Exploring the Public Health Role of Midwives and Maternity Support Workers: Final Report

Research Theme: Maternal, Child and Family Health and Wellbeing

School of Healthcare Sciences

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INTRODUCTION

Background

The UK Faculty of Public Health defines Public Health as “The science and art of promoting and protecting health, wellbeing, preventing ill-health and prolonging life through the organised efforts of society.” (UKFPH 2010). The midwife has long been recognised to have an important public health function. Traditionally the public health role of the midwife centred upon maternal health during pregnancy, infant feeding, and early parenting (Myles 1975). Although this central focus has continued, over recent years there has been an expansion of the public health agenda generally, with a developing role in public health for all healthcare professionals including midwives. Current policy is to maximise the health of the population and reduce health inequalities (DH 2014). This emphasis on maximising health for all individuals has been reflected in an expanded public health role of the midwife, with an increase in both the number and complexity of public health initiatives incorporated into maternity care pathways.

The importance of early interventions for the prevention of illness and health inequality in the future is well recognised (Field 2010). Furthermore, since 2001, maternity support workers (MSW) have been introduced across the UK, providing in many areas an additional professional group to deliver public health related messages. This expansion has come about because pregnancy and the early postnatal period are increasingly recognised as critical to setting the foundations of a healthy childhood and optimal child development and also because families with young babies are regarded as particularly receptive to public health initiatives, being intrinsically motivated to provide the very best start in life for their children (DH 2014).

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

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

(DH 2010 pp.26.)
The role of the midwife on an individual level is described within The Healthy Child Programme (DH 2009) which documented both universal and progressively enhanced programmes of care to be provided in England during pregnancy, infancy and childhood. The Healthy Child Programme has an aim of promoting, establishing and helping to maintain behaviours which promote physical and psychological health for babies and children to the age of five. (DH 2009) A recent DH document has outlined the importance of the midwife’s role in promoting the four central domains of public health:

- **Improving the wider determinants of health** by reducing the negative effects on health and 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 reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

(DH/PHE 2013a)

In order to achieve the desired goals, members of the maternity team, midwives and Maternity Care Assistants (MCAs) in particular, need to be aware of individual, local and national health needs, (Nursing and Midwifery Actions at the Three Levels of Public Health Practice DH/PHE 2013).

Previous work by Bennett et al., (2001a, 2001b) explored midwives’ views on their professional role within health promotion and public health revealing amongst midwives a range of knowledge, skills, experience and training opportunities.

Since Bennett et al’s 2001 publications, the public health remit of the midwife has further expanded and the maternity workforce reconfigured to include maternity support workers, many of whom now have an important role in public health promotion. It was therefore regarded as important that these developments were explored and the impact on the delivery of the public health agenda within maternity services investigated. With this aim the RCM received funding from the Department of Health in England to undertake a project to develop a new model of public health for midwifery. The project will be comprised of two work streams. The first work stream is composed of a qualitative study exploring the views and experiences of health care professionals, followed by a large online survey. This in turn will inform the second work stream, the development of a RCM public health strategy and action plan to empower midwifery and maternity care support workers to meet their remit for public health in the 21st century.
Following tender, Cardiff University was commissioned to undertake the first of these planned activities, the aim and objectives of which are detailed below.

**Research aims**

The aim of this qualitative study was to identify student midwives’, midwives’ and midwifery support workers’ current knowledge of and involvement in the public health agenda in England.

**Research Questions**

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

In addition to the required research questions it was proposed that lay participants would be asked their perceptions of the role of the midwife within public health.
METHODS

It was planned that data would be collected through a series of eight closed online discussion groups using the social networking site Facebook. Each discussion group would comprise a specific group of professionals/stakeholders as follows:

- Maternity Support Workers
- Student Midwives
- Midwives (Bands 5 & 6)
- Modern Matrons / Midwifery managers (Band 7 / Band 8)
- Heads of Midwifery
- Consultant Midwives with a specialist interest in Public Health
- Lead Midwives for Education (LME)
- Service Users

Recruitment:

Participants were recruited through adverts placed on the Royal College of Midwives Facebook page and Twitter account and also through an email advert sent from the RCM to all Maternity Support Workers registered as RCM members. Consultant Midwives received an email invitation via the RCM hosted email list. As it was not possible to place an advert on either the Netmums or Mumsnet Facebook page, service users were invited to participate in the study through the placing of an advert on the Netmums online notice board. Inclusion criteria for the professional discussion groups were that they self-identified as a member of one of the above group of professionals and that they worked within NHS England. Inclusion criteria for service users were that they had received maternity care from the NHS in England in the last 2 years. 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.

