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Research Article

Working with private hospital midwives in Victoria, Australia to identify practice change priorities: Outcomes of a Delphi study

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ABSTRACT

Objective/aim: In this study, we invited midwives working at one metropolitan private hospital in Victoria, Australia to identify their workplace change needs and priorities for research.
Methods: In this two-round Delphi study, all midwifery staff within the maternity unit of a private hospital in Melbourne, Australia were invited to participate. In round one, participants joined face-to-face focus groups to put forward their ideas for workplace change and research ideas, and these data were developed into themes. In round two, participants ranked the themes in priority order.
Findings: The top four themes identified by this cohort of midwives were: 'Ways of working – investigating alternate ways of working to enable greater flexibility and opportunities'; 'Understanding midwifery – working with the executive team to highlight the nuances of maternity care'; 'Education – increase in staff in the education team to provide a greater presence and opportunity for education'; and 'Postnatal specific – review ways of working in postnatal areas'.
Key conclusions: A number of priority research and change areas were identified which, if implemented, would strengthen both midwifery practice and midwife retention in this workplace. The findings will be of interest to midwife managers. Further research to evaluate the process and success of implementing the actions identified in this study would be valuable

Introduction

There is emerging concern regarding a workforce shortage in midwifery, with the impact of an ageing workforce and midwife attrition making a significant contribution to this over the coming years (Callander et al., 2021). In a recent study by Harvie et al. (2019) it was identified that 43% of Australian midwives had considered leaving the profession in the previous six months, with those early in their career more likely to want to do so. Reasons for wanting to leave midwifery put forward by the participants in that study included dissatisfaction with the organisation of maternity care and dissatisfaction with the midwife role (Harvie et al., 2019).

This is not only an issue in Australia, however: in 2016 the United Kingdom, (a country with a similar maternity system to Australia) identified in 2016 that it was short of 3500 midwives, and that a further 1882 UK-based midwives were intending to leave the profession in the ensuing two years (Royal College of Midwives, 2016). The top five attrition drivers at that time were staffing levels, quality of care, workload, working conditions, and models of care (p. 9). The Royal College of Midwives repeated the survey in 2021 and found that 57.2% of midwives surveyed intended to leave shortly for reasons similar to those cited previously, and like their Australian counterparts, respondents in the early years of their career were in the majority (Royal College of Midwives, 2021). It is also evident that being heard is a key determinant of midwives' satisfaction with their role and their job: a World Health Organisation consultation with midwives aimed at determining drivers of and barriers to quality midwifery care (World Health Organisation, 2016) captured the workplace context requirements of 2470 midwives from 93 countries, 32% of whom identified "being listened to" as vital (p.2).

One of the ways to listen to midwives is through seeking their opinions about what practices and processes they perceive should change or could be improved in their practice context. Asking health care workforces to elicit the key work-related issues that they are experiencing and that are identified by them is key in minimising the likelihood of evidence implementation lag, which is important because research evidence is either not implemented into clinical practice in a timely manner, or at all (Morris et al.,

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2011). Greenhalgh et al. (2016) suggests that the best way to achieve impact and address the research-practice gap is to adopt a knowledge co-creation approach that draws on and develops existing principles of co-production; that is, a research team works with key stakeholders within a health service to identify issues, develop solutions, and implement the findings together. An important element of successful implementation is the perceived relevance of the issue where a change is concerned by the health professionals involved in providing care (Damschroder et al., 2009). In terms of successful implementation research, priorities identified by those directly involved in providing care are more likely to have relevance for the profession and results in more successful change and implementation due to the ownership of projects by staff and the direct relevance to the provision of care (Damschroder et al., 2009; Harris et al., 2019).

While midwives' opinions on employment-related matters have been sought previously (Hauck et al., 2012; Teoh et al., 2022), the views of those who work in the private maternity care setting appear to be under-represented. The aim of this study was to explore and identify workplace needs and priorities for midwives working in a metropolitan private hospital setting in Victoria, Australia.

