

# Stepping up to Public Health

A new maternity model for women and families, midwives  
and maternity support workers



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This report brings together work carried out by the Royal College of Midwives (RCM) and University of Cardiff and funded by the Department of Health in England.

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## Glossary

ANC.....	Antenatal care
BFI.....	Baby Friendly Initiative
BMI.....	Body mass index
CMACE.....	Centre for Maternal and Child Enquiries
CPD.....	Continued professional development
DHE.....	Department of Health for England
FGM .....	Female genital mutilation
HCP.....	Health care professional
HoM.....	Head of Midwifery
LME.....	Lead midwife for education
MBRRACE-UK .....	Mothers and Babies: Reducing Risk through Audits and Confidential. Enquiries
MLU.....	Midwifery led unit
MSW.....	Maternity support worker
MW.....	Midwife
PH .....	Public health
PNC.....	Postnatal care
RCM.....	Royal College of Midwives
StMW.....	Student midwife
SU .....	Service user
VBAC.....	Vaginal birth after caesarean

# Executive summary

The Royal College of Midwives embarked on a project to explore the public health role of midwives, maternity support workers and student midwives. The aim was to increase the resources available to support the provision of the public health remit within maternity care. The culmination of this work, together with Cardiff University, resulted in the development of the stepping up to public health model for women and families and a corresponding model for midwives and maternity support workers.

## 1 What we did



Two qualitative studies



One survey



One Audit



One stakeholder think tank session

We identified 35 public health topics and gathered data around what currently happens, what should happen and what resources are needed for practitioners to further support women and families.

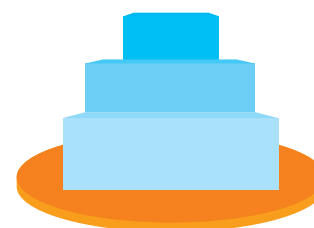
## 2 What we developed

### The Stepping up to public health model

The model outlines resources and suggestions to improve the public health remit as part of providing family-centred care.



Women and families



Midwives, maternity support workers and student midwives

## 3 What we produced

Presentations for dissemination events

Pregnancy and birth information menu

Information repository for women and families and a corresponding Information repository for midwives and maternity support workers

Practice case studies

i-learn modules

App for women to access information repository

# Section 1. Introduction





## Section 1. Introduction

In response to pregnancy being a “teachable moment” or “golden period” in individuals’ lives, midwives have a major and well defined role to play in supporting and sustaining health. For many, pregnancy may provide the first sustained contact that a woman or her partner has with the health service. Midwifery 2020, stated that:

*“Midwives should have a good knowledge of the health and social care needs of the local community; be well networked into the local health and social care system; and be proactive in identifying women at risk, and engaging with the woman, her family and other services as appropriate.” (Midwifery 2020 Programme 2010, p.26)*

A systematic review by McNeil, Lynn et al. (2012) provided a basis for justifying a system wide approach for public health interventions as part of making an impact. While pregnancy and early motherhood is recognised as an ideal time for promoting healthy behaviours, there is a need to encourage women, their partners and the extended family to engage individually with their health, and health-taking responsibilities. This however, requires that maternity service users understand the wide parameters associated with health, and how these parameters can influence the establishment and maintenance of a healthy lifestyle and future positive family-based habits. It is the responsibility of all health professionals, to effectively promote health between preconception and early motherhood as the Healthy Child Programme (DHE/PHE, 2009) clearly outlines. The RCM as a supporter of the First 1000 days initiative recognises the importance of the best start in life from conception to two years.

Historically midwives have contributed to the health of the nation, however more recently Department of Health for England (DHE/PHE, 2013a) outlined the importance of the midwife’s role in obtaining the four central domains of public health:

- Improving the wider determinants of health by reducing the negative effects on health and wellbeing, 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
- Healthcare public health and preventing premature mortality by reducing numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

In order to attain these four goals, the maternity care workforce (in particular midwives and maternity support workers (MSWs) must effectively identify and act upon health needs at an individual, community and population based level (DHE/PHE, 2013b). Since the work of Bennett, Blundell et al., (2001a, 2001b) on the views of midwives in redefining their professional role, there is limited specific needs analysis has been undertaken to guide the mobilisation process related to their role and that of the MSW workforce.

In the past, midwives, when asked about their health promotion role, reported an overall variation in responses including differing individual, specialist knowledge, skills, years of experience and the training resources accessible to them. In addition, midwives’ personal behaviours (such as smoking) were seen to create further variance in relation to their role (Fleming et al., 2016). While many of these workforce challenges still exist the public health role of the midwife has nonetheless extended, becoming more complex. For example:

- the development of the antenatal screening programme,
- the understanding of the importance of perinatal mental health pre and postnatal,
- identifying pregnant women who are experiencing domestic abuse, safeguarding children, the development of guidelines on female genital mutilation (FGM),
- carbon monoxide (CO) assessment to determine levels of smoking by the pregnant woman and carbon monoxide levels in her environment,
- the introduction of immunisation during pregnancy for seasonal flu and pertussis,
- the prevalence of obesity amongst pregnant women and
- the increasing ethnic and cultural diversity of childbearing women.

The importance of early interventions for the prevention of illness and health inequality in the future is well recognised (Field, 2010). Furthermore, since 2001, MSWs were introduced across the United Kingdom (UK), providing an additional workforce dimension to assist in meeting the public health challenge. It therefore follows, that a more contemporary needs analysis is required, that explores the role of the midwife and the MSW in relation to meeting the public health agenda.

Within this context, the RCM, funded by the Department of Health England (DHE), embarked on a project to explore the public health role of midwives and MSWs, raise the profile amongst practitioners and increase the resources available to support the provision of the public health remit within maternity care. The project had four main phases with





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qualitative and quantitative studies and stakeholder consultations. These resulted in the development of a public health model and associated resources, designed to assist practitioners and inform women and their families, the aim being to enhance safe, evidence based maternity care. Dissemination events to showcase the model took place across England including publications and conference presentations.

## Project aims and objectives

The main aim of the project was to conduct scoping and needs analysis; mapping the current public health activities of midwives and MSWs and student midwives. This was followed by the translation of the project findings into practical outputs to support improvements in the provision of care. The aim is to use the findings to assist with strategically guiding the optimisation and mobilisation of the midwifery and MSW workforce in this area, through the provision of specifically-designed educational and practice development activities.

The project objective was to identify midwives, MSWs and student midwives' current knowledge of, preparation for and involvement in the public health agenda as categorised by the four domains of public health (DH/PHE 2013a). There were two main phases to the project with a mixed methods approach of qualitative exploratory work followed by a quantitative survey approach.

In phase one, an exploratory study was undertaken by University of Cardiff practitioners recruited and participating through closed online discussion groups to identify the major themes for the current knowledge of and involvement in the public health agenda. This was supplemented by an RCM study using the same methodology with service users.

The aim of the qualitative study with practitioners was to identify student midwives', midwives' and maternity support workers' current knowledge of and involvement in the public health agenda in England.

The questions addressed were:

- What are student midwives', midwives' and maternity support workers' knowledge and involvement of the public health agenda in relation to maternity care provision?
- 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?
- What do participants believe to be the educational facilitators and barriers associated with their role in making a public health impact?

- What are the level of skills & competencies required by relevant maternity staff in relation to specific user groups and their public health intervention requirements?
- What do participants believe the potential role of specialist referral services to be in meeting the public health agenda?

In addition to the above research questions, service users were asked their perceptions of the role of the midwife within public health from their own experiences of care. The findings are presented together for the practitioners and service users.

The second phase included a large-scale audit and questionnaire exercise to practitioners to identify current experiences and approaches to providing public health within the midwifery context.

The specific questions explored in the quantitative audit and survey were:

- Which public health topics are covered with women by practitioners, at what stage of the pregnancy and the level of involvement, if any, with specialist services?
- What are the experiences and views of practitioners regarding the current context in which public health messages are delivered?
- What are the barriers and facilitators to delivering essential public health from the perspective of practitioners?

## Structure of the report

This report brings together the findings from the qualitative and quantitative studies and the immediate outputs from the project. The next section outlines the methods used for the two phases of the study and the description/demographics for the participants. In sections 3 and 4, the detailed findings are provided for the qualitative and quantitative studies respectively with a discussion of the implications for midwifery practice. Section 5 gives an overview of the stakeholder consultation undertaken as part of the project drawing together the implications from the findings. Section 6 describes the Stepping up to Public Health Model developed from the findings and the associated outputs for the project including the dissemination and learning activities. This is followed by a short summary of the work undertaken to translate the project findings into action through dissemination activities and the development of resources (Section 7).



## Section 2. Methodology





## Section 2. Methodology

This section outlines the methodology for the studies undertaken as part of this project. A project steering group was convened between 2015 and 2016 to provide support and guidance for the development and completion of each of the studies. The members of the Steering group were also involved in the peer review process of the data collection tools, responding to the interim analysis, and informing the developments of the outputs and the deliverables.

### A) Exploring the role of public health – practitioners' perspective

#### Recruitment

Seven closed online discussion groups took place using the social networking site Facebook. Each discussion group comprised of specific groups of professionals/ stakeholders as follows:

- MSWs
- Student midwives (StMWs)
- Midwives (Bands 5 & 6)
- Modern matrons / midwifery managers (Band 7 / Band 8)
- Heads of midwifery (HoM)
- Consultant midwives with a specialist interest in public health
- Lead midwives for education (LMEs) and educators.

Participants were recruited through adverts on the RCM Facebook page, Twitter account and through an email advert sent to all RCM MSW members. Consultant midwives received an email invitation via the RCM-hosted email list. Inclusion criteria were that they self-identified as a member of one of the above groups of professionals and that they worked within England. Potential participants were asked to contact a member of the research team via Facebook messaging, and once they had confirmed their eligibility they were supplied with participant information, the discussion group ground rules and were informed that they would be added to the relevant closed online discussion group.

Ethical approval was granted from Cardiff University School of Healthcare Sciences Research Ethics Committee. All prospective participants were provided with an electronic participant information sheet (PIS). The PIS contained details about the purpose of the study, what participation would entail, measures

taken to protect their identity and that they had a right to withdraw from the study at any point without providing a reason. All respondents were informed that participation in the discussion group confirmed that they had read and understood the PIS and that they consented to take part. Participants were asked not to disclose the identity of individuals or employer. The focus groups were administered and monitored by members of the research team. Participants were provided with the discussion group ground rules, and were requested to act in a respectful way to other members of the group and informed that in order to protect the wellbeing of all taking part, any member who was found to post discussion comments which could be deemed as offensive would be removed from the group by the administrators. In the event no members were removed. Participants were asked to confirm they had read the participant information sheet and were asked to provide brief demographic information prior to being given access to the appropriate group.

Access to the closed discussion groups was only available to those who participated and to the research team. No individuals outside the group had access to the discussion. Following closure, all participants were removed from the group and data were copied into Word documents and anonymised prior to analysis.

#### Data collection

The closed discussion groups ran for 3 weeks in January 2015. Questions were posted by the researchers in order to facilitate and guide the discussion Table 1. These questions related to the research questions and were posted sequentially over the course of the discussion. On completion of the discussion all participants were thanked privately via Facebook message for their contribution.

#### Analysis

Data were independently read and re-read by members of research team and were thematically analysed using a basic coding framework. The coding framework was developed by incorporating the research questions and the four objectives. Following initial thematic analysis, a meeting with the Steering Group was then arranged to cross check the themes and subthemes for the discussion and agreement of the final coding.



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Table 1. Questions for the discussion group

Student Midwives	<ul style="list-style-type: none"> <li>• What aspects of public health are you involved in within your current role?</li> </ul>
Midwives	<ul style="list-style-type: none"> <li>• What areas of public health do you feel are most pertinent to midwives in providing care to childbearing women?</li> </ul>
Modern matrons/Senior midwives	<ul style="list-style-type: none"> <li>• Are there aspects of public health that midwives are currently involved in that you feel could/should be undertaken by others?</li> </ul>
Consultant midwives	<ul style="list-style-type: none"> <li>• How are maternity staff in your organisation supported in their public health role?</li> </ul>
Heads of midwifery	<ul style="list-style-type: none"> <li>• What do you feel are potential barriers and facilitators to you in fulfilling your public health role?</li> <li>• Are their particular groups/clients who present more of a challenge to you in fulfilling your public health role?</li> <li>• What do you see as the potential role of specialist referral services in meeting the public health agenda?</li> </ul>
Maternity support workers	<ul style="list-style-type: none"> <li>• Are you as a maternity support worker involved in any public health role (e.g. facilitating breastfeeding, newborn bloodspot screening, etc.)?</li> <li>• Are there aspects of public health that midwives are currently involved in that you feel could/should be undertaken by others?</li> <li>• 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?</li> <li>• 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?</li> <li>• Are there particular groups/clients who present more of a challenge to you and your midwifery colleagues in fulfilling your public health role?</li> <li>• What do you see as the potential role of specialist referral services in meeting the public health agenda?</li> </ul>
Lead midwives for education and educators	<ul style="list-style-type: none"> <li>• What aspects of public health do you feel are most pertinent to midwives in providing care?</li> <li>• Are there aspects of public health that midwives are currently involved in that you feel could/should be undertaken by others?</li> <li>• Which aspects of public health are included within your midwifery undergraduate curriculum?</li> <li>• What support do you provide for students to help them to talk with women about public health issues?</li> <li>• What do you feel are the potential barriers and facilitators that midwives face in fulfilling their public health role?</li> <li>• Are there particular groups/clients who you feel may present more of a challenge to midwives in fulfilling their public health role?</li> <li>• What do you see as the potential role of specialist referral services in meeting the public health agenda?</li> </ul>
Service users	<ul style="list-style-type: none"> <li>• What was your experience of health promotion/protection that you remember your midwife or maternity support worker providing or discussing with you? (e.g. breastfeeding or newborn bloodspot screening etc.)</li> <li>• How do you view the midwife's role in public health?</li> </ul>



Table 2. Number of participants

Participant Group	Expressed interest	Recruited	Actively participated
Maternity support workers	44	41	20
Student Midwives	16	13	11
Midwives (Bands 5 and 6)	31	20	1
Modern matrons/ midwifery managers (Bands 7 and 8)	7	6	5
Heads of midwifery	7	5	3
Consultant midwives	4	1	1
Lead Midwives for Education	10	9	5
Service Users	1	0	0

## Participants

A total of 120 individuals contacted the study team and expressed an interest in participating. The total numbers of participants who were recruited and those who took part can be seen in Table 2.

There were a very high number of MSWs who expressed an interest and were recruited to the group and this would suggest a clear interest in the public health role by this particular group. The team had originally decided that a maximum of 15 participants would be added per group. However, the maternity support workers were especially slow in posting comments to the discussion and as a result more were recruited. Less than half of the number of maternity support workers who were recruited actively participated in the discussion. Of disappointment was the lack of successful recruitment of service users to the study. This was due in part to the difficulties experienced in obtaining permission to place an advert to recruit on the Facebook page of the two organisations that provide social networking for mothers. Time constraints prevented the research team from pursuing this further.

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 the consultant midwives, LMEs and the HoMs. This was thought to be due to the negative press that Facebook sometimes receives when used inappropriately by health professionals. The

researchers reiterated the closed nature of the Facebook discussion and reassured potential participants that data was secure, but this was insufficient to reassure some potential participants. This may account for the lower number of individuals participating in these senior midwife groups.

Basic demographic details were obtained from those participants who were clinically based (Table 3). It was evident that participants worked in a variety of clinical settings with diverse amounts of practice experience. For example, amongst the Bands 5 and 6 midwives, length of experience ranged from less than one year up to 23 years in practice (mean of 8.6 years). There was a similar picture for the experience level of maternity support workers which ranged between 1 and 25 years (mean of 6.5 years).

## B) Exploring the role of public health – service users' perspective

### Recruitment

An attempt was made to recruit service users through an advert on Netmums online notice board. However, this did not result in participants being recruited successfully into the study. Therefore, a new approach was used with the recruitment of a group of mothers in the London Borough of Barking and Dagenham. After an initial face-to-face discussion, the women were sent an invitation to a closed facebook group set up for the purpose of the focus group and were asked to invite friends

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Table 3. Demographics of participants

	Clinical area =n (%)	Length of experience =n (%)
Student midwives n=11	Rotational 11 (100)	Year 1 4 (36.3) Year 2 5 (45.4) Year 3 2 (18.2)
Midwives n=15 (Band 5 n = 2) (Band 6 n = 13)	Community 5 (33.3)	≤5 years 7 (46.7) 6-10 years 2 (13.3) 11-15 years 2 (13.3) ≥ 15 years 4 (26.7)
Senior midwives n=5	Delivery/MLU 2 (40.0) Specialist MWs* 2 (40.0) Community 1 (20.0)	10-15 years 2 (40.0) ≥ 15 years 3 (60.0)
Maternity support workers n=20	Post/Antenatal 9 (45.0) Community 5 (25.0) Rotational 4 (20.0) Delivery/MLU 1 (5.0) Antenatal clinic 1 (5.0)	≤5 years 14 (70.0) 6-10 years 3 (15.0) 11-15 years 0 (0) ≥ 15 years 3 (15.0)

## Box 1. Questions used to start the online focus group

To kick off our discussion, below is (quite a long) list of issues which midwives may have discussed with you before, during or after your pregnancy.

- Smoking,
- Drinking alcohol,
- Drugs and medicines in pregnancy,
- Diet in pregnancy,
- Supplements,
- Managing your weight,
- Exercise,
- Your feelings / mental health,
- Immunisations,
- Infections in pregnancy,
- Screening tests,
- Preparation for birth and parenting,
- Breast and bottle feeding,
- Bonding and skin-to-skin contact,
- Care of your pelvic floor and postnatal exercise,
- Female genital mutilation,
- Contraception, domestic violence,
- Keeping your baby safe,
- Safe sleeping practices and support services in your area.

Do you remember your midwife discussing these with you? How did it go? Were there any which you wanted her to discuss but she didn't? Were there any which she discussed which you felt were irrelevant and the time could have been better spent? Are there any other issues which you think midwives should be discussing with women and their partners?

The floor is yours .....



from other geographical areas. The inclusion criterion was that the participant should be the parent of a child under two years, born in England. The term 'parent' was used in order to include fathers if they wished to be involved.

The invitation to be part of the group clearly explained that by accepting the invitation, the participant's views would be used as part of a wider research project run by the RCM. It was made clear that the contributions would be anonymised and that if an anonymous contribution identified a participant, their consent would be sought before their contribution was used for a publication.

### Data Collection

The focus group was set up in March 2015 and was active for 4 weeks. The initial starting question are show in Box 1. The scope was deliberately broad initially to allow topics to be picked up according to the interest and experience of the participants. After this, prompts were used to pick up on particular topics that were of interest for the research. Discussion flowed well initially, with the majority of comments being made within the first ten days. Prompts at this stage provoked some fresh discussion. Regular new prompts and questions produced dwindling responses until the final day of the focus group.

### Analysis

The data were transferred to a Word document, and names removed from the text. Contributions were identified by the code SU1 to SU14 (service user 1 to 14). City names and areas were left in as they gave a sense of geographical spread without risking identifying a participant. All names of individuals within the text were removed.

As part of the wider public health project, and a supplement to the work already done by Cardiff University, the data were considered alongside that produced from the professionals' focus groups, with a view to how this piece of work would add insight into the development of the new model of public health for midwifery. For ease of referral, the themes identified by the main report were used as a basis for analysis, and novel subthemes were placed within the most appropriate major theme.

Most of the themes identified within the service user focus group fitted within the first major theme of 'The scope of midwives' public health role, as most discussion focussed on specific areas of public health advice and input by midwives. However, there was also significant discussion around how those messages were delivered, with considerable discussion

about the midwife's approach, communication skills and relationship with the woman. These 'how' comments were more aligned to the second and third major themes of 'training for the public health role' and 'barriers and facilitators', and finally there were insightful contributions about the different types of care, which fitted into the fifth major theme 'The role of specialist services'.

### Participants

Twenty four mothers accepted the invitation to the focus group. Of these, fourteen took part in the discussion groups and no fathers participated. The women had been cared for by fourteen different NHS Trusts across England, as some reflected on births that had taken place in other parts of the country with previous pregnancies. The recruitment through the 'new mothers' group aimed to reach ethnically diverse women with an age range of 15 to 41 years. As the snowballing technique was used to recruit participants, there were some similarities across the demographics for the participants. Four of the initial participants were white British women within the age range of 25 to 38 years and they invited others with a similar demographic resulting in a fairly homogeneous group.

## C) Audit and survey with practitioners

### Recruitment

Our approach was to conduct an audit and survey through an online questionnaire sent via email to RCM members. This included midwives, MSWs, student midwives, and health visitors. Based on the funding, the project requirement was for England only, however the survey was rolled out to all four countries. This is because the RCM scope of work covers the UK and we wanted responses from all four countries to look for any country specific differences.

Participants were recruited through an email newsletter including a link to the survey to all RCM members across the UK. This database consisted of 35,590 members, however, it was expected that there were under 5,000 active members who may be interested in participating and with relevant experiences.

Ethical approval was not required for this arm of the project as it was managed by the RCM and only members were invited to participate. Anonymity was assured as part of the process. Members are regularly consulted on key topics and this project was included as part of the RCM workstream.





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## Data collection

The questionnaire was designed to capture information about the care of a specific woman in the form of an audit, and the experiences and view of practitioners on their public health role (Box 2). The audit and accompanying questions were chosen from the results of focus groups with service users and maternity staff. The questionnaire was devised and piloted amongst RCM staff members including midwives, researchers, and communication staff. Amendments were made based on the responses and the survey was finalised ready for the dissemination.

The survey was open for four weeks between June and July 2015 and was available online using survey monkey. Participants did not have to provide their contact details and were thanked for their involvement upon submission.

### Box 2. Sections for the Audit and Questionnaire

**Demographics:** including role, location, area of work within maternity care, length of time working or studying

**Audit:** the practitioner was asked to consider the last woman they cared for, providing background such as parity, the type of involvement the practitioner had, and which public health topics were covered (from a list of 35 topics deemed essential at some stage of the continuum). Finally, if not discussed, why not?

**Questionnaire:** on the experiences and views of the practitioners including:

- The timing for undertaking key appointments throughout the pregnancy continuum (average time taken, time the trust allocated and their views of how much time they felt was actually required)
- Confidence in giving advice to women and the training/Continuing professional development (CPD) received on public health topics
- Ease of referral to other health and social care (multidisciplinary) professionals
- Their views on the most appropriate professional to provide information on each of the 35 public health topics
- Percentage of the practitioners' time spent on public health as part of the care that they provide
- Opportunity to provide open feedback on new public health topics or any other comments

The RCM members were offered an incentive to participate with the chance of winning one of four £25 vouchers for either Amazon or Marks and Spencer vouchers and were asked for an email address as part of the survey. The email address was only used to enter the participants into the prize draw and was not used in the analysis.

## Participants

The first mail-out resulted in 32,609 being delivered to the relevant email systems, 8,219 were opened and 1,397 clicked on the survey link. A reminder was sent to those who didn't open the email newsletter from round 1 and this resulted in a further 394 clicking on the survey link. A third reminder was sent out to those who hadn't opened the original email and this resulted in a total of 2,242 participants.

Of the 2242 participants, 86% were from England with responses from all four countries (Table 4). In England, 9 regions were represented (Table 5) and this was broken down with representation from London (20%), North West (15%) and East of England (14%). The smaller proportions were from East Midlands (6%) and the North East (4%).

Majority of the respondents were midwives and student midwives with all membership categories represented (Table 6). Those in the 'other' categories were also qualified midwives however they were undertaking other midwifery roles such as education or research as their primary role. The majority of midwives had 12 years or more experience and 34% had less than 5 years experience (Table 7).

In describing their main area of work, the respondents represented a wide range of settings including community and hospital settings (for around 80%) and the remaining from education or management settings (Figure 1). There were a greater proportion responding from the educational setting in England and Wales as compared to Northern Ireland and Scotland. Also, there were higher proportions responding from midwifery units as their primary area of work in Northern Ireland and Wales (Table 8).



Table 4. Proportion of respondents by country

Country	Percentage (%)	Total (n)
England	86%	1922
Northern Ireland	4%	78
Scotland	6%	143
Wales	4%	85
Not known	1%	14
Total		2242

Table 5. Proportion of respondents from areas in England

Regions in England	Percentage (%)
East Midlands	6%
East of England	14%
London	20%
North East	4%
North West	15%
South Central	11%
South West	10%
West Midlands	9%
Yorkshire and Humber	9%

Table 6. Respondents by primary role

	Maternity support workers	Student midwives	Midwives	Health visitors	Neonatal midwives/nurses	Others	Not known	Total
England (%)	3%	15%	79%	1%	0.5%	2%	1%	101.5%
UK total (%)	3%	14%	80%	0.5%	0.5%	2%	1%	102%

Table 7. Length of time in their roles by country

Length of time in the roles	England	Northern Ireland	Scotland	Wales	Total
0 to 2 years	21%	15%	11%	12%	20%
3 to 5 years	13%	5%	5%	12%	12%
6 to 8 years	87%	4%	6%	8%	7%
9 to 11 years	7%	8%	8%	1%	7%
12 or more years	52%	68%	69%	67%	54%
Not known	0%	0%	0%	0%	0%
Total (n)	1720	78	143	85	2026

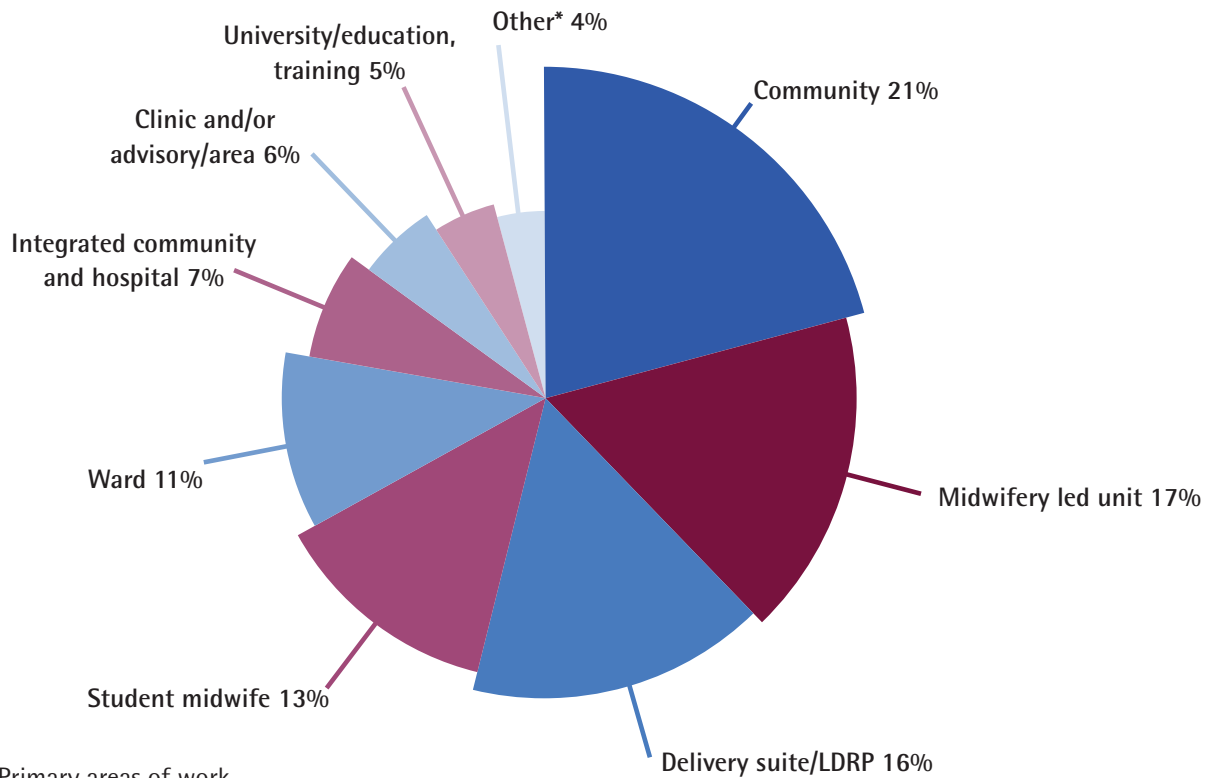


Figure 1. Primary areas of work

\* include HoMs and those in national and neonatal roles (and roles represented in small proportions)

Table 8. Breakdown of primary role by country

	England	Northern Ireland	Scotland	Wales	Total
Community	21%	17%	20%	22%	21%
Delivery suite/LDRP	16%	13%	15%	13%	16%
Midwifery led units	17%	29%	16%	24%	17%
Ward - antenatal, postnatal, day assessment, triage and rotational	11%	14%	11%	15%	11%
Integrated community and hospital	7%	4%	11%	7%	7%
Clinic and/or advisory roles/ Ultrasound sonography/screening/PH advisor	5%	4%	11%	4%	6%
Student midwife	14%	13%	7%	2%	13%
University/education/training	5%	4%	6%	6%	5%
Other*	4%	3%	6%	7%	4%
<b>Total</b>	<b>1712</b>	<b>77</b>	<b>142</b>	<b>85</b>	<b>2021</b>

\* include HoM and those in national and neonatal roles (and roles represented in small proportions)

# Making the case

Historically midwives have contributed to the health of the nation and more recently the importance of the midwife's role in obtaining the four central domains of public health have been outlined.

Reducing the negative effects on health, wellbeing, and inequalities

Protecting the population from major incidents and other threats

Helping people make healthy choices

Preventing premature mortality

(DfE/PHE, 2013a)

With variation identified across the research on the implementation of public health in maternity, a more contemporary needs analysis was required (Fleming et al., 2016).

The RCM embarked on a project to explore the public health role of midwives, MSWs and student midwives, raise the profile amongst practitioners and increase the resources available to support the provision of public health within maternity.

## Exploring the public health role

### A. Practitioners' Qualitative Study

Seven closed online discussion groups using Facebook with a total of 46 participants of MSWs, student midwives, midwives, and lead midwives for education.

### B. Service Users' Qualitative Study

Face-to-face focus groups and online closed discussion group using Facebook with 14 service users and linking analysis with the practitioners' study.

### C. Audit and survey with practitioners

Online questionnaire with responses from 2,242 midwives, MSWs, student midwives, health visitors and other practitioners and representation from across the UK.

### Theme 1: Scope of the Public Health Role

- i) Range of involvement
- ii) Pertinence of public health aspects of midwifery
- iii) Potential for aspects of public health role to be undertaken by others

### Theme 2: Training & Support

- i) The amount of training that maternity staff receive in relation to their public health role
- ii) The content of this training (types of issues covered)
- iii) The approach taken to the training
- iv) Communication skills training

### Theme 3: Barriers & Facilitators

- i) Time and resources
- ii) Relationships with women
- iii) Language and culture
- iv) Midwives' approach
- v) Educational barriers & facilitators

### Theme 4: Specific Client Groups

- i) Language
- ii) Attitudes to public health information
- iii) Teenage mothers
- iv) Mothers with high academic achievement
- v) Meeting individual client needs

### Theme 5: Role of specialist referral services/ HCPs

- i) The value of support services
- ii) Specialist services eroding midwifery skills
- iii) Specialist services leading to potential fragmentation of care
- iv) Resourcing specialist services

### The results are presented in six sub-sections

- i) Public health role in midwifery
- ii) Time available for public health
- iii) Most appropriate professional for public health topics
- iv) Referrals
- v) Level of confidence
- vi) Understanding implementation through audit

## Seven key themes generated from the studies

### Stakeholder think tank

Around 60 public health experts, service users, midwives, student midwives and MSWs participated to provide feedback on barriers and facilitators, as well as potential solutions.

Seven key themes generated from the studies and considered as part of group exercises.

#### Communication

*"It's difficult to broach some sensitive topics... We aren't taught how" (MW)*

#### Most appropriate HCP to address individual topics

*"I strongly feel that all professionals have public health responsibilities with women and families and the wider community" (MW)*

#### Continuity of carer

*"The fact that I never saw one midwife more than once... I was never able to build up a relationship" (SU)*

#### Timing

*"Women in the postnatal period are given too much information" (MSW)*

#### Time constraints

*"I cover these topics by working longer hours, if I stuck to allotted times I wouldn't be able to cover all the things I do" (MW)*

*"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" (MW)*

#### Method of conveying information

*"Use of technology to support information giving" (SU)...  
"need to be careful about the source/credibility of online information" (StMW)*

#### Education

*"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" (MSW)*

### Making an impact

We have used the findings to develop the new Stepping up to the Public Health Model and have ten main outputs including an information repository, a pregnancy and birth information menu for women, RCM i-learn modules, and printed publications.



Women and families



Midwives, maternity support workers and student midwives







## Section 3. Exploring the Public Health Role



## Section 3. Exploring the Public Health Role

In this section, the role of public health in midwifery is explored through two qualitative studies using closed online discussions involving practitioners' and service users'. The main message from the study was that 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. This deficit particularly impacts on their ability to provide the quality of public health advice and support that they would like to offer and which would be of particular benefit to

specific user groups, such as vulnerable and 'at-risk' families. Service users echoed some of the findings from practitioners.

The findings have been presented as 5 themes as shown in Table 9. Each section is covered in detail with sub-sections and followed by a discussion of the findings. All participants have been allocated a code to identify their group, and an individual participant number to protect their identity for presenting the findings and this is shown in Box 3.

Table 9. Major themes from the qualitative study

<p><b>Theme 1: Scope of the Public Health Role</b></p> <ul style="list-style-type: none"> <li>i) Range of involvement</li> <li>ii) Pertinence of public health aspects of midwifery</li> <li>iii) Potential for aspects of public health role to be undertaken by others.</li> </ul>
<p><b>Theme 2: Training &amp; Support</b></p> <ul style="list-style-type: none"> <li>i) The amount of training that maternity staff receive in relation to their public health role</li> <li>ii) The content of this training (types of issues covered)</li> <li>iii) The approach taken to the training</li> <li>iv) Communication skills training</li> </ul>
<p><b>Theme 3: Barriers &amp; Facilitators</b></p> <ul style="list-style-type: none"> <li>i) Time and resources</li> <li>ii) Relationships with women</li> <li>iii) Language and culture</li> <li>iv) Midwives' approach</li> <li>v) Educational barriers &amp; facilitators</li> </ul>
<p><b>Theme 4: Specific Client Groups</b></p> <ul style="list-style-type: none"> <li>i) Language</li> <li>ii) Attitudes to public health information</li> <li>iii) Teenage mothers</li> <li>iv) Mothers with high academic achievement</li> <li>v) Meeting individual client needs</li> </ul>
<p><b>Theme 5: Role of specialist referral services/ HCPs</b></p> <ul style="list-style-type: none"> <li>i) The value of support services</li> <li>ii) Specialist services eroding midwifery skills</li> <li>iii) Specialist services leading to potential fragmentation of care</li> <li>iv) Resourcing specialist services</li> </ul>

Box 3. Key coding/codes for quotations

St	Student midwife
MW	Midwife (Band 5/6)
Sr	Senior midwife (Band 6/7)
MSW	Maternity support worker
Cons	Consultant midwife
HoM	Head of midwifery
LME	Lead Midwife for Education
SU	Service users





## Theme 1: Scope of midwives' public health role

The findings related to the scope of midwives' practice are discussed in three subthemes:

- i) Range of involvement
- ii) Pertinence of public health aspects of midwifery
- iii) Potential for aspects of public health role to be undertaken by others.

### i) Range of involvement

There were extensive comments in all Facebook groups in response to this question. All participants identified a wide range of public health related topics in which midwives were engaged, during the antenatal and postnatal periods.

*In my current role I am involved in public health in the areas of smoking cessation & carbon monoxide exposure for pregnancy women & babies, healthy diet & avoidance of obesity, food hygiene & the avoidance of food poisoning, avoidance of alcohol in pregnancy, the health benefits of breastfeeding for both mother & baby & the signs & symptoms of Group A strep infection in pregnancy & the puerperium leading to sepsis. Contraceptive choices to enable healthy family spacing, prevention of SIDS & the promotion of pelvic floor exercises postnatally are also within my role. (MW9)*

*The public health role that midwives undertake tends to depend on the health complexities of their clientele and thus is a dynamic concept and truly hard to define completely. I suppose if you consider the health issues that are relevant to all childbearing women in the first instance such as: promoting breast feeding, advising on cervical cytology / breast screening, diet and exercise to reduce obesity and diabetes and perinatal mental health to then move onto more specific issues pertinent to the individual woman. These may include smoking, alcohol and substance misuse, homelessness, physical and mental abuse, including forced marriages etc. (LME2)*

*I have experienced promoting health issues in all aspects of my training -mental health, screening, vaccines, breastfeeding, smoking and alcohol, diet (we try and discuss throughout but it's often missed). (St8)*

The breadth and complexity of the midwife's public health role was commented on by many.

*.. a huge agenda.. (LME5)  
The role is endless. (LME2)*

The implications of this broad and complex role are discussed later in this section. Table 10 provides details on the areas of public health identified by participants and this is followed by detailed findings for each of the frequently discussed topics.

Within this theme focussing on the breadth of the public health role, a small number of topics were discussed at length by the service users, whereas others were mentioned briefly or not at all. The topics commented on by the majority of participants

Table 10. Areas of public health identified

Key areas frequently discussed	Areas less often discussed
Breastfeeding/ infant feeding	Alcohol use
Smoking cessation	Food safety/hygiene
Screening	Domestic abuse
Mental health/ psychological wellbeing	FGM
Obesity prevention	Diabetes
Contraception	Bereavement
SIDS prevention/ safe sleeping	Immigration support
Immunisation	Language support
Infection/sepsis prevention	Social inclusion/exclusion
Sexual health	Drug/substance misuse
General healthy lifestyle	Homelessness
Intrapartum public health: a. Skin to skin contact b. Delayed cord clamping	Forced marriages
Pelvic floor exercises	Cervical cytology
	Breast screening
	Involvement of partners/dads
	Communicable disease
	PN physiotherapy
	Pre-conceptual health (HoMs only)



were infant feeding and safe sleeping, whilst contraception, pelvic floor care, mental health, infection and immunisations were also raised by some women. All the areas mentioned were already covered in the discussions with practitioners and some are also relevant to later subthemes of 'continuity of care' and 'the use of leaflets'.

## Key area – Breastfeeding

Breastfeeding (and to a lesser extent infant feeding in general) was identified as a major area of public health involvement by all participants, which was seen as a public health priority. Breastfeeding was discussed in all Facebook groups, often in some detail. This was especially notable where maternity units (or universities) had Baby Friendly Initiative (BFI) accreditation or were working towards this. This emphasis on breastfeeding was also evident in the later discussions on training and support.

