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Women's views of continuity of information provided during and after pregnancy: a qualitative interview study

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Manuscripts

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3 **Women's views of continuity of information provided during and after**
4 **pregnancy: a qualitative interview study**
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9 **Abstract**
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13 Straightforward transfer of care from pregnancy to the postpartum period is associated
14 with health benefits and is **desired** by women worldwide. Underpinning this transfer
15 of care is the sharing of information between healthcare professionals and the
16 provision of consistent information to women. In this qualitative study, two aspects of
17 continuity of information were examined; firstly the information passed on from
18 midwife to health visitor regarding a woman and her baby before the health visitor
19 meets the woman postnatally and secondly, the consistency of information received
20 by women from these two healthcare professionals (the main healthcare providers
21 during and after pregnancy in England). To be eligible for the study, women had to
22 have had a baby in England within 12 months prior to the interview. Participants also
23 needed to be able to read and speak English and be over 18 years old. Recruitment of
24 participants was via word of mouth and social media. Twenty-nine mothers were
25 interviewed of whom 19 were first time mothers. The interviews took place in the
26 summer and autumn of 2016 and were transcribed verbatim and analysed using
27 Framework Analysis. Two overarching themes were identified: not feeling listened to
28 and information inconsistencies. Women reported little experience of midwives and
29 health visitors sharing information about their care, forcing women to repeat
30 information. This made women feel not listened to and participants recommended that
31 healthcare professionals share information; prioritising information about labour,
32 mental health and chronic conditions. Women had mixed experiences regarding
33 receiving information from midwives and health visitors, with examples of both
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3 consistent and inconsistent information received. To avoid inconsistent information,
4 joint appointments were recommended. Findings from this study clearly suggest that
5
6 better communication pathways need to be developed and effectively implemented for
7
8 midwives and health visitors to improve the care that they provide to women.
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14 **Keywords**

15 Interviews; maternity care; postnatal care; midwife; health visitors; transfer of care,
16 qualitative
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21 **What is known about this topic**

- 22 • Effective transfer of care from pregnancy to the postpartum period is
23 associated with health benefits.
- 24 • Straightforward transfer of care is **desired** by women.
- 25 • Little is known regarding women's experiences of continuity of information
26 provided by UK midwives and health visitors.
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41 **What this paper adds**

- 42 • Recent mothers have to repeat information due to limited communication
43 between midwives and health visitors.
- 44 • Recent mothers want healthcare professionals to prioritise information
45 regarding labour, mental health and chronic conditions.
- 46 • Joint working and sharing of resources between midwives and health visitors
47 is expected to improve consistency of information.
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1. Introduction

The length of postnatal hospital stays are decreasing worldwide (Barimani & Hylander, 2012; Henderson & Redshaw, 2017) meaning midwives have less time to monitor maternal and infant health (Kurth et al., 2016). This subsequently puts more pressure on postnatal care in the community. Optimal community care should be co-ordinated to ensure continuity of care provided by midwives and health visitors.

Midwives are healthcare professionals who have completed a programme of education to prepare them to care for women during pregnancy and immediately following birth (International Confederation of Midwives, 2017). Health visitors are midwives or nurses who have completed an additional educational programme to equip them to provide expert guidance, assessment and interventions to families with children aged 0-5 years of age and they may also be in contact with women antenatally (NHS England, 2014).

Clear and straightforward transfer of care from pregnancy to the postnatal period has been associated with care satisfaction (Kurth et al., 2016; Tuominen, Kaljonen, Ahonen, & Rautava, 2014) and has consistently been found to be important to women worldwide (Barimani, Oxelmark, Johansson, & Hylander, 2015; Hildingsson, Waldenström, & Rådestad, 2002; Jenkins, Ford, Morris, & Roberts, 2014; Kurth et al., 2016). Furthermore, continuity of care, as provided by several healthcare professionals, has been associated with breastfeeding maintenance (Hoddinott, Britten, & Pill, 2010). Despite this evidence, women have been found to experience little transfer of care from pregnancy to the postnatal period in countries such as Australia (Psaila, Schmied, Fowler, & Kruske, 2014b), Finland (Tuominen et

