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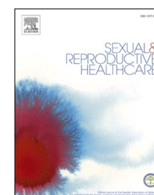

How to improve newly qualified midwives' transition-into-practice. A Delphi study

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ABSTRACT

Background: In the Netherlands, newly qualified midwives start work as registered midwives without any formal transition support. Research shows that newly qualified midwives do not feel sufficiently confident and competent in their work during the period following graduation. This could impact the quality of care provided by newly registered midwives.

The aim of this study is to seek consensus with stakeholders concerning viable components of support for newly qualified midwives working in midwifery care in the Netherlands.

Methods: A Delphi study was conducted among maternity care stakeholders in the Netherlands. During two rounds, sixteen statements derived from a theoretical framework of organizational socialization theory and previous studies were assessed (round 1, n = 56; round 2, n = 52). Stakeholders (N = 61) were invited and completed an online questionnaire that included spaces for opinions and remarks.

Results: Stakeholders agreed about an introductory support period for newly qualified midwives, involving performance feedback and regional-level backup from fellow midwives during shifts. They further agreed on the responsibilities of established professionals that they should support newcomers in practice and provide mentoring or group coaching, although they face organizational barriers for supporting newcomers.

Conclusions: Stakeholders found consensus upon several components of support at the workplace. In addition, a stable work environment seemed less important in their opinion while previous research suggests otherwise. Practice organisations need to improve the employment conditions and support for newly qualified midwives to ensure the quality of midwifery care is guaranteed.

Background

Over the past 20 years, the working context of newly qualified midwives (NQMs) in the Netherlands has changed. In 2004, most NQMs worked as partners in a professional practice, whereas in 2017, three out of four NQMs in the community work as locum midwives or as temporarily employed midwives in a hospital [1]. There are growing concerns about the transition of newly qualified midwives into practice as a result of changing working conditions, with NQMs less connected to colleagues [2,3]. Dutch NQMs start work right after graduation, as registered midwives in the community (82%), or in hospitals (15%) [1]. NQMs need encouragement in their decision making and 24/7 backup to help them work confidently and competently in practice [2.3]. However, none of these work contexts seem to meet the NQMs' support needs [4].

Previous studies [5,6] found that NQMs' do not feel sufficiently

Abbreviations: NQMs, Newly qualified midwives; NQPs, Newly qualified practitioners; RDM, Royal Dutch organisation of midwives; VSV, Regional maternity care partnerships (in Dutch: verloskundig samenwerkingsverband.

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confident and competent in their professional practice in the period following graduation [7]. This could have an impact on the quality of care they provide [5,6]. This period at the start of a midwife's career is acknowledged to be a transitional phase [8]. During this time, NQMs build their competence and confidence as autonomously working, newly registered practitioners. With regard to NQPs (newly qualified practitioners), workplace issues are known to be correlated with a decreased quality of care and higher patient mortality [9]. Furthermore, in the Netherlands, Offerhaus et al. suggested that insecurity and a lack of confidence on the part of NQMs could cause them to choose safer options. This leads to operating on the safe side, and, in turn, might explain the rising referral rates to secondary care seen in low-risk women during labour [10].

Transition-into-practice for newly qualified health professionals can be viewed as 'a foundational period of time, at the start of a career, whereby a newly qualified practitioner can build competence and confidence as an autonomously working professional' [11]. As opposed to countries as the UK, Canada, New Zealand, and Australia, NQMs in the Netherlands, Belgium and Germany are registered directly after graduation and allowed to work in community and clinical practice [7,11]. Transition or bridging programmes have been designed to facilitate the transition for NQMs and to ensure quality of care for pregnant people [11]. In the Netherlands, NQMs feel that their transition to professional practice is very difficult, whether in a community or in a hospital setting [2,3]. NQMs lack work experience in professional practice and need to develop routines. In addition, many find it difficult to transition from working with backup from a supervising midwife during their placements to working autonomously after graduation. Furthermore, aside from caring for their clients, NQMs must perform the numerous organisational and administrative tasks involved in everyday practice, all of which are new to them [3]. In the hospital setting, NQMs must learn to work partly autonomously and partly under the supervision of an obstetrician. In addition, they must also learn to care for several clients at the same time, in different delivery rooms. This requires a good overview of the situation and the ability to delegate tasks to obstetric nurses [2].

Previous studies revealed that Dutch NQMs felt there was a lack of support during their transition into professional practice [2,3]. In the community, there are no orientation programmes for NQMs, nor are there introductions to specific workplaces [3]. In community practices, their position as a locum offers limited options to collaborate with fellow midwives [3]. In theory, hospital settings do include formal orientation programmes, however such programmes are often impacted by staff shortages [2]. Also, hospital-based NQMs need (but often do not have) an opportunity to work alongside fellow midwives, who can then act as role models and mentors or buddies [2].