Methods

This study was conducted using Delphi methodology. This approach was chosen for its ability to facilitate and structure a group communication process based on individuals' inputs to establish consensus on an issue (Keeney et al., 2011). The method involves 'rounds', each building on the previous, to allow expert participants to progressively and anonymously refine their own views in light of those expressed by others (Millar et al., 2006). For this study, a two-round Delphi method was selected to enable us to address the aim of the study; we wanted to seek the views of a particular group of expert stakeholders (midwives) about factors in a specific setting, collate those stakeholders' feedback, and then ask them to determine their priority order. Further, we wanted to maintain the views of all participants while providing a safe means (via anonymous voting) for the group to reach consensus (Keeney et al., 2011).

Setting

The study was undertaken at a private hospital maternity service that provides care for approximately 2240 childbearing women and their babies per year.

Sample, recruitment and participants

All midwifery staff at the study site were invited to contribute to either or both round one and round two of the study, and all who agreed were required to provide their informed consent for each round. There were over 90 midwifery staff employed at the site when the study was conducted, comprising 55 permanent staff members and the remainder in casual positions. Of the permanent staff, 10% were full time, 70% were part time, and casual staff worked between 0 and 35 hours a week. Two weeks prior to Round 1 data collection, flyers were distributed in the study site maternity unit tea rooms and staffing common areas alerting the midwifery staff to the purpose of the study and the upcoming dates, times and method of data collection. Those interested in contributing were instructed to attend a data collection session at which their informed consent would be obtained. Twenty-seven and 39 participants contributed to Round 1 and Round 2 respectively, which is consistent with the guidance that there is no standard size of panel for the first round, and they vary from 10 to 1000 (typically between 10 and 100) in published studies, and a double-digit number close to 30–50 is considered optimum for subsequent rounds (Nasa et al., 2021).

Data collection and analysis round 1

Two researchers (authors 1 and 2) attended in person at the designated participant recruitment and data collection times in both the maternity ward (postnatal) and delivery suite; sessions were provided at night shift to morning shift handover times, and at morning shift to afternoon shift handover times for one week. These times were chosen in collaboration with the management team at the organisation to facilitate maximum opportunity for all midwifery staff from all shifts to participate in Round 1. Despite this strategy some potential participants chose not to or were not able to contribute (for example, because they wanted to contribute anonymously, were on leave, or were between rosters), and for those midwives, paper participant information forms that included a QR code link to an online free text questionnaire was provided. This option was available for two weeks beyond the face to face data collection time.

All who participated in round one (focus groups) were required, after the study was explained to them and an opportunity to ask questions was provided, to give their informed consent in writing (consent form). Participant contributions made during the face to face data collection session were recorded by one member of the research team in the form of hand written notes, thus were anonymous beyond the point of collection. These notes were subsequently transcribed into an electronic format, and the responses for those who participated online were downloaded and added.

All Round 1 data were analysed using reflexive thematic analysis (Braun and Clarke, 2021): initial codes were identified, and the codes were then grouped to develop themes, which were given representative names. The research team discussed the data to identify any discrepancies in understanding and to reach consensus on the key ideas and issues that emerged from the data. Once consensus was reached amongst the research team, which included two midwives from the study site (who provided member checking), about the themes developed from the Round 1 data, these were translated into workplace change ideas in preparation for Round 2 of the study.

Data collection and analysis round 2

In Round 2, paper voting forms, in which the themes developed from Round 1 and the related worklace change proposal/s for each were listed, were left in prominent places in maternity unit tea rooms and other staff common areas, and study site project champions alerted the midwives on each shift to them. Midwives at the study site were invited to identify their top 5 priorities from a list of 17 items (Table 1) and were provided with a locked voting box in which to post their submission, and this round was open for a two-week time frame.

The first author, who is a University academic, collected and tallied all Round 2 voting forms.

Ethical considerations

Approval was sought and granted from the study site Human Research Ethics Committee (HREC) of the hospital and once received, reciprocal permission was sought and granted from the University HREC. Each participant was provided with a participant information letter and consent form to complete for Round 1 of the study. In-person participants were advised that because their participation was completely anonymous, it would not be possible to extract their data if they wished it at a later date. Online participants in Round 1 were provided with instructions about how

Table 1
Themes and subthemes identified in Round 1 with proposed actions.