1
2
3 al., 2014), Sweden (Barimani et al., 2015), Switzerland (Kurth et al., 2016) and the
4
5 UK (Donetto et al., 2013).
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8 Transition of care between healthcare professionals is multifaceted (Jenkins et
9
10 al., 2015) with one key aspect being continuity of information. Continuity of
11
12 information is described by women as healthcare professionals having *access* to the
13
14 same information and *providing* the same information (Jenkins et al., 2015). Poor
15
16 communication and not receiving consistent information has regularly been identified
17
18 by women as a key concern (Baas, Erwich, Wiegers, de Cock, & Hutton, 2015;
19
20 Jenkins et al., 2014) as well as by their partners (Kurth et al., 2016). There is scant
21
22 knowledge of women's experiences of transfer of care provided by midwives and
23
24 health visitors in the UK.
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29 Collaboration between midwives and health visitors is recommended by both
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31 researchers (Aquino, Olander, Needle, & Bryar, 2016; Barimani & Hylander, 2012;
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33 Donetto et al., 2013; Psaila, Fowler, Kruske, & Schmied, 2014a) and policy makers
34
35 (National Maternity Review, 2016; Public Health England, 2013). Current policy
36
37 recommendations in England highlight the need for collaboration between the
38
39 healthcare professionals who care for women during and after pregnancy (Public
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41 Health England, 2013). These policies are similar to national policy in other countries,
42
43 such as Australia (Schmied et al., 2015).
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48 The aim of the current study was to explore recent mothers' experiences and
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50 views of the continuity of information shared and provided by midwives and health
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52 visitors during and after pregnancy in England. Specifically, two aspects of continuity
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54 of information was examined, firstly the information passed on from midwife to
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56 health visitor regarding a woman and her baby before the health visitor meets the
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58 woman postnatally and secondly, how consistent the information received by women
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3 from these two healthcare professionals is. In addition to pre-existing research and
4 policy, the importance of this research was highlighted by our research centre's
5 Patient and Public Involvement (PPI) group. Women's views are key to the conduct
6 of maternal health research and women should be consulted when identifying research
7 priorities (Pandey, Porter, & Bhattacharya, 2015). Our PPI group reported mixed
8 experiences regarding continuity of information from midwives and health visitors,
9 however, they consistently suggested that continuity of information needed
10 improvement. One of our PPI group members was part of the research team (and co-
11 author) for the current study to ensure its relevance to current service users and
12 provided input on initial study protocol, recruitment, discussion of findings and
13 implications for practice.
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33 **2. Methods**

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36 This is a qualitative interview study. A qualitative study design was regarded as most
37 appropriate for the study aim to explore recent mothers' experiences and views of the
38 continuity of information shared and provided by midwives and health visitors during
39 and after pregnancy in England. This study is part of a larger programme of work
40 aiming to improve the collaboration between healthcare professionals caring for
41 women during and after pregnancy.
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54 *2.1 Participants and recruitment*

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57 To be eligible for the study, women had to have had a baby within 12 months prior to
58 the interview. Participants also needed to be able to read and speak English, be over
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3 18 years old, and have had antenatal and postnatal care in England. We included
4
5 women living anywhere in England as services may differ in different areas. Women
6
7 were recruited through two methods: word-of-mouth and social media. Word-of-
8
9 mouth recruitment was done by the research team and others affiliated to the authors'
10
11 research centre, and the PPI representative. It was done by briefly telling women with
12
13 young children about the study and some of them told other mothers in turn.
14
15

16 Recruitment on social media (Twitter and Facebook groups relevant to the participant
17
18 population) was done both by the researchers and a large UK charity, the National
19
20 Childbirth Trust. As this was an exploratory study no formal sample size was decided
21
22 upon *a priori*.
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26 27 28 29 30 2.2 Data collection

31
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33 All women interested in participating in the study were asked to email the researchers.
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35 The women were then sent a participant information sheet and an interview was
36
37 organised. The participants were offered a telephone or a face-to-face interview in
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39 London or the West Midlands (where the research assistants conducting the
40
41 interviews were based). Both interviewers were women, educated to MSc level in
42
43 psychology and had previous experience conducting interviews. Consistency between
44
45 interviewers were assessed by comparing their first interview transcript which showed
46
47 good consistency. Four participants chose face-to-face interviews in their home and
48
49 the remainder were interviewed by telephone. All women consented to take part in the
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51 study before the interview started, verbally if taking part in a phone interview or
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53 written consent if a face-to-face interview. None of the interviewers knew the
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3 participants before the interview and no one else was present during the interviews.

4
5 The interviews were conducted during summer and autumn of 2016.

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8 The interview schedule was informed by previous research (Aquino et al., 2016;
9
10 Jenkins et al., 2015), current policy (National Maternity Review, 2016; Public Health
11
12 England, 2013) and experiences from the research team (a mix of midwifery, health
13
14 visiting and health psychology expertise, and recent experience of childbirth). The
15
16 interview schedule was not pilot tested, instead it was discussed by the authors' after
17
18 the first few interviews to see if it needed to be revised. It was decided that no
19
20 revision was necessary. Our PPI representative suggested a small incentive to show
21
22 appreciation to participants for their contribution; therefore, all participants were
23
24 offered a £5 Amazon voucher as a token of appreciation for taking part in the
25
26 interview. This study, including its methods of taking participants consent, was
27
28 approved by the authors' school ethics committee (Reference PR/MCH/Staff/16-
29
30 17/02). Before each interview, participants were reminded that all discussions would
31
32 be kept anonymous.
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41 **2.3 Data analysis**

