Florence Nightingale School of Nursing & Midwifery
at King's College London

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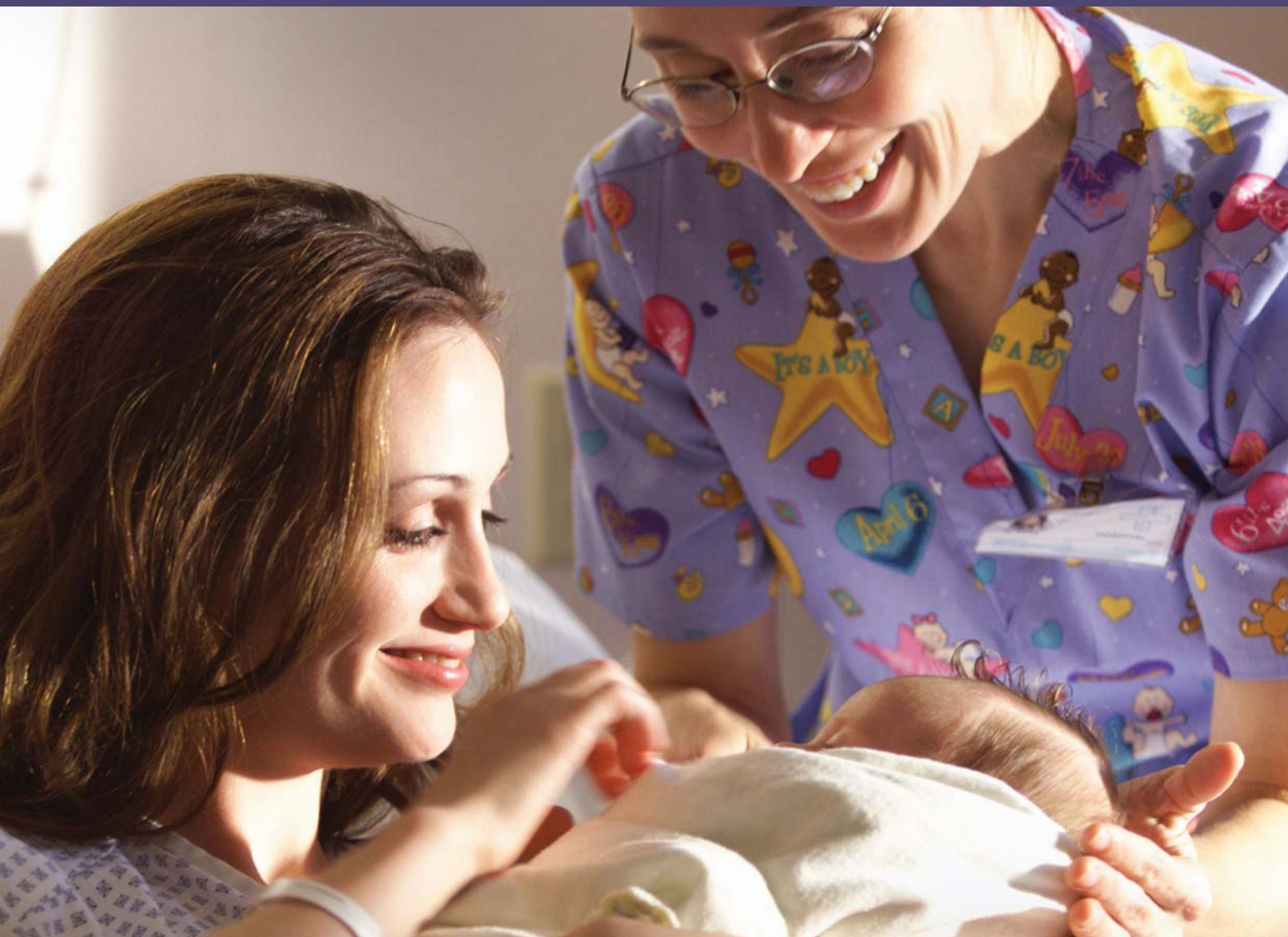
Support workers in Maternity Services: *a national scoping study of NHS Trusts providing maternity care in England 2006*

Final Report

Jane Sandall, Jill Manthorpe, Amanda Mansfield and Linda Spencer



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Florence Nightingale School of Nursing & Midwifery
at King's College London
Waterloo Bridge Wing
Waterloo Campus
150 Stamford Street
London SE1 9NH
www.kcl.ac.uk/nursing

Executive Summary

Background

Support workers are perceived to play a key role in the future maternity workforce and although the role has been established for some time, there has been little overview of who makes up the support workforce, what they do, and what competencies they possess. This study was commissioned in October 2006 by the Department of Health in order to provide guidance as to areas for future policy, research, and routine data collection, and initial findings were reported in December 2006.

