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Midwives' perceptions of the support they provide to new graduates and the role of the health service in Australia: A survey of midwives

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ABSTRACT

Problem: Evidence suggests new midwifery graduates are leaving the profession prematurely during the initial graduate years due to workplace stress.
Background: Graduate midwives are essential to provide a future midwifery workforce. Support for new graduates in the initial years of practice is essential in retaining them in the midwifery profession.
Aim: The aim of this study was to explore midwives' perspectives of the support they provide new graduates within existing midwifery graduate programs, and their experiences and perceptions of the health service processes to support midwifery graduates.
Methods: A cross-sectional study was undertaken with a purposive sample of Australian midwives. Descriptive statistics were used to analyse frequencies and percentages of responses. Spearman's correlational analyses were used to determine associations between the variables. Responses to open-ended questions were analysed by content analysis.
Findings: In total, 167 midwives responded to the survey. Just over a third (34.1 %) of midwives felt they had sufficient resources to support a midwifery graduate. Half (50.9 %) of the midwives engaged in reflective practice

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with midwifery graduates. The majority (97 %) of midwives reported that they felt it was important for midwifery graduates to have a mentor.
Discussion: A lack of protected time to provide mentoring opportunities and support new graduates to gain further experience and education was identified. These findings support the need for a formal mentorship program to be introduced.
Conclusion: This study offers insights into the perspective of midwives dealing with the realities of striving to support midwifery graduates in their initial years of practice.

Statement of significance

Problem or issue: In Australia, there is attrition of graduate midwives leaving the workforce early in their career.

What is already known: There is a midwifery workforce crisis within the Australian maternity services.

What this paper adds: Insight into the perspectives of Australian midwives regarding their role in supporting graduate midwives, the role of the health service, and the probable causes of graduates' early career exit.

Introduction

The mission of the International Confederation of Midwives' [1] is "to strengthen midwives' associations and to advance the profession of midwifery globally by promoting autonomous midwives as the most appropriate caregivers for childbearing women and in keeping birth normal, to enhance the reproductive health of women, their newborns and their families". Yet maternity services in Australia [2] and other nations [3] are experiencing critical midwifery workforce shortages. The total number of midwives with general registration in Australia is 33, 358 in 2024 [4]. The first year of midwifery practice after initial registration is recognised as a transition to practice period in many countries [5–15]. Countries such as Iran [11], Jamaica [12], United Kingdom, [13] and Australia [14] recommend a transition program that offers supervision, continued education, and the support of a mentor within hospital settings. In comparison, new midwives in New Zealand [7], The Netherlands [8,9] and Canada [10], commence practice as an autonomous midwife, working with other midwives usually in private practice programs that aim to provide opportunities for critical reflection on practice. In Europe, despite organised transition to practice programs, attrition of new graduates is a problem [15].

The first years of midwifery practice can be challenging and may be associated with a sense of 'vulnerability, fear, and professional uncertainty' as graduates navigate their new professional roles and responsibilities ([16], p. 1). A recent scoping review [17] identified early career midwives, those within the first five years, experienced a lack of support, workload stress, and job dissatisfaction. Early career midwives have been identified as having a passion for midwifery, relationships, and autonomy in their role as a midwife, indicating that support is critical to retention and addressing workplace attrition [17].

The challenges of the first years of practice are influenced by educational experiences. Stulz et al. [18] identified that midwifery students would most likely complete their studies and remain in the profession if they received nurturing mentorship. Midwifery graduates transition into the workforce with differing levels of confidence influenced by their academic pathway, the length of their midwifery education, previous professional background (for example, previous nursing experience), clinical experiences as a student, quality of mentorship and support, and exposure to different maternity models of care [7,8,10].

Structured programs for graduate midwives [19] and the support of a midwifery mentor during the first year of midwifery practice, have been identified as valuable in building professional confidence and retaining new graduates in the workforce [19–21]. Whilst many Australian midwives undertake a graduate program in their first year of practice, questions have been raised about the necessity of mandating the completion of a graduate program, as not all hospitals offer one, and midwives can be employed at the time of registration as a midwife without a formal graduate program [21]. Graduate programs vary in structure, length, continuing education, mentoring support, and opportunities to consolidate professional capacities across the maternity care continuum [21,22]. One previous study reported that new graduates seek out relationships with other midwives, acting as a life raft to assist them in staying afloat during their transition to professional practice [23]. More recently, Hopkinson et al. [22] reported that experienced midwives act as coaches, nurturing new midwives in midwifery group practice models to provide continuity of care and gain subsequent job satisfaction. Despite a growing body of knowledge about new graduates, further insight on how to prepare and support the transition from midwifery student to registered midwife, and how best to develop their capability to the full scope of midwifery practice is required. The aim of this study was to explore midwives' experiences of how they support midwifery graduates within the existing Australian midwifery graduate programs and their perceptions of the role of the health service in providing that support.