Studies in other countries have shown that support for NQPs has a positive impact on their wellbeing in practice. Introductory and orientation programmes have a positive impact on job satisfaction and commitment to the organisation, while preventing early turnover [12,13]. Transition support influences job satisfaction [14–17], enhances feelings of self-confidence and competence [18], decreases stress [16,17] and prevents early departure from the job [16,17]. This support is particularly effective when it involves a range of elements, such as training, observation, contacts with peers and mentoring [14,16,19]. In the Netherlands, there is no formal transition support for NQMs [4]. However, a recent study among Dutch midwives suggests that they are aware that NQMs need support and that they are willing to offer it, provided that they are given the means to do so [4].

As stated in previous outcomes, little information is available concerning the transition of NQMs into community-based practice and within continuity of care models [7]. However, 82% of Dutch NQMs work in community practice [1], so this is an ideal opportunity to study support for practising NQMs. Based on our current knowledge of effective transition support and on the recognised need to support Dutch NQMs in their professional practice, the aim of this study is to explore stakeholder consensus concerning viable components of support for NQMs working in midwifery care in the Netherlands.

Research question

Which components of support do stakeholders deem to be appropriate, in terms of improving the wellbeing of NQMs in Dutch midwifery practice?

The outcomes of this study will provide us with a range of viable and applicable components of support for NQMs that are endorsed by a representative sample of stakeholders, that can be implemented in both community-based and hospital-based practice in the Netherlands. In addition, this study add information for the international community on transition-into-practice experiences of NQMs working in continuity of care models.

Midwifery care in the Netherlands

In the Netherlands, maternity care is organised in a primary, secondary and tertiary care model [20]. Primary care, for low-risk women, is provided by midwives and general practitioners (GPs). Secondary care is provided by obstetricians and hospital-based midwives in general hospitals, and tertiary care by obstetricians and clinical midwives in academic hospitals. Maternity care is based on the idea that a healthy woman with an uncomplicated pregnancy and uncomplicated (low risk) childbirth is best cared for by a midwife [20]. This minimises the chances of having unnecessary interventions of any kind, providing a high standard of care, and is cost-effective. A woman is accompanied by a midwife who is autonomous in her actions and decisions. Emphasis is placed on the physiology of the process, with midwifery diagnosis and intervention used when necessary. A midwife will consult or refer to an obstetrician when problems arise.

The population of practicing midwives in the Netherlands consists of community-based midwives (63%), and hospital-based midwives (27%) [21]. To enable community-based midwives to take holidays, they usually employ a locum midwife. Locum midwives work self-employed and are hired by primary care midwifery practices to cover for holiday, maternity or sick leave. Of all midwives, 25% work as locums. These are mostly midwives who recently completed their training [1].

Methods

This qualitive study was conducted using a Delphi technique [22]. This technique is defined as a multi-stage survey designed to achieve consensus among a group of experts on a given issue where none previously existed, or where there was uncertainty or lack of evidence [23]. As they are not hampered by group dynamics, the participants in a Delphi study can all contribute equally to the discussion. This method's advantages include anonymity, iteration, controlled feedback and the statistical aggregation of group response. This study was reported in accordance with the CREDES guidelines [24].

Theoretical framework

The theory of organisational socialisation theory was used as a framework for this study about transition into professional practice. Organisational socialisation is defined as 'a learning and adjustment process that enables an individual to assume an organisational role that fits both organisational and individual needs' (p. 6) [25]. Based on this theory, we explored organisational and individual tactics in a previous study of support for Dutch NQMs [4]. These different tactics were operationalised in components of support according to this study on actual and desired support for NQMs, as shown in Fig. 1. Support in the workplace (Fig. 1) is broken down into workplace-dependent support and workplace-independent support. The latter form of support takes place outside the workplace.

Socialisation and orientation are workplace-dependent components of support, in which back-up by – and consultation with – fellow midwives help newcomers to meet the expectations of that specific workplace (community practice / hospital organisation). Workplace-independent support entails support provided by professionals who are not linked to the specific workplace. Mentoring is support from a

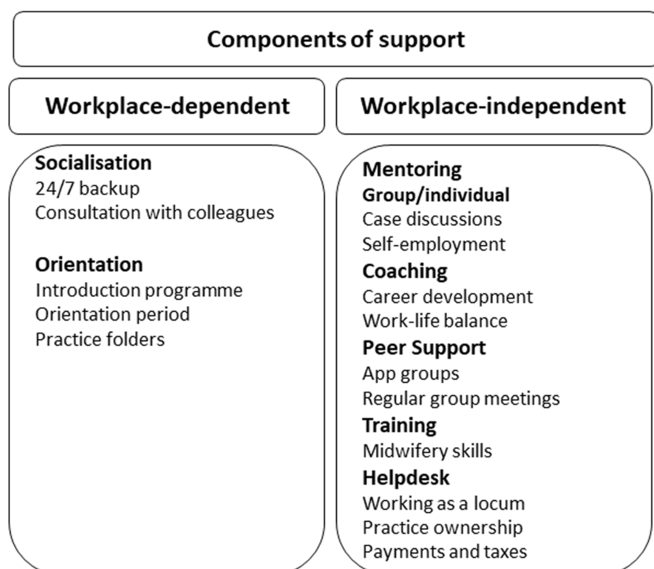

Fig. 1. Components of support for NQMs [4].

colleague, an experienced midwife, who provides guidance to an NQM in dealing with midwifery related issues [24], such as reflecting on decision making. Coaching is support from an experienced professional who helps the NQM to achieve a specific personal or professional goal, relating to professional development and career-related issues such as work-life balance, self-efficacy, dealing with uncertainty [26]. Coaching can be organised in a group or individually.