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43 Interviews were semi-structured, audio-recorded, transcribed verbatim by a
44
45 professional transcription agency and anonymised. Two of the authors analysed the
46
47 transcripts using Framework Analysis (Ritchie & Spencer, 1994). Framework
48
49 Analysis was chosen as the interview schedule focused on several aspects of
50
51 continuity of care and each was analysed separately. Findings concerning continuity
52
53 and transfer of information are reported here and were derived from the data. Analysis
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55 involved the following steps: reading all the transcripts to become familiar with the
56
57 data and focussing on findings relevant to continuity of information. These steps were
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2
3 done independently. Subsequently two of the authors identified similarities and
4 differences in participants' accounts before codes and themes were derived. Finally,
5 the data were mapped and interpreted. Data analysis by two authors enabled
6 researcher reflexivity where the authors acknowledged their assumptions about
7 transfer of care.
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21 **3. Findings**

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23 A total of 40 women contacted the research team, of which 29 women were
24 interviewed in the summer and autumn of 2016. The remaining 11 women chose to
25 not contact the researchers after having received the participant information sheet,
26 reasons for this are unknown. The participants were on average aged 33 years (range
27 28-38). Most participants (N=26) lived in urban areas (i.e. cities). The most common
28 area mentioned was Greater London, but other areas were represented in the sample
29 such as the West Midlands and Southwest of England. Almost all (N=27) of the
30 participants described themselves as White British or White other. At the time of the
31 interview, the participants' youngest child was on average 5 months old (range 1-11
32 months), and 19 participants were first time mothers. Eleven women were recruited
33 through word-of-mouth, with the remaining women learning about the study via
34 social media. Participants' experiences during pregnancy and labour differed widely
35 and included different modes and places of birth. Most participants reported low risk
36 pregnancies; however, complications such as postpartum haemorrhage, gestational
37 diabetes, hypertension and depression and anxiety were reported. The majority of
38 babies were born well but three experienced conditions including pneumonia,
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3 resuscitation and a brain cyst. Thus, the participants had experiences where numerous
4 healthcare professionals had provided care to them and/or their baby. Interviews took
5
6 on average 28 minutes (range 16-49 minutes).
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10 Two overarching themes were identified: not feeling listened to and
11 information inconsistencies. These themes and their subthemes are described below.
12
13 See figure 1 for a thematic network diagram of the themes and subthemes. Quotes
14
15 related to each theme are presented and, to provide context, information about
16
17 participants' parity (primip - primiparous or multip - multiparous) and age of baby at
18
19 the time of the interview has been added. Participants have been given a pseudonym
20
21 to ensure confidentiality.
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31 *3.1 Not feeling listened to*

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33 This theme focuses on the information women perceived was shared postnatally from
34
35 their midwife to their health visitor about their and their child's care. This theme
36
37 include four subthemes: (i) women's experiences regarding the information shared
38
39 about them and their baby by the midwife to the health visitor, (ii) women's
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41 suggestions for what information needs to be prioritised, (iii) their concerns regarding
42
43 information sharing and (iv) their perceptions of the benefits of sharing this
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45 information.
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51 *3.1.1 Women's experiences of information shared between midwives to health visitors*

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53 The participants consistently stated that they knew little about the process of how
54
55 information is shared about themselves and their baby from the midwife to the health
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57 visitor. Many participants expressed doubt that there was any information sharing, as
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3 many of them found themselves having to repeat information to the health visitor. It
4
5 was clear that women expected health visitors to know more about their previous care
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7 and experiences than they actually did. Linda for example (see quote below),
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9
10 explained how the health visitor knew nothing about her birth experience ahead of
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12 their first meeting. Linda expected the health visitor to have this information, which
13
14 shows the importance of ensuring women have appropriate expectations of their care
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16 – it is common practice to pass information from midwife to health visitor through a
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18 letter via the woman. For another participant, Joanna, passing information from
19
20 midwife to health visitor was perceived as continuity of care.
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24 *She [health visitor] didn't really have any of the knowledge of what had*
25 *happened during my labour. I don't know if she was even aware that I had a*
26 *homebirth and she hadn't received any of the, I handed her the envelope with*
27 *the information about the birth and the transcript and all the information that*
28 *she needed the first time that she came round to the house, and that's the first*
29 *time she was made aware of anything other than the fact that she was*
30 *obviously coming to see a baby of a certain age. Linda, multip, 6 month old*
31 *baby*
32
33