Methods

A cross-sectional study design with an online survey using the Qualtrics [24] platform was undertaken. The survey was developed by an expert panel of midwifery educators, with many of the questions based on their previous focus group and interview guides for qualitative research and other studies [16,20,21,23,25]. The survey was reviewed and refined amongst members of the study team of experienced midwives and academics for accuracy. The 51-item survey consisted of questions that enquired about: (1) Sociodemographic information, (2) perceived support in new midwifery graduate programs, (3) expectations about what new graduate midwives could perform at the end of their first year of employment, (4) how the midwives viewed the skills and knowledge of the midwifery graduates, (5) how the midwives provided support for new midwifery graduates, and (6) why they thought that new midwifery graduates leave the profession (Supplementary File 1). The survey also included questions with free-text responses. Survey data were collected and analysed anonymously.

Purposive sampling was undertaken to include those participants who had the best knowledge of our research topic. Participants were eligible to complete the survey if they were currently practising as a midwife in Australia, (even if they had recently commenced working as a new graduate) irrespective of geographical location or model of care. The survey was distributed via our own professional social media platforms with the capacity for the link to be forwarded to others. This snowball sampling approach assisted in sending the survey to midwives nationally. The Australian College of Midwives has 5000 midwives (including students) members of the Australian College of Midwives who also distributed the link to member midwives via their Facebook page. Participation was voluntary, anonymous, and no reimbursement or honorarium was offered.

Survey responses were downloaded from Qualtrics [24] into Excel, checked for completeness by the first and final authors, and quantitative data was uploaded to the Statistical Package for Social Sciences (SPSS,

version 28) for analysis. The reliability of the survey was assessed by Cronbach's alpha to determine if this survey could be used in another similar population, an acceptable result for a new survey being 0.7 or higher [26]. Descriptive statistics were used to analyse frequencies and percentages of responses. Frequencies were used instead of percentages where participants could provide more than one response. Spearman's bivariate correlational analyses were used to determine associations between the variables that had the same Likert responses. Responses to open-ended questions were analysed by content analysis [27] by the first and final authors. All qualitative data were downloaded into a word document. All the statements were coded using each of the open-ended text responses [27] using colour coding and numerals to highlight similarities between the responses. It was in this way that the two main categories were elicited. Ethics approval was first gained from the primary researcher's institution (H14145) with reciprocal approval gained from the universities of all other authors.

Results

Quantitative results

Thirty-eight questions were assessed for reliability which showed an overall Cronbach's alpha result of 0.917, which is very good, the other 13 questions were not measured on a Likert scale, so unsuitable for assessment. A tool has perfect reliability when it has a coefficient of 1.0. Rarely is an instrument perfectly reliable. Reliability is more often reported as less than 1.0, that is, 0.8 [28]. The final sample consisted of 167 midwives, with a mean working years of 13.3 (SD 12.5). The distribution of working years, the type of qualification, the type of service they currently worked in, and the state or territory in which they worked are reported in Table 1. Thirty-nine midwives had been practising two years or less, but we did not want to exclude new graduates to complete the survey as we believed that many of the questions were also pertinent for them and their opinions mattered. Some of the questions they could not answer. Over half the sample (53.2 %) had been working for less than ten years. Some results show less than 167 responses due to respondents not answering those questions. Qualifications ranged from hospital certificate to doctoral qualification. The majority (70.7 %) of midwives worked in metropolitan / tertiary hospitals and the highest (53.3 %) number of midwives who responded worked in New South Wales and the Australian Capital Territory.

Table 1
Characteristics of the sample n = 167.

