Changing times: why direct-entry midwives are re-training as Health Visitors and how this affects their professional identity

Background to the study

Health visitors play a vital role in the care of families with babies and young children. In the latter part of the 20th Century, the roles of the health visitor and midwife were distinct and complementary, with health visitors focusing on the wider family and typically taking over the care of the mother/baby pair following their discharge from maternity care. In recent years, however, the roles of the two professions have increasingly overlapped, with health visitors now frequently involved in providing ante- and postnatal care and breastfeeding support.

Health visiting was traditionally a career open only to those with nursing qualifications. Since 2004, direct-entry midwives (those without a nursing qualification) have been able to train as Specialist Community Public Health Nurses (SCPHN), leading to registration as health visitors, provided they maintain their midwifery registration with the Nursing and Midwifery Council (NMC).

In 2011 the Health Visitor Implementation Plan (Department of Health, 2011) sought to produce 4,200 new health visitors. Since that time, not only has the number of students on health visiting programmes increased, but one university in the South of England has seen an increased percentage of students coming from a direct-entry midwifery background, alongside other backgrounds (nursing alone or nursing and midwifery). Anecdotally, a similar pattern seems to be occurring in other UK universities.

Table 1: Health visitor (HV) students with a direct-entry midwifery background. Numbers from a single university in the South of England

Year	Total number of HV students	Number who qualified as direct-entry midwives	% of total HV students
2011-12	56	5	9.4 %
2012-13	59	12	20.3%
2013-14	108	20	18.7%

Attrition from the midwifery profession is a subject of increasing concern, particularly in view of the recent Maternity Service Report (RCM, 2015) which identified a need for 2,600 more midwives to cope with the rising birth rate. In the area in which this study took place, it had been noted that in recent years, an increasing number of direct-entry midwives were leaving midwifery careers to re-train as health visitors. Many of these midwives had been identified as high achievers during their undergraduate years and/or their subsequent clinical careers. This apparent drift of potentially high-calibre midwives from local maternity units into health visiting has implications for workforce development and planning in both professionals. It also begs the question of causation: what factors are driving midwives into health visiting and away from midwifery?

The latter part of the 20th Century saw a nationwide decline in the number of health visitors, most markedly in London and the East of England. At the time, negative perceptions of the health visiting profession abounded, making it an unattractive career choice for midwives (Whittaker et al. 2013). Pay scale downgrading in the wake of 'Agenda for Change' (Department of Health, 2004) led to concerns about starting salaries, with health visitors often receiving a lower grade of pay than midwives (Lindley et al, 2010; Whittaker et al, 2013). Furthermore, opportunities for career progression were limited, contributing to a longstanding problem of low morale (Lindley et al, 2010). Since the 2011 Health Visitor Implementation Plan (DH, 2011) however, changes to the health visiting profession and a growing desire for greater professional autonomy among midwives is believed to have brought about a change in attitudes to health visiting and a more positive image of the profession (Whittaker et al, 2013).

Concern with attrition from midwifery is not new and was the impetus for the Midwives' Career Project; a longitudinal study of midwives who trained in the 1970s and 1980s (Robinson 1994). Reasons for attrition were attributed to the difficulties of combining career and family life and keeping up to date with professional development, with poor pay and low levels of staffing cited as contributing factors. It should be noted that prior to the 1990s, direct-entry midwifery was rare in the UK, thus it is likely that most or all of the respondents in this early study had first trained as nurses.

Curtis et al (2006a), reporting on a large survey of former midwives by Ball et al (2002), noted that the chief reasons for quitting the profession (apart from planned retirement and ill health) were dissatisfaction with midwifery and conflict with family commitments. Curtis et al (2006a) suggested that where other factors were included, dissatisfaction with the role was likely to provide the tipping point, with many respondents claiming that they could not provide an appropriate standard of care or develop meaningful relationships with women due to staff shortages and obstructive, inflexible management. Many participants felt that their own health had suffered as a result of stress.