Data collection

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. The closed discussion groups ran between 5th – 30th January 2015. On completion of the discussion all participants were thanked privately via Facebook message for their contribution.

Questions were posted by the researchers in order to facilitate and guide the discussion (see Table 1 below). These questions related to the research questions (see page 6) and were posted sequentially over the course of the discussion.
<table>
<thead>
<tr>
<th>Group</th>
<th>Questions</th>
</tr>
</thead>
</table>
| Student Midwives              | • What aspects of public health are you involved in within your current role?  
                                  | • What aspects areas of Public Health do you feel are most pertinent to midwives in providing care to childbearing women?  
                                  | • Are there aspects of public health that midwives are currently involved in that you feel could/ should be undertaken by others?  
                                  | • How are maternity staff in your organisation supported in their public health role?  
                                  | • What do you feel are potential barriers and facilitators to you in fulfilling your public health role?  
                                  | • Are there particular groups/clients who present more of a challenge to you in fulfilling your public health role?  
                                  | • What do you see as the potential role of specialist referral services in meeting the public health agenda?  
| Midwives                      | • Are you as a Maternity Support Worker involved in any public health role (e.g. facilitating breastfeeding, newborn bloodspot screening, etc.)?  
                                  | • Are there aspects of public health that midwives are currently involved in that you feel could/ should be undertaken by others?  
                                  | • How are Maternity Support Workers in your organisation supported in their public health role? (E.g. Materials, websites, training days etc) and Have you received any training in helping you to talk with women about public health issues?  
                                  | • What do you feel are the potential barriers that prevent you from fulfilling your public health role? And what do you feel facilitates or helps you?  
                                  | • Are there particular groups/ clients who present more of a challenge to you and your midwifery colleagues in fulfilling your public health role?  
                                  | • What do you see as the potential role of specialist referral services in meeting the public health agenda?  
| Modern Matrons/senior Midwives | • What aspects of public health do you feel are most pertinent to midwives in providing care?  
                                  | • Are there aspects of public health that midwives are currently involved in that you feel could/ should be undertaken by others?  
                                  | • Which aspects of public health are included within your midwifery undergraduate curriculum?  
                                  | • What support do you provide for students to help them to talk with women about public health issues?  
                                  | • What do you feel are the potential barriers and facilitators that midwives face in fulfilling their public health role?  
                                  | • Are there particular groups/ clients who you feel may present more of a challenge to midwives in fulfilling their public health role?  
                                  | • What do you see as the potential role of specialist referral services in meeting the public health agenda?  
| Consultant Midwives           | • What aspects of public health do you feel are most pertinent to midwives in providing care?  
                                  | • Are there aspects of public health that midwives are currently involved in that you feel could/ should be undertaken by others?  
                                  | • Which aspects of public health are included within your midwifery undergraduate curriculum?  
                                  | • What support do you provide for students to help them to talk with women about public health issues?  
                                  | • What do you feel are the potential barriers and facilitators that midwives face in fulfilling their public health role?  
                                  | • Are there particular groups/ clients who you feel may present more of a challenge to midwives in fulfilling their public health role?  
                                  | • What do you see as the potential role of specialist referral services in meeting the public health agenda?  
| Heads of Midwifery            | • What aspects of public health do you feel are most pertinent to midwives in providing care?  
                                  | • Are there aspects of public health that midwives are currently involved in that you feel could/ should be undertaken by others?  
                                  | • Which aspects of public health are included within your midwifery undergraduate curriculum?  
                                  | • What support do you provide for students to help them to talk with women about public health issues?  
                                  | • What do you feel are the potential barriers and facilitators that midwives face in fulfilling their public health role?  
                                  | • Are there particular groups/ clients who you feel may present more of a challenge to midwives in fulfilling their public health role?  
                                  | • What do you see as the potential role of specialist referral services in meeting the public health agenda?  
| Maternity Support Workers     | • What aspects of public health do you feel are most pertinent to midwives in providing care?  
                                  | • Are there aspects of public health that midwives are currently involved in that you feel could/ should be undertaken by others?  
                                  | • Which aspects of public health are included within your midwifery undergraduate curriculum?  
                                  | • What support do you provide for students to help them to talk with women about public health issues?  
                                  | • What do you feel are the potential barriers and facilitators that midwives face in fulfilling their public health role?  
                                  | • Are there particular groups/ clients who you feel may present more of a challenge to midwives in fulfilling their public health role?  
                                  | • What do you see as the potential role of specialist referral services in meeting the public health agenda?  
| Lead Midwives for Education    | • What aspects of public health do you feel are most pertinent to midwives in providing care?  
                                  | • Are there aspects of public health that midwives are currently involved in that you feel could/ should be undertaken by others?  
                                  | • Which aspects of public health are included within your midwifery undergraduate curriculum?  
                                  | • What support do you provide for students to help them to talk with women about public health issues?  
                                  | • What do you feel are the potential barriers and facilitators that midwives face in fulfilling their public health role?  
                                  | • Are there particular groups/ clients who you feel may present more of a challenge to midwives in fulfilling their public health role?  
                                  | • What do you see as the potential role of specialist referral services in meeting the public health agenda?  
| Service Users                 | • What was your experience of health promotion/protection that you remember your midwife or maternity worker providing or discussing with you? (e.g. breastfeeding or newborn bloodspot screening etc.)  
                                  | • How do you view the midwives role in public health?  

