



Introducing a new retention midwife role within NHS maternity services in England: a qualitative study

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ABSTRACT

Objective: To explore the perspectives of 'retention midwives' about the implementation of their novel role supporting the retention of colleagues in maternity services in England.

Methods: A qualitative descriptive study, based on semi-structured interviews with 21 retention midwives, analysed using inductive thematic analysis.

Results: Three themes were developed: (1) 'Defining the role: flexibility and ambiguity'; (2) 'Implementation context: buy-in and readiness to change'; and (3) 'Supporting midwives in specialist roles'. Effective implementation was characterised by role clarity balanced with the flexibility to adapt the role locally without losing the focus on retention; by a local context where leaders were open to innovation, willing to take risks and not overwhelmed by extreme funding and staff shortages; by clear reporting structures and accountability; and by access to peer support through organised networks. It was undermined by short-term funding; role overload; unclear communication about the role from funders to maternity leaders and from leaders to staff; and a lack of management training for clinical midwives in their first management role.

Conclusions: The non-negotiable components of a new role should be clearly defined to ensure that it is implemented effectively in all trusts, and not reliant on enthusiastic individual leaders who are willing to take risks on innovation. Funding structures should ensure that the creation of a new role does not exacerbate understaffing in non-specialist areas. Future national implementation of specialist midwifery roles could include more structured use of change management principles and be accompanied by formal process evaluation.

Statement of significance

Issue

A novel specialist 'retention midwife' role was introduced in 120 maternity trusts in England. There has been no research into how these roles were implemented.

What is already known

Implementation of new health service roles can be undermined by

poor definition and communication, weak leadership, and insufficient training, support and evaluation.

What this paper adds

- The retention midwife role was introduced with uneven success in different trusts, reflecting capacity and openness to change.
- Adding significant extra responsibilities can undermine the core purpose of a flexible role.
- Intentional peer support networks enable the spread of effective practice between specialist midwives.

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Introduction

Maternity services in England have faced high staff turnover and persistent shortages of midwives, estimated in April 2023 to be 2,500 full time equivalent posts, which is 10% of the total needed for a safe service (Royal College of Midwives, 2023). The midwifery profession in England is divided into band 5 (newly qualified), band 6 (more experienced), band 7 (specialist, manager, education and research), and band 8-9 (senior manager, consultant, head of midwifery) (NHS Staff Council National Evaluation Group, 2025). Band 5 and 6 midwives are more likely than midwives at band 7 and above to give up their profession for reasons other than retirement (Feeley & Stacey, 2024; Hunter et al., 2019). Key reasons include burnout, workload, staffing, lack of colleague support, lack of autonomy, and concern about the quality of care to the public (Hunter et al., 2019; Nursing and Midwifery Council, 2023).

The issue of unsustainable numbers of National Health Service (NHS) staff leaving practice has triggered a national policy response, including a specific focus on nurses and midwives (NHS England, 2022). In 2021-2022, the central commissioner NHS England made a payment of £50,000 to each of the 120 NHS trusts in England that provide maternity services, to fund the novel employment of supernumerary, unit-based retention midwives with a lead role in supporting retention of their colleagues (Care Quality Commission, 2024). Ring-fenced payments were renewed annually until April 2025, after which local commissioners had discretion about continuing to fund the role locally. Retention midwives may have contributed to a significant reduction in turnover of midwives and an increase in midwifery numbers, which grew by 13.5% between March 2022 and March 2025 (NHS England, 2025; Royal College of Midwives, 2024a).

Aside from a single organisational case study (Feeley & Stacey, 2024), there has to date been no follow up to investigate the implementation of the new retention midwife role in England. The purpose of this research is to explore the perspectives of retention midwives recruited under this programme about how their roles were introduced and operationalised. This can inform future policy and practice on the implementation of specialist roles within maternity services. A separate article will report their experiences of carrying out their role as retention midwives.