34
35 *I think there is continuity of care because I know that my notes got transferred*
36 *and, well, I know some, not my notes, sorry. I ... that the midwives basically*
37 *said to the health visitor we're handing her over to you and then the health*
38 *visitor gave me a call because I got that call and then I had all these notes*
39 *from my midwife which I handed on to my health visitor. There is, it did work*
40 *fairly well because the midwife stops then the health visitor started. Joanna,*
41 *multip, baby 2 months old*
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46 One woman, Isabel, reported that both midwife and health visitor visited her at the
47
48 same time, suggesting they had not communicated about their visit.
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52 *I don't think she [health visitor] had [contact with midwife] because they*
53 *actually turned up at exactly the same time for a visit and, so, I had, suddenly*
54 *the flat had two visitors in it and they were a bit surprised to have overlapped*
55 *and they had, so they made, it was quite funny really, because they said oh are*
56 *you checking that or am I checking that, or what, who wants to do what? So,*
57 *no, I don't think they had had contact. Isabel, primip, baby 7 months old*
58
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3 However, other participants reported examples of information sharing. Hannah
4
5 reported that her midwife and health visitor had been in contact, but only after a test
6
7 result had not been shared.
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12 *There was a little bit of a mix up between the midwife and the health visitor*
13 *with regards to some of the test results I can't remember, I think it was the*
14 *heel prick test so my midwife submitted it, the test, and then the health visitor*
15 *didn't know, or sorry couldn't get access to the results so they had to, they had*
16 *a quick chat, I think after the test. Hannah, multip, baby 7 months old*
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21 In the case of one woman, Julia, the lack of continuity influenced how she
22
23 subsequently accessed the health visiting service.
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28 *Certainly felt I didn't get the impression that my health visitor, when she took*
29 *over, knew anything about us or knew anything about the pregnancy or how*
30 *it's gone or how the labour had gone or anything like that, so I think that*
31 *would have been, that would be really useful in future, for them to know a bit*
32 *more about you, so that when they come, it doesn't feel like we're starting all*
33 *over again, because I'm sure that's impacted on the way that I, why I haven't*
34 *accessed them, because I don't feel like we've had that, I guess you don't feel*
35 *like you've had that relationship or continuity. Julia, primip, baby 6 months*
36 *old*
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40 41 42 43 44 3.1.2 Information to be prioritised 45

46
47 Participants consistently stated that it was important that information was shared
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49 between midwives and health visitors. They reported that they would be happy for
50
51 any pertinent information to be shared, like Leah below. Some women, like Beatrice,
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53 highlighted specific issues such as maternal mental health issues or chronic conditions
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55 and illnesses.
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3 *Oh, everything, everything and anything that might impact the mother and the*
4 *baby is a good idea to share. Leah, multip, baby 11 months old*
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8 *Mother's mental health probably... I think a lot of people and possibly myself*
9 *included has, will suffer postnatal depression or will struggle with being a*
10 *first time mum in particular and if the health visitor notices it but doesn't pass*
11 *it on, or the midwife notices it but doesn't pass it on...it could be a very long*
12 *time before someone gets any support at all. Beatrice, primip, baby 2 months*
13 *old*
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19 Other information prioritised by participants included details of the birth. Beatrice, for
20 example, had to retell her traumatic birth story to both community midwives and
21 health visitors, an issue she would rather have avoided. Katherine on the other hand,
22 had a straightforward birth and suggested that whilst information sharing is positive, it
23 should not replace a woman's discussion with the healthcare professional.
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33 *Yes I think so because then they could have [shared information], the things*
34 *that weren't shared from the hospital midwives to the health visitor I ended up*
35 *having to explain what was a quite traumatic birth story three or four times to*
36 *the health visitor and a couple of different community midwives and it's*
37 *something I would rather have not talked about. If they'd passed on all of that*
38 *information it might have made it a bit easier on me. Beatrice, primip, baby 2*
39 *months old*
40

41
42 *In my situation, no, because I had a very straightforward birth and it, and*
43 *most of it, nearly all of it was to do with the birth and obviously prenatal*
44 *check-up information, so actually I don't think it would have been particularly*
45 *helpful for her to have it. ...I mean they both asked me how the birth was and*
46 *you sort of give your story of that but I think that's quite a nice thing to do, I*
47 *wouldn't want that information to be passed. Not necessarily I wouldn't want*
48 *it but I think it's quite a nice dialogue to have with your health visitor so they*
49 *understand properly where you're coming from, rather than actually it just be*
50 *flat information, it's quite an emotional information. Katherine, primip, baby 7*
51 *months old*
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56 Women who had experienced miscarriages expressed a desire that this information
57 was shared with health visitors as a priority, as suggested by Donna below.
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3 *Just so that they've got a bit of prior awareness because before I had my*
4 *daughter I had a miscarriage and obviously the midwife was aware of that*
5 *when... but the way [the health visitor] approached it, one of the first things*
6 *she said was, how are you getting on with your third child and I was like, he's*
7 *my second which was just a little bit awkward really. Donna, multip, baby 1*
8 *month old*
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15 However, the majority of women were unable to or reported that it was inappropriate
16
17 to prioritise specific information which should be shared between midwives and
18
19 health visitors. For these participants, all information about any factors which could
20
21 affect the wellbeing of a woman or her baby was considered important. Clara explains
22
23 how information regarding both antenatal and postnatal mental and physical health is
24
25 important to share:
26
27