**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 described by the Royal College of Midwives on page 5 of
their call for tender (see page 63). The coding framework and explanation of how it incorporated these elements can be found in the appendices. Following initial thematic analysis, a meeting was then arranged to cross check the themes and subthemes and for the discussion and agreement of the final coding.

**Ethics**

Ethical approval was sought and 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 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, departments or organisations. 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 viewed as offensive would be removed from the group by the administrators. In the event no members were removed.

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.
FINDINGS:

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.

<table>
<thead>
<tr>
<th>Participant Group</th>
<th>Expressed interest</th>
<th>Recruited</th>
<th>Actively participated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Support Workers</td>
<td>44</td>
<td>41</td>
<td>20</td>
</tr>
<tr>
<td>Student Midwives</td>
<td>16</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Midwives (Bands 5 &amp; 6)</td>
<td>31</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>Modern Matrons/Midwifery managers (Bands 7 &amp; 8)</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Heads of midwifery</td>
<td>7</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Consultant midwives</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Lead Midwives for Education</td>
<td>10</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Service Users</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

There were a very high number of Maternity Support Workers who expressed an interest and were recruited to the group and this would suggest a clear interest in the public health role of 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, Lead Midwives for Education and the Heads of Midwifery. This was thought to be due to the sometimes negative press that Facebook 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 and can be found in Table 3. It was evident that participants worked in a variety of clinical settings with diverse amount of practice experience. For example amongst the band 5/6 midwives, length of experience ranged from less than one year up to 23 years in practice (mean of 8.6 years). And there was a similar picture for the maternity support workers experience which ranged between 1 and 25 years (mean of 6.5 years).