Characteristic		Number	Percentage
Years working as a midwife			
	< 10	89	53.2 %
	10 – 19	26	15.6 %
	20 – 29	21	12.6 %
	30 – 39	26	15.6 %
	≥ 40	5	3 %
Qualifications (all that apply)	Doctor of Philosophy (PhD)	4	N/A
	Masters by Research	6	N/A
	Masters	29	N/A
	Bachelor	87	N/A
	Graduate Diploma	53	N/A
	Hospital Certificate	36	N/A
Place of employment	Metropolitan	60	36 %
	Tertiary / metropolitan	58	34.7 %
	Regional / rural	49	29.3 %
Location in Australia	Queensland	35	21 %
	New South Wales	49	29.3 %
	Australian Capital Territory	24 %	40
	Victoria	18	10.8 %
	Tasmania	2	1.2 %
	South Australia	16	9.5 %
	Western Australia	5	3 %
	Northern Territory	2	1.2 %

The type of model that the participant midwives worked in is reported in Fig. 1. Six questions asked how often midwives provided support for midwifery graduates and these results are provided in Fig. 2. Thirty questions asked how midwives provided support for midwifery graduates and what that support looked like. The first set of these results is shown in Fig. 1a in Supplementary File 2. The majority (99.4 %) of midwives reported that establishing relationships with other midwives and women is important to enable midwifery graduates to transition into confident practitioners. The majority (97 %) of the midwives reported that it was important for midwifery graduates to have a mentor. Only a quarter (24.6 %) of midwives reported that managers and other key stakeholders provide a reduced workload to midwifery graduates. The majority (85.6 %) of the midwives were able to support midwifery graduates to work autonomously.

Fig. 1b in Supplementary File 2 shows that almost two-thirds (62.1 %, n = 137) of the midwives agreed or strongly agreed that their service offered an appropriate clinical experience to support graduates' consolidating their midwifery knowledge. Over half (54 %, n = 137) of the midwives agreed or strongly agreed that their service provided experiences that enable new midwifery graduates to work to their full scope of practice (see Fig. 1b in Supplementary File 2). Just over half (51.8 %, n = 137) of midwives agreed or strongly agreed that their service fostered a culture that facilitated evidence-based midwifery practice (see Fig. 3b).

Fig. 1c in Supplementary File 2 shows that over half (51.8 %, n = 137) of the midwives reported that their midwifery graduate program supported midwifery graduates to advocate for women's rights. Almost a third (32.1 %, n = 137) of midwives disagreed or strongly disagreed that their service provided a midwifery graduate program that included role models that demonstrated positive self-care practices. Over half (51.8 %, n = 137) of the midwives agreed or strongly agreed that their service provided experiences that promoted the importance of midwifery continuity of care. One question asked if the midwifery graduate is a safe practitioner who seeks confirmation and clarification and the majority (92.7 %, n = 164) of midwives agreed or strongly agreed (see Fig. 3).

Almost one-third (29.2 % n = 164) agreed or strongly agreed that a new graduate follows hospital policies without questions. Spearman's rho was used to identify correlations between responses to questions and these are presented in Table 2. Spearman's bivariate correlations showed that there were statistically significant ($p < 0.01$, 2-tailed) relationships between the variables, which means that each of these statements had positive associations. A perfect correlation is equal to 1.0, so we have shown positive associations that are higher than 0.5. Statements were categorised into two categories: those that related to "Having a voice" and those related to "Evidence-based / Best practice". The "Having a voice" category encapsulated four variables that showed significant relationships with other variables that included: 1) New midwifery graduates during their first year of practice are encouraged to voice their opinions in the workplace, 2) Our midwifery graduate program values new midwifery graduates' clinical opinions, 3) My service provides opportunities for new midwifery graduates to voice any concerns about their clinical experiences, and 4) Our midwifery graduate program supports new midwifery graduates to advocate for women's rights. The "Evidence based / Best practice category encapsulated two variables that showed significant relationships with other variables that included: 1) My service fosters a culture that facilitates evidence-based midwifery practice, and 2) Our midwifery graduate program creates opportunities for sharing professional best practice.

Higher rho coefficients denote a stronger magnitude of relationship between variables with positive values indicating a positive relationship: as the response for one variable increases, so does that of the corresponding variable. For example, the first correlation presented in Table 2 below (coefficient 0.647) indicates that as responses to the first

