Cull, Joanne, Hunter, Billie, Henley, Josie, Fenwick, Jennifer and Sidebotham, Mary (2020) "Overwhelmed and out of my depth" : responses from early career midwives in the United Kingdom to the Work, Health and Emotional Lives of Midwives study. Women and Birth.

Abstract

Background

Efforts to resolve the longstanding and growing staffing crisis in midwifery in the United Kingdom have been hampered by very poor retention rates, with early career midwives the most likely to report burnout and intention to leave the profession.

Aims

To establish the key, self-described factors of satisfaction and dissatisfaction at work for early career midwives in the United Kingdom, and suggest appropriate and effective retention strategies.

Methods

Thematic analysis was undertaken on a subset of free text responses from midwives who had been qualified for five years or less, collected as part of the United Kingdom arm of the Work, Health and Emotional Lives of Midwives project.

Findings

Midwives described feeling immense pressure caused by an unremittingly heavy workload and poor staffing. Where relationships with colleagues were strong, they were described as a protective factor against stress; conversely, negative working relationships compounded pressures. Despite the challenges, many of the midwives reported taking great pleasure in their work, describing it as a source of pride and self-esteem. Midwives valued being treated as individuals and having some control over their shift pattern and area of work.

Discussion

These results, which reveal the strain on early career midwives, are consistent with the findings of other large studies on midwives' wellbeing. All available levers should be used to retain and motivate existing staff, and recruit new staff; in the meantime, considerable creativity and effort should be exercised to improve working conditions.

Conclusion

This analysis provides a 'roadmap' for improving staff wellbeing and potentially retention.

Abbreviations

WHELM, Work, health and emotional lives of midwives; UK, United Kingdom; NHS, National Health Service; RCM, Royal College of Midwives; MW, midwife

Keywords

Midwives, Dissatisfaction, Workforce; Stress; Emotional Wellbeing; Burnout.

Statement of significance

Problem or issue

Previous research has revealed the poor emotional wellbeing of midwives in the United Kingdom, which is both affected by and perpetuates the ongoing recruitment and retention crisis.

What is already known

Several international studies have found that early career midwives are more likely to report burnout and intention to leave the profession.

*What this paper ad*ds

This analysis adds to understanding of the reasons for the high levels of stress, burnout, anxiety and depression reported by early career midwives, and provides insight into how the emotional wellbeing of midwives can be improved.

Introduction

The Royal College of Midwives has described "colossal pressures weighing down on midwives" (p6) in the United Kingdom resulting from not only an increase in the number and complexity of pregnancies, but significant workforce issues[1]. There is a persistent staffing shortage estimated at 3,500 full-time midwives in England, and the skills, experience and confidence brought by the one in three midwives in their fifties and sixties is increasingly being lost as they retire. The staffing shortage is partly attributable to chronic retention difficulties; for every 30 new student midwives, the net result is an increase in the workforce of just one midwife[2]. A report by The Health Foundation, Nuffield Trust and the King's Fund[3] states that "the workforce challenges in the NHS in England now present a greater threat to health services than the funding challenges […] even if commissioners have the resources to commission additional activity, health care providers may not have the staff to deliver it" (p2). Whilst the Government has committed to training an additional 3000 midwives in England[2], it is unclear how this will be achieved, at least in the short term; student intake numbers are ultimately restricted by clinical and academic capacity, and 25% of student midwives in England leave the course before qualifying[4].

Although the British maternity system could be considered progressive, with free maternity care at the point of use under the National Health Service, and continuity of care by a known midwife a part of formal government policy for over twenty years, in reality there has not been large scale integration of midwife-led continuity of care models within mainstream maternity services in the United Kingdom[5]. A public sector pay cap imposed in 2010 saw a prolonged loss of earnings in real terms for UK midwives, resulting in significant dissatisfaction within the profession[6]. In

addition to financial challenges, the most recent National Maternity Review highlighted that midwives are more likely than any other NHS staff group to experience work-related stress, possibly due to the unique stressors faced as autonomous practitioners working within a medicalised maternity care system[5,7]. This is deeply concerning, as staff wellbeing is a powerful antecedent of positive patient experience, with staff engagement closely linked to quality and safety of care, in addition to lower levels of absenteeism and turnover[8]. Pezaro, Pearce and Bailey[9] carried out a study which explored the psychological wellbeing of midwives from the perspective of ten new mothers. Although small, the study had important findings. The researchers found that midwives' stress levels were clearly visible to service users; three of the women had seen their midwife cry or become emotional, and several participants described the midwife looking to them for support, perhaps in response to a lack of support available by managers or colleagues.