28
29 *Prioritising information in terms of, let me just think properly. The midwife's*
30 *going to pass on information to the health visitor and the kind of information*
31 *they can pass on I guess to the health visitor is how the woman's been through*
32 *pregnancy, their general wellbeing physically and mentally and again the*
33 *birth and how the woman seemed immediately afterwards. Clara, multip, baby*
34 *8 months old*
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39 40 3.1.3 Concerns regarding information sharing

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42 The majority of women reported feeling confident about information being shared
43
44 appropriately, for example Stella (primip, baby 11 months old) told us *...it's all*
45 *confidential, they're all professionals so it should be all right.* However, a few
46
47 participants raised concerns regarding information sharing. For example, Clara
48
49 expressed concern that a remark made once could be taken out of context. Hannah
50
51 mentioned how health visitors are seen by some as 'front line social services' which
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53 has implications for what women may choose to disclose to them.
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I wouldn't want the health visitors discussing necessarily if something happened... the health visitor brought up something that was just a meaningless discussion with the midwife during pregnancy. Clara, multip, baby 8 months old

I suppose I've had someone tell me [about] bad health visitors, that they're kind of a front line social services and to be perhaps a bit wary about that. So should you not disclose things about their mental health? Hannah, multip, baby 7 months old

3.1.4 Perceived benefits of information sharing

The benefit most commonly described by women when discussing sharing of information was not having to answer the same questions repeatedly. This was reported to be tiring as highlighted by Isabel below. Other participants reported that repeating the same information could be emotionally difficult, especially for women who experienced a difficult birth.

...when you're very tired, as I say, the more that you have to repeat yourself about an experience you've had or a concern that you've got, it's quite tiring, it's better if you can say it once and then the person coming to see you next knows what's what. Isabel, primip, baby 7 months old

Women also stated that sharing information could have benefits for healthcare professionals by enabling them to practise more effectively. For example, Isabel suggested more midwife-health visitor contact could lead to more streamlined services and Donna mentioned sharing information could reduce the risk of duplicating work.

I think they [midwives and health visitors] themselves would like to have more contact because it will probably streamline their caseload really if somebody's seen somebody and that's OK and then they don't need to see them or whatever. It's probably more efficient. Isabel, primip, baby 7 months old

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3 *It appeared that some people get their baby weighed by a midwife on Tuesday*
4 *and a health visitor on Thursday which is a little bit pointless. Donna, multip,*
5 *baby 1 month old*
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10 Sharing information was perceived as facilitating the development of the relationship
11 between women and professionals, thereby improving care. Imogen felt like her
12 transfer of care was not very linked up, which made her perceive the health visitor
13 service as not very personal. Improved communication between midwives and health
14 visitors was considered a factor in ensuring women felt their concerns were
15 recognised and taken into account. Flexible, individualised care where everyone is on
16 the 'same page' and in which women's needs were understood was highly valued by
17 the participants as outlined by Linda.
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30 *I never really got the impression anything was very well linked up... do I*
31 *really think [the health visitor] knows who I am? it's not a very personal*
32 *service. Imogen, primip, baby 1 month old*
33

34 *It helps the parents or the mother feel like she has a team of people supporting*
35 *her through what is a very emotional period in your life and feeling like that's*
36 *a united team that are all, that all know the same information and are all on*
37 *the same page of helping out is really useful. Linda, multip, baby 6 months old*
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43 In summary, this theme **shows** how women do not feel listened to due to a lack of
44 information being passed on from midwives to health visitors. This has implications
45 for how care is perceived and whether women access it. Few concerns regarding
46 information sharing were identified, with numerous benefits mentioned.
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3.2 Information received by mother

This theme concerns the participants experiences of information provided to them by midwives and health visitors and is part of women's experiences of continuity of information. Consistent information would suggest that midwives and health visitors are in contact regarding women's care and would be supportive and helpful to women. Information did not have to focus on their antenatal, intrapartum or postnatal care, but instead postnatal issues such as breastfeeding. This theme has two sub-themes: (i) experiences of receiving consistent information and (ii) suggestions for ensuring consistent information provision.

