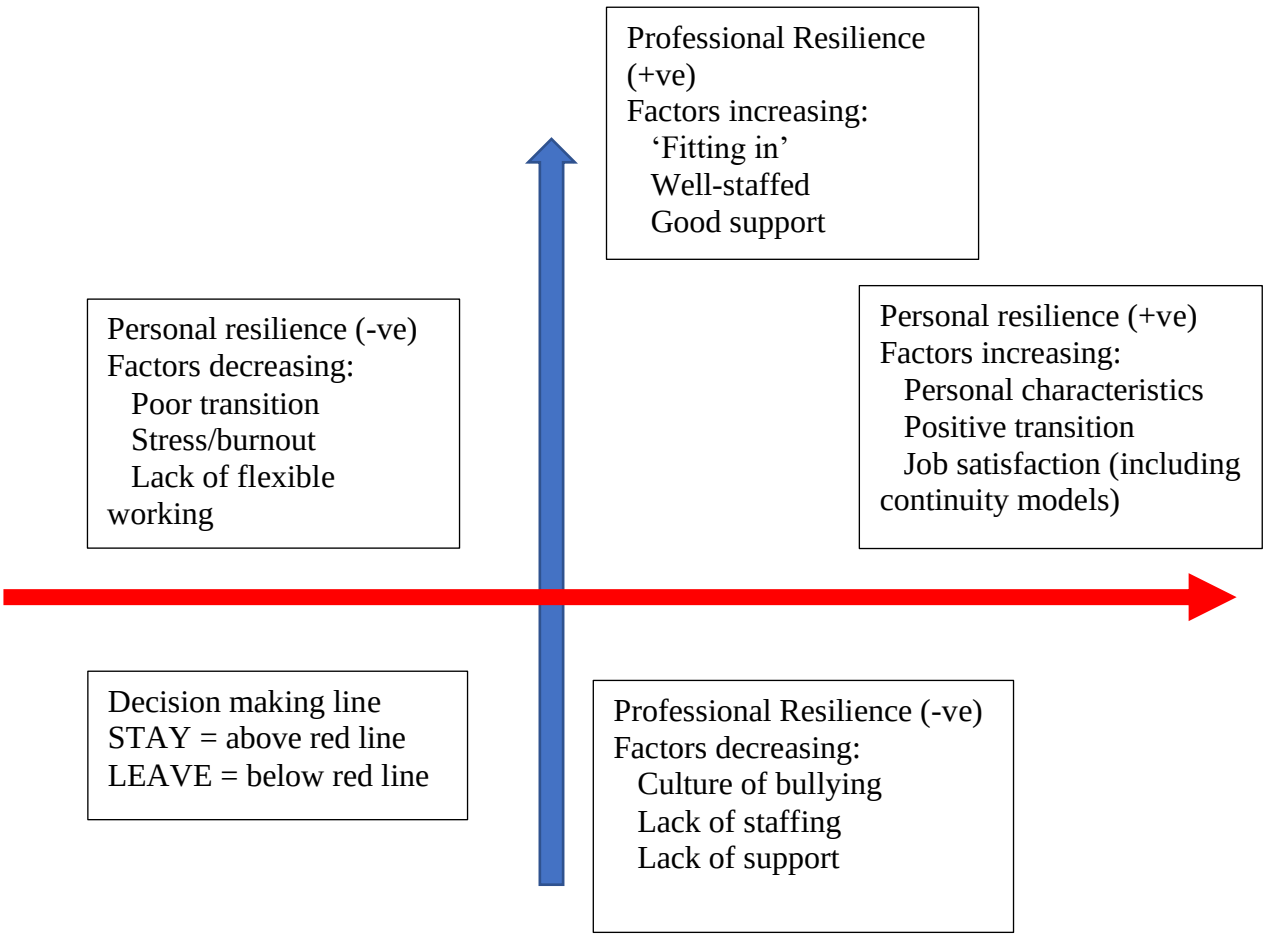
Concepts of personal and professional (or workplace) resilience are intrinsically linked and as the discussion of the data has shown, they cannot be considered in isolation. Nevertheless, in my research, these concepts were addressed separately using two scales (relating to resilience and wellbeing) and the most negatively rated elements in each scale were explored through the interviews. When analysing the data from the scales, only the Bower Midwife Wellbeing Scale was found to be statistically significant to the questions '*Have you considered leaving your post/midwifery in the last six months?*' The personal resilience scale (Connor-Davidson Resilience Scale) was not found to be statistically significant when analysing these questions. The analysis of interview data, however, revealed that both intrinsic characteristics (affecting personal resilience) and extrinsic work-related factors (influencing midwife wellbeing and resilience) were inter-connected and inter-dependent. From these findings, it is proposed that the overall measure of resilience be plotted on a two-dimensional 'resilience' scale. My data indicate that where a person has stronger characteristics of personal resilience,

they may be able to withstand greater adverse professional or workplace conditions. If their personal resilience is lower, they may be less able to cope with adverse working conditions, demonstrating lower professional resilience.

The relationship between personal and professional resilience found in my research can be illustrated by the retention model below. This identifies the positive and negative elements of both personal and professional resilience found in the survey and interviews. The model draws together aspects of personal and professional resilience that are more or less likely to enable NQMs to remain in midwifery. It illustrates pictorially how the relationship between personal and professional resilience influences this decision. In the survey, the Connor-Davidson Resilience score did not affect the midwives' intention to leave. The NQM's personal resilience score is therefore plotted above the red (stay) line. The Bower Midwife Wellbeing score illustrating professional resilience, however, was the most significant predictor of whether the midwife had considered leaving, so the NQM's mean midwife wellbeing score is plotted against the vertical line. If the NQM's midwife wellbeing score is above the red line, it is hypothesised they are most likely to stay. If they have low professional resilience and their score falls below the red line, it may be predicted that they are most likely to leave. Given that personal resilience, however, has been shown to influence professional resilience, the relationship between personal and professional resilience also needs to be considered in the model. This will be discussed below, although further research would be required to test this hypothesis.

The model below (Figure 5.3) illustrates the findings from the survey that an increased midwife wellbeing score is more likely to predict that midwives have not thought of leaving either their post or midwifery. None of the midwives, however, who completed the survey had yet left midwifery as they were required to be in post to access it. It is not known how many of the midwives in the survey went on to leave as there was no follow-up to the initial survey. This would be useful to include in future research. It is therefore of interest to look at the NQMs' scores in depth as more is known about both their intentions and their state of employment at the time of the interviews. For instance, it is known that two of the NQMs were planning to leave.

Figure 5.3 CONCEPTUAL MODEL OF RESILIENCE



The NQMs who were interviewed can be identified in the survey data because they gave consent to be interviewed, thereby forming a sub-set of data. Having identified them, their individual personal resilience and midwife wellbeing (representing professional resilience) scores were calculated and the relationship between their scores and their intention to stay or leave (as expressed at interview) was mapped. The mean score for each NQM for each element of the scales was calculated out of a possible score of 5. The total score was divided by the number of elements, which gave each NQM a mean score (out of 5) for each scale. Before plotting these scores, consideration needed to be given to where the decision line was placed on the professional resilience scale, and at what mean score a NQM might consider leaving. It was hypothesised that an average professional resilience score of 3 out of 5 (the neutral point on the scale) might be the point below which NQMs decide to leave, but examining the data from the NQMs, it was found that this decision may, in fact, be inter-dependent with the personal resilience score of the NQM as well. This will be explained through case studies below.

All the NQMs who were interviewed had personal resilience scores above 3. Seven of the NQMs also had professional resilience scores above 3 and all seven of these midwives were planning to stay in midwifery. Four of the NQMs who were interviewed had professional resilience scores below 3 (meaning that they were more likely to disagree or strongly disagree with the work-related statements in the Bower Midwife Wellbeing Scale). This was an indication that their professional resilience was low, in other words that adverse working conditions affected their perception of these statements. These four midwives and their individual circumstances will be used as case studies below (see Table 5.1).

Table 5.1 Relationship between personal and professional resilience scores

NQM	Personal resilience score	Professional resilience score
2	5.0	2.5
3	4.0	2.4
6	3.1	2.0
7	4.1	1.7

Key: Green = intending to stay; orange = intending to leave

NQM 2: Although this midwife had a low midwife wellbeing score, her personal resilience score was very high. She had chosen to work part-time as a clinical midwife and part-time as a research midwife. She felt the balance between the two roles enabled her to stay in midwifery and spoke about not being able to imagine leaving midwifery. It seems that her abundance of personal resilience had helped her to make changes to her working conditions (improving her professional resilience) to make it possible for her to stay.

NQM 3: The personal resilience score for this midwife was relatively high, although her midwife wellbeing score was below 3. She had found the bullying culture particularly difficult during her preceptorship period and felt that she had been subjected to bullying by one of her managers. She had made the decision to take time out of midwifery and was planning to leave her post imminently. Passionate about midwifery, she was determined to return to midwifery practice after taking time out but was not planning to remain in London.

NQM 6: This midwife had a relatively low personal resilience score (just above 3) as well as a low midwife wellbeing score. She was working in a caseload team, so the fact that her professional resilience was low is perhaps surprising, as she talked about the personal and professional benefits of working in a continuity model. However, she had also experienced bullying and spoke at length in the interview about the negative effect this had had on her. She spoke passionately about being a midwife but was not planning to stay in midwifery long term and talked about becoming a health visitor in the future. Whether her low personal resilience was the reason for not having made any changes yet will be discussed below.

NQM 7: This midwife had a relatively high personal resilience score, although her midwife wellbeing score was the lowest of all NQMs. She had made the decision to leave midwifery and had already handed in her notice. She stated the main reason for leaving was because of poor culture and staffing, which explained her low professional resilience. She had a place to study medicine and felt she would have more opportunities in that profession. It seems that her high personal resilience enabled her to make changes to her situation despite poor professional resilience, even though this meant her leaving midwifery.

From such a small number of NQMs, it is difficult to draw firm conclusions about the accuracy or interpretation of these scores, but it is possible to propose the model with some evidence of theoretical and experiential underpinning. It seems that a low score on the Bower Midwife Wellbeing Scale required the NQMs to make changes to their working environment, either to enable them to stay in midwifery or to make the decision to leave. All four NQMs with low midwife wellbeing scores had adapted – or were planning to adapt – their working conditions to improve the factors they perceived to be affecting their professional resilience. The midwife who had the lowest midwife wellbeing score (less than 2) had made the decision to leave midwifery. This is a potentially significant finding, albeit in a small number of NQMs, and would be worth investigating in a future study on a larger scale. This will be discussed in the next chapter.

These case studies also pose another question: whether midwives have resilience to stay or resilience to leave. In other words, can resilience function in both directions and enable midwives to stay or to leave? The findings of the survey demonstrate that higher professional resilience protects midwives from thinking of leaving, but this was not the whole picture. The data demonstrate that having low professional resilience is a stimulus to change. All four of the midwives with less than neutral professional resilience (defined by a mean Bower Midwife Wellbeing score of less than 3) had made changes to their working arrangements or were planning to leave. However, two made the decision to stay, at least for the immediate future, whereas two made the decision to leave. Interestingly, the NQM with the lowest personal resilience had not yet made any changes, which raises the question of whether high personal resilience is also required for midwives to take action, despite having a low level of professional resilience. All three midwives who had made changes or were planning imminent changes had a personal resilience score of above 4, demonstrating high personal resilience. The relationship between personal and professional resilience should be explored in future research and forms one of the recommendations in the next chapter.

In summary, the results from the survey and the interviews, when brought together, demonstrate that the key factor to staying in midwifery is the level of professional resilience

indicated by the Bower Midwife Wellbeing mean score. It is clear from my research as well as from the literature, however, that there is an interdependent relationship between personal and professional resilience. Given this inter-relationship, if professional resilience is to be improved, factors that improve personal resilience, as well as improving adverse working conditions, need to be addressed. This is supported by the findings of this research and the literature. The role of education in building resilience will be considered in the next chapter.

The final chapter will summarise the findings from my research and discuss the recommendations arising from this work. The recommendations will draw on the factors identified in the research that enable NQMs to stay. Recommendations will be considered under the headings education, research, policy and practice. The chapter will also identify issues relating to both personal and professional resilience for NQMs, making recommendations about developing resilience, so that retention of this crucial group of midwives can be improved.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This thesis started with the overarching question: 'Why do newly qualified midwives (NQMs) choose to stay in London?' Currently, midwives are leaving the profession in greater numbers than in previous years (Bonar, 2023; NHS Digital, 2022). According to NMC data, this is particularly true of NQMs (Nursing and Midwifery Council, 2022). The highest vacancy rate for midwives in all areas of the UK is in London (NHS Digital, 2022). Whilst much research has taken place into why midwives leave, there has been very little investigation, particularly in the UK, into why midwives stay. There has been no investigation in London, or in the UK, about the factors that enable NQMs to stay in midwifery. Given that NQMs form the future workforce, it is important to understand what these factors are so that strategies can be put in place to keep these midwives in midwifery. This is particularly relevant to London where one in eight midwifery posts is vacant (NHS Digital, 2022).

In this mixed methods study, three research questions formed the basis of my research:

1. What are the internal and external factors that enable midwives in London to remain in post?
2. What are the personal and professional attributes that influence newly qualified midwives in London to remain in post?
3. What is the relationship between personal and professional resilience and the decision of newly qualified midwives to remain in post?

This chapter summarises the research findings and discusses how these influence policy, practice, education and research. The chapter identifies the original contribution of this research to policy and practice and how this might influence improvements in the retention of NQMs. It also addresses the limitations of the study and my own personal journey during the research. It concludes by discussing a resilience model, developed from this research, which could be used to predict which NQMs are more likely to stay in midwifery and which of them may need more support. There is then a post-script which outlines recent maternity

reports and their relevance to my thesis, given their publication during and subsequent to my research.

6.1 Summary of findings

The research gathered both quantitative (survey) and qualitative (interviews) data. The survey was distributed to all midwives in four London Trusts (n= 1,502), with a 16.3% response rate (n = 248). Using the 10-item Connor-Davidson Resilience Scale, which has been previously validated (Campbell-Sills and Stein, 2007), and the Bower Midwife Wellbeing Scale, developed for this research, the survey addressed the first research question: *what are the internal and external factors that enable midwives in London to remain in post?* The Connor-Davidson resilience scale measured personal attributes (personal resilience) and the Bower Midwife Wellbeing Scale measured midwives' reactions to work-related factors (midwife workplace wellbeing, inferring a measure of ongoing professional resilience). Logistic regression was used to analyse the relationship between both scores and whether midwives had considered leaving their post/midwifery/London in the last six months. The data revealed an association between high professional resilience and intention to stay; the higher the Bower Midwife Wellbeing score, the less likely midwives were to have considered leaving their role within the past six months.

Interviews with NQMs were conducted to answer the second research question: *what are the personal and professional attributes that influence newly qualified midwives in London to remain in post?* The interviews were used to explore their transition from midwifery student to professional midwifery practice. The aim of the interviews was to uncover the factors that had influenced NQMs to stay in midwifery in the two years after qualifying. Integrating the findings from the survey, the two statements from each scale that had scored the most negatively were identified. These statements related to midwives' responses to failure, stress, shortage of staff and bullying at work. NQMs were asked about the statements in the interviews. They were also asked why they had chosen to stay in midwifery. When asked why they had chosen to stay, all NQMs talked about their professional identity as a midwife, expressed through job satisfaction, their love of midwifery and their positive relationships

with women. These defining factors of professional identity are also supported by the literature (Kirkham *et al*., 2006; Bloxsome *et al*., 2019).