The Work, Health and Emotional Lives of Midwives (WHELM) in the United Kingdom study[10] used validated tools to assess burnout, stress, anxiety and depression, and found that levels of each were significantly higher in UK midwives than the general population, and above the levels recorded for midwives in other countries in which the WHELM study had been carried out[10, 12, 13, 18, 41]. Further, two-thirds of respondents had considered leaving the profession within the last 6 months. The researchers found that poor emotional health was increased in younger participants and in those with fewer years of clinical experience[10], with similar findings in the Australian, Norwegian and Swedish arms of the WHELM collaborative[11-13]. Improving the wellbeing of midwives is crucial to support ongoing recruitment and aid retention efforts in order to ultimately preserve a safe maternity service; an in-depth study of the emotional wellbeing of UK midwives and identification of factors which influence staff experience of the workplace, both positively and negatively, was therefore urgently needed. In light of the findings above, it was felt to be important

to analyse the free text responses provided by early career midwives in the UK WHELM study to gain deeper insights into their experiences.

Aims: The specific aims of the analysis presented in this paper were to establish the key, self-described factors of satisfaction and dissatisfaction at work for UK midwives who have been qualified for five years or less, to compare the findings with other relevant studies, noting similarities and discrepancies; and suggest appropriate and effective retention strategies.

Participants, ethics and methods

Methods

The UK WHELM study[10] used a cross sectional research design to examine the association between the emotional health of UK midwives and their work environment; study methods are described in full in that paper. The WHELM survey tool was developed in Australia, and variations of the study have since been carried out in New Zealand, Sweden, Canada and Norway[12,13,18, 41, 43]. The survey was designed to allow the collection and analysis of both quantitative and qualitative data, and contained a number of open questions which asked midwives to identify up to five main factors each contributing to satisfaction and dissatisfaction in their work. Tavener, Chojenta and Loxton[14] propose that free text survey responses represent a rich data source in their own right. The results of the quantitative analysis have been published separately[10]**.** This paper reports on the analysis of free text responses to the following questions:

1. Please identify up to five main factors which contribute to satisfaction in your work; and
2. Please identify up to five main factors which contribute to dissatisfaction in your work.

Participants

The UK WHELM study was commissioned by the Royal College of Midwives (RCM). An estimated 90% of midwives in the UK are RCM members. Only Registered Midwives who were RCM

members at May 2017 were eligible for inclusion in the study, and an email invitation to participate was sent out between May and July 2017.

Ethics

Ethical approval to conduct the study was granted by X University School of Healthcare Sciences Research Ethics Committee on 21st April 2017 and ratified on 9th May 2017.

Data analysis

Free text responses to the selected questions were extracted for all midwives who reported that they had been qualified for five years or less, described henceforth as early career midwives. Themes were identified in an inductive way by three members of the research team; the first author led the initial analysis and refrained from reading widely around the topic until the main themes had been identified, so that the data could be analysed interpretatively. Thematic analysis was carried out using the guidance of Braun and Clarke[15], who provide a six-step approach to the analysis and interpretation of qualitative data. The data involved were repeatedly read and initial codes in which data were named and given meaning were generated through colour coding the transcripts by hand. The colour coded transcripts were reviewed in order to identify primary themes, which were then refined, described and labelled. Finally, relevant text was chosen from the responses for inclusion in the report. Following initial analysis by the first author, the second and third authors critiqued the coding and themes to enhance rigour and trustworthiness: the themes were discussed and refined until consensus was achieved within the research team. Four main themes were identified from the data, and a thematic map was developed. As an early career midwife herself, the first author paid careful attention throughout to how her personal experiences, views and beliefs may have influenced the interpretation of the responses.

Findings

1997 midwives, representing 16% of the RCM membership, participated in the UK study, with a mix of employers including the NHS (community, hospital and birth centres), university and private / independent sectors. Of the 1997 survey respondents, 620 midwives had been qualified for five years or less, representing 31% of the UK WHELM study sample. Of these midwives, 503 submitted free text responses about sources of satisfaction at work, whilst 512 submitted responses about sources of dissatisfaction at work. Table 1 summarises the demographic and work characteristics of the sub-set of UK WHELM respondents who had been qualified for five years or less. Almost all of the respondents were female, the average length of qualification time for this group was just over 2 years (2.08), and the average age was 34.9 years. The majority of respondents were married, in a civil partnership or cohabiting (66%), and had children or step children (53%).

Place table 1 here

Responses varied from a few words to longer, more detailed answers. Four themes were generated: work stress; role satisfaction; interpersonal factors; and role support. The findings are presented below, with illustrative quotes supporting the findings. Quotes are identified by participant number, for example midwife 152 is referred to as MW 152, and clarified where needed using square brackets. Figure 1 shows the thematic map, which summarises the key themes.

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Work stress: Midwives under intense pressure

The strongest theme identified was the immense pressure felt by midwives. Almost every respondent reported staff shortages, unmanageable workloads or both as sources of dissatisfaction. Respondents described feeling "*overwhelmed and out of my depth [...] doing a*

half job" (MW 222) and spending time away from work "*worrying that I may have made a mistake, or missed something because of the time pressures felt*" (MW 480). Long shifts, coupled with no breaks, were described by over a quarter of midwives, and resulted in exhaustion and a consequent impact on mental health.

