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Midwifery

journal homepage: www.elsevier.com/midw

A wall of information? Exploring the public health component of maternity care in England

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ARTICLE INFO

Article history:

Received 10 August 2015

Received in revised form

28 October 2015

Accepted 30 October 2015

Keywords:

Public health

Health education

Midwifery

Online focus groups

ABSTRACT

Background: midwives have traditionally had an important role in providing public health messages to women. The range and diversity of the public health remit within maternity services has expanded rapidly over the past decade and maternity support workers as well as midwives are now engaged in public health work in many areas. Given these changes a review of current practice was indicated.

Objective: to identify student midwives', midwives' and midwifery support workers' current knowledge of and involvement in the public health agenda in England.

Design: descriptive qualitative study using online discussion forums.

Setting: England, United Kingdom

Participants: undergraduate student midwives, midwives and maternity support workers employed by the National Health Service in England and University employed Leads for Midwifery Education.

Findings: key themes identified were: the scope of the midwives' public health role, training and support for public health role, barriers and facilitators, specific client groups, specialist referral services. Student midwives, midwives and maternity support workers view engagement with, and delivery of, public health initiatives as an integral component of their roles, but are on occasions frustrated by constraints of time, training and public engagement.

Key conclusions: the National Health Service in England aims to engage pregnant women and new mothers in a diverse range of population based and individualised, public health initiatives. Currently, there are high levels of involvement in the public health agenda from the maternity workforce across a wide range of activities. However, midwives and maternity support workers are restricted by barriers of time, training and resources. These barriers will need addressing for optimal maternity care engagement in public health to be realised.

Implications for practice: policy makers, commissioners and National Health Service providers need to provide clear guidance on the expectations of the public health remit of midwives and maternity support workers and ensure that such expectations are appropriately resourced to provide effective delivery.

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Introduction

The United Kingdom (UK) Faculty of Public Health defines Public Health as 'The science and art of promoting and protecting health, wellbeing, preventing ill-health and prolonging life through the organised efforts of society' (UKFPH, 2010). Midwives have long been recognised as having an important public health function, traditionally centred upon maternal health during

pregnancy, infant feeding, and early parenting (Myles, 1975). Although this central focus has continued, over recent years the public health agenda has expanded and hence the public health role for all health-care professionals including midwives has developed. Current UK policy is to maximise the health of the population and reduce health inequalities (DH, 2014). This new emphasis is reflected in an expanded public health role of the midwife, with an increase in both the number and complexity of public health initiatives incorporated into maternity care pathways.

The importance of early interventions for the prevention of future illness and health inequality is well recognised (Field, 2010). Pregnancy and the early postnatal period are increasingly

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identified as priority areas setting the foundations of a healthy childhood and optimal child development particularly amongst more vulnerable social groups (PHE, 2013). In addition, pregnant women and families with young babies are regarded as particularly receptive to public health initiatives, being intrinsically motivated to provide the very best start in life for their children (DH, 2014).

Pregnancy and the early postnatal period often represent the longest episode of health care engagement experienced by a woman or her partner at that point in their life course. It is the nature of this engagement that places the midwife in a prime position to understand the public health needs of her local community. Midwifery 2020, which laid out the scope and nature of midwifery practice throughout the UK stated that the midwife should:

"...have a good knowledge of the care needs of the local community; be networked with the local health care and social care system, ensuring that there is a midwifery contribution at policy, strategic, political and international level".

(DH, 2010, 26 pp.)

The role of the midwife on an individual level is described within The Healthy Child Programme (DH, 2009) which documented both universal and progressively enhanced programmes of care to be provided in England during pregnancy, infancy and childhood. The Healthy Child Programme has an aim of promoting, establishing and helping to maintain behaviours which support physical and psychological health for babies and children to the age of five (DH, 2009). A recent English Department of Health (DH) document outlined the importance of the midwife's role in promoting the four central domains of public health:

Improving the wider determinants of health by reducing the negative effects on health and well-being, and health inequalities.

Health improvement by helping people make healthy choices and reduce health inequalities.

Health protection by protecting the population from major incidents and other threats, while reducing health inequalities.

Health-care public health and preventing premature mortality by reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities (DH/PHE, 2013a, 2013b).