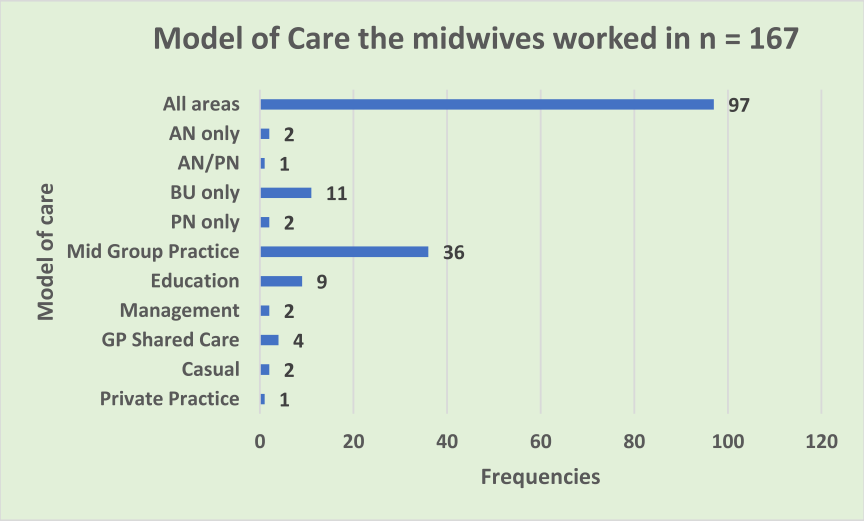

Fig. 1. Model of care the midwives worked in. AN = Antenatal, PN = Postnatal, BU = Birthing Unit, Mid = Midwifery, GP = General Practitioner.

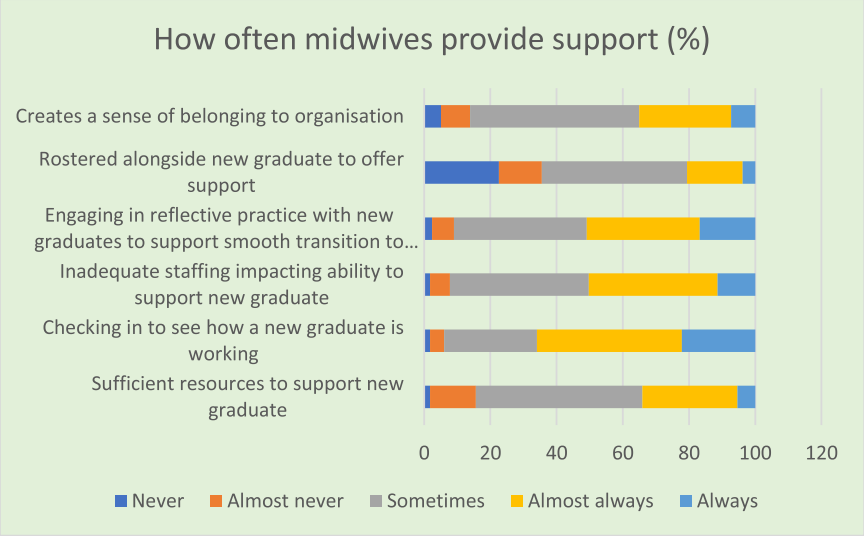

Fig. 2. How often midwives provided support to midwifery graduates.

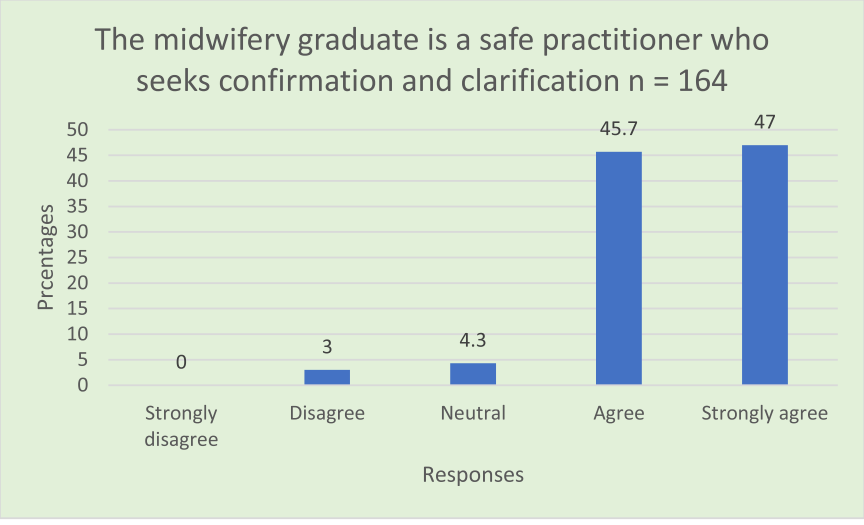

Fig. 3. The midwifery graduate is a safe practitioner who seeks confirmation and clarification.

Table 2
Significant Spearman's correlations ($p < 0.01$, (2-tailed)).