Midwives recounted constant pressure to *"hurry, hurry, hurry"* (MW 479). In the community, midwives described overbooked clinics with eighty to one hundred women to be seen; on the birth suite, a rush from one birth to the next without finishing paperwork or handing over; on the postnatal and antenatal wards, staffing shortages left midwives with significant safety concerns, with one midwife noting *"safety is compromised due to staffing levels and the conveyor belt business model of the NHS"* (MW 450). A number of midwives reported feeling their workload was ever-increasing. A worsening staffing situation was perceived to be exacerbated by pressure to improve services, become involved in research trials and move from paper to electronic records. For many respondents this move to electronic records resulted in more work, not less, as documentation was now duplicated. One respondent encapsulated the views of many when she stated her frustration at the amount of: *"Patience, physical effort, emotional effort, secretarial skills required to carry out […] increasingly non clinical roles which compromise time that could and should be spent caring for clients, supporting parents, observing and caring for babies"* (MW 296). Homebirth team and community midwives frequently expressed resentment at being used to *"provide cover for understaffed hospital care at night, causing a knock-on effect on already high workloads"* (MW 63) and impacting on the availability of homebirth services.

The UK WHELM study[10] demonstrated the high levels of stress, anxiety, depression and burnout experienced by UK midwives. Further insights into the impact of these negative emotional experiences are provided by this qualitative analysis, with respondents describing feeling out of control, unable to enjoy their time off and to 'switch off'. One midwife felt "*so tired on my days off*

that I don't have the energy to do the things I want to do" (MW 135); another "*a loss of control over my life as work is all consuming"* (MW 280). Unsurprisingly, participants struggled to retain their passion for midwifery, with one stating "*I got a first [first class honours degree] at uni and was so excited about my work but that is dissipating quickly"* (MW 287). Perhaps the most concerning response was from the heartbreakingly honest midwife who confessed *"I don't have time to connect to the women as individuals […] I have increasing lack of compassion for women"* (MW 503).

Midwives recounted a workload so unmanageable that overtime, essentially enforced and unpaid, was necessary to fulfill their responsibilities. Respondents worked late, completed administrative tasks at home and regularly worked twelve and a half hour shifts with no breaks. Numerous participants detailed their lack of hydration or even toilet breaks. Exacerbating their sense of injustice, several midwives noted that the lack of breaks was blamed on personal time management. One stated: *"If anything you get a telling off for not taking a break but you are pushed to discharge women by certain times meaning there is no time to do it"* (MW 448). The difficult working conditions were intensified for some midwives by the absence of a staff room and harsh policies such as not being allowed to drink while working or sleep during breaks on night shifts. In contrast, the British Medical Association[16] advises doctors to nap during breaks on night shifts to minimise fatigue and optimise decision making, and further counsels that employers should provide appropriate facilities for this. Little mention was made of attempts to improve conditions for staff, with one participant citing "*laughably token 'staff wellbeing' and 'resilience training' (e.g. why not take a walk around the hospital during your lunch hour? What lunch hour?)*" (MW 335). Many midwives found the workload so draining that they felt they needed to reduce their hours to part-time in order to cope, despite the financial consequences: *"Having to work part time as full-time workload would be exhausting and very stressful [sic] [...] part time pay not enough"* (MW 165).

Providing care which midwives perceived as substandard was reported as one of the key sources of dissatisfaction. Participants felt enormous frustration at being unable to give the quality of care they wished to, and described feeling compromised and a strong sense of *"letting women down"* (MW 54), as demonstrated by this powerful quote:*"The feeling of failure when you've physically exhausted yourself and couldn't possibly do any more is demoralising. Above everything, not giving women and babies the care they deserve is the worst aspect"* (MW 316). Midwives felt they had to become *"task centred rather than woman centred"* (MW 502) and worried that lack of time would mean they missed newborn feeding problems, postnatal depression or other issues. One respondent, echoing many, felt she had *"not enough time to deliver good care, can just about manage safe care*" (MW 389).

Many respondents linked workload and staffing issues directly to patient safety, describing a regular inability to provide one to one care in labour, unsafe staff to woman ratios on antenatal and postnatal wards, and reluctance by management to close maternity units when levels of staffing were not safe. One respondent described the *"huge responsibilities and fear of making a mistake when workload is too much*" (MW 447); another noted *"tiredness and busyness leading to making mistakes"* (MW 22). Midwives recounted a tokenistic approach to the reporting of concerns to management (escalation): *"With management in general, there is a request for escalation, but when it happens there is no support with a lot of mumblings of 'you just got on with it in my day'"* (MW 448).