The interview data also revealed that the participants had all experienced sub-optimal working conditions that had made their transition to professional practice challenging. Conditions included poor workplace culture, inadequate staffing levels, inflexible working patterns, and lack of support. Experiences of transition were expressed using water metaphors and analogies, such as '*sink or swim*', keeping one's '*head above water*' and '*paddling like mad*'. NQMs have also described the transitional period using water analogies in previous research (Hughes and Fraser, 2011; Fenwick *et al*., 2012). The most negative finding from my interviews was that all eleven NQMs had either experienced bullying themselves or had witnessed it happening to other NQMs. For two NQMs, this had been the overriding factor in making the decision to leave midwifery, at least temporarily. Despite this, nine of the eleven NQMs had made a successful transition to qualified practice and were planning to stay in midwifery, at least for the foreseeable future. A summary of the findings from the research questions can be found in Table 6.1.

Table 6.1 Summary of findings from research questions

Research question	Methodology	Findings
What are the internal and external factors that enable midwives in London to remain in post?	Survey: Connor-Davidson Resilience Scale and Bower Midwife Wellbeing Scale	Lowest mean scores for statements relating to failure, stress, shortage of staff and bullying at work – explored in interviews
What are the personal and professional attributes that influence newly qualified midwives in London to remain in post?	Interviews: experience of transition to NQM, why they had chosen to stay and two most negative statements from both scales	Positive finding: All midwives had a strong sense of professional identity (I love midwifery). Negative finding: all NQMs had experienced or witnessed bullying of NQMs
What is the relationship between personal and professional resilience and the decision of newly qualified midwives to remain in post?	Mixed methods: integration of data from survey and interviews	Relationship between personal and professional resilience: high Bower Midwife Wellbeing score = NQMs more likely to consider staying in midwifery

Integrating the findings from the survey and the interviews generated an in-depth exploration of the relationship between personal and professional resilience. All three research questions were addressed by relating their findings to NQMs' decisions about staying in midwifery. The survey demonstrated a significant relationship between low professional resilience (Bower Midwife Wellbeing Scale) and thinking of leaving, but there was no relationship between personal resilience (Connor-Davidson Resilience Scale) and midwives thinking of leaving. It is acknowledged, however, both from my research and in the literature, that personal and professional resilience are inextricably linked (Scammell, 2017).

The integration of these findings is used to propose a resilience model for NQMs, as outlined in Figure 5.3 (see previous chapter). NQMs with a mean Bower Midwife Wellbeing score of lower than 3 could be identified as having low professional resilience. The findings show that midwives with an overall score of less than 3 are less likely to stay in post/midwifery and if they stay, are more likely to make changes to their working conditions. This finding is unique to my study because the Bower Midwife Wellbeing Scale was developed for this research. The results in this study are based on small numbers, however, and these findings need further exploration. What is clear is that additional support should be offered to those with low professional resilience, whilst also paying attention to the workplace factors that may be responsible for this. These findings will be explored further through the recommendations.

6.2 Original contribution: Why NQMs stay and resilience

The originality of my work lies in demonstrating the relationship between NQMs who choose to stay in midwifery and their resilience. Through the research, two categories of resilience have been identified and explored: personal resilience (determined by personal characteristics required to overcome adversity) and professional resilience (determined by working conditions that are conducive to staying). Through the survey, my research identified that low professional resilience (measured using the Bower Midwife Wellbeing Scale) was the only significant factor predicting whether midwives had thought of leaving their post or leaving midwifery in the last six months. In the survey, there was no correlation between

midwives' personal resilience scores (measured using the Connor-Davidson Resilience Scale) and the thought of leaving their post or midwifery.

The interviews shed further light on the survey findings. My research showed that NQMs with a high score in both personal resilience (Connor-Davidson Resilience Scale) and professional resilience (Bower Midwife Wellbeing Scale) were more likely to stay in midwifery. The findings also showed that a low Bower Midwife Wellbeing score appeared to be the trigger for NQMs to decide to leave their post or to leave midwifery and that their ability to make this change was dependent on their level of personal resilience. Those with high personal resilience and low professional resilience were more able to make work-related changes, either to leave their post or leave midwifery, whereas those with both low personal and professional resilience were less likely to be able to make a change to their situation. Given such small numbers of NQMs in the interviews, these findings need further exploration. There is no previous work on the relationship between NQMs, resilience and intention to stay in or leave midwifery (specifically in London), so this research provides a unique perspective on why NQMs in London choose to stay.

Analysis of the literature revealed that international evidence focuses on why midwives leave (Ball *et al*., 2002; Cameron, 2011; Leversidge, 2016; Perry *et al*., 2017; Harvie *et al*., 2019). Existing research investigating why midwives stay is either outdated or was not conducted in the UK (Kirkham *et al*., 2006; Sullivan *et al*., 2011; Alnuaimi *et al*., 2020; Bloxsome *et al*., 2020). Reasons for both students and NQMs leaving the profession have also been researched (Cameron *et al.*, 2011; Bacchus and Firth, 2017) but no research has examined the factors that influence NQMs to stay, and specifically in London. London is of particular interest because, as identified previously, the vacancy factor in midwifery in London is higher than anywhere else in the UK (NHS Digital, 2022). The relationship between NQMs, intention to stay and resilience has never been explored, providing a gap in the evidence to which my research has now contributed.

It is clear from my research, including the literature review, that there is an interdependent relationship between personal and professional resilience. As my study shows, if professional resilience is to be improved, factors that enable development of personal resilience, as well as working conditions that affect professional resilience, also need to be improved. The recommendations arising from this research will, therefore, address issues relating to both personal and professional resilience for NQMs with the aim of increasing retention. Recommendations are discussed below in sections 6.3–6.6 under the headings of education, practice, policy and research.

6.2.1 Considerations and limitations of the research and personal research journey

This section discusses the considerations and limitations of my research, contextualising this within my personal journey. One of the major influences on the research was the timing of the pandemic. The survey was due to be launched just as COVID-19 was becoming a concern, and the decision made to delay the launch was, in hindsight, a positive one. The effect of the pandemic on healthcare and healthcare education was seismic. As a midwifery lecturer at that time, pausing my studies gave me the time and opportunity to focus on the needs of our healthcare students. I did not feel it was appropriate to distribute the survey until November 2020, which was timely as it went out just before the second major wave of COVID-19 infection in December 2020. However, the second wave also meant delaying the interviews, so these were not commenced until March 2021. This meant that my timeframe slipped by almost a year.

During the pandemic, all research interactions went online; I was, therefore, able to reapply for ethical approval to hold my interviews and/or focus groups via Microsoft Teams. This meant I was able to fit interviews around midwives' individual needs, although it also resulted in arranging interviews rather than focus groups as trying to get four or more NQMs together online proved an impossibility. I was able to interview three pairs of midwives together, which created better discussion than interviewing midwives individually but may have prevented honest opinion if the participants had no previous relationship. In fact, two of the three pairs knew one another well and the interviews were lively and candid.

There has been much discussion about the pros and cons of being an 'insider' researcher (Ellis-Caird, 2017; Wood 2021). As I am also a midwife, the NQMs assumed a shared language during the interviews, meaning they were able to use midwifery jargon in the knowledge that I would understand. This created economy of time as the NQMs did not have to spend time explaining midwifery terms and nuances of practice. As a midwifery lecturer, I was also aware that I was in a more senior position to the NQMs and, indeed, two of the participants coincidentally had been my students. There was no current relationship with any of them and it could be assumed by their voluntary participation in the interviews that they did not feel inhibited by this. The potential influence that this had on the research, however, should be noted as a possible limitation.

Ellis-Caird (2017) discusses the problematic aspects of 'insider' research for the outsider. She states that although the 'insider' perspective allows for understanding and nuances of the specialism, this may be at the cost of excluding the 'outsider' who is reading the research and lacks such 'insider' knowledge. My research was supervised by two nurses and one educationist; therefore, none of my supervisors was a midwife. Their viewpoints have provided 'outsider 'perspectives; taking account of their feedback has required me to be more explicit about midwifery nuances that, as an 'insider', I had taken for granted. This was useful learning and will be beneficial when publishing future work in non-midwifery-specific journals.

As a doctoral student, I am at the beginning of my research career. I was very helpfully told at the beginning of the doctoral process that this journey was a 'training ground' for becoming a researcher. This has enabled me to take risks in the research process by choosing a mixed-methods approach that challenged me and has enabled me to develop a wide range of methodological skills. Development of some skills may have been limited by being a doctoral student, and by being the sole researcher in the process. The process of applied thematic analysis, for instance, would have benefited from having two researchers cross-check the themes identified, but this is not possible within the context of a doctoral study. Undertaking a mixed-methods study, despite its complexities, has been a positive learning experience and

will provide me with good foundations for future such studies. My lack of experience in this methodology has been a limitation to the study but with good supervision, I believe the research has provided useful and worthwhile findings that have the potential to impact future midwifery education, practice, policy and research. Based on these findings, the recommendations of the study are now discussed.

6.3. Recommendations for midwifery education

6.3.1 Developing personal resilience in midwifery education

As discussed previously, there is a gap between expectations and reality of the transition to newly qualified practice which has been identified in the literature over a long period of time (Newton and McKenna, 2007; Dyess, 2009; Ashforth and Kitson-Reynolds, 2019). My research demonstrates that a successful transition to newly qualified midwifery practice depends, amongst other factors, on the NQMs' level of personal resilience. Thomas (2018) suggests that the resilience of an organisation is determined by the personal resilience of its workforce. It follows that by increasing personal resilience in individuals, there will be a consequential increase in the resilience of an organisation. This suggests it could be beneficial to the retention of NQMs in maternity services if the personal resilience of individual midwives is strengthened and developed.

The literature review in Chapter 2 considered whether resilience is inherent in the individual or whether it can be learnt (Rogers, 2016). It is widely reported that personal resilience can be developed, which is of direct relevance to midwifery education (Jackson *et al*., 2007; Williams, 2021). My research concurs with previous literature in finding that personal and professional resilience are inextricably linked (Scammell, 2017; Yu *et al*., 2019). Strengthening personal resilience would, therefore, appear to strengthen NQMs' ability to deal with factors affecting professional or organisational resilience. This is of significance for pre-registration midwifery programmes because strengthening the resilience of midwifery students would enhance their resilience as NQMs.

Stress and burnout were found to undermine midwife wellbeing and therefore professional resilience in the NQMs in my study. A review of the literature of psychological interventions to strengthen resilience in healthcare students showed that these had some positive effect on reducing stress and anxiety (Kunzler *et al.*, 2020). The literature also suggests strategies and models to improve resilience in students with the aim of preventing attrition of newly qualified practitioners (Avrech Bar *et al*., 2018; Williams and Hadley, 2022). The work of Hunter and Warren (2014) on resilience in midwifery made clear recommendations for pre-

registration programmes to strengthen resilience during midwifery students' education. These recommendations included strengthening professional identity, developing self-awareness and strengthening the use of reflection throughout the programme. Sun *et al*. (2022) also support the idea of developing professional identity during pre-registration midwifery education to prevent attrition. These findings resonate with my own work because strong professional identity was found to be a crucial factor in determining that NQMs intended to stay in the profession.

A key recommendation from my research, therefore, is to develop personal resilience training, structured around the resilience model developed from this work (Figure 5.3). The purpose of my research does not extend to developing detailed resilience training, but training should include addressing the personal resilience characteristics that were most negatively rated by the Connor-Davidson Resilience Scale in my survey (dealing with stress and overcoming a sense of failure) as well as strengthening professional identity. For instance, the MaRIS model developed by Chan *et al*. (2020) used contemplative pedagogy to develop personal resilience in medical students to overcome unavoidable stressors. This could be adapted by pre-registration midwifery programmes to build personal resilience prior to qualification with the aim of preventing attrition in the early career period.

> **Þ Recommendation:**
>
> ***It is recommended that personal resilience training be developed (using the resiliency model in Figure 5.3 as a framework) in all midwifery pre-registration programmes to strengthen professional identity and to improve students' response to stressful situations and sense of failure.***

6.3.3 Developing professional resilience in midwifery education

In addition to strengthening personal resilience during pre-registration midwifery programmes, it is also worth considering how to improve the resilience of students (in preparation for becoming NQMs) in the workplace. My research demonstrated that several factors undermine professional or workplace resilience in NQMs. These factors could be addressed through pre-registration education to mitigate the 'culture shock', identified by

the NQMs through the interviews, when joining the workforce. The workplace factors that were most negatively scored in the survey were poor staffing levels and bullying at work. In the interviews with NQMs, the culture of bullying was identified as a key reason for considering leaving the profession. Whilst these are organisational issues, and pre-registration midwifery education may not be able to address staffing levels and bullying directly, students can be better prepared to withstand and to challenge these situations.

Midwifery students, like NQMs, have also been found to experience bullying in the workplace (Hakojärvi *et al*., 2014; Capper *et al*., 2020, 2021). Many of the NQMs in my study spoke about the bullying they had experienced as students, in addition to that they had been subjected to as NQMs. Capper *et al*. (2021) identify how midwifery students learnt to accept the culture of bullying by learning to socialise into this culture. The culture is then perpetuated when they become NQMs. This does not address or change the negative culture within midwifery. Instead, Hakojärvi *et al*. (2014) suggest that healthcare students should be given training to cope with bullying and to challenge this behaviour. One method of enabling students to cope with bullying in the workplace has been developed using blended learning (Hogan *et al.*, 2018). This appears to have been successful because students were able to share their experiences and therefore receive support. As the authors state, it would be better to prevent bullying in the first place, and research identifying mechanisms to prevent bullying of students is much needed (Hogan *et al.*, 2018).

The evidence, both through my study and through the literature, demonstrates that students and NQMs experience bullying. Preventing this culture within midwifery is a long-term goal and, indeed, informs the recommendations from recent maternity services reports (Independent Maternity Review, 2022; Kirkup, 2022). Meanwhile, NQMs need tools to cope with this culture, along with the other adverse working conditions identified through my research. If students can be taught tools and techniques to manage and overcome workplace adversities during their pre-registration training, it is likely they will have greater professional resilience when they enter the workforce as NQMs. In turn, this is likely to improve the retention of NQMs in the midwifery workplace in the future.

Þ Recommendation:

It is recommended that professional resilience be developed (also using the resiliency model in Figure 5.3 as a framework) in all midwifery pre-registration programmes to provide techniques to manage and challenge adverse working conditions and poor workplace culture, such as bullying.

6.4 Recommendations for practice

6.4.1 Job satisfaction

Job satisfaction is the main reason given by the NQMs in my study for staying in midwifery. This is expressed as a love of midwifery based on the ability to develop professional relationships with women. The NQMs stated that this was difficult in areas with shortage of staff, high workloads and high turnover of women such as the ante/postnatal ward. They felt that it was difficult to form meaningful relationships with women in this environment and this resulted in job dissatisfaction as well as stress and burnout. NQMs felt they were unable to be the midwife they aspired to be and that at times, primarily due to poor staffing levels, the working environment was unsafe.