3.2.1 Experiences of receiving consistent information

Participants reported varied experiences regarding the information they had received from midwives and health visitors. Several women, such as Katherine and Sarah reported receiving consistent information from both healthcare professionals on topics such as self-care with stitches and breastfeeding. Grace's experience was different however, where she received different information regarding how much expressed milk to feed her baby. Other topics where women reported receiving conflicting advice were physical activity postpartum, baby weight gain and treating cradle cap.

Yeah, pretty much, yeah... No, completely consistent... It was more, probably personal care after having the baby. Just because I had stitches and it was just how to look after, how best to look after them and that, how to make yourself feel a bit better about it. Both of them gave me advice on that and it was exactly the same advice. Katherine, primip, baby 7 months old

Yeah I think it was pretty consistent. ...Well I think they probably both spoke a bit about feeding and breast feeding, and I think the health visitor provided information about local clinics or walk in breast feeding café kind of things

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3 *that just went along with the information that the midwives gave. Sarah,*
4 *multip, baby 8 months old*
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8 *...with my second son, I was exclusively expressing, and there was definitely a*
9 *disparity between how much they felt the right amount of milk was to feed,*
10 *using expressed breast milk, and it would have been helpful if I could have had*
11 *the same information. Grace, multip, baby 4 months old*
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14 One mother, Joanna, reported how she had received conflicting advice from the
15 midwife, health visitor and GP about how to avoid her baby getting chicken pox from
16 an older sibling. She did recognise however that this was a less common issue, and
17 overall the information she had received had been consistent.
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25 *Generally it has been fairly consistent on the normal stuff, the kind of*
26 *everyday, having a baby, giving birth, breastfeeding etc. I did have some*
27 *frustrations with having, getting very different information about the chicken*
28 *pox issue, with my son having chicken pox and whether I needed to keep them*
29 *apart and every midwife had a different opinion and the health visitor had a*
30 *different opinion and the GP had a different opinion and I found that really,*
31 *really quite hard to find the mid route between that, but that was an unusual*
32 *issue. On the standard things, then I think everything was pretty consistent*
33 *really. And the most important, well, no, that was important but like the things*
34 *to do with my health and the baby's health, everyone was yeah, everyone was*
35 *singing from the same hymn sheet, so yeah. Joanna, multip, baby 2 months old*
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40 Moreover, consistent information was mentioned by participants as something
41 influencing their confidence in healthcare professionals. Imogen (primip, baby 1
42 month old) explains *I guess you just feel a bit more that they [healthcare*
43 *professionals] understand what you're going through, that you feel you trust them,*
44 *and you're getting the most appropriate advice.*
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54 3.2.2 Suggestions for ensuring consistent information provision

55 The interviewed women made several suggestions to help midwives and health
56 visitors provide consistent information. These suggestions included meeting with both
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3 professionals at the same time as mentioned by Grace (amongst others) below. Emma
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5 recommended that midwives and health visitors attended the same training and used
6
7 the same guidelines.
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10 *So in that case [query about expressing milk] that would have been good to*
11 *have had both of those, both the health visitor and the midwife there at the*
12 *same time, because I definitely got different messages there. Grace, multip,*
13 *baby 4 months old*
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16 *I think the only way that you could do it is almost to, almost make sure that the*
17 *actual training is mirrored and the guidelines are very much mirrored,*
18 *whereas I don't necessarily feel, I feel like there's midwifery guidelines and*
19 *then there's public health guidelines and I think that they don't necessarily*
20 *always talk to each other... Emma, primip, baby 1 month old*
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23 Stacey's quote below summarises many participants' views – it is unclear how
24
25 midwives and health visitors work together, but with greater communication the care
26
27 they provide to women and their babies would be improved.
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30 *I mean, if they probably talked more to each other. I don't know, if they had, I*
31 *don't know how they work, but if they had meetings and they discussed cases.*
32 *I don't know, on a monthly basis if they talked about a patient they go and see*
33 *and the information, and problems the mums come up with and the solutions*
34 *they come up with. And maybe they shared a little of their experience with*
35 *each other, and they probably would realise that they are giving different*
36 *information and maybe that would help, and yeah. They can come up with a*
37 *consensus, we should all say this and why we should say this. Stacey, primip,*
38 *baby 3 months old*
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43 This theme highlights the importance of midwives and health visitors providing
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45 consistent information to women, both in terms of how to manage issues such as
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47 breastfeeding but also to ensure women feel they can trust them. Based on their
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49 experiences, the participants made a number of suggestions to help midwives and
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51 health visitors provide the same information, including joint training, using the same
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53 guidelines and face-to-face communication.
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4. Discussion

The women interviewed in this study were mostly unsure if there was information shared between midwife to health visitor and suggested changes to improve the sharing of information and providing consistent information. Whilst this study was conducted in England, findings may be relevant to other countries where models of antenatal and postnatal care are similar and provided by a range of healthcare professionals.