Having a voice	Spearman's rho	
New midwifery graduates during their first year of practice are encouraged to voice their opinions in the workplace	.647	Our midwifery graduate programme values new midwifery graduates' clinical opinions
	.557	My service provides experiences that prepare new midwifery graduates to be change agents for maternity services reform
	.551	New midwifery graduates are enabled to work to their full scope of practice
	.504	My service provides opportunities for new midwifery graduates to practise self-care strategies (e.g. Taking breaks, clinical supervision)
Our midwifery graduate programme values new midwifery graduates' clinical opinions	.674	New midwifery graduates are likely to stay in the workforce if they identify feeling a sense of belonging with their colleagues in their workplace
	.637	Our midwifery graduate programme creates opportunities for sharing professional best practice
	.586	My service provides experiences that prepare new midwifery graduates to be change agents for maternity services reform
	.580	My service provides a midwifery graduate programme that includes role models that demonstrate positive self-care practices
	.570	My service provides opportunities for new midwifery graduates to voice any concerns about their clinical experiences
	.551	My service provides experiences for new midwifery graduates that facilitate progressive development of their confidence
	.541	My service fosters a culture that facilitates evidence-based midwifery practice
	.538	My service provides experiences for new midwifery graduates that show the importance of the midwife in supporting women to have a positive birth experience
	.522	Our midwifery graduate programme supports new midwifery graduates to advocate for women's rights
My service provides opportunities for new midwifery graduates to voice any concerns about their clinical experiences	.601	My service provides a midwifery graduate programme that includes role models that demonstrate positive self-care practices
	.568	My service fosters a culture that facilitates evidence-based midwifery practice
	.566	Our midwifery graduate programme creates opportunities for sharing professional best practice
Our midwifery graduate programme supports new midwifery graduates to advocate for women's rights	.560	My service provides experiences for new midwifery graduates that show the importance of the midwife in supporting women to have a positive birth experience
	.530	My service provides experiences that prepare new midwifery graduates to be change agents for maternity services reform
	.527	Our midwifery graduate programme creates opportunities for sharing professional best practice
	.516	My service provides experiences that promote the importance of midwifery continuity of care
Evidence based/Best practice		
My service fosters a culture that facilitates evidence-based midwifery practice	.659	My service provides experiences that reinforce the positive influences of new midwifery graduates on the health and well-being of women and their families
	.568	My service provides opportunities for new midwifery graduates to voice any concerns about their clinical experiences
	.564	Our midwifery graduate program creates opportunities for sharing professional best practice
	.560	My service provides experiences for new midwifery graduates that show the importance of the midwife in supporting women to have a positive birth experience
	.549	My service provides experiences that enable new midwifery graduates to work to their full scope of practice
	.524	My service provides experiences that promote the importance of midwifery continuity of care
	.517	My service provides opportunities for new midwifery graduates to practise self-care strategies (e.g. Taking breaks, clinical supervision)
Our midwifery graduate program creates opportunities for sharing professional best practice	.637	Our midwifery graduate programme values new midwifery graduates' clinical opinions
	.630	Our midwifery graduate program creates a sense of belonging to the organization
	.626	My service provides experiences that prepare new midwifery graduates to be change agents for maternity services reform
	.612	My service provides experiences that reinforce the positive influences of new midwifery graduates on the health and well-being of women and their families
	.588	My service provides experiences that support new midwifery graduates' professional growth
	.584	My service provides experiences for new midwifery graduates that show the importance of the midwife in supporting women to have a positive birth experience
	.566	My service provides opportunities for new

(*continued on next page*)

Table 2 (*continued*)

Having a voice	Spearman's rho	
		midwifery graduates to voice any concerns about their clinical experiences
	.564	My service fosters a culture that facilitates evidence-based midwifery practice
	.552	My service provides a midwifery graduate programme that includes role models that demonstrate positive self-care practices
	.527	Our midwifery graduate programme supports new midwifery graduates to advocate for women's rights

statement (left column) increase (towards agree, strongly agree) so does the response to the second statement (right column).

These results demonstrate a relationship between providing new graduate midwives with a voice (whether this is in regard to clinical opinions, advocacy or voicing concerns), and graduates being valued and more likely to be retained in the workplace. There is also a relationship between having a voice and promoting evidence based/best practice. Evidence based/ best practice is strongly correlated with reinforcement of the positive influence midwives can have on the wellbeing of women and their families and promotion of best practice with creating a sense of belonging for new graduates and their preparation as change agents.

Expectations of graduate midwives

Midwives were asked what skills they would expect of midwifery graduates at the end of their first year in the workforce (see Fig. 4). The highest responses included being able to perform neonatal resuscitation (153), then being able to make decisions about referring for an obstetric consultation (148), followed by being able to perform an amniotomy (134) and, attaching a fetal scalp electrode (125). The lowest number of responses were related to being able to perform perineal infiltration and repair (37), followed by being able to perform cannulation (95).