Where NQMs were already working in continuity of care teams, they expressed high levels of job satisfaction and an intention to stay in midwifery. Two of the NQMs interviewed stated that this was the main reason they were still in midwifery. The benefit of working in continuity of care and caseload models is supported by evidence from the UK and from Australia, as identified in the literature review (Griffiths *et al*., 2019a; Wilson *et al*., 2020). From their research, Griffiths *et. al.* (2019: 5) stated:

> *'New midwives must be supported to transition straight into caseload models for which they are well prepared. The lack of opportunity to work in this way could contribute to attrition from the profession if not addressed.'*

The necessity to experience continuity of care and carer is written into the Nursing and Midwifery Council Standards for pre-registration midwifery and is a requirement of all pre-registration midwifery education programmes in the UK (Nursing and Midwifery Council,

2019b). All NQMs, therefore, will have had experience of working in continuity of carer environments as a student. If this model of care improves job satisfaction and, therefore, increases midwifery retention, it would seem obvious that preceptorship should include working in continuity models of care and that NQMs should be facilitated to work in this way. The recent Ockenden Report, however, recommends that NQMs should not work in continuity teams for their first year of practice until staffing levels in midwifery have improved (Independent Maternity Review, 2022).

From my research and from the existing evidence, working in continuity of carer settings is the key to job satisfaction and, therefore, retention of midwives in the first few years of their career. The NQMs in my study discussed how continuity of carer models developed their professional identity and this is one of the key elements in improving professional resilience. It is imperative to improve midwifery staffing levels so that continuity of carer teams can be used safely to support the development of NQMs in this setting during their preceptorship period (RCM, 2022).

> **Þ Recommendation:**
>
> ***It is recommended that preceptorship programmes include the option to work within continuity of carer models. This has been demonstrated to increase job satisfaction in NQMs, thereby improving their professional identity, which is known to increase professional resilience and potentially improve retention of NQMs.***

6.4.2 Preceptorship

Preceptorship is an important transition period during which the NQM already has the knowledge and competence required to register as a midwife but still needs to develop her skills and experience to meet the challenges of qualified practice. The NMC has compiled preceptorship principles as previously discussed (Nursing and Midwifery Council, 2020), but these do not have the status of 'standards' and are, therefore, not compulsory. Other organisations have produced principles and guidance for the standardisation of preceptorship programmes, such as NHS England (NHS England, 2023), the Royal College of Midwives (Royal College of Midwives, 2022) and (of relevance to this London-based study) the Capital Midwife

Preceptorship Framework (Health Education England and NHS England and NHS Improvement, 2019). Despite these publications, my findings support the literature, demonstrating that preceptorship programmes vary widely and are not always implemented due to staff shortages and high workloads (Mason and Davies, 2013; Wain, 2017).

In the interviews, NQMs expressed that they need more support than they are receiving to meet the challenges of newly qualified practice and to make a successful transition to becoming a midwife. In the literature, adequate support was also cited as a key requirement in ensuring NQMs had a positive transition to professional practice (Feltham, 2014). Most NQMs experienced a lack of support or support that was withdrawn too early. Although the role of the preceptor midwives (midwives employed to support preceptees) was viewed positively, the support from this role was usually only available Monday to Friday and one midwife in this role was often not sufficient to support the number of preceptees within each Trust. NQMs in the interviews also stated that support was not available when staffing was inadequate, and they were then left on their own without the support that was expected or required. This was also the result of a predominantly junior workforce.

All the NQMs from my interviews were still working as a midwife after their initial preceptorship year, but the two midwives who decided to leave midwifery did so after this first year. Anecdotally, the NQMs told me this was also the case for a significant number of their peers; they survived the first year of transition as a NQM but then made the decision to leave after their preceptorship period. This poses the question as to whether one year is long enough to make the transition to newly qualified practice and to ensure long-term retention of NQMs. Given the vulnerability of this period, it could be suggested that the period of transition needs to be more individualised with the option to extend for more than one year. Recent literature has introduced the term 'early career midwives', although this definition includes those who qualified anywhere between one and seven years, depending on the country and the research (Bryce *et al*., 2017; Woeber and Sibley, 2018; Cull *et al.*, 2020; Reeves, 2022). The Royal College of Midwives is leading a project to support early career midwives which spans the first three years after qualification (Royal College of Midwives,

2023). Extending the length of time support is offered to NQMs needs to be explored further, but NQMs should be given better and protected support, which is individualised and develops their autonomy and independence.

> **Þ Recommendation:**
>
> **It is recommended that NQMs receive consistent and protected support during their preceptorship period, with a standardised and structured preceptorship package. Support should be individualised during the preceptorship period and the opportunity to extend the length of time graded support is available should be considered for all NQMs.**

6.4.3 Culture of bullying

The culture of bullying directed towards NQMs was personally experienced or witnessed by all eleven NQMs interviewed in my research. This is a significant – and unacceptable – finding but it resonates with both the midwifery literature (Gillen *et al.*, 2017; Newman, 2019) and recent reports on maternity services (Kirkup, 2022; Independent Maternity Review, 2022). Workplace culture and bullying was the main reason given by two of the eleven NQMs interviewed for making the decision to leave midwifery. If this were to be replicated across all NQMs, 18% of NQMs would leave within the first two years because of poor workplace culture. This is a very high cost, both to the NHS who has supported their supervision as both student and NQM, and to the individual NQM who has invested in midwifery education.

Following a recent survey of NHS staff, the subsequent report states that '*levels of violence and bullying and harassment… remained unacceptably high*'(NHS England, 2022b: 1). The report identifies a culture of bullying within the NHS that goes well beyond midwifery. In a recent NMC report surveying nurses and midwives leaving the register (Nursing and Midwifery Council, 2022a), over one-fifth (21.3%) of those leaving cited workplace culture as the main reason, with 4.8% specifically identifying bullying as their reason for leaving. This was exacerbated by a shortage of staff. One midwife in the NMC report was quoted as saying: *"I have concerns for the newly qualified midwives and feel they will "burn out" very quickly despite being very motivated."* (Nursing and Midwifery Council, 2022a: 15)

My findings add to the findings of previous research and reports, that a culture of bullying pervades midwifery settings. Despite the many studies on this subject, it is still astonishing to hear first-hand the level of bullying experienced or witnessed, with NQMs being particularly vulnerable. Bullying is manifested in the way NQMs are spoken to and treated by both peers and managers, and by a wilful lack of support in their transition to newly qualified practice. What my work adds to this discussion is the concept of resilience. If NQMs have the personal and professional resilience to overcome this culture, they are more likely to get through the transition and stay in midwifery. If they lack the personal and professional resilience to overcome this period, or the bullying culture is severe, they reach a tipping point where they can no longer sustain practising as a midwife and they make the decision to leave midwifery. This finding highlights the previous discussion about organisational failures being blamed on individuals. Given the severity and adverse consequences of a poor culture in midwifery, not just in my own research, but in the findings of investigations such as the recent Ockenden Report (Independent Maternity Review, 2022), it is time to challenge this culture and to take more decisive action. If the culture of bullying in midwifery continues to be ignored, it follows that midwives, particularly NQMs, will decide not to stay.

It is clear from several recent reports that workplace culture and bullying are endemic within the NHS and midwifery is an area of particular concern. Although this has been identified over many decades (Hadikin, 2001; Curtis *et al*., 2006d; Gent, 2018) it seems from my research that there has been no improvement in the midwifery culture. There is recent and patchy interest in tackling such culture through efforts such as bystander training (Haynes-Baratz *et al.*, 2021), but this is unevaluated. Further work on such training is needed if NQMs are to be retained and workplace culture must be addressed as a priority.

Þ Recommendation:

It is recommended that clear strategies be developed to address the culture of bullying in midwifery and specifically towards NQMs, and that this includes workplace cultural training for all midwives of all grades.

6.4.4 Inadequate staffing

Poor staffing was cited by the NQMs in my study as one of the most negative aspects of their preceptorship period. It has also been cited as one of the main factors influencing poor maternity care in recent reports (Kirkup, 2022; Independent Maternity Review, 2022). A recent NMC report identified that the number of midwives leaving the NMC register had increased for the first time in five years, with numbers joining the register almost static, unlike any of the other professions (Nursing and Midwifery Council, 2022b). From the most recent NHS data, this trend appears to be continuing (NHS Digital, 2023). In the NMC's Leavers' Report, midwives were more likely than other professional groups to cite too much pressure (23%), stress and mental health as the reasons for leaving the register (Nursing and Midwifery Council, 2022a). In a recent RCM survey, 57% of midwives surveyed said they were considering leaving in the next 12 months, with more than 8 out of 10 of those leaving or considering leaving concerned about poor staffing levels (Walton, 2021). The group of midwives most likely to express dissatisfaction with working conditions were those who had been qualified for five years or less. The most recent data show that midwife numbers have reduced further, despite efforts to increase the number of students entering midwifery education (Bonar, 2023). Bonar (2023) states this is of great concern, not only for current staffing levels and the safety of maternity services, but also for future workforce planning.

> **Þ Recommendation:**
>
> **It is recommended that adequate midwifery staffing levels be addressed as a matter of urgency as this is a significant cause of intention to leave and attrition amongst NQMs and early career midwives.**

6.5 Recommendations for Research

One of the most significant findings from the survey data in my research is the predictive relationship between the Bower Midwife Wellbeing Scale and midwives thinking of leaving midwifery. Midwives who had a lower mean Bower score were significantly more likely to have thought of leaving their post and the midwifery profession in the last six months. When exploring this finding with the NQMs, having a low Bower score was also indicative of either intending to or actually leaving their post or the midwifery profession. It is proposed that the

Bower Midwife Wellbeing Scale developed for this research be further tested and developed with a larger sample of NQMs to see whether these findings are replicated on a wider scale. If this is the case, the Bower Midwife Wellbeing Scale could be used as a screening tool for NQMs to determine their resilience to stay in midwifery. It would also be useful to compare this scale with existing validated tools that assess workplace wellbeing, such as the Practice Environment Scale (Pallant *et al*., 2016), which has already been used with midwives.

The literature on professional resilience supports these findings, that lower ability to adapt to adverse workplace conditions is more likely to result in midwives (and other healthcare professionals) leaving the profession (Hunter and Warren, 2014; Huey and Palaganas, 2020). The development of a scale that predicts those who might leave and those who are more adapted to stay, however, is unique to this research. This finding has implications for retention in the midwifery profession. If the Bower Midwife Wellbeing Scale can be developed to detect those who have low midwife wellbeing and therefore professional resilience, and are more likely to consider leaving the profession, targeted interventions might be used for these individuals to prevent them from leaving and to increase retention of NQMs. This will be revisited in the policy section below.

The relationship between the personal resilience and midwife wellbeing scales also needs further exploration. It appears from my interview findings that the combination of low professional resilience (Bower Midwife Wellbeing Scale) and high personal resilience (Connor-Davidson Resilience Scale) triggers the NQMs to decide to leave their post or even to leave midwifery. Those with low professional resilience as well as low personal resilience appear less able to make changes to their situation. This needs further exploration as it has the potential to be another screening tool to provide additional and individual support to vulnerable NQMs to improve retention.

This study was conducted in London and, therefore, reflects the midwifery workforce in the Capital, which may not be generalisable to any other area of the UK. The Capital Midwife preceptorship project would provide an ideal opportunity to take this work forward in London

and to test both scales on a wider population of NQMs. This work, however, may also have wider reaching implications and testing this hypothesis on a much larger scale could impact the UK midwifery workforce and beyond. It would be interesting to compare findings with other areas – both urban and rural – to see whether findings are comparative in different settings.

Þ Recommendation:

It is recommended that the Bower Midwife Wellbeing Scale developed for this work be further refined and tested on a larger sample of NQMs and early career midwives in London. A larger study could explore whether the findings of this research can be used to predict NQMs who are more likely to stay and who are more likely to leave, and whether these findings are replicated on a wider scale.

Þ Recommendation:

It is recommended that the relationship between personal and professional resilience, using the scales from the study, be further explored to determine their potential in identifying NQMs and early career midwives who are more likely to consider changing their situation, and would benefit from additional or individualised support to improve retention in their early career period.

Þ Recommendation:

It is recommended that the Bower Midwife Wellbeing Scale is tested against an existing workplace wellbeing scale such as the Practice Environment Scale to compare its validity and reliability with a previously validated tool.

Þ Recommendation:

It is recommended that the study be repeated in other areas to see whether the findings in London are replicable in other geographical areas and settings.

6.6 Recommendations for Policy

This research comes at an opportune time in midwifery. The findings substantiate many of the issues raised in recent reports as already outlined. Recent surveys and reports have identified NQMs as a group of midwives who are less likely to stay in midwifery (Walton, 2021; Independent Maternity Review, 2022; Nursing and Midwifery Council, 2022a). This research, therefore, adds weight to the recommendations of these reports as NQMs are highlighted as a particularly vulnerable group who are leaving the profession in greater numbers than other midwives. For this reason, findings from my research are timely and resonate with current midwifery policy. Specific policy initiatives, such as recruitment and retention initiatives, may provide ideal opportunities to act on the recommendations from my research (Beesley, 2022).

There are localised efforts to support NQMs and some preceptorship programmes, such as the Capital Midwife Preceptorship Framework, are regionally standardised (Health Education England and NHS England and NHS Improvement, 2019). A national, standardised approach to preceptorship and to supporting NQMs is needed if retention is to be addressed on a wider and more coordinated scale. This has been recognised by NHS England who launched their Midwifery Preceptorship Framework as this thesis was being completed (NHS England, 2023). How this is implemented will be interesting to see. The Royal College of Midwives have also recognised the specific needs of NQMs and are working to support them through their Early Career Midwives' project (Royal College of Midwives, 2023). In addition, the NMC has developed a Principles for Preceptorship document (Nursing and Midwifery Council, 2020). Recognition of the need to standardise preceptorship, however, has to take place at policy level with additional funding to support NQMs if they are to be retained in the profession.

NHS England's national Midwifery Preceptorship Framework (NHS England, 2023), in line with that already produced for nursing (NHS England, 2022), is intended for all maternity services, and this is to be welcomed. Publishing a policy framework, however, does not equate to implementation of the framework in all maternity services and NHS England needs to monitor and incentivise Trusts to adopt the framework and adhere to the preceptorship principles. Adoption of new principles usually requires ringfenced funding and this should be provided

to all Trusts if this standardised and evidence-based preceptorship framework is to be adopted by all. Funding adequate preceptorship support would reap financial benefits by improving wellbeing and retention of NQMs.

In addition to a preceptorship framework and adequate preceptorship funding, policy improvements for NQMs could include routine use of the Bower Midwife Wellbeing and Connor-Davidson Resilience scales. If further testing of the scales confirms the findings of my research, and these are replicated on a wider scale, both resilience and wellbeing scales could be given to all NQMs six months to one year after qualifying. The scales could be used to identify NQMs who have a mean Bower Midwife Wellbeing score of less than 3, and further targeted support could be offered to ensure they are retained in the profession. If they also have a high Connor-Davidson Resilience score, my research suggests they have the personal resilience required to make changes to their situation and are particularly vulnerable to leaving their post or midwifery. Concurrently, the factors influencing a low score should be examined to identify organisational issues that need to be addressed. Knowing that these midwives are more vulnerable to leaving midwifery will enable strategies to be put in place to enhance retention.