In 2013, a survey of 1,025 Royal College of Midwives (RCM) members found an undercurrent of resentment about terms and conditions of employment in the NHS, with 36 per cent of respondents reporting that they often thought about quitting and 24 per cent saying they would probably look for an alternative career in the next twelve months. The conclusion from the RCM was that the midwifery workforce was largely demoralised; disillusioned and burnt out (RCM, 2013)

To date, there appears to be no literature specifically addressing career movement between direct-entry midwives and health visiting. Studies by Thurtle (2005) and Poulton et al (2009) surveyed students on community and SCPHN programmes, concluding that regardless of their professional backgrounds, the impetus for a career change was similar, including the desire for increased autonomy, community-based working and better working hours. However neither study specifically addressed those coming from midwifery backgrounds. The current study was therefore undertaken to address this shortfall in knowledge, with the following specific aims:

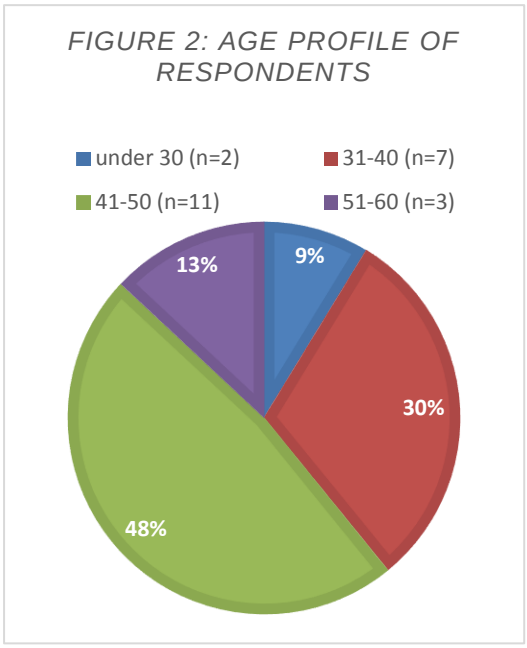
- To investigate why direct-entry midwives move into health visiting
- To explore how direct-entry midwives in health visiting sustain their registration
- To enquire into how dual trained midwives and health visitors view their professional identity