Theme	Subtheme	Proposed action	Number of votes
Ways of Working	Increased continuity of care opportunities	Review models of midwifery care - understand how we can create greater continuity of care in the private system	11
	Elective Caesarean process	Evaluate the process for women having an elective caesarean section - including booking, admission, pathways	13
	Develop team leader role that everyone rotates into and is supported by more senior staff (include training)	Investigate team leader training, roles and responsibilities	12
	Increase emotional support for women accessing care	Review well-being midwife role and workload, for capacity to expand the EFT (Effective Full Time)	7
	Support for staff after an adverse event	Review EAP (Employee Assistance Program) provision: is it inclusive of bystander Post Traumatic Stress Disorder? Explore other resources that could be promoted to support staff following an adverse outcome	7
	Staff moving out of midwifery due to shift work and better pay	Investigate other ways of working in midwifery that enable greater flexibility and pathways to other opportunities	17
	Car parking is too expensive and a disincentive to work	Review car parking fees for staff	7
	Managers are too busy filling the gaps to progress idea	Investigate how to protect managers' planning and visionary leadership time	7
Birth Suite Specific	Graduates and junior staff not exposed to enough 'normal' birthing	Investigate how to promote exposure to spontaneous labour and birth for Graduates, students and new staff.	9
	Shift structure needs review – more hours on floor and flexibility to suit ebbs and flow in demand	Review ways of working in Birth Suite – looking at peak periods of work, recognising midwifery role and work flow in collaboration with obstetric work flow and role.	12
Postnatal Specific	Workload when caring for women post caesarean section; formula use; Domicillary home visiting; team work; handover style; BF support; Senior midwife contribution	Review ways of working in postnatal area – handover structure and timing, re-introduction of Breastfeeding/ family room and staffing of such	20
Education	Mock codes/training/refresher courses to update knowledge; seminars; in-services; psychology support training; family violence training; complex care updates; resource/ education board	Investigate providing education time between shifts and education resources for staff	13
	Peer learning and training, to train staff and sign off competencies.	Introduction of training of staff to be peer teachers and assessors – across all shifts	10
	On-site education team; cover all shifts (at least partially); clinical resource midwives; more time on floor.	Explore moving the education team on-site, increase educators' EFT (Effective Full Time)/capacity for presence on floor	24
Understanding Midwifery	Lots of hidden work that is not considered in work hours/staffing, maternity needs and nuances not understood	Explore working with the hospital executive group to highlight the work of the maternity unit, the nuances and complexities of working in maternity – why maternity services and staffing needs are different to other areas.	20
Processes and Equipment	Greater involvement in guideline development and practice	Introduction of journal club (literature review) and/or guideline review group to stay up to date with evidence; staff engagement in guideline decision making.	2
	Concerns re: efficiency of documentation and necessity in maternity	Review documentation needs and possible efficiencies.	4
Strong Sense of community	Staff valued and supported one another – a sense of being part of a team of midwives.	*this was reported back but not voted on	
	Staff identified that they appreciated being listened throughout the process of the study/ project	*this was reported back but not voted on	

to withdraw their data if they wished to. Consent to participate by those who took part in Round 2 was implied by submission of a completed voting form. To prevent any perceived power imbalance between the study site members of the research team (authors 3 and 4), they were not present at any of the Round 1 Focus Groups.

Results

Round 1

During Round 1 of this study, researchers held ten focus groups (two per day) over one week in November 2021. During these, 25 midwives (27% of the study site's midwifery workforce) contributed their ideas and opinions; an additional two responses (2% of the eligible study population) were received via the online survey.

Sixty-two issues/ideas were identified in this Round. Following analysis, 17 sub-themes, captured in seven themes, were identified that represented the key issues of importance to the participants. Five issues identified in the initial focus groups already had recently been or were being addressed through projects or actions implemented, thus they were not included in round two of the study for voting, but rather acknowledged as issues that had been identified in Round 1 and a description provided of how they were already being actioned.

The seven themes identified were: 'Ways of working'; 'Birth suite specific actions'; 'Postnatal specific actions'; 'Education'; 'Understanding Midwifery'; 'Processes and equipment'; and 'A strong sense of community'. The themes and subthemes from Round 1 were aligned with proposed actions to present actions that could stem from the issues identified, and these are presented in Table 1.