In addition to midwives, since 2001 maternity support workers (MSWs) have been introduced across the UK. Maternity support workers are employed to assist in the care of mothers and babies under the supervision of qualified midwives. They provide many aspects of care across maternity services provision including the delivery of public health related messages. Despite the attention given to the public health role of the midwife in recent UK and English policy, there has been little previous research into midwives' views of this role.

A study over a decade ago by Bennett et al. (2001a, 2001b) explored midwives' views on their professional role within health promotion and public health revealing a range of knowledge, skills, experience and training opportunities. However, since Bennett et al.'s study, the public health remit of the midwife has further expanded and the maternity workforce reconfigured to include maternity support workers, many of whom now have an important role in public health promotion. It was these changes that prompted the current study.

More recently a mixed methods study exploring public health education for midwives was conducted by McNeill et al. (2012). This identified that understanding of the public health role of midwives by pre-registration students and qualified midwives was inadequate. They argued that midwifery education in this area

should be reviewed to address this in order to enable midwives to achieve public health goals.

It was therefore considered timely that developments on the delivery of the public health agenda within maternity services were investigated. With this aim the Royal College of Midwives (RCM) received funding from the Department of Health in England to undertake the development of a new model of public health for midwifery. This paper reports on the first of a series of planned work packages under this programme: a descriptive qualitative study exploring the views and experiences of health care professionals.

Research aims and questions

The aim of this study was to identify student midwives', midwives' and midwifery support workers' current knowledge of and involvement in the public health agenda in England. The research questions were:

1. What are student midwives', midwives' and maternity support workers' knowledge of and involvement in the public health agenda in relation to maternity care provision?
2. In the opinion of these staff how clinically relevant is the public health agenda in relation to specific user groups, such as vulnerable and 'at-risk' families?
3. What do participants believe to be the educational facilitators and barriers associated with their role in making a public health impact?
4. What are the level of skills and competencies required by relevant maternity staff in relation to specific user groups and their public health intervention requirements?
5. What do participants believe the potential role of specialist referral services to be in meeting the public health agenda?

Methods

This study used a qualitative descriptive approach which is known to be beneficial when resources are limited (Neergaard et al., 2009). It is the preferred approach when a straight description of the phenomena is required as a preliminary stage to capture maximum variation of experience and breadth of knowledge prior to subsequent theoretical development and testing (Sandelowski, 2000).

Seven closed Facebook based discussion groups were used for data collection:

Maternity Support Workers
Student Midwives
Midwives
Senior Midwives/Modern Matrons/Midwifery Managers
Heads of Midwifery
Consultant Midwives with a specialist interest in public health
Lead Midwives for Education (LME)

Each discussion group was planned with an upper limit of 15 participants, a number which had previously been demonstrated to yield adequate engagement of participants, whilst being sufficiently personal for individual interaction (Hunter and Warren, 2014).

Recruitment

Adverts were placed on the RCM Facebook page and Twitter account to attract participants to all planned online groups. In addition an email was sent from the RCM to all maternity support

workers with RCM membership, and consultant midwives and LMEs received an email invitation, and follow-up email, via the RCM hosted email lists. Potential participants contacted the research team via Facebook messaging, eligibility was confirmed and participant information and ground rules supplied prior to participants being added to the relevant closed online discussion group.

Data collection

The online discussion groups ran for a period of one month during January 2015. In order to facilitate and guide discussions, questions were posted sequentially by the researchers (Table 1). When participants responded to questions, their posts were acknowledged and where necessary further prompts were given to clarify answers and encourage further discussion. The use of online discussion groups has been found to be an effective tool for data collection in previous research involving midwives (Hunter and Warren, 2014), and is especially useful when participants are recruited from a wide geographical spread and when they have varied working patterns.

Analysis

Data were copied and pasted into a Word document, anonymised, then independently read and re-read by the research team and thematically analysed using a coding framework, which incorporated the research questions. Following initial thematic analysis, subthemes were identified and agreed by the research team.

Ethics

Ethical approval was obtained from Cardiff University, School of Healthcare Sciences Research Ethics Committee. Prospective participants were provided with an electronic participant information sheet (PIS) including details about the study, what participation would entail and measures taken to protect their identity. All respondents were informed that participation in the discussion confirmed that they had read and understood the PIS and consented to take part. Participants were requested not to disclose the identity of individuals, departments or organisations and to act respectfully online. The groups were administered and monitored

by members of the research team. Participants were provided with discussion group ground rules including maintaining anonymity of themselves, workplace and women. Access to the closed discussion groups was restricted to participants and the research team. Following closure of the discussion, all participants were removed from the group and data anonymised prior to analysis.