Þ Recommendation:

Following publication of the NHS England Midwifery Preceptorship Framework, it is recommended that NHS England prioritise preceptorship as a distinctive career period that requires additional funding to implement the nationally agreed preceptorship principles and to improve support for NQMs if they are to be retained.

Þ Recommendation:

It is recommended that structural and organisational factors influencing poor professional resilience be addressed at policy level, such as ensuring there is a healthy workplace culture and appropriate staffing to support NQMs.

Þ Recommendation:

If further research confirms the findings of this study, it is recommended that the Connor-Davidson Resilience Scale and the Bower Midwife Wellbeing Scale be administered to NQMs after six months to one year of their preceptorship period and that NQMs with a mean Bower Midwife Wellbeing score below 3 be offered individualised and targeted support.

6.7 Summary statement

My research provides a unique contribution to understanding the reasons why NQMs choose to stay in midwifery practice in London. This mixed-methods research sought to find what the personal and professional factors are that influence NQMs to stay in post in London. It also explored the relationship between personal and professional resilience and the decision of NQMs to remain in post and in midwifery. The originality of this study came from the use of resilience and wellbeing scales to predict those NQMS who are likely to stay in midwifery.

The Bower Midwife Wellbeing Scale, developed for the survey, provides a new tool to explore midwives' workplace wellbeing and, by implication, professional resilience. My study found that the lower the mean score of the scale, the more likely NQMs were to have thought of leaving their post and midwifery in the last six months. If further research consolidates the findings of my research, this scale has the potential to predict those NQMs who require additional intervention or support to prevent attrition from the midwifery profession during the early years of a midwife's career. Given the vulnerability of NQMs to leave the profession, this tool could improve retention in the workforce. With further testing, this scale has the potential to be used more widely.

Despite the fact my research focuses on why midwives stay, many of the findings also shed light on why midwives leave. The factors that influence leaving, such as stressful workplace situations, lack of support, bullying and poor staffing levels, were identified by all NQMs in the interviews. My research has highlighted, however, that there are different reasons for staying and leaving; these are not just the opposites of one another. Reasons for staying in

midwifery, identified in the survey and supported by the interviews with NQMs, strongly relate to professional identity, job satisfaction and meaningful relationships with women (including working in continuity models). Reasons for leaving midwifery relate to poor working conditions, with poor workplace culture and bullying being the main reasons given by the NQMs who had already decided to leave.

My research suggests that to improve the retention of NQMs in London, attention needs to be given to the reasons they stay. The professional identity of NQMs needs to be strengthened if they are to be retained. This can be achieved by improving their job satisfaction and enabling them to work within continuity of carer or caseload models during their preceptorship period. This is just as important as addressing the poor organisational factors causing them to contemplate leaving. From this research it was clear that the NQMs strongly identified themselves with the midwifery profession, and if the conditions were right, they wanted to stay in midwifery because they loved being a midwife.

The midwifery workforce is at a crucial and pivotal point. A further decline in midwife numbers would put the maternity services in severe crisis. NQMs are the future workforce yet they are the group of midwives leaving in the largest numbers. If we are to retain our midwifery workforce, we must take action: this research provides some of the evidence as to what keeps them in the profession and why newly qualified midwives choose to stay.

6.8 Post Script: The Ockenden and Kirkup Reports

At the end of writing up my thesis, the Ockenden and Kirkup Reports were published (Independent Maternity Review, 2022; Kirkup, 2022). Whilst I have attempted to include their findings in my thesis, I felt it worth adding a post-script to make explicit links between the findings of the reports and the results of my research.

The reports investigated the maternity services in Shrewsbury and Telford NHS Trust (Independent Maternity Review, 2022) and in East Kent (Kirkup, 2022) over a period of several decades. The findings were damning to the Trusts and to their maternity services. There were systemic failings in care and governance, with consequential high mortality and morbidity rates amongst both mothers and babies. In the Ockenden Report, fifteen Immediate and Essential Actions (IEAs) were identified and in the Kirkup Report, four broad areas for action were identified. These recommendations have implications for all Trusts in England.

The findings of the reports resonate very closely with my own findings. One of the major findings in both reports was an embedded culture of bullying. The word 'bully' or bullying' appears 20 times in the Ockenden Report and 68 times in the Kirkup Report. The Kirkup Report states: '*We have found divisions among the midwives which at times included bullying to such an extent that the maternity services were not safe'* (Kirkup, 2022: 4). Given the previous findings and recommendations in such reports, this is a real concern. In the Ockenden Report, actions for the Trust include:

> *14.62 The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices [survey] initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service…*(Independent Maternity Review, 2022: 159).

As identified earlier, these are not the first reports to find a bullying culture in maternity services and although bullying has been reported throughout the NHS (NHSE, 2021), it appears that this is of particular concern in midwifery. My research substantiates this finding and provides more evidence to support the call for change. A bullying culture specific to

midwifery has been discussed in the literature for over 20 years. Given the gravity of the recent maternity reports, substantiated by my findings, this poor workplace culture in midwifery must be addressed if midwives are to be retained in the profession. This is of particular concern for NQMs, as highlighted in recent NHS data (NHS Digital, 2023).

The other significant finding from the reports, also substantiated by my own research, is the negative impact of staffing shortages on maternity services. In the executive summary, the Ockenden Report states:

> *Staff also cited suboptimal staffing levels and unsafe inpatient-to-staffing ratios to the review team, and said they often felt fearful and stressed at work due to poor staffing levels.* (Independent Maternity Review., 2022: p. x).

The shortage of midwives is a national issue of concern and, as the data show, is becoming worse. The Ockenden Report outlines the government's additional funding and suggested spending for maternity services, including an additional midwife in every Trust to support NQMs. The Kirkup Report states that, while poor staffing levels undoubtedly played a role, there was no evidence that this was a causative factor in the poor care.

The Ockenden Report makes a direct recommendation around NQMs, with a specific action relating to preceptorship:

> *All trusts must implement a robust preceptorship programme for newly qualified midwives (NQMs), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this* (Independent Maternity Review., 2022: 162).

Given the findings of my research, this is a welcome and much needed recommendation, which will carry weight in ensuring this action is implemented. All recommendations will be monitored so Trusts will be held to account if these actions are not achieved. This report may provide the best opportunity in decades for NQMs to be fully and effectively supported. This will depend on the effectiveness of the monitoring, however, and how well Trusts are held to account. Nevertheless, both the Ockenden report and the Kirkup Report provide a well-timed platform to initiate actions which echo the recommendations from my research.

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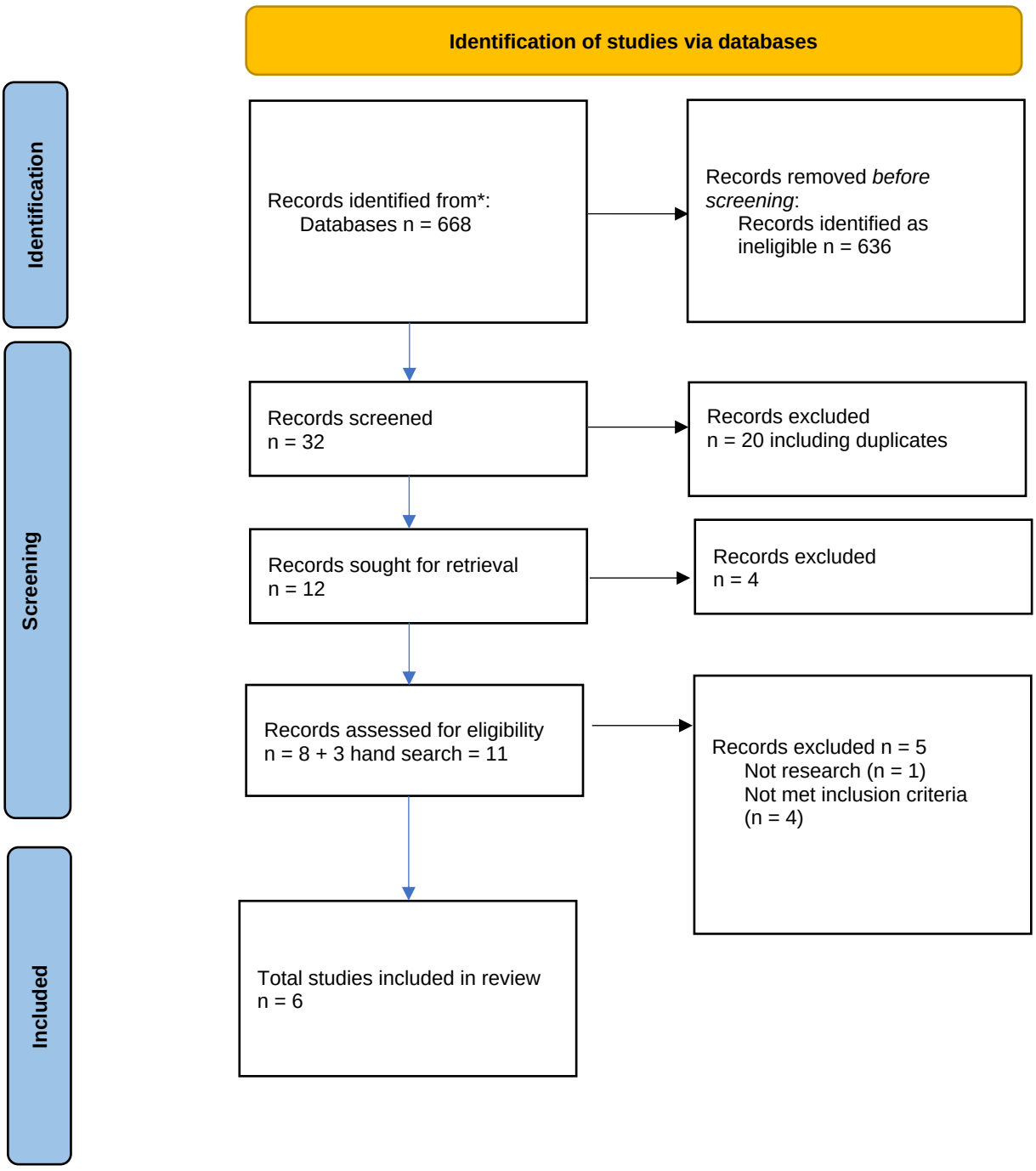
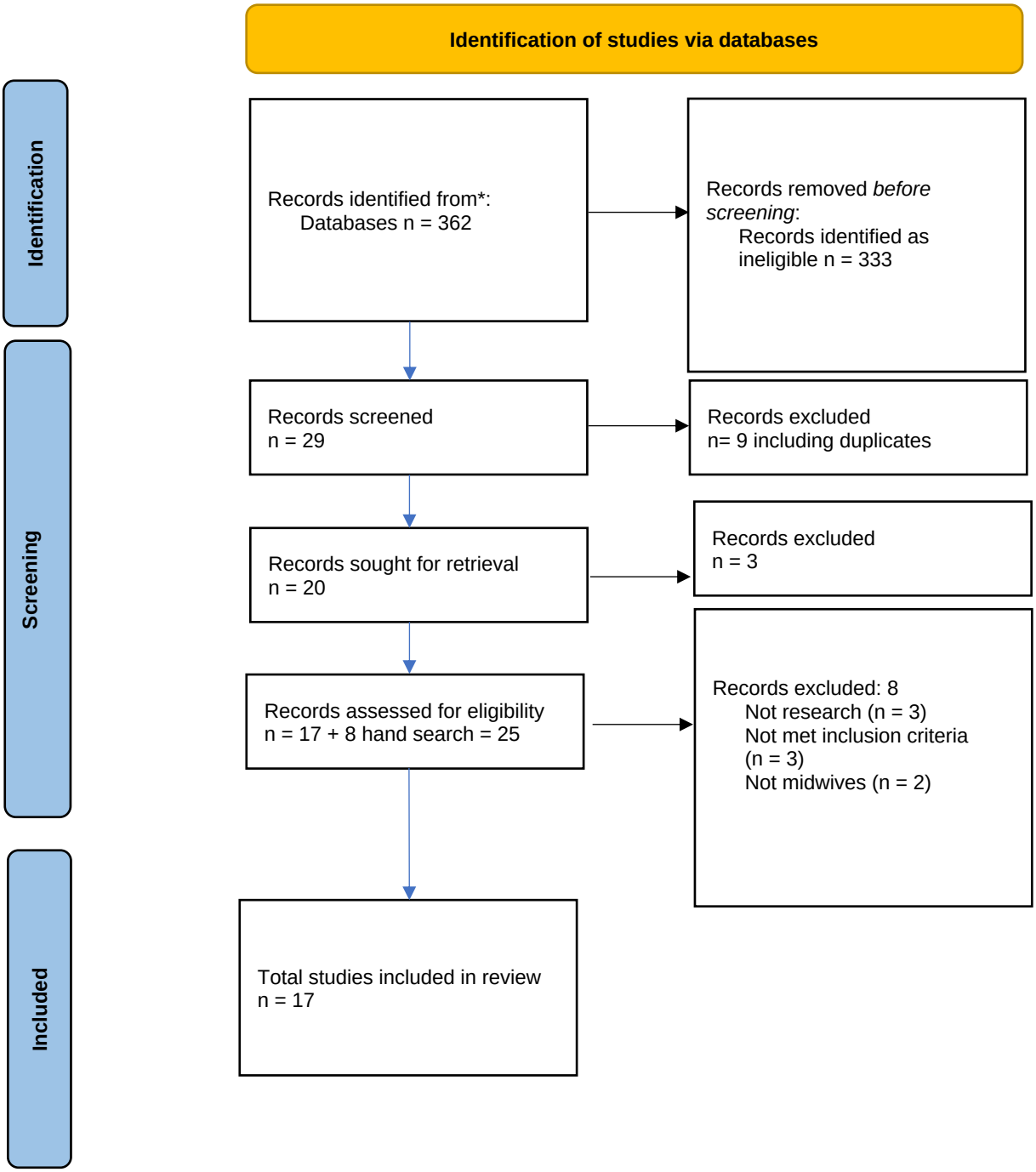
APPENDIX 1a PRISMA diagram: Why do midwives stay?



APPENDIX 1b PRISMA diagram: Why do midwives leave?