Graduate midwives' attrition

Midwives were asked why they thought midwifery graduates would leave the profession (see Fig. 2 in Supplementary File 2). The highest responses included stress and pressure of the clinical environment (140), then workplace culture (127), followed by disillusionment with challenges to working in alignment with professional philosophy (122). The least number of responses were lacking psychological safety (77), followed by lack of support in graduate transition (110).

Open-ended responses

Analysis of the open-ended responses indicated that midwifery graduates left the profession for two main reasons: 1) Lack of support and being bullied in the workplace, and 2) Lack of confidence and competence.

Lack of support and being bullied in the workplace

The lack of support reported by midwives as: *"The lack of support extended from all levels of management" (P1),* and "*These new grads are not supported to enhance their skills." (P3)* One midwife commented on the inequality of the support: *"A junior workforce and staff shortages mean that some graduates with greater needs may suffer. Graduates who are deemed to be thriving may sometimes not receive as much support as they need due to a perception that they are ok." (P4)* Midwives reported that midwifery graduates have experienced bullying and poor workplace culture which has resulted in them leaving the profession, *"Bullying and being left to sink or swim" (P5), "They are bullied until they leave" (P3),* and *"Workplace culture definitely." (P2)*

Lack of confidence and competence

Midwives reported that midwifery graduates who lacked confidence and competence have left midwifery practice.

> "I feel as students they are not always encouraged to undertake all necessary practical assessments regularly, that is, vaginal examinations or catheterisation and thus, they lack in confidence during their graduate year. Most feel highly pressured, especially in high-risk areas, as they have not had confidence instilled into them through frequent practice, even by their third year." (P6)

Midwives reported that they felt universities were not preparing

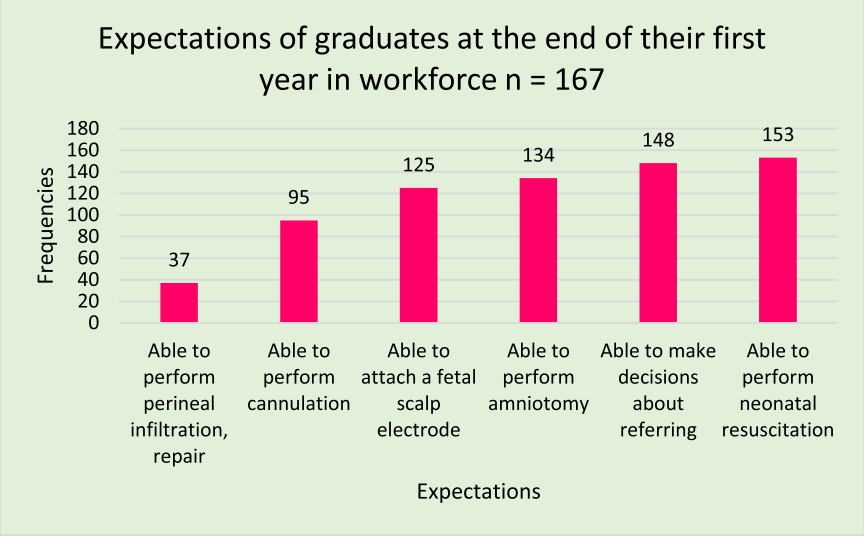

Fig. 4. Expectations of graduates at the end of their first year in workforce.

graduates for the realities of working life as a midwife.

> "Universities are not preparing them for appropriate practice. Midwifery students are lacking prioritising and time management skills when entering a hospital based system." (P7)

Participants felt that the emphasis on continuity of care during their education did not prepare graduates for the reality of work life, and they needed to care for several women simultaneously including those with high-risk pregnancies.

> "Not work ready, not ready for shift work or truly being on call and having other work to do as well, as a student focus on one woman, as a midwife have several to provide equal attention." (P8)

> "In our hospital/bachelor degree, there is a major emphasis on continuity of care. However, most graduates end up in a tertiary level hospital full of high-risk women/pregnancies and are therefore unprepared for the level of stress and risk. They need to spend more time on the wards and less time in continuity." (P9)

Discussion

The findings in this study provide insight into how midwives support new graduates as they transition into the midwifery workforce. Growth in midwifery graduates is essential for maintaining a strong fit-for-purpose workforce [29]. A recently published report recommended growing the midwifery workforce by increasing student numbers by 20 % to enable around 1500 graduates. However, those graduates require support to maintain a healthy workforce [4].