Aim and design

The study aimed to provide a systematic overview of the numbers, scope and range of practice, levels of training, skill mix and service model arrangements of support workers working in maternity services in England. A telephone questionnaire of a representative sample of NHS Trusts providing maternity care in England was conducted. In October 2006, 155 acute and 10 primary care trusts containing 252 consultant and midwife led units provided maternity services. Overall, 63% of acute trusts (N=98), and 100% of primary care trusts (N=10), stratified by size of trust were sampled, with a 70% and 40% response rate respectively (n=73 Trusts). Within each trust each maternity unit was surveyed separately achieving a total respondent sample of 94 maternity units. Data collection relied on reports from managers about the way the role was operating in practice, and the job elements that were currently undertaken. The study did not collect data directly from observation of practice or directly from women and their families about their experiences.

Key Findings

Managers were enthusiastic about the contribution that support workers were making to the work of the maternity team. For example, providing more breastfeeding support in the community, providing continuity of care and one to one care in labour, having more time to support vulnerable women, attendance at home births, assisting in obstetric theatres, and running antenatal and postnatal groups. However, there was substantial variation in title, range of activities, required entry level of training, and grade, and support workers carrying out similar roles were paid differing rates. Some tasks required considerable levels of training and competence, and governance regarding delegated responsibility and accountability were variable.

Discussion

There is great potential for support workers to contribute to improving the quality of maternity care and facilitating women's choices. However, the lack of consistency regarding title, task and training has the potential to leave women, managers and midwives with uncertainty as to the scope of practice and competence of the individual support worker. If improving the quality of care is to be fully realised, it seems to be essential that there is a national framework for training and competencies determined by job profile for roles in different settings, and appropriate arrangements for governance. The greatest cost-benefit in terms of freeing up midwives' time may be for more support workers to be employed in areas where they have always provided support, rather than training support workers to take on complex new roles. There was very little evidence of the impact on quality of care and resource use in terms of the contribution of the support workforce, and there is a need to model the likely effects of workforce scenarios on expected outcomes and costs. Potential areas for future research should include:

- Investigation of the impact of the support worker role on outcomes for mothers and babies.
- Assessment of the cost-effectiveness of the support worker role at different levels of training and scope of practice.
- Exploration of the views and experience of women receiving care from support workers.

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1.0 Introduction and Context

A range of service specific, as well as general NHS directed, initiatives are driving changes in the organisation and delivery of maternity care. The Maternity Standard of the NSF for Children's, Young People and Maternity Services specified that 'Every woman [should be] able to choose the most appropriate place and professional to attend her during childbirth based on her wishes and cultural preferences and any medical and obstetric needs she and her baby may have'. This has consolidated a policy direction for maternity care that emphasises choice and care close to home, with the view that for the majority of women, pregnancy and childbirth are straightforward processes and events, facilitated by health professionals, during which medical interventions should only be recommended if they are of demonstrable benefit to mother and/or child [1].

Changes in obstetric workforce deployment, revisions to medical training, the European Working Time Directive[2], obstetric staffing standards[3] and neonatal service reconfigurations are all altering professional practice boundaries. This has resulted in senior medical staff taking on direct care, extending the roles of nurses and midwives to include activities usually undertaken by junior doctors, and the introduction of support workers in maternity care. The scope of midwifery practice of UK midwives is already broad compared to many other countries. In 2005, there were 18,949 FTE practising midwives[4] and 1,612 consultant posts[5] in the UK. In 2004-05, hospital doctors attended about 36% of births and 64% by midwives. The overall balance between the professions has changed steadily since 1989-90 when 24% of births were attended by doctors and 76% by midwives.

The implementation of these initiatives is taking place within a complex service, provided by a range of caregivers in different settings across the acute and primary care sectors, to meet diverse needs which range from promoting health and well-being to high dependency care of sick women and babies. The aims of many of these reforms are to encourage staff to take on new responsibilities in order to improve patient care, access to services out of hours and to free up doctors, nurses and midwives' time. In line with the changing face of maternity services, the role of the support worker as part of the maternity team, has itself undergone significant reconstruction from clerical, environmental and physical tasks to providing clinical care, mainly as a strategy to address the shortage of qualified staff [6].

Such changes have been supported by Agenda for Change which modernises the NHS pay system to reflect new working practices and skill mix[7], the Changing Workforce Programme which provided toolkits to support NHS organisations to develop new staff roles through skill mix changes, expanding the depth and breadth of jobs and shaping tasks and skills around particular client/patient needs [8]. The NHS Knowledge and Skills Framework (NHS KSF) which defines and describes the knowledge and skills which NHS staff need to apply in their work, and provides a single, consistent, comprehensive and explicit framework on which to base review and development for all staff [9], and Skills for Health products (for example, National Occupational Standards and National Workforce Competencies).