*Breastfeeding is also a biggie! Loads more support now than say 10 years ago. (St1)*

*I agree with the above in that screening, breastfeeding and smoking are big aspects of public health that are discussed. (St6)*

*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 and keen to share information. (St4)*

*I work across all areas of hospital based care but mostly in the postnatal ward. We obviously cover breastfeeding throughout a woman's stay with us. (MW2)*

*Infant nutrition! Support HV services to achieve full UNICEF BFI accreditation, which we did in XX 2014. I also support women with complex breastfeeding problems. (Sr6)*

MSWs described themselves as having a central role in relation to breastfeeding promotion and support. Most MSWs mentioned extensive breastfeeding involvement, especially running antenatal and postnatal support groups and providing support to women on postnatal wards and in the community. MSWs also mentioned how these breastfeeding focused activities could be used as a platform for providing more general public health support and advice. The enthusiasm of MSWs in relation to breastfeeding support was very noticeable, and MSWs expressed their keen motivation to contribute more in this area (see also support/training).

*Within my role I run antenatal breastfeeding classes and postnatal drop in breastfeeding groups. (MSW3)*

*Yeah I also provide infant feeding support to mums and sign post them to help available in children's centres and other community settings. (MSW1)*

*I work on postnatal ward so my main area of public health promotion would be breast feeding support.... MSW2)*

*Working on the postnatal ward I am mainly involved with breastfeeding support, referring for tongue tie clinic and general baby care and safe sleeping advice. (MSW11)*

*I'm involved in breastfeeding support, general baby care and safe sleeping. Would like to be involved in more. (MSW7)*

*I work on a very busy postnatal ward. I do an awful amount of breast feeding support and we have a lot of babies that need courses of antibiotics so are with us for 5-7 days. This prolonged stay gives me a chance to discuss generally the looking after and wellbeing of both the mother and baby, as well as establishing breast or bottle feeding. (MSW16)*

Midwives and MSWs presented a unanimous view that breastfeeding was universally covered with all women. The service users' discussion presents a more mixed experience. This seemed to reflect differences in midwives' attitudes and knowledge within the same maternity setting and differences between settings, possibly reflecting BFI status.

*I asked for support with feeding and they sent a support worker to me who was brilliant and they did check I was confident before discharge. A lost 12.5% so I went back in to hospital and received excellent care and was shown how to use a breast pump; I was contacted by phone and text by breast feeding support worker, great support in Sheffield for this. (SU7)*

*Obviously breast feeding is promoted far above any other option but I heard a midwife talking to a girl next to me in the hospital who had a 10lb baby and was struggling to feed him. He cried a lot and I heard her crying in the night too. The midwife said she should give him formula too as 'he was obviously still hungry'. I was surprised at this as so quick after giving birth, it seemed to me the midwife didn't give her another option. (SU7)*

*...my community midwife never talked to me about feeding. Just after labour however, the midwife who delivered the baby helped me to latch him on and gave me advice so it really does differ between midwives. (SU2)*

*This time round the only discussion about feeding was a midwife standing at the door of our four bedded ward and calling to me "breast or bottle mum?" I replied breast and she wrote on the notes in her hand and left....that was the full extent of discussion and support I received. (SU6)*

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Regarding formula feeding, comments reflect some of the sentiments from the main report, in that it is rarely mentioned and women feel unsupported when choosing to formula feed.

*In my antenatal class one woman expecting twins asked about mixed feeding and the midwife said she'd speak to her privately afterwards as she didn't want to talk about bottle feeding in the group. We felt like we could have done with info on how to bottle feed safely when we had to give formula. (SU4)*

*So after three babies (5 months 3 yrs and 5 yrs) I have not heard a midwife even say bottle feed! Which adds to the guilt if you switch as I do because my kids all struggled to be satisfied when I feed them beyond 3 months. (SU5)*

### Key area – Smoking cessation

There was some discussion of involvement in smoking cessation advice across the groups, however most participants reported that midwives would give general advice and then refer to a specialist midwife. Carbon Monoxide (CO) monitoring was briefly referred to by some.

*In my current role I am involved in public health in the areas of smoking cessation & carbon monoxide exposure. (MW9)*

*In my job role I am involved in promoting healthy lifestyle choices to women and their families...including things such as smoking cessation. (MSW1)*

*Some on smoking but not really anything else! I know it is an opportunity and women are receptive at this time but I don't see it happening much in reality. (St9)*

*I've found that smoking cessation is talked about but the ins and outs are usually left for the smoking cessation worker to discuss. (St2)*

### Key area – Screening

Screening was identified as part of the midwife's public health role, especially by students. Qualified midwives tended to include it in a list of activities, rather than discussing it in any depth and there was a sense that this was a taken-for-granted aspect of the midwifery role.

*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... (MW12)*

The students differentiated between diagnostic screening for fetal abnormalities, and screening of maternal health and wellbeing (e.g. mental health screening). They raised questions about the way antenatal screening for fetal abnormalities is discussed with women, observing that there was not always enough time for adequate discussion, as in the following conversation.

*Screening is a big part. Questions at booking appointments etc to maximise multi-disciplinary team involvement. (St1)*

*Do you think that women understand screening though? I sometimes feel that they go along with it thinking it is expected of them and don't necessarily understand the implications. Community midwives don't always have time to really go into it. (St9)*

*I agree that time constraints are difficult to deal with in community. At booking appointments it's used to screen for those who would benefit from referrals such as smoking or mental health teams. I agree that screening for those who would benefit from diagnostic testing is often not discussed thoroughly. Like you suggest, the implications of a positive diagnosis are often not looked at... (St1)*

*I've done a few bookings and what I've found difficult is approaching the subject of 1st trimester screening. In our area we are asked by antenatal clinic to consent women in the community for the screening yet I don't feel that giving them the info and then asking them if they would like the screening within an hour appointment is really giving them informed consent or the opportunity to discuss it with their partners. (St2)*

### Key area – Mental health/psychological wellbeing

Mental health was mentioned in many of the groups, often as part of a more general discussion of public health activities undertaken by midwives and /or MSWs.

*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. (MSW2)*

*My current role is specialist midwife safeguarding and vulnerable women. I work within a team of 5 midwives, we support women with mental health problems, who are victims of domestic violence, women who misuse substances whilst pregnant, vulnerable teenagers, women with learning difficulties, and pregnant victims of human trafficking. (Sr3)*



Most students had experience of midwives at least raising the issue of mental health with women and possibly their partners and wider family, but also noted the varied amount of attention given to mental health, which was attributed to constraints of time and lack of continuity.

*Mental wellbeing is often looked at in my experience. Antenatal appointments always start with "how are you doing? How are the kids? (St1)*

*I find that mental health is often mentioned briefly but not particularly thoroughly discussed but I feel like this is due to the time restraints and lack of continuity of care to allow the relationship with a client to establish. (St6)*

*.. agree with the above [comment] that postnatal depression and the baby blues are discussed during every discharge, preferably with their partner or family member around so they know what signs to look out for too! Lots of encouragement about not being afraid to seek advice from GP if they feel down for a while. Haven't noticed much else! (St11)*

Mental and emotional health were not discussed widely by the service users, but one woman with a history of depression shared a concerning experience of her pregnancy journey. It appears that there was room for improvement in many aspects of her care, but lack of continuity of care – a subtheme under 'Barriers and facilitators' clearly contributes here:

*I found that I wasn't given enough support when it came to my mental health. Having suffered from mental health problems for 10 years and having taken anti depressants for 7 years prior to becoming pregnant, I was told at my first midwife appointment that I would be referred to a special mental health team within the hospital. However this never happened, even after me asking many of the different midwives that I saw on every occasion. Considering that I was also weaning myself off of anti depressants I did not receive any support at all, luckily I was mostly coping fine throughout my pregnancy but it would of still been good to have someone checking in with me, and it could of been very different for someone else. During my labour I was questioned by the midwife if I had a birth plan that had been talked through with the mental health team to which I told her I had never actually ever been referred. She was very surprised and expressed her concern about this. I think that it was just a lack of communication between departments and also the fact that I never saw one midwife more than once so never was able to build a relationship or personal bond between myself and them. (SU12)*

## Key area – Obesity prevention

Obesity prevention and healthy eating were mentioned in many of the groups (particularly the student and MSW groups); however, discussion was fairly limited. Advice about healthy eating was often described as broad based and occurring within a more general discussion of healthy lifestyle behaviours, supplemented by leaflets for more specific information. Apart from one participant who was a lead midwife for obesity, participants described this aspect of the midwife's role as being rather vague.

*I am the lead midwife on obesity. I have an immense passion for public health and the midwife's role in influencing it. (Sr4)*

*I find that diet and exercise are discussed and leaflets provided at booking but then after that it is just viewed as a 'lost cause'. (St6)*

*I have noticed midwives talking about diet a bit with mothers at discharge but little is actually said about it and it's more of a "make sure you eat healthy so that you can provide the best breast milk for your baby" type thing. (St11)*

Some MSWs described having a role in this area, again as part of more generalised healthy lifestyle advice:

*In my job role I am involved in promoting healthy lifestyle choices to women and their families. ... including things such as healthy eating, promoting changes to diet for the whole family that will promote a good healthy diet in the long term for everyone. (MSW1)*

*I also talk to women about trying to stick to a healthy diet throughout pregnancy and postpartum. (MSW3)*

## Key area – Contraception

The main discussion related to contraception occurred in the student group. Many student participants felt that discussing contraception at discharge was inappropriate timing and thus not taken seriously by women.

*Contraception advice is quite high on the agenda. However a lot of ladies laugh it off and don't really take it too seriously, mainly because they are 10-14 days after giving birth, not really the first activity on most ladies minds. I believe the health visitors discuss it in more detail. (St2)*

*I agree It's also mentioned in discharge talks but most women laugh or give the impression they don't need to hear it because they've heard it all before! (St11)*

*Oh yes contraception comes up too but in a postnatal setting it is generally met with laughter! (St3)*

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Contraception was only mentioned by two women as part of the service users group, but their comments resonated strongly with those expressed by the student midwives, that women can find the topic inappropriate and overly emphasised.

*I felt contraception was talked about too much by pretty much every medical person I came across during and after pregnancy! I understand a need to be sensible but felt it was always brought up unnecessarily. (SU2)*

*Agree with S [another participant] re contraception, it seemed like an obsession! (SU4)*

### Key area – Sudden Infant Death Syndrome (SIDS) prevention/safe sleeping

SIDS prevention and advice on safe sleeping was mentioned by students, MSWs and some Bands 5 and 6 midwives. It was notable that several MSWs commented specifically on this aspect of their role, describing how they incorporated this information into general baby care advice.

*In my job role I am involved in promoting healthy lifestyle choices to women and their families..... promoting things such as safer sleeping guidance. (MSW1)*

*I discuss the risk factors of SIDs with families too. (MSW1)*

*Safe sleep is discussed at my visits when I see people's sleeping arrangements for their newborn. (MSW19)*

*MSW's discuss safe sleep and reducing the risk of cot death during routine discharge chats. (MSW2)*

*I work in the community.... I also discuss safe sleeping/co-sleeping, baby-care etc on visits. (MSW5)*

In the Bands 5 and 6 midwives group, there was an interesting discussion about the ambiguity experienced when personal practices (e.g. co-sleeping with their own babies) clashed with the guidelines they were expected to promote.

From the service users' perspective, women highlighted the issues with co-sleeping associated with breastfeeding. There was a feeling amongst the participants that midwives were reluctant to discuss how to co-sleep safely, despite this being common practice for breastfeeding women. Some comments suggest a coercion rather than a sharing of information to allow an informed choice, and that midwives may not be confident to advise on how to make co-sleeping safer.

*I do feel that in both cases soon after my babies were born, midwives who I was looking to for reassurance and sensible, balanced advice applied undue amounts of pressure on me to do what they wanted me to do, based on one set of values/information. With my second child I*

*had a midwife make me promise that I would never bed share with my baby or I "would smother her" and when I said that I felt that I had had good advice about how to safely share a bed with my baby and that neither myself or my partner drink or take any drugs, she proceeded to tell me a story about a mother who smothered her baby and that that would happen to me if I shared a bed. I have had such a positive bed sharing experience with my babies, and I know that there is research out there to say how positive and safe it can be, but I was made to feel like I would be being hugely irresponsible to do so. I also felt pushed into promising not to do it, and only did so as I felt that my disagreeing with a midwife after the birth of my first child had backed me into a corner in such a negative way that I would do anything just to get her to move on. (SU14)*

*It always felt to me that they had to 'tow the party line' with sleeping advice - I was always strongly advised not to feed the baby in bed or co sleep & not told (specifically) about safe sleeping by a midwife! (SU1)*

*I felt with both BF and safe sleeping the midwives were nervous to advise me to exclusively BF in case he lost weight & terrified of me co sleeping in case I smothered him! It felt like they didn't want anything they said to come back & bite them! (SU1)*

*I agree with H about towing the party line. Sometimes I felt like asking "but what do you really think?" However, I can see why the messages do need to be reasonably consistent. (SU3)*

### Key area – Immunisation

Immunisation was not widely mentioned, apart from identifying that flu and whooping cough vaccines were encouraged.

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

*oh yes the vaccines are encouraged. (St9)*

*At 16 weeks women are given leaflets about flu and whooping cough vaccines and asked to book in with a nurse if this is something they wish. We then ask at 32 weeks if they have had their vaccines and record this and it appears the majority of women do have them. (St4)*

### Key area – Infection/sepsis prevention

There was limited discussion in relation to prevention of maternal or neonatal sepsis, although it was identified briefly by two participants.



*In my current role I am involved in public health in the areas of (...) the signs & symptoms of Group A strep infection in pregnancy & the puerperium leading to sepsis. (MW9)*

*I feel infection and sepsis post delivery is discussed quite frequently. (St8)*

Similarly to the midwives/MSW discussion, there were limited comments on these topics with service users. Where these two service users do discuss infection, they seem to be mainly referring to themselves rather than their babies:

*Could have done with more info on immunisations – had to investigate myself (particularly whooping cough). I also felt unsure about best practice for looking after myself to avoid infection. (SU9)*

*Agree with S [another participant] re info on preventing infection – I had so much conflicting advice from different midwives and doctors which was quite scary at the time as it felt like I might be increasing my chances of infection whatever I did! (Had CS (caesarean section)). (SU4)*

## Key area – Sexual health

Apart from a mention of contraception and family planning, it was notable that there was very little mention of other sexual health advice or screening.

*Contraceptive choices to enable healthy family spacing, prevention of SIDS & the promotion of pelvic floor exercises postnatally are also within my role. (MW9)*

## Key area – General healthy lifestyle

It was mainly MSWs who described their involvement in general healthy lifestyle advice and support, which could be focused on the mother, her baby or on the wider family. As discussed earlier, this was often integrated with breastfeeding support.

*In my job role I am involved in promoting healthy lifestyle choices to women and their families. ...including things such as healthy eating, promoting changes to diet for the whole family that will promote a good healthy diet in the long term for everyone, smoking cessation, promoting things such as safer sleeping guidance. (MSW1)*

*I work in the community (...) I also discuss safe sleeping/co-sleeping, baby-care etc on visits, and often answer questions on diet, alcohol consumption, smoking and health benefits of baby weaning mainly postnatally. (MSW5)*

*In community, my time involves general postnatal wellbeing, and also safe sleeping, feeding support and healthy eating advice. (MSW13)*

## Key area – Intrapartum public health

Apart from a mention of contraception and family planning, it was notable that there was very little mention of other sexual health advice or screening.

*Contraceptive choices to enable healthy family spacing, prevention of SIDS & the promotion of pelvic floor exercises postnatally are also within my role. (MW9)*

## Breadth and complexity of the midwife's role: Implications:

As noted earlier, there were extensive comments about the 'enormous breadth of the midwife's role in public health' (LME6) and the implications of this for quality of care. These points are summarised here and discussed further in the 'Barriers' section of the findings.

*public health has a huge agenda and is obviously a really hot topic (hence this study I guess!). Midwives' roles in health promotion are ever increasing. (LME5)*

*Supporting what has already been said, the public health role that midwives undertake tends to depend on the health complexities of their clientele and thus is a dynamic concept and truly hard to define completely. (LME2)*

There were numerous comments regarding the lack of time to discuss public health issues effectively, and that this problem was exacerbated by an ever growing public health agenda, which further decreased the time available. The students demonstrated a very broad understanding of public health (presumably as the result of the emphasis within their undergraduate programmes), and were very aware of these challenges. They noted a disparity between theories of public health as taught in the classroom and what they observed in practice.

As a result of these time pressures, midwives described (or were observed to employ) a range of 'rationing' strategies such as:

- Giving generalised advice characterised as 'one size fits all' (student midwife), rather than bespoke advice focused on what individual women actually need. As a result, professional agendas can dominate and women's concerns and choices are not prioritised.

*Sometimes the high profile of so many public health agendas means that there is no time left to actually be with woman. I agree that women need information but I do worry that the information we are giving is biased towards the lowest common denominator rather than individualised risk assessment. In this case I am particularly thinking of the blanket advice not to sleep*

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*with one's baby – one piece of public health advice which mitigates directly against the pro breast feeding message. (MW12)*

- Using closed questions to manage consultations.
- Leaflets being used to supplement or in place of discussions. This led to women being 'bombarded' (MW2) with information, especially at booking and discharge. This was seen as inappropriate and ineffective.

*On discharge from hospital we bombard women with info and leaflets on:*

- Emotional health
- Pelvic floor exercises
- Postnatal physiotherapy and exercises
- Contraception and family planning
- Breastfeeding support
- Bottle feeding advice if that is their choice
- Who and when to call for help if needed
- Preventing perineal/wound infections
- Smoking cessation.

*I do find it difficult because we usually give this info out shortly before discharge when women and partners are more concerned with packing up and getting ready to go home. (MW2)*

*'We hit our ladies and partners with a wall of information.' (MW8)*

However, one of the Heads of midwifery (HoM) commented that although the role was broad, the various elements had now been accepted by midwives in his/her local area.

*Smoking, weight management, mental health, pre-conceptual health, CO (carbon monoxide) monitoring is undertaken where I am based the midwives although reluctant at first – time constraints etc. now see this as part of their normal and routine AN Care. (HoM2)*

## ii) Pertinence

The second question relating to scope of practice asked participants which aspects of the role they felt were most pertinent to midwives when providing care. Their responses have been divided into antenatal, intrapartum and postnatal priorities.

In the antenatal period, prioritised areas most pertinent to midwives were identified as smoking cessation, flu vaccines, whooping cough vaccine, mental health and domestic abuse.

Discussions particularly focused on the importance of mental health.

*Emotional health is also high on my priority list, there is so much media pressure surrounding early motherhood, and making women and families aware of the emotions around pregnancy birth and parenting is something I am passionate about, happy mums = happy babies and children in my book. (MW2)*

*I think mental health is a big one. The journey to becoming a parent is such an important one and being really well supported is vital for the family unit. Broaching this area needs time and sensitivity... (St9)*

As might be expected, consultant midwives and HoMs had a particular focus on identifying local priorities and planning for future public health programmes.

*Priorities are to get smokerlyzer things up and running, plan for next year's flu jabs and FGM. (Cons)*

*I would agree that smoking cessation is always high on the public health agenda. Other priorities for me locally are teenage pregnancies and perinatal mental health will be a focal point in 2015. (HoM5)*

*I am passionate about getting dads involved to get more home births and bf (breastfeeding) mums and reduced smoking rates and I also want to do some work with perpetrator programmes regarding D.A. (domestic abuse) as it can reduce severity/instances of D.A. which is good considering women are subjected to an average of 30 instances before leaving etc. (Cons)*

One midwifery educationalist took a slightly different stance to prioritisation, which described an individualised process that moved from the general to the particular needs of specific clients.

*The public health role that midwives undertake tends to depend on the health complexities of their clientele and thus is a dynamic concept and truly hard to define completely. I suppose if you consider the health issues that*



*are relevant to all childbearing women in the first instance such as: promoting breast feeding, advising on cervical cytology / breast screening, diet and exercise to reduce obesity and diabetes and perinatal mental health to then move onto more specific issues pertinent to the individual woman. These may include smoking, alcohol and substance misuse, homelessness, physical and mental abuse, including forced marriages etc. The role is endless. (LME2)*

As noted earlier, discussions of intrapartum public health issues were limited, but did include a focus by students on the importance of delayed cord clamping and skin to skin contact.

*Delayed cord clamping (3 mins) and immediate skin to skin are big where I work! (St1)*

*Delayed cord clamping and skin to skin are big at my trust too, including with caesarean sections, they try where possible to delay weighing and giving vitamin K and get baby to mum to have skin to skin as quickly as possible! (St3)*

In the postnatal period, the priorities for midwives were seen as breastfeeding (it was notable that there was little mention of safe bottle feeding), mental health and SIDS prevention.

*One thing that stands out for me is mental wellbeing, there's a lot of focus on postnatal depression, particularly in postnatal discharge chats where my mentors try where possible to include the husband/partner in the talk. If there is a husband/family member there the midwife will say that it's important to recognise if there is a change in the mother. They talk about baby blues and depression and about the importance of talking through how they are feeling with their partner or family. (St3)*

One midwife identified breastfeeding as a priority but also questioned the timing and approach taken to breastfeeding promotion.

*Infant feeding is the big one for me, but I think we leave it much too late, this should be addressed at a much younger age, normalising breastfeeding for the next generation. There is just too much fuss about breastfeeding, media articles and Facebook campaigns make breastfeeding seem 'special' when in actual fact it should just be a normal part of life, I think it should be the default not a positive choice. I have been into secondary schools to talk to 15/16 year olds about infant feeding and I was surprised about just how distorted their views were, for a lot of them artificial feeding was normal and desirable. By the end of the sessions they were much more breastfeeding orientated and understood the benefits, so it's not difficult to talk to youngsters about it. (MW2)*

As noted earlier, midwives also commented that contraception advice was something that they were obliged to provide, but this was seen as poorly delivered advice at the wrong time.

Identified as a 'less often discussed' topic by midwives, pelvic floor care from service user's point of view was apparent with one participant sharing her personal experience. She argued why midwives should consider pelvic floor care a key topic for discussion with all women.

*I don't think anyone emphasized the importance of pelvic floor exercises antenatally.....I strongly believe this is something midwives should talk to women about. Both the importance of them (the whys.....who wouldn't be motivated when given all the reasons why you should....!?!?) but also how to – how often – etc.....and what to expect after delivery and what exercises to do how often how soon.....I probably did a lot of damage through ignorance in my first 2 pregnancies....and it's only after problems developed and I saw a physio that I learnt how to care for myself properly. I so wish it was advice I had received during my first pregnancy.... Because it is not something that causes acute problems during pregnancy it perhaps is not considered important....but it can significantly make a difference to your quality of life – if not in the immediate antenatal or postnatal period for most of us who have children at some point in our lives. Protection and prevention of problems is so much better....I would like to see every woman given that opportunity!! (SU6)*

### iii) Potential for aspects of public health role to be undertaken by others

The third question in this section related to whether there were aspects of public health which midwives were currently involved in which could be delivered by others.

Midwife participants identified the General Practitioner (GP) and various specialist health centre based services (such as health visitors, social workers, school nurses, family planning / sexual health nurses) as the most suitable providers for:

- Flu/Whooping cough vaccination
- Smoking cessation
- Health Education
- Contraception
- Vitamins
- Pre-conception advice.

It was also thought that there could be more antenatal involvement by GPs in relation to weight management, smoking cessation, domestic abuse and exercise.





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*It makes so much sense to delegate public health initiatives like flu and whooping cough vaccination, smoking cessation. (MW6)*

*I think GP services could do a lot more – pre conceptual info packs for example could cover most of the general public health info. (MW12)*

*Why aren't the GPs more involved in weight management, smoking cessation/CO (carbon monoxide) monitoring, DV (domestic violence/abuse), exercise, etc during pregnancy? (MW7)*

It was interesting to note that midwives did not mention the role of MSWs in relation to public health. This was surprising given the extensive involvement reported by MSWs themselves. It may be that MSW involvement in public health has become an accepted part of everyday practice, but this anomaly would merit further exploration.

Although midwives identified other health professionals who could undertake some aspects of their current public health role, there was also discussion around the unique relationship and trust which can exist between the midwife and woman and how this can mean that the midwife is ideally placed for public health advice and support. This may indicate a paradox: midwives feel that the current expectations of their public health role are unrealistic and unsustainable, but there may also be a reluctance to let go of some elements. Midwives also commented on the potential disadvantage of being held in such esteem by women, whereby decision-making may be deferred to the midwife.

*That's a difficult one to answer. Most women trust midwives so are more likely to seek and listen to information provided by them. But then would that mean that they are less likely to make an informed choice. (St5)*

Where it was identified that other providers could be involved, it was also noted that there were a number of facilitators and barriers to this working effectively, for example, convenient location, resources, access to relevant healthcare professionals, funding and professional rivalry.

*Where midwives are situated in a health centre where there is easy access to other health and social care professionals, such as health visitors, social workers, school nurses, dental hygienists, family planning / sexual health nurses and other specialist services, there is much more scope to refer the childbearing woman directly to them. (LME2)*

*Flu and pertussis vaccinations while funding goes to GPs to undertake this, it isn't part of midwifery practice although if funding to support this was available again it could be seen as a vital element of AN care. (HoM2)*

*Conversely I think there are some aspects of public health that midwives should be involved in but aren't to the extent they should be, due to GP politics and funding issues. (HoM5)*

Broader public health education was recognised as important, but it was felt that this should be a life-long collaborative approach with GPs and schools, on which midwives could build specific maternity related issues.

*I feel contraceptive methods, breastfeeding and pre-conceptual health promotion such as vitamins etc should be done in high schools as part of citizenship lessons. (St4)*

*...it would also be useful if some of issues we broach with women around pregnancy (breastfeeding, pelvic floor health, implications of obesity, good sexual health,) were shared as part of a more general public health strategy rather than waiting for the time when women become pregnant to communicate these messages. (MW4)*

MSWs identified a number of public health areas in which some were currently engaged in supporting the midwife and where others would like to be involved. Some of these were practical activities: Breastfeeding support, parentcraft classes, newborn blood spot screening, referring when feeding issues arose, weighing infants. Others were related to education and advice giving: Infant feeding (breast and bottle feeding), baby care, maternal diet/physical activity, smoking cessation, alcohol consumption, SIDS and maternal mental health.

*I absolutely think MSWs 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. (MSW1)*

*I run antenatal and postnatal breastfeeding groups which encourages healthy eating, we discuss alcohol and also smoking choices during the antenatal and postnatal period. Safe sleep is discussed at my visits when I see people's sleeping arrangements for their newborn. (MSW19)*

*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. (MSW2)*

MSWs described feeling appreciated and valued by midwives, though it is not clear if this was specifically in relation to their public health role or their wider remit.

*I met one of our new midwives recently and she came from a trust that did not have MSWs and she thinks we are so important and loves the support we provide. I think this is fab and great to be appreciated. (MSW18)*

*Where I work the midwives are soooo grateful to the MSWs, we are greatly appreciated and often told that without us the ward would fall apart! (MSW16)*

## Theme 2: Training and support for public health role

In the second major theme, the findings related to training and support for the public health role of both midwives and MSWs is discussed. The findings are considered in four subthemes and discussions related to undergraduate education are integrated within each subtheme:

- i) The amount of training that maternity staff receive in relation to their public health role
- ii) The content of this training (types of issues covered)
- iii) The approach taken to the training
- iv) Communication skills training.

### i) Amount of public health training

There was considerable variation in the amount of public health related workplace training received by midwife and MSW participants. Some described their training experiences positively, particularly when specific time was allocated to public health issues within mandatory training. Others expressed dissatisfaction with the amount of public health focused training that was on offer. It was notable that there were pockets of good practice especially in relation to breastfeeding training (especially where there was BFI accreditation, or units were working towards this). The public health elements of the undergraduate curriculum were viewed positively by both student and LME participants.

There was an apparent difference between how the more senior midwife participants perceived training (i.e. good) and what was experienced on the ground (i.e. sometimes inadequate, especially for Bands 5 and 6 midwives and MSWs).

*Public health has time on the mandatory day 2 with updates on smoking, perinatal mental health, vulnerable women, FGM, sexual exploitation, screening, infectious diseases. (HoM2)*

However, as numbers of senior midwife participants were low, and experiences vary from Trust to Trust, this finding should be treated with caution.

### Positive comments

*We have various training and update days throughout the year. Plus continuously updated guidelines that are emailed to everyone – but it gets to the stage where it's hard to keep current sometimes. I think the areas where I would say I have had no training would be weight management / obesity and drug / alcohol. I have good access to regularly update patient leaflets too. Having read above it looks like I'm in the minority. (MW7)*

*We have a lot more than this: our mandatory training is more than five days. We all do a full day of safeguarding which includes sessions on FGM, HIV and mental health. We have specialist midwives for all of the above. All our staff have done the 15 hours bf (breastfeeding) training as we are BFI accredited. There is also a full day on domestic violence which is not mandatory but a lot of our staff do it. (Sr1)*

*We attend training on infant feeding support, have a vast array of public health leaflets many different in house training programmes and the opportunity to attend external training courses. (MSW1)*

*Our unit is going through the baby friendly initiative, and therefore i have received a lot of breast feeding training through workshops, study days and especially on the job training, as well as the mandatory annual update. (MSW16)*

*We have a lot of trust updates (general ones, i.e. manual handling, safeguarding etc) and training days with regards to breastfeeding we have a large booklet to complete and then 2 full days of learning/training (...) My trust is looking into funding a bereavement counselling course for me to do. My trust is pretty good at informing us of training programmes etc. (MSW14)*

Several MSWs noted that they received public health training as a component within generic mandatory update days.

*We have mandatory studies day on adult/infant resus, obstetric emergencies, health/safety, moving handling, cannulation, safeguarding, phlebotomy & big on Breast feeding as just in last couple of years gained baby friendly. (MSW4)*

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*We have mandatory training update days which does include breast feeding as we have the baby friendly initiative. However we do not really have specific training in relation to public health issues such as mental health issues, screening and vaccination and support with substance misuse for example. (MSW15)*

The amount of attention given to public health in the undergraduate curriculum was commented on favourably by both students and LMEs. Commonly, a broad approach to public health was described, followed by focused sessions on particular topics. Public health was commonly introduced in year one, usually within a specific module and then woven throughout the three year curriculum. Public health specific modules typically covered theories related to population health and health promotion, epidemiology, health inequalities, and social determinants of health. LMEs observed how the midwifery focus on public health has increased and how educationalists have responded to this when developing new curricula. Once again, having university BFI accreditation, or working towards this, increases the focus on breastfeeding and quality of breastfeeding input.

*Our latest curriculum (2013) was developed with a stronger than previously public health theme, and we begin the theme in the first year with health promotion and related theory. At the time we did have a concern that this would mean also introducing aspects of complexity at an early stage, but we are finding we are able to build on case studies and students seem to really get a sense of public health concepts embedded, though it is early days. (LME6)*

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 practise communication skills. These points are considered more fully in the 'content of training' and 'approach to training' sections.

## Negative comments

There were many comments which indicated that both midwives and MSWs thought the amount of public health training provided by their employers was inadequate. For these participants, there was limited or no time allocated to public health issues within mandatory training, and a lack of relevant leaflets available. While the time allocated for mandatory training was valued, concerns were voiced that any other public health training often needed to be undertaken in personal time.

These negative comments are particularly concerning given the expected scope of the midwife's role identified in the previous theme on the scope of midwives' public health role, as they raise questions about how possible it is for midwives to be well prepared for this aspect of their role.

*We receive very little support. Safe sleeping – no training and the literature is always running out – paying for it seems to be an issue. Vaccinations – no training no literature. Breastfeeding – training sporadic literature hard to come by. Smoking – good input from smoking cessation midwife. Diet and nutrition/obesity – scant training (grow charts) and no literature. Some midwives work in Target clinic for weight management in pregnancy but info not shared. Very little info/literature available for hand hygiene. One day of training for drink and alcohol use. (MW12)*

*Sober reading isn't it! Our specialist midwife roles have been eroded and currently we only receive "breastfeeding" training within our 3 annual mandatory study days. There may be an email circulated with info for public health issues eg co-sleeping, vaccination, obesity etc but so find reams and reams of updated Trust guidelines. (MW6)*

*PS we don't have a smoking cessation midwife & we have no training for vaccinations, drug & alcohol use, hand hygiene. (MW9)*

*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. (MW10)*

*It isn't too difficult to get staff released for Mandatory training this is 3 days out of practice and covers all obstetric emergency drills, resus. (resuscitation) adult and newborn! And risk etc... The only public health aspects are maternal mental health and bf (breastfeeding)! Nothing on smoking and brief interventions, and nothing on maternal obesity. I think these are vital and shouldn't be missed! (Sr6)*



*... very similar picture we have 3 days of mandatory training we are also made to follow a core programme laid down by our trust which has very little to do with the low risk birthing unit and a large community area which our trust serves. (Sr3)*

MSWs frequently commented on their frustration with their lack of training opportunities. The lack of training available to them contrasts with their enthusiasm for becoming more involved in public health, as described in the previous major theme. For example:

*I feel within my unit we do not have enough relevant training / a lot of the training sessions delivered are for midwives only and we aren't allowed to attend. (MSW3)*

*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. (MSW19)*

*We attend in house updates yearly for breastfeeding but that is about the extent of it. We don't have the opportunity to enhance our knowledge of public health, many of us cover topics of public health within our QCF course. (MSW8)*

*I attend yearly training days but focus tends to be on dealing with obstetric emergencies. We used to have mandatory BFI training but this has now stopped which is a shame and this is now a much shorter session during training days that is focused on benefits of breast feeding but no practical training. We also receive short info based session on smoking cessation. (MSW2)*

*We have no further training opportunities other than mandatory yearly trust training but this covers nothing regarding maternity apart from a few hours of breastfeeding update. (MSW17)*

The contribution of the service user focus group is less obvious within this theme, as it deals more with professional perceptions of the content, style and quality of training needed to fulfil the public health role. However, one comment was made specifically about midwifery training.

*those that I saw (in next pregnancy in a different Trust) were not as knowledgeable or confident and seemed less caring. To me it shows just how important it is to invest in midwives and their ongoing training – a great midwife gives great care and I am sure that impacts significantly too on not only Mum's perception of care given but how she is therefore able to care for herself and her baby... (SU6)*

## ii) Content of public health training

Qualified midwives identified that the key content of public health training focused on breastfeeding, smoking cessation and mental health.

There was limited mention of training related to the following:

- Safeguarding
- Issues related to vulnerable women (e.g. FGM, sexual exploitation, domestic abuse)
- Infectious diseases/infection prevention
- Drug/alcohol use
- Screening
- Safe sleeping
- Immunisation
- Diet/obesity

For MSWs, most public health training focused on breastfeeding only. MSWs commented on the lack of attention to other public health issues and how much they would appreciate more training in these areas.

In relation to the content of undergraduate training, a range of topics were identified. These generally moved from broad population-based issues to specific themes. For example, participants described initial general theoretical discussions about 'what is health', epidemiology, demographics, global health and the impact of gender and inequalities. This underpinned more focused sessions on specific areas of public health such as breastfeeding, smoking cessation, diet/obesity, body image, mental health, domestic abuse, drugs and alcohol, contraception, sexually transmitted infections, FGM and cervical screening.

*Yes we had a module covering health inequalities and how to tackle them. Topics ranged from sexism, the female role in society, social influences, barriers to health care ranging from post code lottery to language and transport, breastfeeding and media influences and theories from various models as well as epidemiology and historical events that have shaped healthcare, health opinions (even politics e.g. teenage pregnancy and efforts to reduce prevalence), smoking, healthy living, poverty etc. and their effects And the evolving role of the MW who is facing these challenges to improve the psychosocial wellbeing of the woman. It was very very interesting. (St5)*

*It's very early days in my course but I feel we've had an opportunity to think about how we might contribute to wellbeing for communities with a focus on communicating effectively. (St7)*

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*In year 1 our students currently have a module 'Health Promotion and the Midwife' which covers: what is health? Definitions of health and health promotion; approaches to health promotion; what is it? Health inequalities and epidemiology; vulnerable groups; substance misuse (alcohol, drugs): obesity: smoking and an overview of health promotion initiatives at national and local levels. Other modules cover screening. This foundation level education is scaffolded throughout years 2 and 3. (LME5)*

*Within the curriculum we have a whole module which has strong public health focus. That has session on principles, equity, diversity, inequalities, vulnerabilities, population demographics etc as well as specific topic. But actually topics come up throughout the curriculum – for example breast feeding which I would consider major public health issue is across several modules, and in all 3 years for pre reg programme. The other topics mentioned already are also covered. (LME4)*

### iii) Approach to public health training

Qualified midwives and MSWs described a range of approaches to public health training. As noted earlier, training was often provided via lecture based updates within work time, often as part of mandatory training. However, it was also evident that some participants were expected to undertake updates in their own time.

*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. (MW10)*

Both midwives and MSWs described how circulated leaflets and guidelines were used for training purposes, but some questioned the effectiveness of this approach for learning.

*There may be an email circulated with info for public health issues e.g. co-sleeping, vaccination, obesity etc but so find reams and reams of updated trust guidelines. (MW6)*

*We have various training and update days throughout the year. Plus continuously updated guidelines that are emailed to everyone – but it gets to the stage where it's hard to keep current sometimes. (MW7)*

Online training was also provided in some Trusts, but this could also present difficulties for some staff in terms of access and time. It was not clear from the data whether midwives valued online training, and this is an area worth exploring further:

*We have online programmes to complete as well which can prove quite difficult to do as we never get the time during work to do them. (MSW14)*

*We have online programmes too, for safeguarding etc but getting the time and access to a pc is always difficult. (MSW5)*

Several participants commented that when training was provided, it often took a standardised approach that failed to take into account local needs.

*We are also made to follow a core programme laid down by our trust which has very little to do with the low risk birthing unit and a large community area which our trust serves. (Sr3)*

Where locally relevant training was provided, for example by specialist midwives, it was valued.

*We have a full infant feeding study day which is mandatory and about every 2-3 years (I've forgotten as I've only done it once). It's brilliant though. Goes into loads of detail. Plus our infant feeding specialist midwife is great at updating us on changes (she comes to other study days and emails). (MW1)*

MSWs also commented that the training they attended was often generic for all health care support workers, and lacked relevance for maternity work. MSWs described informal, on the job training.

*I agree with much of what has been said above particularly about the lack of role specific training (we are expected to complete a HCA development programme – modules include: caring for the dying and understanding dementia). We have mandatory training update days which does include breast feeding as we have the baby friendly initiative. However we do not really have specific training in relation to public health issues such as mental health issues, screening and vaccination and support with substance misuse for example. (MSW15)*

*Delivering antenatal group information on the unit was pretty much being told what they wanted to be delivered and watching a senior midwife deliver it, then doing it myself. I gained much more knowledge and confidence delivering it from undertaking my foundation degree. (MSW3)*

As alluded to in the previous quote, some MSWs were undertaking other training such as a Foundation degree. This was commented on positively.