The researcher's characteristics and competencies

The researcher (first author) is an educator in the field of midwifery and is experienced in the use of both qualitative and quantitative research designs. For several years, the researcher has studied the experiences of NQMs as they transition into professional practice, so the possibility of bias does exist. The possibility of bias is reduced by the supervising team on this study, which consist of researchers with different backgrounds. Accordingly, the various phases of the study and its findings were discussed by a team of experienced researchers (other three authors). They also were familiar with the use of the Delphi technique.

Participants

Participation was restricted to professionals in the field or to members of relevant organisations or institutions involved in maternity care: hospitals, midwifery practices, Royal Dutch Organization of Midwives, and midwifery academies. To ensure that this group was representative, we included stakeholders working in different regions of the Netherlands.

First, a stakeholder analysis [see Additional file 1] was conducted to identify stakeholders in midwifery care. A list of Delphi panel participants was compiled from (1) the primary stakeholders concerned: hospital employers/managers, practice owners in community-based midwifery, experienced midwives (hospital-based and community-based), NQMs and (2) the secondary stakeholders concerned: obstetricians and staff members of the Royal Dutch Organisation of Midwives (RDM). Participants were recruited via the authors' networks, all three midwifery academies in the Netherlands, the RDM and via snowballing. Invitations were sent to potential participants by email. These contained information about the study, the aim of the study and what was expected of participants. All participants were informed that their participation in a maximum of three rounds of the Delphi study would involve a timeframe of three to six months. In an iterative approach, the next round was based on the results of the previous round and depended on the consensus rate we were aiming for [27]. We expected to include a group of about 30–50 participants with diverse perspectives [27]. For the different primary stakeholders, we aimed for several participants of each discipline as identified in our stakeholder analysis.

Ethics approval and consent to participate

The medical ethical review board of the University of Groningen in the Netherlands has declared that this study fulfil all the requirements for patient anonymity and has followed the regulations for publication of patient data (reference: M23.309800).

All participants gave prior written informed consent. To ensure confidentiality, the participants' personal data was separated from the outcomes and saved according to the University of Groningen's data management rules.

Conducting statements and questionnaires

The members of the research team formulated initial statements based on workplace- dependent and workplace-independent components of support (Fig. 1) and on a literature search for effective support for NQPs. In the course of that search, systematic reviews and *meta*-analyses on transition support were studied and summarised [see Additional file 2]. Questions were also added about stakeholders' background, working context and managerial responsibilities. Sixteen statements were pilot tested among a group of 10 researchers and lecturers, all with a background as a midwife in a community or in a hospital setting. They were asked to comment on the clarity of the statements and on the time taken to complete the questionnaire. Based on the feedback provided by all 10 participants, we reformulated the text of the statements and added background information to make them clearer to participants.

In Round 1, further information was added in the form of hyperlinks. This included a document containing background information on outcomes of previous research on NQMs for practising NQMs, plus definitions of the terms used. Each statement included two questions: one about importance and one about applicability in practice [27]. Each question used a five-point Likert scale (strongly agree to strongly disagree). After each statement, space was provided for the participants' feedback or remarks.

Data collection

The various data collection steps are shown in Fig. 2. In an online environment (Qualtrics XM), the participants were invited to review various written statements and questions and to provide the research team with informed consent. In Round 1, we sent an email via Qualtrics with a personal link to each participant. After two weeks, Qualtrics issued automatically reminders to any non-responders in the form of a personalised email and personal link. After three weeks, any remaining non-responders received an invitation from the first author in the form of a personal email and personal link. The invitations and reminders used in the second round were equivalent to those used in Round 1.

The questionnaire used in the second round was based on statements on which there was no consensus. In Round 1, participants were given the opportunity to first read or watch previous research findings on NQMs in the Netherlands [see Additional files 2 and 3] via hyperlinks in the questionnaire. In Round 2, participants were given the opportunity to first read the outcomes of Round 1 via a hyperlink in the questionnaire [see Additional file 4].