Findings

Participant demographics

Of 120 individuals who expressed interest, 95 were recruited and 60 actively participated in the Facebook groups (see in Table 2). The number of maternity support workers recruited was above the planned maximum of 15 as discussion within the group was initially limited and therefore additional recruitment had taken place.

Participants worked in a variety of clinical settings with a range of practice experience (Table 3). Amongst the midwives group, duration of experience ranged from less than one year to 23 years and the maternity support workers' experience, ranged from 1 to 25 years.

Thematic analysis of the data identified five overarching themes; scope of the public health role, training and support for the public health role, barriers and facilitators, specific client groups and specialist referral services. Each of these themes is discussed in turn, illustrated with brief extracts from the data.

Table 2
Participant numbers.

Participant group	Expressed interest	Recruited	Actively participated
Maternity Support Workers	44	41	20
Student Midwives	16	13	11
Midwives	31	20	15
Modern Matrons/Senior Midwives	7	6	5
Heads of Midwifery	7	5	3
Consultant Midwives	4	1	1
Lead Midwives for Education	10	9	5

Table 1
Discussion group questions.

Student Midwives Midwives Modern Matrons/senior Midwives Consultant Midwives Heads of Midwifery	What aspects of public health are you involved in within your current role?What aspects areas of Public Health do you feel are most pertinent to midwives in providing care to childbearing women?Are there aspects of public health that midwives are currently involved in that you feel could/ should be undertaken by others?How are maternity staff in your organisation supported in their public health role?What do you feel are potential barriers and facilitators to you in fulfilling your public health role?Are their particular groups/clients who present more of a challenge to you in fulfilling your public health role?What do you see as the potential role of specialist referral services in meeting the public health agenda?
Maternity Support Workers	Are you as a Maternity support worker involved in any public health role (e.g. facilitating breast feeding, newborn bloodspot screening, etc.)?Are there aspects of public health that midwives are currently involved in that you feel could/should be undertaken by others?How are Maternity support workers in your organisation supported in their public health role? (e.g. Materials, websites, training days, etc.) and Have you received any training in helping you to talk with women about public health issues? What do you feel are the potential barriers that prevent you from fulfilling your public health role? And what do you feel facilitates or helps you?Are there particular groups/ clients who present more of a challenge to you and your midwifery colleagues in fulfilling your public health role?What do you see as the potential role of specialist referral services in meeting the public health agenda?
Lead Midwives for Education	What aspects of public health do you feel are most pertinent to midwives in providing care?Are there aspects of public health that midwives are currently involved in that you feel could/ should be undertaken by others?Which aspects of public health are included within your midwifery undergraduate curriculum?What support do you provide for students to help them to talk with women about public health issues?What do you feel are the potential barriers and facilitators that midwives face in fulfilling their public health role?Are there particular groups/clients who you feel may present more of a challenge to midwives in fulfilling their public health role?What do you see as the potential role of specialist referral services in meeting the public health agenda?

Table 3
Demographic details of participants.

	Clinical area	n	%	Length of experience	n	%
Student midwives (St) n=11	Rotational	11	100	Year 1	4	36.3
				Year 2	5	45.4
				Year 3	2	18.2
Midwives (MW) n=15 (Band 5 n=2) (Band 6 n=13)	Community	5	33.3	≤ 5 years	7	46.7
	Hospital based	4	26.7	6–10 years	2	13.3
	Delivery/midwife led unit	4	26.7	11–15 years	2	13.3
	Antenatal/post-natal ward	1	6.7	≥ 15 years	4	26.7
	Case-loading	1	6.7			
Senior midwives (Sr) n=5	Delivery/midwife led unit	2	40.0	10–15 years	2	40.0
	Specialist MW*	2	40.0	≥ 15 years	3	60.0
	Community	1	20.0			
Maternity support workers (MSW) N=20	Antenatal/post-natal ward	9	45.0	≤ 5 years	14	70.0
	Community	5	25.0	6–10 years	3	15.0
	Rotational	4	20.0	11–15 years	0	0
	Delivery/MLU	1	5.0	≥ 15 years	3	15.0
	Antenatal clinic	1	5.0			

* A midwife with a specialist role e.g. Lead for vulnerable adult/Lead for obesity.