*I am currently studying the foundation degree which is giving me a much better insight into public health issues and more support regarding breastfeeding. (MSW11)*

*many of us cover topics of public health within our QCF course. But we don't ever hear of external courses. (MSW8)*



*I've been doing the level 3 maternity and paediatric support worker diploma which covers a load of topics plus the annual mandatory training and we also have access to training online. We also get leaflets to hand out to parents. I think what is missing is a mentor for MSW to get support. (MSW10)*

Most notably, many MSWs described undertaking personal study in their own time.

*I gain further Bf training from breastfeeding conferences etc I do as part of my own breastfeeding counsellor training. (MSW17)*

*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. (MSW1)*

*I do feel though, that it is up to the individual msw to create their own learning and it is very hard to move yourself forward, there is always a huge brick wall in the way! (MSW16)*

Within the undergraduate programmes, a range of approaches to public health education were noted: lecture-based input from academics, sessions from specialist midwives, directed student-centred study, online study and interactive sessions.

*Over the whole course we cover all areas of public health including global, in class and online and directed study work (...) For key areas of public health we have specialist midwives from practice join us in class sessions eg breastfeeding, perinatal mental health, domestic abuse, drugs and alcohol, antenatal and neonatal screening, fgm, parent education (LME6) we too invite specialists in the various fields and service users to contribute to the theoretical components: FGM, smoking cessation, substance abuse [misuse], perinatal mental health etc. (LME2)*

In addition, both students and LMEs commented on the students' everyday exposure to public health issues when on clinical placements.

*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. (LME6)*

*I have noted midwives offer guidance support, advice and linking to services for: infant care, antenatal class, social support/inclusion, domestic abuse, financial support, healthy eating, screening tests, bereavement, coping alcohol limitation, emotional support, smoking cessation, diabetic care, immigration support including asylum*

*seekers, overcoming with barriers to access care e.g language, explaining medical jargon in simple English, coping with drug abuse or management of it. (St5)*

Experiential learning was particularly valued by students.

*In first year we had to individually research and make a health promotions tool to use in community and present it to the class, it was assessed. I did a fridge magnet to remind women to take their vitamins and spoke about the importance of vitamin D. Watching other presentations meant we covered a number of issues. We've had lectures on weight management and how it relates to body image. Which I found really interesting because it wasn't as straight forward as just talking about obesity. It opened debate. (St4)*

*We've just had a whole module on it ending with an assessment of presenting an artefact that we have designed to promote health including its utilisation by the midwife, discussing how to approach the conversation regarding your subject and promoting health not just of the pregnant woman but of her family. (St6)*

#### iv) Communication skills support

Midwives and MSWs rarely identified or mentioned receiving any training to enhance their communication skills for discussing public health issues with women's discussed in the 'approach to training' section, the type of training received was usually focused on the content of public health messages rather than how best to engage with women about these messages. It was also usually expert-led rather than experiential.

*We used to have mandatory BFI training but this has now stopped which is a shame and this is now a much shorter session during training days that is focused on benefits of breast feeding but no practical training. We also receive short info based session on smoking cessation. I know there are packs aimed at helping women who smoke but they are not available on the ward. I feel my knowledge in promoting public health issues with postnatal women could be improved and would welcome suggestions if anyone knows of any e learning I could access. (MSW2)*

In contrast, there was evidence that communication skills sessions were included in undergraduate curricula and were thought by both LMEs and students to be valuable. These included a variety of learning triggers and resources including women's stories (live or podcasts), skills based workshops, involvement of specialist midwives. There was an emphasis on experiential learning embracing rehearsing skills via role play and critical reflection on the skills of self and others. One LME specifically mentioned the possibility of introducing motivational interviewing into the curriculum.

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To help students discuss sensitive topics with women, from BF, to domestic violence [abuse] or carbon monoxide screening they have theory sessions, online resources which where possible include podcasts or women's cases/stories and skills based workshops, often the opportunity to practice on each other, attend workshop with their mentors in practice and of course observe and participate in practice. We are working interprofessionally across the Faculty so get experts in where appropriate, or clinical experts, and we are currently looking at including introduction to motivational interviewing for students as well to help with supporting the public health agenda. (LME4)

Specialist midwives frequently co-facilitate sessions with service users/ ex users and of course students greatly value this. Hearing women's stories seems valuable and the students' first assessment helps them get to grips with the challenges of health promotion by designing methods to address diverse needs and sharing these. Reflection is a key component of our curriculum and students can use this to explore their own skills in health promotion interactions as well as their observations of midwives doing these, around for example smoking cessation, obesity, drug use etc. in class as well as online discussion/storyboards podcasts or other methods to present their ideas and use online resources where available to support class teaching. (LME6)

In relation to the next question (communication skills support), this is more difficult in a classroom setting – we invite service users to come to speak to our students and the podcasts of service users telling their story are very useful triggers for discussion. In the clinical area it is the mentors who facilitate this type of learning and interaction. We also signpost students to the huge variety of online resources aimed at both the general public and healthcare professionals. (LME5)

Most students also commented positively on the opportunities they had been given to develop their communication skills, although one observed the lack of training.

*We have done a lot on breastfeeding and theory relating to this but no training in helping us to communicate about this or other public health issues. (St9)*

However, most students provided examples of experiential learning which they found beneficial.

*It's very early days in my course but I feel we've had an opportunity to think about how we might contribute to wellbeing for communities with a focus on communicating effectively. (St7)*

*I've found role playing sessions where we've thought about how we might approach traditionally difficult topics particularly useful. The gap between what you think you'll be able to introduce and the reality of doing it, in an appropriate and confident manner, was a huge learning experience. I was glad to have the opportunity to explore my own feelings and how that will impact on my ability to support women with issues such as domestic violence [abuse] and obesity. (St7)*

*We've just had a whole module on it ending with an assessment of presenting an artefact that we have designed to promote health including its utilisation by the midwife, discussing how to approach the conversation regarding your subject and promoting health not just of the pregnant woman but of her family. (St6)*

From the service user's perspective, most of the comments under this theme deal more with the subtheme of 'communication'. Many of these comments are interwoven with comments about time pressures which will be dealt with under the next major theme. However there are a small number of comments dealing with communication issues independently from time pressure. The first is a clear example of the importance of sensitive communication for sensitive issues.

*I was quite shocked when I had a different midwife one week and she suddenly said 'does your partner hit you?' I had to ask her to repeat it as it came so out of the blue, very bizarre I laughed as I was so taken aback! For the record he doesn't and it goes without saying there may be better ways of broaching the subject! (SU7)*

The importance of active listening and empathy were specifically mentioned by two participants.

*Forgot to mention my best midwife! She was ace. Because she was a great listener. The best healthcare professional ever was a nurse who did my bloods (saw her every 4 weeks) – she was chatty and had kids with same age gap. Sometimes you just need to hear "I know it's tough. (SU5)*

*Think it varied very much from midwife to midwife – the worst never even looked at me when filling in the booking forms, the best really seemed to understand where I was at & were very reassuring. After having C, we had to stay under the community midwives for the full month for prolonged jaundice and they either visited or called every other day for what felt like ages! They were generally really warm and reassuring about it all and very encouraging. However during my first pregnancy, the community midwife rarely talked to me & didn't really seem to care at all. (SU1)*



Interestingly, this participant makes a clear case for continuity of care in terms of how it facilitates better communication as part of reducing the negative impact of time constraints.

*For my first 2 pregnancies in Southampton I saw the same midwife for all my antenatal appointments and really valued that. She managed to build a good positive relationship even in the short appointment times we had – she both listened and answered questions and felt like she really prepared me for my labour and early days and gave good health promotion advice – I really missed that in my third and fourth pregnancies.... (SU6)*

This finding reinforces the need for midwives training to strongly include the 'how' of communication, rather than simply the 'what' of the message.

### Theme 3: Barriers and facilitators

This major theme involved the barriers and facilitators identified by participants that they felt impacted upon their ability to fulfil their public health role. There were a large number of barriers/facilitators identified by participants which are listed in Table 11. These factors have been grouped into five subthemes as follows:

- i) Time and resources
- ii) Relationships with women
- iii) Language and culture
- iv) Midwives' approach
- v) Educational barriers & facilitators.

The service users' focus group also identified similar subthemes, strongly identifying with three namely, time and resources, relationships with women, and midwives' approach.

#### i) Time and resources

There appeared to be general consensus regarding known barriers, such as time and resources. All groups clearly identified that lack of time was recognised as a barrier, with increasing administrative burden, heavy work load and reduced staffing levels all of which contributed to diminished time spent with women and their families.

*I find that the vast amount of documentation that needs to be filled in is a massive barrier in giving appropriate support to women and their families. (St2)*

*Time could also be a barrier and the demands of other aspects of the midwife's role taking precedent, such as delivery and type/venue of care (intrapartum), record keeping, supervision of midwives etc. (LME2)*

*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. (MW3)*

*There are not enough of us within the community to ensure everyone receives the support / information that they need or would be useful. Time is also sometimes short too. (MSW3)*

*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. (MW6)*

Some noted that the timing of public health information being relayed could be a barrier and reduce the efficacy of the message.

*I do find it difficult because we usually give this info out shortly before discharge when women and partners are more concerned with packing up and getting ready to go home. (MW2)*

Several participants noted that the location of services could facilitate the delivery of public health messages and services.

*We used to have MSW's in local Children's Centres but this no longer happens. I think the closure of Children's Centres is going to reduce the number of new Mums receiving public health information. (MSW2)*

*Where midwives are situated in a health centre where there is easy access to other health and social care professionals, such as health visitors, social workers, school nurses, dental hygienists, family planning / sexual health nurses and other specialist services there is much more scope to refer the childbearing woman directly to them. This would then enable the midwife to focus on the specific care associated with the fundamental midwifery role to maximise outcome for both the woman and her baby. (LME2)*

### Increasing public health role

Participants also highlighted that the increasing public health remit meant that midwives were often required to cover a vast amount of information in their limited time with women, leaving them feeling that they were subjecting them to 'information overload', and that this may impact on how much is actually taken in and understood.

*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? (MW12)*



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Table 11. Identified barriers and facilitators

Subtheme	Barriers/facilitators
Time and Resources	Time Workload Staffing Resources Administration/paperwork Increased PH remit Competing demands Timing PH messages are delivered Interprofessional teamworking Information overload
Relationships with women	Public health not prioritised by management Relationships with women Continuity of care PH agenda driven by policy not needs of women
Language and culture	Language Culture Women's receptiveness
Midwives approach	Enthusiasm Dedication Motivation
Educational barriers and facilitators	Training Education Communication skills

*Yes it's a huge amount of information & they glaze over I find. (MW9)*

*From feedback from students and mentors I would suggest major issue is time- imposed 20 min consultations, with AN schedules to follow, with considerable amounts of topics to cover restricts opportunities to cover anything in depth. (LME4)*

Some participants described how the amount of information women receive from their midwife could serve to undermine the unique and trusting relationship.

*Whilst I am not averse to giving a public health message my time is being eroded further and further with fewer available contacts with pregnant women. These days I don't even have the time at a booking visit to ask how a woman actually feels about being pregnant for all the screening nutrition and smoking info etc. I have to impart. Once upon a time midwives were seen as women's allies and friends. These days we are yet another health professional bombarding them with judgements on their behaviours. (MW12)*

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

Not only did the burden of public health information impact upon the relationship with women, but it was also seen to affect midwives' motivation:

*All of the above are barriers in my experience too, and these factors contribute to a conspicuous lack of morale & motivation to deliver these ever-increasing public health messages. (MW5)*

### Competing demands

It was recognised that these pressures on the service, led to midwives having to manage competing demands and sometimes the public health agenda would be the area that was seen as being most suitable for curtailing or leaving till the next appointment.

*Time constraints for midwives to be able to 'fit' everything they need to do in appointments. sometimes the more difficult conversations about weight/diet and smoking are left behind, midwives have to be committed to the public health agenda and sometimes this gets lost. (HoM2)*

The frustration expressed by midwives is strongly echoed by service users as they describe their experiences of care. Comments show recognition of the time pressures midwives are under, but some participants make the point that where a midwife is empathetic and warm, the time pressure is felt less acutely by the woman.

*In my midwife appointments, I always felt like they were a bit pushed for time, and I saw a student a couple of times, who couldn't answer any of my questions! (SU3)*

*I was aware throughout the pregnancy at how stretched the midwives were both in the community and in the hospital (postnatal). (SU11)*

*The community midwives were always running late in appointments and then in such a rush to get you out and the next person in so I had to get my info from other sources. (SU11)*



*In general, the community midwife I saw for my checkups was pretty to the point and I felt I could only really squeeze one question in to each appointment so I always asked the most urgent one and hoped I was doing ok with the rest. (SU2)*

*I had an amazing midwife in pregnancy she was very supportive and I felt she always had time for me even though it was obvious she was over worked. (SU7)*

*She managed to build a good positive relationship even in the short appointment times we had – she both listened and answered questions and felt like she really prepared me for my labour and early days and gave good health promotion advice. (SU6)*

There was a lot of discussion about the use of leaflets as a substitute or reinforcement for a public health message. The response about the use of leaflets was unanimously negative, with women feeling, like MW2, that they were bombarded with leaflets. This is an interesting finding considering the higher than average level of literacy of the group, which may have indicated that written materials may have been desirable. This simply was not the case.

*Not sure I read any of my leaflet mountain – just sifted through for the freebies!! (SU1)*

*So many leaflets!!!!!! When exactly do they expect you to read them? I'm quite bolshie. So I would ask if I had any question but without this personality trait I'm not sure how much would have been discussed. Just basics covered and leaflets. (SU5)*

*I remember right at the start of pregnancy, first meeting the midwife came to my flat and she was there for nearly 3 hours. A lot of questions/form filling. She verbally gave me a lot of information regarding screening and immunisations. She left me with a huge amount of leaflets and booklets which I did briefly look through. (SU11)*

*Keeping baby safe & pelvic floor exercises were not discussed, just leaflets given and the last thing I wanted to do when I got home was read through leaflets! I also felt unsure about best practice for looking after myself to avoid infection. (SU9)*

*Too many leaflets. I much preferred finding stuff out myself through the NHS website, watching all the videos and I joined a couple of UK forums with mums due within the same month of me so gained lots of support and knowledge from that too. (SU11)*

The use of the internet was commonly reported as a way of finding out information, but its unregulated nature was a source of stress. The only reference to being directed to a website is by a breastfeeding support worker; it seems evident that midwives should be familiar with sites such as Start4life and others to recommend to parents.

*There was one website I was told about where I could watch a video about breastfeeding and the benefits of it. But that was by the breast feeding peer support worker at the antenatal class. (SU11)*

*I had a tendency to just Google issues which would leave me convinced both the baby & I were going to die very soon! Had to decide to stop Googling as a lot of the forums are just people who had the worst things happen sharing their stories & a lot of people freely sharing advice & opinion without much input themselves beyond personal experience! Would be great to have forums monitored by midwives. (SU1)*

*Never had a website suggested. I also had to ban late night Googling. I found my best source of info was a baby book I was given. (SU5)*

## ii) Relationships with women

Several of the participants recognised the importance of forming a good relationship with women in order to deliver messages. Many identified that this relationship and the fact that pregnancy provided an ideal opportunity for health promotion meant that in theory midwives were best placed to impart messages that promote the long-term health of mothers and their families.

*midwives are expected to provide so much information to women because 'women are receptive to public health messages around the time of pregnancy' and yet the time available to do this within the NHS is becoming more and more squeezed. (MW4)*

*I personally do feel we hold a responsibility in all the areas of public health promotion we currently engage in, due to that unique position we are in; but that limitations on our ability to perform our role in this respect (time, resources, etc) make a bit of a mockery of the process. (MW5)*

However, it was noted that women's receptiveness to receiving advice, support and information from their midwife was important and in some instances, could prove to be a barrier.

*I agree time, reduced support, and willingness/receptiveness of the woman etc. are definitely barriers. (St5)*

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## Continuity of care

Continuity of care by community midwives was highlighted as ideal in order for the consistent and gradual delivery of public health messages over time.

*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. (MW5)*

*I agree with MW5, restoration of continuity in the ante-natal period, at least, is fundamental to achieving a valid relationship with vulnerable women. (MW6)*

Continuity of care is widely acknowledged as important in midwifery care, but it was noted that the MSWs recognised the importance of this in their role too.

*Agree with everyone above, as well as not having the opportunity to offer continuity of care. (MSW5)*

*Not being able to do consecutive visits on feeding or if parents just need help with confidence building looking after newborns i.e. bathing/feeding/sleeping etc. (MSW20)*

One MSW described how the rapport that she built with women was important in conveying health messages, especially to vulnerable women, she described how this was disrupted when she was moved to cover other areas.

*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 and I only had the one shift with them and they were both upset when I wasn't with them on the ward but had been put on another ward for each of my subsequent shifts. (MSW14)*

Again, the frustration of the midwives and MSWs regarding the lack of opportunity for continuity of care resounds within the service user group. The comments made by midwives about how information can be 'drip fed' throughout the pregnancy if a woman has the same midwife, and how continuity of care is 'fundamental to achieving a valid relationship with vulnerable women' are sentiments found within the service users' comments.

*I like being remembered. I know they see a lot of pregnant women all day, every day, but it's nice when you're not retelling your story to the same person every couple of weeks! (SU1)*

*There were supposedly 2 midwives based at my GP surgery and I wouldn't have minded if it was that I saw them both intermittently throughout the pregnancy but it was never*

*that straight forward. I think consistency is so important for building relationship and trust so that they know you and your 'story'. I had an emergency CS and then had complications with feeding my daughter. I was really disappointed that I saw completely different midwives for the couple of weeks once I was back home. I had someone visiting regularly yet it was almost a different midwife every time so I'd have to explain the same thing time and time again and they always had different opinions and advice (which were sometimes conflicting) and it was really hard to deal with particularly during baby blues!! (SU11)*

*1st time I had two midwives who job shared, so I saw one or other, sometimes both. 2nd time it was just one of them. I really liked seeing the same one(s) all the time. (SU3)*

*The rest of the pregnancy I very rarely saw the same midwife, it tended to be a different midwife every appointment – they were always running about an hour late and at that time in Rotherham were being swapped on to a new computer system so there were huge delays. Because of that, I never really got the time to discuss or ask questions. (SU11)*

Under the theme of relationship with women was the feeling that participants expressed that some midwives saw the episode of care as a tick list. Their views on this vary from it being an acceptable way of issues not being missed, to an impersonal or even dishonest approach to care.

*In my booking appt second time around I didn't think to mention that I'd had a 3rd degree tear first time, and my midwife asked if I had a normal delivery but didn't specifically ask about anything like that. A hospital midwife flagged it up at my 12 week scan... it made me realise how easily things can be missed if it relies on the woman remembering to mention things!! (SU3)*

*One of the community midwives after birth was lovely, but the one who discharged me barely spoke to me. I watched her tick boxes that said 'mental health discussed' etc. Looking back I should have said something. (SU4)*

*My second and third pregnancies were in London and I had a 'joint booking in' at the hospital which was dreadful, you filled in most of the notes yourself and just saw a midwife to have bloods taken very quickly and impatiently. My fourth one was in Derbyshire and saw a community midwife for booking in who gave me an hour one to one appointment and whose team also came to my house postnatally. I know the NHS has a very tight budget but being given time and one to one care was better than any leaflet or series of tick boxes. (SU10)*



*I was really surprised after I was discharged home from hospital after giving birth to find a checklist of topics discussed in my notes...all ticked and signed by the midwife – many of which hadn't even been mentioned let alone discussed. They included things like checking good latching on to breast and how to express, and safe sleeping.... (I can't remember all the topics now) – but no-one came to watch me feed or even asked how it was going. The other topics hadn't even been mentioned. At best it would seem that the midwife had seen it was my 4th child and presumed I would have previously been given advice, at worst it is a complete falsification of records....and certainly not good care or practice. My notes weren't about the care I had been given but a ticklist to (supposedly) show the midwife had done her job. I think it should be the woman who signs to say what has been discussed – it would also ensure there was opportunity to ask any questions she may have rather than presuming that advice has been given therefore adequate care given. (SU6)*

## Parent/women led agenda

There was some discussion regarding the public health agenda being seen as driven by a 'one size fits all' approach rather than a more woman-centred tailored approach. The agenda appeared to be driven by the policies and protocols rather than the individual needs of the women.

*The health promotion and public health spectrum is rather broad. Time constraints mean many healthcare professionals (HCP) must pick and choose what they can cover during appointments; usually a one size fits all approach. ...Then there are times when fear of litigation seems a barrier as does guidelines and the do's and don'ts, I mean there are times when a MW'S hands are tied by policies and protocols etc. So she can't tailor health promotion to the individual. (St5)*

*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. (MW8)*

*Many of these agendas do not sit comfortably with me as I consider myself first and foremost to be an advocate for women's choices and indeed their ability to make those decisions for themselves based on their cultural and societal norms as well as specific evidence. (MW12)*

The group of women in the focus group was fairly homogenous in not falling into some of the usual categories of vulnerability (although one participant speaks frankly about her mental health.) In addition, most of the participants had more than one child. There are quite a number of comments about how they felt that they were seen by their midwives as not needing advice or support due to this perception of normality and experience. Significant here is also the closed nature of the midwives' questioning.

*I did get told by one midwife that I must be fine (socially) as spoke English, had a job, was married & had a house...think round here that may be not the norm. (SU1)*

*...similarly to H, I think they took a look at my history and home situation and figured I was pretty low risk to come to any harm... (SU2)*

*At booking in I did get asked "you aren't suffering from domestic abuse, are you?" Found that a bit shocking! (SU4)*

*Similar to L, I got a lot of questions where they assumed everything was ok, but had to ask, e.g. 'You don't smoke, do you?', 'you're not scared at home, are you?' etc. (SU3)*

*I think everything was very different with second child. I don't think my midwife gave me much information at all, probably assuming that I knew from first time round. (SU3)*

## iii) Language and cultural barriers

Both language and culture were described as potential barriers for maternity staff in delivering their public health role. Language barriers prevented the effective communication of public health messages. The use of interpretation services was seen as beneficial, though it was apparent that much of the more subtle communication could be lost.

*I have also observed language barriers as being a huge barrier which is overcome using interpreters, (both link workers and over phone) however sometimes the telephone service is rubbish and link workers are not always available, at times like those I have observed exceptional communication by way the MW using every means of communication available to her...verbal, body, tone, Sometimes the interpreter service feels more of a barrier as some mw forget to look at woman and they pick up on this. (St5)*

*We have quite a large client group for whom English is not their first language. Public Health education to this group is very challenging. (MSW2)*

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*Additionally many of the women we care for don't speak any English, and while there is information about some subjects in some languages there is often nothing to give. There is only so far hand gestures can take you, and we are discouraged from using language line for things that aren't urgent due to cost implications. (MW3)*

Some identified the lengths they go to try and convey information to women and their families and demonstrates the challenges faced with this group.

*We do try and perhaps use an online translator to write things in the women's first language and have even gone as far as finding simple drawings to link together to give an explanation all very time consuming. We do all go the 'extra mile' to help our women and their families understand what we are saying to them! (MSW14)*

*last time we counted we had 25 different languages it's a fantastic team to work with we are known in the community and we're beginning to see changes. (MSW12)*

Alongside the language issues, cultural barriers were discussed amongst the groups. One student midwife highlighted the negative effect that popular culture and the media has in trying to convey public health messages such as health behaviours and mental health.

*I find the media a large barrier for midwives. The portrayal of pregnancy and childbirth is so different on tv, in magazines or in celebrity culture that it can be hard to discuss the realities sometimes with regards to subjects such as diet and mental health. (ST6)*

The culture of women from lower socioeconomic groups were identified as especially challenging by the midwives and health behaviours seemed to be the biggest concern in this group.

*After pondering this question in relation to my case load my biggest challenge is close strong maternal influences. 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. (MW8)*

*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.' (MW9)*

At the other end of the spectrum, one midwife found it most difficult to convey public health messages to those women with 'alternative' views of healthcare.

*I hold a caseload of very 'alternative' women, who have traditionally shunned all sorts of public health recommendations, vaccines being one of them. They are extremely sceptical, many don't have scans or blood tests. they are all very intelligent and refuse to conform to the dictates of what they see as an overbearing patriarchal society. Makes my job interesting!! (MW6)*

#### iv) Midwives' approach to public health

It was recognised by many participants that the midwives approach, determination and commitment to provide non-biased, consistent information acted as a facilitator to the delivery of public health messages.

*Facilitating factors are if the woman is receptive and open to the message and the midwife's skill in imparting it. (St9)*

*I think the important issue of delivering information is to deliver it in a non biased way, giving them informed choice & reiterate it as the pregnancy progressed reminding them of important issues ie: vaccinations. (MW10)*

*On the flip side, despite this the staff I work with will try very hard to let the lack of time and resources have as much of an impact as they could, and are definitely our greatest asset. Their passion facilitates our public health provision more than anything else. (MW3)*

*Dedicated passionate midwives who are determined, against all the barriers, to provide the next generation with the best care that they can give including imparting as much public health information possible. (MW6)*

#### v) Educational facilitators and barriers

Lack of appropriate training was identified by many of the groups as being a potential barrier, although breastfeeding training was seen as a priority for maternity staff especially those organisations working towards BFI accreditation. Priorities for training received were usually driven by the mandatory requirements of the institution and therefore wider public health issues were not prioritised. Lack of time was recognised as a barrier to receiving adequate and public health focused training.

*Staffing levels are so bad that even ante-natal clinics are being cancelled, so no, no training is being received for public health issues. (MW6)*



*I did my dissertation on the role of the midwife in public health prior to the NHS and this gave me time to reflect on how this part of the role fits in my current trust. The conclusion I came to is that public health is not given a high enough priority by the trust nor is its value appreciated. As a result very little time is allocated to public health related training and financial resources to support public health strategies are limited. From a personal perspective I find this frustrating. (MW4)*

*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. (MW10)*

One LME pointed out that where midwives had received training in public health areas, they found it difficult to develop and embed their learning into practice, due to time constraints and so it would seem that any benefit that training might have provided could be lost without further support.

*Midwives are likely to have attended workshops/updates on many public health areas, although many say they have not enough information, or time to consolidate that learning. Also of concern is they are not using the information they are likely to forget it. So time and education are key barriers I see, which are interdependent factors. (LME4)*

As described in the previous theme on training and support for public health role, the MSWs referred to the frustration they felt at the training they had received which tended to be focussed on the requirements of generic health care support worker as opposed to the specific training needs of those working in maternity.

*Maternity is very specific, and HCA's (health care assistants) of all grades should be seen as specialist. Training that is generic usually focuses on sick patients, not healthy women, and therefore is mainly irrelevant to our roles. (MSW13)*

*More training aimed at our roles instead of training devised for HCA's as a whole our role is completely different in many ways. (MSW17)*

In general the students felt that they had received a wide and varied training regarding the public health role of midwives, and this, they felt facilitated them in delivering these aspects of care. Of note was that some students had been facilitated in the communication of public health messages through role play, providing them with the opportunity to practice and develop their communication skills with potentially difficult messages.

Lack of women's previous public health education was recognised as contributing to the difficulties in communicating messages. Participants described their frustration that the burden for imparting public health information was confined to the brief interaction with maternity services for childbearing women, when many of the topics could have been first addressed prior to pregnancy.

*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! (MW2)*

*I feel contraceptive methods, breastfeeding and pre-conceptual health promotion such as vitamins etc should be done in high schools as part of citizenship lessons. (St4)*

*However I do also feel that there should be far more information and opportunities for children and young people to learn about public health issues in school. (MSW15)*

The service users group also discussed the value of one to one opportunities as well as antenatal classes. It is notable that, having said that they valued the time for one-to-one opportunities, several participants also commented on the usefulness of antenatal classes to have discussions in a group setting:

*First time round, most of the things you have listed were covered in the free antenatal classes I went to at the hospital, although it was mostly focused on what to expect in labour and breastfeeding. I felt prepared for labour and felt certain I wanted to breastfeed, but not really prepared for what to expect afterwards. (SU3)*

*I think the classes at the hospital were best for asking questions and getting information as there was much more time for discussion. (SU7)*

*I went to 2 antenatal classes at the hospital about a month before my due date. 1 was on breast feeding and the other was on labour. Both were really helpful and I was told about skin to skin for the first time. (SU11)*



## Theme 4: Specific client groups

Study participants were requested to consider if there were particular groups who presented a challenge in the fulfilment of their public health role.

Participants engaged in clinical practice (i.e. Band 5 and 6 midwives, senior midwives and MSW's) identified various demographic and life style factors which they considered to increase women's vulnerability to adverse health. Recognised risk factors for adverse maternal and perinatal health included limited English, drug or alcohol dependency, younger maternal age or living with complex social situations such as homelessness or domestic abuse. It was appreciated that the very factors that placed women most at risk of increased maternal and perinatal morbidity, frequently also limited the opportunity for staff to engage women in public health messages. Five subthemes were identified:

- i) Mothers with a limited understanding of the English language
- ii) Attitudes to public health information
- iii) Teenage mothers
- iv) Mothers with high academic achievement
- v) Meeting individual client needs.

### i) Mothers with a limited understanding of the English language

The most common factor identified as limiting women's receptiveness to information relating to public health messages was the inability to understand or read English. One community based MSW observed that at a recent count over 25 different languages were used by women within their community area (MSW12). Although the use of either professional or family interpreters was mentioned as a way of overcoming difficulties in sharing public health information with women with little or no English, this was not viewed as not always possible or acceptable to women.

*We have the same with the language barriers, it can be very difficult as you can't always be sure they fully understand, and if we ask their partners, we aren't always sure everything is fully understood, some [women] prefer not to have an interpreter. (MSW7)*

Whilst the challenges of caring for women with limited English were appreciated, system weaknesses were viewed as further contributing to potential difficulties. In particular the provision of public health literature and materials in languages other than English was considered, on occasions to be lacking.

*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. (MSW1)*

### ii) Attitudes to public health information

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

*I think also some groups ignore public health advice because they don't believe it is important or even actually true, eg 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.' (MW9)*

Women living with, or close to, influential relatives were also reported to be, on occasions, less receptive to public health advice. Relatives, particularly grandparents, were viewed as having a particular influence on younger, less educated women and in such circumstances the midwife was required to engage, and educate, the wider family unit in public health issues.

*Lower social economic groups will do the same as before or as friends say they have done, they don't tend to bed share, but will probably prepare bottles in advance, feed hungrier baby milk, want the baby to sleep through the night, you can sometimes see the eyes rolling or they don't even pretend to be listening when you are trying to give advice at discharge or any point in the PN period. (MW14)*

### iii) Teenage mothers

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.

*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 its not always possible. (MSW18)*

### iv) Mothers with higher academic achievement

It was appreciated that mothers are highly individual and although mothers with higher academic achievements may have the ability to source additional information and may have extensive knowledge of public health issues, this can in itself result in pressure and anxiety to parent 'correctly' This then requires the midwife or MSW to provide additional personalised support.



*I work in a large unit which sees very academic people pass through it. They can prove to be a challenge as they expect to be 'spoon fed' information and advice and want one to one care. They are very often nice people but they have extremely high expectations which far exceed the NHS's remit. (MSW16)*

*I agree with above, different groups present differing problems, women who have high expectations of their care and how they will be a mum, you can see the PN depression building immediately. (MW14)*

### v) Meeting individual client needs

Particular demographic and socio-economic factors were identified as being associated with women being considered less receptive to public health advice provided in conventional formats. It was recognised that on occasions, service limitations to individualise information contributed to the challenge of communicating effectively with the complete spectrum of society who utilise the maternity services. Although focus group participants had been requested to consider socio-demographic factors which may be viewed as increasing the challenge of delivering public health messages it was recognised that women with additional individual needs may go unrecognised unless specific enquiry is made.

*I agree with the other comments which include people whose first language is not English, individuals with learning disabilities, teenagers and people who expect one to one care. I would also like to include parents who have sensory impairment as often we have to rely on their ability to communicate with us rather than it being an equal exchange. And I have often thought about individuals with a learning difficulty too such as dyslexia, especially as we have stated we have so little time and therefore more often than not information is given in the form of a leaflet. (MSW15)*

## Theme 5: The role of specialist referral services

Participants were asked to consider the potential role of additional services to which women could be referred for specialist public health information and support. It was recognised that specialist support on public health issues is available both from within the maternity service and from other services. A range of NHS employed individuals and NHS services, to which women could be referred, were described.

Specialist public health services mentioned by participants included those embedded within maternity services such as specialist midwives, including in some areas consultant midwives or sub-contracted screening such as newborn

hearing; other NHS services such as smoking cessation support; charities such as the National Childbirth Trust (NCT) providing antenatal education; and non-health resources such as social services and housing who also support pregnant women.

Two of the participants in the service user group were cared for outside of midwifery-led care, with their experiences of specialist care being very different in terms of the public health advice and support they were given. For one, that she was cared for by a hospital consultant left her with the sense she had missed out on the conversations she would normally have had with a midwife. For the other, cared for by a public health midwife specialising in diabetes, her experience of genuine continuity of care was seen to add real value to her care.

*I felt I had very little information both before and after birth about any of the above topics. I have a 4 month old and was under joint midwife and consultant care (as I have Crohn's) and I wonder if this impacted on this. It would have been useful if the midwives had been on hand more at my consultant appts to discuss things in more detail as the doctors never did chat more than delivery plan and health of baby. (SU13)*

*Would have made a huge difference to my care to have a named midwife. I commented to my husband that I felt very unsupported throughout pregnancy as a result and didn't feel I had a good patient/professional rapport with anyone. Because I was scheduled for a caesarean section (which actually didn't happen in the end as he arrived too quickly!) I felt I missed out on talking about other things like breastfeeding, etc that may have been covered in more depth under midwife care. (SU13)*

*I was lucky to be under an amazing midwife as I have type 1 diabetes. She was very helpful, not patronising and always available on the phone. One of few perks to being diabetic. The consultant was also brilliant and they seemed to communicate between each other and me really well. (SU4)*

Four sub-themes were identified as follows:

- i) The value of support services
- ii) Specialist services eroding midwifery skills
- iii) Specialist services leading to potential fragmentation of care
- iv) Resourcing specialist services.



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## i) The value of support services

Participants were generally positive about the role of the specialist referral services, recognising the value of their expertise and that with the increasing public health agenda it would not be feasible for midwives to provide all the information and care now expected.

*In relation to maternity services – I would say that the role of the midwife as lead professional will continue to include making appropriate referrals, so a wider range of specialist services would then potentially provide her [the midwife] with more time to concentrate on providing more general health promotion advice to women and their families. (LME5)*

*I think they're essential because a single community midwife cannot give all the public health info & support to her caseload of women antenatally & postnatally. (MW9)*

*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. (MSW16)*

*If you mean midwife specialists, then I feel that this is the only way that we as a profession can hope to meet the public health agenda, as expecting these messages to be effectively delivered during the course of a routine maternity care episode is simply unrealistic, as we have discussed. (MW5)*

*I feel the specialist role is essential as they have the specialist training to meet the needs of the women which require this help sometimes we can only touch on the areas i.e. domestic abuse, child protection etc. (MW10)*

Specialist midwives were seen as a vital resource for other staff, assisting with the education and updating of maternity staff. This was also seen as positive as it increased career opportunities within midwifery profession. information and care now expected.

*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 and can help provide continuity and normalise childbirth for high risk women. The cons can be deskilling of other staff as there is a temptation to hand over care of all these women to the relevant specialties. (Sr1)*

*I believe it is a good idea to have specialist midwives leading on public health issues. As well as raising the profile of the public health agenda in midwifery Specialist*

*midwives act as a resource for other midwives and enhance best practice There is a valid point about deskilling, however you could argue before the advent of specialisms within midwifery issues were possibly muddled through or not addressed. (Sr3)*

## ii) Specialist services eroding midwifery skills

A number of participants considered that outside agencies should be utilised to complement midwifery care, but concerns were expressed that on occasions outside agencies were in fact replacing NHS midwifery care. Participants questioned the use of non NHS agencies which now provide advice or information previously within the scope of the midwife, and some participants expressed concern that this represented of privatisation of the NHS.

*There is the charity for domestic abuse, the private company for smoking cessation healthy eating and exercise/healthy living classes and virgin (yes the same as the TV and holidays) is currently doing newborn hearing screening. Before I started this post I thought privatisation of the NHS was something in the future with the odd exception but it is well and truly established here in the south. It all works well as far as I have seen but [this unit] is a perfect example of the danger of privatisation when the profit goes, so does the service. (Cons)*

*I can see where the likes of the NCT 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 and or rebranding. (MW11)*

There was some discussion around the ability of highly trained specialist public health referral services to target specific groups/people, leaving midwives to focus on midwifery specific care. However, it was also thought that there was a fine balance as this may lead to erosion of the core role of midwives or the loss of key midwifery skills in these areas.

*For midwives to be effective in their multifaceted role, it is vital a balance is struck so that referrals to specialist public health services can be appropriately made without compromising the midwifery care that is expected of ALL midwives regardless of place where the care is undertaken. (LME2)*

*What I don't like is the idea of dismantling of the giving of health advice and sub contracting it out to private service providers outside of the NHS. This is not only the insidious back door privatisation of the NHS but also erodes the core role of the midwives. (MW11)*



*As for specialist services, there needs to be a balance here between midwives concentrating on midwifery and letting others with specific skills support women /families in those areas. Ideally without adversely impacting on the midwife woman relationship, and without the midwife losing the key skills she needs to work with the women. (LME4)*

### iii) Specialist services leading to potential fragmentation of care

One student participant described how a single individual may be referred to several specialist services and as such may lead to a fragmenting of care and potential disengagement of women. For example, a woman with a raised body mass index (BMI) experiencing domestic abuse may be referred to two separate specialist midwives. Another participant suggested that women may feel embarrassed or stigmatised by a referral to specialist care.

*I think that some women feel stigma is attached to having to be referred to a specialist and may be embarrassed or concerned that they are not 'normal' so have limited affect on public health. (St6)*

*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 a different specialist for different aspects of their needs and they feel tied down by maternity services. E.g. A grand multip with worryingly high BMI, diabetes and hypertension ends up falling into too many categories on top of this if she is also a victim of domestic abuse requires social service or asylum support then she can end up spending entire days seeing specialist and possibly repeating history many times. The rate of DNA (non attendance) is more likely as some lose track of where they should be. It can become tedious for the women who sometimes just stop bothering. (St5)*

Communicating with the services available was identified an issue by some participants. One MSW described the difficulty created by having so many different specialist referral services, leading her to feel unsure about how and who she could refer women to. It was suggested that there should be a single mechanism/proforma in use to refer to specialist services, as opposed to having a multitude of different forms.