Analyses

For each round of the Delphi study, the participants' personal

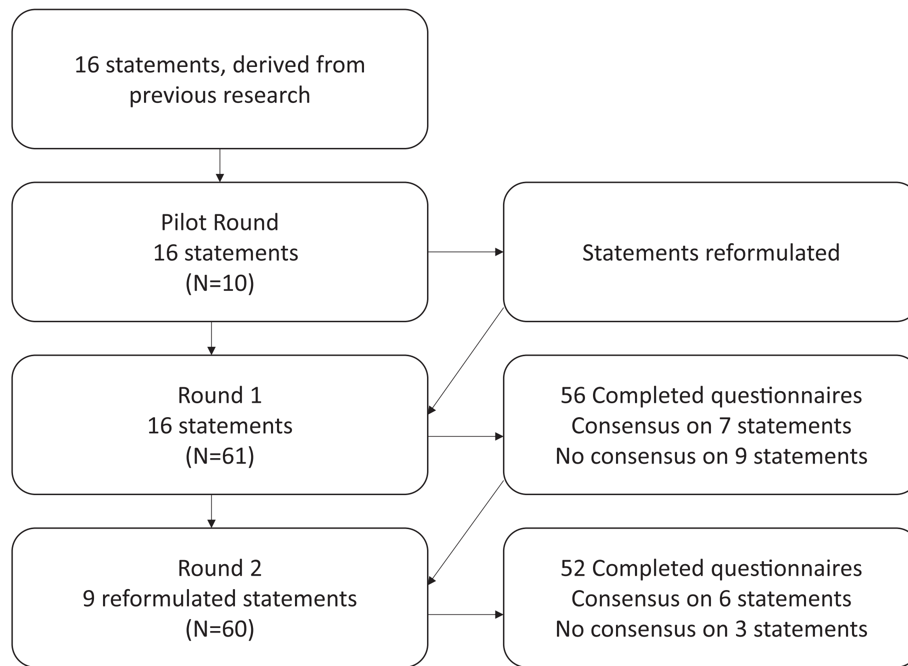

Fig. 2. Flowchart of the Delphi study among stakeholders in midwifery care in the Netherlands.

characteristics (age, workplace, years of experience) were listed. Details of the response rate and frequencies per variable were reported. We used the definition of consensus shown in Table 1. Consensus per statement was deemed to have been reached if the following three conditions were met:

- 70% or more of the participants scored high on importance (agree/strongly agree)
- applicability had a median score > 4 and interquartile range < 1
- remarks about the statement involved no contradictory or inconsistent arguments [21].

The analyses of the quantitative results were performed using SPSS 27.

A thematic content analysis of the remarks and feedback received during Round 1 was conducted in MaxQDA 2022 [28]. Participants' comments were first open coded for each statement. In the next step, the open codes were categorised into axial codes, and in the third step, the categories were thematised using themes according to the framework for healthcare innovations [29].

Table 1
Decision table for consensus on the statements.

Importance	Applicability	Remarks	Conclusion
> 70%	Median > 4 IQR < 1		Consensus
> 70%	Median > 4 IQR < 1	Contradictory remarks/ inconsistencies	No consensus
> 70%	Median < 4 IQR > 1		No consensus
< 70%	Median > 4 IQR > 1		No consensus
< 70%	Median < 4 IQR > 1		No consensus

Results

Procedure

At the start of the study, 61 stakeholders agreed to participate and were invited to complete the questionnaire. The response rate in the first round was 92% (N = 56). In the second round, again all 61 stakeholders were invited to participate, 52 participants responded (response rate: 87%).

The results of the two rounds of this Delphi study are shown in Fig. 2. Two subsequent rounds of statements were sufficient to reach consensus on 13 statements. In the first round, consensus was reached on seven statements. In the second round, nine reformulated statements were submitted to the panel. Consensus was achieved on six statements. Based on the responses received in Round 2, we concluded that there was little likelihood of consensus being reached on the three remaining statements, due to strong disagreement among the respondents. Accordingly, we decided to dispense with a third round.

Table 2 list the characteristics of 56 participants who completed the questionnaire in Round 1. These individuals varied in age distribution, in years of experience, and in their responsibilities as an employer and in the region they worked. The participants were mostly midwives (79%). Half of the group had responsibilities as an employer (50%) and almost 75% worked in community-based midwifery. Almost 75% of our participants were self-employed, either as a practice owner or as a locum midwife.

The findings of these two rounds are presented in Table 3. The statements on which consensus was achieved were coloured green while those in which no consensus was achieved were coloured red, according to the decision table (Table 1).

Round 1

Consensus was reached on statements 2, 3, 7, 8, 11, 13 and 14 (Table 3). Participants emphasised the importance of recognising NQMs as equal members of the team, even if they are not yet fully competent in their professional role. No consensus was reached on statements 1, 4, 5, 6, 9, 10, 12, 15 and 16 (Table 3). The analysis of the remarks per statement produced the following findings:

Table 2
Characteristics of the Delphi study's participants (N = 56).

