Midwifery 52 (2017) 34–41

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

Midwifery continuity: The use of social media

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ABSTRACT

Background: Continuity models of midwifery care improve women's experiences of care and clinical outcomes, but organisationally driven working practices do not facilitate a continuity model and the midwifery care received by most women is fragmented (Sandall et al., 2016, NHS England, 2016). Little is known about the potential for continuity of midwifery care to be achieved using an electronic platform. This paper examines the experiences of women accessing known midwives through a social media platform and their experiences and perception of continuity of care.

Methods: The study forms part of a larger research project aiming to increase understanding about online social learning within professionally moderated social media based communities. This paper reports specifically the concept of midwifery continuity within the online communities. Two secret Facebook groups consisting of 31 mothers and 4 midwife moderators were created (17 mothers & 2 midwives / 14 mothers & 2 midwives). Primary data included 8 online and face to face focus groups, conducted at approximately 10 week intervals, and 28 individual one to one interviews with members of the online community within six weeks of giving birth.

Data analysis: A thematic analysis using a priori themes was undertaken. This involved coding data which evidenced relational, informational and management continuity across the entire dataset (28 interviews and 8 focus groups). The analysis was undertaken broadly following the six stages described by Braun and Clarke (2006).

Findings: Relational and informational continuity were identified across the data. Relational continuity was evident for both the participants and the midwife moderators; informational continuity was described by the participants. Management continuity was not identified. Continuity through social media use was valued by both the mothers and the midwives.

Conclusion: Information and relational continuity needs of women can be met using professionally moderated, social media based groups. They may provide an alternative means of facilitating the continuity that is so often lacking in traditional models of care.

Introduction

Pregnancy, birth and early motherhood are times of significant change and transformation for women (Darvill et al., 2010). Effective midwifery care and support provided for women through this transformational period is not only beneficial for the woman, but their children and wider communities (National Health Service England (NHS), 2016). Foundations for long-term health outcomes are established during pregnancy and early years of life which can significantly influence health outcomes for children and adults as such it is a critical time in terms of maternal, child and family health and wellbeing (Shribman and Billingham, 2009; Marmot et al., 2010; Sandall et al., 2016a).

A fundamental aspect of contemporary midwifery care is continuity of care and relationship building to provide effective support for women through pregnancy, birth and early motherhood. It is essential

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http://dx.doi.org/10.1016/j.midw.2017.05.012
Received 4 April 2017; Received in revised form 15 May 2017; Accepted 22 May 2017

that relationships are formed which can facilitate trust, enable personalised care and bridge gaps and discontinuities in support, to achieve positive physical and psychological outcomes for women (Sandall et al., 2016a, 2016b). Continuity models of midwifery care acknowledge the importance of relationships and meaningful connections developing between women and midwives (Tracy et al., 2013; McLachlan et al., 2016; Sandall et al., 2016a, 2016b).

In a broad health context continuity is associated with improvements in care and is achieved when three fundamental elements are realised: relational continuity through sustained therapeutic relationships with known health professionals; management continuity with seamless communication about and between women, health professionals and health organisations; informational continuity through timely access to relevant information (Freeman et al., 2007; Heaton et al., 2012). Relational continuity has the greatest influence on experience and outcomes, and cannot be substituted by information and management continuity (Guthrie et al., 2008; Sandall et al., 2016b).

Continuity in maternity care is achieved when a known midwife follows a woman through her childbirth experiences regardless of the complexity of the pregnancy, and irrespective of the place where care is provided. This type of relationship based care provides multiple benefits for women including improved health outcomes, a greater sense of satisfaction with their childbirth experience and a greater sense of agency and control (Walsh and Devane, 2012 ; McLachlan et al., 2016; Sandall et al., 2016a).