*In order that we meet targets set by the public health agenda I think our level of worker should become an integral part of the referral service. Within the community I often have much more continuity with the women than*

*the midwives so would therefore be ideally placed to deliver specialist referrals. (MSW3)*

*I find in my role on postnatal ward that knowing how and who to refer women too 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. (MSW2)*

### iv) Resourcing specialist services

Some participants questioned the viability of providing funding and resources for specialist services within a financially challenged NHS. One student midwife described the frustration experienced by specialist smoking cessation midwives and commented the apparent lack of effect.

*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. (St5)*

Sustainability was also raised as an important issue, and it was argued that specialist health care professionals should be funded from outside of core services.

*We have weight management, diabetes, teenage pregnancy. I think it can be really good to have a range of services that meet particular groups of women's needs but they need to be planned, and sustainable and shouldn't take funds from core services. (St9)*

## Discussion

The findings have been presented as five themes identified by thematic analysis of data collected in seven Facebook groups. The themes identified are: scope of midwives' public health role; training and support for public health role; barriers and facilitators; client groups; and role of specialist referral services. Each theme and its related sub-theme have been discussed in detail. The discussion is presented for each of the themes, with acknowledgement of the study limitations and concluding with potential ways forward for the use of the themes in the next phase of the project.

Starting with the research process, rich qualitative data has been collected in most of the Facebook groups. There was a good level of interest in the study from student midwives, Bands 5 and 6 midwives and MSWs, as evident in the response rates and in the quantity and quality of the discussion group posts. The groups held with senior midwives (Band 7) and LMEs contained smaller

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numbers of participants, so the amount of discussion was more restricted. Nevertheless, the quality of discussion was good: posts appeared to be thoughtful and were often lengthy (especially in the case of the LMEs). It was notable that the numbers of HoMs and consultant midwives participating were small and, as a result, discussions were limited. This was attributed partly to lack of familiarity with Facebook use, or to concerns about Facebook for professionally related activities. Data was collected from the service users which reflected many of the areas that practitioners had identified and added to the depth of most of the five major themes.

The findings will now be considered in relation to the analytic themes, identifying where there are areas of overlap. Suggestions for further investigation of these findings via a future survey are identified.

### Discussion of theme 1: Scope of midwives' public health role

The complexity and breadth of the midwife's public health role was commented on in all groups, with concerns being raised by many about the achievability and sustainability of this role given the other demands on midwifery time. A wide range of key public health topics in which midwives were commonly engaged was identified by most participants, as well as a range of less frequently identified topics. It was not clear if some topics were less frequently mentioned due to them receiving 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 the widespread messages about obesity prevention provided to the general public, there was little mention of this topic. This may be linked to the lack of training and specific pregnancy related advice currently available. The wide range of public health issues identified in this study would be useful for constructing survey questions aimed at detailing the scope and focus of midwives' public health engagement.

The ever increasing and shifting public health agenda was commented on by many participants. It appeared that, as new public health issues and initiatives are identified, these take priority. This may explain the lack of mention of some pre-existing public health issues, for example sexually transmitted diseases, which would itself have been a priority area in the past. Prioritising of some public health issues was particularly noted where a strong political/professional focus exists (for example, as a result of CMACE and MBRRACE-UK reports), and where there may be linked targets and audits of practice (for

example, in relation to flu vaccine uptake and sepsis prevention). The implication of this shifting, but ever increasing, public health agenda for the work of midwives merits further investigation as it is unclear whether an increasing agenda is potentially being delivered with decreasing efficacy and effectiveness.

It was notable that specialist midwives were valued wherever they were available, both as a source of referral for expert advice for both women and midwives and also as a training provider.

There was less clarity about whether some aspects of the midwife's public health role could be undertaken by others. Some midwife participants identified the potential contribution of GPs and other health care professionals, however it was striking, given the worries expressed about the unrealistic expectations of the public health role, that some midwives seemed reluctant to let go of any of the elements because of the 'special relationship' that is thought to exist between midwives and women.

It was clear from the data obtained from MSWs that their role included many aspects of public health, with MSWs particularly involved in breastfeeding support and advice about baby care. MSWs were enthusiastic about this aspect of their role and keen to have greater involvement. General public health advice, for example about healthy lifestyle behaviours, was described as being incorporated naturally into chats during support groups or home visits. However, midwives did not mention this contribution by MSWs. This may be because their involvement is seen as the norm and not worth commenting on, or it may be that their input is not apparent to midwives. Again this would be worth investigating further, as the eagerness of MSWs and their understanding of how they could best contribute to the public health agenda indicates that there may be potential to make better use of their role.

### Discussion of theme 2: Training and support for public health role

There were extensive comments about how midwives and MSWs are prepared for their public health role. Training was thought to be very important, but the amount and quality of post-qualification training for midwives appeared to be highly variable and was often thought to be inadequate for the breadth and complexity of their role.

The approach to training and the content of training varied, with both good and insufficient preparation described. A range of training approaches were identified, from traditional updates via face to face lectures to online training and emailed updates. In general, it appeared that face to face training was preferred,



although this warrants further specific exploration. Emailed updates were seen as ineffective, as there was little opportunity to read them in work time. No midwives mentioned any attention being given to enhancing communication skills that are necessary for supporting health messages and behaviour change.

Good training was identified as being public health specific and delivered by experts. The main topics covered in training were breastfeeding, smoking cessation and mental health. Where maternity units were BFI accredited or working towards accreditation, these stood out as examples of good training and support for both midwives and MSWs, with participants commenting very favourably on the training quality. This high quality provision is likely to be attributable to having dedicated funded BFI staff, and a clear organisational focus and target, with sign up from all stakeholders.

The students' preparation for their public health role was commented on very positively by students and LMEs. The LMEs described particular attention being given to public health issues at the curriculum development stage and then throughout delivery of the programmes. Public health topics were considered at macro (global), meso (regional or local) and micro (individual) levels. Students appeared to have a solid grounding in public health theories and their application, which was well integrated throughout their programmes. There was evidence of a good understanding of the scope of the public health role of the midwife and the dilemmas and challenges which this could present. A number of innovative teaching and learning methods were identified by both LMEs and students which were commented on positively (for example, input from service users and specialist midwives, role play and making practical 'artefacts'). Experiential learning was appreciated. It may be that those providing training for qualified midwives and MSWs could learn from such approaches.

In comparison to student and qualified midwives, there was a notable lack of public health training for MSWs. That which did exist was very variable. Many MSW participants described attending generic health support worker training that failed to address either the particular issues of maternity care, or public health. However, as noted previously, many MSWs were engaged in public health related activities and expressed a keen interest in these issues despite their lack of formal preparation. As a result, several described undertaking training in their own time, evidence of their high levels of motivation. The follow on survey could usefully explore the availability, accessibility, amount, content and approach to public health training experienced by midwives and MSWs at all career stages.

### Discussion of theme 3: Barriers and facilitators

A number of key barriers and facilitators to the public health role were identified. Barriers were most frequently commented on, with facilitators often being the converse experience. The key factors of time and resources were commented on extensively in most groups. It was felt that public health advice and support needs to be given adequate time, 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 the number of other competing demands on midwives' time.

The individual midwife's approach to raising public health issues was identified as important, as was a positive attitude to engaging with public health issues. However, the positive attitude of an individual midwife could be compromised by unrealistic demands on his or her time and capacity.

Women's attitudes to receiving public health advice and support were also important facilitators or barriers. Receptiveness to advice made the midwives' role easier, and language and cultural differences could act as impediments, especially when English was not a first language. This is also discussed in the next theme. 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 that could be provided when they knew the woman and her family, for example when continuity of care was possible. Participants questioned the educational value of bombarding women with information and leaflets, but there was a sense that often this was all it was possible to do.

The research brief asked particularly about educational barriers and facilitators, however, these were only one aspect of the barriers and facilitators identified by participants. Educational barriers and facilitators were also considered within the previous training and support theme discussion. In summary, the facilitators were: the attention given to public health as an integral part of the undergraduate curriculum; the innovative approaches to enabling students to engage with real life public health situations; and the high quality of some in-house training especially when delivered by experts. Barriers were: the lack of time given to public health matters in some mandatory training and updates; the lack of bespoke training for MSWs; and the use of emailed briefings and guidelines in lieu of training. There were a number of commonly identified barriers and facilitators which could be used to construct survey questions. In addition, it would be expedient to provide space for free text responses to capture issues not identified in the Facebook groups.



## Discussion of theme 4: Specific client groups

There were specific client groups who midwives and MSWs found more challenging to work with in relation to public health. These were generally also the women who were more at risk to experiencing ill health and therefore had more to gain by public health support. Midwives acknowledged the importance of engaging with these 'hard to involve' groups but also noted the significant challenges that this presented for them.

Receptiveness to public health messages and advice was a key feature of these discussions. A common factor identified by both midwives and MSWs as limiting women's receptiveness was their lack of ability to understand or read English. Supplementary resources to support these women (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, as noted in the barriers and facilitators discussion, time and support for relationship building were often not available. Some midwives also commented that mothers with high educational status could be challenging to work with in relation to public health issues. It may be that these women would also benefit from additional time with the midwife in order to establish a trusting relationship.

Other client groups were also mentioned briefly, for example women with disabilities. There is scope to explore the particular public health needs of specific client groups in more depth in any future research. This question was asked near the end of data collection, when discussions had become more limited and it is likely that further insights could be obtained.

## Discussion of theme 5: The role of specialist referral services

The final theme focused on the role of specialist referral services. In general these services were valued, especially when they involved specialist midwives, as it was acknowledged that it was impossible for midwives to effectively address all the public health elements of their role. However, this was thought to be a fine balance: concerns were expressed that specialist services might erode midwifery skills and also lead to potential

fragmentation of care. This in turn could impact on the care that women received. 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 providers could undermine the NHS.

A range of specialist referral services were described, including those based in NHS maternity services such as specialist midwives, sub-contracted screening services, other NHS public health services (e.g. smoking cessation support), maternity related charities, social services and housing. It would be useful to ask for other examples and identify their potential advantages and disadvantages in future research.

## From the perspective of the service users

Many of the views expressed by service users concur with those voiced in the professional focus groups. Both groups experienced frustration with issues of time constraints and lack of continuity of care, with these two issues seen by service users as the two major barriers to midwives effectively fulfilling their public health role. However, throughout the discussions, service users stress the importance to them of warm, empathetic care and good communication skills, and this is seen to some degree to lessen the negative effects of lack of time and continuity.

When broken down into the 'what' and the 'how' of public health messages, service users express that they want consistent, unbiased information, delivered without coercion in a clear and sensitive way. Face-to-face conversations as part of midwifery care or antenatal classes are both favoured, whereas the use of leaflets is not seen as helpful, especially when used as a substitute for a real conversation. It was felt that some midwives use tick boxes inappropriately, as a way of 'covering their backs'; some women expressed that midwives had ticked boxes for advice and support which they had not given, rather than as a simple way of recording care they had given. As is acknowledged by many of the midwives, the broad scope of the public health role requires sensitivity to the needs of individuals to tailor advice appropriately, whilst recognising that there are some messages which are universally relevant.

## Limitations of the studies

The study with practitioners and service users had some limitations, which should be taken into account when considering the findings. The study was conducted in a very short timeframe, with the research contract running from December 2014 to February 2015. Data collection took place over four weeks (January 2015), later than originally intended



because of administrative difficulties in setting up and recruiting to some of the groups over the holiday period. Some groups started enthusiastic discussions immediately, whilst other discussions took longer to commence.

Use of Facebook has both advantages and disadvantages. It allows 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 are free flowing and productive. However, as noted, lack of familiarity with Facebook use or concerns about data privacy may limit both recruitment and participation. Even reassurance about the closed nature of the discussion groups, ethical approval, data security and group ground rules did not appear to allay some potential participants' concerns.

The limited data obtained in the senior midwife discussion groups, most notably the HoMs 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. Consultation with senior midwives from these groups via a project advisory group may be one way forward. consultant midwives in England have an active membership group who could be utilised to identify more appropriate engagement mechanisms for their members in future activities.

For the service users group, it is acknowledged that there was some selection bias at work in the recruitment of women for this study. Representation was from a white background and women aged between 25 and 38 years old. This clearly puts limitations on how representative the views of these women are of the population as a whole, especially of much younger women and of women with little or no English or literacy. However, it is a strength of this study that the women represent fourteen NHS Trusts across England, and so their experiences are not just from one or two settings. Despite a specific encouragement for participants to ask their partners to join the discussion, no contributions from fathers were made. Some topics were not raised at all; smoking cessation, obesity, alcohol in pregnancy, and screening. It is not evident whether participants simply had no interest in discussing these, or whether they saw them as relevant but did not want to discuss them in a large group.

In summary, this qualitative study has investigated student midwives', midwives' and maternity support workers' current knowledge of and involvement in the public health agenda in England. The main themes and findings were used together with the audit and survey with practitioners (Section 4) to inform the stakeholder consultations and development of resources for women, families, and practitioners.

## Section 4. Audit and survey with practitioners



## Section 4. Audit and survey with practitioners

This section highlights the practitioners' understanding of the role of public health in midwifery, their experience, and the type of barriers and facilitators in place for addressing public health topics with women. An audit was also included to understand the extent to which public health topics are discussed with women at various stages of their maternity care. The findings show that there is an acknowledgement of a role for public health within midwifery and implementation for a wide range of the public health topics. However there is a range of learning needs as well as service level facilitators required to ensure that this role is fulfilled to its maximum potential. A summary of the findings for each of the public health topics presented as infographics are available in Appendix 2. The results are presented as six sub-sections as follows:

- i) Public health role in midwifery
- ii) Time available for public health
- iii) Most appropriate professional for public health topics
- iv) Referrals for specialist services
- v) Level of confidence
- vi) Auditing practitioners' public health engagement with women

### i) Public health role in midwifery

Overall, there was acknowledgement that there is an important role for public health within midwifery. Most of the respondents stated that more than 40% of the work of care and advice they give to women falls under public health (Figure 2). The findings were consistent across all four countries and also illustrated in the qualitative data in terms of the long term consequences for the women and their families.

*A healthy, happy, confident mother is the basis for a strong family unit, failure to achieve this has far-reaching effects on public health. (MW, community)*

*A lot of our role involves prevention and support (prevention) we can make a real difference if we have enough time which will eventually lead to more time as women will feel empowered. (Specialist MW, MLU)*

*Public Health should be integral part of all maternity care like 'physical' and 'mental'. Should not be seen as 'other' or of 'secondary consideration' compared to intrapartum care. It is essence of prevention, early intervention and supporting families to realise their own wellbeing, that impacts across the generations. (Consultant MW, MLU)*

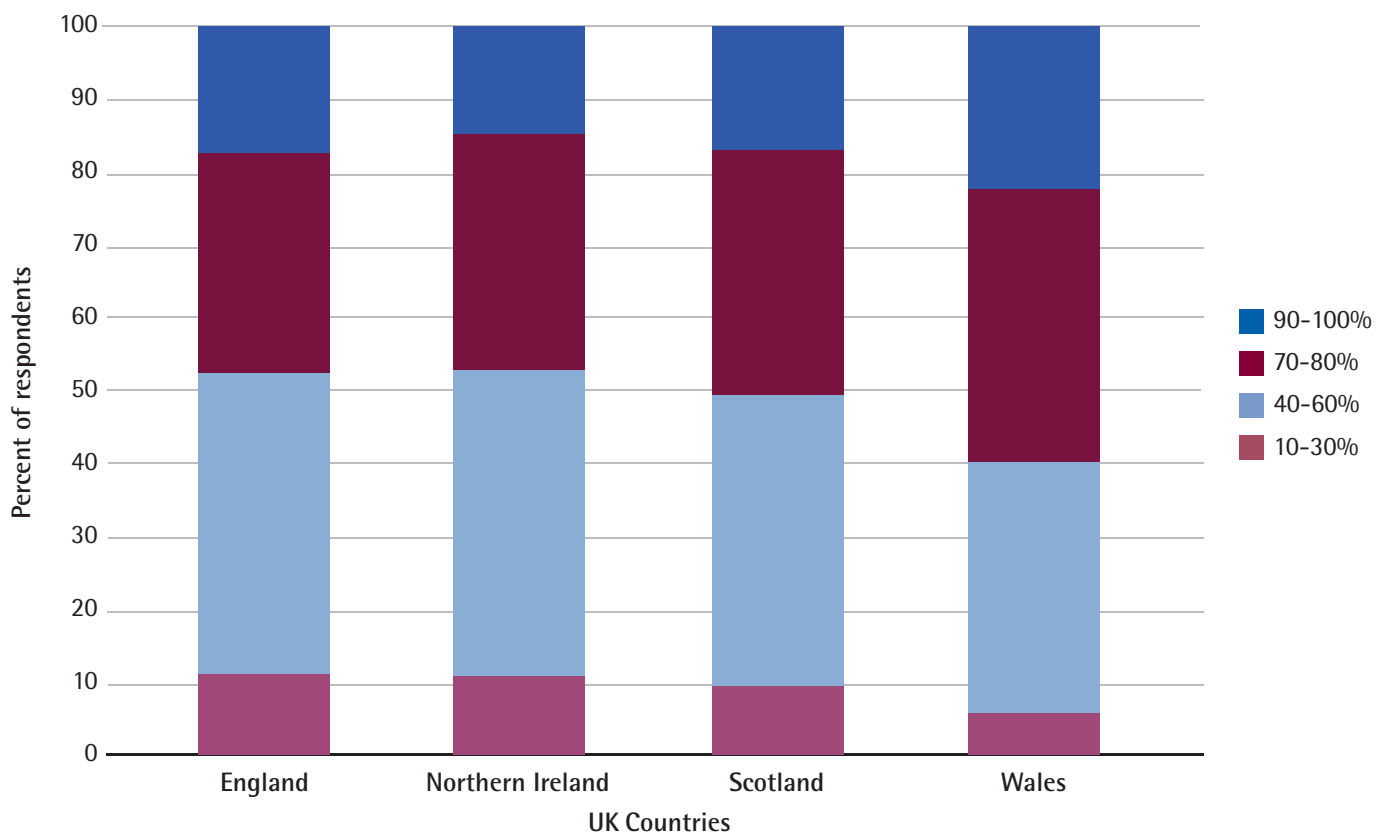


Figure 2. Reported proportion of work falling under public health



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*Public health role of midwife is vital. Community midwives are in a unique position to develop a relationship with the women in their caseload and can act as a contact for those who wouldn't normally access care or advice. However, appropriate training is essential with regular updates and clearly defined care pathways/ referral guidelines as well as sufficient staffing levels to allow appropriate time allocation. (MW, Community)*

*I feel that all of the care that we provide and advice that we give to women is related to public health as our role is to care for women and babies to achieve the best possible health outcomes for both. ... Public health advice is not an "add on" to our role but is integral to every aspect of our role. (Midwifery manager)*

The range of responses varied from having doubt about the definition of public health in midwifery to all encompassing need to have recognition through formalised routes of certification.

*I would have to admit I am not completely clear the exact definition of what comes under the heading 'public health'. (Triage MW)*

*Midwifery is all about public health. It is about normalising birth, making the experience as good as possible and protecting the public from poor health. (Consultant MW)*

*I (...) feel strongly that the midwifery service has a huge opportunity to provide public health information which should be 'backed up' by appropriate training and certification. (Specialist community public health nurse)*

*If the advice is given correctly and incorporates up to date PH guidance then my answer is 100% as midwives should be practising public health every minute of their shifts, however I don't believe this actually happens for the vast majority of midwives and that a lot of public health training is needed so midwives truly understand the public*

*health remit and the value of this. I would like to see many more midwives join me on the UK Public Health Practitioners register. (Midwifery lecturer/Clinical educator)*

Starting with the breadth of public health topics, 35 were already identified based on the qualitative study and stakeholder session and included in the audit and questionnaire (see Box 4).

Participants were asked to highlight additional topics that could be included as public health. These ranged from preconception care to parenting and child care illustrating the importance of the continuum of care. They also identified specific groups who need to be recognised as requiring further support with a wide range identified such as:

- Homeless women
- Asylum seekers and refugees
- Trafficked women and sex workers
- Ethnic minorities
- Young parents
- Women with low BMI
- Survivors of sexual abuse
- Women and men involved in the criminal justice system including paternal involvement in child development and
- Women with physical or learning disabilities.

*The issue of homelessness is never addressed. If a woman is in the UK illegally, she is not entitled to have accommodation, which leads to sleeping on the streets, which leads to prostitution for money, exposes her to STI's, diet is poor, and antenatal care becomes a hideous mockery to her. Homelessness is what most women face through trafficking or abandonment. They are victims who get treated like criminals. Let's tackle homelessness. (Specialist MW/Nurse)*

Box 4. The 35 topics covered in the audit and survey

Alcohol consumption	Contraception	Dietary advice	Domestic abuse
Exercise	Feelings about pregnancy	FGM	Group B strep
Hygiene	Immunisation – baby	Immunisation – mother	Infant feeding
Interaction with baby	Mental health	Newborn physical health	Normalising birth
Oral health	Partner involvement	Pelvic floor exercises	Perineal care
Post natal exercises	Preparation for birth	Safeguarding issues	Safe sleeping
Safety at home	Screening – baby	Screening – mother	Skin to skin
Smoking	Social issues	Substance misuse	Sexual health
Working / employment	VBAC	Wound care	



Transitions were discussed both in terms of the support for loss and bereavement, as well as healthy outcomes. The parenting aspects included bonding and attachment, basic and essential information on hygiene and sterilisation of feeding equipment. This was in addition to health related topics such as rashes in pregnancy, vaccinations for influenza, and pertussis which were also identified as being important by participants. The full set of responses are shown in Appendix 1.

## ii) Time available for public health

The topics, whatever the scope are covered during interactions with women starting with the booking appointment, in antenatal, intrapartum and postnatal care. Participants stated that issues related to the time available to cover the relevant topics were significant as well as a combination of the vast array of clinical and non-clinical tasks that need to be undertaken during the appointments.

*My overall experience tells me that most public health issues fall under the midwives remit, yet this is not accounted for in the time allocated to spend with women. (Student MW)*

*Due to time constraints, many discussions need to be rushed and in blocks. (MW, MLU)*

*I wish I had more time to give bedside care and not so much paperwork. (MW, delivery suite)*

*Sadly there is little or no time allowed on VERY busy P/N ward to convey even basic knowledge to women and families in my care. I have a wealth of knowledge and experience within me. (MW, postnatal ward)*

*During the booking appointments we are expected to get through so much information and (there is) so much paperwork to complete, information overload for the women. 'I sometimes think does it work as a way of passing on information to women regarding public health?' (MW, clinic/advisory)*

*Due to the shortage of staff, we only have 15 minutes slots for seeing women in antenatal clinic in the community, and by the time woman gets ready for abdominal examination and blood pressure, the time is gone! So it's all rushing, thus not providing high quality care to woman and the family. (MW, community)*

*Given the right time and support they can flourish. Often the realities of time constraint means topics are avoided, closed questions asked and often it is not until something has become a problem that it is addressed, then it becomes even more time consuming... There is a greater gain for the woman and family and far greater job satisfaction for the midwife and wider team. (MW, community)*

When participants were asked if they had enough time to cover all the public health topics, around one third stated that they always or mostly had time with a variation of 27% to 36% across the four countries (Table 12). However 40% of the respondents rarely or never had enough time to cover these important topics as part of the care they provide, which is a concern.

On average, an antenatal booking visit was reported to take approximately one hour and around 10 to 20 minutes for the follow-up visit (Figure 3). A small proportion of respondents (n=46) stated that they had between 10 to 20 minutes for their booking appointment which was lower than the average recorded. For the follow up antenatal appointment for women without complications, the time allocated was between 10 and 20 minutes and the majority wanted longer. Appointments for women with complications were of similar length of between 10 and 20 minutes for the majority and respondents wanted to have appointments of between 30 and 40 minutes.

Comparing the current time taken and the required time in the booking visit as part of antenatal care, the majority stated that they had around an hour and nearly half wanted the same or longer. An additional 10 minutes for the follow up antenatal appointments (regardless of risk) was considered to be beneficial for the provision of care.

Table 12. Time available to cover public health topics

	England	Northern Ireland	Scotland	Wales	Total
Always or most of the time	33	27	36	28	33
Half of the time	27	30	25	32	28
Rarely or never	39	43	39	40	40
Grand Total	1651	61	120	72	1904

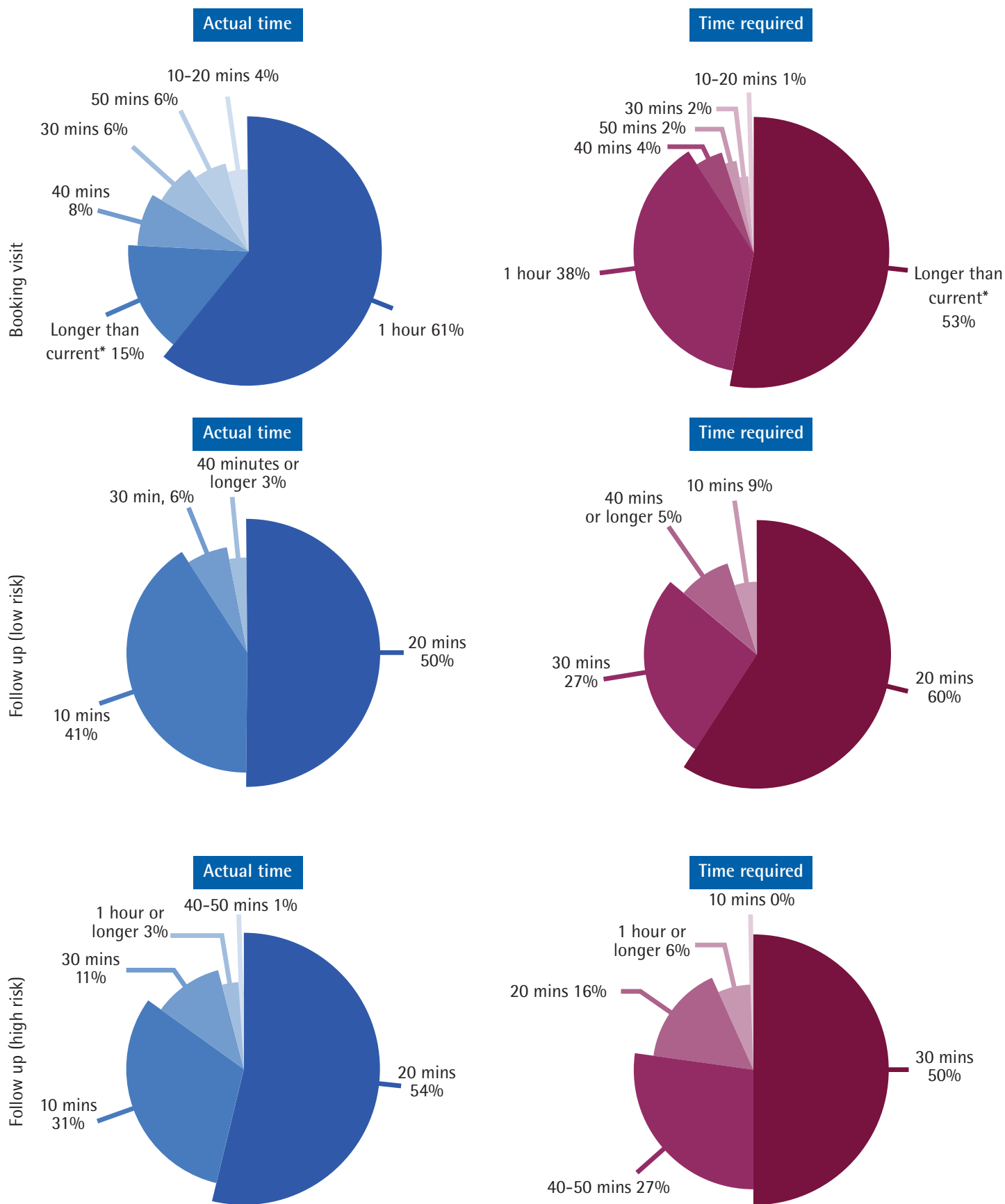


Figure 3. Current and required time for antenatal care

\* Respondents had not given sufficient detail about the current length of time for their appointments for the comparison to be made.

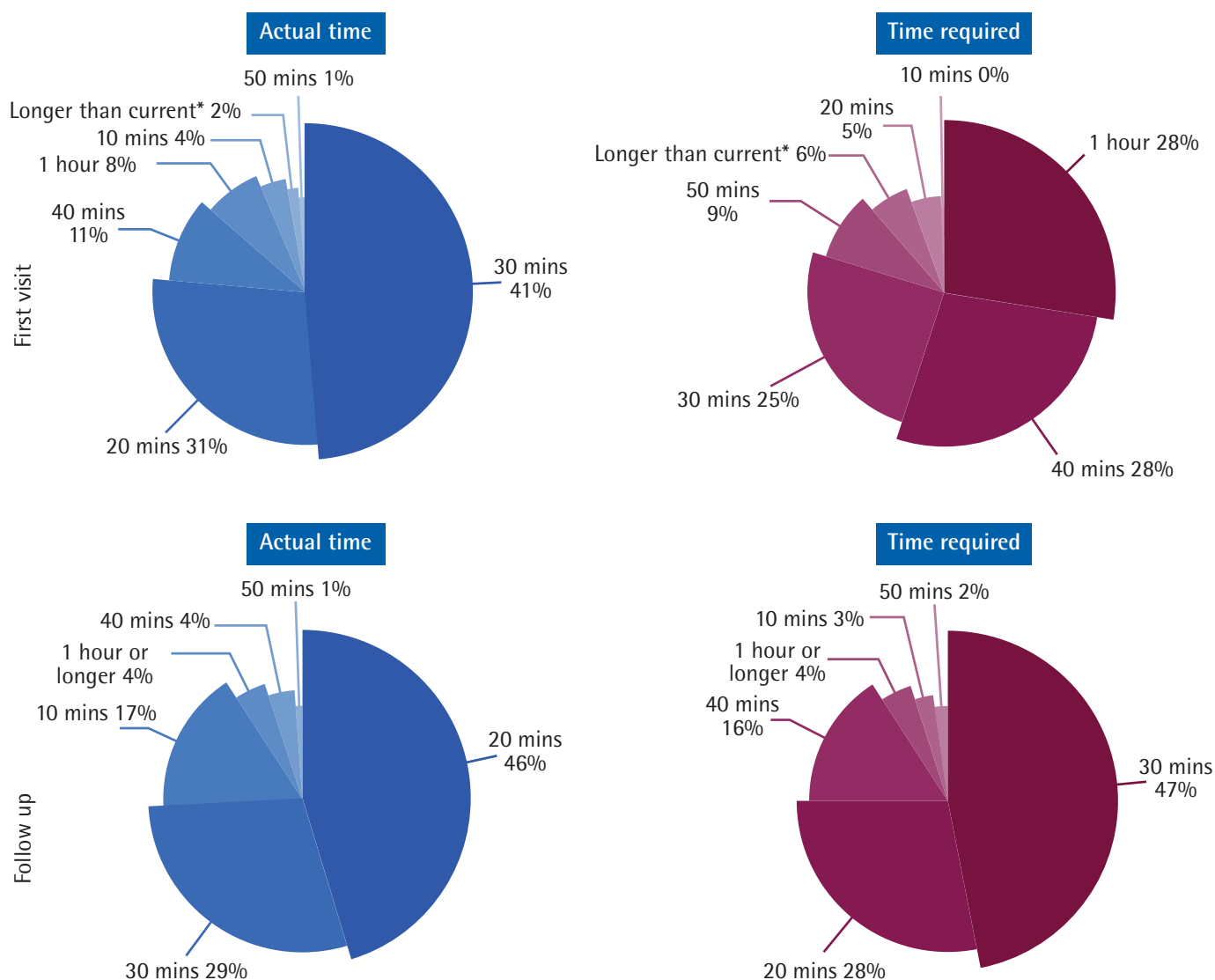


Figure 4. Current and required time for postnatal care

\* Respondents had not given sufficient detail about the current length of time for their appointments for the comparison to be made.

For postnatal care, most of the participants stated they had around 30 minutes for the first appointment and between 20–30 minutes for the follow up (Figure 4). Majority of the respondents wanted 40 minutes for the first postnatal appointment to support them in covering all the clinical care, public health and non-clinical tasks.

Majority of the respondents stated that they needed longer for their interaction with women regardless of the type of appointment (Figure 5). When asked to quantify this, over half wanted between 10 to 20 minutes longer in all appointments (with the exception of the first booking appointment where a period of time was not mentioned by most of the respondents).

In both antenatal and postnatal appointments, the availability of time combined with the right setting for seeing women was considered imperative. There was concern regarding the reduction of antenatal/postnatal classes in some units. This additional resource is considered essential in allowing public health messages to be conveyed in a timely manner, using the most appropriate method of delivery and enabling practitioners to tailor information to the needs of the women and their families.

*I suspect it is a very false economy that parent education classes have been so cut back in the NHS. (Midwifery lecturer/Clinical educator)*

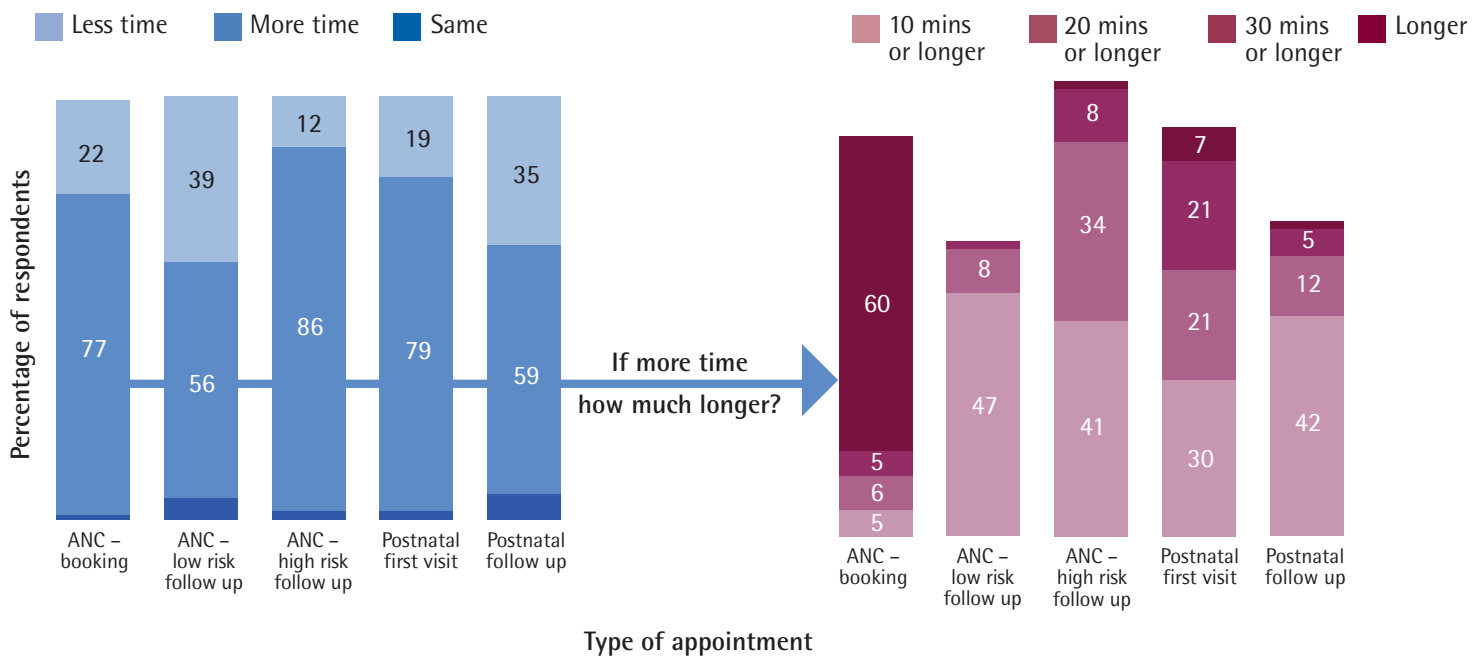


Figure 5. Additional time required for appointments in antenatal and postnatal care

*As a Specialist Midwife (Substance Use, Homeless & Travellers) my clients often have quite complex needs, so I am able to allocate longer booking and antenatal appointments than is usual. I am also able to see women who have substance use issues more frequently than community midwives can. I am able to see women every two weeks throughout pregnancy. (Specialist MW)*

*Each health professional has a role to play in health promotion our time with the women is limited and we are not given enough time to deliver the public health agenda and provide the evidence as well as be there caring for the women and families. The paperwork appears more important than the actual time to do the role as a result the effort will have limited effect. (Midwifery manager)*

*At the booking appointment the midwife has had to cover more topics over the years and women find it hard to recall all that is discussed. The midwife is stressed getting all covered in so short a time and conscious that other women are waiting for her. Putting this information on phone technology for recall as well, especially for the youth enabling them to tap into this information more easily and retain it. (Midwifery manager)*

*As a midwife specialising in public health, I feel very strongly that women should be sign posted at booking to appropriate specialists i.e. raised BMI. This makes the conversations more meaningful and increases the likelihood women will participate in programmes designed to address their particular need. The booking visit has a lot of information crammed into it, and arguably public health messages are lost. (Specialist MW)*

*Lots of opportunities are present and midwives are well placed to provide advice but often provide limited advice because they have little time to have real conversations. (Midwife)*

*They are discouraged from visiting women in their own environments where they would learn a huge amount and be able to praise guide and support not only women but other family members. Seeing where and how women live allows realistic person-centred care to be given. An example is safe sleeping for a new born by visiting during antenatal care and we can view and tailor advice to encompass cultural norms and values and to start to develop inroads to hard to reach families. (Midwifery lecturer/Clinical educator)*

### iii) Most appropriate professional for public health topics

For the most appropriate professional to discuss the public health topics with women, midwives or specialist midwives were identified in most cases. As shown in the breakdown in Figure 6, some of the respondents classified topics such as vaginal birth after caesarean (VBAC), Group B strep and FGM as being most appropriate for obstetricians. Health Visitors were identified for immunisation, and third sector agency for safety in the home, oral health and postnatal exercise. MSWs were identified for aspects of postnatal topics such as skin-to-skin, safety at home, postnatal exercises and infant feeding.