Participants feared causing harm due to stress and high workloads; worryingly, several incidences of clearly dangerous practice were noted, such as caring for up to twelve high risk antenatal or postnatal mother-baby pairs, and *"being in charge of a PN [postnatal] ward or AN [antenatal] ward yet only being a midwife for six months"* (MW 294). Moreover, many respondents commented on

a perceived 'blame culture' in their workplaces, with a resulting impact on their mental health. One midwife described "*coming home worrying about what I have missed, not documented, handed over waking up with flashbacks"* (MW 369); another, "*a constant fear of what might be waiting when I go back to work i.e. have I done something wrong"* (MW 419). Many participants felt *"scrutinised rather than supported by management"* (MW 287) and felt that midwives were treated much more harshly than doctors when involved in incidents, as expressed by this respondent:

"When something goes wrong, which inevitably will always happen, as sadly not every pregnancy ends well, however good the care, midwives are treated appallingly, it is shocking and devastating to observe good hard-working midwives torn apart by the absolutely disgusting way that incidents are dealt with. Babies do and will die, and it is not always somebodies [sic] fault. Trusts […] cover their own back as far as litigation. There is never any support it is a truly horrific witch hunt. I have met so many broken midwives, who then leave the profession" (MW 125).

Another midwife referred to: *"seeing colleagues who have been treated so poorly by senior management when things have gone wrong, that their lives have been destroyed"* (MW 170).

Role satisfaction: the inherently pleasurable work of midwifery

Despite the challenges, many of the midwives reported taking great pleasure in their work, describing it as a source of pride and self-esteem. Midwives referred to the *"simple enjoyment and the love of the job"* (MW 276), *"seeing women and families thrive" (MW 58), and "caring for my local community"* (MW 235). Participants enjoyed the relationship with new families, and providing continuity of care was mentioned as a particular source of satisfaction. Several participants found caring for women living in areas of socio-economic deprivation particularly gratifying, with one midwife finding fulfilment from *"helping women from a poor area of the city in any number of small ways*" (MW 180). Midwives working in well-regarded units felt pride at their reputation, and respondents enjoyed the diversity of the work involved in midwifery. Participants

described the self-worth they felt in *"being part of the special midwifery club that gets to do feminist work empowering women*" (MW 454), *"having good stories to tell"* (MW 69) and "*being part of something so exclusive*" (MW 461).

A consistent theme emerged of midwives providing high quality care despite the intense pressure of their work, with respondents finding satisfaction in "*knowing that I have made a difference to a family whilst they remain unaware of the strain I am under through excessive workloads and poor staffing"* (MW 409); "*surviving a whole shift on a busy postnatal ward with no calamities"* (MW 503) and simply *"finishing the shift feeling I did well*" (MW 385). Many participants enjoyed facilitating natural birth, both in midwife-led and obstetric-led units. Respondents hugely valued positive feedback from women and their families and relished working autonomously. As early career midwives, respondents expressed the satisfaction gained from developing their clinical skills, knowledge and confidence. Indeed, many respondents were in senior positions despite their short post-qualification period, and reported the satisfaction they receive from supporting others: "*Getting everyone a break*" (MW 49); "*Working with midwives who constantly stay over shifts to help out when I am coordinating*" (MW 508); "*I am a team leader and my team are amazing and supportive of each other"* (MW 284). Midwives related the fulfilment they felt from giving care which they felt to be high quality and *"being able to be the midwife I wanted to be throughout my training"* (MW 166).

Interpersonal factors: positive and negative relationships with colleagues

The most commonly reported source of satisfaction was relationships with colleagues and feeling like part of a team; indeed, the words 'colleagues' and 'team' were cited over 400 times in the 503 comments regarding sources of satisfaction. Midwives described a strong team as a protective factor against the stress of the workload, with one respondent stating: *"If I am working with a good team I don't mind how hard the work is"* (MW 287).

The Royal College of Midwives recommends that newly qualified midwives are provided with a 'preceptorship programme' described as "a structured period of transition that develops the newly qualified midwife from a student to an accountable midwife able to work confidently"[17] (p1). During the preceptorship period, which normally lasts up to a year, the midwife should have not only a formal orientation and supernumerary time, but also protected learning time to develop skills and competencies, and feedback and support from an experienced midwife. Surprisingly, however, there was remarkably little mention of preceptorship by study respondents: only eight midwives referred to their preceptorship scheme at all, with a mix of negative and positive comments. More important than receiving support was simply feeling part of a team. The lack of expectations for formal support may be the result of the intense workplace pressures and staffing shortages described in the previous theme, so that newly qualified midwives do not have an expectation, or an experience, of a preceptee period. Nonetheless, participants voiced their appreciation for senior midwives and obstetric staff who respected them, supported their decisions, and valued their opinions; senior staff who showed a positive attitude towards newly qualified midwives and gave *"space to develop your care*" (MW 205) were treasured, as were relationships with other newly qualified midwives.