Continuity models of midwifery care have been advocated since 1993 and relationship based, personalised care forms the basis of current maternity policy in the UK (Department of Health (DH), 1993; DH, 2010; NHS England, 2016). These models have been largely hospital or community based, and can provide continuity to low and high risk women. The most common continuity models are achieved through case-loading or team midwifery (Sandall et al., 2016a). Case-loading midwifery usually consists of a midwife providing care to a group of women and handing over to a midwifery partner when unavailable. Team midwifery is provided by a team of midwives, one of whom will provide most care but women may meet other members of the team (Sandall et al., 2016b). Both models are underpinned by the concept of a named and known midwife providing the majority of care and both models have been successfully implemented in maternity services with no significant differences in outcomes (Sandall et al., 2016b).

Despite being cost neutral with compelling evidence supporting extensive implementation, most women still do not receive continuity of midwifery care (Kenny et al., 2015; McLachlan et al., 2016; NHS England, 2016; Sandall et al., 2016b;). The most common reasons for this are attributed to resource constraints, modern working practices, and the current trend to centralise NHS maternity services. As a result large teams of midwives provide fragmented care to women inhibiting the development of trusting relationships and denying women their rights to safe and high quality maternity care (Page and McCandlish, 2006; Renfrew et al., 2014; McLachlan et al., 2016;).

The underpinning premise of relational continuity is based on the sustained and ongoing midwife mother-relationship. Continuity models need to be scalable and sustainable for all women to receive equitable benefit. Current continuity models have not met service provider conditions for widespread implementation. This paper reports initial qualitative findings, from a larger mixed methods research study, that suggest relational continuity in midwifery care can, for some women, be achieved through online contact, communication and support accessed through a social media platform. This model has the potential to be scalable and sustainable. Given the recent publication 'Relationships: the pathway to safe, high-quality maternity care (Sandall et al., 2016a) calling for continuity models of care the authors believed it was important to release such findings early (prior to the whole study report) to expose new ideas and approaches for maternity care that could be considered.

Methods

Study design

This paper reports the early findings from a larger mixed methods study exploring the use of online communities within a midwifery context, to increase knowledge and social learning to promote health. The focus of this paper is on the embedded qualitative study data, and the experiences of pregnant women (n=31) and midwife moderators (n=4) who were involved in online Facebook groups throughout their pregnancy, gathered using repeated longitudinal focus groups (n=8) and individual interviews (n=28).

Setting, sample and recruitment

Two large NHS Foundation Trusts agreed to support the study and provided access to service users referred to the maternity services. All pregnant women attending for a baseline dating scan or booking appointment (between 6–12 weeks approximately) were potential participants and were approached by the attending midwife (n= 106 total 64/42) and provided with study information material.

Of these 106, 72 (48/24) completed an expression of interest form and were approached by the female researcher. Two women were no longer pregnant therefore not eligible for the study and 28 women failed to respond to the researcher contact, despite two follow up prompts. Therefore, out of 72 women contacted and invited to join the research study, 31 agreed (43% response rate) although only 30% of the target population (Table 1).

The inclusion criteria for the study was restricted to pregnant, English speaking women aged 16 years and over, without a serious mental health condition. The rationale was pragmatic, based on the need for midwives, without additional specialist skills, to be able to moderate the site and communicate effectively with all participants. The majority of women who refused to take part did so because of the demanding schedule of the research (to attend four focus groups and one interview) during their pregnancy.

Four midwives were recruited, two from each Trust and seconded to the research project for the duration of the study (35 weeks) they also participated as additional study participants. Demographic information about the midwives is detailed in Table 1a. The midwives went through a competitive recruitment process and were selected for their enthusiasm about using social media as an adjunct to routine midwifery care and for having a visible social media presence (Table 2).

Online Facebook groups

Facebook provided a platform for the creation of a virtual meeting space for each group. Facebook was selected because it is the largest social media platform most commonly used by women, and its' highest use is reported amongst women aged 18–29 years (Fox, 2011; Duggan

Table 1
Recruitment numbers.

Women approached	Completed initial contact form	Did not respond to initial contact	Not Eligible	Responded to contact by researcher	Consented and Joined	Declined
106	72 (48/24)	28	2	42	31 (18/13)	11