APPENDIX 2 Why Midwives Stay/Leave: Data Extraction Table

Title/Authors/ Country	Aim of study	Research methods	Sample	Findings	Strengths/ Weaknesses	Implications
Bloxome et al (2018) Factors associated with midwives' job satisfaction and intention to stay in the profession: an integrative review *Australia*	Literature review Six studies identified including Nigeria, Afghanistan, Jordan	Integrative systematic literature review Two researchers used pre-determined criteria to assess papers Papers were appraised using Quantitative and Qualitative critical appraisal tools as appropriate	Databases used were MEDLINE, CINAHL and PsychInfo. Search strategy was outlined and PRISMA diagram was included Six papers were identified with no geographical or time exclusion critera	Seven themes were identified which explained why midwives stay: 1.Relationships with colleagues 2.Relationships with women 3.Job satisfaction 4.Sense of accomplishment 5.Hours and money 6. Passion for midwifery 7. Working autonomously	Search strategy was clearly explained, including rationale for exclusion of papers. Themes were clearly outlined from sub-themes. Job satisfaction was included in the search terms which pre-empted findings. One paper related to job satisfaction, not why midwives stay.	The review helps to identify the multiple factors influencing midwives to stay in the profession. Most of these relate to the work itself and to the relationships with others – both women and colleagues. The authors state that midwifery retention needs to be urgently addressed across the globe, yet most research has been about why midwives leave. They suggest further research needs to be done about why midwives stay.
Bloxsome et al (2019) "I love being a midwife; it's who I am": a Galserian grounded theory study of why midwives stay in midwifery *Western Australia*	To explore why midwives choose to stay in the midwifery profession in Western Australia	Semi structured, open ended interviews either face-to-face, via Skype or phone Glaserian grounded theory with constant comparative analysis was used to generate categories	14 midwives working in clinical practice in Western Australia recruited through (1) purposive sampling through Facebook, (2) snowball technique and (3) theoretical sampling	Core category: "I love being a midwife: it's who I am. Three subsidiary categories: 1.The people I work with make all the difference 2.I want to be 'with woman' so I can make a difference 3.I feel a responsibility to pass on my skills, knowledge and wisdom to the next generation	Strengths: in depth interviews were able to elicit depth of meaning behind midwives' reasons to stay. Limitations: only one state in Australia. No newly qualified midwives in the study.	The study identifies factors that sustain midwives in their role, enabling them to stay in midwifery. Professional identity, relationships with colleagues and with women, and responsibility to the next generation of midwives are motivating factors. In turn, these factors increase resilience and sustainability.

Title/Authors/ Country	Aim of study	Research methods	Sample	Findings	Strengths/ Weaknesses	Implications
Butska and Stoll (2020) When midwives burn out: differences in the experiences of midwives in British Columbia and Alberta *Canada*	When midwives burn out: differences in the experiences of midwives in British Columbia and Alberta	Secondary analysis of WHELM (Work Health and Emotional Lives of Midwives) data from Canada, comparing data from British Columbia (BC) and Alberta (A)	In the original survey, 129 (46%) of BC midwives but only 28 (26%) of A midwives responded. Midwives in BC provided continuity of care to 43 women per year; in A, the number was 34. There was a significant difference in burnout between BC and A in the WHELM study.	Analysis of the question: have you considered leaving in the last 12 months? 67% of BC midwives had considered leaving, 44% of them had seriously considered leaving. 43% of A midwives had considered leaving, only 25% seriously. 30% v. 11% of BC v. A midwives predicted they would still be there in 5 years' time.	The WHELM study was conducted in 7 countries using validated tools. All midwives were asked if they had thought of leaving. Secondary data analysis uses datasets that were not for the specific purpose of the report. Proportionally fewer A midwives responded to the survey.	The authors conclude that BC midwives were engaged in a process of 'compensation'. They were paid less, therefore took more clients, which lead to higher levels of burnout. The consequence of this was that their working practice was unsustainable, with poorer work-life balance and they were more likely to intend to leave midwifery.
Cameron (2011) Becoming and Being a Midwife: A Theoretical Analysis of Why Midwives Leave the Profession *Ontario, Canada*	An exploratory study of the phenomenon of midwives leaving professional practice	In depth telephone interviews with midwives who had left the midwifery profession in Ontario within 6 years Analysis of transcribed interviews used grounded theory	108 eligible midwives identified by the Association of Ontario Midwives (AOM); purposive sample of 9 midwives interviewed None were practising as a midwife; all had left within the last 3 years, except one who left 6 years before	Three key themes identified: 1) Becoming – identified positive reasons for wanting to become a midwife 2) Being – described conflict between idealism and reality of the actual job 3) Loss of Self – stress, burnout and loss of connection with women contributed to decision to leave	Strengths: focused research which draws on a relatively small pool of midwives in a 'new' professional group Limitations: self selecting group of midwives; most had recently left midwifery whereas pool of potential midwives spanned 14yrs	Illuminates reasons for midwifery attrition in a country dominated by nurse/midwives. Many of the midwives returned to nursing. Reasons for entering the profession are mirrored in the reasons for leaving if these ideals cannot be met.

Title/Authors/ Country	Aim of study	Research methods	Sample	Findings	Strengths/ Weaknesses	Implications
Catling et al (2022) Midwifery workplace culture in Sydney, Australia *Australia*	Aim to assess midwives' perceptions of workplace culture in two maternity units in Sydney	Survey using Australian Workplace Culture instrument. Also stakeholder groups. Survey analysed using descriptive statistics. Qualitative data analysed using thematic analysis.	Australian Workplace Culture instrument completed by 49 midwives from two units in Sydney. Ten stakeholder groups comprising senior midwifery managers.	Findings were compared with a national survey using the same instrument. Compared to the national results, midwives rated their workplace culture more positively (36.7% of the sample rated it positively compared with 27.9% in the national sample). 35% of midwives in the sample had considered leaving in the last six months, with over two thirds having thought of leave their current post.	Strengths: The ability of the Australian Workplace Culture instrument to assess intention to leave post/midwifery appears to be transferable to different settings. Limitations: small sample size made qualitative analysis difficult to compare with national sample.	Midwifery managers are pivotal to workplace culture and this accounted for the more positive assessment of workplace culture in these units compared to the national sample. Assessing workplace culture and addressing any adverse working conditions is key to retention of midwives.
Cox and Smythe (2011) Experiences of midwives leaving Lead Maternity Care practice *New Zealand*	To explore the stories of 3 midwives who decided to leave LMC practice.	Unstructured, in-depth taped interviews, which allowed midwives to tell their own story. Data was analysed using interpretive methodology informed by phenomenology.	Purposive sample of 3 midwives who decided to leave LMC practice. Midwives had worked for 5-11 years in LMC practice. They had left between 6 months to 3 years prior to the study.	Three themes were identified: 1. Passion and commitment 2. Making the decision to leave 3. Emotional impact of practice In making the decision to leave, common feelings identified were: feeling betrayed, feeling overwhelmed by responsibility, feeling outraged, and feeling exhausted	Strengths: in exploring individual stories in depth, richness of data provides understanding that cannot be obtained from qualitative studies Limitations: it is acknowledged that these results cannot be generalised and that this study only explores one model of care.	For these midwives, LMC practice (offering continuity of carer) was unsustainable. Given that this type of care is held as the 'gold standard' of maternity care, it is recommended that more support is provided to midwives so this model of care can be sustained. A Midwife First Year of Practice programme can provide this support to newly qualified midwives.

Title/Authors/ Country	Aim of study	Research methods	Sample	Findings	Strengths/ Weaknesses	Implications
Dixon et al (2015) Supporting New Zealand graduate midwives to stay in the profession: an evaluation of the Midwifery First Year of Practice Programme *New Zealand*	To evaluate the Midwifery First Year of Practice Programme as a method of increasing retention of Newly Qualified Midwives in the profession	Data obtained from Midwifery First Year of Practice (MTFP) Programme register. This was cross referenced with Midwifery Council of NZ register and workforce data.	Out of 441 graduates between 2007-2010, 415 were registered on the MFYP programme. Demographic data was collected from the 415 midwives on the MYFP programme.	The retention rate of newly qualified midwives undertaking the MFYP programme was 86.3%, with 358 NQ midwives still practising in 2012.	Strengths: robust data was available from the Midwifery Council, the MFYP programme and from workforce data. Limitations: it was not possible to draw comparisons with midwives who had not been on the MFYP programme as no data is held on these midwives.	Although the programme could not be compared with retention rates for those who had not undertaken the programme, the retention of midwives on the programme was very high. The study supports the value of the programme to newly qualified midwives, who are known to be vulnerable to attrition in the first few years after qualifying.
Feijen et al (2022) Intentions to leave and actual turnover of community midwives in the Netherlands: A mixed method study exploring the reasons why *Netherlands*	To study the rate and the reasons for intending to leave, and to explore the reasons for leaving midwifery jobs in the Netherlands.	Mixed methods. Survey using questions from National wellbeing of midwives' question, analysed using SPSS. In-depth interviews with midwives, analysed by using in-depth coding, moving to framework analysis.	Survey: random sample of community midwives + all newly qualified midwives. N = 1241 Interviews: 17 midwives recruited through the Royal Dutch Organisation of Midwives' website.	33.7% of all midwives and 30.4% of NQMs were intending to leave midwifery. The main reasons were dissatisfaction of organisation of care and family commitments. Reasons for actually leaving the profession were similar to those for intention to leave.	Strength: mixed methods study that uses both quantitative and qualitative data. Random sampling ensured cross section of midwifery population. Limitations: transferability to other countries.	One third of community midwives in the Netherlands have indicated their intention to leave their job. Intention to leave is a good indicator of actually leaving. The findings challenge the organization of care, which should focus on continuity of care, job satisfaction and building a sustainable workforce.
Gebrine et al (2019) Impact of sense of coherence and work values perception on stress and self-reported health of midwives *Hungary*	How work values and sense of coherence (SOC) impact on midwives' perceivedhealth and stress.	Cross sectional correlational design. Survey with four scales were used and analysed using stats tests including linear regression.	500 midwives were randomly selected from 13 regional hospitals across Hungary in 2016. 228 completed surveys were analysed.	SOC and health were positively correlated; SOC and stress were negatively correlated. Using linear regression, worst to best perceived health increased intention to stay by 32%.	Cronbach alpha scores were 0.8 or above. 3 out of 4 scales were previously validated. Unclear how the randomisation was performed.	Increasing SOC and work values in midwives and reducing stress improves their health and reduces the probability of them leaving the profession. There appeared to be no difference in midwives who had worked for < or > than 5yrs in practice.

Title/Authors/ Country	Aim of study	Research methods	Sample	Findings	Strengths/ Weaknesses	Implications
Geraghty et al (2019) Fighting a losing battle: midwives experiences of workplace stress *Perth, Australia*	To examine the nature of midwives' work-related stress and the implications, if any, for midwives' overall emotional well-being and career decisions	Audio recorded in-depth face-to-face interviews with midwives currently working in clinical practice in Western Australia Analysis of transcribed interviews using grounded theory based on constant comparison theory	21 midwives were recruited from any unit/ practice in W. Australia. After 21 interviews, data saturation was reached so no further midwives were recruited. Purposive sampling was initially used; then theoretical sampling to gain all perspectives.	Core theme: fighting a losing battle. Core problem: Midwifery is stressful but it's not the job itself Sub-themes included 'thinking very seriously about leaving'. Not being able to perform the job they loved in the way they wanted was the primary reason for wanting to leave.	Strengths: the study developed a clear theoretical framework to explain the findings Limitations: the authors acknowledge that this is a snapshot of one area of Australia, where the healthcare system is predominantly private.	Most midwives said they wanted to stay in the profession. Reasons given were that they felt they were defined by being a midwife; that they loved their work, even if they did not love the way in which it had changed; that they wanted to remain 'with woman'.
Harvie et al (2019) Australian Midwives' intentions to leave the profession and the reasons why *Australia*	To explore the reasons for midwives leaving the profession, including causes of dissatisfaction	Sub set data analysis of dataset collected for Work, Health and Emotional Life of Midwives (WHELM) study. Questionnaire included open and closed questions about intentions to leave midwifery. Analysed using descriptive statistics and latent content analysis	WHELM survey was distributed to 4600 midwives across Australia through the Australian College of Midwives over 8 weeks in 2014. 1037 surveys were returned completed. Group 1 (443) had considered leaving midwifery in the last 6 months.	42.8% of sample had considered leaving in the last 6 months; 6.1% did not see themselves in midwifery in 1yr. 27.1% said it was unlikely they would be in midwifery in 5yrs time. Two main reasons: 1.dissatisfaction with organisation 2. dissatisfaction with my role as a midwife	Strengths: large data set; mixed methods study. Comparative statistics to determine specific cohorts of midwives who were most likely to express intention to leave. Limitations: data was collected for a different purpose (ie emotional wellbeing survey), although questions were included in original dataset.	'Dissatisfaction with my role as a midwife' was statistically more significant amongst those midwives practicing for less than 5 years ($p>0.05$). They felt they could not be the midwife they wanted to be. This suggests a mismatch for newly qualified midwives between the ideal and the reality.

Title/Authors/ Country	Aim of study	Research methods	Sample	Findings	Strengths/ Weaknesses	Implications
Hildingssen et al (2013) Burnout in Swedish Midwives *Sweden*	To investigate Swedish midwives' levels of burnout and their attitudes towards leaving the profession.	Questionnaires sent to random sample of members of the Swedish Midwives' Association. Copenhagen Burnout Inventory (CBI) used as basis for questionnaire. Cronback alpha values used to analyse results	1000 questionnaires sent to random sample of Swedish midwives – 475/978 eligible returned (48.6% response rate) Overall number of midwives in SMA not stated.	39.5% of midwives scored highly in personal burnout; 15% scored highly in work and client burnout. Most susceptible to burnout were early career midwives, <40yrs old. 1 in 3 midwives had considered leaving.	Strengths: random sample of all midwives in Sweden with relatively high return rate. This provides the study results with generalisability. Limitations: CBI has not been used in many midwifery studies – 2 studies using CBI showed contradictory results.	Reasons for considering attrition were more significant than characteristics of midwives for those experiencing burnout. Thus burnout and attrition are closely linked. Addressing the causes of burnout eg heavy workloads would prevent attrition.
Jarovsa et al (2014) Job satisfaction and leaving intentions of midwives: analysis of a multinational cross-sectional survey *Czech Republic*	To explore the relationship between leaving intentions and job satisfaction in midwives across 7 countries.	Questionnaire – distributed as paper copy in 6 countries (45 hospitals) and as online in 1 country. 73.7% response rate overall. Data was analysed with STATA package, using Kruskal-Wallis rank test and Pearson's chi square test.	1190 hospital midwives from Italy, Poland, Czech Republic, Slovakia, Portugal, Singapore and South Korea. Convenience sample from numerous hospitals.	Most job satisfaction was derived from co-workers, whilst least job satisfaction most significantly correlated with 1. Extrinsic rewards, 2. Professional opportunities ad 3. Work-life balance Positive job satisfaction correlated with less intention to leave the job, profession or country.	Strengths: Seven country approach provided comparison between countries. Limitations: there was no explanation for the countries chosen. Maternity services in each country were not described but only hospital midwives (therefore obstetric led maternity services) were included in the study.	Lower job satisfaction correlated with higher intention to leave the organisation, the profession and the country. Factors influencing job satisfaction should be considered by employers to improve retention of midwives in both their place of employment and the profession.