Many participants spoke of the friendships they had developed at work, and the positive impact of this on their experience of the workplace. Others described "*working with colleagues who are positive and empowering*" (MW 133), feeling "*always welcomed by colleagues"* (MW 124) and working with "*dedicated and hard-working midwives who maintain enthusiasm and compassion despite a lot of negativity"* (MW 85). The respondents who worked in supportive teams still talked of the daily strain of engaging in such an overstretched service, but expressed that having positive relationships with caring colleagues and "*good team spirit*" (MW 124) gave them a much needed

morale boost. The responses gave a real sense of the camaraderie and support in some teams, with one midwife reflecting the sentiments of many:

"The awesome sense of humour and teamwork even in the hardest clinical situations when our backs are against the wall. Clinical staff of all bands seem to pull it out of the bag which is probably why the NHS hasn't collapsed yet - credit to them all" (MW 445).

Conversely, a number of midwives cited relationships with colleagues as a prime source of dissatisfaction in the workplace. Thirty-four of the 512 responses on sources of dissatisfaction at work (7%) specifically mentioned bullying, most commonly from the lead midwife on shift and / or managers, and many others reported negative working relationships with fellow midwives, managers, doctors and senior midwives. One midwife described: "*feeling too intimidated to ask for help due to attempts to humiliate myself and other newly qualified staff in front of colleagues by senior members of staff"* (MW 372).

Frequent divisions were noted between midwifery-led units (MLUs) and their sister obstetric units, with midwives feeling that they were treated condescendingly by obstetric unit midwives if they were moved to work from the MLU to the obstetric unit, to meet organisational needs. Community staff often described feeling undervalued and that their work was unrecognised compared to hospital staff; and there was persistent discord described between obstetric and midwifery staff. Some participants made a connection between the workload and staffing levels and the negative collegial environment, with low staff morale frequently mentioned and one midwife noting that poor working relationships often occur "*where people and resources are under pressure*" (MW 136).

Relationships with managers, perhaps unsurprisingly given the midwives' other experiences, were mixed. Midwives valued acknowledgement and appreciation from managers and senior

clinical staff, after a difficult shift or emergency, or 'just' for the day to day grind of a heavy workload and missing a break. A number of respondents described their managers as kind and supportive, with one respondent noting:

"I'm fortunate to work with some very good managers who haven't forgotten where their roots are and they are visible to staff, they know their staff by name and take an interest in them personally which goes a long long way in maintaining morale throughout the department" (MW 445).

Managers who were viewed as 'hands on' were particularly prized, conversely, one participant spoke for many when she proposed that her managers do not understand "*the challenges on the frontline having not clinically worked for many years*" (MW 114). Notable resentment was expressed against managers who were perceived as not visibly present or not helping out clinically when services are at a critical level, with midwives feeling *"left to cope*" (MW 261). Several midwives conveyed the perceived dissonance between the desire to provide good care and the demands of the system: *"I was told by a manager to stop trying to provide high standard midwifery care and to settle for okay level care"* (MW 503). For some midwives, frustration at not providing the level of care they wanted to spilled over into anger at "*high expectations of some women, often unachievable and unrealistic"* (MW 284), *"the feeling of never 'winning', either upsetting patients or management or both"* (MW 69), and having to "*constantly apologise*" (MW 306) for delays and substandard care.

Role support: Personalised, compassionate care for midwives, not only birthing women

Roster issues contributed significantly to the wellbeing of respondents. Midwives described the importance of knowing which shifts they would be working, (referred to as the "off-duty"), well in advance to allow them to plan childcare, family commitments and social events; short notice of the off-duty caused particular resentment, with one participant commenting: "*The off duty is never*

released on time, and managers don't care" (MW 21). Being transferred to different clinical areas, often with little or no notice, also caused stress and anxiety; midwives reported feeling unable to consolidate their skills in any area as they were moved so frequently. Enforced rotations were also unpopular, as participants disliked the uncertainty of not knowing where they would be working, and wanted their preferences to be taken into account.

Perhaps the most striking observation of the comments made about working patterns was that no one system or solution could be considered to be suitable for every working midwife. Many midwives remarked that they enjoy working long (12 or 12.5 hour) shifts, which gave them more days off per week, the opportunity to work extra bank shifts and in some cases fitted in well with home life. Others found short (7.5 or 8 hour) shifts more convenient for childcare and less tiring. Some respondents complained that they worked a disproportionate amount of nights and weekends; others wanted to work predominantly nights and weekends and were told by their manager they could not. Accommodating staff preferences for shift type, although logistically more difficult, appears to be one important aspect of staff retention. Roster difficulties contributed to several participants either choosing to go part-time or leaving their substantive post altogether and working only on the bank (providing temporary cover for staffing shortfalls), in order to have control and the ability to organise their shifts around their preferences and family commitments. Conversely, several midwives cited the ability to choose their shifts and working patterns as a source of satisfaction. Participants who felt their requests and personal needs were disregarded harboured significant resentment at: *"impersonal treatment by managers moving people around areas to meet needs of service rather than seeing midwives as people"* (MW 42).

Numerous participants described the negative impact of having a lack of control over their working hours on their friendships, family life and ability to pursue hobbies or interests on a regular basis, all of which are sources of wellbeing. One midwife expressed:

"My partner is a police officer and works shifts which are always the same. I wish I could have that! It would make life so much easier and we could actually plan our lives more than 1 month ahead! It's frustrating for me, my friends and family to never know when to book things etc. Then you go ahead and book after requesting days off and don't get those days off. Then it's my problem and my responsibility to get it swapped if I can" (MW 316).