Maternity Support Workers (MSW) are perceived to play a key role in the future maternity workforce and a Rapid Roll out Programme delivered by NHS Employers Large Scale Workforce Change (LSWC) Team[10] was evaluated in May 2006 [11]. The evaluation commissioned by Care Services Improvement Partnership (CSIP) found that MSW were perceived to be a valuable addition to the maternity team in terms of improving quality of care to women, freeing up midwives' time and improving working lives, improved continuity of carer, and importantly support in establishment of breastfeeding but there was little data on the degree of change, and what midwives (and other maternity team members) were doing instead. Some of the maternity units needed to develop clear lines of accountability and monitoring for all support staff, due to some inappropriate employment and delegation which had the potential to be detrimental to the overall safety and quality of care. Inconsistent role specification, remuneration, qualification and training were causing considerable discontent amongst MSWs and some concern among midwives and managers.

The above study specifically focused on maternity support worker roles set up by the NHS Employers Programme, however there has been little reliable or accurate official data on the overall number of support workers working in the area of maternity care employed in the National Health Service (NHS). Although the role has been established for some time, there has been no clear

understanding of who makes up this workforce, what they do and what competencies they possess. This study was commissioned to inform NHS workforce and maternity policy in October 2006, and initial findings were required by December 2006.

2.0 Aims and Objectives

The study aimed to provide a systematic overview of the numbers, scope and range of practice, skill mix and service model arrangements of support workers working in maternity services in England. Training and supervision arrangements, examples of benefits and guidance as to areas for future research, and future routine data collection.

The following objectives were set:

- Consult with an internal and external reference group (Appendix 1).
- Conduct survey of representative (50% sample of maternity trusts in England stratified by health region and size of unit) by telephone.
- Describe numbers, scope and range of practice, skill mix and service model arrangements.
- Provide a typology of a range of roles to include innovative roles and potential risks in relation to delivery of NSF Standard 11.
- Investigate whether data for cost-benefit analysis is available and robust on a number of key indicators and, where data is available, forward to DH analysts.
- Synthesise findings from local evaluations and business cases.
- Document the availability and nature of routine data sources and provide an indication of what data could/should be collected by Trusts to enable analysis to be conducted in a robust manner, over a longer time frame.
- Suggest areas where future research is required.

3.0 Design and Methods

To achieve the aims of the scoping study within a short period of time, a pre-emailed/faxed structured questionnaire with a representative sample of NHS Trusts in England providing maternity care was completed by telephone. The views of members of an e-internal and e-external reference group (Appendix 1) and all regional LSA midwifery officers were sought regarding pertinent issues. The reference groups also commented on a briefing paper that formed a draft of the final report. In order to clarify understanding we used a definition developed in a previous review of the role of support workers [12].

'A worker who provides face-to-face care or support of a personal or confidential nature to patients and/or service users in clinical or therapeutic settings, community facilities or domiciliary settings, but who does not hold qualifications accredited by a professional association and is not formally regulated by such a body.'

3.1 Sampling frame

England is divided up into 10 strategic health authorities (SHA) where a total of 155 Acute and 10 Primary Care Trusts (PCTs) provide maternity care. Some NHS trusts contain a number of maternity units on different geographical sites. A sampling frame was constructed based upon a dataset constructed comprising both acute and primary care trusts providing maternity services in England. Maternity facilities were grouped according to Strategic Health Authority (SHA) using the NHS configuration of SHA's (N=10) [13].

3.2 Sample, access and ethical approval

The unit of sampling was at acute or primary care trust level. To ensure a representative sample, a target of 50% of all eligible Acute Trusts, and all PCT's were included in the sample frame. Details of all trusts in England were compiled in Excel and double-checked with routine data sources such as Dr Foster and Birth choice UK web sites[14]. All units participating in the NHS Employers Maternity Support Workers programme who had established (>3 WTE in post) [15] were included (N=40 out of 52 sites in the programme). Further stratification was undertaken according to size of unit using the RCOG typology of unit size[16], and 50% of Acute Trusts were sampled within each category. The sampling strategy is highlighted in Figure 1.