**Table 3; Demographics**

<table>
<thead>
<tr>
<th>Clinical area</th>
<th>Length of experience</th>
<th>Clinical area</th>
<th>Length of experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Midwives n=11</td>
<td>Rotational</td>
<td>11 (100)</td>
<td>Year 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Year 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Year 3</td>
</tr>
<tr>
<td>Midwives n=15 (Band 5 n= 2) (Band 6 n= 13)</td>
<td>Community</td>
<td>5 (33.3)</td>
<td>≤5 years</td>
</tr>
<tr>
<td></td>
<td>Rotational</td>
<td>4 (26.7)</td>
<td>6-10 years</td>
</tr>
<tr>
<td></td>
<td>Delivery/MLU</td>
<td>4 (26.7)</td>
<td>11-15 years</td>
</tr>
<tr>
<td></td>
<td>Post/Antenatal</td>
<td>1 (6.7)</td>
<td>≥ 15 years</td>
</tr>
<tr>
<td></td>
<td>Case-loading</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>Senior Midwives n=5</td>
<td>Delivery/MLU</td>
<td>2 (40.0)</td>
<td>10-15 years</td>
</tr>
<tr>
<td></td>
<td>Specialist MW*</td>
<td>2 (40.0)</td>
<td>≥ 15 years</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>1 (20.0)</td>
<td></td>
</tr>
<tr>
<td>Maternity Support Workers N=20</td>
<td>Post/Antenatal</td>
<td>9 (45.0)</td>
<td>≤5 years</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>5 (25.0)</td>
<td>6-10 years</td>
</tr>
<tr>
<td></td>
<td>Rotational</td>
<td>4 (20.0)</td>
<td>11-15 years</td>
</tr>
<tr>
<td></td>
<td>Delivery/MLU</td>
<td>1 (5.0)</td>
<td>≥ 15 years</td>
</tr>
<tr>
<td></td>
<td>Antenatal clinic</td>
<td>1 (5.0)</td>
<td></td>
</tr>
</tbody>
</table>

(* e.g. Lead for vulnerable adult/Lead for obesity)

The findings from this study have been categorised into five distinct sections reflecting the coding framework (see Table 6 on page 63), Findings will be discussed in turn with extracts of data used to illustrate each of the themes.

- Scope of midwives’ public health role
- Training and support for public health role
- Barriers and facilitators
- Specific client groups
- The role of specialist referral services

All participants were allocated a code to identify their group, and an individual participant number to protect their identity.

**Key: Professional codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>St</td>
<td>Student Midwife</td>
</tr>
<tr>
<td>MW</td>
<td>Midwife (Band 5/6)</td>
</tr>
<tr>
<td>Sr</td>
<td>Senior Midwife (Band 6/7)</td>
</tr>
<tr>
<td>MSW</td>
<td>Maternity Support Worker</td>
</tr>
<tr>
<td>Cons</td>
<td>Consultant Midwife</td>
</tr>
<tr>
<td>HoM</td>
<td>Head of Midwifery</td>
</tr>
<tr>
<td>LME</td>
<td>Lead Midwife for Education</td>
</tr>
</tbody>
</table>
MAJOR 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.

For example:

*MW9* 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

*LME2* ... the PH 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.

*St8...* 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)

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 4 (page 14) provides details on the areas of public health identified by participants.
<table>
<thead>
<tr>
<th>Frequently discussed</th>
<th>Areas less often discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding/infant feeding</td>
<td>Alcohol use</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>Food safety/hygiene</td>
</tr>
<tr>
<td>Screening</td>
<td>Domestic abuse</td>
</tr>
<tr>
<td>Mental health/psychological wellbeing</td>
<td>FGM</td>
</tr>
<tr>
<td>Obesity prevention</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Contraception</td>
<td>Bereavement</td>
</tr>
<tr>
<td>SIDS prevention/safe sleeping</td>
<td>Immigration support</td>
</tr>
<tr>
<td>Immunisation</td>
<td>Language support</td>
</tr>
<tr>
<td>Infection/sepsis prevention</td>
<td>Social inclusion/exclusion</td>
</tr>
<tr>
<td>Sexual health</td>
<td>Drug/substance abuse</td>
</tr>
<tr>
<td>General healthy lifestyle</td>
<td>Homelessness</td>
</tr>
<tr>
<td>Intrapartum public health:</td>
<td>Forced marriages</td>
</tr>
<tr>
<td>Skin to skin contact</td>
<td>Cervical cytology</td>
</tr>
<tr>
<td>Delayed cord clamping</td>
<td>Breast screening</td>
</tr>
<tr>
<td></td>
<td>Involvement of partners /dads</td>
</tr>
<tr>
<td></td>
<td>Communicable diseases</td>
</tr>
<tr>
<td></td>
<td>PN physiotherapy</td>
</tr>
<tr>
<td></td>
<td>Pre-conceptual health (HOM only)</td>
</tr>
</tbody>
</table>

**Table 4: Areas of Public Health identified**

**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 (see page 27).

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

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

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

*MW2* 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
Sr6 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

Maternity Support Workers (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 page 27.)