Some of the specialist roles identified were for physiotherapists for exercise and problems with pelvic floor, dentists for oral health, and summarised as the supporter with the best relationship and

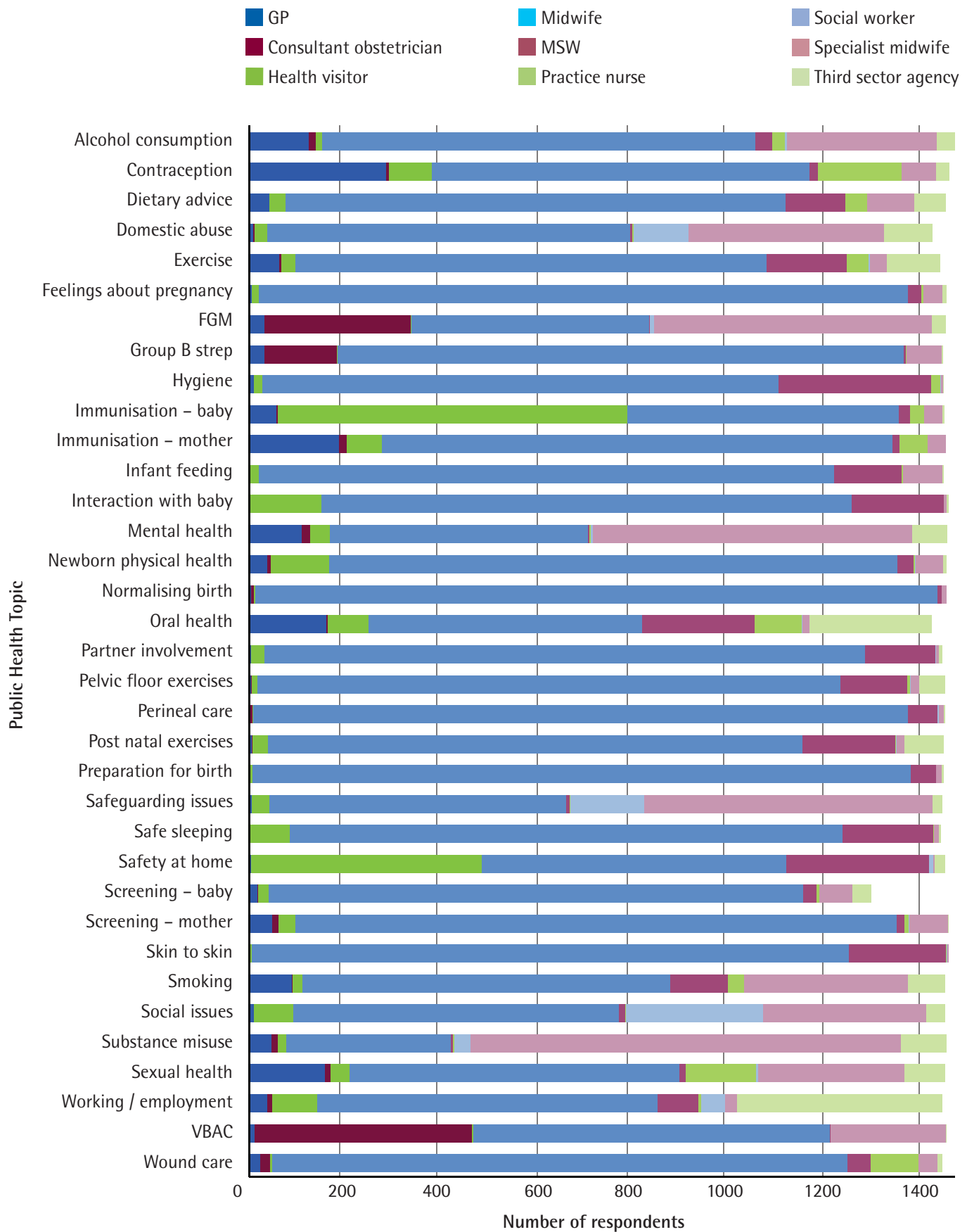


Figure 6. Appropriate roles for discussion by individual public health topics



knowledge base". Some of the interplay between roles in maternity care, either through working closely together or previous experience was also highlighted.

*I feel that MSWs have a great role to play. Specialist midwives should be concerned with complex cases and leading evidence based projects rather than doing all the day to day roles. This would enable them to become more involved in research and driving the public health agenda forward within organisations. (Specialist MW)*

*I think there is an opportunity for more collaboration with practice nurses and GPs who see women pre-conceptually as more needs to be done during this period so that midwives aren't covering aspects of public health too late. (Student midwife)*

*"...being a midwife but practising as a family nurse has given me an enormous knowledge base needed if you work in teen pregnancy I have far more knowledge now than I ever had as a midwife and if I was to go back into midwifery practice would be a far more effective midwife. Almost all of my practice as a family nurse is in the public health arena. I have to say also I am a far better family nurse being a midwife and having the midwifery knowledge. (Specialist MW/Family nurse)*

The importance of the multidisciplinary team and tailoring their care through referral systems were identified as being important as well as being able to designate the most appropriate profession or team member. Again, continuity of carer was highlighted as being beneficial to ensure consistency of advice.

*Sometimes there is more than one answer! The midwife may give initial advice but may then need to refer to a specialist midwife or obstetrician. The important thing is that there is a clear and easy referral system in order to give the woman evidence based advice and support. (Community MW)*

*The MW role in public health is widely acknowledged but the time and resources given to this appear to be lacking. I think there is an opportunity for more collaboration with practice nurses and GPs who see women pre-conceptually as more needs to be done during this period so that MWs aren't covering aspects of public health too late. (Student MW)*

*Again, the midwife should be the first contact and know who to refer to – best care must surely come for a multi disciplinary team in an atmosphere of mutual respect and supported by good communication. (MW)*

*In my estimation, public health works best when all health professionals are giving similar information and taking the opportunities of each interaction. If all the information is given at one time e.g. at discharge, as often happens, it*

*leads to 'information overload'. The benefit of continuity of care is the MW may have a better idea of what she has or hasn't told the women in her care. (MW, MLU)*

## iv) Referrals for specialist services

Discussing how easy it is to make referrals for specific areas of concern, more than 1 in 4 stated that maternal mental health referrals are difficult or very difficult, followed closely by maternal weight and social issues (Table 13). On the other hand, maternal and newborn physical health was stated to be easier for referrals.

Table 13. Difficulty for referrals for specialist services

	Total
Concern about maternal mental health	28
Maternal weight concern	23
Social issues	22
Domestic violence	18
Female genital mutilation	15
Infant feeding problem	8
Maternal physical health	6
Newborn physical health	3

The difficulties indicated include the timing of the referral being accepted and acted on, the appropriateness of the referral, and lack of specialist care in certain areas of public health, such as for obesity.

*Easy to do a referral, takes ages to materialise. (MW, antenatal care, day assessment and triage)*

*A ridiculous situation RE: mental health. There is no support for depression/anxiety!!! (MW, integrated community and hospital care)*

*It is good that this is being addressed. There is no one right solution and certainly no one right health care professional, though the midwife should take the lead and know when and to whom to refer. This means a trusting and mutually respectful relationship between the multi-disciplinary team (including MSWs). I work mainly in the high risk team and there tends to be an issue with some midwives referring inappropriately (possibly due to lack of confidence/knowledge/experience) whilst others give inaccurate advice and do not refer when appropriate.*

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*This is a complex issue worthy of further research" (Research MW)*

*...in the area I work, we do not have any specialist midwives, bar the infant feeding co-ordinator. This makes referring women say with a raised BMI difficult as there is no one in a specialised role to support and give adequate time and tailored advice. (StMW)*

## v) Level of confidence

When asked about their level of confidence in providing public health advice to women, there was a general view that practitioners lacked confidence when addressing sensitive public health issues, for instance, mental health, safeguarding and obesity. Some areas were also seen to be deficient in providing information and support in topics such as maternal vaccinations, Vitamin D supplements, and social deprivation such as poverty, poor housing and economic deprivation.

*..I think there are a great amount of public health issues that midwives overlook or are not confident in addressing. (Student MW)*

*More information and guidance is required regarding alcohol consumption in pregnancy. There seems to be a wealth of information regarding smoking and pregnancy but very little evidence relating to alcohol and pregnancy. (MW, community)*

The quantitative data showed that around 63% of midwives, 51% of midwifery managers, and 37% of MSWs were mostly confident in providing public health advice. However, around 1 in 4 midwives responded that they were 50/50 for confidence or needed additional training. Just over half MSWs (51%) fell into this category. The majority reported that they had learnt about the public health topics as a student and also through in-house training or CPD activities (Figure 7). A smaller proportion had covered this learning from independent e-learning approaches for some of the topics. Some of the participants reported undertaking some of the learning using their own resources in their own time in order to develop confidence in their role.

*have sought out a considerable amount of training around substance use to enable me to fulfilling my role. I have self funded a degree in contraception and sexual health. (Specialist MW)*

*For specialist role, independent learning and extra training given for tongue tie and infant feeding. (MW, MLU)*

*Normalising birth covered very poorly in CPD updates by Health Board (Midwifery lecturer/Clinical educator)*

*I have undertaken a variety of additional training since qualifying as a midwife, both study days funded by the*

*trust and local council and self-funded courses (MW, caseload team)*

*For most topics, I have attended myself as independent study days to gain more knowledge in order to feel confident when caring for women and their families (MW, community)*

*I enjoy the Public Health part of my remit, but have had to update myself by attending study days in my own time & reading these topics (MW)*

*All above questions are continually changing and keeping updated as to those changes is paramount. (MW)*

One in four respondents reported needing additional training for topics such as normalising birth, Group B strep and giving dietary advice (Figure 8). Aside from oral health, more than 1 in 10 respondents stated that they would need additional training for the public health topics highlighted in this study.

*As a student midwife I think there are a great amount of public health issues that midwives overlook or are not confident in addressing. (StMW)*

## vi) Auditing practitioners' public health engagement with women

As well as understanding the context, barriers and facilitators to practising public health, the study also included an audit to understand how implementation was taking place. In this audit questionnaire, participants were asked to consider a woman for whom they had recently provided maternity care. The questions were a combination of demographics of the woman they cared for, the context, and relevant public health topics which can impact on the care of the woman. Thirty five public health topics were presented and participants had to state whether the topics were addressed and if they were not, they were asked to give reasons.

The majority of the respondents completed this section of the survey providing a response (n=1650/74%) and the responses were received from all four countries. It was anticipated that the number of responses in this section would be lower than those responding to the survey as some of respondents would not be involved in direct clinical care at the time, i.e. managers and educationalists. Most of the responses included were from midwives including specialist and consultant midwives. Based on the data from the UK, 15% of the responses were from student midwives, a small proportion from MSWs (2%) and just over 1% from other practitioners such as health visitors. There were a mix of settings and areas of work represented in the audit including caseloading, integrated teams, clinics, wards, delivery suites and birth centres.



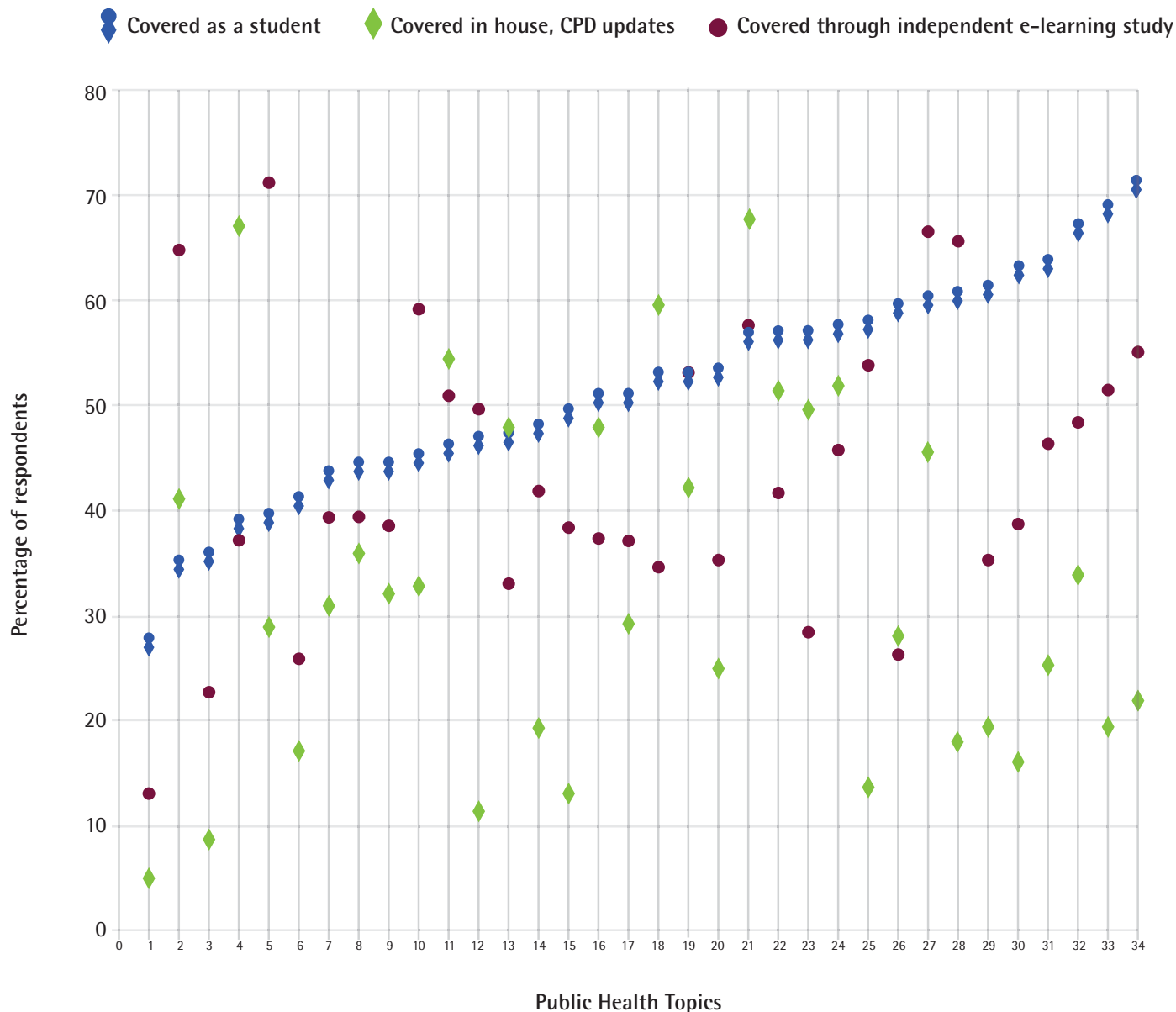


Figure 7. Public health topics covered through student, CPD or independent learning

Key

- |                         |                               |                       |                              |
|-------------------------|-------------------------------|-----------------------|------------------------------|
| 1 - Oral health         | 10 - Alcohol consumption      | 18 - Skin to skin     | 27 - Normalising birth       |
| 2 - FGM                 | 11 - Mental health            | 19 - Safe sleeping    | 28 - Dietary advice          |
| 3 - Working/employment  | 12 - Exercise                 | 20 - Sexual health    | 29 - Hygiene                 |
| 4 - Domestic abuse      | 13 - Substance misuse         | 21 - Infant feeding   | 30 - Post natal exercises    |
| 5 - Group B strep       | 14 - Feelings about pregnancy | 22 - Screening mother | 31 - Newborn physical health |
| 6 - Safety at home      | 15 - Partner involvement      | 23 - Smoking          | 32 - Perineal care           |
| 7 - Immunisation Mother | 16 - Social issues            | 24 - Screening baby   | 33 - Pelvic floor exercises  |
| 8 - VBAC                | 17 - Interaction with baby    | 25 - Contraception    | 34 - Preparation for birth   |
| 9 - Immunisation Baby   |                               | 26 - Wound care       |                              |

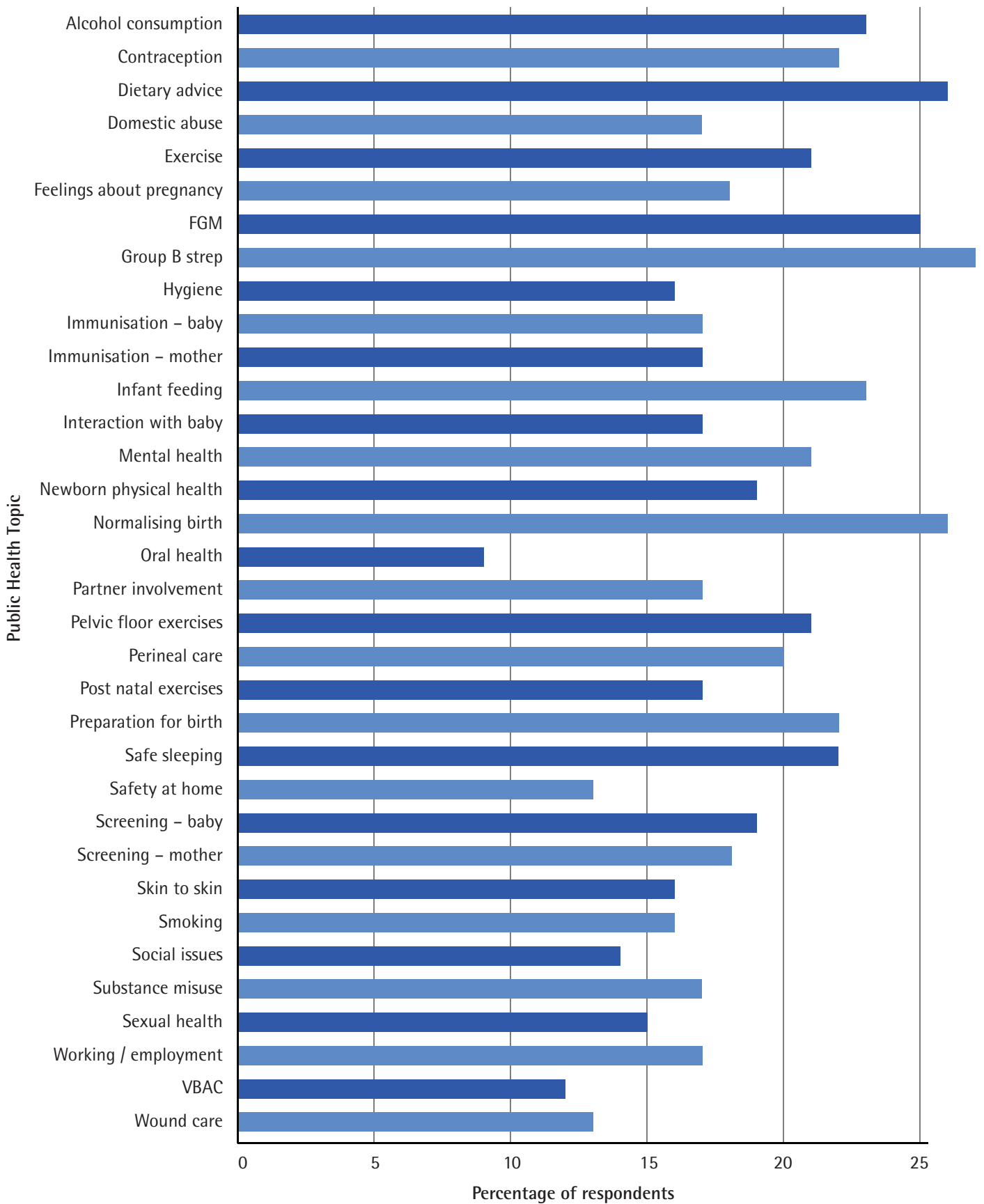


Figure 8. Additional training required by public health topic



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Table 14. Settings for the audit

Care setting	England %	Total UK (%)
Delivery Suite	31	30
Woman's home	17	18
Clinic/GP surgery	19	19
Stand alone/alongside birth centre or MLU	10	10
Ward – A/N	6	6
Ward – A/N & P/N	6	6
Ward – P/N	9	9
Other/More than one area	2	2
Total	1397	1640

Table 15. Age bands for the multiparous women

Age of the woman	Multiparous women (%)
19 or below	9
20 to 34	45
35 to 45	65
46 or older	63
Total for all women	48

As reported in the audit, just under one third of the women's care took place in a hospital and specifically the delivery suite and a similar proportion were working across antenatal and postnatal care including community and ward-based midwives (Table 14). Around half of the group were multiparous (52%), and their care settings were similar to that reported for primiparous women. The majority of women (74%) were aged between 20 and 34 years old (Figure 9). As expected there were fewer women in the 19 and below category for the multiparous women as compared with primiparous women (Table 15).

As shown in Figure 10, the majority of respondents stated that they were only providing care at specific points in the continuum including antenatal (17%), intrapartum (21%), and postnatal (17%). One in four respondents identified themselves as the main carer for the woman, and some of them for the continuum of care from antenatal through to the postnatal period.

For 80% of the women, at least 20 of the 35 public health topics were discussed (Figure 11) and parity did not impact on this. The number of topics ranged from 7 to 18 topics for 43% of the women and between 0 and 4 topics for 10% of women (Figure 12).

When asked about the discussion of each public health topic with women, most of the participants either stated that they had discussed the topic in the last contact with the woman or that they had not discussed the topic as it was not applicable. This accounted for more than 85% of the responses for each of the public health topic (Figure 13). On average, 43% stated that the public health topic was discussed and 52% stated that it was not discussed as it was not applicable at the time of the most recent contact. Some of the topics such as infant feeding, skin-to-skin and involvement of fathers were discussed in majority of cases. In contrast, FGM, domestic abuse and safeguarding were seen as not applicable at the time. For some topics such as safety at home, oral health and sexual health, some participants did highlight that they did not have sufficient time to address these. In the case of oral health, a knowledge gap was a reason for not addressing it.

Where the discussion was seen as applicable, but not discussed, reasons given included referral to a specialist, insufficient time, insufficient knowledge, or that the woman declined to discuss the topic. Out of the respondents giving these reasons, most cited insufficient time for the discussion. The breakdown for each public health topic is provided in Figure 15. Smoking and infant feeding were topics more than 30% of women were reluctant to discuss or declined.

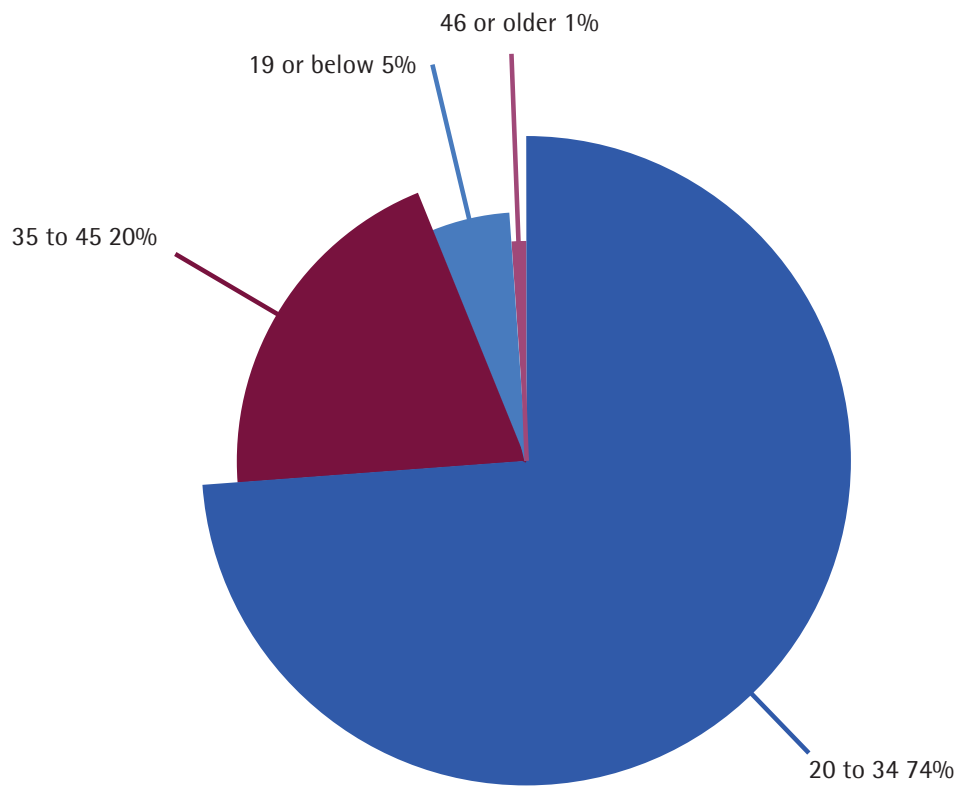


Figure 9. Age bands for women included in the audit (UK)

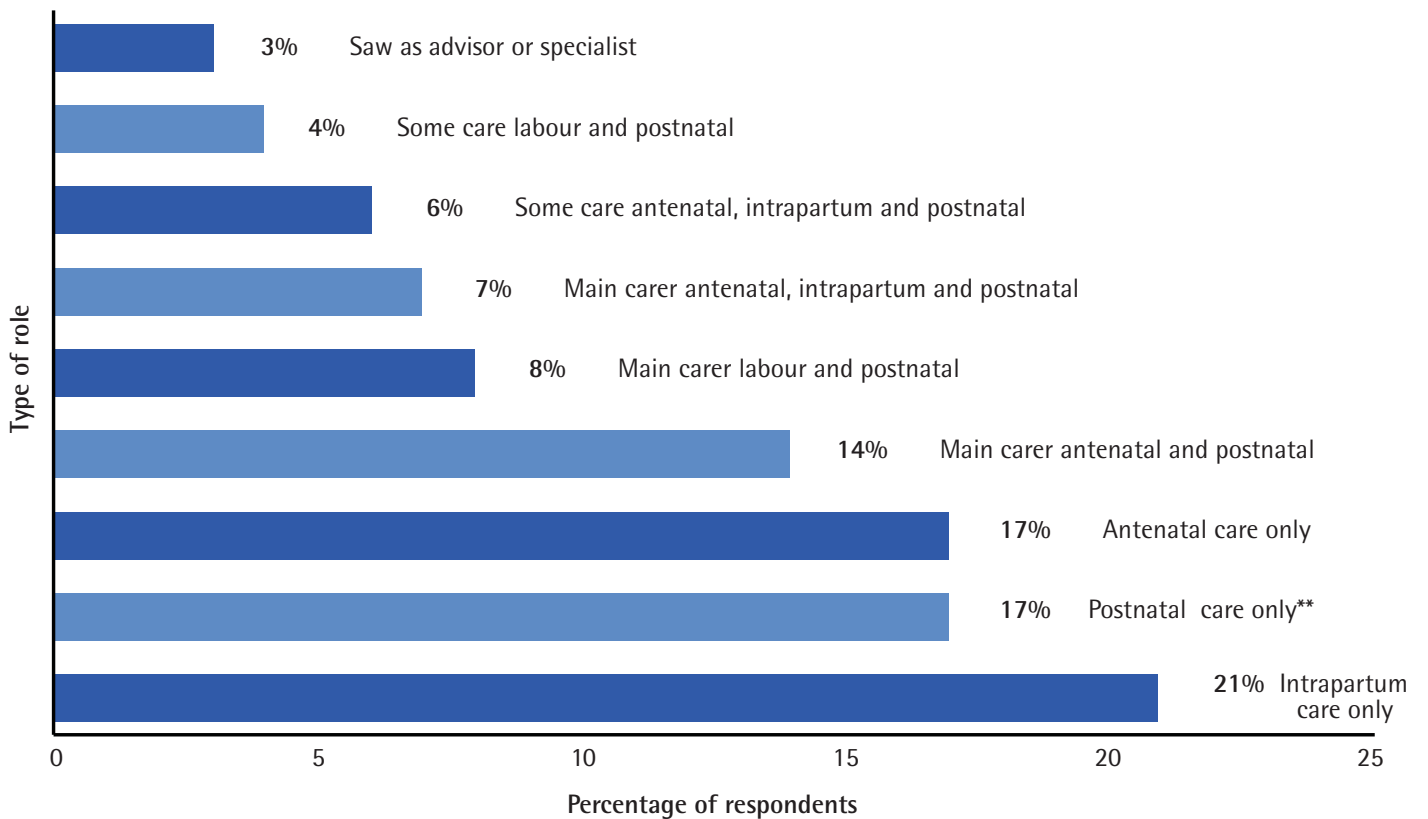


Figure 10. Role with women as part of the audit

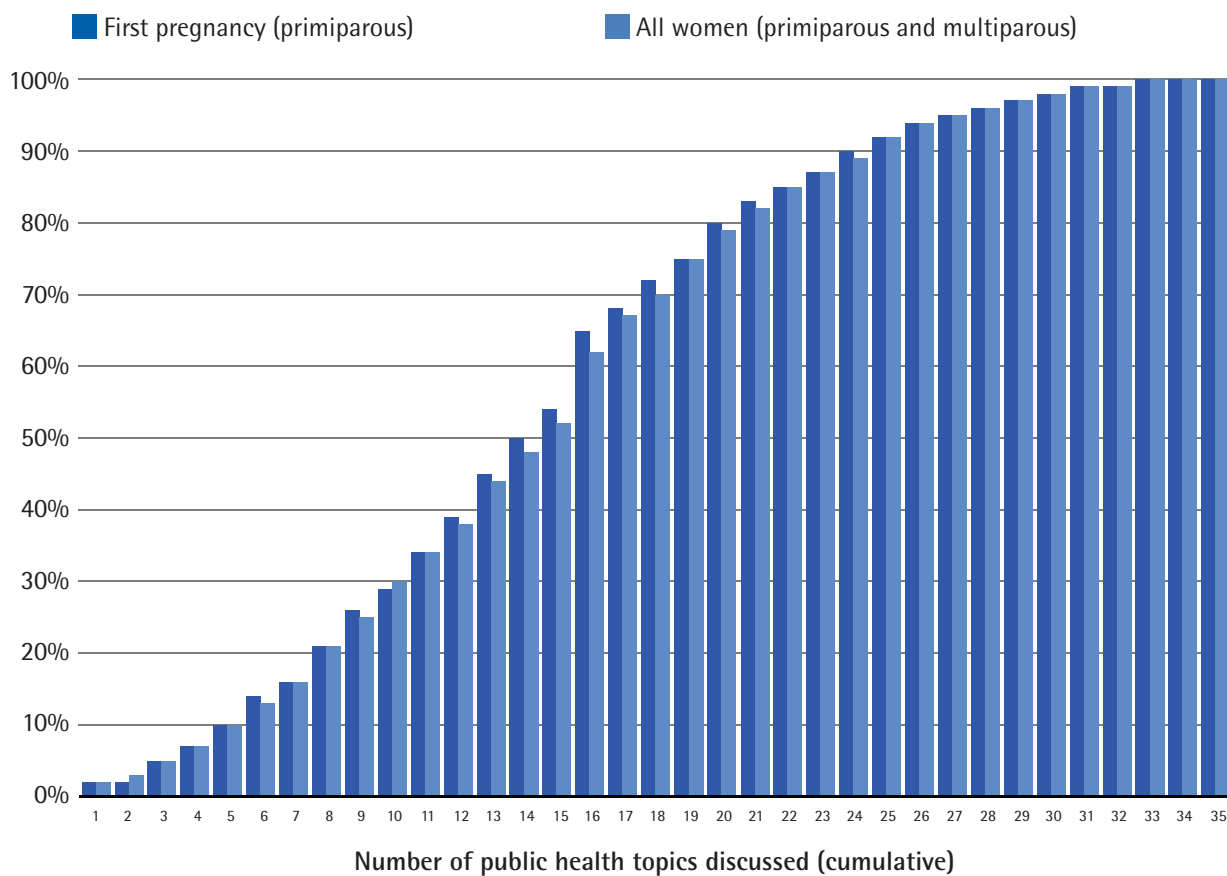


Figure 11. Number of public health topics discussed (cumulative)

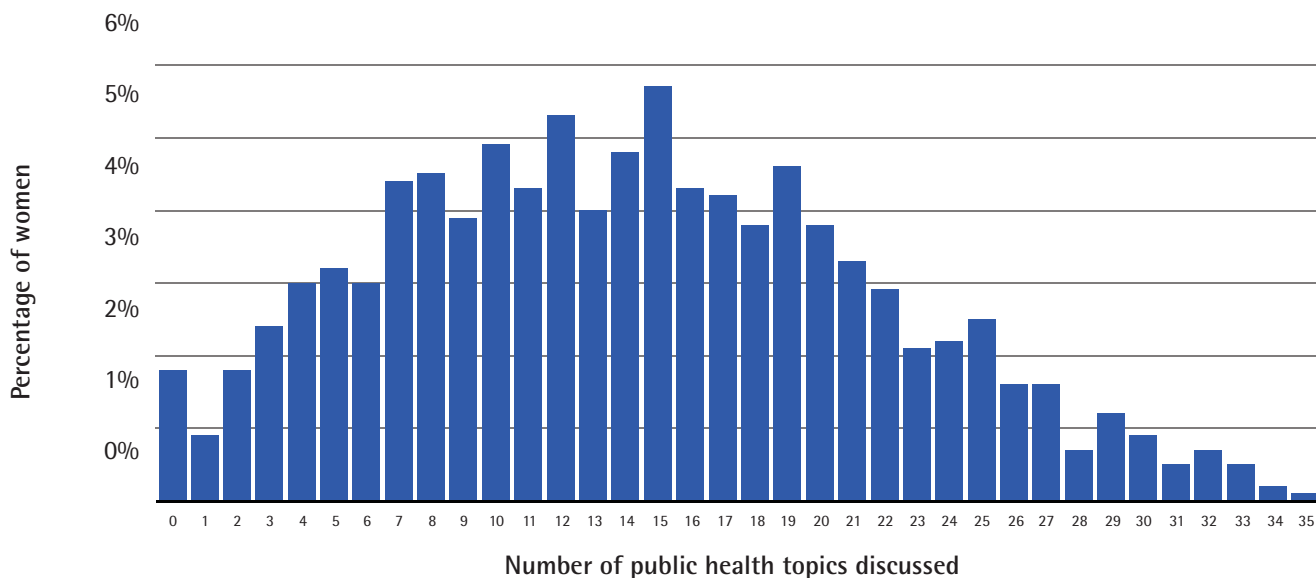


Figure 12 Total number of public health topics discussed

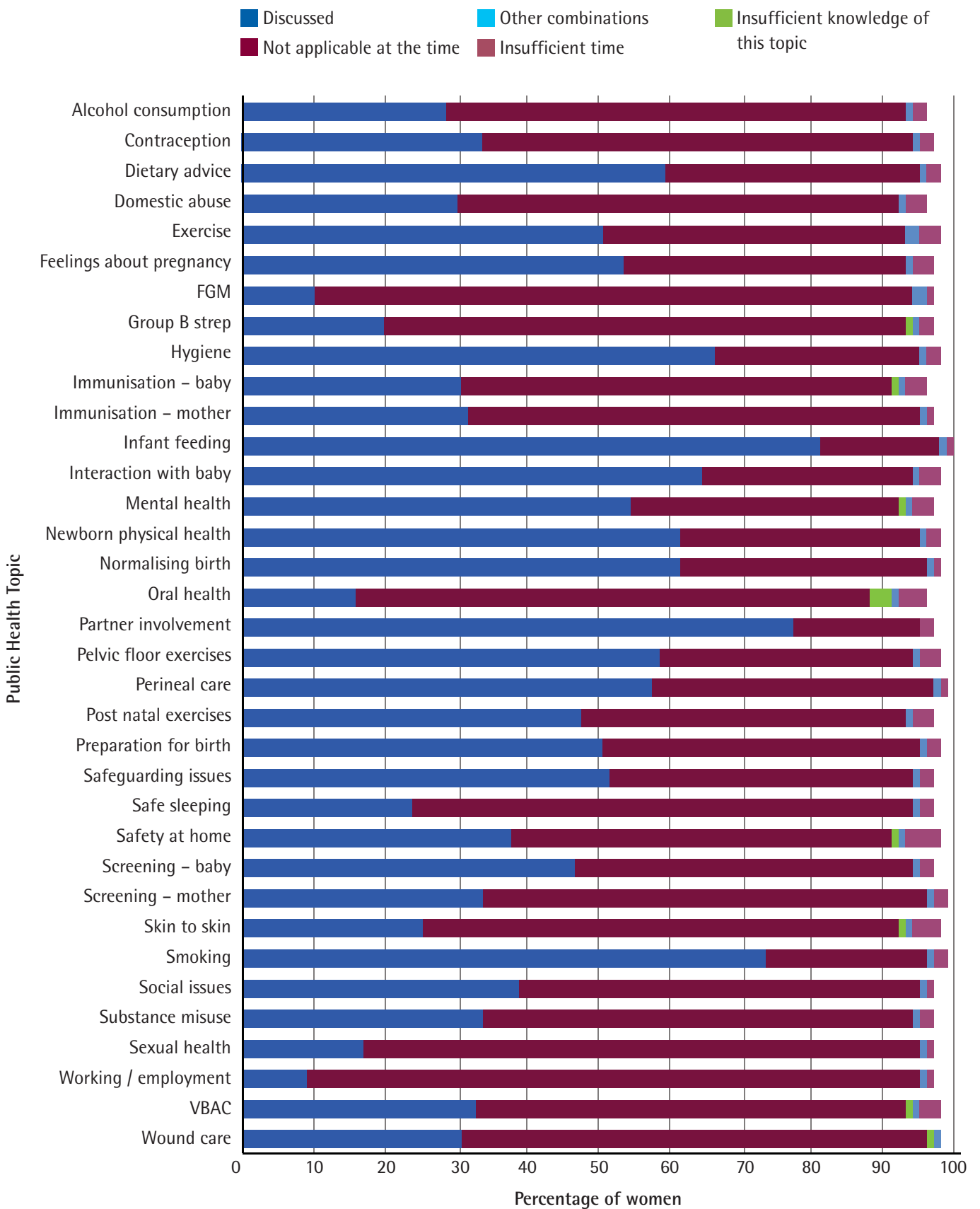


Figure 13. Public health topic being discussed or not discussed with women

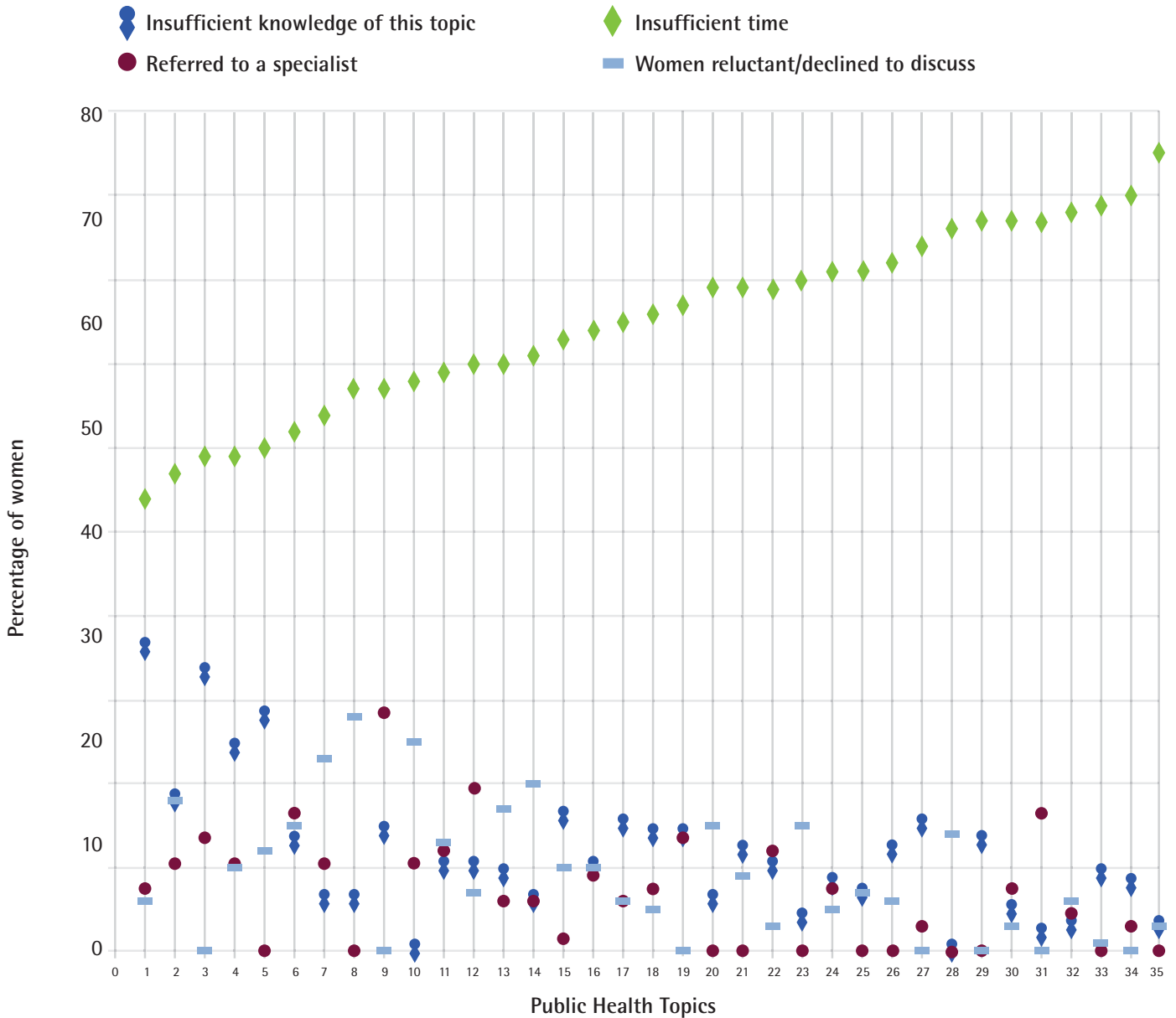


Figure 14. An overview of why public health topics are not discussed with women even when seen as relevant