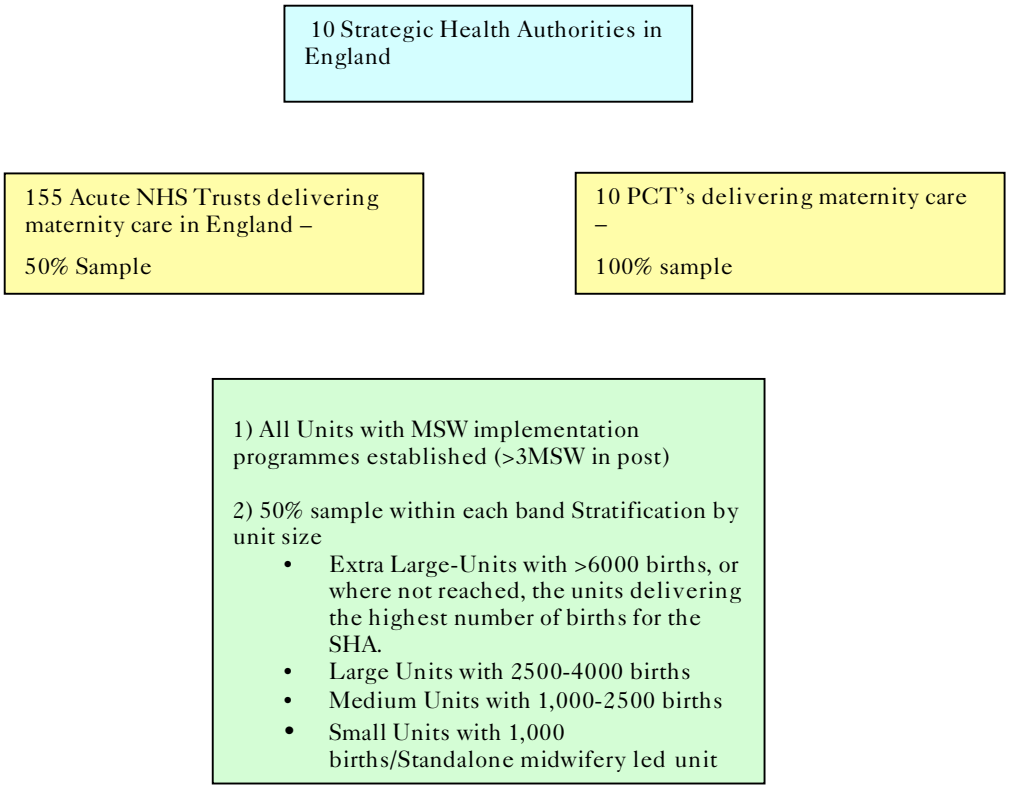


Figure 1. Sampling Strategy

Based on the information provided, the advice from the Central Office for Research Ethics Committees (COREC) was that the study was classified as a service evaluation. On this basis it did not require review by a NHS Research Ethics Committee. For each SHA, HoM's details were identified by accessing the local supervisory midwifery officer (LSAMO) for the respective SHA. Information regarding type of unit i.e. consultant-led (CLU), joint consultant-led and midwifery-led (MLU/CLU) and standalone midwifery-led unit (MLU) was collected including number of births occurring. Where PCT's provided maternity services, the responsible HoM was identified. All participants were contacted by telephone regarding the purpose of the study and a convenient time arranged for the telephone interview to be conducted. A follow-up email with an introductory letter and a copy of the questionnaire was then forwarded to the participants, for completion where possible, prior to the formal interview. Figure 2 identifies that overall 63% of Acute Trusts and 100% of PCTs were sampled with a response rate of 70% and 40% respectively (N = 73 Trusts overall, containing 94 maternity units), 5 units returned data too late to be included in the analysis. Forty maternity units were NHS Employers implementer sites.

Figure 2 Sample details

SHA	Total Acute Trusts	Total acute trusts sampled	Completed	Refused	Total PCT	Total PCT Sampled (%)	Completed	Refused
North East	8	4	3	1	0	0	0	0
North West	23	11	9	2	1	1	0	1
Yorkshire & Humber	14	8	4	4	0	0	0	0
East Midlands	9	8	4	4	2	2	0	2
West Midlands	16	9	5	4	1	1	0	1
East of England	18	13		3	0	0	0	0
London	28	19	17	2	0	0		0
South East Coast	12	8		3	0	0	0	0
South Central	11	10	4	6	2	2	0	2
South West	16	8	8	0	4	4	0	4
Total	**155**	**98**	**69**	**29**	**10**	**10**	**4**	**6**
Completion Rate		**63% Sampled**	**70% Response rate**			**100% Sampled**	**40% Response rate**	

There was considerable variation in response rates between SHAs and all data relating to PCTs derive from one SHA may mean that activities in the community may be under reported, in particular the reporting of joint activities with other agencies such as Sure Start and Children's Centres. It is unknown why variations existed in the response rate between Regions and Trusts, but contextual organisational change may have limited the ability of organisations to respond to us in the timeframe.

3.3 Questionnaire administration and content

Data collection took place over a three-week period in November 2006 by 6 full time researchers. A questionnaire was constructed which drew on the findings of previous work in the area. to gather information pertinent to the study aims (Appendix 2). Content included workforce profile and activity, skill mix and service models, training and governance arrangements, benefits and examples of innovative practice. Local evaluations, job descriptions, Birth-rate Plus reports and business plans were also collated where available. Routine/standardised data to inform modelling of cost-effectiveness and productivity were also requested. An e-reference group was established to which the questionnaire was distributed for comments and modifications. Due to time restrictions, the questionnaire was piloted in two sites, where user acceptability and question flow were checked. The structured questionnaire was completed through a pre-arranged telephone interview. This enabled clarification to take place and some discussion and comment was noted. The process was not tape-recorded but anonymity was assured following consent of participants for inclusion in the study.

Where sites had areas of innovations, consent for their details to be distributed and replicated in the report was ascertained. In total, 3 sites completed economic data, 7 sites submitted Birth-Rate Plus[1] reports,[17] 6 sites submitted evaluations, 3 sites submitted business plans (1 of which reported outcome data), 25 sites submitted job descriptions, and 8 sites submitted a Knowledge Skills Framework. Due to the voluntary process, it is unknown whether such information was not submitted due to non-availability or a wish not to share with the research team.