Title/Authors/ Country	Aim of study	Research methods	Sample	Findings	Strengths/ Weaknesses	Implications
Leinweber et al (2017) A socioecological model of posttraumatic stress among Australian midwives *Australia*	To develop a comprehensive model of personal, trauma event-related and workplace-related risk factors for post-traumatic stress subsequent to witnessing birth trauma among Australian midwives.	Descriptive, cross-sectional design using a survey. The Post-traumatic Stress Disorder Symptom Scale Self- Report measure. was used to assess trauma symptoms. Multivariate logistic regression was used to analyse data.	Members of Australian College of Midwives were invited to participate in online survey (N = 601). Power calculation had recommended a sample size of 580. Average age = 43 years Average length of time since qualifying = 14 years	Intention to leave midwifery was found to have the strongest correlation with probably PTSD. Respondents with probable PTSD were 4 times more likely to express an intention to leave than those who did not have PTSD.This was explained by re-traumatisation at traumatic births.	Strengths: this is the first study to correlate personal birth trauma with PTSD and intention to leave. Limitations: midwives were self-selecting so this may have biased the sample towards those who had experienced birth trauma.	Midwives with a history of birth trauma may be better employed in less trauma-prone areas such as caseload midwifery or management positions. This will result in enhanced workforce satisfaction and midwifery retention.
Pallant et al (2016) Adaptation and psychometric testing of the Practice Environment Scale for use with midwives *Australia*	To adapt the Practice Environment Scale (PES) for use with midwives, to better understand their decision to leave the profession.	Data was extracted from a cross sectional study exploring emotional wellbeing of midwives in New Zealand. The PES tool aimed to identify midwives who had considered leaving the profession in the last 6 months. Principle component analysis was conducted - SPSS.	Data was used from 600 midwives working for a hospital organization. Age ranged from 21-70yrs (mean=46yrs). Experience range from 1-42 years (average = 15 years).	From the analysis, 4 factors were identified as being significant to midwives considering leaving the profession: 1. Quality of management 2. Midwife-Dr relations 3. Resource adequacy 4. Opportunities for development	Strengths: rigorous statistical analysis was undertaken to ensure scale represented good internal consistency reliability. Limitations: The PES was designed for use with nurses; this adapted scale was being used for the first time with midwives.	Identifying factors that influence midwives to consider leaving is important for employers, who may be able to make adjustments based on these findings. PES needs to include a measure of autonomy, which has been identified as important for midwives.

Title/Authors/ Country	Aim of study	Research methods	Sample	Findings	Strengths/ Weaknesses	Implications
Peter et al (2021) Work-related stress and intention to leave among midwives working in Swiss maternity hospitals – a cross-sectional study	To investigate work-related stress among midwives working in Swiss maternity hospitals, and the stressors associated with midwives' intention to leave the profession.	Secondary data from two cross sectional studies (STRAIN and Job Satisfaction studies) were analysed using Kruksal-Wallis test and logistic regression. Original data were collected via two self-report questionnaires, one question on each was about intention to leave.	98 midwives working in 12 Swiss public maternity hospitals (randomly selected) in labour and delivery, postnatal care, gynaecology. Data were collected between 2017-18.	If midwives were compensated for their overtime quickly, they were less likely to intend to leave (OR 0.23, p<0.5) . If their work life impacted their private life, they were more likely to intend to leave (OR 6.81, p<0.5). The youngest generation were significantly more likely to intend to leave.	Multi-centre studies therefore potential for generalisability is improved. Swiss model of maternity care is different to the UK. Secondary data therefore initial intention was not the purpose of this study. Sample size small which may affect strength of findings.	Protective factor against intention to leave was job satisfaction. However, work-private life conflict was a strong reason to intend to leave. This was increased for the younger generation. Managers need to compensate for overtime quickly and improve staffing levels to retain midwives.
Pugh et al (2013) Western Australia facing critical losses in its midwifery workforce: a survey of midwives' intentions *W Australia*	To determine the factors which contribute to midwives intentions to leave their job and/or leave the profession.	Cross sectional survey distributed by the Western Australian Nursing and Midwifery Office, Dept. of Health. Midwives were invited to complete the questionnaire via email link. Data was analysed descriptively using PASW statistics.	1600 midwives were invited to respond: 712 (44.5%) responded, representing 1/5 of midwives in Western Australia. Midwives were from public and private facilities.	Midwifery experience ranged from less than 1 yr – 48 yrs (M=15.8) 52% were part time, while 16% worked casual hours. 46% intended to move jobs in next 5 yrs, with >35yrs being statistically higher. 20% of those <55yrs intended to leave. Most common reasons were for work–life balance, change of career, family commitments.	Strengths: 20% of midwifery workforce completed the survey so potentially representative. Limitations: self administered questionnaire; no attempt to demonstrate sample is representative of whole midwifery population in W Australia.	Midwives identified 3 factors that would encourage retention: Flexible working, increased remuneration, staffing levels. These factors should be considered by employers as a means to retain midwifery staff in the workplace and in the profession.

Title/Authors/ Country	Aim of study	Research methods	Sample	Findings	Strengths/ Weaknesses	Implications
Royal College of Midwives (2016) Why Midwives Leave – Revisited. *United Kingdom*	To revisit the 2002 survey conducted on behalf of the RCM and investigate why midwives leave in comparison to the findings in 2002.	Online survey, open for 2 weeks in August sent to all midwives in the RCM and promoted on social media.	Survey was completed by 2,719 midwives who had left in last 2 years or intended to leave in next 2 years. 12.8% were under 30 and 85% lived in England.	Top 6 reasons for leaving / intending to leave were: 1.Poor staffing levels 2.Lack of quality care they were able to give 3.High workload 4.Lack of support (left) 5.Poor working conditions 6.Not happy with model of care (intending to leave)	Good sample size. Online survey therefore self-selected participants. Would have been useful to include how long midwives had been qualified – no differentiation between length of time they had been a midwife.	Recommendations to government were to improve pay, staffing levels and working conditions. 27% of midwives intending to leave said they might be persuaded to stay; of those, 84% said it would need a change in workplace culture
Stoll et al (2019) A survey of burnout and intention to leave the profession among Western Canadian midwives *Canada*	To understand how midwives experience burnout and stress; to explore whether this is linked to intention to leave the profession	Online survey distributed through Midwives' Associations in 3 Canadian states. survey included 5 validated tools: WHELM survey, Copenhagen Burnout Inventory, Quality of Life Scale, Perception of Empowerment in Midwifery Scale and Practice Environment Scale.	1100 midwives in British Columbia, Alberta and Ontario were invited to participate. 242 surveys returned but 84 surveys excluded; 158 midwives participated. Average age = 41 yrs. 18 participants in 1st year of practice; out of remaining 140, average length of practice was 8.8yrs.	99 midwives (67.3%) had considered leaving in past year. Reasons for leaving were negative impact of on call working (84.8%), concerns about mental health (80.8%) and physical health (57.6%). 18 midwives had already left and impact of on call working on personal life was primary reason (39.8%).	Strengths: all tools used in the survey are previously validated tools, although not previously used with Canadian midwives. Limitations: low number of midwives returned surveys (47% of midwives working in BC and 26% of those working in Alberta).	Canadian midwives practice caseload midwifery, which was associated with a high level of personal burnout. It is suggested that midwives need more flexibility in working patterns and more choice in the model of midwifery they practice if midwives are to be retained in the service.

Title/Authors/ Country	Aim of study	Research methods	Sample	Findings	Strengths/ Weaknesses	Implications
Sullivan et al (2011) Factors that contribute to midwives staying in midwifery: a study in one area health service in New South Wales, Australia *NSW, Australia*	To determine the factors that contribute to the retention of midwives in New South Wales in order to assist workforce planning	Descriptive study in two phases: Phase 1: focus groups to adapt an English questionnaire to the Australian context Phase 2: survey to ascertain why midwives stay (quantitative and qualitative data)	Phase 1: convenience sampling through posters in 4 sites – 36 midwives took part in focus groups Phase 2: all midwives in 7 identified sites were asked to take part. 209 / 392 midwives completed the survey (53% response rate) Data from phase 2 was analysed using SPSS to calculate descriptive statistics.	Three main reasons for midwives staying in midwifery were: 1.I enjoy my job 2.I am proud to be a midwife 3.I get job satisfaction Reasons for job satisfaction were: 1.Feeling I make a difference to women 2.Interaction with women in my care 3.Interaction with work colleagues	Strengths: replication of a previous study conducted in the UK, therefore able to compare findings to provide a wider perspective. Limitations: although focus groups were used to ascertain the relevance of the English questionnaire to the Australian population, no formal validity or reliability testing was performed on the tool.	The study identified three main reasons why midwives stay in midwifery: 1.relationships; 2.professional identity as a midwife 3.the practice of midwifery These factors need to be considered in workforce planning to retain midwives in the profession. Practices that promote professional identity, such as continuity schemes, should also be increased.
Versaevel (2011) Why do Midwives Stay? A descriptive study of retention in Ontario midwives *Ontario, Canada*	To examine why midwives in Ontario decide to stay in clinical practice.	Descriptive study Web based survey distributed by email 'Why midwives stay' tool was used from UK, amended for Canadian context, pre tested for validity, then piloted for reliability in the setting. Quantitative data analysed using descriptive statistics Qualitative data analysed usinginductive content analysis	Pre test – 10 midwives in London All midwives registered in 2010 in Ontario. Survey distributed via email by practice administrators to 470 midwives in 75 midwifery group practices. 175 completed surveys (37%)	Top three reasons for staying in midwifery: Enjoyment of work, wanting to make a difference to childbearing women, commitment to clients Top three reasons for job satisfaction: Feel I am making a difference, autonomy as a midwife, interaction with women in my care	Strengths: validated tool that has been used in midwifery context in other research – piloted for Canadian context. Limitations: lower response rate from smaller group practices where experiences may be different. High number of missing values from those who responded.	Although study focused on why midwives choose to stay, 48% of the sample had considered leaving midwifery. Factors relating to both retention and attrition are closely related. More work needs to focus on positive factors that promote retention such as working practices, relationships and continuity of care.

Title/Authors/ Country	Aim of study	Research methods	Sample	Findings	Strengths/ Weaknesses	Implications
Warmlink et al (2015) Career plans of primary care midwives in the Netherlands and their intentions to leave the current job *Netherlands*	To assess the association between intentions of primary care midwives in the Netherlands to leave their job and factors associated with the likelihood of making this choice	Data collection was part of DELIVER – a prospective cohort study to evaluate primary care midwifery in the Netherlands. Intention to leave question was correlated with personal/professional characteristics. Validated survey tools were used to assess work pressure and job satisfaction. Data was analysed using SPSS.	20/519 primary care midwifery practices were invited to participate representing 108 midwives. Practices were selected to represent type of practice, level of urbanization (urban/rural) and region.	99/108 midwives responded (91.7%) 95.9% of midwives were working in group practices. Of 32 midwives who wanted to leave their current job, 26 were self employed. Of intention to leave group, no significant differences in work related or personal characteristics, with exception of age: 30-45yr age group were twice as likely to have an intention to leave (56.3% compared with 25.8% of younger and older age groups). High job satisfaction strongly correlated with lack of intention to leave.	Strengths: high response rate; good representation of all primary care midwives therefore high generalisability. Limitations: higher proportion of group practice midwives compared with duo or solo midwives. Focus on primary care midwives means this is not generalisable to all midwives in the Netherlands. Some factors, such as job alternatives were not accounted for.	Given the recent changes towards hospitalization in the Netherlands, it is important to understand the motivation of primary care midwives to stay in their role. The finding that job satisfaction is strongly correlated with their reason to stay in primary care is an important finding in planning future services. Individual components of job satisfaction should be explored in further research.

APPENDIX 3a Sample email to recruit midwives to the survey

Dear midwife

Why have you have chosen to work as a midwife in London and what has made you stay?

I am a midwifery lecturer and doctoral student at the University of Greenwich, and I am undertaking a study to explore why midwives stay in London. I am writing to ask you to participate in a short online survey about your experience as a midwife in London. As you will be aware, there is a high turnover of midwives in London, particularly newly qualified midwives, and my study aims to look at what we can do to keep midwives working in the Capital. This work is complementary to, but independent of, the Capital Midwife project.

I would be grateful if you could take part in this short (10 minute) online survey to answer some questions about your experience of working as a midwife in London. There is a short introduction, which explains the project and if you are happy with this, your consent is gained by taking part. You have the right to remain anonymous throughout and I will be the only person who has access to the study data. **Please click on the link to access the survey:**

https://greenwichuniversity.eu.qualtrics.com/jfe/form/SV_9nR4kgiC06Ov165

At the end of the survey, if you have qualified in the last 2 years, there is an invitation to take part in a focus group to talk further about your experiences and this would give you the opportunity to talk to other midwives too. Each focus group would be for a maximum of 45 minutes and would take place at a location that is convenient to you. If you would be happy to be contacted to take part in a focus group, please leave me your email address or preferred contact details at the end of the survey.

It is hoped that this work will provide information that can be used for our future workforce in London to improve the experience of midwives working in London. Thank you for reading this and thank you in anticipation for taking part.

Best wishes,

Heather Bower (Lead Midwife for Education and Doctoral student)
University of Greenwich, Southwood Campus, Avery Hill Road, Eltham. London SE9 2UG

Supervisor: Karen Cleaver, Head of School of Health Sciences, University of Greenwich, Southwood Campus, Avery Hill Road, Eltham. London SE9 2UG

APPENDIX 3b Survey participant Information Sheet: 'Why do midwives stay?' project

Why have you have chosen to work as a midwife in London and what has made you stay?

I am a midwifery lecturer at the University of Greenwich, studying for a doctorate. I am interested in the factors that influence midwives in London to stay in the profession, particularly during the first two years after qualification. This work will contribute to the work being undertaken around recruitment and retention of midwives in England, although the focus of my work is specifically around retention of midwives in London.

I would like to ask you to participate in a short online survey to explore the reasons why you have decided to stay in midwifery and why you have decided to stay in London. The survey should take about 15 minutes to complete.

The survey you fill out will only be accessible to me. All data will remain anonymous for the purposes of data analysis and for any subsequent reporting and publications. Data will be stored electronically on a password protected device and will only be accessible to me and my supervisors. All data storage will meet GDPR requirements.

At the end of the survey, you will be asked if you have qualified as a midwife in the last 2 years, and if you would be willing to participate in a focus group to discuss your experiences of being a newly qualified midwife in more detail. If you are, I would be grateful if you could provide your name and contact details at the end of the survey. The purpose of the focus group will be to follow up and explore issues raised by the survey.

I would like to thank you in advance for your participation in the survey and I hope that this work will improve the experience of all midwives and their retention within the midwifery profession in London.

Best wishes

Heather Bower, University of Greenwich, Southwood Campus, Avery Hill Road, Eltham. London SE9 2UG

Supervisor: Karen Cleaver, Head of School of Health Sciences, University of Greenwich, Southwood Campus, Avery Hill Road, Eltham. London SE9 2UG

The survey can be accessed via the following link: (QUALTRICS survey)

https://greenwichuniversity.eu.qualtrics.com/jfe/form/SV_9nR4kgiC06Ov165

APPENDIX 4 Online Survey – indicative questions

Demographic data: professional

1. In which year did you qualify as a midwife?

2. Where did you do your pre registration midwifery education?
   UK Yes/No
   If UK Yes,
   Did you train in London Yes/No If no, where?
   If UK No,
   Did you train in the EU Yes/No If no, where?