MSW3 Within my role I run antenatal breastfeeding classes and postnatal drop in breastfeeding groups

MSW19 I run antenatal and postnatal breastfeeding groups which encourages healthy eating

MSW1 Yeah I also provide infant feeding support to mums and sign post them to help available in children’s centres and other community settings

MSW2 I work on postnatal ward so my main area of public health promotion would be breastfeeding support.....

MSW11 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.

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

MSW16 I work on a very busy postnatal ward. I do an awful amount of breastfeeding 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

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. CO monitoring was briefly referred to by some.

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

MSW1 In my job role I am involved in promoting healthy lifestyle choices to women and their families...including things such (....) smoking cessation
**MSW2** I work on post natal ward so my main area of public health promotion would be breast feeding support and encouraging women to engage in smoking cessation support services.

**St9** 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.

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

### 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 midwifery work.

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

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:

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

**St9** 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.

**St1** 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.

**St2** 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.
**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.

*MSW2*...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.

*Sr3* 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.

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.

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

*St6* 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.

*St11* And agree with the above that post natal 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!

**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.

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

*St6* 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'.

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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

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

MSW1 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....

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

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.

St2 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.

St11 I agree St2. 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!

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

Key area – Sudden Infant Death Syndrome (SIDS) prevention/safe sleeping
SIDS prevention and advice on safely sleeping was mentioned by students, MSWs and some Band 5 & 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.

MSW1 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.

MSW19 Safe sleep is discussed at my visits when I see people’s sleeping arrangements for their newborn.

MSW2....MSW's discuss safe sleep and reducing the risk of cot death during routine discharge chats.
**MSW5** I work in the community...... I also discuss safe sleeping/co-sleeping, baby-care etc on visits

In the Band 5 & 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.

**Key area - Immunisation**

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

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

*St9* oh yes the vaccines are encouraged.

*St4* 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.

**Key area - Infection/sepsis prevention**

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

*MW9* 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.

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

**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.

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

**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.

*MSW1* 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.

**MSW5** 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.

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

**Key area - Intrapartum public health**

Most groups focused their discussions on antenatal and postnatal aspects of public health. Interestingly, however, students also discussed aspects of intrapartum care which they considered to be public health related, in particular skin to skin contact, delayed cord clamping. Only one qualified midwife mentioned this, and she was a midwifery educationalist.

**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 (see page 40).

**LME5**... 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.

**LME2** Supporting what has already been said, the PH 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. (...) The role is endless.

There were numerous comments that there was inadequate 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:

- Giving generalised advice characterised as ‘one size fits all’ (**St5**), 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.
MW12 ... 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 with one’s baby - one piece of public health advice which mitigates [sic] directly against the pro breast feeding message....

- 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.

MW2 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.

MW8 ‘We hit our ladies and partners with a wall of information’

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

However, one of the HoMs commented that although the role was broad, the various elements had now been accepted by midwives in his/her local area:

HoM2 smoking/weight management/mental health/ pre-conceptual health, CO 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.

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:

**MW2** 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.

**St9** 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...

As might be expected, Consultant Midwives and Heads of Midwifery had a particular focus on identifying local priorities and planning for future public health programmes:

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

**HoM5** 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.

**Cons** 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 da (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.

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:

**LME2** the PH 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.

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

**St3** 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!

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.

**St3** 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.

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

**MW2** 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.

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.

**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 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-conceptual advice

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

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

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

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

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

Although midwives identified other health professionals who could undertake some aspects of their current public health role, there was also discussion around what was thought to be 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 high esteem by women, whereby decision-making may be deferred to the midwife.

*St 5 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.*

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 health care professionals, funding & professional rivalry).