3.4 Data Analysis

All data collected from the questionnaire was entered into SPSS (Version 14) and coded into numeric variables for frequency calculations and proportions. Some questionnaire items had a poor response rate, and the implications of this will be addressed on a case-by-case basis. In particular, only 3 units (all part of the NHS Employers programme) had adequate data to complete additional items in question 25a regarding quantitative estimates of midwives' time saved. Summaries of additional information provided during the administration of the questionnaire was written up by the interviewer and has grouped by themes and categories using simple content analysis (Appendix 3).

4.0 Findings

Table 1 shows the distribution of the respondent units by size compared to the distribution in the complete sampling frame. A total of 155 acute trusts and 10 primary care trusts contained 252 maternity units. The size of maternity units ranged from zero births per annum in some PCTs, and from 84 births per annum in 2005/6 to 11,100 p/a in Acute Trusts. A total of 42% of sites were implementer sites in the NHS Employers MSW study, 22% of units were freestanding midwife/GP led units, 66% were consultant units, 12% reported aggregated data for their component maternity units in an Acute NHS Trust.

Table 1 Distribution of respondent units by size

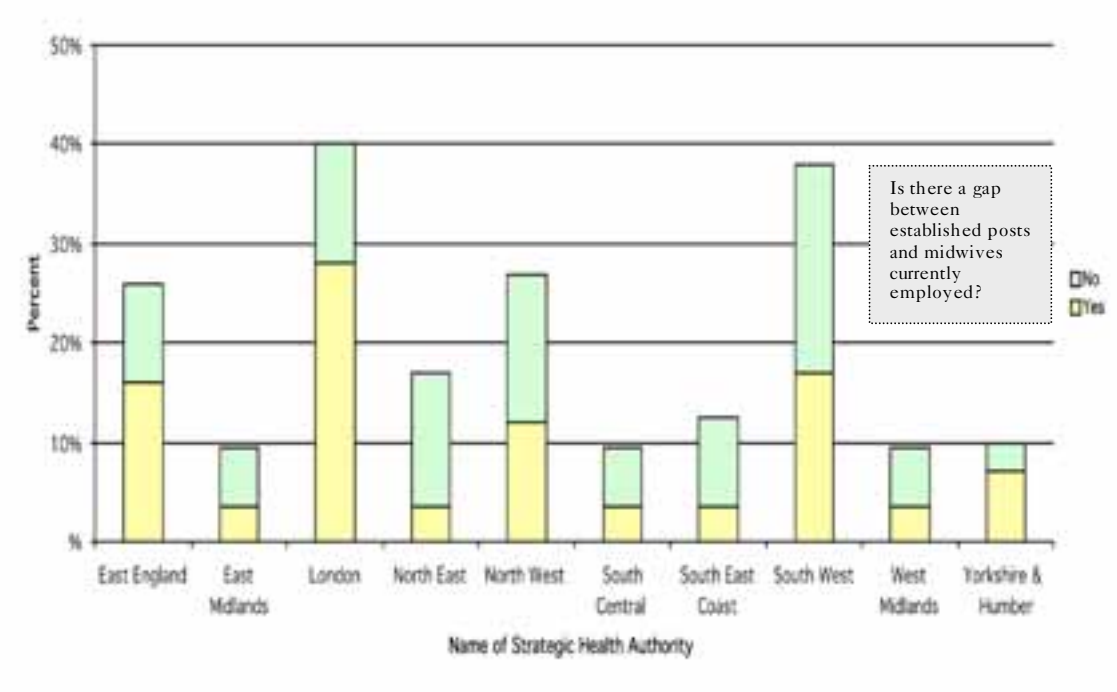
Size of maternity unit	Sample %	Total number units %
<999 Births	21%	23%
1000-3999 births	51%	57%
4000 – 5999 births	21%	12%
> 6000 births	6%	2%
Total N=94	100%	Total 252

[1] Birthrate-Plus is a framework for Workforce Planning and Decision-making for Midwifery Services. The methodology calculates the midwifery and non-midwifery staff required to provide the care required by a specific group of women and their babies.

4.1 Midwifery workforce

The range of WTE midwives currently employed in each unit extended from 5.5 WTE to 328.69 WTE. A total of 63% units (57/91) said there was a gap between WTE established posts and numbers employed. There was no association by size of unit; however, Figure 3 shows differences by SHA region.

Figure 3 Vacancy gap by SHA Region



A total of 79% of units stated that the main reasons were due to restructuring, frozen posts and waiting for new appointees. Other reasons given were over establishment, unable to recruit and the creation of new posts. A total of 51% of units reported that the gap was being managed by employment of other professionals, and conversion of midwifery posts to support worker posts (25 units). Table 2 shows that 90% of the midwifery workforce was employed on AFC band 6 and 7.