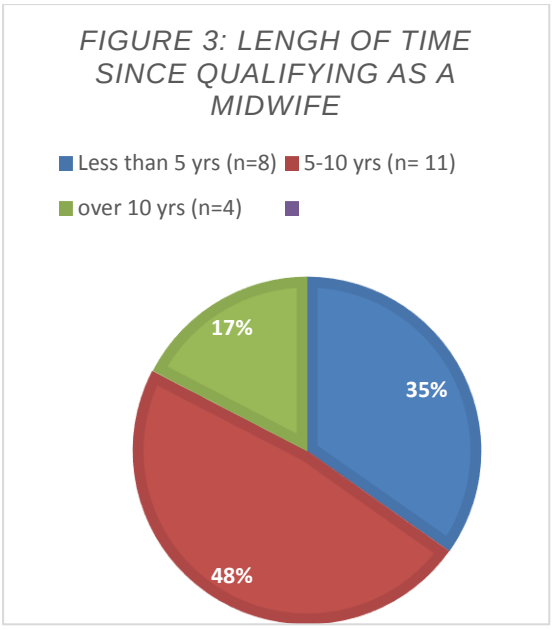
Study design

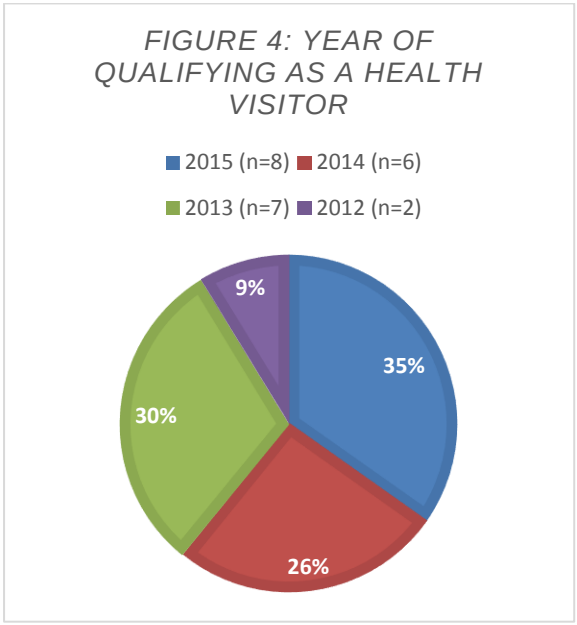
Data was collected initially via an online questionnaire (part 1) and subsequently via a focus group and face to face interviews (part 2). Part 1 of the study used the Bristol Online Survey software and was piloted between December 2014 and January 2015 among health visitors who were not potential participants. Full ethical approval for the entire study was granted by the university ethics committee. A link to the questionnaire was emailed to all former health visiting students from the university in question, who had a direct-entry midwifery background and who qualified as health visitors in the years 2011- 2015 during the enactment of the Health Visitor Implementation Plan (n=37). Non-responders were sent a reminder email after 2 weeks and then again after 4 weeks. 23 questionnaires were completed. The survey consisted of 23 questions, mostly multiple choice with space for free-writing in some. Basic demographic data were requested (see below). The questionnaire sought interest in participation in stage two of the study, which necessitated the inclusion of identifying details from those willing to be interviewed or take part in a focus group. Full anonymity of participants was assured. This paper describes the findings of the questionnaire only: future papers will consider the outcomes of the entire study, once qualitative data from part two has been analysed.

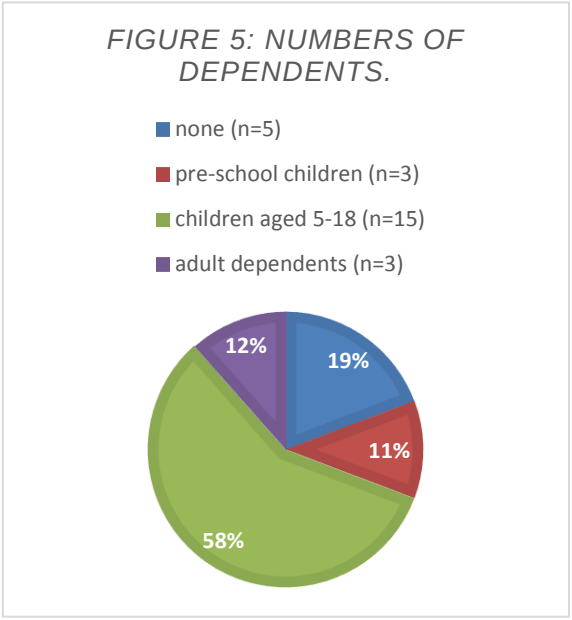
Sample characteristics

The sample group consisted only of women, since there were no men in the sample population. Age profiles, years since qualifying as a midwife and as a health visitor and number of dependent relatives are displayed in figures 2-5.









Most respondents were working solely as health visitors in the area where they had undertaken their training (N = 18). One was employed as a health visitor in another area and one was working as a family nurse practitioner. Two were working mainly as health visitors in the area where they had trained, with some occasional 'bank' midwifery work. One was also doing occasional 'bank' midwifery shifts whilst working primarily as a health visitor, but did not state whether she was working in the

area where she trained or elsewhere. All were employed in publically funded organisations.

Findings

Questions focused on reasons for leaving midwifery and becoming a health visitor, how respondents maintained their midwifery registration and their future career plans. Respondents were able to choose one or more from a list of options and to add further information if desired. Individual quotations are identified by numbers to protect anonymity.

Reasons for leaving midwifery

The chief reasons for leaving midwifery centred on the working environment and subsequent stress or 'burnout' (tables 2 and 3). Most respondents ticked several boxes, hence numbers add up to more than 23.

Table 2: Reasons for leaving midwifery: the working environment

Reasons	Number of responses
Low morale in midwifery	18
Low staffing levels	15
Fear of litigation	14
Found midwifery too stressful	13
Disliked working antisocial hours	10
Too much responsibility/excessive workload	10
Professional 'burnout'	5
Lack of support/poor management	3
Bullying	1

Reasons not related to the working environment included difficulty aligning family commitments with midwifery (n=10), a wish to provide family-centred care (n=14) and a desire for personal career development (n=5).

Those who cited stress or professional 'burnout' as reasons for leaving midwifery were asked to provide further details in their own words. As both questions generated similar responses, these are summarised together in table 3 and examples of text are provided below.