Characteristics	Participants (n, (%))
Age	17 (30)
< 30	17 (30)
30–39	12 (22)
40–49	10 (18)
> 50	
Profession	27 (48)
Midwife, practice owner	19 (34)
Midwife, employed (or self-employed)	5 (9)
Manager/employer	1 (2)
Obstetrician	4 (7)
Staff member	
Working context	43 (75)
Community	10 (18)
Hospital	4 (7)
Other	
Years of work experience	11 (20)
0–3	15 (27)
3–10	18 (32)
10–20	12 (21)
20+	
Responsibilities as employer/manager	28 (50)
Yes	28 (50)
No	
Employment status	14 (25)
Locum	29 (52)
Self-employed	10 (18)
Employed	3 (5)
Not answered	
Region	19 (34)
North	31 (55)
Middle	6 (11)
South	

The participants commented that, in community practice, there are insufficient opportunities to give locum NQMs a proper introduction (Statement 1). Several participants remarked that, because locum midwives work with billable hours, introductory programmes would be too costly.

The participants indicated that, for NQMs, the ability to choose their workplace was more important than a stable workplace in their opinion (Statement 4). They seemed to refer to their own experiences as NQMs, rather than to what NQMs now need and expect. They pointed out that it is beneficial for the development of an NQM to have a variety of working environments (multiple community practices or hospitals).

The participants did not prioritise the benefits of a regional commitment to supporting NQMs (Statement 5). In their remarks, they questioned the importance of such commitments.

The participants' remarks revealed that providing backup for NQMs in community practice was not a viable option (Statement 6). Backup requires midwives to be available 24/7, which is impossible in a small practice. The participants also stated that a backup period of one year would be too long, and that arranging for backup facilities imposes an increased workload on practising midwives.

The participants' remarks revealed the importance that stakeholders place on the necessity for NQMs to gain work experience (Statement 9). They placed greater value on time spent working than on training programmes for professional education and support.

When it came to mentoring, the participants had various opinions concerning its feasibility (Statements 10 and 12). They stated that a one-year mentoring period would be too long. Other participants commented on the aspect of financial feasibility – there are currently no facilities for mentoring and support. Others wanted to link up with existing consultations in professional practice, in terms of discussing cases in midwifery practice.

The participants also commented on the importance of the role played by the profession as a whole in supporting NQMs, as opposed to the part played by academies (Statement 15). According to participants, the academies were responsible for support until graduation. After graduation, both the midwifery workforce and the midwifery association were responsible for providing support for NQMs. The participants stated that giving student midwives employment status in their final year (Statement 16) was not a viable option. Nor did they express any desire to make major changes to the midwifery curriculum.

Round 2

In Round 2, consensus was reached on six of the nine statements. The findings showed that consensus was reached on responsibilities (Statements 14 and 15). The participants agreed that while the academies are responsible for preparing undergraduates for work in everyday practice, it was the workplace' responsibility for introducing graduates to professional practice. The stakeholders felt that the workplace was responsible for clarifying NQMs' tasks and responsibilities (Statement 2), for providing feedback on their performance (Statement 7) and for organizing backup facilities for NQMs (Statement 6).

No consensus was reached regarding the importance and applicability of the NQMs' need for a stable working environment (Statements 4 and 5). Nor was there any consensus regarding curriculum changes designed to increase the number of placements in the final year (Statement 16). After discussing these three statements (without consensus) in the research team, the alternatives for a new statement on the same topic would not add any new information about the importance and applicability. The remarks on the statements were mostly similar to the first round. We decided not to carry out a third Delphi round.

Table 4 briefly summarises the final findings on the various statements on which consensus was achieved, in terms of components of support for NQMs and responsibilities in practice, based on stakeholders' views and recommendations.

Discussion

The aim of this Delphi study was to reach consensus among stakeholders in midwifery care in the Netherlands concerning important and applicable components of support for practising NQMs. The stakeholders agreed that socialisation and orientation in professional practice are the responsibility of the workplace. Regardless of the type of employment involved, the practice or organisation must provide NQMs with an introductory period, performance feedback and backup from fellow midwives during shifts. According to the stakeholders, it is important to provide support based on the needs of NQMs and to offer them a range of components of support. The stakeholders felt that mentoring is important for NQMs. Each NQM deserves mentoring or group coaching by a midwife (from the workplace itself of external). Consensus was reached about the importance of trained mentors and about providing mentoring facilities in professional practice. The stakeholders felt that both the midwifery workforce and the midwifery association should be responsible for mentoring and coaching. While the stakeholders felt that a stable workplace, which implicates a period of a year whereby a NQM work in one region, was applicable in practice. They did not reach a consensus on the level of importance, nor on longer term (beyond 3 months) employment commitments for NQMs, or on their importance and applicability. The stakeholders also felt that it is the academies' responsibility to prepare undergraduates for professional practice. No consensus was achieved concerning modifications to the curriculum with regard to alternative placement arrangements.