Key

- |                          |                               |                              |
|--------------------------|-------------------------------|------------------------------|
| 1 - Oral health          | 13 - Social issues            | 25 - Exercise                |
| 2 - Substance misuse     | 14 - Alcohol consumption      | 26 - Preparation for birth   |
| 3 - Immunisation Baby    | 15 - Sexual health            | 27 - Working/employment      |
| 4 - FGM                  | 16 - Normalising birth        | 28 - Skin to skin            |
| 5 - Group B strep        | 17 - Mental health            | 29 - Screening mother        |
| 6 - Safeguarding issues  | 18 - Wound care               | 30 - Dietary advice          |
| 7 - Domestic abuse       | 19 - Perineal care            | 31 - Pelvic floor exercises  |
| 8 - Infant feeding       | 20 - Feelings about pregnancy | 32 - Newborn physical health |
| 9 - VBAC                 | 21 - Hygiene                  | 33 - Safety at home          |
| 10 - Smoking             | 22 - Screening baby           | 34 - Interaction with baby   |
| 11 - Contraception       | 23 - Partner involvement      | 35 - Safe sleeping           |
| 12 - Immunisation Mother | 24 - Post natal exercises     |                              |

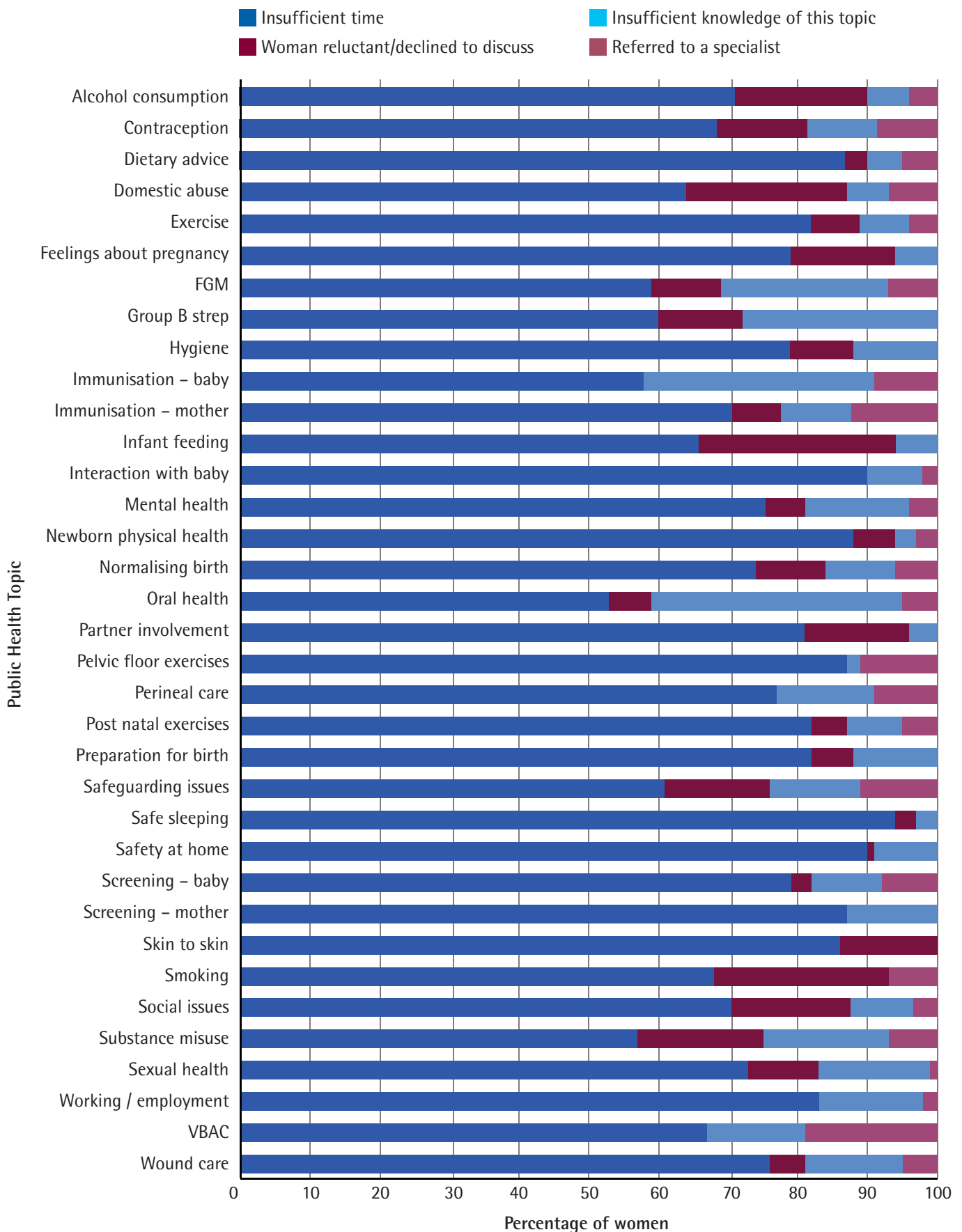


Figure 15. Reasons for each public health topic not being discussed with women even when seen as relevant





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## Discussion of the survey results

Overall there was general agreement that a large proportion of the work of the midwife falls under the public health remit and this was shared across the four countries. Practitioners had a wide definition for the types of interventions and information topics that fall within public health and saw the role as crucial for the immediate care being provided and for the health of the family unit.

Using the 35 public health topics as markers for understanding barriers and facilitators for implementation, one of the key findings was the lack of time for the different stages of care. Even an additional 10 minutes in the antenatal period and 10 to 20 minutes in the postnatal period above the average appointment time was seen as an important step to improving the current provision. The ability to provide the information in a consistent and timely manner with the contextual setting of the appointments and follow up through continuity of care was highlighted in this study.

On the whole midwives were identified as the most appropriate professional for delivery of the majority of the public health topics highlighted in the study. Obstetricians, MSWs, and Health Visitors were suggested as being appropriate for some of the topics. In some cases, other professional groups were identified based on their expertise, such as physiotherapists for pelvic floor and exercise and MSWs for safety in the home, which was based on the time that can be spent to ensure the topic is fully covered.

The need to pull on the multidisciplinary team to ensure consistency of information and form layers of referral pathways to fully cover all the relevant public health topics was also reported as being important. Although, this was seen as ideal, it was acknowledged that difficulties can be experienced in getting support through specialist care for women, and this included topics such as for mental health and maternal weight concerns. The tailored support and advice that practitioners wanted was not readily accessible even if the referral pathways were established and available. Some of the accessibility issues stemmed from the waiting time for being seen after referral to the lack of expertise or a public health lead in a given area within the trust or health board.

The provision of care requires confident practitioners and this research study showed that this was an issue that needs to be addressed. Further training and a greater understanding of certain public health topics was reported as being crucial by the practitioners. Even topics such as vaccinations and Vitamin D were identified in addition to the more sensitive ones with obesity and safeguarding being specifically mentioned. From the 35 public health topics used in this study, all but one (oral health) were seen

as areas for further training. On the whole, oral health was identified as a topic that fell out of the midwives remit and one which should be addressed by dentists to ensure appropriate care/advice. Given that the majority reported having learnt many of the topics as a student, it is inevitable that there will be gaps in knowledge and confidence over time.

The findings from the survey provide the context for the UK on how public health topics are considered by practitioners and helped quantify some of the barriers and facilitators to implementation. As with any study, there are some limitations to note from this survey and two of the main areas are highlighted here are the number of respondents and diverse spread of roles and the public health topics covered in this study.

Starting with the respondents and participation in the study, it is important to note that whilst there was a good response rate to this survey, some of the roles were not fully represented in this study. The majority of respondents were practising midwives working clinically, both within the NHS and independently. Represented also were midwives in managerial, educational and research posts, some of whom also worked in the clinical setting. This was not surprising given that participants were recruited via the RCM's membership database whereby qualified midwives account for 74% of members. Other participants included student midwives, MSWs, health visitors and neonatal nurse/midwives.

Future research could aim to widen the invitation for participation to other professionals and seek collaborations from other organisations to support data collection. Given the depth of information that was sought from this quantitative research study, the response rate and the wide sample that was used to gather the data, the response rate is seen as sufficient to inform the project and the next stages.

The second main limitation is the use of 35 public health topics as the markers for exploring the role of public health in this study. The 35 topics included were selected with input from the qualitative study, Midwifery Advisory Group at the RCM and through wider analysis of the main public health topics. Some topics such as high and low BMI were covered in the public health topics under the topic dietary advice and exercise. The topics did not take into consideration population groupings such as ethnicity and vulnerabilities as the topics were expected to be of relevance to different population groups or all women based on context.

The respondents identified a number of other topics which were directly or indirectly related to public health. Some of these were very specific such as Vitamin D supplementation, delayed cord clamping and the use of legal highs whilst others were more generic such as issues around sexual abuse and supporting women with poor engagement in maternity services.



Inevitably, with any data collection, there are time constraints to be considered for participants. Therefore it was necessary to limit the number of public health topics alternative set of public health topics could have been used in the questionnaire and audit, and that the data collection was not comprehensive in its listing of the topics. Despite this limitation, the study has been able to show trends for certain public health topics and future studies could use more focussed surveys to explore barriers, facilitators and experiences for a wider set of topics.

## Discussion of the audit results

As part of the audit, practitioners were asked to consider their most recent contact with a woman for maternity care and provide detailed information on the discussions taking place around the 35 public health topics. The demographics of the women identified for the audit were broad with fairly good representation from parity, age, role of the practitioner and care settings. Over 50% of the women were cared for in a hospital setting and at least one fifth were in the home setting. The role of the practitioners in their care ranged from being the main carer for all of their maternity care to only providing care for one part of the continuum either for antenatal, intrapartum or postnatal care. For a small proportion of the women included in the audit, the practitioners were providing advisory or specialist care.

The findings showed that at least half of the topics had been discussed with the majority of women and that there were no differences between primiparous and multiparous women. The two most popular responses for the audit were that either discussion had taken place or that it was not relevant at the time. Eighty percent of women had discussed at least 20 of the public health topics and 5% had discussed more than 28 of the 35 topics. For the topics that were not viewed as applicable at the time, this may be because of the audit including women in intrapartum care and as expected, topics such as antenatal screening are unlikely be covered during this time. However, for cases where the discussions were not taking place even though it was applicable, lack of time was identified as a major factor. This finding has been reflected in the survey as well as the qualitative study in this project.


The findings from the audit provide an evidence base for the number of topics that are discussed across care settings and the type of topics that are less likely to be discussed. As with any study, there are limitations that need to be taken into consideration. The main limitations for the audit are in the omission of specific information in the demographics collected and the inability to capture the public health topics discussed over previous contacts with women included in this audit.

There were important demographics included in the audit, however, it was not possible to collect detailed information about each woman. Questions such as ethnicity, gestational age, social deprivation scale, and whether English was a second language, presence of a partner and number of previous contacts would have enhanced the analysis. These could have increased understanding of the differences in the number of public health topics that were discussed and potential barriers.

The number of public health topics could be influenced by the context at the time of the contact. As there were some midwives who were providing continuity of carer, for either antenatal and postnatal or including intrapartum, the number of topics reported as being discussed may be higher as the discussions may have taken place in previous appointments. Therefore, the number of public health topics reported in this audit provides an indication and cannot be used as a definitive guide of the number that are discussed throughout the pregnancy.

As with the survey, these limitations exist because of the need to reduce the number of questions in the overall questionnaire. The methodology for the audit provides a starting point for measuring implementation and can be adjusted for the care context. Future studies could capture baselines and progress being made over the continuum of care.

In summary, this study provides a basis for understanding the current context, experiences and the extent to which implementation takes place across the UK. These findings together with the qualitative work, were taken forward to the next stage for stakeholder input and development of resources for both women, families and practitioners.



Section 5. Stakeholder  
think tank



## Section 5. Stakeholder think tank

Following analysis and theming of the qualitative and quantitative data, a think tank involving key stakeholders was convened to consider the findings. This provided a platform on which to build a cohesive, usable model for maternity care. Around 60 public health experts, service users, midwives student midwives and MSWs participated in the think tank event held in August 2015. This section provides an overview of the process and the outcomes from the day.

The day started with presentations from the researchers of the qualitative and audit/survey studies. This was followed by interactive sessions to gather feedback from each of the seven groups with a wide spread of roles/disciplines represented in each group. The groups considered the main themes generated from the research studies and were guided by points for discussion, questions, and quotations from the studies (Table 16).

Table 16. Identified barriers and facilitators

Theme	Considerations/Guiding Questions
Timing – antenatal, intrapartum, postnatal	<p>What, when, who</p> <p>"Its not really part of my role (public health) as I'm core staff on delivery suite" (MW)</p> <p>"Women in the postnatal period are given too much information" (MW)</p>
Communication	<p>How do we address women being given conflicting information?</p> <p>How can we ensure that sensitive information is given/sought appropriately?</p> <p>Is there an alternative to leaflets?</p> <p>"its difficult to know how to broach some sensitive topics...we aren't taught how" (MW)</p> <p>"She suddenly said 'Does your partner hit you?' I had to ask her to repeat it as it came out of the blue, very bizarre" (SU)</p>
Continuity of carer/care	<p>How can we ensure individualised care?</p> <p>How can fragmented care be avoided?</p> <p>"the benefit of continuity of care is that midwife has a better idea of what she has or hasn't told the women in her care" (MW)</p> <p>"The fact that I never saw one midwife more than once ... I was never able to build a relationship" (woman with MH problems) (SU)</p>
Education and training	<p>What, when, by whom</p> <p>Also: differing need of health care professionals including midwives, MSWs, student midwives</p>
Most appropriate HCP to address individual topics	<p>How might we best utilise all areas of the workforce to deliver important public health messages at the most optimum time?</p> <p>Who should be involved</p> <p>What specialist services do we need?</p> <p>"I strongly feel that all professionals have public health responsibilities with women, families and the wider community" (MW)</p> <p>"I do not think MSW's should be giving women advice" (MW)</p>
Time constraints	<p>How can this best be addressed?</p> <p>Who needs to be involved?</p> <p>"I cover these topics often by working longer hours, if I stuck to allotted times I wouldn't be able to cover the things I do" (MW)</p>

The stakeholders were asked to provide feedback on barriers and facilitators, as well as potential solutions. The feedback was provided to the wider group and facilitators for each group captured the discussion in written format to inform the next stages of the project.

The feedback reflected some of the barriers and facilitators, such as lack of time and partners needing factual information as reported in the project. Two main areas were highlighted

across all the groups. These were in terms of improving experiences and supporting individualised care through continuity of carer. Better communication of information and the use of alternative approaches to sharing information including technological solutions were discussed as well as face-to-face antenatal group classes. A visual summary of the prominent words from the Think Tank feedback is presented in Figure 16 and some of the feedback notes are shown in Appendix 3.



Figure 16. Visual summary of the prominent discussion areas from the Think Tank





Section 6. The Stepping up  
to Public Health Model

# Section 6. The Stepping up to Public Health Model

The Stepping up to Public Health model for women and families starts with the concept that all women and families are given individualised support, information and care in regard to their public health needs. The whole approach is family-centred bringing fathers and partners into the discussions and care.

The Stepping up to Public Health Model has 3 tiers and should be read from the bottom up. Tier 1 states:

*“The first appointment with a midwife maximises the opportunity for a women-centred discussion. With guidance, women are supported to tailor a unique package of information and support. This will be appropriate to their existing knowledge, recognise individual needs and be responsive to changing circumstances. Choice will be facilitated by offering options for accessing evidence-based information.”*

There are subgroups of women who may have additional needs. Tier 2 of the model includes women with additional risk factors and/or women with complex social factors. With a smaller subgroup on Tier 3, are the women who require additional care outside the midwifery team, while still remaining under the primary care of their midwife.

Presented as a podium, women and families may move up or down or sideways at any given time in the care pathway. The three interacting factors across all women and families and the subgroups are:

- Preconception advice, support and care is included as part of the model.
- Preparation for pregnancy, birth and beyond
- Information about and/or referral to third sector support in the community.

Tier 1: For all women and families by all midwives and maternity support workers

Support – Information – Care

### All women and partners

The first appointment with a midwife maximises the opportunity for a women centered discussion. With guidance, women are supported to tailor a unique package of information and support.

This will be appropriate to their existing knowledge, recognise individual needs and be responsive to changing circumstances.

Choice will be facilitated by offering options for accessing evidence based information.

CPD – Education & Practice

### All Midwives and Maternity Support Workers

Midwives support women and partners to design their own journey into parenthood, whilst ensuring that essential key topics are raised with all women. Midwives receive ongoing training to enable them to deliver woman-centred public health messages in a sensitive, consistent and timely manner, ensuring that they are up to date with all current information. MSWs are supported with training for all relevant aspects of their public health role in order to ensure that by developing their knowledge and skills their contribution to the midwifery team is widened.



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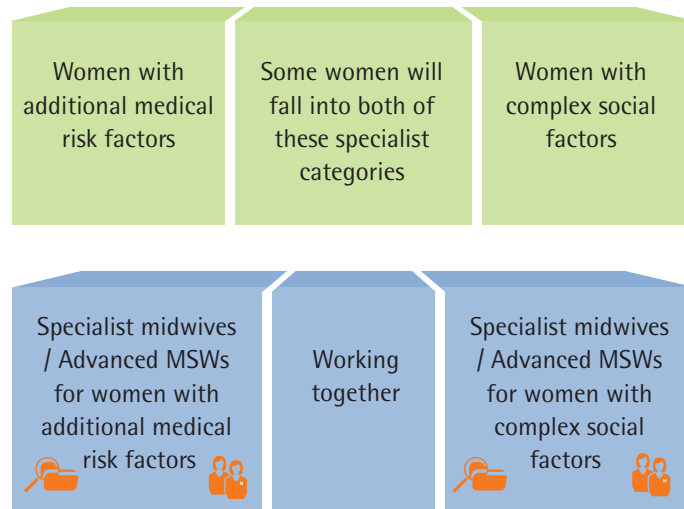
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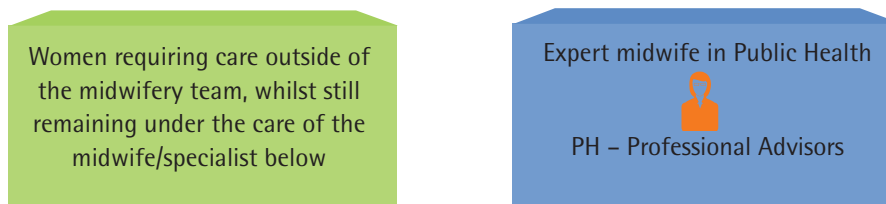
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## Tier 2: For some women and working together



## Tier 3: Specialised expertise required for some women



The Stepping up to Public Health model for midwives and MSWs is complimentary to the model for women and families. However, it also has a focus on the CPD, education and practice elements necessary for successful implementation of public health in maternity.

As all women and families will receive the care of midwives, it is expected that all midwives and MSWs are engaged in the first tier of the podium in order to maximise the initial and subsequent appointments and contacts. Tier 1 for this model states:

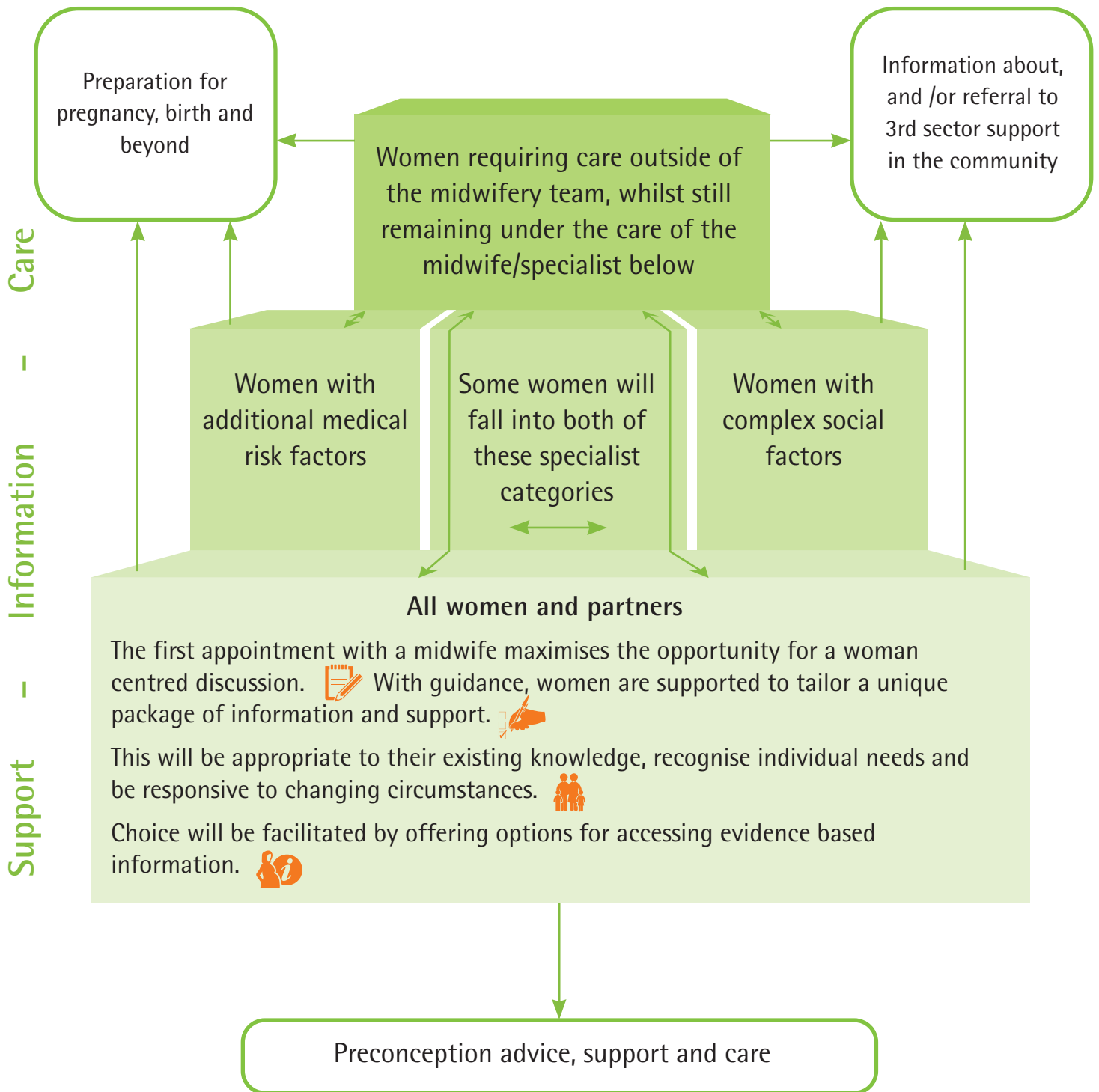
*"Midwives support women and partners to design their own journey into parenthood whilst ensuring that essential key topics are raised with all women. Midwives receive ongoing training to enable them to deliver woman-centred public health messages in a sensitive, consistent and timely manner, ensuring that they are up to date with all current information. MSW's are supported with training for all relevant aspects of their public health role in order to ensure that by developing their knowledge and skills their contribution to the midwifery team is widened."*

Supporting women in prioritising key topics and adapting them according to need requires up-to-date skills and knowledge. Some midwives and MSWs may develop specialist skills to support a subgroup of women such as in tier 2 with complex social factors or additional risk factors. The specialist midwives for medical and/or social risks may work together across the maternity care system. Tier 3 for the model brings in a level of expertise best resourced by consultant midwives or Professional Advisors in public health. Moving from this tier to the strategic level for PH planning and commissioning is part of enabling a system wide approach in maternity care.

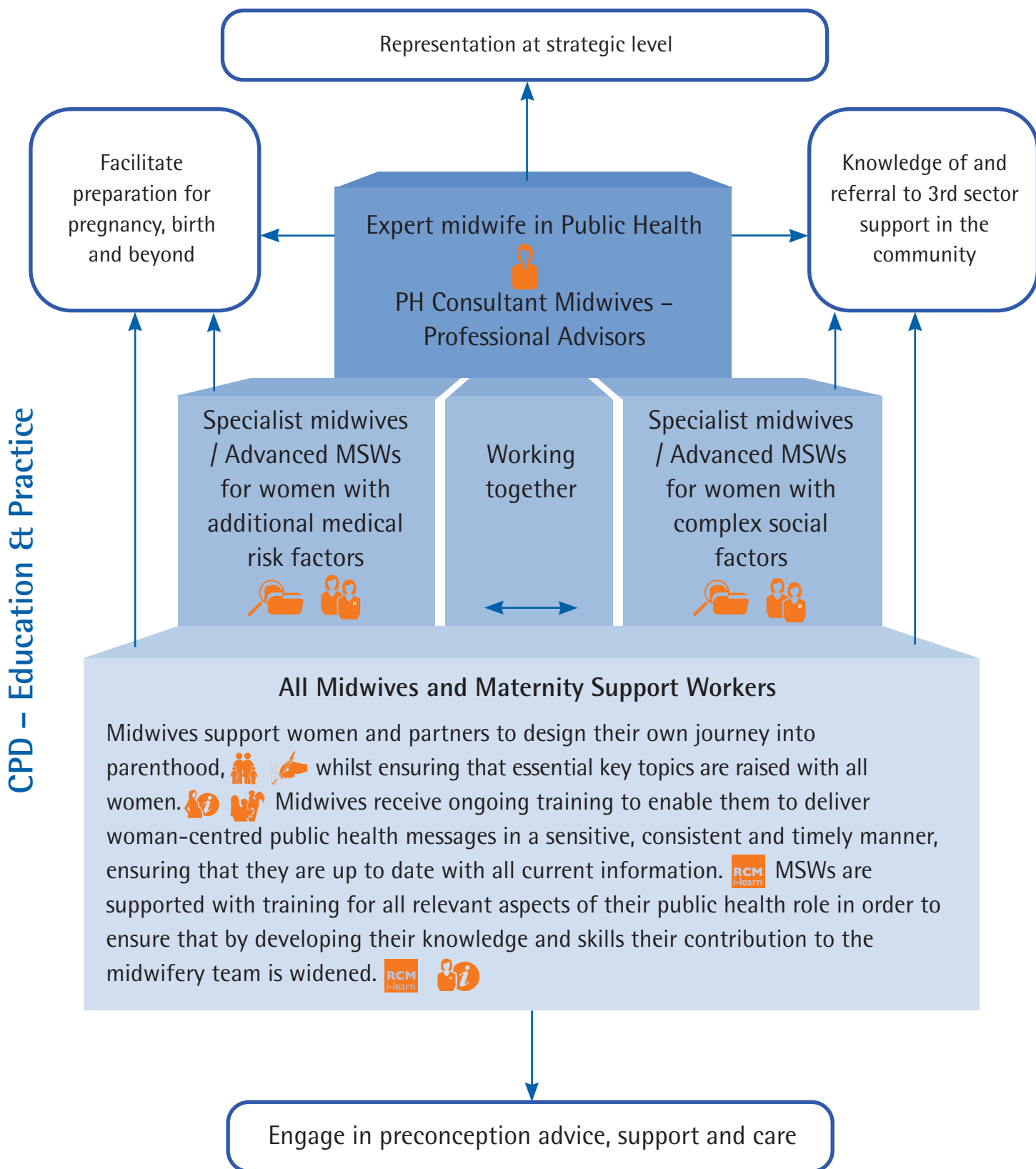
The three interacting factors across all women and families and the subgroups are captured in the Stepping up to Public Health model for midwives and MSWs through engagement, facilitation and being knowledgeable.

The full models are presented in the following two pages. There is also a key outlining resources and suggestions for improving the public health remit as part of providing family-centred care.

## Women and Families – Stepping up to Public Health



## Midwives and MSWs – Stepping up to Public Health





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# Key for the Stepping up to Public Health Models

## Women fill in their own notes

Women are given the option of filling in their own notes prior to seeing the midwife for their first appointment. This will reduce the time midwives spend completing paperwork and increase the time spent tailoring care and advice to women's needs.



## Women can choose from a menu of topics

A menu of public health-related topics will be given to women when they are referred or self-refer for maternity services. They will then decide what they want to discuss with their midwife at each appointment. This will avoid the tick box exercise many women have commented on and allow women, not services, to prioritise the messages discussed. It is the woman's responsibility to sign the menu before discharge to confirm that information was discussed with them.



## Information repository for women

A user-friendly one-stop source of safe, evidence-based public health messages. The internet is a popular source of information for women, but unregulated content can cause high levels of anxiety and confusion. This RCM-hosted site will allow families to access information that is unbiased by commercial interest, factually correct and is issued by reputable sources.



## Information repository for midwives and MSWs

The public health remit is becoming wider, with ever more information and advice being issued which midwives and MSWs need to be aware of. The RCM will help them stay informed by hosting a repository of the most up-to-date information and advice, with downloadable leaflets, useful contacts, and hyperlinks direct to reputable, non biased support sites for women and their families, midwives and MSWs.



## Family-centred care

Women do not exist in isolation; advice and care should be tailored to couples and families, with fathers/partners being included in discussions where appropriate. This enables partners to be informed about the importance of public health issues. Evidence suggests that women whose partners are supportive are more likely to breastfeed for longer, make a successful attempt to stop smoking and be less likely to develop postnatal depression.



## Some topics are for everyone

Whilst giving women the freedom to choose which public health messages are discussed, there are some topics that need to be raised with all women/couples. This is not an exhaustive list and is adaptable at local level: domestic abuse, alcohol in pregnancy, smoking (risks of passive smoking even for non-smokers), screening for mum and baby, immunisations (flu and pertussis), weight management, mental health, FGM.



## Good practice case-studies

There are a wealth of excellent public health initiatives around the country. These will be gathered into a collection of case-studies, allowing good practice to be widely shared, particularly around specialist public health midwifery roles. Case studies will give insights into the process of setting up a new service, as well as practical tools such as care pathways.



## Public-health midwifery leadership

We recommend that each trust/health board employs a consultant midwife in public health with specific knowledge about the population they care for. They would sit at strategic level and influence the wider strategic organisations, such as children's services and the third sector. This would ensure that public health in maternity services remains high on the agenda and truly impacts on population health and wellbeing outcomes.



## I-learn Public Health modules

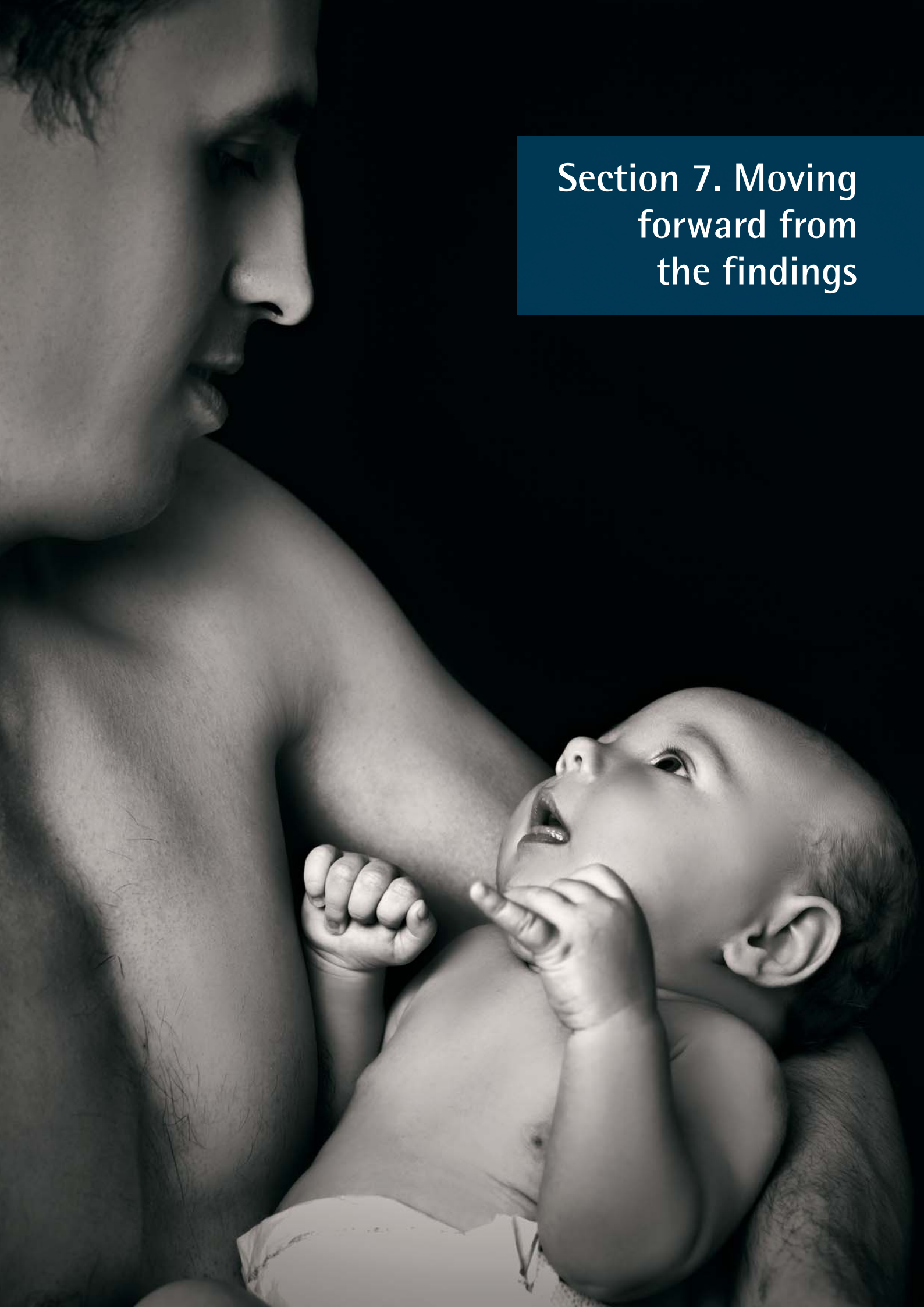
The RCM i-learn provision covers a wide range of public health topics. All learning can be uploaded to a professional portfolio, facilitating CPD and revalidation requirements. These are a few examples which meet the public health remit: (1) understanding asylum seekers and refugees, (2) nutrition and obesity, (3) relationship support: an early intervention, (4) the changing social context of parenting. Additional modules have been added as part of the project such as motivational interviewing.



## Role of the Maternity Support Workers

The maternity support worker role in contributing to the public health remit must be recognised and better utilised. This is not as substitutes for midwives but to work alongside, providing assistance and support for the maternity team.



A black and white photograph showing a man's profile on the left, looking towards a baby on the right. The man is shirtless, and the baby is also shirtless, wearing a diaper. The baby is looking up at the man with its mouth slightly open. The background is dark. A dark blue rectangular box is overlaid on the top right of the image, containing white text.

**Section 7. Moving  
forward from  
the findings**

# Section 7. Moving forward from the findings

A number of key deliverables were achieved following the completion of the quantitative and qualitative data collection and the Stakeholder Think Tank. The ten main outputs have been outlined in this section with the rationale and online links to further information where relevant.



Rationale






Description



Output




## A new Stepping up to Public Health Model for women and families in maternity.

-  In light of key government publications, it was recognised that there was ambiguity around the public health role of midwives.
-  Using the research findings, a new model emerged for supporting the future direction for public health in maternity and informing practice, policy and research.
-  <http://bit.ly/2sgVJgR> and as shown in page 82



Output




## Information repository for women and families to access credible sources around public health topics.

-  Women were telling us that they did not know which information was correct or safe online, and they did not find leaflets the best way of receiving public health messages.
-  Information repository available online and as an app accessible to the public called RCM Pregnappp.
-  [pregnapp.rcm.org.uk](http://pregnapp.rcm.org.uk)



Output

## Pregnancy and birth information menu for women to self-complete and acknowledge receipt of the information.

-  Women expressed concern that although their notes indicated that certain topics had been addressed, they did not recall being given the information.
-  The menu enables women to prioritise information they feel they need. It can be accessed online and used locally as a standalone document or integral within the maternity notes.
-  <http://bit.ly/2sraVGL> and as shown in Appendix 4

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Output

### A new Stepping up to Public Health Model for midwives and maternity support workers to inform practice and professional development.