Table 3: Reasons for stress and professional 'burnout'

Reasons	Number of responses
Unable to provide a safe level of care due to excessive workload	9
Lack of support from senior staff	6
Long working days with no breaks	5
Shortage of staff in maternity units	4
Lack of sleep due to excessive workload	2
Lack of equipment	1
Daily incident forms	1
'Not cut out' for work on labour ward	1
Didn't 'fit in'	1
Hostile working environment	1

'I felt guilty most days that I had not provided care that I wanted to or was trained to do, as there was never enough time to do it. I felt that every shift was dangerous and I became frustrated that nothing was being done to protect me or the patients'. [No.21, qualified as a midwife in 2007]

'I had to take time off with stress […] as I felt burned out from too many community 'on calls' and sleep deprivation. I was worried that I would make a mistake due to extreme tiredness when called to a home birth at night, having worked hard all day.' [No.4, qualified as a midwife in 2000]

'Finding myself in situations where the lives of women and children were at risk, with limited support' [No.2, qualified as a midwife in 2013]

It was evident that the majority of reasons cited for leaving midwifery related to the working environment and to the difficulty in maintaining client safety. However, interpersonal issues were also a strong factor, notably lack of support from senior staff. There was no link between the year of qualifying as a midwife and reasons for wanting to move away from clinical practice: reasons such as stress and over-work were just as evident among those qualifying several years ago as among those more recently qualified. This challenges anecdotal arguments that newly qualified midwives are less resilient than their more experienced colleagues and suggests that the working environment has deteriorated over the years, to the point where 'old hands' are experiencing as much stress as newly qualified staff.

Reasons for becoming a health visitor

There was much congruence between reasons for leaving midwifery and reasons for becoming a health visitor. Reasons chiefly centred on a desire to provide better care for clients and a need for better working conditions.

> *'I did not feel supported as a newly qualified midwife. As a newly qualified health visitor I am totally supported by the whole team' [No.18]*

> *'I wanted to provide some continuity and ongoing care to clients' [No. 5]*

Only five people reported being influenced by advertising for the health visitor programme. All respondents cited more than one reason for their career change: these are summarised in table 4:

Table 4: Reasons for wanting to become a health visitor

Reasons	Number of responses
Wanted to do more work in the community	18
Preferred the hours in health visiting	17
Saw health visiting as less stressful	14
Wanted to work in health promotion	11
Wanted more autonomy	8
Influenced by advertising	5
Wanted a higher income	1
Enjoyed a 'taster' day with the health visitors whilst a student midwife	1
Wanted to provide better continuity of care	1
Wanted to spend more time with families	1

Maintaining midwifery registration

Respondents were asked how they demonstrated that they were maintaining their midwifery practice, in accordance with NMC requirements (NMC, 2012). A list of options was offered and there was scope to include free-form answers. Responses are summarised in table 5. Several chose more than one option, hence numbers add up to more than 23.

Table 5: How respondents maintained their midwifery practice

Means of maintaining midwifery practice	Number of responses
Working with families with babies under 28 days old	22
Breastfeeding support	22
New birth visits	22
Antenatal visits	22
Child health clinics	21
Following up blood spot screening tests	12
Antenatal teaching	7
Bank work as a midwife	4
Follow-up care e.g. in cases of neonatal jaundice, PND etc.	2
All of the above	1

All responses related to paid work: none was involved in the voluntary sector. An anomaly was noted in relation to 'bank' midwifery work: four cited this as a means of maintaining registration (see table 5) yet in earlier questions asking about their current roles, only three had mentioned this. This is assumed to have been an oversight.

An interesting comment was offered by the respondent who was employed as a family nurse practitioner:

> *'[…] I practise all the above alongside delivery of the FNP programme. I practise more midwifery in this role, than I was able as a midwife! [No. 10]*

Participants were asked whether or not they agreed with the requirement for direct-entry midwives to maintain their midwifery registration in order to work as health visitors. Only one respondent felt that this **should** be required:

> '*It underpins my practice as a health visitor' [No. 8].*

Five were unsure of their feelings on this question, whilst the remaining seventeen felt that this requirement was unnecessary. Comments included:

> *'Health visiting should be a profession in its own' [No.4]*
>
> *'Nurses do not have to have intention to practise forms signed to prove their registration and health visiting is often far from what they did in their training/speciality. So why just midwives? [No. 5]*

'Should be optional as with nursing and dependent on professional future progression i.e. development in one or both professions optional' [No. 6]

Participants were asked how they regarded themselves in terms of their profession. Opinions were fairly evenly spread: ten saw themselves primarily as a health visitor, two as a midwife and eleven as both a health visitor and a midwife.