The midwives in this study reported that they provided support for graduates by nurturing professional relationships, which enable graduates to have a voice and deliver evidence-based best practices. A recent scoping review found that early career midwives (within the first five years of practice) who were supported to work to the full scope of practice, such as in midwifery continuity of care models and engage in a woman-centred philosophy, were more likely to continue in their midwifery career [25]. Scaling up midwifery continuity of care has been recommended to enable midwives to work to their full scope of practice, important for the future Australian workforce [4]. Newly graduated midwives begin their midwifery careers with a philosophy that is committed to continuity of care underpinned by woman-centred care [30]. Many enter graduate programs within fragmented health service institutions where midwives do not prioritise the learning experiences of continuity of care for students [31].

Over half of the midwives in our study reported that their service promoted the importance of continuity of care to graduate midwives. Working as a hospital employed midwife doing shift work, instead of working flexibly with a woman in a continuity of care model has resulted in feeling lost in the system [16]. Visionary leaders have employed new midwifery graduates in continuity of care models. Managers have been known to staff these models by identifying students who they think are suitable for continuity of care models and subsequently providing them support and a smoother transition [22,32]. Findings from these studies and our current study indicate the importance of providing opportunities for new graduate midwives to transition directly into continuity of care models which may contribute to great job satisfaction and retention of early career midwives. Workforce retention is a significant factor, compounded by graduates leaving soon after registration or choosing to work part-time [33].

Our survey findings provide valuable insights into the current employment experiences of midwives.

Over half our sample had been working for less than ten years. This could be explained by a potential loss of midwives due to the aging profession, with a consistent decline in numbers seen for registrants aged 45–59 years since 2014 ([4], p. 47), [34]. However, data from the Midwifery Futures survey and focus groups, along with previously published workforce models, demonstrate a lack of secure workforce provision for the future [4]. One potential explanation for the mismatch between registrant numbers and people's experiences in midwifery workplaces may be that not all midwives are working as midwives, or they are not engaged in providing clinical care.

Only one-third of the midwives in our study reported feeling confident and prepared to support graduates in the workplace, however there was limited organisational support, such as mentoring in midwifery. Given the heavy reliance on midwifery colleagues' support for successful graduate transition to the workforce, further investment in formal support strategies such as mentoring may be warranted [35]. The Midwifery Futures report recommends quality mentoring programs for graduates however the midwives need education into how to provide mentoring [4]. Innovations in the United Kingdom have been in place for the past ten years to assist new graduates to transition into practice [36]. One joint initiative is run between a health service and an academic institution that incorporates exposing the new graduate to case-loading [36]. Since 2007, new graduates in New Zealand have been mentored by the Midwifery First Year of Practice program, supported by the New Zealand College of Midwives and funded by the government [19,37]. While formal mentoring programs were advocated by most participants in our study, only one-quarter reported that workplaces facilitated a reduced workload for the mentor, to support them with the extra workload of mentoring. Clinical workload allocations that acknowledge midwives' requirements to support students and graduates would support experienced midwives' wellbeing and workforce retention [38]. Positive relationships with mentors and support from colleagues have been identified as key factors in retaining early career midwives, whereas poor working relationships challenged graduate confidence and retention [22,39].

Despite acknowledging that establishing a relationship with other midwives is important for graduates to develop as confident practitioners, only half of the midwives in this study felt they could provide support 50 % of the time, and only one-fifth reported they were rostered alongside a graduate due to inadequate staffing. Nevertheless, two-thirds of the participants checked in to see how the new graduate was going throughout the shift. Most of the midwives in our study also reported that graduates are more likely to stay in the workforce if they identify a sense of belonging with their colleagues in the workplace. A previous Australian study [23] also found that midwives considered relationships with peers as important. Midwives who welcome new graduates and encourage them to feel part of a team promote a sense of belonging [23]. In a study by Pairman et al. [40], graduates reported that support from midwives and engagement in the graduate midwifery program was important to increasing their confidence.

Midwives' highest expectations for new graduates' clinical expertise in our study included being able to perform neonatal resuscitation, being able to make decisions about referring, and clinical skills including amniotomy, and attaching a fetal scalp electrode at the end of the first year of practice. Midwifery-specific decision-making relies on the midwife's knowledge about the scope of practice of each multidisciplinary team member and the ability to refer when necessary [41]. An important goal of education is promoting students' clinical skills [42]. One study [42] found that only 49 % of midwifery students possessed appropriate knowledge about neonatal resuscitation, and these are the minimum skills required before entering the workforce. These findings reinforce the importance of providing support for students, such as mentoring that has been reported as increasing confidence [43] before they enter the field [42]. Most midwives in our study agreed that graduates were safe practitioners, and only one-third agreed that graduates followed hospital policies without question.