The interviewed women were unsure if there was any information sharing between midwives and health visitors, or if they had access to the same information. This finding is consistent with a small UK study (Aquino, Olander, & Bryar, 2018) and an Australian study where women stressed the importance of their information being available to healthcare professionals (Jenkins et al., 2014). Numerous benefits were mentioned regarding information sharing. Women were tired of repeating the same information, and it was acknowledged that healthcare professionals could provide better care if they shared information about the woman and her child as it would support continuity of care and help facilitate relationships with healthcare professionals. Having to repeat information has been identified as frustrating by women (Baas et al., 2015; Hesson, Fowler, Rossiter, & Schmied, 2018), as this makes them feel they are not listened to (Donetto et al., 2013). The current participants recommended that midwives and health visitors should share all relevant information, with some suggesting a specific focus on birth details, mental health, physical health and chronic conditions would be beneficial. Sharing this type of information would help healthcare professionals provide better care for women and facilitate report building. Concerns regarding information sharing was raised by a few women, specifically about the risk that information could be taken out of context. Thus,

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3 women need to be reassured about how privacy of personal information is ensured
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5 (Hesson et al., 2018) and the purpose of the information sharing, before this takes
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7 place.
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10 Participants also recognised that information sharing would improve the
11 consistency of information they receive. As with other research, our participants
12 reported receiving inconsistent information from different healthcare professionals
13 (Jenkins et al., 2014; Kurth et al., 2016; Psaila et al., 2014a). For example,
14 breastfeeding was mentioned by several participants as a subject where information
15 from midwives and health visitors differed significantly. This adds to previous work
16 which found mothers did not know who to ask for support with breastfeeding
17 (Barimani & Hylander, 2012) and that information about breastfeeding is important to
18 women (Barimani et al., 2015). Lastly, consistent and clear information was
19 mentioned by women as a factor influencing their confidence in midwives and health
20 visitors. Considering all this, it must also be noted that providing the right level of
21 information is not easy for healthcare professionals, with some women reporting
22 feeling overwhelmed by too much information and others reporting they did not
23 receive enough (Baas et al., 2015).
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44 The interviewed women made several suggestions to help midwives and
45 health visitors provide consistent information. These suggestions included meeting
46 with both professionals at the same time, midwives and health visitors receiving the
47 same training, and sharing information about women. Joint home visits by a midwife
48 and child health nurse have been reported favourably by Swedish women and enable
49 continuity of care as the midwives can introduce women to the child health nurses
50 (Barimani & Hylander, 2012). Recently, a UK study also identified this as something
51 that can improve postnatal care (Aquino et al., 2018). Collaboration and improved
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3 communication systems have also been identified by healthcare professionals as
4 something that would improve the care they provide women (Aquino et al., 2016;
5 Psaila et al., 2014a; Schmied et al., 2015). An integrated approach to transfer of care
6 may also mitigate the general anxiety parents may feel shortly after the birth of their
7 child (Woodward, Zadoroznyj, & Benoit, 2016).
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18 *4.1 Strengths and limitations*

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20 There are a number of strengths associated with this study. The number of participants
21 was appropriate, and we had a multi-professional research team (including midwifery,
22 health visiting and health psychology expertise) with input from a service user, who
23 together developed the interview questions, and analysed the findings. The service
24 user input has been summarised in line with the recent Guidance for Reporting
25 Involvement of Patients and the Public (Staniszewska et al., 2017) and can be found
26 in the supplemental material.
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36 A few study limitations must also be noted. Firstly, like other research with
37 this participant group (Aquino et al., 2018; Donetto et al., 2013; Woodward et al.,
38 2016) the women who participated in this study are a self-selected sample. The
39 majority of women also lived in Greater London, and thus their experiences may not
40 be representative of the postnatal population in other areas. There may also be some
41 bias due to being recruited via word-of-mouth and social media. No information was
42 collected regarding socio-economic status, thus it is unknown to what extent the
43 participants lived in deprived communities. Women who did not speak English were
44 excluded from the study and future research should explore women's experiences
45 regarding transfer of care in these population groups. That said, there was diversity in
46 age, parity, place of birth and care, and the participants were not solely women with
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3 positive experiences. It is also important to acknowledge that some questions may
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5 have been difficult for women to answer due to being about healthcare professional
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7 practice. Research with midwives and health visitors in England about transfer of care
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9 is needed to complement the findings reported in this study.
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13 Secondly, this study reports on information shared from midwife to health
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15 visitor. With the mandatory antenatal contact by health visitors, it is likely that health
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17 visitors' share information with midwives, but this was not mentioned by our
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19 participants. This direction of conveying information needs to be explored in future
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21 research as well as information sharing between other healthcare professionals women
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23 may come in contact with such as general practitioners and specialist perinatal mental
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25 health professionals.
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29 Lastly, there are other aspects of continuity of care that need to be considered
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31 alongside continuity of information including management continuity – the
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33 communication across teams, agencies, and professionals and women – in order to
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35 improve continuity of care holistically. More research in this area is needed.
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41 *4.2 Implications for practice and policy*