**R** Having developed the women and families model, a corresponding model was needed for practitioners.

**I** The new action model highlights the professional perspective for implementing public health in maternity.

**L** <http://bit.ly/2sFSlga> and as shown on page 83

5

Output

### Information repository for midwives and maternity support workers to access credible sources on public health topics.

**R** To compliment the information repository for women and families, a version was needed where additional information was given in greater depth for members.

**I** Online information repository accessible to RCM members

**L** [www.rcm.org.uk/public-health-repository-for-maternity-staff](http://www.rcm.org.uk/public-health-repository-for-maternity-staff) (available to members only)

6

Output

### A list of public health topics for women to compliment the self-completion menu.

**R** An important caveat to women choosing topics is that there are some messages that must be raised with all women and families.

**I** Recommended public health topics with invitation for local level adaptations

**L** As shown on page 84 titled 'Some topics are for everyone'

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Output

### RCM i-learn modules for members to develop their knowledge and skills

- R** Both midwives and MSWs identified training needs around public health topics with gaps in the available training resources. They particularly highlighted the need for guidance around broaching sensitive issues with women and their families.
- D** Modules already available in the RCM i-learn have been badged for public health. Two additional modules have been developed with one focussing on public health topics for all, but particularly aimed at MSWs and the other, for use by all practitioners, addressing communication around sensitive topics.

 [www.ilearn.rcm.org.uk](http://www.ilearn.rcm.org.uk)

8

Output

### Trust dissemination events

- R** Interactive face-to-face dissemination events were needed to inform the project.
- D** Forty maternity units in England were visited between December 2015 and September 2016 aimed at maternity staff, commissioners, local authorities, health visitors and educators. A few additional visits took place at higher education institutions where it wasn't possible for staff to attend a Trust event.

9

Output

### Printed publications and conferences attended to disseminate findings and the Stepping up to Public Health model.

- R** Multiple approaches to dissemination to reach a wider audience in midwifery, research, policy and planning, it was necessary to consider.
- D** Five publications were produced between 2015 and 2016, with two in the RCM Midwives magazine and peer reviewed journals. In addition, six presentations and workshops at healthcare conferences.

 [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth) and as shown in Appendix 5

10

Output

### Practice case studies to give insights and knowledge sharing.

- R** It is clear from visiting maternity units that there is an abundance of excellent public health practice/innovations around the country and sharing would support implementation plans.
- D** 10 case studies were collated to enable sharing of good practice establishing services as well as practical tools, such as care pathways. These have been made available online in relevant formats.

 [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)





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# Appendix 1. Additional Public Health Topics

## Some of the additional public health and related topics identified by participants

Although many of the public health topics are covered in the audit and survey, respondents were asked for additional topics and they identified subgroups to the categories already used in the questionnaire. An example of this would be that bed sharing is covered under safe sleeping and breast feeding is under infant feeding in the questionnaire. Some of the topics such as male genital mutilation and smear testing were also considered by the Project Steering Group to be outside of the boundaries of the role of the midwife in public health. The resources that were developed for midwives and for women took into account the additional topics highlighted by respondents and covers topics such as cancer in pregnancy and bereavement.

### Nutrition and weight management

- Obesity
- Anorexia and body image amongst women who have a low BMI
- Healthy postnatal weight and fitness

### Vaccinations

- Infectious diseases such as TB (Tuberculosis), flu vaccinations
- Influenza in pregnancy and vaccination
- Maternal vaccinations i.e. whooping cough

### Screening

- Smear testing and breast screening

### Parenting and Infant care

- Attachment and bonding
- Weaning
- Feeding equipment sterilisation
- Jaundice in babies
- Needs of the baby including basics such as clean clothing
- Relationships between parents & parenting and transition to parenting

### Mental health

- Paternal mental health and wellbeing

### Community, social and other groupings

- Asylum seekers
- Cultural practices for minority ethnic groups
- Gay relationships
- Learning difficulties access to maternity services
- Gay/lesbian relationships related to childbirth
- Ethnic minorities
- Migrants / asylum seekers / refugees
- Maternal age for the under 19s and over 40s
- Physical and learning disability
- Poor engagement with maternal services
- Paternal involvement in criminal justice system
- Poverty, poor housing, and economic deprivation, pertinent to perinatal and maternal morbidity and mortality
- Survivors of sexual abuse (childhood and adulthood)
- Teenage pregnancy
- Women with HIV and issues such as disclosure
- Vulnerable groups including young parents and recent immigrant women

### Vulnerable groups

- Child Sexual Exploitation and trafficking
- Homelessness, immigration, trafficking and sex working
- Issues around sexual abuse continues to be silent and a stigma for those who have suffered. This needs to be the next focus following the excellent work on domestic abuse. Routine enquiry may be the way forward

### Alcohol and drugs

- Drug misuse
- The use of legal highs

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## General health care

- Allergies, intolerance and hay fever
- Bladder care
- Posture and back care
- Future back pain and ill health
- Health and wellbeing in relation to health lifestyle for antenatal and postnatal

## Specific concerns in pregnancy

- Rashes in pregnancy
- Pre-eclampsia
- Stillbirth
- Fetal growth restriction, stillbirth and monitoring fetal movements
- Vitamin D maternal supplementation

## Medical complexities

- Cervical cancer screening
- Diabetes
- Cardiac checks

## Experiences

- Bereavement
- Birth experience

## Types of interventions

- Complementary therapies
- Self-help groups
- Parent education
- Delayed cord clamping
- Specific ways of avoiding/reducing caesarean birth

## Life skills

- Going back to work
- Housing, cooking skills, budgeting skills, benefits

## Support with information

- Guidance on internet use in pregnancy
- Home deliveries
- Specific information about the risk of birth vs benefits of procedures offered e.g. epidural, induction of labour.
- Specific, evidence based information and support led by the maternity care provider and endorsed by the trust as a whole.

## Other

- Male genital mutilation
- Pre-conception healthy lifestyle, advice and care
- Future pregnancies

# Appendix 2. Infographics for findings from the audit and survey practitioners for 35 public health topics



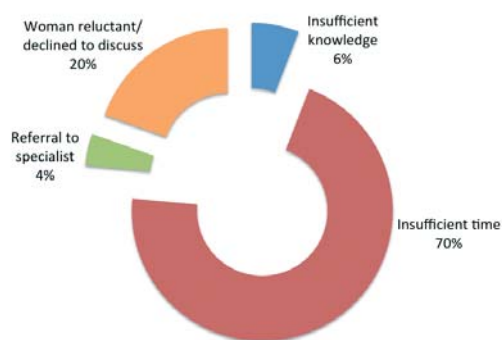
## Public health topic: Alcohol consumption



29 per cent of practitioners discussed the topics with women

65 per cent said it was not applicable at the time

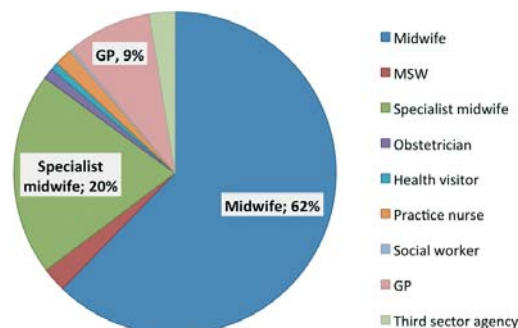
Reasons for not discussing the topic when it was applicable (n=51, 3%)



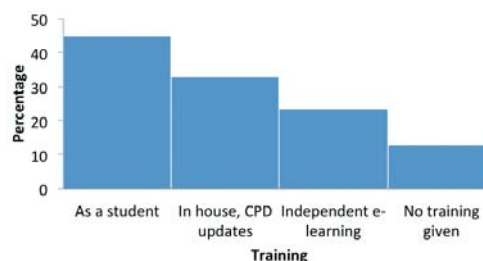
19 out of 100 practitioners want additional training

For more information and resources to support discussions on alcohol consumption, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered for training.



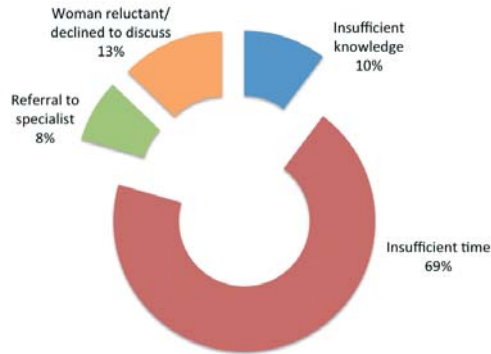
Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers

Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

34 per cent of practitioners discussed the topics with women

61 per cent said it was not applicable at the time

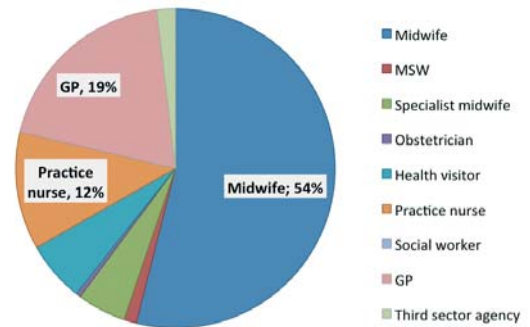
Reasons for not discussing the topic when it was applicable (n=39, 2%)



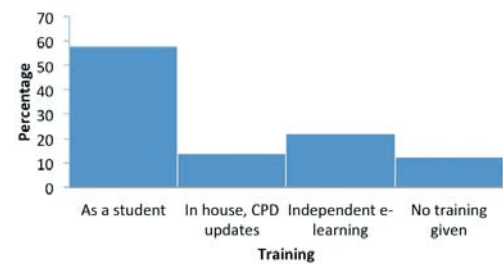
25 out of 100 practitioners want additional training

For more information and resources to support discussions on contraception, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

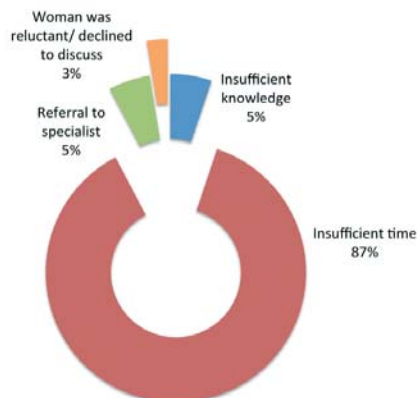


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

60 per cent of practitioners discussed the topics with women

36 per cent said it was not applicable at the time

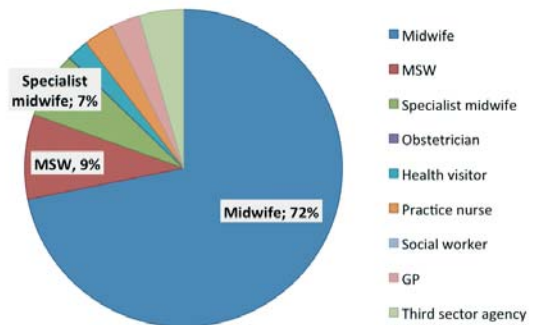
Reasons for not discussing the topic when it was applicable (n=39, 2%)



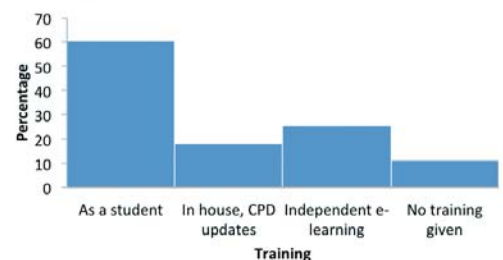
16 out of 100 practitioners want additional training

For more information and resources to support discussions on dietary advice, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

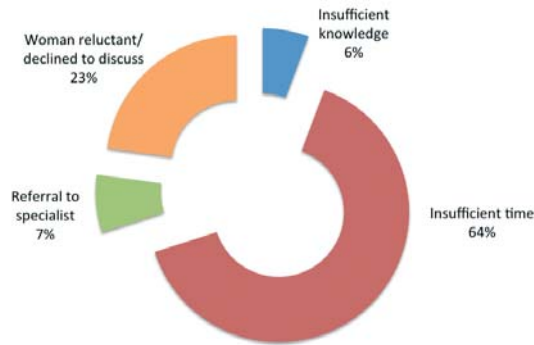


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

30 per cent of practitioners discussed the topics with women

62 per cent said it was not applicable at the time

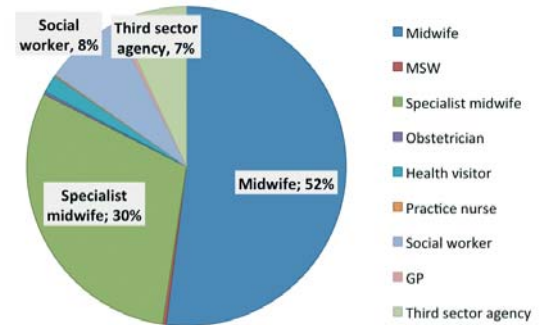
Reasons for not discussing the topic when it was applicable (n=70, 4%)



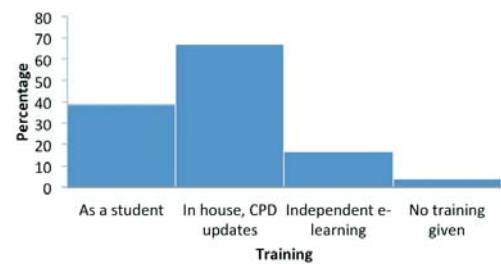
12 out of 100 practitioners want additional training

For more information and resources to support discussions on domestic abuse, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.



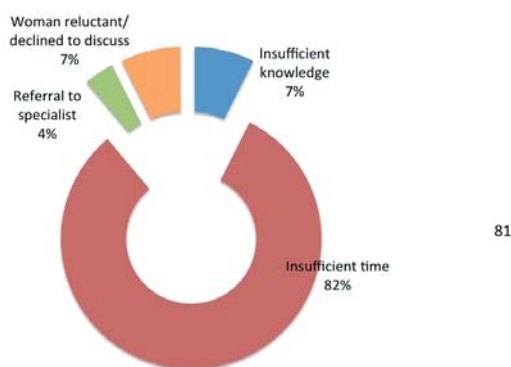
Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers

Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

51 per cent of practitioners discussed the topics with women

43 per cent said it was not applicable at the time

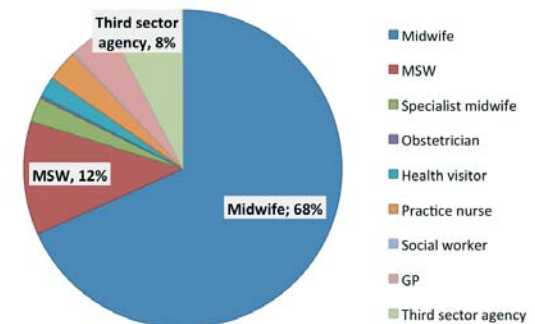
Reasons for not discussing the topic when it was applicable (n=54, 3%)



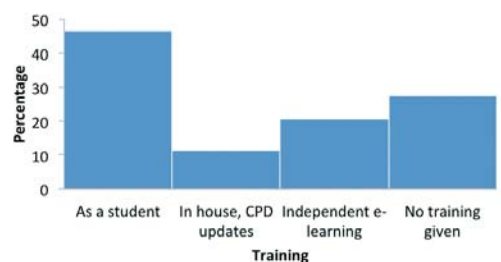
32 out of 100 practitioners want additional training

For more information and resources to support discussions on exercise, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

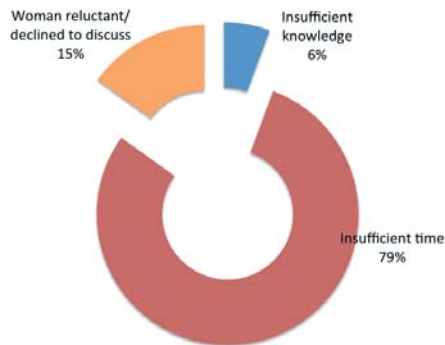


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers

Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

54 per cent of practitioners discussed the topics with women  
40 per cent said it was not applicable at the time

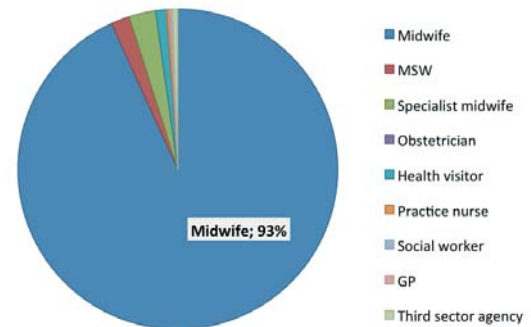
Reasons for not discussing the topic when it was applicable (n=53, 3%)



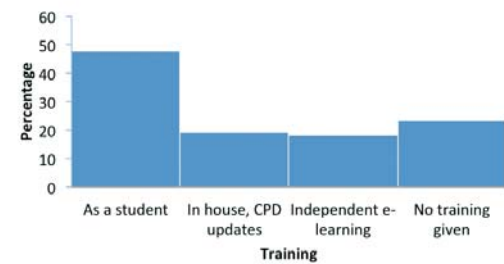
28 out of 100 practitioners want additional training

For more information and resources to support discussions on feelings about pregnancy, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



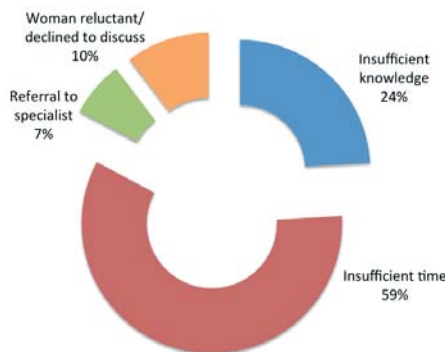
How this topic was covered.



Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

10 per cent of practitioners discussed the topics with women  
85 per cent said it was not applicable at the time

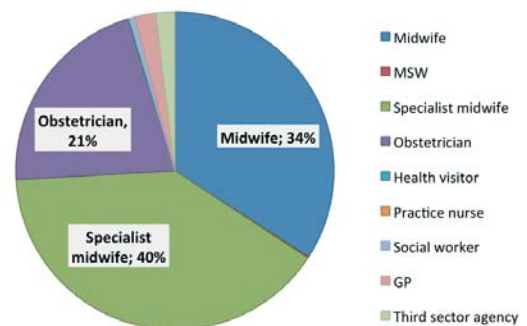
Reasons for not discussing the topic when it was applicable (n=29, 2%)



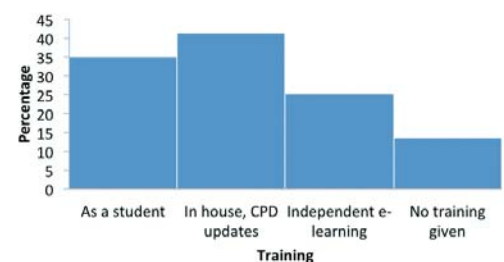
21 out of 100 practitioners want additional training

For more information and resources to support discussions on FGM, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

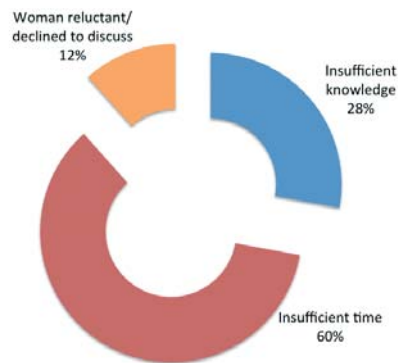


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)



20 per cent of practitioners discussed the topics with women  
74 per cent said it was not applicable at the time

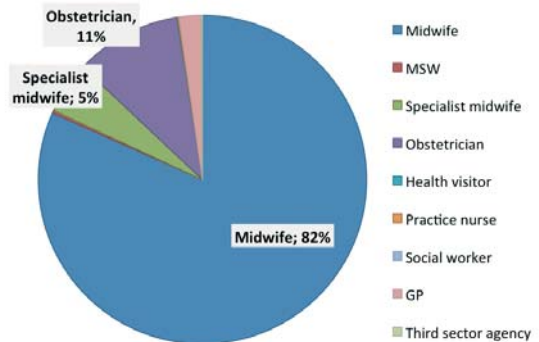
Reasons for not discussing the topic when it was applicable (n=43, 2%)



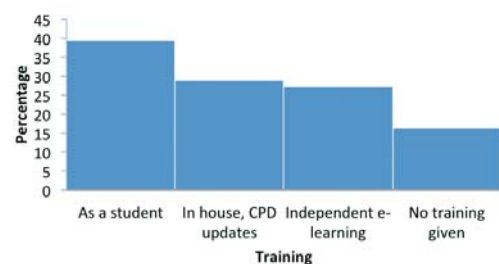
22 out of 100 practitioners want additional training

For more information and resources to support discussions on Group B Strep, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



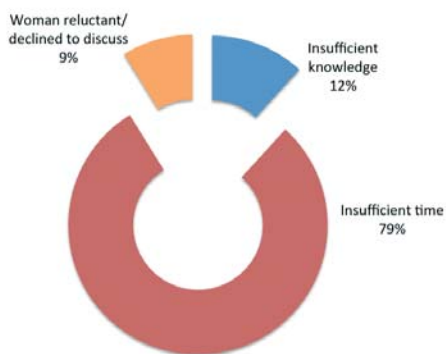
How this topic was covered.



Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

67 per cent of practitioners discussed the topics with women  
29 per cent said it was not applicable at the time

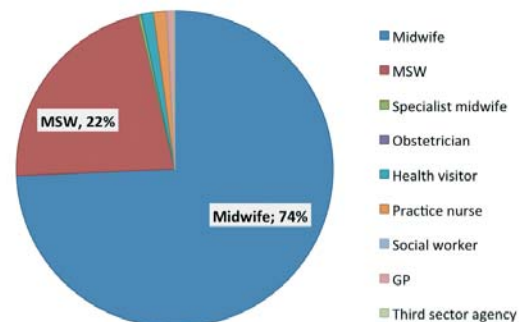
Reasons for not discussing the topic when it was applicable (n=34, 2%)



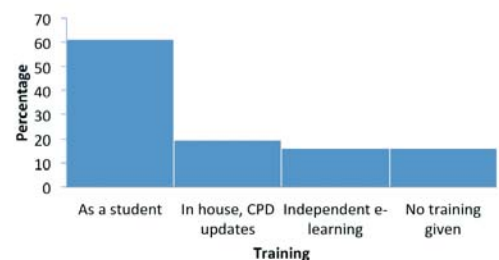
17 out of 100 practitioners want additional training

For more information and resources to support discussions on hygiene, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

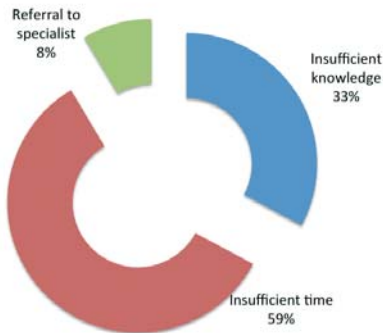


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

31 per cent of practitioners discussed the topics with women

61 per cent said it was not applicable at the time

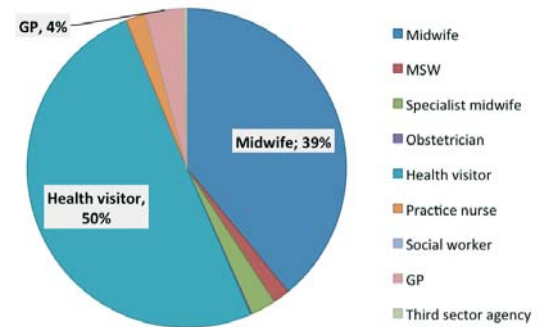
Reasons for not discussing the topic when it was applicable (n=70, 4%)



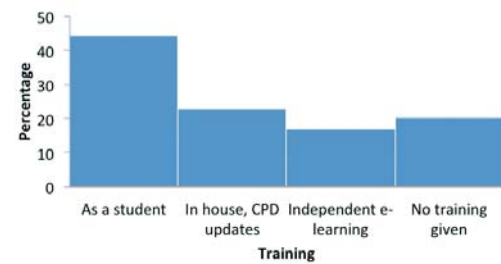
29 out of 100 practitioners want additional training

For more information and resources to support discussions on immunisation baby, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.



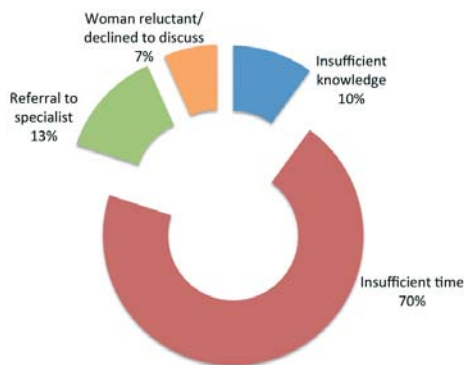
Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers

Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

32 per cent of practitioners discussed the topics with women

64 per cent said it was not applicable at the time

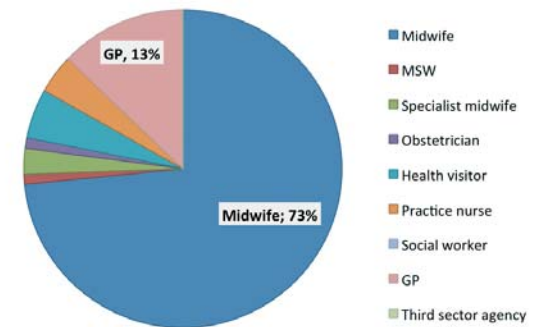
Reasons for not discussing the topic when it was applicable (n=30, 2%)



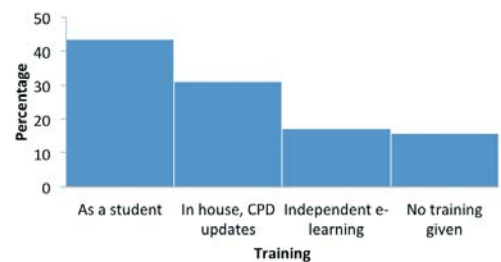
24 out of 100 practitioners want additional training

For more information and resources to support discussions on immunisation mother, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.



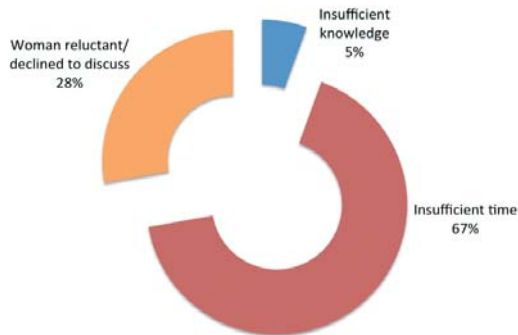
Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers

Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

81 per cent of practitioners discussed the topics with women

17 per cent said it was not applicable at the time

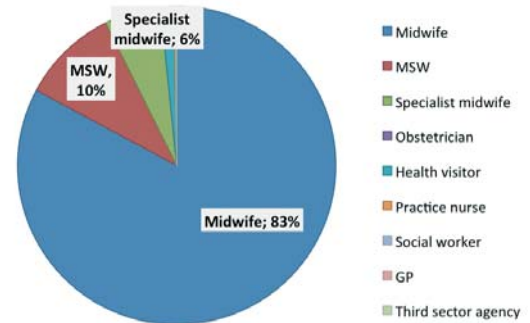
Reasons for not discussing the topic when it was applicable (n=18, 1%)



3 out of 100 practitioners want additional training

For more information and resources to support discussions on infant feeding, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.



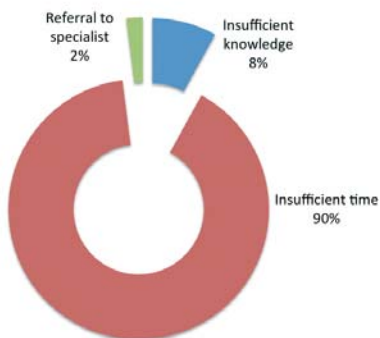
Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers

Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

65 per cent of practitioners discussed the topics with women

30 per cent said it was not applicable at the time

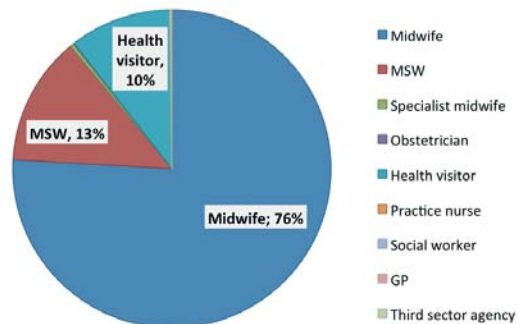
Reasons for not discussing the topic when it was applicable (n=50, 3%)



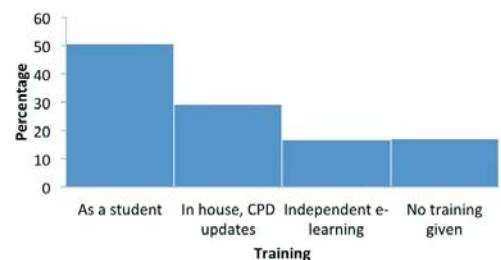
19 out of 100 practitioners want additional training

For more information and resources to support discussions on interaction with baby, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.



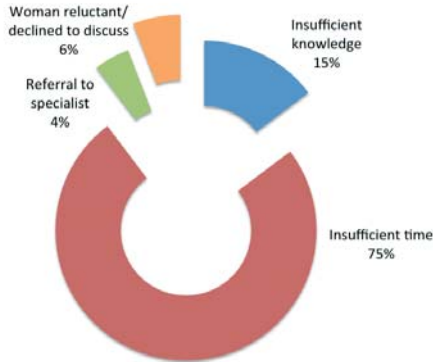
Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers

Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

55 per cent of practitioners discussed the topics with women

38 per cent said it was not applicable at the time

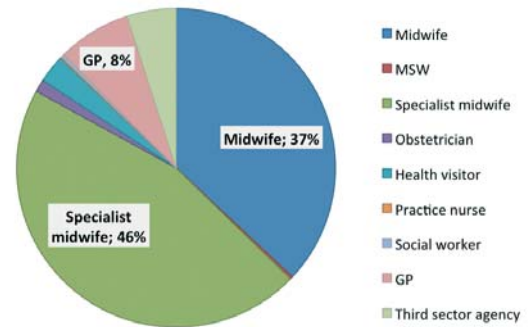
Reasons for not discussing the topic when it was applicable (n=68, 4%)



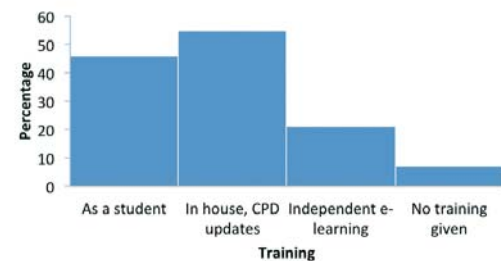
21 out of 100 practitioners want additional training

For more information and resources to support discussions on mental health, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

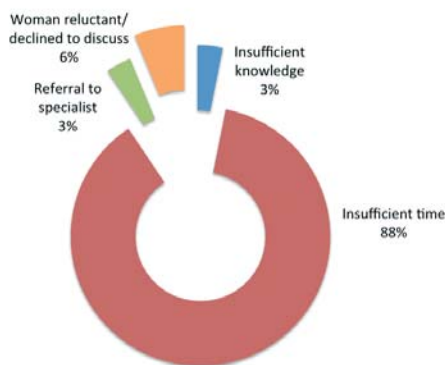


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

62 per cent of practitioners discussed the topics with women

34 per cent said it was not applicable at the time

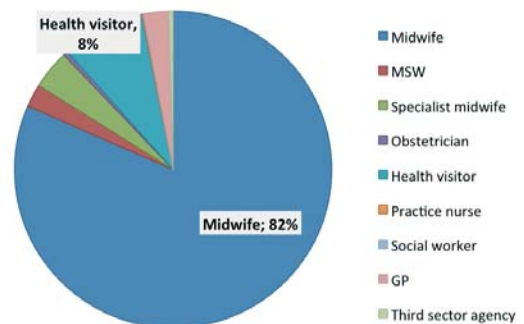
Reasons for not discussing the topic when it was applicable (n=32, 2%)



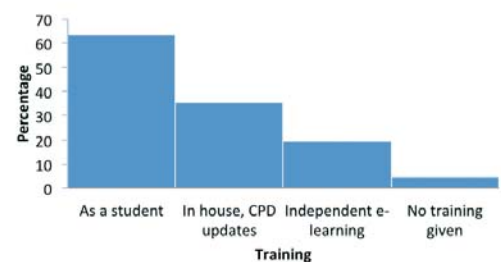
12 out of 100 practitioners want additional training

For more information and resources to support discussions on newborn physical health, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

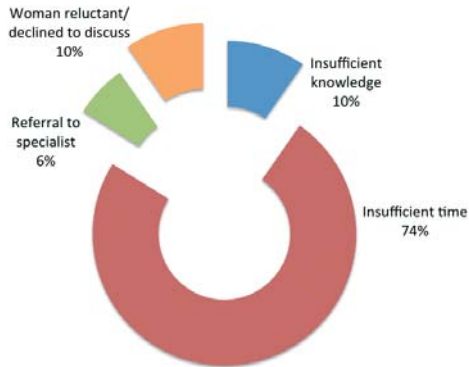


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

62 per cent of practitioners discussed the topics with women

35 per cent said it was not applicable at the time

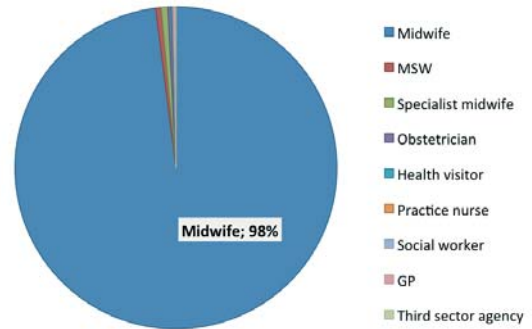
**Reasons for not discussing the topic when it was applicable (n=31, 2%)**



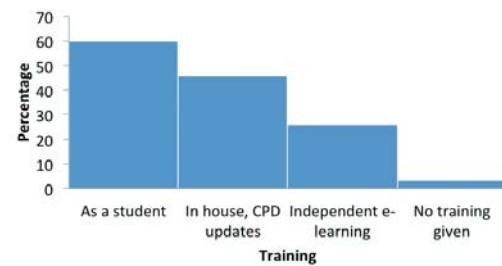
7 out of 100 practitioners want additional training

For more information and resources to support discussions on normalising birth, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

**Who is the most appropriate practitioner for this topic?**



**How this topic was covered.**

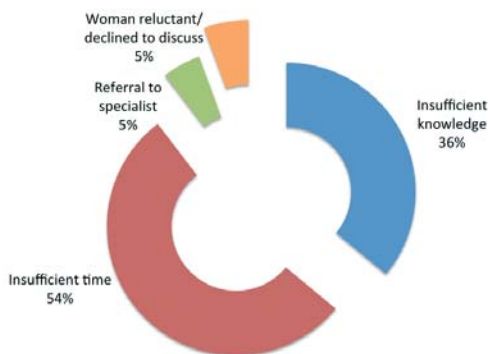


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

16 per cent of practitioners discussed the topics with women

73 per cent said it was not applicable at the time

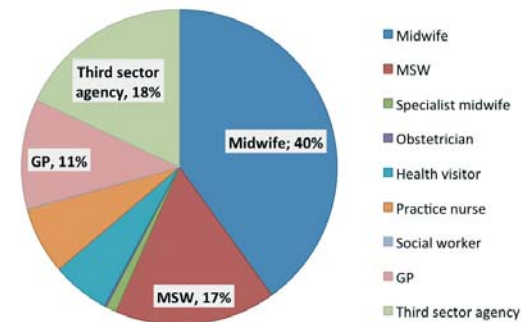
**Reasons for not discussing the topic when it was applicable (n=125, 7%)**



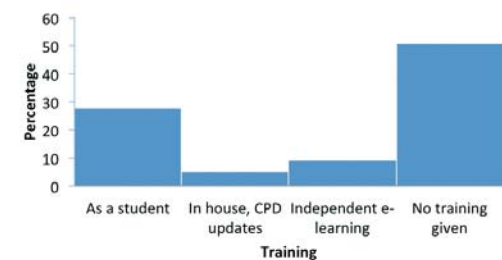
55 out of 100 practitioners want additional training

For more information and resources to support discussions on oral health, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

**Who is the most appropriate practitioner for this topic?**



**How this topic was covered.**

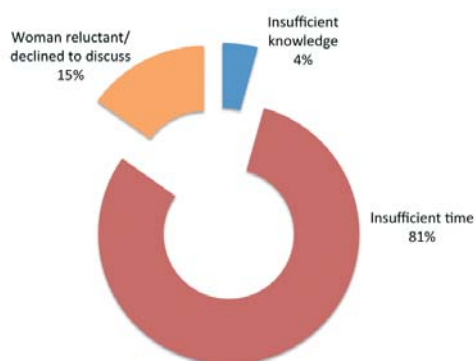


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

78 per cent of practitioners discussed the topics with women

18 per cent said it was not applicable at the time

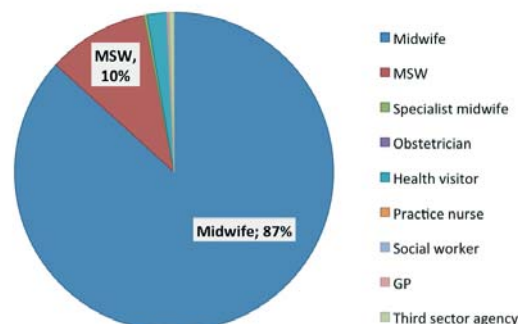
Reasons for not discussing the topic when it was applicable (n=46, 3%)



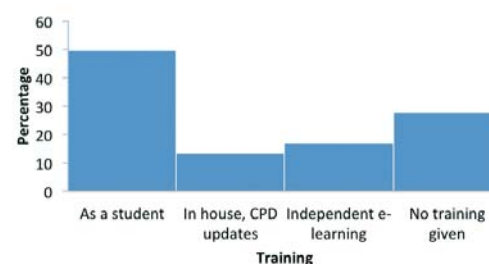
30 out of 100 practitioners want additional training

For more information and resources to support discussions on partner involvement, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