A significant finding from our study showed the importance of the new midwifery graduate having a voice for their opinions and being heard in the workplace, especially their clinical opinions. Being encouraged to voice their opinion was also associated with the service providing experiences that prepared new midwifery graduates to be

change agents for maternity services reform, being able to work to their full scope of practice, and practising self-care strategies. Almost all of the midwives in our study reported that new midwifery graduates should have allocated supernumerary time in their designated clinical area. However, the opportunity for supernumerary experience for graduates in our study was minimal. An alternative to a formal graduate program to facilitate a smooth transition to the workforce has been successfully implemented in the United Kingdom whereby new graduates are provided preceptorship sessions and supernumerary status to enable them time to develop their skills [36]. An Australian study [23] found that supernumerary time enabled graduate midwives to adjust to their role without the stress of working with a full clinical load and time and space to ask questions. Graduate midwives who were not offered supernumerary time reported this extremely negatively [23].

Midwives in our study reported that new graduates lacked prioritisation and time-management skills and the emphasis on continuity of care during their studies did not prepare them for the reality of the workplace. Considering that Australian midwifery students have a minimum of ten continuity of care experiences and so many more hours of clinical placement, the lack of prioritising and time-management skills could be due to their being inadequately supported in their final year of midwifery professional experience placement to develop these skills. More work could be targeted at working with clinicians to better understand students' needs for skill development and provide opportunities for students to develop their autonomy in a safe and supported way [44] to assist with the attrition of new graduate and early career midwives.

In our study, midwives reported that one of the highest reasons midwifery graduates leave is due to the pressures within the clinical environment. Only one-quarter of midwives in our study found that managers and other key stakeholders provided a reduced workload to new midwifery graduates. Other studies have shown that extremes of activity and lack of staff due to increased absenteeism can contribute to burnout, especially for early career midwives [45,46]. Early career midwives have reported that the top reasons for thinking about leaving the profession included: burnout, the irregular nature of working shift work, and staff shortages [46].

Workplace culture was the next highest reason why midwives in our study believed that new midwifery graduates leave the profession. Even though autonomous practice was supported in our study, self-care was not. Negative experiences can persist when midwives begin their career and contribute to them leaving the profession prematurely [47]. Midwives also reported that new graduates also leave due to bullying in the workplace and this has been substantiated by an integrative review which highlights the prevalence of workplace bullying towards midwifery students [48]. Part time and casual hours assist with coping by reducing stress levels but means it takes longer for new graduates to feel confident.

Strengths and limitations of the study

The strengths of this study lie in the fact that it is the first study to explore midwives' perspectives on factors that influence graduate midwives' transition into the workforce. There was representation from all Australian jurisdictions. It is important to note that this research presents the views of the midwives who support or work alongside the new graduate and the new graduate midwives themselves. Consequently, a limitation of this study is that it presents a small sample size, and portion of the representative population of the Australian midwifery workforce. A limitation of our study is the length of time the survey was open from December 2020 and January 2023. The low sample size was due to the nature of our purposive sampling strategy. To address this limitation we introduced snowball sampling as well, however the response rate remained low and we had to leave the survey open. The timeline also included the period of time during COVID-19 which presented workforce challenges, which were not really unexpected.

Conclusions

Midwives reported in the survey that they provide support to new graduate midwives, however analysis of responses identified perceived challenges faced by new graduates, which include being overwhelmed by the workload, lack of available support, and bullying. The results of this study should be considered by university educators, hospitals, and health care providers who provide midwifery students with midwifery professional experience placements. Insights from this study on the first year of practice include; a lack of mentoring opportunities and protected hours to gain further experience and professional development. There were minimal opportunities for new graduates to consolidate their midwifery philosophy or work in continuity models of care. Midwives should be given opportunities so that they can feel prepared to support new graduates in the workforce. These findings support the need for graduate programs that offer formal mentoring and ongoing professional development. Midwives can assist new graduates by making them feel part of the team and valuing their opinions. Providing education for midwifery students on decision-making and clinical skills before they enter the workforce would be valuable. The increased quantity and quality of the workforce, requires the provision of a safe and supportive environment that facilitates job satisfaction and sustainable ways of working for new graduate midwives.

Conflict of interest

Linda Sweet, Deborah Davis, Allison Cummins and Lois McKellar have editorial duties with this journal. To reduce any real or perceived conflict of interest, they had no role in the processing or peer review of this paper. All other authors do not have a conflict of interest.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2025.101913.

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