Scope of midwives' public health role

The scope of the midwives' public health role was described by participants with many topics being identified, some generating more discussion than others (Table 4). All participating groups provided extensive comments regarding the complexity and 'enormous breadth of the midwife's role in public health' (LME6). The following comment was typical:

MW12 Many areas of my role are concerned with public health. Diet and nutrition, Smoking cessation, Alcohol use, Substance misuse, Mental health, Breastfeeding, Prevention of SIDS, Screening, More screening!, Prevention and management of obesity, Detection and prevention of communicable diseases, Prevention of sepsis through hand hygiene, Contraception, Sexual health, More screening, More safe sleeping, Place of birth.

Participants stated that antenatal period priorities included delivering population based screening programmes such as the identification of women at risk of mental illness and domestic abuse. Newer initiatives such as vaccination of pregnant women against flu and whooping cough were also regarded as service priorities:

St2 I've noticed that the flu vaccine and whooping cough vaccines are regularly discussed and encouraged.

For individualised initiatives, breast-feeding support and smoking cessation were mentioned. Discussions focused mainly on antenatal and postnatal periods. Intrapartum public health strategies such as optimal timing of cord clamping and skin-to-skin contact following birth received little comment from the qualified staff, although there was discussion on these topics among the student midwives:

St4 Breastfeeding and skin to skin are also discussed at about 32 weeks and there is a checklist with all the information the midwives should discuss with the women. The midwives I have worked with have been very pro-breastfeeding a keen to share information. ... At 36 weeks reducing SIDS (Sudden Infant

Table 4
Areas of Public Health identified.

Discussed often	Discussed less often
Breast feeding/infant feeding	Alcohol
Smoking cessation	Food safety/hygiene
Screening	Domestic abuse
Mental health/psychological well-being	Female Genital Mutilation
Obesity prevention	Diabetes
Contraception	Bereavement
SIDS prevention/safe sleeping	Immigration support
Immunisation	Language support
Infection/sepsis prevention	Social inclusion/exclusion
Sexual health	Drug/substance abuse
General healthy lifestyle	Homelessness
Skin to skin contact	Forced marriages
Optimal timing of cord clamping	Cervical cytology
	Breast screening
	Involvement of partners/dads
	Communicable diseases
	PN physiotherapy
	Pre-conceptual health

Death Syndrome) is discussed... Intrapartum during early labour vitamin K, active third stage and skin to skin is discussed. As the women bring baby onto chest we ask their method of feeding and offer support with the first feed and encourage them to almost just 'give it a go'. Delayed cord clamping is the practice unless the women ask otherwise.

Whilst the midwife was considered ideally placed for public health advice and support because of her relationship with women, participants identified the general practitioner (GP) and other professionals including health visitors, social workers, school nurses, family planning/sexual health nurses as equally suitable providers for some aspects of care. Possible devolved aspects of care included flu and whooping cough vaccination, smoking cessation, health education, contraception advice and provision, vitamin distribution and pre-conceptual advice. Where other providers could feasibly be involved, a number of facilitators and barriers were identified to this working effectively. The importance of convenient location, adequate funding and resources, access to relevant health care professionals and potential professional rivalry were all noted as needing consideration when planning services. It was also thought that there could be more pre-conceptual and antenatal involvement by GPs in relation to weight management, smoking cessation, DV and exercise:

MW12 I think GP services could do a lot more-pre conceptual info packs for example could cover most of the general public health info

MW6 it makes so much sense to delegate PH initiatives like flu and whooping cough vaccination, smoking cessation

MW7 Why aren't the GPs more involved in weight management, smoking cessation/CO monitoring, DV, exercise, etc. during pregnancy?