Methods

Design

This was a qualitative descriptive interview-based study (Sandelowski, 2000), which acknowledges the roles of both participants' understandings and the researchers' interpretations in the production of knowledge (Madill et al., 2000; Sandelowski, 2010). This design was chosen because the purpose was to explore participants' experiences and to stay close to their accounts without imposing or creating theory (Sandelowski, 2000).

Recruitment

Participants were midwives who were currently or formerly employed in a specialist retention midwifery role introduced under the national programme. Maximum variation sampling was used to recruit midwives from services across England, in both urban and rural locations.

Participation was invited through an email circulated by NHS England and professional midwifery networks. Near the end of recruitment, participants were invited to forward the invitation to colleagues in under-represented geographical areas. Retention midwives who responded to the invitation email were sent the participant information leaflet and consent form by email, at least 24 hours before an interview.

Recruitment continued until thematic data saturation was reached,

that is participants were repeating what had been expressed by previous participants and there were no new codes or themes (Saunders et al., 2018). The researchers had no previous contact with any participants.

Data collection

Each participant took part in one semi-structured interview, carried out using video-conferencing software in April-August 2025. Before the interview, the purpose of the research and its confidentiality were reiterated, participants were invited to ask questions, and informed consent was taken. The interviews covered the introduction of the retention midwife role (reported here) and their experience of carrying out the retention role (reported separately). Interviews were audio-recorded and fully professionally transcribed. Identifying details were removed from transcripts and each participant was given a participant number beginning RMW.

Data analysis

Thematic analysis was carried out in parallel with data collection, using the steps outlined by Braun and Clarke (2006). During iterative data collection and analysis, developing analytical ideas were discussed with interviewees. Interview transcripts were checked against the audio-recordings, de-identified, and reread for close familiarisation. NVIVO 12 software was used to record the inductive coding of data. Codes were refined as data collection continued, and themes were developed to describe implementation of the roles. To increase validity, one researcher analysed all the transcripts and two researchers analysed a subset (24% of total). Codes and themes were discussed and agreed; example codes are shown in Supplementary Material 1. Throughout the process of data collection and analysis, the researchers worked with a reflexive awareness of their own positionality including both midwifery and non-midwifery backgrounds.

Results

Participants

Twenty one retention midwives were interviewed, from different trusts and drawn from all NHS England regions. Interviews lasted 37-82 minutes (mean 57 minutes). Fourteen retention midwives were currently in post, and seven had left or their role had been discontinued; a further three were planning to leave soon. Their age range was 26-63 years (mean 40 years). Sixteen identified their ethnicity as White British, two as Mixed/Multiple, one as Black Caribbean, and two as White European. Table 1 shows further details about the participants and their roles.

Themes

There were three themes: (1) 'Defining the role: flexibility and ambiguity', containing subthemes 'Purpose, scope and activities', 'Combination with other responsibilities', and 'Impact of short-term funding'; (2) 'Implementation context: buy-in and readiness to change'; and (3) 'Supporting midwives in specialist roles', containing sub-themes 'Training for a new specialist role', 'Peer support' and 'Evaluation'. Figure 1 shows these with illustrative quotations.

Defining the role: flexibility and ambiguity

The retention midwife (RMW) role was intentionally flexible to allow trusts to adapt the resource to their local needs. Adaptation was reflected in the heterogeneity of the roles when implemented, as shown in Table 1. This included the combination of the role with other varied lead responsibilities; status (bands 7 or 8); and the hours allocated to the post (from 0.4 - 1 full time equivalent). Some retention midwives were given responsibility for retention at an individual maternity unit, others for all

Table 1
Participants' roles, experience and training.