Round 2

In March 2022 we presented the subthemes, major themes and related proposed actions to the midwifery staff to vote on their top five priorities; 39 responses were received. The theme "Strong Sense of Community" was, however, not included as a topic for voting on as it did not have a proposed action linked to this theme; rather, it was reported back to the midwifery staff within the in-

formation in the voting form that it was identified in Round 1 that a strong sense of community existed within the midwifery group. Every remaining proposed action received some votes (see Table 1), and the priority order is reported below.

Two proposed actions received the most 'top priority' votes; these were:

Ways of working: 'Investigate other ways of working in midwifery that enable greater flexibility and pathways to other opportunities', and

Understanding Midwifery: 'Explore working with the hospital executive group to highlight the work of the maternity unit, the nuances and complexities of working in maternity – why maternity services and staffing needs are different to other areas'

There were four proposed actions that received more than 15 votes in total, which included the two topics above as well as:

Education: 'Explore moving the education team on-site; increase educators' EFT ('equivalent full time hours')/capacity for presence on floor', and

Postnatal specific: 'Review ways of working in PN (postnatal) area - handover structure and timing, re-introduction of BF (breastfeeding)/family room and staffing of such'

The proposed actions with the least 'total' votes were:

Processes and equipment: 'Introduction of a journal club and/or guideline review group to stay up to date with evidence'

Processes and equipment: 'Review documentation needs and possible efficiencies'

More information about the characteristics of each theme can be found in the 'Subtheme' column in Table 1.

Discussion

Seven major themes were identified that represent the work-related priorities of midwives working in a private sector hospital in Victoria, Australia. A number of issues that the participants felt needed addressing were raised in Round 1 of the study, all of which were identified to be important to the midwives to a lesser or greater degree in Round 2. The top four themes identified by this cohort of midwives were: Ways of working – investigating alternate ways of working to enable greater flexibility and opportunities; Understanding midwifery – working with the executive team to highlight the nuances of maternity care; Education – increase the education team's capacity to provide greater presence and opportunities for education; and Postnatal specific – review ways of working in postnatal areas.

In itself, the project afforded the midwives at the study site an opportunity to have their knowledge and views to be heard, which as we noted in the introduction to this article, is known to be an important factor in retention of this professional group in their discipline and in their workplaces. The two themes ranked 'top priority' themes also reflect this desire to be heard, and to be understood, and this may be due to the fact that although the maternity service managers at the study site were all midwives, those at the next level of power ownership were not, and there was a sense amongst the participants that the scope of the midwife's role, and what gives midwives job satisfaction (and by extension, what retains them in workplaces) was not well understood at that tier. Despite the fact that midwifery was divorced from its historical parent profession, nursing, with the passing of the National Health Practitioner Law Act in Australia over a decade ago (Queensland Government, 2009), ignorance still exists about the difference between the two professions and about the unique characteristics of midwifery practice. Advertisements for midwife job vacancies, for example, routinely list registration as a nurse (not as a midwife) as a requirement, and being a registered midwife is still commonly not a requirement for managers and leaders of midwives (Bloxsome et al., 2021).

A small number of Delphi studies have been conducted previously with midwives in Australia and internationally that report both similar and different topics of importance to those that emerged from our project. Participants in this study identified that a degree of flexibility within the shift work pattern of work and opportunities for promotion and development would support ongoing wellbeing and retention, identifying that midwives are leaving shift work for other jobs with more pay and more 9–5 type hours. The suggestion was that if more flexibility was present, with opportunities for promotion and a diversity in roles available to move into, this may keep midwives in the profession. These are not new issues however, with Fenwick et al. (2006) and Hauck et al. (2012) both previously reporting concern from midwives about staffing levels and retention, as well as suggestions to improve workflow and ways of working as part of the solution to these issues.