Maternity support workers reported that they were already supporting midwives in delivering many aspects of the public health agenda. Activities included the practical provision of health education including breast-feeding support, parentcraft classes, and weighing infants. They also recognised their educational and advisory role regarding: Infant feeding (breast and bottle feeding), general baby care, maternal diet/physical activity, smoking cessation, alcohol consumption, Sudden Infant Death Syndrome (SIDS) and maternal mental health. Most maternity support workers thought that they had potential for greater involvement in the provision of public health messages:

MSW2 I work on postnatal ward so my main area of public health promotion would be breast feeding support and encouraging women to engage in smoking cessation support services. MSW's also talk to women about the importance of maintaining good mental health and knowing how to recognise when the normal emotional feelings post delivery become concerning and how to access help. We discuss safe sleep and reducing the risk of cot death during routine discharge chats.

MSW1 I absolutely think msw's could be much more involved in other aspects of public health education to women and their families with the correct knowledge and training we could give advice on vaccinations- flu and whooping cough vaccines, and as MSW3 points out if we could be more involved in these aspects of care it would free up time for the midwives to undertake the more specialised aspects of care that we are not able to support them with.

Training and support for public health role

There was considerable variation in the amount and quality of public health related workplace training received by midwives and maternity support workers. Some described their training experiences positively, for example lecture-based updates within work time as part of mandatory training and the regular circulation of leaflets and guidelines:

MW7 We have various training and update days throughout the year. Plus continuously updated guidelines that are emailed to everyone.

It was notable that there were pockets of good practice especially in relation to breast-feeding training, especially where there was Baby Friendly Initiative accreditation, or units were working towards this.

Although mandatory training was valued by those who received it, concerns were voiced that any other public health training needed to be undertaken in personal time. Many midwives and maternity support workers thought the public health training provided by their employer was inadequate, reducing enthusiasm for further involvement in public health activities. Participants from some units described limited or no time allocated to public health issues even within mandatory training, and a lack of relevant leaflets available:

MSW19 I attend yearly breastfeeding updates but I feel in my unit we are not given the opportunity to enhance our knowledge on public health. A lot of my knowledge has come from personal study.

MW10 Most of our training days of late have had to be in our own time and only our mandatory ones seem to be allowed in work time.

Midwives and maternity support workers received little or no training to enhance their communication skills for discussing public health issues with women; with training focused on the content of public health messages rather than how best to engage with women. In contrast, communication skills sessions included in undergraduate curricula were considered valuable by Leads for Midwifery Education and students. Students' responses regarding amount of public health course content mainly concurred with LMEs and were overwhelmingly positive. They particularly valued input from specialist midwives, interactive sessions and opportunities for debate, as well as opportunities to practice communication skills. Students and LMEs also commented on the students' everyday exposure to public health issues when on clinical placements:

LME6 For a number of years we have had the students out in community midwifery for their first placement, partly to expose them to more frequent health promotion interactions and inter professional public health work.

Barriers and facilitators

A large number of barriers were identified by participants, which were considered to collectively limit the effectiveness of the public health activities that could be provided. All groups identified lack of time as a barrier to providing good care:

MW3 We don't have time to help with initiating breastfeeding after birth when we are under pressure to get them to postnatal ward within a strict 2 hour time frame post birth. Then the postnatal ward is too busy for the midwives there to be able to give the time they would like to either.

MW6 The 15 minutes allocated for an ante-natal appointment is so restricting that unless one is super human it is nigh on impossible to get women to discuss important issues.

Participants described using closed questions to manage consultations and also providing leaflets to supplement or even replace discussions. This led to women being 'bombarded' (**MW2**) with information, especially at booking and discharge. This was seen as inappropriate and ineffective:

MW12 I agree entirely with the bombarding of information.... I feel overwhelmed with the info I have to give at booking, discharge or first visit at home after birth, so how much of it actually gets heard by the parents?

MW8. I do agree that we hit our ladies and partners with a wall of information.

Continuity of care by community midwives was highlighted as facilitating the consistent and gradual delivery of public health messages over time:

MW5 I agree that we fire a huge amount of info at people & often wonder how much gets through. If continuity was still a reality, there would be time for a more 'drip drip' approach.

The development of a good relationship with women was seen as a facilitator not only by midwives but also by maternity support workers:

MSW14 I feel sometimes when we have built a very good rapport with a family and have a good level of trust with them that we should stay on the ward they are on until they leave the hospital. I have had a couple of women (one a language barrier and one with learning difficulties) who were very comfortable with me.