*LME2 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*
HoM2 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

HoM5 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.

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

St4 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.

MW4 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

Maternity Support Workers 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, taking blood spots, 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.

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

MSW19 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

MSW2 I work on post natal 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.

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:

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

**MSW16** Where I work the midwives are sooo grateful to the msw's, we are greatly appreciated and often told that without us the ward would fall apart!
MAJOR 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 will be discussed.

The findings are considered in four subthemes. 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 Band 5 & 6 midwives and MSWs).

Cons Training and resources for issues such as asking about mental health and screening etc are good and one of my first tasks is the get the test for smoking off the ground

HoM2 Public health has time on the mandatory day 2 with updates on smoking/perinatal mental health/vulnerable women/FGM/sexual exploitation/Screening/infectious diseases

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

**MW1** 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.

**MW7** 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.

**Sr1** 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.

**MSW1** 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.

**MSW16** 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.

**MSW14** 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.

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

**MSW4** 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.

**MSW15** We have mandatory training update days which does includes 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.

Again it was notable that any breastfeeding training was commented on favourably.
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.

**LME6** 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.

**LME4** 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.

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.

**Amount of training - 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 Major Theme: 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.
MW12 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

MW6 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 PH issues eg co-sleeping, vaccination, obesity etc but so find reams and reams of updated Trust guidelines

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

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

Sr6 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. adult and newborn! And risk etc... The only public health aspects are maternal mental health and bf! Nothing on smoking and brief interventions, and nothing on maternal obesity. I think these are vital and shouldn't be missed!

Sr3 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

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:

MSW3 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.

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

MSW8 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.

MSW2 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 breastfeeding but no practical training. We also receive short info based session on smoking cessation.

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

### 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

Some participants made a point of commenting on this gap, particularly in relation to obesity prevention.

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.
**St5** 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 postcode 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.

**St7** 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.

**LMES** 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.

**LME4** 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.

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:

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

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:

**MW6** There may be an email circulated with info for PH issues eg co-sleeping, vaccination, obesity etc but so find reams and reams of updated Trust guidelines
MW7 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.

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:

MSW14 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.

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

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

Sr3 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

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

MW1 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).

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:

MSW15 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 includes 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

MSW3 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.

As alluded to in the previous quote, some MSWs were undertaking other MSW training such as Foundation degree. This was commented on positively, as follows:
**MSW11** I am currently studying the foundation degree which is giving me a much better insight into public health issues and more support regarding breastfeeding.

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

**MSW10** 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

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

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

**MSW1** 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.

**MSW16** 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!

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.

**LME6** 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

**LME2** we too invite specialists in the various fields and service users to contribute to the theoretical components: FGM, smoking cessation, substance abuse, perinatal mental health etc.

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

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

**St5** 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.

Experiential learning was particularly valued by students:

**St4** 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.

**St6** 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.

iv) Communication skills support

Midwives and MSWs rarely identified mentioned receiving any training to enhance their communication skills for discussing public health issues with women. As 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.

**MSW2**. 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 post natal women could be improved and would welcome suggestions if anyone knows of any e learning I could access.

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: women’s stories (live or podcasts), skills based workshops, involvement of specialist midwives. There was an emphasis on experiential learning: 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.

**LME4** To help students discussion sensitive topics with women, from BF, to domestic violence 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.

**LME6** 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.

**LME5** 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.

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

**St9** 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.

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

**St7** 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 and obesity.

**St6** 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.
MAJOR 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 5. 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

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i) Time & 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.

*St2* 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.

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

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

*MSW3* 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.

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

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

*MW2* 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.

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

*MSW2*... 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

*LME2* 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.
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.

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

MW9 Yes it’s a huge amount of information & they glaze over I find.

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

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

MW12 Whilst I am not averse to giving a ph 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.

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

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

MW5 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 ph messages

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.

HoM2 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 PH agenda and sometimes this gets lost.
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.

MW4 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

MW5 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

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.

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

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

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

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

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.

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

MSW20 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

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

**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.

**St5** 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

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

**MW12** 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

**iii) Language & 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 were seen as beneficial, though it was apparent that much of the more subtle communication could be lost.