	Number of participants
Current grade of retention midwife post	
Band 7	18
Band 8	3
Hours allocated to post	
Full time (including job shares)	14
0.8 whole time equivalent	5
0.6 whole time equivalent	1
0.4 whole time equivalent	1
Additional lead responsibilities combined with retention	
Recruitment	16
Wellbeing / Pastoral	3
Preceptorship	3
Internationally educated midwives	1
Practice development	1
Lead Professional Midwifery Advocate	1
Education	1
No additional responsibilities	2
Time since qualification as a midwife	
0-5 years	1
6-10 years	9
11-15 years	7
16-20 years	2
21+ years	2
First specialist role at band 7 or above	
Yes	11
No	10
Access to NHS England training, seminars or support	
Yes	11
No	10

maternity units within the trust. Some trusts restricted the retention midwife's activities to a specific workforce segment - for example, newly qualified midwives or internationally educated midwives. Other trusts gave them responsibility for all midwives, or for midwives and maternity support workers below band 7.

Purpose, scope and activities. At the start of the programme, there was guidance available from NHS England at a national and regional level about the purpose and suggested activities of the new role. Retention midwives who came into post early in the programme had mostly found this very helpful.

"[The regional lead] defined the role and what I should be doing and what I wasn't involved in, and why that funding had come about and what the purpose of it was for. So that gave me a good insight into what I should and shouldn't be doing." RMW5

Even with this support available, most retention midwives said that they were not entirely clear about the scope of the role. A few retention midwives said they had flourished in the creativity that this offered. Many, however, had found it challenging to identify and maintain appropriate boundaries.

"I've been given a lot of freedom, and I have made the role what I want it to be." RMW3

"It would be better if there was a clear overall structure of what's expected of the role nationally. Because people don't really know ... So it leaves people feeling uneasy about what's actually expected of them ... We're winging it and figuring it out for ourselves." RMW15

Retention midwives were particularly likely to have experienced role confusion if they came into post when NHS England support was no longer available. They described arbitrary recruitment and a lack of clear job description, objectives or recommended activities.

"And I didn't get a job description. I didn't get a criteria. It was just, 'We'll pop that on. You can be our recruitment and retention.'" RMW12

"There wasn't a goal ... I was just plonked in ... I went in with nothing. 'Right, okay you've got to retain your midwives, what are you going to do?' 'Err...'" RMW16

Retention midwives reported that there could be inconsistency and ineffective use of resources when decision-making about the scope of the role was delegated to local managers, who were not necessarily well informed about the programme.

"It was very much down to the trusts individually, how they utilised that [money]. And I was very aware that the rest of the [local area], they implemented those roles very, very differently, and it didn't work. It didn't have the same impact." RMW13

There were also operational difficulties for many of the retention midwives when their managers and colleagues were confused about the new role, as this had not been clearly communicated to them.

"What I learned very quickly doing the role is that you need to have buy-in from the people above you, and if they don't actually understand what the role entails it's very difficult. And I did face those difficulties." RMW19

This confusion could result in colleagues feeling defensive if they were concerned that the new role encroached on their own jobs. On the other hand, some colleagues had attempted to offload aspects of their work onto the retention midwife.

"It has been really difficult ... there was a challenge and a bit of a pushback from some of the matrons, from the practice development team ... they thought that some aspects of my role were their role." RMW1

"We aren't here to take on things that people are already doing but actually to offer things that haven't been able to be offered previously... I think sometimes people put the wrong things on to us." RMW8

By contrast, there were also examples of good practice. In some services, local managers had a clear and coherent vision for the new role, and there was a shared understanding about what the role was for and what was expected of the post holder.

"What was really helpful when I first started, is that the heads of midwifery on both sites came to me with a plan that they had already made. They had certain aims that they wanted to achieve... and they had already thought what kind of things they wanted to implement. So it was a lot easier to meet those objectives because they were clear." RMW11

Combination with other responsibilities. Most of the retention midwives had retention roles that were combined with one or two other lead responsibilities, typically recruitment, preceptorship, wellbeing, professional midwifery advocacy, and/or student practice placement facilitator. Two of the band 8s had responsibility for recruitment and retention across both maternity and neonatal care. Some felt that these combinations were logical and beneficial, but many reported that it was impossible to do justice to their varied responsibilities within the limited hours available.