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44 The current findings suggest several implications for practice and policy. To aid
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46 consistent information provision, women suggested sharing of guidelines and joint
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48 training. Current NICE guidelines on postnatal care recommend having local
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50 protocols for how to communicate regarding the transfer of care from one healthcare
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52 professional to another (National Institute for Health and Care Excellence, 2018).
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54 Information exchange throughout pregnancy and up to 14 days postnatally between
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56 midwives and health visitors is also recommended by Public Health England (Public
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3 Health England, 2013). Findings from this study suggest that these guidelines are not
4 yet successfully implemented.
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8 Joint training has been identified as aiding collaborative practice (Olander,
9 Coates, Brook, Ayers, & Salmon, 2018; Psaila et al., 2014a) with limited resources
10 being a barrier for midwives and health visitors' collaborative working (Aquino et al.,
11 2016). Moreover, midwives and health visitors must be reassured that women are
12 happy for information regarding their care to be shared in an appropriate manner. Any
13 concerns women have about this information sharing must be considered. A
14 consistent finding in this study was that women had minimal concerns regarding
15 information sharing and encouraged this practice. Previous research suggests that
16 transfer of information is prevented due to difficulty sharing patient information
17 (Aquino et al., 2016; Kurth et al., 2016; Schmied et al., 2015). Thus, developing
18 appropriate information pathways, in line with policy, must be a priority for practice
19 development as well as research. The new initiative to digitise all maternity records in
20 England (Professional Record Standard Body, 2019) is likely to aid information
21 sharing between healthcare professionals. Information regarding a woman's care
22 history is used to inform care planning and is thus crucial for healthcare professionals
23 to be aware of, in particular, when they do not know the family (Psaila et al., 2014b).
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48 **5. Conclusion**

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50 Findings from this study echo previous international research – women want
51 integrated care during and after pregnancy (Barimani & Hylander, 2012; Kurth et al.,
52 2016). The novel study finding is that women want information shared about their
53 care needs and conditions throughout the perinatal period, and the majority of the
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3 study participants expressed confidence in healthcare professionals' ability to do this
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5 in an appropriate manner. The findings from this study strengthen the call for better
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7 communication pathways to be developed for midwives and health visitors to improve
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9 the care they provide to women.
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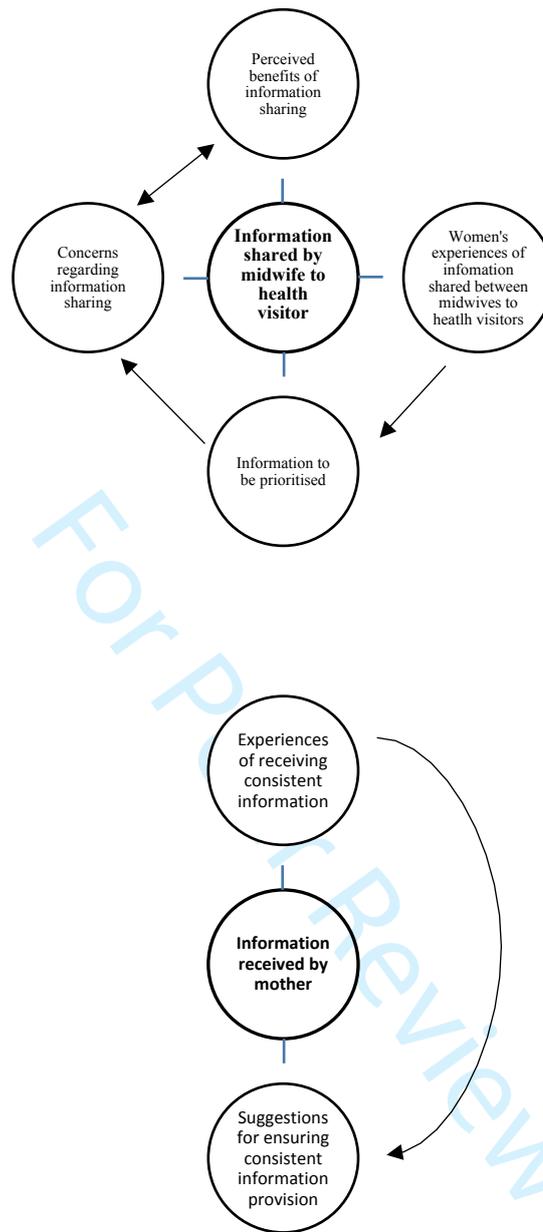


Figure 1. Thematic network diagram of themes and sub-themes