Table 2 Midwifery workforce currently employed

WTE AFC band	WTE AFC band	WTE AFC band	WTE AFC band	WTE AFC band
Midwife entry level £17,475 – 24,803	Midwife community/hospital/ Integrated	Midwife higher level £24,803 – 36,416	Midwife Consultant/manager A-D	Senior Midwife Manager £63,417 - 88,397
473.02 7%	3922.57 60%	2000.39 30%	174.31 3%	6.80 0.1%

Total WTE 6,577.09

Table 3 shows no clear pattern in distribution by unit size.

Table 3 Distribution of midwifery workforce (grade) by size of maternity unit (Number of units)

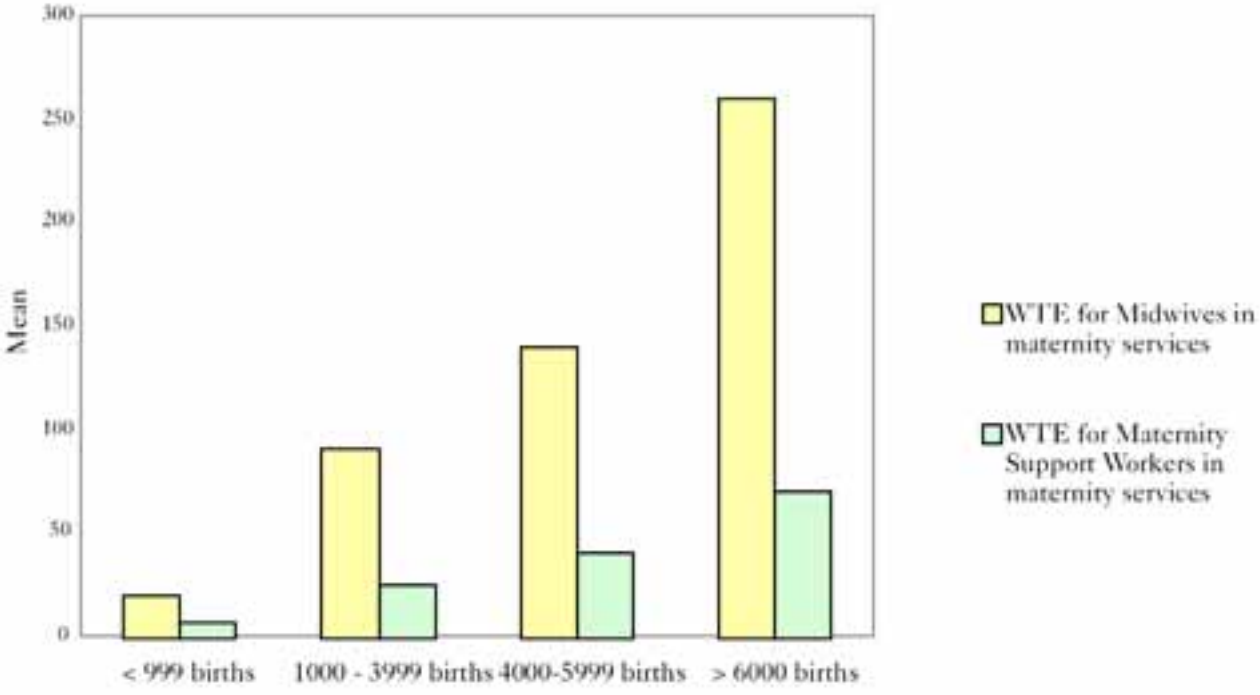
AFC pay band	<999	1,000-3,999	4,000-5,999	>6,000
AFC band 5	1	29	12	4
AFC band 6	16	34	17	4
AFC band 7	16	36	17	4
AFC band 8	9	34	15	4
AFC band 9	0	2	0	2

Total 94 Units

4.2 Support worker workforce

The number of WTE support workers employed ranged from 3.0 – 78.4 WTE. The mean WTE of support workers and midwives by size of unit is shown in Figure 4.

Figure 4 Mean WTE support workers and midwives by size of unit



RCOG Classification

Table 4 shows that there was little relationship between the pay band of a support worker and job title, apart from assistant practitioners who tended to be paid on higher levels.

Table 4 Distribution of support workers by pay grade

Support worker	WTE on AFC band 1	WTE on AFC band 2	WTE on AFC band 3	WTE on AFC band 4	Total WTE
Pay range £	**11,782 - 12,853**	**12,177 - 15,107**	**12,853 -16,799**	**15,107-19,730**	
Auxiliaries N=19 Units	10.9	111.12	22.3	0	144.32
Health care support worker N=16 Units	0	121.26	32.46	1.66	155.38
Health care assistant N=32 Units	62.04	419.84	84.64	3.0	569.52
Maternity care assistant N=26 Units	0	366.31	102.21	11.6	480.12
Midwifery assistant N=5 Units	0	56.95	64.27	0	121.22
Maternity support worker N=22 Units	0	73.37	71.87	5.5	150.74
Nursery nurse N=14 Units	0	12.4	8.57	20.38	41.35
Assistant practitioner N=5 Units	0	0	0	4.91	4.91
Maternity Unit assistant N=2 Units	2	0	0	0	2
Total					1669.56

Table 5 shows that that there was also little relationship between title of support worker and minimum level of training required on appointment apart from assistant practitioners and nursery nurses who were required to have a Foundation Degree.