In particular, respondents noted the importance of having sufficient time between shifts to recover, particularly when moving between night shifts and day shifts. A poor shift pattern was felt to contribute to poor physical and emotional health, with one midwife stating: "*No pattern to the shifts, causing mental health problems I've not had before. I don't remember the last time I had any energy and wasn't completely exhausted*" (MW 452). Consistent with the findings reported in the UK WHELM quantitative paper[10], numerous participants discussed their poor emotional wellbeing, mentioning exhaustion, burnout, depression, stress and anxiety.

Repeated requests from managers to work additional shifts arose frequently as a source of dissatisfaction. Midwives described managers "begging" for them to work extra shifts; even if they did not agree to these extra hours they felt guilty. The requests impacted on their enjoyment of their days off and they began to dread phone calls or texts asking them to work overtime, as summarised by this respondent: *"not being able to fully relax on days off due to the knowledge that extra hours are needed if you have said no"* (MW 347). Perhaps predictably for a vocational profession, salary levels in themselves did not seem a high priority for respondents. However, it was commonly felt that the salary does not match the responsibility involved in the role, with one midwife confiding "i*t is terrifying sometimes the pressure we have, the fear of litigation, the fear of something awful happening" (MW 323).* Further, participants described feeling treated with contempt by the *"government who should serve us*" (MW 108) regarding pay restraint in the NHS[6]. While salary did not seem to be a strong motivator for the majority of participants, access to

additional training and the opportunity and support for career progression was felt to be important by a number of respondents.

Discussion

The UK WHELM quantitative results paper[10] highlighted the poor emotional wellbeing of UK midwives, with levels of stress, anxiety, depression and burnout well above population norms and those of midwives in other WHELM collaborating countries. While any level of burnout among midwives is concerning, 83% of UK WHELM study participants reported personal burnout, compared to 65% in the Australian arm, 43% in the Swedish arm and 20% in the Norwegian arm of the study[10,12,13,18]. This subset analysis confirms and elaborates on these findings for respondents qualified for 5 years or less.

Overall, the results were consistent with other large studies of staff wellbeing, including the Caring for You survey carried out by the Royal College of Midwives[19], which found half of midwives felt stress every or most days, only one-fifth regularly took their entitled breaks, and nearly one-fifth admitted "I often cry at work because of the pressure I am under". Cramer and Hunter[20] carried out a literature review of research examining the association between midwives' emotional wellbeing and their working conditions; the authors found a strong correlation between high workload and emotional distress in midwives, with a clear relationship between emotional wellbeing and the quality of relationships with colleagues. Encouragingly, the RCM Caring for You survey[19] found that midwives working in organisations which take positive action on health, safety and wellbeing were less likely to feel stressed or bullied, and more likely to report delivering the level of care they wish to and feeling proud to work as a midwife. The report concluded that "Investment in staff is an investment in care for women and their families" (p2).

The relationship between an unmanageable workload and poor outcomes is well documented. For example, the latest NHS staff survey[21] showed that nearly half of midwives had witnessed potentially harmful errors, near misses or incidents within the last month. The Each Baby Counts review of stillbirths, neonatal deaths and brain injuries occurring in labour[22] noted that "when analysing the reviews, there was a recurring theme of perceived inadequate staffing levels and high unit activity contributing towards staff stress and fatigue" (p66). Excessive workload has also been linked to the provision of disrespectful and inhumane care: Robert Francis QC, discussing the investigation of care failings in Mid Staffordshire NHS Foundation Trust, stated "the overwhelmingly prevalent factors were a lack of staff, both in terms of absolute numbers and appropriate skills, and a lack of good leadership"[23](p1). Mandatory standards for midwifery staffing levels and skill mix have been rejected by the Government in England, despite campaigning by the Safe Staffing Alliance, a confederation of nursing and patient groups, which led to even Francis himself reconsidering his position and recommending minimum staff to patient ratios[24].

The pervasive blame culture documented by early career respondents of the UK WHELM study is a great concern. Indeed, the Berwick report[25] highlighted the damaging effects of such attitudes on safety and improvement work, stating:

"Good people can fail to meet patients' needs when their working conditions do not provide them with the conditions for success […] Abandon blame as a tool. Trust the goodwill and good intentions of the staff, and help them achieve what they already want to achieve: better care and the relief of human suffering. Misconduct can occur and it deserves censure. But, errors are not misconduct and do not warrant punishment" (p10).