3. Which Trust do you work in?
   King's College Hospital NHS Foundation Trust
   Bart's Health NHS Trust
   Imperial College Healthcare NHS Trust
   University College London Hospital
   St George's NHS Foundation Trust

4. How long have you worked in London?
   Less than 1 year
   1-2 years
   2-5 years
   5-10 years
   10-15 years
   15-20 years
   20+ years

5. What is your Agenda for Change Band?
   Band 5
   Band 6
   Band 7
   Band 8
   Other (please specify)

6. In which area of maternity services have you worked in the past year? Tick all that apply:

Delivery Suite	Antenatal ward
Postnatal ward	Maternity Assessment Unit
Day Assessment Unit	Triage
Birth Centre	Community midwifery
Caseload midwifery	Neonatal unit
Specialist midwife role	Consultant midwife role
Midwifery manager role	Other (please specify)

Demographic data: personal

7. How old are you?

8. What is your ethnic background?

White

- 1. English / Welsh / Scottish / Northern Irish / British
- 2. Irish
- 3. Gypsy or Irish Traveller
- 4. Any other White background, please describe

Mixed / Multiple ethnic groups

- 5. White and Black Caribbean
- 6. White and Black African
- 7. White and Asian
- 8. Any other Mixed / Multiple ethnic background, please describe

Asian / Asian British

- 9. Indian
- 10. Pakistani
- 11. Bangladeshi
- 12. Chinese
- 13. Any other Asian background, please describe

Black / African / Caribbean / Black British

- 14. African
- 15. Caribbean
- 16. Any other Black / African / Caribbean background, please describe

Other ethnic group

- 17. Arab
- 18. Any other ethnic group, please describe

9. How long does it take you to travel to work on an average day?
    a. < 30 mins
    b. 30 – 60 mins
    c. 60 – 90 mins
    d. >90 mins

10. Where do you live?
    a. Rented accommodation
    b. Own property (with mortgage)
    c. Own property (no mortgage)
    d. Living in parents' property
    e. Living in other family members' property
    f. Other (please state)

11. Do you have dependents?

    No
    Yes – dependent children under 18yrs
    Yes – dependent children over 18yrs
    Yes – dependent parents
    Yes – dependent relative(s)

Yes – other (please specify)

12. Have you thought of leaving your current post in the last 6 months? YES/NO

13. Have you thought of leaving midwifery in the last 6 months? YES/NO

14. Have you thought of leaving London in the last 6 months? YES/NO

15. Has your experience of COVID influenced your intentions? YES/NO

16. If yes, how?
    Comment……..

17. Did you have experience of healthcare before becoming a midwife? YES/NO
    If so, what was this experience?
    Comment…….

18. What is the <u>main</u> reason you are still practising as a midwife?
    Comment……

19. Please rate the following statements according to how strongly you agree/ disagree with them:
    5 = True nearly all of the time
    4 = Often true
    3 = Sometimes true
    2 = Rarely true
    1 = Not true at all

	5	4	3	2	1
1) I am able to adapt to change					
2) I can deal with whatever comes					
3) I can see the humorous side of things					
4) I believe coping with stress strengthens me					
5) I tend to bounce back after illness or hardship					
6) I believe I can achieve my goals despite obstacles					
7) Under pressure, I can focus and think clearly					
8) I am not easily discouraged by failure					
9) I think of myself as a strong person					
10) I can handle unpleasant feelings					

18. Please rate the following statements according to how strongly you agree/ disagree with them:
    5 = Strongly agree
    4 = Agree
    3 = Neither agree nor disagree

2 = Disagree
1 = Strongly disagree

	5	4	3	2	1
The staffing levels are usually safe					
I have flexibility in my working pattern					
I am required to work on call shifts					
I feel valued by my colleagues					
I feel I am included in the team					
I have never experienced bullying at work					
I feel confident while at work					
I experience a high level of job satisfaction					
I have a strong sense of identity as a midwife					
I feel I have good work-life balance					
I am able to exercise autonomy in my work					
I can access professional learning and development opportunities					

19. If you have qualified as a midwife in the past 2 years, would you agree to be contacted to take part in a small focus group (45 minutes) to discuss your experiences as a newly qualified midwife in London? Confidentiality of your information is of utmost importance to the study. The focus group will be held at a time to suit you and on Trust premises / Royal College of Midwives premises:
    Yes / No / NA – I qualified more than 2 years ago

20. If you have answered YES to the above question, please can you write your name and email address here:
    ……

APPENDIX 5 Interview/Focus group – indicative questions

1. Tell me about your first 6 months / year as a newly qualified midwife?

2. What was your greatest challenge in the first 6 months of being qualified?

3. What are the factors that have enabled you to remain in midwifery practice?

4. In the survey, the most negatively rated statements in the resilience scales were:
    a. I believe coping with stress strengthens me
    b. I am not easily discouraged by failure
    c. The staffing levels are usually safe
    d. I have never experienced bullying at work

    Can you tell me what you think about these statements?

5. What are your plans in midwifery over the next 2 years?

6. What might make you decide to leave midwifery?

7. What might make you decide to leave London?

APPENDIX 6a Interview/Focus group Information sheet

Researchers:
Principal Investigator: Professor Karen Cleaver
Researcher: Heather Bower

What is the purpose of this study?
The purpose of this phase of the study is to explore the factors that encourage newly qualified midwives in London to stay. As you will be aware, there is a high turnover of midwives in London, particularly newly qualified midwives, and my study aims to look at what we can do to keep newly qualified midwives working in the Capital.

Why have I been asked to take part?
You have been asked to take part because you indicated in the online survey that you were potentially interested in being interviewed for the study.

Do I have to take part?
No. Your participation is entirely voluntary and if you do decide that you would like to take part, please keep this information sheet to refer to later on. You are free to withdraw from the research at any time without giving a reason. Your withdrawal from the study will not affect your relationship with the University of Greenwich or with your current employer.

What will I be asked to do?
If you are happy to take part, you will be asked to complete a consent form and attend a focus group which will last around 45 minutes. We will also be happy to talk with you on the phone or arrange an informal meeting in person if you would like to discuss the research in more detail before taking part. During the focus group, you will be asked some questions about your experience as a midwife since qualifying and you will have opportunity to share your experience with other newly qualified midwives.

Where will the research take place?
The focus group will either be conducted at your place of work or at a central London location. If you are invited to travel to central London your travel cost will be reimbursed.
What are the possible risks/benefits of taking part in this research study?
The benefits of taking part in this study are that you will be informing the recruitment and retention work that is taking place in London. It is important that we understand what attracts midwives to work in London and more importantly, what encourages them to stay. The information you provide will be anonymised and used with a pseudonym in any research transcripts or reports. Each participant will receive a copy of the research report once the study has been completed if they wish to. This research was approved by the University of Greenwich Research Ethics committee on [insert date]

Will my details be kept confidential?
Yes. To ensure confidentiality and data protection (Data Protection Act, 1998) your identity will not be disclosed to anyone other the main research team (see above). When we transcribe and write up the research findings, any identifying information you provide will be removed on transcripts or reports. All information relating to you will be stored and locked securely in the University of Greenwich. If you choose to withdraw from the study then you have the right to request that this data is not used, using the details below.
The interview will be recorded on an audio device and transcribed by a professional transcription service in order for the researchers to conduct analysis.

What about the results of the study?
I intend to publish the results of the study as a doctoral thesis and as journal articles. Your identity will remain anonymous. We will also send you a general summary of the research findings at the end of the project.

Who can I contact if I have more questions?
If you need to know any more about the study you can either: Email or write to Heather Bower, Room 118, Mary Seacole building, Avery Hill Campus, Southwood Site, University of Greenwich. SE9 2UG.

If you have any concerns about this research, please contact: Dr. Karen Cleaver, Head of School of Health Sciences, Avery Hill Campus, Southwood Site, University of Greenwich. SE9 2UG.

Thank you for taking time to read this information sheet
We look forward to hearing from you

APPENDIX 6b Consent for interview/focus group

PARTICIPANT CONSENT FORM

To be completed by the participant. If the participant is under 16, to be completed by the parent / guardian / person acting *in loco parentis*.

- I have read the information sheet about this study
- I have had an opportunity to ask questions and discuss this study
- I have received satisfactory answers to all my questions
- I have received enough information about this study
- I understand that I am / the participant is free to withdraw from this study:
    - At any time (until such date as this will no longer be possible, which I have been told)
    - Without giving a reason for withdrawing
    - (If I am / the participant is, or intends to become, a student at the University of Greenwich) without affecting my / the participant's future with the University
- I understand that my research data may be used for a further project in anonymous form, but I am able to opt out of this if I so wish, by ticking here.
- I agree to take part in this study

Signed (participant)	Date
Name in block letters	
Signature of researcher: Heather Bower	Date 21.1.19
This project is supervised by: Professor Karen Cleaver, Dr. Jennifer Patterson, Dr. David Evans	

Researcher's contact details (including telephone number and e-mail address):
Heather Bower, University of Greenwich, Southwood Site, Avery Hill Road, SE9 2UG

Supervisor: Karen Cleaver, Head of School of Health Science, University of Greenwich, Southwood Campus, Avery Hill Road, Eltham. London SE9 2UG

University Research Ethics Committee Application Form

Checklist

Name of applicant: Heather Bower	
Faculty/Directorate: FEH Department: ECS	
Title of research: Why do midwives stay? A mixed methods study of the factors influencing newly qualified midwives in London to remain in post.	
These papers must be attached to this application form (please tick):	
• Participant information sheet	✓
• Participant consent form	✓
These papers may be required (tick if included):	
• Letters (to participants, parents/guardians, participating institutions etc)	✓
• Questionnaire(s) or indicative questions for interviews	✓
• Advertisement /flyer/copy of message inviting participation	✓
• Annex I - Drugs and medical devices	NA
• Annex II - Research involving the storage of human tissue	NA
• Annex III - Ionising radiation	NA

Has the form been signed? **YES**
Have any annexes been signed where necessary? **YES**

SECTION 1: APPLICANT DETAILS

1.1 Surname: Bower Forename: Heather Title: Ms

Faculty/Directorate: FEH (ECS Department)

University address, including Faculty Department
Room 118, Mary Seacole, Southwood Site, Avery Hill Road, Eltham, London, SE9 2UG

University telephone: E-mail:

1.2 Are you:
A student?
A member of staff?
A member of staff applying as a student? **Yes**
Other (please specify)?

Programme of study (if applicable to this application)
MPhil / PhD / **EdD** / Masters by Research / other (please specify)

If you are a postdoctoral degree student, has your research project been approved by your Faculty Research Degrees Committee? No

If YES, when? What is the FRDC reference number?

If NO, why not? **EdD student so FRDC approval not required – straight to UREC**
UREC approval number: UREC/18.3.5.7

1.3 What is the primary purpose of the research? (Please indicate YES or NO)

- Educational qualification: **YES**
- Internally funded research: No
- Externally funded research (please provide details of funding): No
- Other (please specify)……

1.4 Project supervision (students only) – give the name of the research supervisor(s) and their contact information
Karen Cleaver:
Jennifer Patterson:
David Evans:

1.5 Details of any co-researchers within the university
N/A

1.6 Details of any co-researchers external to the university
N/A

1.7 Membership of professional bodies - are you or any co-researcher(s) a member of any professional, or other, bodies which set (i.e. require compliance with) ethical standards of behaviour or practice such as the British Psychological Society, Nursing and Midwifery Council, medical Royal Colleges etc.? If so, please specify.
Y**ES** – Nursing and Midwifery Council

SECTION 2: PROJECT DETAILS

2.1 What are the principal research questions in this research? Describe briefly, in lay terms, the proposed research project including step by step methodology, and its potential outcomes and benefits (no more than 250 words).

The first two years after qualification is a particularly vulnerable period for newly qualified midwives, which can result in attrition from the profession (Fenwick *et al.*, 2012). Understanding some of the factors that facilitate this transition to encourage midwives to stay in midwifery in London will have implications for both recruitment and retention.
Mixed methods will be used to address the following questions.

1. What are the personal and professional attributes that enable newly qualified midwives in London to remain in post?
2. What are the factors that influence newly qualified midwives' decisions about remaining in the midwifery profession in London?

Phase 1: Online survey for all midwives distributed by five Trusts. The survey will gain demographic data and identify personal and professional attributes that predispose midwives to remain in post. These attributes will be explored in newly qualified midwives through phase 2. Data will be analysed using SPSS to generate both descriptive and inferential statistics.
Phase 2: To explore the narrative around the factors that influence newly qualified midwives to remain in midwifery and in London. A purposive sample of newly qualified midwives in each Trust will be invited to attend focus groups - permission for further contact will be obtained through the survey. In addition, preceptee midwives will be approached via email by the preceptorship midwife who oversees preceptees in each Trust, on behalf of the researcher, inviting them to take part in an interview / focus group. One senior midwifery manager in the same Trusts will be invited for interviews. Potentially a small purposive sample of midwives who have left the profession will be interviewed (access permitting). It is proposed that narrative analysis will be used to analyse focus groups and individual interviews within an interpretivist paradigm (Reissman, 1993).

2.2 Are any of the following involved? (Please indicate YES or NO)

- Intrusive procedure e.g. questionnaire, interview, focus group, diary, video or voice recording (attach a copy of your questionnaire or indicative questions) **YES**
- Invasive procedure e.g. venepuncture, tissue sampling NO
- Physical contact NO
- Covert observation or covert filming / recording (video or voice) NO
- Children / young people (under 18) – please include age of participants NO
- Vulnerable people (elderly, physically or mentally ill, people with learning difficulties, in care, bereaved, prisoners, other) NO
- Research involving animals (refer to 1.2.2 of the University of Greenwich Research Ethics Policy for more information) NO
- Research involving harmful or criminal, or sensitive or extremist subject matters or research protocols (refer to 1.2.3 of the University of Greenwich Research Ethics Policy for more information) NO
- Drugs, medicinal products or medical devices (if YES, complete Annex I) NO
- Storing human tissue (if YES, complete Annex II) NO
- Working with sources of ionising radiation (if YES, complete Annex III) NO

2.3 Has there been a pilot study (refer to 2.2.1 of the University of Greenwich Research Ethics Policy for a definition) for this research? (If YES, please give details)
YES –the survey has been tested on a purposeful sample of three recently qualified students to ensure the questions are understandable and that the survey can be completed within a realistic timeframe.

2.4 What is the proposed start date (i) of the project and (ii) of the fieldwork (if different)?
What is the proposed end date (i) of the project and (ii) of the fieldwork (if different)?
Amended timeline:

Ethical clearance – December 2019

Data collection (phase 1) – November - December 2020

Data analysis (phase 1) – January – February 2021

Data collection (phase 2) – March – May 2021

Data analysis (phase 2) April – June 2021

Write up – June-December 2021

SECTION 3: PARTICIPATION AND CONSENT

3.1 What are the selection criteria for the proposed participants in the study?
Phase 1: all midwives working in 5 identified Trusts, one in each of the 5 STPs in London.
Phase 2: newly qualified midwives (less than 2 years post-graduation) working in the five identified Trusts in London. These midwives will self select from the survey and will be invited to a focus group. They will also be invited to interview / focus group by the preceptorship midwife (on behalf of the researcher) in each Trust. One senior midwifery manager (for instance, the Head of Midwifery) will be identified in each Trust. They will be interviewed separately.

3.2 How many participants are to take part?
Phase 1: 60 – 100. There are approximately 300 midwives working in each of the four Trusts. If a 10% response rate is assumed, this will result in 120 responses to the survey. However, online survey response rates are often low, therefore numbers have been calculated on a 5-8% response rate.
Phase 2: 10-15. It is planned to hold 3-4 focus groups, virtually via Teams, with 4-8 midwives in each group. If numbers are lower than this (given that they are self-selected), focus groups will be merged or data will be collected through individual interviews. Heads of Midwifery (or other senior role) will be interviewed individually.