Plans for the future

One question asked participants where they hoped their careers to be in five years' time. Up to three options could be chosen from a set list and there was space for free writing. Table 6 details the responses:

Table 6: Career aspiration for five years hence.

Career aspirations	Number of responses
Specialist health visitor	17
Band 6 health visitor	9
Combined Health visitor/Midwife role	7
Practice teacher	4
Specialist midwife	3
Health visitor team leader	2
Health visitor lecturer	2
Band 7 health visitor	2
Midwifery lecturer	1
FNP supervisor	1
Another public health role	1
No specific aspirations	1

There was a strong relationship between respondents aged 31-50, with school-age children and those with higher career aspirations. Fourteen hoped for a specialist role in either health visiting or midwifery, 7 hoped to hold a dual role and 5 planned to seek a band 6 (health visitor) post. Others in this category aspired towards a role in education. There were no strong links between other age groups or categories of dependents and future career plans. It was interesting to note that three

respondents aspired to a career as a specialist midwife, implying that they hoped to return to midwifery at some point in the future.

Discussion

The first part of this study supports earlier works which suggest that attrition from midwifery is rarely due to a single issue, but more often relates to a complexity of reasons, both personal and related to the working environment, including the need for more autonomy, flexibility and support (Green & Baird, 2009; Curtis et al, 2006d). Reasons relating to or alluding to interpersonal difficulties (bullying, 'not fitting in', hostile working environment) were not common, which supports the findings of Curtis et al (2006d). The latter, however, found that this reason for quitting was more prevalent among direct-entry midwives than among those with nursing qualifications, which raises questions about whether they are less resilient or whether they perceive discrimination from their dual-qualified peers.

It was evident that many respondents had felt very unhappy with their careers as midwives, yet cared deeply about the women and families in their charge. Curtis et al (2006b and 2006c) highlighted divisions between the philosophical stance of those who quit midwifery and those who stayed, referring to 'idealists' and 'realists'. The woman-centred care that the idealists sought to provide was seen by realists as a luxury in units that were under particular stress. This may account for the frustration felt by respondents in the current study, who were unable to provide the standard of care they aspired to and felt obstructed by an unsupportive management system.

Curtis et al (2006e) noted that most midwives who left clinical practice did so with some regret and sought other roles with similar characteristics. From the responses of participants in the current study, it seems that health visiting not only offered an escape route from the stress of clinical practice, but also offered career development opportunities. Stevens (2010) suggested that with the growing number of a high calibre candidates for direct entry midwifery, not all will want to stay as 'grass roots' midwives, yet managerial positions remain limited. The stated career ambitions of respondents in the current study showed that many were aware of the possibilities of advancement into specialist roles within health visiting, which may not have been

available in clinical midwifery. However, they also recognised in health visiting the opportunity to expand their public health role in a community based setting and to develop their woman and family-centred skills. Sacrificing their involvement in caring for women in labour appears to have been a price they were willing to pay. Participants in this part of the study were not asked what they would have done had health visiting not been an option: this would be explored in depth in part two.

The requirement for direct-entry midwives to maintain their registration with the NMC was regarded by most as an anomaly in the present day, when much of their role involved using midwifery skills and knowledge. The majority of respondents had ambitions to progress into higher roles, which has positive implications for the future of the health visiting profession. However, this represents a loss to midwifery of a body of conscientious and ambitious women, with a vision for the future, whose talents might have enhanced the profession had they been supported to continue in the role for which they had originally trained.

Conclusion

The reasons why direct-entry midwives leave their original calling and move into health-visiting are numerous and complex. A system of maternity care which frustrates attempts to deliver the best possible care to women appears to be the main driving force. Part two of this study builds on the outcomes of the questionnaire and explores in depth the experiences and feelings of a sub-set of respondents. The findings of part two are currently being analysed by all three investigators and will be offered for publication later in 2016.

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