Some participants expressed concern that a 'one size fits all' approach to public health was taken, rather than a more woman-centred tailored approach. Public health messages appeared to be driven by current policies and protocols rather than the individual needs of women:

MW8 We also use a computer program where you have to achieve all your 'ticks' to be compliant. Every time a new public health initiative appears so does another box yet it still has to be done in 15 minutes along with the antenatal check, how can you possibly do this? It should be possible to make it more tailored to the individual rather than ensuring tick box compliance.

Women's lack of previous public health education was recognised as problematic for communicating messages. Participants described frustration that imparting public health information was

confined to the brief period of women's interaction with maternity services, when many topics could have been first addressed prior to pregnancy:

MW2 I feel we often seize the opportunity of pregnancy as the first real engagement with health services to try and educate people in every area we can, like squeezing 20 or 30 years' worth of public health info into 9 months!

Specific client groups

Study participants were asked to consider if particular social groups presented additional challenge in the fulfilment of their public health role. It was appreciated by participants that the very factors that placed women most at risk of increased maternal and perinatal morbidity, frequently also limited opportunities for staff to engage women in public health messages

The most common factor identified as affecting women's receptiveness to public health messages was limited ability to communicate in English. One community-based maternity support worker (MSW12) observed that a recent assessment indicated over 25 different languages were used by women within community area. Whilst the challenges of caring for women with limited English were appreciated, system weaknesses were viewed as further contributory factors. In particular limited provision of public health literature and materials in languages other than English was noted:

MSW1 Groups who have limited understanding of the English language can prove very challenging in terms of public health education and materials are not always available in certain languages to provide for these families.

Midwives and maternity support workers commented that some women were naturally less receptive to engaging in public health discussions, on occasions due to their own scepticism regarding the value of public health advice, and in particular when advice had changed over time:

MW9 I think also some groups ignore public health advice because they don't believe it is important or even actually true, e.g. smoking & safe sleep. The lower socio economic groups often say things like – 'I smoked with the others & they're alright' or 'it'll change again soon – we were told to put babies on their fronts years ago.'

Relatives, particularly grandparents, were viewed as having a particular influence on younger, less educated women's receptiveness to public health advice. In such circumstances the midwife was required to engage, and educate, the wider family unit in public health issues:

MW8 I work in a deprived area where education is left as soon as possible but there are very large, close families. These are great for support however when delivering public health messages the challenge is to get past 'granny knows best' and most times involves more education of the usually maternal members of the family than the actual lady I'm looking after. It means a lot of work to build relationships with the whole family and can be very challenging.

Teenage and younger mothers were identified as a group who may require additional time and support to develop trusting relationships with health care professionals. Unfortunately, when such relationships had not developed, younger mothers, although being recognised as anxious to develop and gain confidence in their parenting skills, were identified as a group less receptive to information provided in standardised formats:

MSW18 Some teenagers can be a challenge because they expect too much, they don't always listen to advice from staff or their families. I can understand they are nervous etc. and want to get it right. I think we need to spend more time with them to give them help and reassurance but on a very busy ward it's not always possible.

Specialist referral services

Participants considered the role of additional services to which women could be referred for public health information and support, acknowledging that it was available both from within the maternity service and from other services.

Participants were generally positive about the role of the specialist referral services, considering it would not be feasible for midwives to provide all the information and care expected:

MSW16 Specialist referral services are vital in meeting the public health agenda as they have the time and resources allocated to them to give the public the information they are looking for.... Without the specialist referral services the hospital staff would be totally overwhelmed.

Specialist midwives were viewed as a vital resource, for support and education of maternity staff. However it was also thought that a fine balance was needed, as specialism may lead to erosion of key midwifery skills:

SR1 There are pros and cons with specialists it's great to have people to turn to when they are needed for advice and to lead care. They also lead on teaching staff ... The cons can be deskill of other staff as there is a temptation to hand over care of all these women to the relevant specialties.

Although some participants considered that non-NHS agencies should be utilised to complement midwifery care, others questioned whether this represented privatisation of the NHS:

MW11 I can see where the likes of the NCT [National Childbirth Trust] can compliment services but shouldn't be a substitute or a buy in option. Other areas of the NHS have had this type of model introduced. For instance sexual health services in some regions are being provided by private companies with ultimate loss of clinicians jobs.