Similarly to the UK WHELM study, the seminal research over a decade ago on midwifery retention and return in the English NHS[26–28] found that supportive relationships with colleagues were valued highly and sustained midwives in their work. Conversely, unsupportive colleagues generated

feelings of isolation and high stress levels. In the most recent NHS staff survey[21], almost one-third of midwives reported experiencing harassment, bullying or abuse from staff in the last 12 months. Bullying and harassment have been shown to be endemic in the NHS, affecting all staff groups including midwifery students, midwives, trainee doctors, obstetricians and even chief executives. An already poor working culture is exacerbated by organisational pressures, and efforts to improve working culture are in most cases reactive rather than proactive[29–31]. In addition to impacting on individual wellbeing and retention rates, there is a growing body of evidence linking bullying and undermining behaviours to poor patient safety; the Francis and Kirkup reports revealed high levels of both[32–34].

The impact of unpredictable shift patterns on family life was a recurrent theme in the study. One NHS trust has tried to address this issue by introducing a 10pm-6am shift to accommodate workers with caring responsibilities, and believes this has helped staff retention[35]. The 2006 study by Kirkham, Morgan and Davies found that working part-time was felt to limit the effects of stress and help respondents persevere as a midwife; the authors noted, however, that while part time working may help individual midwives manage occupational stress, the overall effect is a reduction of the available workforce and further staff shortages.[28]. This trend appears to have continued, with numerous respondents to the UK WHELM study[10] highlighting the protective effects of part-time work against stress. Indeed, the Caring for You survey[19] found that 47% of respondents worked part-time - a situation which contributes significantly to staffing shortages.

Ways of working and models of care appeared to be important: numerous participants noted the positive impact of a caseloading model on their enjoyment of work, remarking on the ability to develop warm relationships with families and provide improved quality of care. The most recent National Maternity Review[5] proposed that by 2020/21, maternity services should be reorganised such that most women receive continuity of carer in the antenatal, intrapartum and postnatal

periods, and ambitious work is underway at local and national levels to achieve this. International research on the experiences of midwives working in caseload models, including new graduates, report high levels of professional satisfaction and low burnout rates[36–38]. In the Australian WHELM study[39], Fenwick et al. compared emotional and professional wellbeing among Australian caseload and non-caseload midwives, concluding that midwives providing continuity of care had significantly lower burnout, anxiety and depression levels; similar results were found by Dawson et al. in Australia, Dixon et al. in New Zealand and Jepsen et al. in Denmark[40, 41, 42]. This finding was replicated in the literature review carried out by Cramer and Hunter[20], who noted that "clinical autonomy and models of midwifery that prioritise women's needs and choices are related to midwives' wellbeing" (p6). However, Stoll and Gallagher[43], who surveyed 158 exclusively caseloading Western Canadian midwives in the Canadian arm of the WHELM project, found high levels of work-related burnout and intent to leave the profession, particularly among midwives with young children. The authors speculate that the burnout levels, which were significantly higher than caseloading midwives in Australia and New Zealand, may be in part due to the lack of flexibility offered, with little opportunity to work part time. Further, the midwives had very limited choice over which midwifery model to work in, as almost all midwives in the geographical area they studied provide exclusively caseload care.

Implications for practice

These findings have a number of implications for practice. In a 2018 report on NHS staffing, The Health Foundation, Nuffield Trust and the King's Fund[3] proposed that a tipping point is being reached at which staffing levels make the workload so difficult that retention falls further, and as a consequence safe staffing and skills mix levels cannot be preserved. The current spend on agency midwifery staff, totalling £20.6m in England[44], underscores the difficulty in recruiting and retaining permanent staff. At a systems level, all available levers should be used to retain and motivate existing staff, and recruit new staff. An NHS workforce implementation plan, to clarify

the workforce expansion and reform necessary to achieve the goals of the health service, is currently being developed and will be published later in 2019. A report by The Health Foundation, Nuffield Trust and the King's Fund[45] lays out a series of policy reforms which they suggest should be included in the NHS plan, including increasing international recruitment and financial support for student midwives, improving workplace culture and a greater focus on supporting staff at the beginning of their careers.

In the meantime, considerable creativity and effort should be exercised to improve working conditions, ensuring that midwives are able to take regular breaks (including toilet breaks), have access to drinks during the shift, are allowed to nap during night shift breaks and are provided with their roster as early as reasonably possible. Attempts to incorporate individual preferences for shift type and provide the maximum practicable number of shift requests are hugely appreciated by midwives and may improve retention. The Royal College of Midwives has had substantial success encouraging NHS organisations to sign up to its Caring for You charter. The college should now consider enhancing the charter to include specific elements of staff wellbeing such as the above; further, these could be included in formal quality assessments of maternity services, such as those undertaken in England by the Care Quality Commission. The emerging international evidence confirming that midwives who work in caseload models experience greater autonomy, higher levels of satisfaction and better emotional health than those working within fragmented shift based models of care should be considered when exploring ways to provide an optimum working environment for midwives – that will also enable the provision of evidence based maternity care.