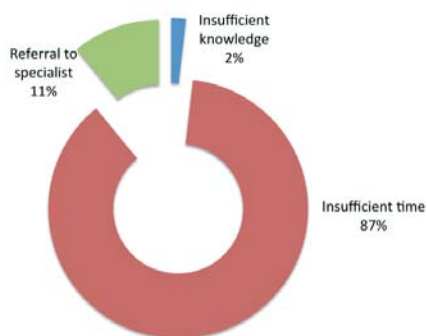


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

59 per cent of practitioners discussed the topics with women

36 per cent said it was not applicable at the time

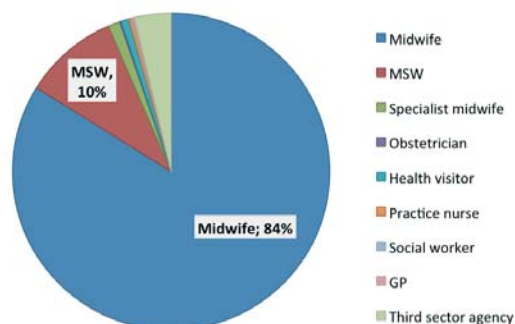
Reasons for not discussing the topic when it was applicable (n=55, 3%)



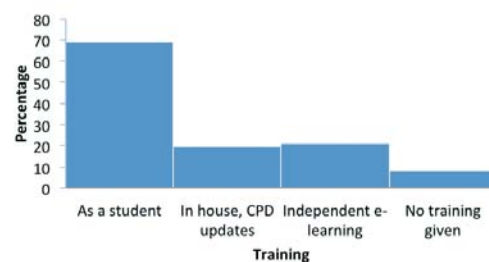
13 out of 100 practitioners want additional training

For more information and resources to support discussions on pelvic floor exercises, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

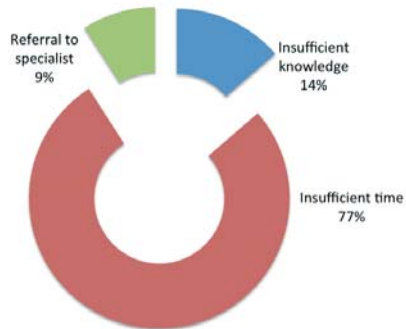


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

58 per cent of practitioners discussed the topics with women

40 per cent said it was not applicable at the time

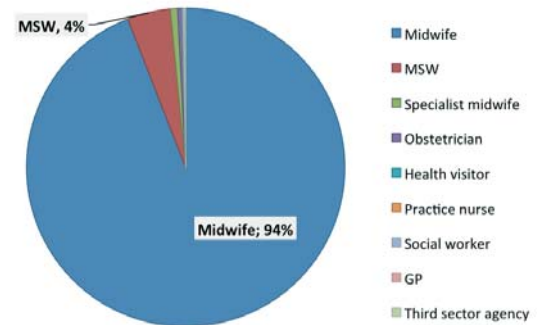
Reasons for not discussing the topic when it was applicable (n=22, 1%)



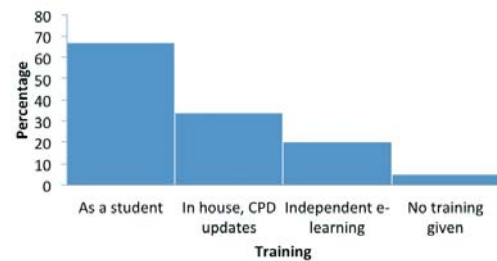
9 out of 100 practitioners want additional training

For more information and resources to support discussions on perineal care, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

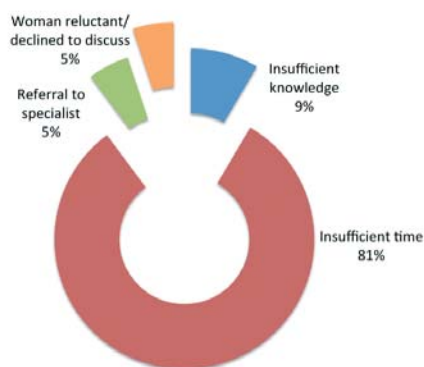


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

48 per cent of practitioners discussed the topics with women

46 per cent said it was not applicable at the time

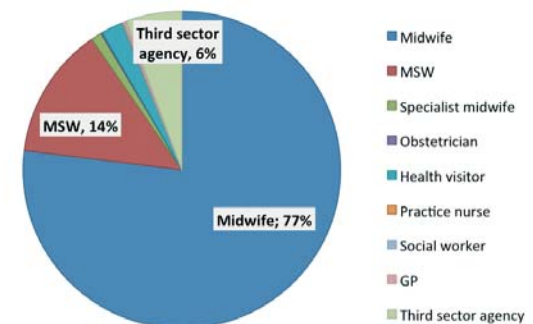
Reasons for not discussing the topic when it was applicable (n=59, 3%)



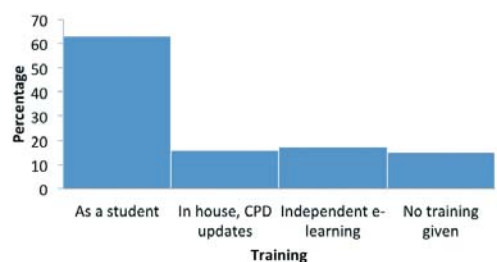
20 out of 100 practitioners want additional training

For more information and resources to support discussions on post natal exercises, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

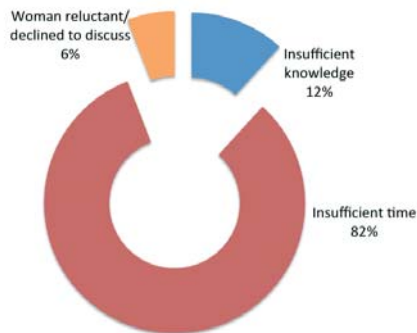


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

51 per cent of practitioners discussed the topics with women

45 per cent said it was not applicable at the time

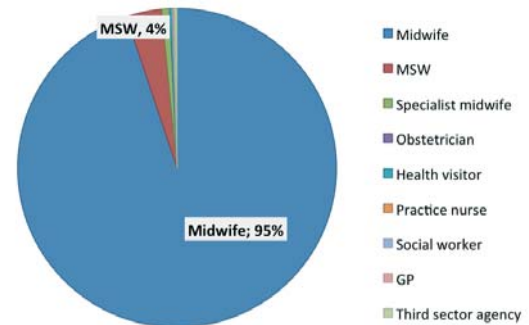
Reasons for not discussing the topic when it was applicable (n=34, 2%)



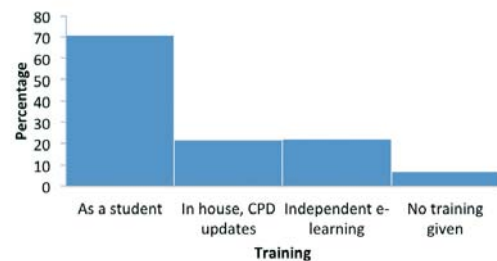
10 out of 100 practitioners want additional training

For more information and resources to support discussions on preparation for birth, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.



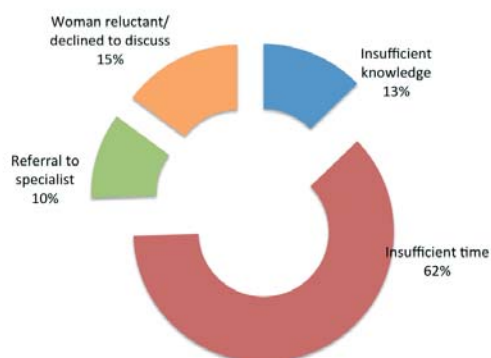
Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers

Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

24 per cent of practitioners discussed the topics with women

71 per cent said it was not applicable at the time

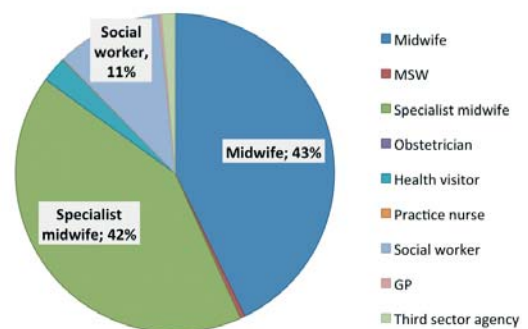
Reasons for not discussing the topic when it was applicable (n=47, 3%)



Please note that information on training needs is not available.

For more information and resources to support discussions on safeguarding, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

Please note that this information is not available for this topic.

Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers

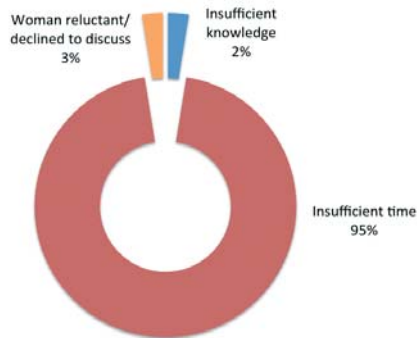
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)



52 per cent of practitioners discussed the topics with women

43 per cent said it was not applicable at the time

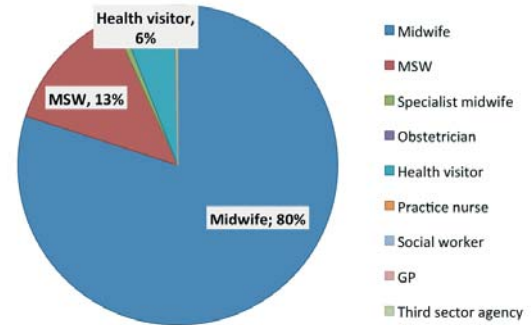
Reasons for not discussing the topic when it was applicable (n=39, 2%)



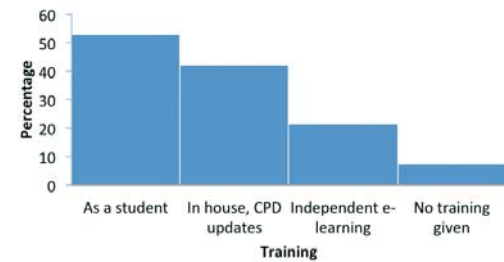
11 out of 100 practitioners want additional training

For more information and resources to support discussions on safe sleeping, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

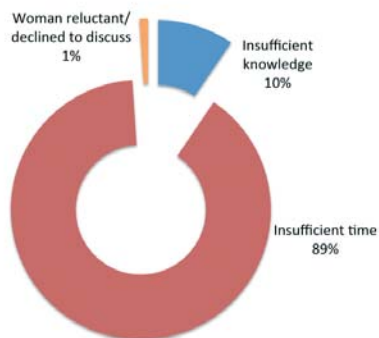


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

38 per cent of practitioners discussed the topics with women

54 per cent said it was not applicable at the time

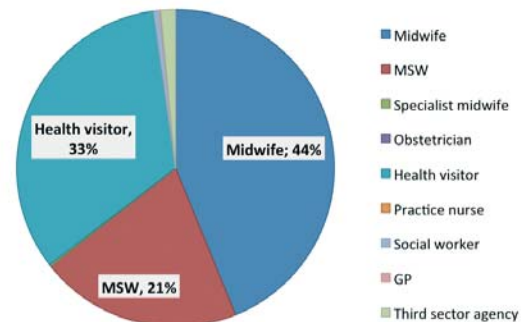
Reasons for not discussing the topic when it was applicable (n=95, 6%)



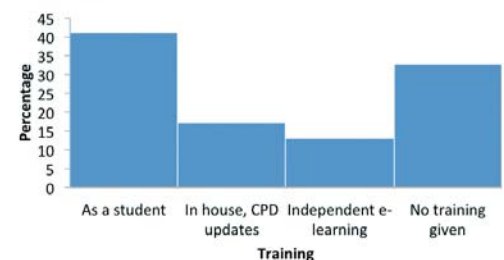
35 out of 100 practitioners want additional training

For more information and resources to support discussions on safety at home, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

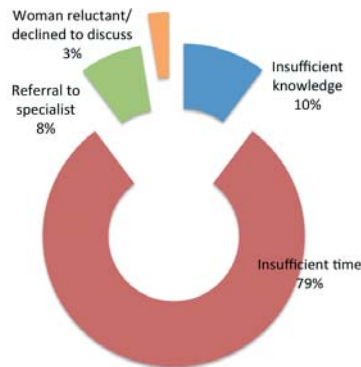


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

47 per cent of practitioners discussed the topics with women

48 per cent said it was not applicable at the time

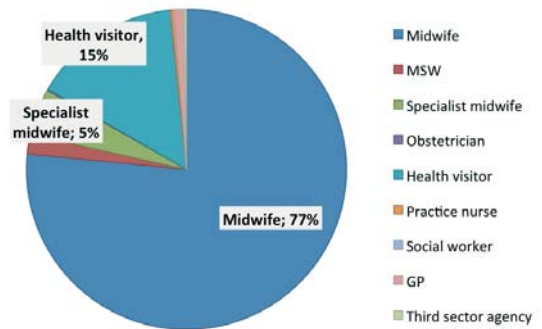
Reasons for not discussing the topic when it was applicable (n=39, 2%)



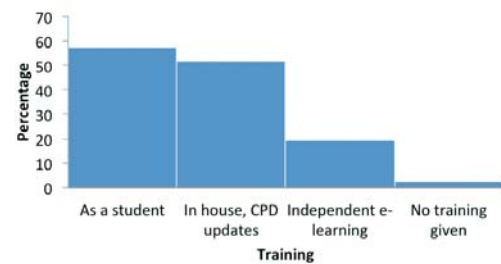
7 out of 100 practitioners want additional training

For more information and resources to support discussions on screening baby, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

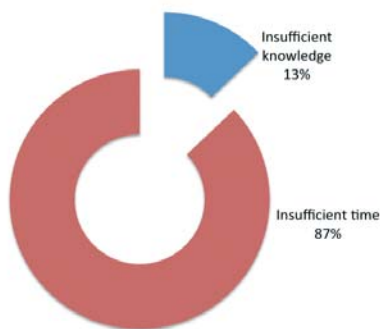


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

34 per cent of practitioners discussed the topics with women

63 per cent said it was not applicable at the time

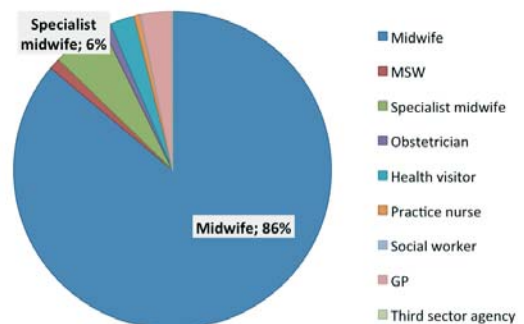
Reasons for not discussing the topic when it was applicable (n=31, 2%)



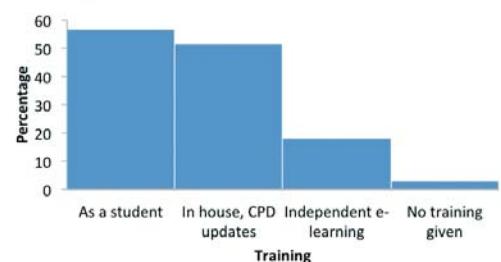
7 out of 100 practitioners want additional training

For more information and resources to support discussions on screening mother, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

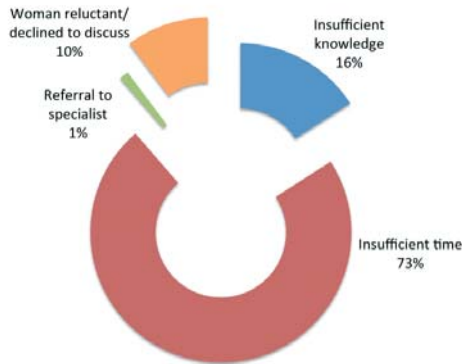


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

25 per cent of practitioners discussed the topics with women

67 per cent said it was not applicable at the time

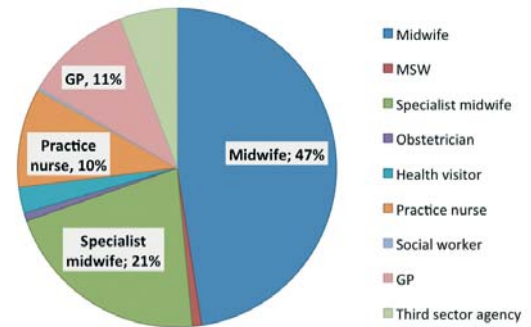
Reasons for not discussing the topic when it was applicable (n=88, 5%)



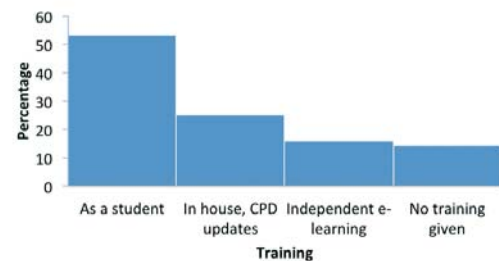
26 out of 100 practitioners want additional training

For more information and resources to support discussions on sexual health, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.



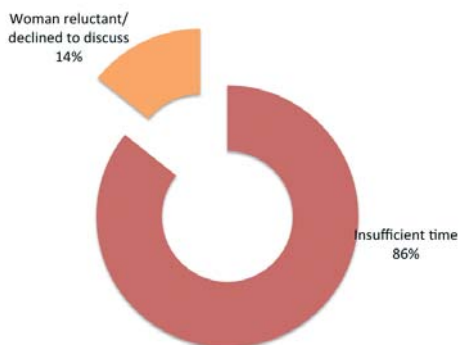
Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers

Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

74 per cent of practitioners discussed the topics with women

23 per cent said it was not applicable at the time

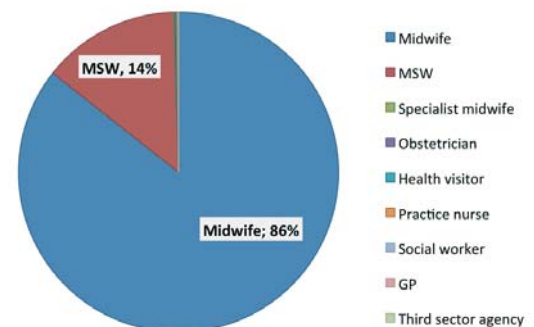
Reasons for not discussing the topic when it was applicable (n=28, 2%)



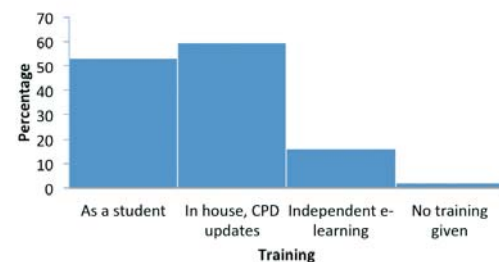
3 out of 100 practitioners want additional training

For more information and resources to support discussions on skin to skin, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.



Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers

Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

39 per cent of practitioners discussed the topics with women  
57 per cent said it was not applicable at the time

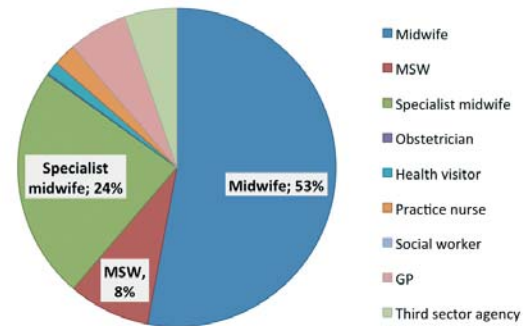
**Reasons for not discussing the topic when it was applicable (n=28, 2%)**



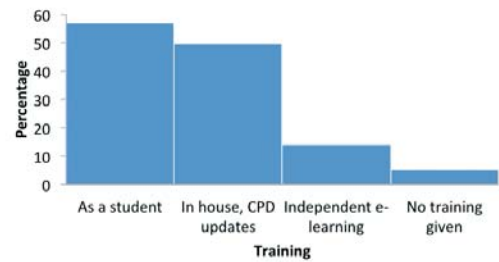
9 out of 100 practitioners want additional training

For more information and resources to support discussions on smoking, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

**Who is the most appropriate practitioner for this topic?**



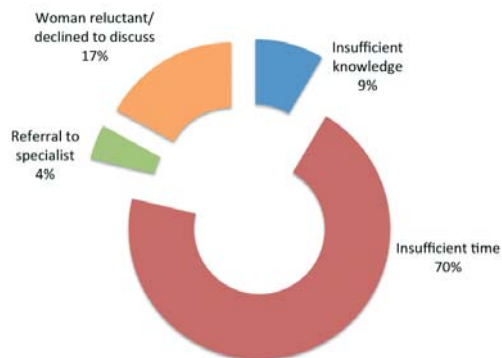
**How this topic was covered.**



Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

34 per cent of practitioners discussed the topics with women  
61 per cent said it was not applicable at the time

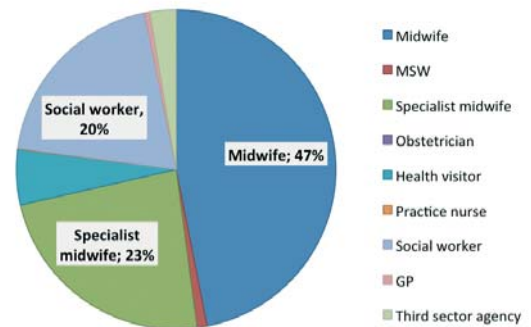
**Reasons for not discussing the topic when it was applicable (n=47, 3%)**



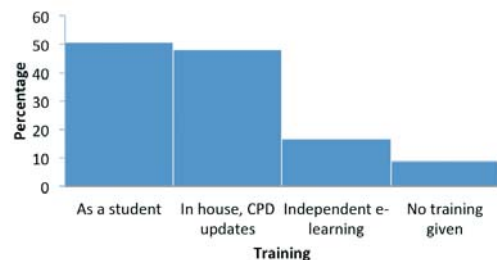
18 out of 100 practitioners want additional training

For more information and resources to support discussions on social issues, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

**Who is the most appropriate practitioner for this topic?**



**How this topic was covered.**

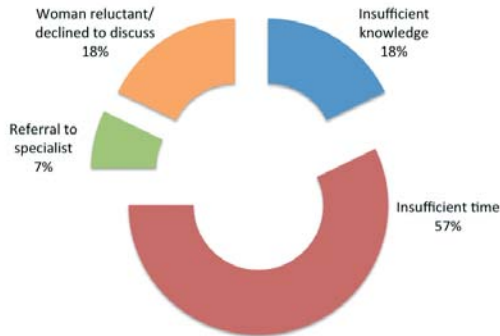


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

17 per cent of practitioners discussed the topics with women

79 per cent said it was not applicable at the time

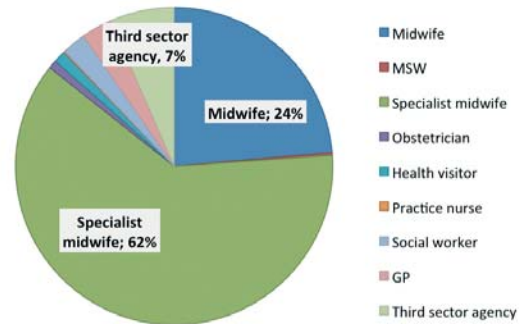
Reasons for not discussing the topic when it was applicable (n=28, 2%)



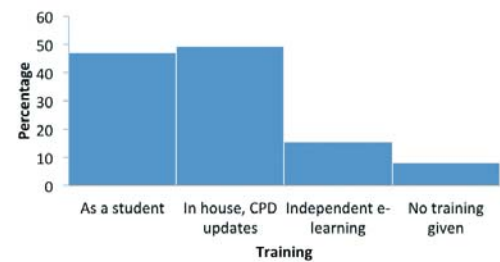
18 out of 100 practitioners want additional training

For more information and resources to support discussions on substance misuse, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

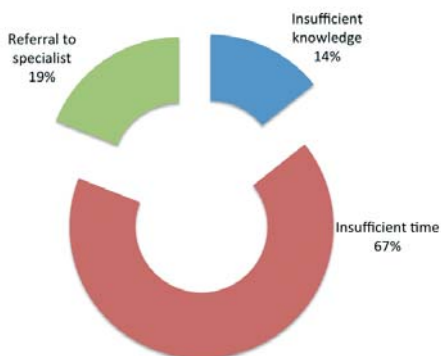


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

9 per cent of practitioners discussed the topics with women

87 per cent said it was not applicable at the time

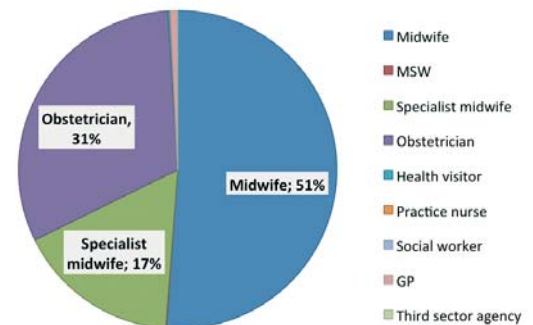
Reasons for not discussing the topic when it was applicable (n=21, 1%)



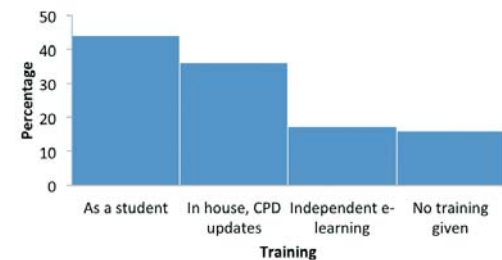
20 out of 100 practitioners want additional training

For more information and resources to support discussions on vaginal birth after delivery, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

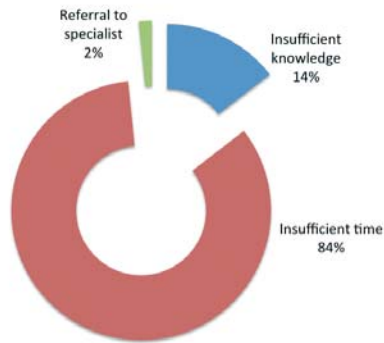


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

33 per cent of practitioners discussed the topics with women

61 per cent said it was not applicable at the time

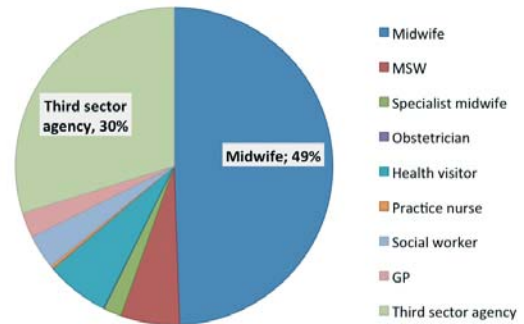
Reasons for not discussing the topic when it was applicable (n=62, 4%)



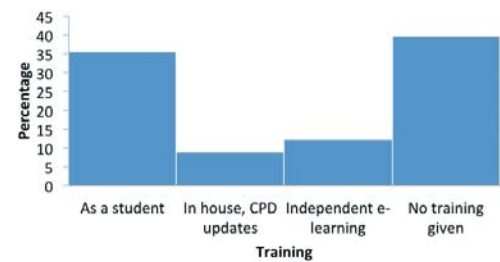
47 out of 100 practitioners want additional training

For more information and resources to support discussions on working/employment, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered.

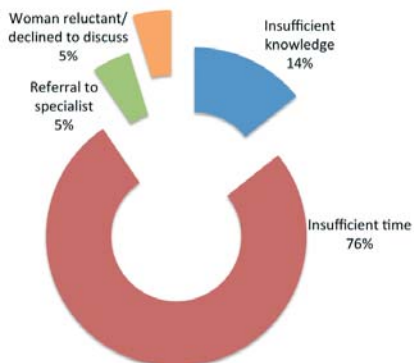


Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

31 per cent of practitioners discussed the topics with women

66 per cent said it was not applicable at the time

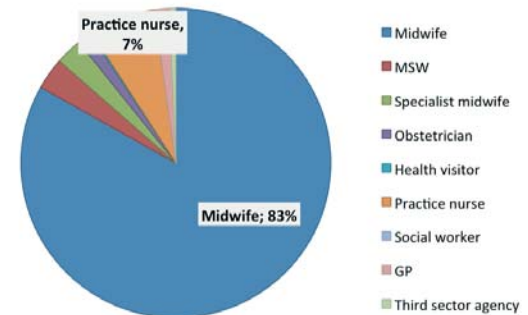
Reasons for not discussing the topic when it was applicable (n=21, 1%)



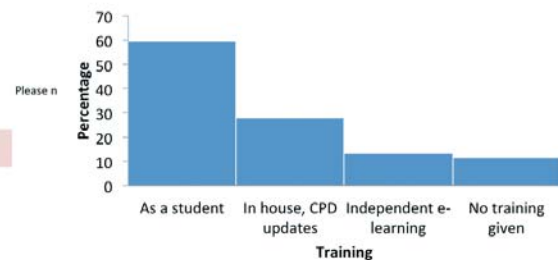
20 out of 100 practitioners want additional training

For more information and resources to support discussions on wound care, please go to [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)

Who is the most appropriate practitioner for this topic?



How this topic was covered for training.



Source: Stepping up to Public Health: A new maternity model for women and families, midwives and maternity support workers  
Data was based on a practitioners survey and audit carried out by the Royal College of Midwives for 35 public health topics. More online: [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth)



## Appendix 3. Feedback from the groups in the Think Tank

### 1. Timing

This is specifically for the provision of information in the antenatal, intrapartum and postnatal periods.

"Windows of opportunity are slim and 'discussion' is often a tick list and questions/information omitted on the basis of assumption e.g. information on DV [domestic violence/abuse]."

"Staff need to be more alert to 'red flags'".

"Information needs to be relevant and timed differently for primiparous and multiparous women".

### 2. Communication

"Good communication is key, lack of time tends to lead to 'tick box' mentality"

"A website or online information specific for maternity would be good" (as mentioned by a service user)

"The question is 'are midwives reluctant to raise difficult issues?' and this could be because of a lack of knowledge, lack of referral routes, personal beliefs (own baggage), or lack of personal awareness."

"Sensitive information should be given or sought and sits well with continuity of carer as a relationship is established with the women. There should also be midwifery knowledge of what to do next in the case of disclosure, and a range of other considerations such as:

- Ensure time alone with woman and midwife
- Training for midwives on how to handle sensitive information
- Give information – say ' why they are asking?' (service user suggestion)
- Change order of questions (on IT)
- Flexible appointments (evenings/weekends)
- Have time with woman."

### 3. Continuity of carer

"Continuity of carer is key to ensuring public health messages are given consistently"

"Some areas of the UK ,for example London, have a very transient population and it is a challenge to provide public health information to women in bite-size/manageable pieces. Also challenging when moving across services e.g. maternity and paediatric unless carers have access to the same information and

are consistent in their messaging – continuity of carer makes real difference."

"Delivery of public health advice needs to be individualised. Continuity of care(r) will help to address individual needs."

"Midwives working closely together through continuity of carer would help address conflicting information."

"The support needs to be throughout the experience, it's not just about continuity in the antenatal period."

### 4. Most appropriate healthcare professional to address individual topics

"Whoever provides advice/information on public health issues needs to be trained and competent, therefore if doesn't necessarily all need to be done by a midwife, important to involve multidisciplinary/multiagency team, particularly health visitors."

### 5. Time constraints

"These can be addressed in a number of ways such as having continuity in place, education on communication skills, reducing duplication, funding more appointments and removing the resource blocks, centering as in the group antenatal classes, using social media skills for communication as well as texting and email."

"There needs to be involvement at all levels including central government, CCGs, GPs, RCM support with the involvement of RCM members, attention from the Trust Board, reliable appointments (on time) with involvement of women users, and group information sessions, such as early bird at 6 -8 weeks, for postnatal and group classes such as centering, in addition to midwives creating tools to increase interaction through approved and standardised apps."

### 6. Method of conveying information

"Paperless technology and electronic notes would really help."

"There needs to be alternatives to current provisions such as leaflets which identified as not being read (based on feedback from women as well as practitioners). The women usually feel bombarded receiving information this way."

"It feels like we are providing a lot of information to prevent against litigation, rather than to promote health"



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"Information session may be best first so that women get information and ask questions when they see midwife for booking. This could be done in the evening so partners could attend. It does not reduce the required time for booking appointments, but it makes women better informed and focuses the discussion better during the appointments."

"There are different options online for information including social media, "Maternity Assist" and perinatal app and other examples such as:"

- On line information – specific NHS choices
- Video / YouTube information
- Facebook groups
- 'Baby buddy' app
- Group antenatal sessions
- On line notes, prompt for supplementary information.

This information should be from credible sources."

## 7. Importance of specialist services

There is generally good support for specialist services from both practitioners and service users."

"There are concerns that specialisms leads to erosion of the knowledge for the practitioners working in the general areas."

"Every midwife should have core knowledge."

"Public health is such a big topic that midwives cannot be expected to know it all."

"It is unclear if having specialist areas has resulted in midwives abdicating responsibility for giving public health messages."

"Could there be lack of confidence to utilise their skills in all areas?"

"Midwives in practice don't look at the holistic approach."

## 8. General facilitators and barriers

"On a larger scale, we need to challenge the tariff system and the mantra from CCGs/commissioners that everything is within the tariff."

"We need universal principles which can be contextualised based on local need."

"Women need to be at the centre of care, we need to ask 'what do you know?', 'what do you need to know?'"

## 9. Education and training

"At the moment, student midwives have 'broad' public health content contained within the university programme but their

clinical experience may be limited and be dependent on what they see or are involved in during the course of their programme. Students on qualification will therefore have varying sets of knowledge and skills with regard to public health and care of women and babies."

"Employers would prefer students to have most of the knowledge in place and then be able to provide annual updating/refresher course – have national standards for public health would help with this identifying generic and specialist knowledge."

"There are increasingly demands to expand the content of the curriculum in response to public health demands, examples included dementia awareness (sic), immunisation for pregnant women, FGM screening and reporting."

"The use of learning passport for students could be considered so that employers know what their skill set is and where additional education and training would be required. This would also avoid repeating knowledge and skills where the student is competent. This could also help with the variations in MSW training."

"The National Screening Committee has a lot of on line learning resources that would be helpful to midwives and MSWs and is continually expanding – needs better signposting."

"Availability of post registration education and training is dependent on where midwives are based. This can also influence the CPD that is usually provided by expert/specialist midwives such as PDMs, public health consultant midwives and educationalists."

## 10. Education provisions for service users

"The importance of antenatal/parentcraft classes is usually underestimated."

"Some liked the idea of group antenatal e.g. pelvic floor exercises. The women paid privately, husband learnt loads and was able to be much more helpful."

"Access to antenatal classes where public health information would be provided is variable and tends to focus on labour rather than transition to parenthood. Issues with resourcing, often contracted out and attendance is predominantly white, middle class and often excluded partners. It would be helpful to think about variable models of delivery in particular social media and promote this as it is a much more inclusive medium."

"Decrease in provision of children's centres/community services will impact on public health. There needs to be a campaign to retain these services and for there to be facilities in the community where women can meet with midwives to discuss public health issues."

"Some examples of good practice include 'Health beginnings' at Kings. This is group interaction with women discussing public health issues & parenting. This is an interesting and interactive way of informing women about public health issues."





# Appendix 4. The Menu



<http://bit.ly/2ruZtIR>

## Pregnancy and birth information menu

### Advice and information for pregnancy, birth and beyond

We want to make sure that the information you receive is tailored to you and your family's individual needs. Below is a list of topics which you may want to know more about to help you understand your pregnancy and plan your care. Some topics will routinely be covered by your midwife or other healthcare professional.

You can find out about all of these topics and more on the Royal College of Midwives' Pregnancy and Birth Information Hub [www.rcm.org.uk/hub](http://www.rcm.org.uk/hub). Please tick the boxes below to show which topics you feel you know enough about already and which ones you would still like to discuss.

	I feel I already know enough about this topic	I would like to discuss this more	Signature of healthcare professional when topic discussed
<b>Information and support for your pregnancy</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol and pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	
What to expect from your <b>Antenatal care</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Dental health	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Dietary advice / Dietary supplements	<input type="checkbox"/>	<input type="checkbox"/>	
Need support for <b>Domestic abuse?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise in pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	
Information for <b>Fathers and birth partners</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Find out more about <b>Female Genital Mutilation (FGM)</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Immunisations</b> for pregnant women	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Infections</b> in pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Interacting</b> with your baby before birth	<input type="checkbox"/>	<input type="checkbox"/>	
If you or your partner have a <b>Learning disability</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional and <b>Mental health</b> in pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	
Support for <b>Miscarriage and stillbirth</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Baby's Movements</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Pelvic floor</b> exercises	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Pregnancy conditions</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Need support for your <b>Relationship?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Screening tests</b> in pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	
If you have experienced <b>Sexual abuse</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Smoking and pregnancy</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Substance misuse</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Need <b>Support</b> with social, immigration, housing, or financial issues?	<input type="checkbox"/>	<input type="checkbox"/>	
If you're a <b>Teenager</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Concerns about <b>Trafficking</b> or about forced marriage	<input type="checkbox"/>	<input type="checkbox"/>	

Print name \_\_\_\_\_

Signature \_\_\_\_\_

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Visit [www.rcm.org.uk/publichealth](http://www.rcm.org.uk/publichealth) for more information.



## Appendix 5. Dissemination through printed publications and conferences

### Printed Publications

Gomez, E. (2016). Stepping up to Public Health. *Midwives*, 19 (spring): 68-69.

Gomez, E., and November, L. (2016). Resourcing the Public Health Role. *Midwives*, 20 (summer); 58-59.

Gomez, E. (2016). Advancing the Public Health Role for Midwives and Maternity Support workers. *The Practising Midwife*, 19(6): 8-11.

November, L. (2016). Are we getting the message across? Women's perceptions of public health messages in pregnancy. *British Journal of Midwifery*, 24(6): 396-402.

Sanders, B., Hunter, B., and Warren, L. (2016). A wall of information? Exploring the public health component of maternity care in England. *Midwifery*, 34: 253-260.

### Key Conferences

Silverton, L., Hunter, B., Gomez, E. (July, 2017) International Congress of Midwives (ICM) Symposium. Toronto, Canada.

Silverton, L., Hunter, B., Gomez, E., November, L. (December, 2016) European Midwives Association Conference. London, UK.

Gomez, E. (June, 2016) Maternity Support Workers Conference. Birmingham, UK.

Gomez, E. (November 2015) Royal College Midwives (RCM) Annual Conference. Telford, UK.

Hunter, B & November, L. (November 2015) Royal College Midwives (RCM) Annual Conference. Telford, UK.

Gomez, E. (May, 2015) Legal Birth Conference. London, UK.

Gomez, E. (May, 2015) Primary Care Live Conference. Birmingham, UK.





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