Specialist referral was identified as having some limitations. For example, the potential for women to experience a sense of stigmatisation by feeling singled out, or for possible multiple referrals with the risk of fragmented care:

St5 I have mixed feelings when it comes to specialist services. Sometimes they appear to be effective in tailoring care to the individual. At other times it seems more of a hindrance (reductionist comes to mind) Sometimes the women end up seeing different specialist for different aspects of their needs and they feel tied down by maternity services.

Communicating with specialist services was identified as potentially problematic. One maternity support worker described how having many different specialist referral services led her to feel unsure about how and who she could refer women to:

MSW2 I find in my role on post natal ward that knowing how and who to refer women to for support can be a nightmare. We do have lead midwives but they are not always available. It might be helpful to have a one stop shop to refer women to so I would fill in one form detailing help needed and then the specialist support services could source the best help available.

One student midwife questioned whether specialist roles can be justified given the amount of investment required to see an effect:

St5 One mentor I had was the smoking cessation specialist and as hard as she tried many women were too dedicated to their smoking habits to succeed. Observing her clinics and the lack of adherence and compliance made me wonder if resources and her time would have been better spent somewhere else.

Discussion

The complexity of the maternity public health agenda was widely recognised, with concerns raised about the achievability of addressing this agenda effectively and the sustainability of this role. Midwives were identified as being commonly engaged in a wide range of public health topics.

However, some topics were less frequently mentioned by the midwives than expected. It was not clear whether this was because they received less midwifery attention, or because they were embedded in practice and had become taken for granted. For example, there was little discussion about antenatal screening or immunisation (except by student midwives for whom all aspects of public health work were relatively novel) and no mention of sexually transmitted diseases. Interestingly, given current public health concerns, obesity also received little attention during discussions amongst the qualified midwives.

The ever increasing and shifting public health agenda was commented on by many participants. The impression from the discussion was that as new public health issues and initiatives are identified, these take priority. Prioritisation was particularly noted where a strong political/ professional focus exists for example, as a result of confidential enquiries into maternal deaths, and where there may be linked targets and audits of practice for example, flu vaccine uptake and breast-feeding promotion to achieve and maintain Baby Friendly Initiative accreditation.

Some midwife participants identified the potential contribution of GPs and other health care professionals. A report by The Kings Fund which defined a future role for GPs within maternity care similarly identified GPs potential to be involved in many aspects of public health pertinent to the pregnant population from the early antenatal period through to the six week postnatal check and future family planning (Smith et al., 2010). However generally the midwives in this study wished to retain responsibility for public health within their role.

It was clear from the data obtained from maternity support workers that their role included many aspects of public health, with particular involvement in breast-feeding support and baby care. Maternity support workers were enthusiastic about their role and keen to have greater involvement. It has been noted that there is a wide degree of variation regarding the role of maternity support workers across the UK (Sandall et al., 2006; Stout, 2007). In a bid to address some of these inconsistencies, the Royal College of Midwives recently produced a publication outlining the role and responsibilities of maternity support workers (RCM, 2015). This document identifies a range of tasks which could be included as part of the role of MSW and recognises that with appropriate training, knowledge and skills maternity support workers can contribute to the public health agenda. Thus far, there has been minimal research conducted which considers the views of maternity support workers and service users in this area. Therefore it would be worth investigating further to explore whether it would be feasible and acceptable for maternity support workers to contribute more fully to public health in maternity care.

Training in delivering the public health agenda was thought to be very important, but the amount and quality of post-qualification training for midwives was highly variable and was often considered inadequate. In contrast the students' preparation for their public health role was commented on very positively. Previous research had identified midwifery pre-registration education in this area to be lacking (McNeill et al., 2012), and it is therefore encouraging that midwifery programmes appear to be addressing this. However, there was a notable lack of public health training for maternity support workers, many of whom described attending generic health support worker training that failed to address their needs.

Lack of time and resources were key barriers commented on extensively in most groups. It was felt that public health advice and support needed to be given adequate time and resources, as well as being well-timed and individualised to women's needs. When these factors existed, the midwives' public health role was facilitated. When they were absent or lacking, as was frequently the case, effective public health working was compromised because of numerous other competing demands on midwives' time. This finding is unsurprising as limited time and resources has been frequently identified as being problematic in providing high quality midwifery care by many researchers (for example Buck, 2007; Smith and Dixon, 2008; McNeill et al., 2012; Hunter and Warren, 2014).