3.3 How will prospective participants be recruited / contacted and informed about their role in the project? (Give details and attach your participant information sheet, advertisement, email etc.)

Subject to UREC approval, the relevant Trust R and D departments will be approached to seek local R&D approval. I have already made initial contact with Directors / Heads of Midwifery via my professional networks and obtained agreement to approach their staff. The HoMs have agreed to coordinate the distribution of the survey tool via email, once ethical and Trust approval has been obtained. An explanatory email will accompany the link to the survey (see Appendix 1), which explains that consent is given by clicking on the survey link. At the end of the survey, there will be an invitation to join a focus group with instructions about contact details.

3.4 Where will the interaction with participants take place? E.g. online, classroom, public facility, laboratory, office, home etc.

Phase 1: online survey via link from NHS email account, distributed by the respondents' NHS trust
Phase 2: focus groups will be held virtually, using Teams and inviting midwives via email.

3.5 Are any external bodies' premises or resources to be used? Please indicate YES or NO and give details of permission sought.

NO

3.6 What is the expected total duration of participation in the study for each participant? E.g. 20 minutes to complete a questionnaire, an hour for an interview, etc.

Phase 1: 20 minutes (maximum) for online survey
Phase 2: 1 hour (maximum) for focus groups and interviews

3.7 Is consent to be obtained using the UREC consent template? (Please indicate YES or NO and attach your consent form). If NO please indicate how consent is to be obtained, and attach a copy.

YES

Phase 1 consent will be obtained by emphasising that this is a voluntary survey. It is explained to participants in the email and information sheet (Appendices 1 and 2) that they will be giving consent by clicking on the link to complete the survey.

Phase 2 consent will be given by answering the question in the survey inviting them to participate in a focus group and by providing their contact details. Alternatively, it will be given by responding to an email inviting them to take part in either an interview or focus group from their preceptorship midwife. They will sign a consent form before they participate in the focus group (see Appendix 5).

3.8 If children or young people (under 18) are involved, please say how consent will be sought, from both the children / young people and, if they are under 16, their parents, guardians or those acting *in loco parentis* (e.g. school).

N/A

3.9 Will any payment, incentive or reimbursement of expenses be made? (Please indicate YES or NO and give details, including amount)

NO

SECTION 4: ETHICAL CONSIDERATIONS

4.1 What do you consider are the main ethical issues and risks that may arise in this research? (Refer to the Guidance on Ethical Approval for Research, point 3.1). What steps will be taken to address each issue?

Phase 1: anonymity and confidentiality of online data
Survey data will be distributed via Trust email and data will be downloaded onto SPSS for data analysis. The data file will be password protected on an encrypted USB device, which will be kept locked when not in use. Each participant will be given an individual survey ID so there will be no identifiable data. Data will be destroyed within 2 years in line with data protection requirements.

Phase 2: confidentiality of audio recorded data and transcripts
Transcripts will be downloaded onto a password protected and encrypted USB device, which will be kept locked when not in use. Data will be destroyed within 2 years in line with data protection requirements.
A professional transcribing service will be used to transcribe the data, such as The Typing Works, which are already a preferred supplier to the university, and are therefore used to managing confidential data.

It is acknowledged that there will be confidential data held as a consequence of the research. For instance, email addresses will be made available to me through the survey and will be used by me to contact participants for phase 2 only with permission from the participant. This data will only be used for the purposes of the research. This is in line with the UK Data Protection Act (2018) and GDPR. When writing up the work, all data will be anonymised, including any quotes used in the final work.

It is acknowledged that I am both a doctoral student and a member of staff and this raises potential ethical concerns. It is possible that participants may be ex-students of the University of Greenwich and therefore known to me. However, as qualified midwives I have no responsibility for them or for their practice. Participants will be advised that they can withdraw from the research at any time and that participation or the lack of it will have no effect on their professional work. If any participants are know to me in either Phase 1 or 2, I will acknowledge this anonymously when writing up.

4.2 Will personal data, as defined by the Data Protection Act 1998, be collected during the research (Refer to the Guidance on Ethical Approval for Research, point 3.2)? Indicate YES or NO. If YES, please specify the nature of the personal data to be collected and give details of how you will deal with that data.

YES

Phase 1: password protected (via email) online questionnaire – anonymous unless respondent chooses to provide name and contact details for focus group. Data will be encrypted, password protected and stored in a secure location.

Phase 2: audio recorded data will be password protected and will be transcribed anonymously – data will be encrypted, password protected and stored in a secure location. Personal details linked to each transcript will be known only to the researcher.

All data will be destroyed within 2 years in line with data protection requirements.

SECTION 5: FINANCIAL INTERESTS

5.1 Indicate by "YES" or by ticking one of the statements below:

- I declare there is no financial or other direct interest to me or my Faculty or Directorate arising from this study **YES**

- I declare there is a financial or other direct interest to me or my Faculty or Directorate arising from this study (supply details)

Signatures

I undertake to carry out research in accordance with the University's Research Ethics Policy. In the case of a higher degree, I confirm that approval has been given by the Faculty Research Degrees Committee.

Signature of applicant: **Date: 21.1.19**

Print name: Heather Bower

I have discussed the project with the applicant, I confirm that all participants are suitably qualified to undertake this research and I approve it.

Signature of supervisor (to be signed if applicant is a student) **Date 28.01.2109**

Print name Karen Cleaver

I have reviewed the project with the applicant, or applicant's supervisor, and I confirm that all participants are suitably qualified to undertake this research and I approve it.

Signature of <u>UREC representative</u> **Date 11.2.19** **Print name Jill Jameson**

APPENDIX 8a Initial Codebook

Codebook for Why Do Midwives Stay? Interviews													
STRUCTURAL CODE/ THEME	NEWLY QUALIFIED MIDWIVES' EXPERIENCE			CULTURE AND RESILIENCE			REMAIN			LEAVE			
CONTENT CODE	Survival SURVIVE	Support SUPPORT	Transition TRANSIT	Culture of bullying CULTURE	Sense of Failure FAIL	Stress and burnout STRESS	Job satisfaction JOBSATIS	Development DEVEL	London LONDON-R	Work/life balance WORKLIFE	Staffing STAFF	London LONDON-L	COVID
Brief Definition	Terms/phrases denoting survival	Support / lack of support	Transition to qualified practice.	Culture of midwifery, including bullying behaviour.	Sense of personal or professional failure	Stress, burnout and fear.	Job satisfaction as a result of being a midwife.	Opportunities for learning and development in future.	Reasons to remain in London.	Work/life balance and sustainability of working patterns.	Poor staffing levels.	Reasons to leave London.	Working life affected by COVID.
Full Definition	Terminology that is used to express ideas of surviving or battling during the experience of being a newly qualified midwife.	Any formal or informal support mechanism for NQMs - or lack of support provided for NQMs.	Any description of the transition from student to NQM, which may include references to learning and development.	Description of the culture of midwifery practice or oppresive behaviours of (individual) midwives relating to bullying or degradation or frustration.	Description of how they deal with failure and whether failure is a discouragement or a motivator to improve practice	Ideas relating to the stressfulness of the job, stressful situations and environments, burnout caused by the job and negative words such as fear.	Job satisfaction relating to the work of a midwife, midwifery itself or of feedback from women and families. Satisfaction from providing continuity.	Opportunities provided by midwifery for future professional development and/or learning and career development opportunities.	Reasons given by midwives as to why they want to remain in London. These might include short term or long term plans for staying in London.	Work/life balance is used to explain rotas or patterns of working that are either compatible or incompatible with having a personal life and sustaining this.	Description of situations where staffing levels are poor, including staffing levels described as unsafe.	Reasons given by midwives as to why they want to leave London. These might include short term or long term plans for leaving London.	Description of how working life or working conditions have been affected by COVID. ***This is not being treated as a theme but will be coded for discussion.***
When to use	Apply to words or phrases that depict ideas of survival, surviving, battling. These ideas may be expressed in metaphors.	Apply to description of support mechanisms, whether formal or informal. Or description of lack of support by sustem / colleagues	Apply to words relating to terms such as 'learning curve' or any description of the journey from student to NQM. Includes clinical skills development.	Apply to any words or phrases relating to oppresive behaviour such as bullying, whistle-blowing, or generally putting down NQMs.	Response to question about how they deal with failure and whether they feel that failure is a discouragement or not including the consequences of failure.	Apply to any description of stress, burnout, fear or other negative words associated with the work environment. This might relate to generic or specific situations.	Apply to any description of midwifery work which enables midwives to feel satisfied with the work they do. This might include continuity of carer teams or schemes.	Apply to descriptions of future plans where career development opportunities or plans are discussed. This might include further education, specialisation or specific career plans.	Apply to descriptions of why midwives are choosing to stay in London (short or long term). These might be for personal or professional reasons.	Apply to descriptions of working patterns that either engender a work/life balance or prevent an acceptable and sustainable way of working that interferes with personal life.	Apply to any description of shifts or situations where poor staffing was a source of concern or was described as unsafe. This may include staffing levels affected by COVID.	Apply to descriptions of why midwives are intending to leave London (short or long term). These might be for personal or professional reasons.	Apply code to any description of how COVID has affected working conditions or environment, including NQMs' attitude towards working in COVID.
When not to use	Do not use this code for ideas relating to support / lack of support - use SUPPORT. Or for comments relating to transition to NQM - use TRANSIT.	Do not use this for stress/bullying (STRESS) or for ideas / metaphors about survival (SURVIVE). If the description is about staffing levels, use STAFF.	Do not use for ideas/ phrases relating to survival, such as 'sink or swim'. This should be coded under SURVIVE. Description of future develop-ment should be coded DEVEL.	Do not use where the behaviour relates only to lack of support (SUPPORT) and is either not intentional or is outwith the midwives' control.	Do not use to describe ideas relating to stress or burnout (STRESS) or to describe how they dealt with challenging situations when first qualified (TRANSIT)	Do not apply to descriptions of shortage of staff alone (STAFF) - but these codes may be related. Do not apply if the scenario described is related to bullying (CULTURE).	Do not apply to negative descriptions of being a midwife, such as poor job satisfaction, being overworked (STRESS) or shortage of staff (STAFF). Do not apply to cultural difficulties (CULTURE).	Do not apply to descriptions of immediate learning as a NQM or the learning and development required to transition from student to NQM (TRANSIT).	Do not apply to reasons for intending to leave London (London-L).	Do not use for descriptions of poor staffing levels (STAFF) or where NQMs expresss that they are or are not receiving support at work (SUPPORT).	Do not apply to situations that were affected by poor staff attitudes or behaviours rather than staffing levels. In this situation, the code CULTURE should be applied.	Do not apply to reasons for intending to stay in London (London-R).	Do not apply to descriptions of poor staffing levels as a result of COVID. This should be coded under STAFF as it is part of the theme of LEAVE

APPENDIX 8b Final Codebook

STRUCTURAL CODE/ THEME	HEAD ABOVE WATER			PROFESSIONAL CONFLICTS			PROFESSIONAL IDENTITY			LONDON		COVID
CONTENT CODE	SurvivalSINK/SWIM	Support SUPPORT	Transition TRANSIT	Culture of bullying CULTURE	Stress and burnout STRESS	Staffing STAFF	Job satisfaction JOBSATIS	Work/life balance WORKLIFE	Fittingin	London LONDON-R	London LONDON-L	COVID
Brief Definition	Terms/phrases denoting survival	Support / lack of support	Transition to qualified practice.	Culture of midwifery, including bullying behaviour.	Stress, burnout and fear.	Poor staffing levels.	Job satisfaction as a result of being a midwife.	Work/life balance and sustainability of working patterns.	Fittingintothecutureo ftheworkplace	Reasons to remain in London.	Reasons to leave London.	Working life affected by COVID.
Full Definition	Terminology that is used to express ideas of surviving or battling during the experience of being a newly qualified midwife.	Any formal or informal support mechanism for NQMs - or lack of support provided for NQMs.	Any description of the transition from student to NQM, which may include references to learning and development.	Description of the culture of midwifery practice or oppresive behaviours of (individual) midwives relating to bullying or degradation or frustration.	Ideas relating to the stressfulness of the job, stressful situations and environments, burnout caused by the job and negative words such as fear.	Description of situations where staffing levels are poor, including staffing levels described as unsafe.	Job satisfaction relating to the work of a midwife, midwifery itself or of feedback from women and families. Satisfaction from providing continuity.	Work/life balance is used to explain rotas or patterns of working that are either compatible or incompatible with having a personal life and sustaining this.	Fittinginisused	Reasons given by midwives as to why they want to remain in London. These might include short term or long term plans for staying in London.	Reasons given by midwives as to why they want to leave London. These might include short term or long term plans for leaving London.	Description of how working life or working conditions have been affected by COVID. ***This is not being treated as a theme but will be coded for discussion.***
When to use	Apply to words or phrases that depict ideas of survival, surviving, battling. These ideas may be expressed in metaphors.	Apply to description of support mechanisms, whether formal or informal. Or description of lack of support by sustem / colleagues	Apply to words relating to terms such as 'learning curve' or any description of the journey from student to NQM. Includes clinical skills development.	Apply to any words or phrases relating to oppresive behaviour such as bullying, whistle-blowing, or generally putting down NQMs.	Apply to any description of stress, burnout, fear or other negative words associated with the work environment. This might relate to generic or specific situations.	Apply to any description of shifts or situations where poor staffing was a source of concern or was described as unsafe. This may include staffing levels affected by COVID.	description of midwifery work which enables midwives to feel satisfied with the work they do. This might include continuity of carer teams or schemes.	Apply to descriptions of working patterns that either engender a work/life balance or prevent an acceptable and sustainable way of working that interferes with personal life.		Apply to descriptions of why midwives are choosing to stay in London (short or long term). These might be for personal or professional reasons.	Apply to descriptions of why midwives are intending to leave London (short or long term). These might be for personal or professional reasons.	Apply code to any description of how COVID has affected working conditions or environment, including NQMs' attitude towards working in COVID.
When not to use	Do not use this code for ideas relating to support / lack of support - use SUPPORT. Or for comments relating to transition to NQM - use TRANSIT.	Do not use this for stress/bullying (STRESS) or for ideas / metaphors about survival (SURVIVE). If the description is about staffing levels, use STAFF.	Do not use for ideas/ phrases relating to survival, such as 'sink or swim'. This should be coded under SURVIVE. Description of future develop- ment should be coded DEVEL.	Do not use where the behaviour relates only to lack of support (SUPPORT) and is either not intentional or is outwith the midwives' control.	Do not apply to descriptions of shortage of staff alone (STAFF) - but these codes may be related. Do not apply if the scenario described is related to bullying (CULTURE).	Do not apply to situations that were affected by poor staff attitudes or behaviours rather than staffing levels. In this situation, the code CULTURE should be applied.	Do not apply to negative descriptions of being a midwife, such as poor job satisfaction, being overworked (STRESS) or shortage of staff (STAFF). Do not apply to cultural difficulties (CULTURE).	Do not use for descriptions of poor staffing levels (STAFF) or where NQMs expresss that they are or are not receiving support at work (SUPPORT).		Do not apply to reasons for intending to leave London (London-L).	Do not apply to reasons for intending to stay in London (London-R).	Do not apply to descriptions of poor staffing levels as a result of COVID. This should be coded under STAFF as it is part of the theme of LEAVE