There were a number of workflow ideas suggested in our data that were either postnatal care-specific or birth suite-specific, and the suggestion of a review of 'ways of working' in the postnatal area gained a large number of votes in round two. This in congruent with the study of midwives views and workplace needs conducted by Hauck et al. (2012) a decade ago, which identified specific 'ways of working' suggestions such as '…midwives antenatal clinic; case load midwifery; team midwifery [and a] breastfeeding clinic for postpartum women after discharge' as important issues to participants.

Support from senior management, especially at the executive level, has been identified as an important issue for midwives both in this and other studies, both in Australia and internationally (Butler et al., 2009; Hauck et al., 2012). Support from executive level reportedly includes recognising the unique and distinctive nature of midwifery (Butler et al., 2009) as well as the unpredictable nature of maternity care (Hauck et al., 2012). Feeling respected, supported and recognized are key determinants of job satisfaction and positive practice settings (Papoutsis et al., 2014; Sullivan et al., 2011) and organisational and leadership issues have been associated with attrition (Harvie et al., 2019; McCarthy et al., 2007). The views of the midwives in our study identified with existing evidence, in that they put forward that further work with the executive team would support their positive practice environment, with acknowledgement of the nuances of maternity care in comparison to other medical areas of the organization.

Provision of education services to support midwives has been identified as an important issue for midwives in a number of previous studies (Butler et al., 2009; Hauck et al., 2012; Maimbolwa et al., 2015), for example, midwives have formerly noted that their ability to promote evidence based practice could be developed through in-services and upskilling (Butler et al., 2009), better access to professional development (Hauck et al., 2012) and support with midwifery training and clinical care (Maimbolwa et al., 2015). The respondents in our study clearly identified that they want greater access to education to support learning, for students and graduates through in-service education and competency assessment support for all. In-house education support not only supports the attainment of the required Continuing Professional Development (CPD) requirements that were put into place for midwives and other health practitioners with the passing of the National Health Practitioner Law act in Australia in 2009 (Geffen, 2014); it supports midwives in myriad other ways, including that it makes them "feel valued, motivated and confident" (Broughton and Harris, 2019).

The midwives contributing to this study identified a number of priority areas which in their view would strengthen both midwifery practice and retention in this workplace. Some of these issues were already developing into projects within the organization,

while others have potential for further exploration and development.

Limitations

While a limitation of this study is that it occurred at one site only, the themes that emerged were similar to those reported in the literature. Further, we cannot be certain that the findings are representative of the age, experience, seniority level or educational background of the population we sampled from because no demographic data were collected, and nor can we claim that the views captured represent those of all midwives at the study site. Finally, although the opportunity to participate was extended to all midwifery staff at the study site, we recognize that maternity services are extremely busy and the study was conducted during the COVID19 pandemic, which was a period of both extreme staff shortage and workplace stress for health service workers across Australia (Bradfield et al., 2022).

Conclusion

The aim of the study reported in this paper, which was to determine the workplace needs and priorities of midwives working in a metropolitan private hospital setting in Victoria, Australia, was broadly achieved and although the study participants were from a single non-Govement maternity service in Australia, the issues and priorities in their workplace that they highlighted as needing attention are common to midwives more generally. Consequently, and given the predicted age-related levels of attrition from the midwifery profession, the findings will be of interest to managers and leaders of both non-Government and Government maternity services across Australia, and perhaps provide a basis for international employers of midwives to start retention-focused discussions with their midwifery workforces. Further research is recommended to evaluate the process and impact of implementing change initiatives that result from this and similar studies.

Ethical approval

Ethical approval was granted from St Vincent's Hospital Melbourne HREC reference number LRR 138/21, reciprocal approval was granted from Australian Catholic University HREC 2021-182R.

Declaration of Competing Interest

We have no conflict of interests to declare.

CRediT authorship contribution statement

Kate Dawson: Conceptualization, Methodology, Formal analysis, Writing – review & editing. **Sara Bayes:** Conceptualization, Methodology, Formal analysis, Writing – review & editing. **Stacey Gilbert:** Conceptualization, Methodology, Formal analysis, Writing – review & editing. **Kylie Sayers:** Conceptualization, Methodology, Formal analysis, Writing – review & editing. **Isabella Kelly:** Conceptualization, Methodology, Formal analysis, Writing – review & editing.

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