Midwives commented that relationships with women were all important for facilitating public health work. Rather than 'hitting the women' with 'a wall of information' that did not attend to individual needs and concerns, midwives valued the opportunities provided when they knew the woman and her family, for example when continuity of care was possible.

A common factor identified by both midwives and maternity support workers as limiting women's receptiveness was their lack of ability to understand or read English. Supplementary resources (e.g. translated leaflets) were often lacking or inadequate. Attitudes to public health information also affected receptiveness across some social groups. Participants described women's scepticism about the value of public health advice, in particular when advice had changed over time or was challenged by influential family members.

It was appreciated that teenage and younger mothers might require additional time and support to develop trusting relationships with health care professionals, and that without such relationships public health support would be difficult. However, time and support for relationship building were often felt not to be available.

In general specialist referral services were valued, such as specialist midwives, sub-contracted screening services, other NHS public health services (e.g. smoking cessation support), maternity related charities, housing and social services. However, concerns were expressed that specialist services might erode midwifery skills and also lead to potential fragmentation of care. Midwives described how dealing with multiple services was problematic and time consuming, and ran the risk that women might 'fall through the gap'. There were also concerns raised that resourcing specialist services within the NHS would be challenging financially, and that introducing non-NHS services could undermine NHS principles of equity of service provision.

Limitations of the study

Whilst the study achieved its aim of obtaining the views of a range of health care professionals employed in the maternity services, the views obtained cannot be assumed to be representative of others who did not participate.

The limited data obtained in the senior midwife discussion groups, particularly the Heads of Midwifery and Consultant midwife groups, should be noted. The reasons for this may be linked to the use of Facebook groups for data collection, but there may also have been other factors which it was not possible to identify. Any further research will need to carefully consider how best to recruit from these groups, including identifying the most effective method of data collection.

Use of Facebook had both advantages and disadvantages. It allowed virtual focus group discussions with participants from widespread geographical areas who would not otherwise be able to meet. When participants are used to this medium of communication, discussions have previously been found to be free flowing and productive (Hunter and Warren, 2014). However, lack of familiarity with Facebook or concerns about data privacy and professional boundaries (NMC, 2015) may limit recruitment and participation. It was noted that some individuals, although interested in participating, were either not regular Facebook users or expressed reservations about using Facebook for work related activities. This was most evident with the more senior groups of professionals including Consultant midwives, Lead Midwives for Education and Heads of Midwifery. This was thought to be due to the sometimes negative press that Facebook receives when used inappropriately by health professionals (NT, 2013). The researchers reiterated the closed nature of the Facebook discussion and reassured potential participants that data was secure, but this appears to have been insufficient to reassure some potential participants.

A further limitation is the sole focus on professionals' views. It is also important to gain insights into the experiences of families receiving midwifery public health activities, thus it is recommended that the service user perspective is included in any future research.

Conclusion

This descriptive qualitative research study investigated student midwives', midwives' and midwifery support workers' knowledge of and involvement in the public health agenda in England, with data collected via seven Facebook groups. Thematic analysis of the data using a coding framework generated five key themes: scope of midwives' public health role; training and support for public health role; barriers and facilitators; specific client groups and role of specialist referral services.

The study highlighted expectations for the maternity services to facilitate delivery of a complex and increasing public health agenda to women and their families with diverse or complex health or social needs. Student midwives, midwives and midwifery support workers in England have high levels of involvement in the public health agenda across a wide range of activities, but frequently lack the time, training and resources to meet the demands of this aspect of their role. Such deficits reduce the ability of the maternity services to provide the quality of public health advice and support expected, limits the potential to benefit particularly vulnerable and 'at-risk' families and will need to be addressed if the high expectations for public health delivery within the maternity services are to be realised.

Policy makers, commissioners and National Health Service providers need to provide clearer guidance on the expectations of the public health remit of midwives and maternity support workers and ensure that such expectations are appropriately resourced to provide effective delivery.

Conflict of Interest Statement

BH's post as RCM Professor of Midwifery at Cardiff University is partly funded by the Royal College of Midwives. This research study was funded by RCM.

Acknowledgements

We are grateful to the Royal College of Midwives, UK (RCM UK) for funding and all focus group participants who gave freely of their time, opinion and experience.

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