Workplace-dependent support

In this study, as in previous studies into NQMs [2,3], the stakeholders felt that, in practice, a proper introduction in the workplace is both important and applicable. In the first round, however, the stakeholders remarked that, in practice, this might not apply to community based

Table 3
Results from the Delphi study representing stakeholders in midwifery care in the Netherlands.

No.	Statement Round 1	Imp. (%)	Appl. (Median, IQR)	Consensus	Statement Round 2	Imp.	Appl.	Consensus
Workplace-dependent								
Orientation								
1	Every newly qualified midwife should be introduced to professional practice in the workplace, regardless of their employment contract (e.g. temporary contract or locum).	91	4/1	Discrepancies in remarks	Every newly qualified midwife should be introduced to professional practice in the workplace, regardless of their employment contract. If the midwife is a locum or is self-employed, their time spent on this must be compensated.	92	4/0	Yes
2	Every workplace should provide newly qualified midwives with clarity on tasks and responsibilities.	96	4/1	Yes				
3	A newly qualified midwife must be treated as a full team member because this contributes to their involvement in the workplace and to their self-confidence.	93	4/1	Yes				
Socialisation								
4	To create a stable work environment, every newly qualified midwife should work in a salaried job at a workplace for their first year.	16	3/1	No	Newly qualified midwives work better in a stable work environment, and so they should only be deployed for locum periods longer than three months in their first year after graduating.	54	3/2	No
5	Each newly qualified midwife should only work in one VSV (*verloskundig samenwerkingsverband*; regional maternity care partnerships) in their first year after graduating.	43	3/1	No	Newly qualified midwives should preferably work within a VSV in their first year so that they work with stable collaboration partners and with only one set of protocols/agreements.	65	4/1	No
6	In the first year after newly qualified midwives graduate, they should have a fellow midwife colleague who is available for consultation and/or backup.	91	4/1	Discrepancies in remarks	Within a VSV, a backup staff member/colleague is always available to newly qualified midwives during their first year after graduating for consultation and/or to act as a sparring partner.	87	4/1	Yes
7	Newly qualified midwives regularly get feedback on their performance from a partner/manager.	88	4/1	Yes				
Workplace-independent								
8	In the first year after newly qualified midwives graduate, they receive facilities (for training/coaching) to fully master their profession.	79	4/1	Yes				
9	In the first year after a newly qualified midwife graduates, they must take part in a transition programme to get a good feel for the field.	43	3/2	No	Mentors of newly qualified midwives are trained in advance, for which they are compensated (either with quality register points or with financial reimbursement).	96	4/0	Yes
10	In the first year after newly qualified midwives graduate, they have a mentor at their workplace whom they can consult about all sorts of work situations.	75	4/1	Discrepancies in remarks	In the first year after newly qualified midwives graduate, they are entitled to guidance (through supervision, a mentor, a buddy, or another form of guidance) to be able to spar about all sorts of work situations.	89	4/0	Yes
11	During newly qualified midwives' first year in practice, they all have a guiding peer support group to ensure that they will continue to learn and develop.	73	4/1	Yes				
12	Newly qualified midwives all have a mentor outside their own workplace, who can support, coach, and advise them in work matters.	64	4/1	No	If desired, newly qualified midwives should have access to a mentor outside their own workplace, with whom they can discuss work matters.	87	4/1	Yes
13	Mentors of newly qualified midwives are trained in advance, for which they are compensated (either with quality register points or with financial reimbursement).	86	4/1	Yes				
14	The university of applied sciences (HBO) Bachelor's programme in midwifery is responsible for well preparing all VIOs (*verloskundigen in opleiding*; midwives in training) for them to start as professionals in birth care.	97	4/1	Yes				
15	The university of applied sciences (HBO) Bachelor's programme in midwifery is partly responsible for guiding newly qualified midwives in their first year after graduation.	54	3/2	No	The profession field of midwives is responsible for guiding newly qualified midwives in their first year after graduation.	79	4/1	Yes
16	The second half of the university of applied sciences (HBO) Bachelor's programme in	71	4/1	Discrepancies in remarks	In the last two years of the university of applied sciences (HBO) Bachelor's	69	4/1	No

(*continued on next page*)

Table 3 (*continued*)

No.	Statement Round 1	Imp. (%)	Appl. (Median, IQR)	Consensus	Statement Round 2	Imp.	Appl.	Consensus
	midwifery is offered in dual form, whereby the student partly follows an educational programme and partly works as a midwife in training (VIO, *verloskundige in opleiding*).				programme in midwifery, the emphasis lies more on gaining practical experience than on theoretical education.			

No. = number of statement; importance (Imp.(%)); applicability (Appl): median and interquartile range (IQR).

Table 4
Components of support for NQMs, based on stakeholders' views on responsibility.