Table 5 Minimum level of training required on appointment

Support worker	None	NVQ 1	NVQ2	NVQ3	Foundation degree
Auxiliaries	18	1	1		
Health care support worker	11		4		
Health care assistant	19	4	10		
Maternity care assistant	15	1	5	4	
Midwifery assistant			3	2	
Maternity support worker	9	1	4	8	
Nursery nurse				2	1 10 (NNEB)
Assistant practitioner					6
Maternity unit assistant	1				

Total 94 maternity units

Table 6 shows that there was little pattern of where different types of support worker were working, apart from the employment of assistant practitioners in the North West Region only.

Table 6 Distribution of type of support worker by size of maternity unit

Support worker	<999	1,000-3,999	4,000-5,999	>6,000
Auxiliaries	6	5	1	0
Health care support worker	2	6	3	0
Health care assistant	1	13	3	2
Maternity care assistant	7	11	3	2
Midwifery assistant	0	3	2	1
Maternity support worker	3	6	3	0
Nursery nurse	0	10	4	0
Assistant practitioner	0	1	0	1

Total 94 maternity units

4.3 Service model arrangements and skill mix

Table 7 shows that a range of support workers were employed in community and stand alone settings, with fewer in children's centres. Nursery nurses and assistant practitioners were more limited in setting and only worked in acute hospital postnatal ward areas. There were wide variations in the ratio of support workers to midwives, and the numbers of units with support

workers working in community were very small indeed. Due to the wide variation between the roles of each type of support worker, it was not possible to collapse groups for further analysis. There was no difference in the range of titles employed, or where staff were working between sites that were participating in The NHS Employer Maternity Support Worker Programme (N=40), and those who were not. For example, 9 units employed staff with this title that were not part of the programme.

Table 7 Number of WTE midwives and support workers working in each area

	Hospital Antenatal clinic/ Day Assessment Unit/ Antenatal ward	Hospital Delivery suite	Hospital Postnatal ward	Rotates in hospital areas	Operating theatre	Community team/ practice	Stand-alone Midwife Led Unit	Children's centre/ Sure Start
Midwives	379.93	778.42	390.62	965.70	9.80	850.48	116.41	8.66
Auxiliaries	11.89	27.18	22.23	12.0	0	0	41.87	0
Healthcare support worker	14.17	13.61	19.71	71.05	1.13	0	0	0
Healthcare assistant	81.4	100.43	143.19	90.95	2	15.03	40.7	3
Maternity care assistant	102.28	100.78	146.50	180.49	7.6	26.73	17.65	5
Midwifery assistant	3.3	2	2	0	0	4.8	0	0
Maternity support worker	14.38	13.3	14.7	33.6	0	21.2	15.35	0.4
Nursery nurse	0	0	28.61	0	0	0	0	0
Assistant practitioners	0	0	2.5	0	0	0	0	0
Total WTE Support workers	227.42	257.3	379.44	388.54	10.73	67.76	115.57	8.4
Ratio support workers/ midwives	**0.6**	**0.33**	**0.97**	**0.4**	**1.09**	**0.07**	**1.00**	**0.97**

4.4 Support worker workforce and scope of practice

Table 8 shows the number of maternity units who reported that a support worker '**ever**' engaged in a particular task. It is interesting to note the wide range of tasks undertaken by the support workers. Some units were employing staff with a range of different titles to perform the same task, thus will be double counted in Table 8. Some were employing support workers for more advanced tasks, for example, pre-natal screening counselling, conducting the booking appointment (without a midwife or doctor present in the consultation), abdominal palpation, recording CTG's [2], carrying out Doppler ultrasound, vaginal examination, scrubbing in operating theatre, newborn hearing screening, newborn bloodspot screening, 2nd person at the home birth, sole night cover at stand-alone midwife led unit. Due to the questionnaire being conducted by telephone, there was opportunity to clarify meaning of the items, and data entry of these items was double checked.

When the role of the maternity support worker (MSW) was compared between NHS Employer MSW Programme implementer sites and non-implementer sites, the following pattern emerged (> 10% difference). MSWs in NHS Employer sites were **less** likely to do the following tasks: serve meals, order pharmacy stock, portering, transfer emergency patients, run GTT clinics, record foetal

[2] CTG = recording of the foetal heart with an electronic foetal monitor or cardio-tocograph.

CTGs, conduct Doppler ultrasounds, theatre runner, post-operative care, sole night cover on stand alone birth centre.