**St5** 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 pickup on this.
MSW2 We have quite a large client group for whom English is not their first language. Public Health education to this group is very challenging.

MW3 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.

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

MSW14 We do try and perhaps use an online translator to write things in the women's first language and have even gone so 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!

MSW12 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

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.

St6 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.

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.

MW8 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

MW9 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"
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.

**MW6** 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!!

**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.

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

**MW10** 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.

**MW3** 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.

**MW6** 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 PH information possible.

**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 Baby Friendly Initiative (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.

**MW6** staffing levels are so bad that even ante-natal clinics are being cancelled, so no, no training is being received for PH issues.

**MW4** 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.

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

One LME pointed out that where midwives had received training in public health areas, they found it
difficult to 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.

**LME4** Midwives are likely to have attended workshops/updates on many PH
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.

As described in the previous major theme (see page 31), the maternity support workers 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.

**MSW13** Maternity is very specific, and HCA’s 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.

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

As discussed in the previous theme, 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 the use of 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.
**MW2** 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** 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.

**St4** 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.

**MSW15** 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.
MAJOR 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 & 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. Four subthemes were identified:

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

i) 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 Maternity Support Worker (MSW12) observed that at a recent count over 25 different languages were used by women within their community area. 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.

*MSW7* 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.

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.

ii) Attitudes to public health information

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

MW9 I think also some groups ignore public health advice because they don’t believe it is important or even actually true, 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."

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.

MW8... 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.

MW14... lower socio 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.

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

iv) Mothers with higher academic achievement

It was appreciated that mothers are highly individual and although mothers with higher educational achievement 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 Maternity Support Worker to provide additional personalised support.

**MSW16** 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.

**MW14** 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. Trying to get family involvement, [and] advice of ‘it’s ok to have some me time.’

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.

**MSW15** 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.
MAJOR 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 subcontracted 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. Four subthemes 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

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.

LMES 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

MW9 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.

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

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.

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.

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 deskillling of other staff as there is a temptation to hand over care of all these women to the relevant specialties.

I believe it is a good idea to have specialist midwives leading ion 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 deskillling, however you could argue before the advent of specialisms within Midwifery issues were possibly muddled through or not addressed.

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 dash charity for da [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 Hitchinbrooke is a perfect example of the danger of privatisation when the profit goes, so does the service.

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.

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.

**LME2** 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.

**MW11** 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.

**LME4** As for specialist services, there needs to be a balance here between midwives concentrating of 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.

### 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 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.

**St6** 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.

**St5** I have mixed feelings when it comes to specialist services. Sometimes they appear to be effective in tailoring care to the individual. At other times it seems more of a hindrance (reductionist comes to mind) Sometimes the women end up seeing different specialist for different aspects of their needs and they feel tied down by maternity services. 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 is more likely as some lose track of where
they should be. It can become tedious for the women who sometimes just stop bothering.

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.

**St9** Everyone needs to know what they are too so that women have a clear care pathway.

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

**MSW2** I find in my role on post natal 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.

### iv) Resourcing specialist services

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

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

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.

**St9** 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.
Summary of findings

The findings have been presented as five major themes. These major themes were identified by thematic analysis of data collected in seven Facebook groups, using a coding framework created from the research questions and RCM study objectives (see Table 6 on page 63).

The major themes identified are: Scope of midwives’ public health role; Training and support for public health role; Barriers and facilitators; Client groups; Role of specialist referral services. Each major theme and its related sub-theme have been discussed in detail, illustrated by data extracts from all Facebook groups.

A number of key issues have been identified, which could inform the development of a questionnaire or audit tool to survey a large sample of student midwives, midwives and MSWs, as proposed by RCM for Step Two of the project. These key issues are set out in the following discussion section.

DISCUSSION

In this final discussion, the original research aim and questions are returned to, and the extent to which these have been answered is considered. Study limitations are identified and the findings of the study are discussed. Suggestions are made for future research, including how the themes identified in this first phase could be followed up in a broader survey.