Component	Content	Period	Responsibility
Socialisation	Around the clock backup	First year	Midwives (in regional partnerships
	Collaborating with an experienced colleague	First weeks	Manager/practice owner
	Feedback on performance	First year	Manager/practice owner
Orientation	Incremental increases in tasks and responsibilities	First few months up to one year	Manager/practice owner
	Practical arrangements	First shifts available	Workplace
	Introductory meeting		
	Practice folder		
Mentoring	Personal development as a fully functioning midwife	First year	Trained mentors, RDM facilitate training
	Learning from experiences in practice		
Group coaching	Learning from experiences in practice	First year	Coaches. RDM facilitate matching coaches-coachees
Stable working environment	Safe learning and stability in workplace	First year	RDM facilitate in policy Managers/Practice owners/Regional Collaboarations
Preparation for professional practice	Issues regarding working as a midwife	Just in time before graduation	Bachelor programmes Midwifery

NQMs who are employed as locums. As self-employed midwives, locums face an organisational barrier in the form of hourly billing, which would make an introductory period far too costly. Consensus was achieved in the second round, when we reformulated the statement to include financial compensation for midwives who introduce NQMs to professional practice. Organisational barriers and midwives' opinions regarding locum midwifery tend to impede support for practising NQMs. This finding resembles those of a previous study concerning support for practising NQMs, in which midwives were only willing to support NQMs if they were given the means to do so [4].

We will consider four different components of the socialisation process within the organisation [25]. As stated in the theoretical model, organisational socialisation enables newcomers to use these components to help them adapt to their new role. Firstly, they need fellow midwives at the workplace, secondly NQMs need around-the-clock backup, thirdly they need feedback on their performance and fourthly they need a stable working environment. With regard to the first component, the stakeholders agreed on the importance of providing NQMs with support in the workplace. However, previous studies on NQMs show that NQMs lack sufficient support and that – in both hospital- and community-based settings – they spend insufficient time collaborating with fellow midwives [2,3]. Previous studies also have shown that NQM need fellow midwives as role models and for purposes of consultation [2,3,7,30]. The stakeholders in this study recognised NQMs' needs. In their remarks on this statement, they indicated that formal consultation meetings with the teams might be one way of meeting these needs. The midwifery profession as a whole might be willing to provide support in the context of existing collaborative meetings, from an organisational standpoint. From the NQMs' point of view, this might not provide the support they need. This finding appeared to resemble the findings of previous studies into newcomers in independent practices [31]. Newcomers reported that working as a locum and therefore engaging with multiple sites led to inadequate opportunities to access meaningful long-term relationships with fellow doctors. Furthermore, organisational socialisation in professional practice needs more tailoring, to meet the organisation's needs and those of the newcomers [25].

The second socialisation component concerns around-the-clock backup from fellow midwives in professional practice. The stakeholders agreed on the importance of backup for NQMs. However, they only considered backup to be applicable if responsibility for this facility was shared among regional maternity care partnerships (in Dutch: VSV). The stakeholders' willingness to provide backup appeared to be in line with NQMs' needs for around-the-clock backup, to enhance their self-confidence and to enable them to provide safe care [3]. However, it might be difficult to organise this in practice. Without a firm commitment at the socio-political level, it will not be possible to provide backups for all practising NQMs [32]. The Royal Dutch Organisation of Midwives can enhance this by creating policies and resources that emphasise the importance of backup facilities that enable NQMs to provide high quality midwifery care in the community. This could make it easier to implement support for NQMs at local or regional level.

The third component of socialisation indicates that it is the employer's responsibility to communicate details of tasks and responsibilities. The stakeholders in this study agreed on the importance of informing NQMs what is expected of them, in terms of tasks and performance. The outcomes suggest that providing clarity about their tasks, roles and responsibilities can help to prevent newcomers becoming frustrated or demotivated [14]. Previous studies showed that, in practice, there is no steady build-up of NQMs' tasks and responsibilities, nor do they receive feedback on their performance [2,3]. The views of midwives concerning their position with regard to NQMs and the associated impact on their workload seemed to pose problems for the organisational socialisation of NQMs in practice. Midwives' opinions regarding their role as practice owners (which is more a commissioning agent rather than an employer), prevented them from acting as supportive managers [3,4]. By accepting the responsibilities towards supporting NQMs in practice, as shown by the commitment among stakeholders in this study, a step towards improving the working conditions of NQMs in maternity care can be taken.

The fourth component of the socialisation of practising NQMs concerns the importance of a stable working environment. Although the importance of a stable working environment for NQMs is widely recognised [2,3,8,31], there was no consensus on these statements among the stakeholders in this study. In Dutch midwifery practice, three out of four NQMs start their career as a locum (self-employed) midwife in community-based midwifery, which implies working in different

practices and therefore not a stable work environment [1]. In hospital-based work environments in the Netherlands, most NQMs have temporary employment contracts. This lack of a stable working environment hinders an NQM's development and makes it difficult for them to request help [32]. The stakeholders in this study may have underestimated the importance of a stable working environment for the wellbeing of practising NQMs. Another explanation might be the organisational barriers in practice to implement stable employment arrangements for NQMs due to a history of autonomous and independent working midwives [33].