"We were trying to wear a lot of hats. And therefore you can do a bit with that and a bit with that and you can't do all of it." RMW19

Although the funding was earmarked for retention, the lack of clarity about the role had meant that retention activities were frequently deprioritised in favour of recruitment, which was seen as the more urgent need.

"Recruitment and retention, yes. Which is very tough, because actually there is not enough time for retention at all. Recruitment takes up all of my time." RMW20

Another problematic issue was the widespread practice of relying on specialist midwives as a pool who could be 'pulled' to work clinically at

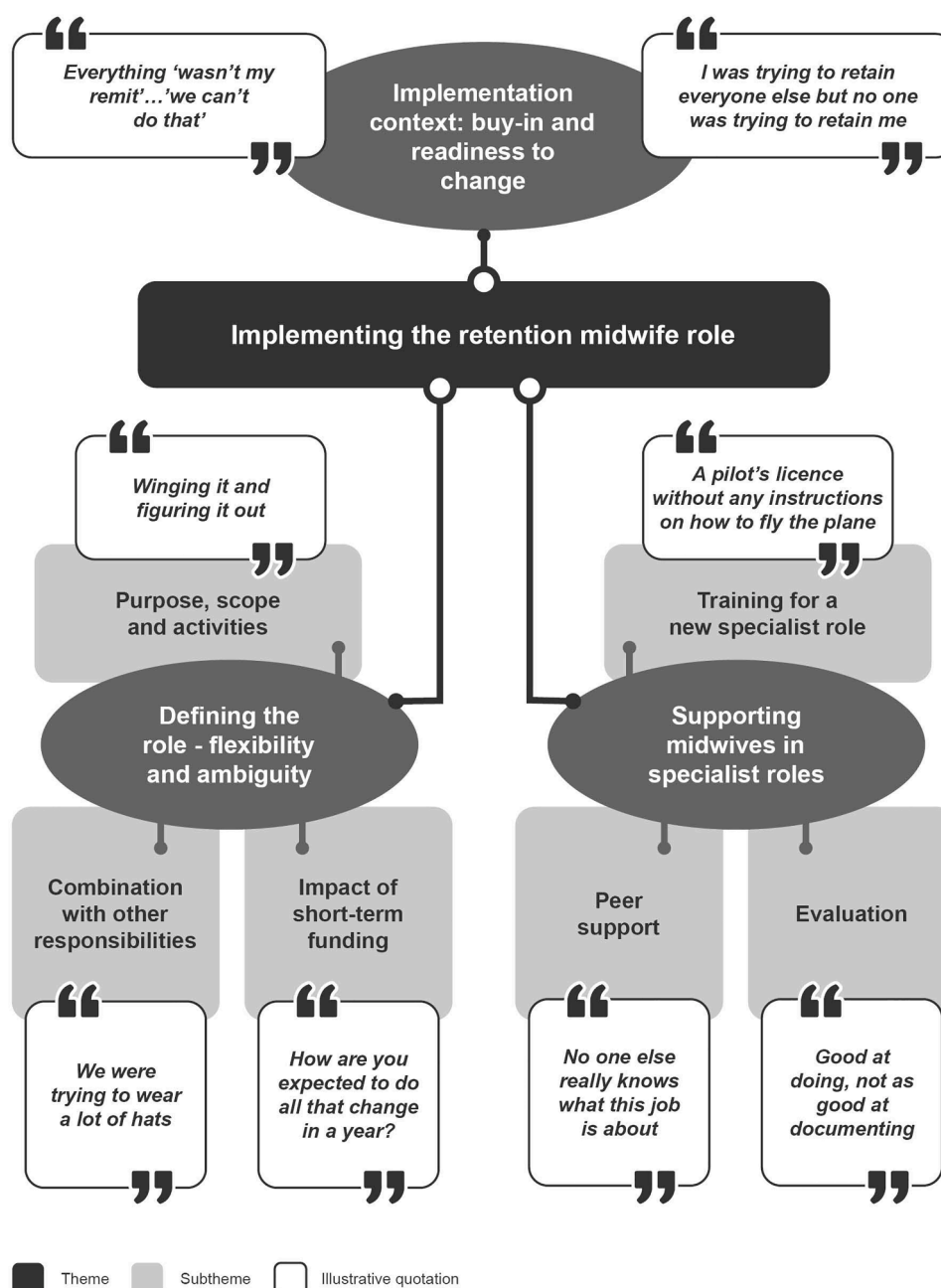


Figure 1. Themes and subthemes for implementing the retention midwife role.

short notice, to cover staff shortages. Some retention midwives reported that this was a frequent occurrence, to the detriment of their retention work.

"At least half my role I'm pulled to work clinically... I've had to cancel [planned retention activities]. ... It does make me feel like the role is so undervalued. And like, why am I doing this role? Because clearly I'm just here as a spare part. And that's really disheartening." RMW15

One retention midwife, whose role was set up so that she could not be 'pulled', identified her ability to focus as the most important factor in her retention success.

"I think if you're going to give somebody the role, you give them the protected time to do the role and that is my number one thing. I've done all that I've done [successfully] because I've had protected time." RMW6

Impact of short-term funding. The original NHS England funding for the retention midwives was for one year. The funding was in fact renewed several times, although not all the posts were continued. Most of the retention midwives said that their posts were therefore created as short fixed-term contracts, offered for periods of 3-12 months.

Some retention midwives observed that it was very difficult to achieve meaningful change in a maternity service in a year or less. Several had decided to leave their jobs because of the chronic uncertainty of rolling short term contracts, and the demotivation of knowing that their work might soon be discontinued.

"I've been on a fixed term contract since I started, so it's an extra six months, an extra 12 months... If it had gone permanent, I would have been very happy to stay and develop the role and make it work. But because they've not invested in it... I needed to look for something else." RMW1