Research aim and questions:

Research Aim:

The team at Cardiff University was commissioned to conduct qualitative research with the aim of identifying student midwives’, midwives’ and midwifery support workers’ current knowledge of and involvement in the public health agenda in England. This aim has been achieved, with rich qualitative data being collected in most of the Facebook groups.

There was a good level of interest in the study from student midwives, Band 5 & 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 numbers of participants, so that 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. As noted in the Methods section, it was not possible to recruit to a service user discussion group, due to difficulties in obtaining permission to place an advert on the Facebook pages of Netmums or Mumsnet, the two organisations that provide social networking for mothers. Although alternative strategies to encourage engagement were considered, the short timeframe for the study prevented the research team from pursuing alternative options for the engagement of users, HoMs and Consultant Midwives.

Research Questions
The RCM’s original study aims were formulated into the following research questions. Responses to the questions are identified in bold according to their analytic theme:

6. What are student midwives’, midwives’ and Maternity Support Workers’ knowledge and involvement of the public health agenda in relation to maternity care provision? **Response:** Theme = ‘Scope of midwives’ public health role’

7. 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? **Response:** Theme ‘Scope of midwives’ public health role’ and theme ‘Client groups’

8. What do participants believe to be the educational facilitators and barriers associated with their role in making a public health impact? **Response:** Theme ‘Training and support for public health role’ and theme ‘Barriers and facilitators’

9. What are the level of skills & competencies required by relevant maternity staff in relation to specific user groups and their public health intervention requirements? **Response:** Theme ‘Training and support for public health role’

10. What do participants believe the potential role of specialist referral services to be in meeting the public health agenda? **Response:** Theme ‘The role of specialist referral services’

In addition to the required research questions it was proposed that lay participants would be asked their perceptions of the role of the midwife within public health. **No response, due to lack of participation by lay participants**

Limitations of the study.
The study 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 1st 2014 to 27th February 2015. Data collection took place over four weeks (5th – 30th 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.

As noted, it was not possible to recruit lay participants. This was disappointing, although inclusion of this participant group was not a requirement of the original commission but rather had been included by the research team to further enhance the data collected. It is however still regarded as important to gain insights into the experiences of families receiving midwifery public health activities and it is recommended that the service user perspective is included in any future research.

**Discussion of the findings**

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

**Discussion of Major 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 because they received less midwifery attention, or because they were embedded in practice and had become taken for granted. For example, there was little discussion about antenatal screening or immunisation (except by student midwives for whom all aspects of public health work were
relatively novel) and no mention of sexually transmitted diseases. Interestingly, given 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 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 M-BRACE 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 may be that 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 MSW’s contribution is seen as the norm and not worth commenting on, or it may be that the contribution of MSWs 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 these maternity workers.

**Discussion of Major 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.

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, and participants commented 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.

A 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 Major 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 Major 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 Major 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 services 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.

Conclusion:

This qualitative research study has investigated student midwives’, midwives’ and midwifery support workers’ current knowledge of and involvement in the public health agenda in England, with data collected via seven Facebook groups.

Thematic analysis of the data using a coding framework generated five key themes: Scope of midwives’ public health role; Training and support for public health role; Barriers and facilitators; Specific client groups; Role of specialist referral services. These have been discussed in detail, using data extracts from across the participant groups to illustrate the main points.

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.
References


Appendix1: Coding Framework

Table 6 Analytical coding framework incorporating RCM objectives and research questions

<table>
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<th>THEME 1: Scope of the Public Health Role</th>
<th>Research Questions</th>
<th>RCM objectives</th>
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<td>THEME 5: Role of specialist referral services/ HCPs</td>
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Research Questions

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

RCM Tender objectives

(See page 5 of Call for tender)

i. Student midwives’, midwives’ and MSWs’ knowledge of and involvement in the wider public health agenda (including their opinions of the social and clinical relevancy in relation to specific user groups, such as vulnerable and ‘at-risk’ families)
ii. The educational facilitators and barriers associated with their role, in making a public health impact
iii. The level of skills & competencies required of MSWs, student midwives, midwives and specialist midwives, in relation to specific users groups and their public health intervention requirements
iv. The potential role of specialist referral services