The importance of a positive working environment on the wellbeing and retention of midwives cannot be overemphasised. Every effort must be made to ensure supportive workplace behaviour is normalised, using all available strategies to address undermining behaviours. The provision of

formal and informal staff support also appears to be valued by midwives, confirming the findings of other studies. Hunter and Warren[46] undertook a qualitative exploratory study into the professional resilience of midwives: the authors found that social support and love of the job protected midwives against the adversities of the workplace, and propose that formal approaches to developing resilience are included in both initial and continuing midwifery education. Further, Pezaro, Clyne and Fulton[47] carried out a systematic review of interventions to improve midwives' wellbeing; the authors noted the growing evidence that clinical supervision, resilience workshops and mindfulness interventions significantly reduce stress, and call for large scale trials, stressing the importance of a flexible intervention that midwives can access in their own time. Additionally, provision of client feedback to midwives may not only improve their awareness of women's experiences, but also bolster existing high levels of motivation and job satisfaction[48].

Consistent with the findings of the UK WHELM quantitative paper[10], this subset of early career midwives reported low satisfaction with the quality of managerial support provided and felt managers did not understand the pressures of working clinically in the current stretched environment. This suggests that managers should be supported to improve their leadership skills. Additional formal support for newly qualified midwives is needed, in the form of preceptorship. The Royal College of Midwives notes that midwives entering their first post often find the transition from student to qualified midwife highly stressful[17], and asserts that preceptorship schemes support midwives and reduce stress, absence levels and ultimately attrition. As a priority, NHS trusts should ensure such schemes are fit for purpose and properly funded.

Conclusion

This subset analysis of the UK WHELM study data adds to our understanding of the reasons for the high levels of stress, burnout, anxiety and depression reported by early career midwives in the WHELM study, and provides insights into their impact on emotional wellbeing. The impact of

the unremittingly heavy workload on the mental health and wellbeing of midwives is clearly evident. However, these findings also provide insights into sources of work satisfaction for this group of midwives, thus providing a 'roadmap' for how the wellbeing of midwives can be improved. Key features of the roadmap are: improving working conditions, including the fostering of a positive and supportive work environment, by building on existing high levels of motivation; and as far as possible providing a work pattern tailored to the individual preferences of the midwife, with plenty of notice of shifts to allow relaxation, social activities and family time. A great deal of knowledge and skills have already been lost through the early retirement of experienced midwives, and the retention of more recently qualified midwives is essential to preserve safe staffing and skills mix levels. There is no 'quick fix' solution to the maternity staffing crisis, and for the foreseeable future the workload for qualified midwives will be uncomfortably high, but it is essential that, until a properly funded service is put in place and additional students are trained, all available approaches should be used to improve staff wellbeing.

Acknowledgements and disclosures

We would like to give our sincere thanks to all the midwives who participated in the original study.

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Table 1.

Demographic and work characteristics of sub-set of UK WHELM study respondents qualified for 5 years or less

		Total participants = 620 No. (%)
Age (n=612)	<25 years	88 (14.4%)
	25-34 years	260 (42.5%)
	>34 years	264 (43.1%)
Sex (n=618)	Female	616 (99.7%)
	Male	2 (0.3%)
Marital status (n=618)	Single	169 (27.3%)
	Married / Civil partnership / Cohabiting	409 (66.2%)
	Separated / divorced	35 (5.7%)
	Widowed	5 (0.8%)
Has a disability, impairment, health condition or learning difference/disability?	Yes	59 (9.5%)
	No	559 (90.5%)

(n=618)		
Has children / step children (n=619)	Yes	328 (53%)
	No	291 (47%)
Region (n=612)	England – London, England South, South East, South West England, West Midlands, East Midland, East of England	432 (70.6%)
	England – North East, North West, Yorkshire and the Humber	96 (15.7%)
	Scotland	43 (7%)
	Wales	31 (5.1%)
	Northern Ireland	10 (1.6%)
Employer (n=618)	NHS	571 (92.4%)
	Bank or agency midwifery	14 (2.3%)
	Independent practice and NHS sector and/or private sectors	1 (0.2%)
	University sector only	4 (0.6%)
	University sector and NHS and/or private sectors	6 (1%)
	Private sector only	7 (1.1%)

	Both NHS and private sector	8 (1.3%)
	Other	7 (1.1%)
Work location (n=613)	District general hospital	370 (60.4%)
	Tertiary referral unit	98 (16%)
	Stand-alone birth centre	27 (4.4%)
	Alongside birth centre	26 (4.2%)
	Community - primary care setting only	82 (13.4%)
	University	10 (1.6%)
Urban/Rural (n=619)	Capital or large city	142 (22.9%)
	City	224 (36.2%)
	Large town	202 (32.6%)
	Small town	36 (5.8%)
	Rural or remote area	15 (2.4%)
Type of clinical work (n=559)	Continuity	33 (5.9%)
	Modified continuity (antenatal and postnatal care for a defined caseload of women)	60 (10.7%)
	Rotation hospital only	273 (48.8%)
	Rotation hospital and community	108 (19.3%)

	Non-labour care only	23 (4.1%)
	Labour / birth care only	62 (11.1%)