"I don't think it helps when you're in a job where you're like, 'I'm doing all this hard work but it might not continue in six months' time'... That is a huge thing because change takes time, and how are you expected to do all that change in a year?" RMW7

Where there was a short fixed-term contract, this could also deter colleagues from taking the role seriously and adapting to what it could offer.

"People's ability to engage in something that's there for 12 months and then isn't going to be, it's like, 'Oh well fine, you've done it now but is it going to happen again?'" RMW18

Implementation context: buy-in and readiness to change

All maternity services had recently been through a period of high stress and high staff turnover during the covid-19 pandemic, but recovery from these stresses had been uneven. The implementation of the retention midwife roles was profoundly affected by the local contexts into which they were introduced, particularly the capacity and willingness of maternity management to accommodate innovation. The new specialist roles were reported to be most successful in maternity services where the leadership was supportive of the programme, open to change, and prepared to take risks on new ideas.

"A lot of what I was able to do was because [the manager] was so open, and she wasn't risk averse, in terms of she wasn't putting up barriers. She was just saying, 'I trust you ... sounds great, let's just give that a try.'" RMW14

At the opposite extreme, some retention midwives had come into their new roles in maternity services that were still in a deep crisis of finances, staffing and morale.

"When I came into post we had [a very large number of] full-time equivalent vacancies. Because of that we needed to put people that weren't very experienced into quite senior roles ... So that did destabilise the work force ... That had some effect on civility and culture as well because people were burnt out. Then to compound to that, we had our CQC [Care Quality Commission] inspection which came back 'inadequate'." RMW1

This context of crisis in some services meant that local leadership did not have capacity to engage with the rollout of the retention midwife programme. Staff in these services could be resentful at the creation of a specialist role that took a clinical midwife away from the wards.