Workplace-independent support

Aside from workplace considerations, the stakeholders did reach consensus on support for NQMs in the form of mentoring or group coaching. Previous findings on Dutch midwives produced similar outcomes – experienced midwives feel that NQMs need to learn from experience in practice, coupled with mentoring, as that enables them to develop a good overview of their tasks and responsibilities [4]. Thus, while this study shows the recognition of NQMs' need for further professional development as midwives, no such facilities have yet been put in place. The situation regarding formal transition support is very similar. Systematic reviews of transition support for NQPs show that effective transition support involves combining professional practice with mentoring and coaching [14,16,17].

Increased workload for midwives was mentioned as a barrier to supporting NQMs in practice. This seems a remarkable finding. In most professions it is part of the professional role to be responsible for training and mentoring new colleagues [33]. This role is not specifically defined in the professional profile of midwives in the Netherlands. Furthermore, compulsory and realistic programmes for transition to practice are not recognised, unlike in other countries [7].

Midwifery academies are responsible for preparing undergraduates for their future career, according to stakeholders in this study. This resembles the findings of a study into effective support for newly qualified healthcare professionals [34]. Preparing for their future career consists of the issues regarding working in community-based and in hospital-based working contexts [2]. Furthermore, students have to perform tasks in practice organisation and -administration in their final placements before graduation to prepare them to work in practice after graduation.

It was clear from our findings that there was little support from stakeholders for making real systemic changes to improve the wellbeing of NQMs in practice. This was evident in statements made about, for example, employment contracts, a permanent post in the first year after graduation, and a proposed change to dual training. Stakeholders seemed less willing to organise adjustments to improve socialisation in practice. A previous study on midwives' perceptions on NQMs showed similar findings [4]. NQMs need to adapt to the prevailing practice instead of the practice organization using tactics to improve the transition-into-practice of NQMs [36].

Strengths and limitations

A strength of this study was the response rate in both Delphi rounds. This supports our view that the study is a true reflection of the opinions held by the midwifery workforce in the Netherlands. Another strength of this study was the online version of a Delphi study, which demanded very little of the stakeholders' time and effort.

A limitation of this study can be the somewhat limited generalisability of our findings to midwifery contexts in other countries, due to the distinctive way in which midwifery is organised in the Netherlands. However, our findings might be generalisable for support in independent practice in the community in other countries, due to the community-based midwifery features prominently in our findings. Another limitation of this study might be the choice for the statements. Other components of support might have been valued by the stakeholders, which were not included in the questionnaire. Furthermore, a limitation might be the analysis of the open-ended remarks in the questionnaire. The analysis of these remarks could be interpreted by the researchers with interpretative or confirmation bias.

Recommendations

The sustainable implementation[1] of components of support for NQMs in midwifery practice in the Netherlands requires collaborations at local, regional and national level.

Based on our findings we recommend NQMs getting employment contracts for their first year in practice to enable NQMs to develop into fully-fledged professionals in a stable working environment [34]. A stable workplace can contribute to NQMs' self-confidence and competence in professional practice by having long-term working relationships with their fellow midwives [35].

We recommend workplace-dependent support that consists of a proper introduction period in the practice, facilitated and implemented at the workplace with introduction folders and support from responsible practice owners or hospital-based managers, depending on the workplace.

In addition, we recommend that NQMs get workplace support during their first year in practice [34]. This support can be provided by fellow midwives in the workplace (workplace-dependent), but can also be provided within a region (workplace-independent) [35]. As a result, both the workplace and the regional maternity care cooperative groups will be responsible for providing around-the-clock backup for NQMs.

Workplace-independent support should include being assigned to a (group)coach or mentor in order to ensure that all NQMs are equally supported. Moreover, midwives need to be trained and facilitated for their role as a mentor or coach [15,18,19].

An implementation plan needs to be developed (with the RDM taking the lead) to implement stable working conditions for NQMs, arrange workplace-independent support for all NQMs, and develop mentoring and coaching for midwives.

Conclusion

Components of support for NQMs as agreed by stakeholders include proper induction in practice, expansion of tasks and responsibilities with performance feedback from practice owners or managers, 24/7 back-up during a shift, and mentoring and/or coaching on work experiences. Systemic, organizational, and cultural aspects of midwifery care in the Netherlands hinder the implementation of formal support. Establishing a transition period for all NQMs in their first year of practice was recommended, supported by stable employment combined with practice support by mentoring and coaching. Midwives in the Netherlands should take up their role and their responsibilities to train and mentor new colleagues as part of their professional role in practice.

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Authors' contributions

EK, FGS, ADCJ, EIF have participated in conception and design of this study; EK, EIF have analysed the data; EK, FGS, ADCJ, EIF have contributed to the interpretation of the data.

EK drafted the article and revising it; FGS, ADCJ, EIF have provided feedback on the intellectual content; and all authors did approved the final manuscript.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary material

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