"Nobody else was invested in that information [about the retention role] ... [so] that wasn't really being taken very seriously." RMW19

"And winding up people on the shop floor because they're like, 'We are crying out for people, you're taking another midwife off the shop floor!'" RMW9

Two retention midwives said they had come into their posts during a serious vacuum in leadership. Several described being passed between multiple line managers, which meant the role lacked traction.

"I didn't have a line manager for a dedicated amount of time, which is the ironic thing, that I was trying to retain everyone else but no one was trying to retain me... I found out on my first day that my boss was leaving, their boss was leaving, and their boss was leaving." RMW7

For some, this lack of support from managers meant that they felt unsupported as they tried to establish the scope and possibilities of the role, and undervalued as they tried to carry out their responsibilities. A lack of leadership interest in the programme meant that in some services, the retention midwives' activities were blocked and ultimately phased out even though the funding was available.

"Everything 'wasn't my remit', you know... They like the idea of [the role], but when it actually comes to it, [when I suggested] things that we

can do to make it better for the midwives: 'We can't do that. No, we can't do that'. So I sort of lost the momentum." RMW12

Supporting midwives in specialist roles

Training for a new specialist role. The retention midwives had widely differing experiences of training and support to prepare them for the new role. A few said that seminars and individual advice from NHS England nationally or regionally had provided a strong foundation.

"I had a couple of meetings with the regional recruitment and retention midwife who's brilliant, and I had some one-to-one training from her... [she] has been really supportive." RMW18

More commonly, retention midwives reported encountering "a massive learning curve coming into this role" (RMW13), without any preparatory training. They pointed out that this had made them take longer to become effective in the role, because they were learning by trial and error.

"It's funny, I have better development at a voluntary role with my pre-school... I got nothing here. I've had no input, no training ... you're just on your own. If that changed, I would enjoy it a lot more." RMW3

For nearly half of the retention midwives, this was their first specialist role at band 7. They felt exposed because of the lack of relevant skills training available to support the transition into a leadership and project management role.

"We are just clinical midwives put in really high-powered positions, and all of a sudden expected to know how to do X, Y and Z. There were leadership courses to go on but ... there wasn't the practical 'This is how you lead a project, this is how you write a report, this is how to measure the outcomes and analyse a survey'... [I feel like] I've been given a pilot's licence without any instructions on how to fly the plane." RMW9

Many of the retention midwives were also given line management responsibilities. Those who were in their first band 7 role were dismayed by the absence of training or mentoring to fulfil these responsibilities effectively.

"When you come from a band 6 clinical role and you go any band 7 role, you actually have no training in NHS at all for management. You literally have nothing, and you go from a clinical role to then managing people." RMW17

This created stress and distraction for the new retention midwives, as well as the risk of perpetuating poor experiences of line management for those they were managing.

"I think they need to get you onto core managerial training within the first four weeks - that would have made a huge difference in reducing stress levels... And having some sort of mentor ... So that you can put your less stressed mind on the actual role." RMW16

Peer support. Many of the retention midwives said they felt isolated, because they were the only person in the new specialist role in their maternity unit or sometimes in the whole NHS trust. Some NHS England regions organised regular meetings that brought the retention midwives from different trusts together and gave them the opportunity for peer support. Retention midwives who had experienced these networking opportunities had generally found them very helpful for sharing practical ideas, experiential learning and moral support. Others said that lack of peer support made their work less efficient, as they did not have the opportunity to learn from what others had tried.

"I used to find those sessions really useful for bouncing ideas between you and hearing about things that are going on in other Trusts... Because no

one else really knows what this job is about, knows what's working, what's not working, ideas that we could bring in." RMW8

A few midwives said that peer support was a key facilitator of success for a specialist role. They believed it could be used strategically to support retention midwives who were new in post, and to create a reservoir of knowledge to compensate for lack of organisational memory.

"Because you've got this vast amount of knowledge now, if they do continue the role and they expand the role to get them back in some places [where they've been disbanded]... I would say, use the experience of the people who have done it to help people... We've just got so much information that we can give!" RMW6

Evaluation. There was no consistency in how the retention midwives were expected to evaluate the impact of their new specialist roles. Some described robust reporting structures where they recorded their retention activities and monthly statistics about the workforce. These reports created lines of accountability and oversight to their NHS England regional team as well as within their NHS trust.

"We do monthly reports that go to our senior management team but also go regionally, that have things like how many [retention activities] have

it? And please feed back... Was that money you put into it worth it or not?" RMW19

Discussion

This study found a complex picture of the implementation of the new specialist role of retention midwife, with examples of both effective and ineffective implementation. Effective implementation was characterised by sufficient role clarity, supported by resources (including training seminars) made available through NHS England national and regional structures, and balanced with the flexibility to adapt the role as needed to the local context without losing the intended focus on retention. It was further characterised by a local context where leaders were open to innovation, willing to take risks and not overwhelmed by extreme funding and staff shortages; by clear reporting structures and accountability; and by access to peer support through organised networks for emotional support and sharing practice. Effective implementation was undermined by short-term funding leading to short fixed-term contracts; role overload when too many different responsibilities were allocated to one post; unclear communication about the role from funders to maternity leaders and from leaders to staff; and a lack of management training for clinical midwives in their first management role. The key lessons for introducing new specialist roles are summarised in [Box 1](#).

Box 1

Key lessons for introducing new specialist midwifery roles

- ✓ Define the role clearly, balancing the need for local adaptation with clarity about fixed core components.
- ✓ If the role is fixed term, offer the contract for a sufficient length of time to enable meaningful change and reasonable job security.
- ✓ Communicate the purpose and responsibilities of the new role to management and staff.
- ✓ Encourage the use of national change management resources to support the local process of change.
- ✓ Offer new post holders sufficient training and support to understand and fulfil the responsibilities and expectations of the role.
- ✓ Offer management training and mentoring to post holders who are taking up their first specialist role.
- ✓ Ensure that the creation of the specialist role does not adversely affect clinical staffing.
- ✓ Enable peer support between post holders in different trusts.
- ✓ Evaluate the implementation and impact of the new role.

we offered. It also has a box where we put our achievements for the month. We put what our struggles are, what we need to escalate and what our plans are for the next month." RMW8

Some retention midwives said they focused on gathering mainly qualitative feedback from their colleagues about the effect of their retention activities. Others were surprised to be asked about evaluation of their role as they said this was not something they had ever been asked to do, or that this task had been added later.

"I'm good at doing, I'm not as good at documenting what I'm doing. Which is something that I am learning to do ...because actually we need to demonstrate to the Trust what I'm doing with my role and I haven't recorded that." RMW4

Two retention midwives expressed frustration that there was little interest within their maternity service in evaluating their role. This could be linked to management indifference to the role itself, and these retention midwives believed it represented a missed opportunity to learn from the innovation.

"I felt it was a tick box exercise...and then nobody really asked for anything at the end of it. And I would have loved them to have done that... if you're going to put something in place, what do you want at the end of

There is a limited literature addressing the implementation of new NHS roles, for example specialist mental health midwives ([Royal College of Midwives, 2024b](#)), and nursing, physician and anaesthesia associates ([Department of Health and Social Care, 2025](#); [Lucas et al., 2021](#)). These studies have all highlighted the problems that arise when groundwork has not been done to prepare staff and managers affected by a new role. The factors undermining effective implementation in the present study have been consistently reported in these earlier studies, namely: a lack of shared vision; weak leadership and communication; role clarity sacrificed to role flexibility; and insufficient training, supervision, and ongoing monitoring. Two novel findings of this study concerned the risks to the integrity of a flexible new role, either when significant extra responsibilities are added to the core purpose, or when the post holder is frequently diverted from their work to fill clinical shortages.

People management is a learned skill, and this study illustrated the challenges for clinical midwives who are promoted to a new specialist role involving line management. The newly-promoted retention midwives reported that the lack of training and mentoring for this task made them less effective both as managers and as specialist midwives. This reflects a longstanding theme in UK maternity reports and reviews, that robust training is essential to overcome the ineffectiveness of midwifery management and leadership, which impact negatively on colleagues and

on the care of service users (Bannon et al., 2017). Resentment of the promotion of band 6 clinical midwives to new band 7 specialist roles has also been noted in a small qualitative study where it was perceived to have “decimated the shop floor” (Foley et al., 2025). The present study highlights the importance of communicating to staff about the purpose and benefits of a new role, and of ensuring that the creation of a new role does not exacerbate understaffing in non-specialist areas.

Research on the introduction of primary mental health care workers (England & Lester, 2007) identified how professional isolation could undermine both the effectiveness of a new role and the wellbeing of a post holder. This study adds the insight that the creation of intentional peer support networks is a powerful way to address this isolation and to promote mutual learning that enables the rapid spread of effective practice as the role is pioneered.

The three inductively-developed themes of this study can be broadly mapped onto constructs of the Consolidated Framework for Implementation Research (Damschroder et al., 2009). Theme 1 (Defining the role: flexibility and adaptability) correlates to the constructs of *Intervention Characteristics – Adaptability* and *Process – Planning and Engaging*. Theme 2 (Implementation context: buy-in and readiness to change) correlates to the constructs of *Inner setting – Implementation Climate and Readiness for Implementation*. Theme 3 correlates to the constructs of *Process – Executing and Reflecting & Evaluating*. The successful implementation of the retention midwife role in some trusts, contrasted with the less successful implementation in other trusts, adds to the evidence that the NHS will benefit from more systematic adherence to its own theoretically-informed change management tools when introducing new roles into systems under pressure (Department of Health and Social Care, 2025; Lucas et al., 2021; Royal College of Midwives, 2024b).

Strengths and limitations

It was a strength of this research that the participants came from maternity services across England, reflecting a range of positive and negative implementation experiences. It was a limitation that it was not possible to triangulate participants’ perspectives with those of their managers and colleagues, due to the national scope of this study, the recruitment process, and the importance of confidentiality.

Conclusion

Role flexibility is valuable for adapting to local context within a national programme, but the non-negotiable components of a new specialist midwifery role should be clearly defined and communicated to ensure that it is implemented effectively in all trusts, and not reliant on enthusiastic individual leaders who are willing to take risks on innovation. In local contexts where the leadership and staff are under extreme stress, there may be a lack of capacity to engage with change which leads to resistance to the new role. Funding structures should ensure that the creation of a new role does not exacerbate understaffing in non-specialist areas. Post holders in their first specialist role need training in line management and project management, and post holders in isolated specialist roles benefit from national or regional structures for mutual learning and peer support. Future national implementation of specialist midwifery roles in the NHS could include more structured use of change management principles and be accompanied by formal process evaluation.

Ethics declaration

Written informed consent to take part in the study and to publish the article has been obtained from all participants or their legal representatives. The privacy rights of participants have been observed.

This study was performed in compliance with relevant laws, regulatory frameworks and guidelines where the research took place. This study was approved by the Oxford University Medical Sciences

Interdivisional Research Ethics Committee (Approval No. 865410).

Availability of data and materials

The datasets generated during the current study are not publicly available due to the consent process but are available from the corresponding author on reasonable request.

Engagement of public in research

There was no involvement of maternity service users in this research, due to the topic being the experiences of retention midwives about the implementation of a role focused on supporting other midwives.

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CRediT authorship contribution statement

Jenny McLeish: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Conceptualization. **Jenny McNeill:** Methodology, Formal analysis. **Julia Sanders:** Writing – review & editing, Methodology. **Fiona Alderdice:** Writing – review & editing, Methodology, Formal analysis, Conceptualization.

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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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2026.104986.

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