Staff working in NHS Employer MSW Programme implementer sites were **more** likely to do the following tasks: data entry computer, planning of care, prenatal screening counselling, phlebotomy, advice smoking cessation, assist midwives in labour, provide one to one support in labour, support vulnerable families in the home, infant feeding support at home, assist antenatal and groups. In sum, support workers in implementer sites were doing less of the routine work of supporting the organisation and doing more of the innovative roles, particularly in the community. The following tasks were only being done in the implementer sites and were thus **innovative roles**: conduct booking interview, scrub and assist in theatre, run baby discharge clinic, newborn hearing screening, assist and run postnatal groups, run antenatal groups, be a second person at a home birth, provide teenage pregnancy advice. This may be due to more systematic approaches to role redesign being used in these sites.

Table 8 Number of maternity units reporting a task ever undertaken by a support worker

Task	Auxiliary N =19 units	Health care support worker N=16 units	Health care assistant N=32 units	Maternity care Assistant N = 27 units	Midwifery assistant N=5 units	Maternity support worker N=22 units	Nursery nurse N =14 units	Asst Practitioner N=5 units
Housekeeping and clerical								
Cleaning and hygiene	19	14	32	25	3	19	8	3
Serving meals	18	13	28	21	4	11	2	0
Housekeeping	19	14	25	14	3	13	4	4
Stocking up	19	15	31	26	3	18	8	3
Clerical duties	16	13	30	24	3	21	5	3
Data entry computer	14	12	25	22	4	19	5	5
Audit	5	5	12	10	1	8	3	5
Ordering Pharmacy stock	0	1	10	4	0	5	1	1
Portering	8	12	15	18	2	11	1	3
Transfer of emergency	0	4	11	11	1	7	2	1
Transfer of babies to other departments	3	7	18	20	3	10	11	5

Table 8 continued

Task	Auxiliary N =19 Units	Health care support worker N=16 Units	Health care assistant N=32 Units	Maternity care Assistant N = 27 Units	Midwifery assistant N=5 Units	Maternity support worker N=22 Units	Nursery nurse N =14 Units	Asst Practitioner N=5 Units
Clinical duties								
Planning of care	7	8	8	12	2	9	7	4
Pre-natal screening counselling	0	0	1	1	1	4	0	1
Conducting booking appointment	0	0	3	5	1	5	1	4
Phlebotomy	1	5	13	18	3	14	1	3
Running Glucose Tolerance Test clinics	0	1	5	6	4	7	0	1
Advice Smoking cessation	6	2	14	9	2	9	2	3
Abdominal palpation	0	0	2	0	1	0	0	1
Recording Foetal CTGs	0	0	2	4	1	1	0	1
Carrying out Doppler ultrasound	0	0	0	1	0	1	0	0
Vital sign observation	8	8	25	24	5	18	10	4
Administering medication	0	0	2	2	0	4	2	1
Assistance to midwives during labour	14	11	20	15	4	16	3	4
One to one support of women in labour	2	1	4	3	2	8	0	5
Vaginal examination	0	2	0	1	0	0	0	0
Washing women after birth	14	9	29	25	4	19	1	3

Table 8 continued

Task	Auxiliary N =19 Units	Health care support worker N=16 Units	Health care assistant N=32 Units	Maternity care Assistant N = 27 Units	Midwifery assistant N=5 Units	Maternity support worker N=22 Units	Nursery nurse N =14 Units	Asst Practitioner N=5 Units
Theatre scrub	0	1	3	2	2	2	0	2
Theatre assisting	0	3	2	2	2	1	0	4
Theatre runner	11	8	30	20	3	12	1	1
Post-operative care	2	4	12	16	3	12	2	5
Infant feeding advice and support	17	11	32	25	5	22	14	5
Advice on routine care of the baby	17	9	29	25	5	21	14	5
Running baby discharge clinic	2	1	4	6	2	2	14	1
Doing Newborn hearing screening	0	0	0	3	0	1	3	1
Doing Newborn blood spot screening (Guthrie test)	0	1	1	5	3	4	10	0
Newborn serum bilirubin blood test	0	0	2	0	3	5	11	2
Telephone support	4	4	11	10	3	17	4	4
Public health roles								
Health advocacy	3	5	14	11	4	12	6	5
Support vulnerable families in home	0	1	6	11	3	15	0	4
Infant feeding support in home	0	1	8	16	5	13	1	4
Assist Postnatal groups	0	0	4	7	3	10	0	5
Run Postnatal groups	0	0	0	3	0	5	2	4

Table 8 continued

Task	Auxiliary N =19 Units	Health care support worker N=16 Units	Health care assistant N=32 Units	Maternity care Assistant N = 27 Units	Midwifery assistant N=5 Units	Maternity support worker N=22 Units	Nursery nurse N =14 Units	Asst Practitioner N=5 Units
Assist Antenatal groups	1	1	8	8	3	15	0	4
Run Antenatal groups	0	0	0	2	0	6	0	4
Second person at home birth	0	0	1	3	1	2	0	0
Support to community midwifery team	0	3	8	18	5	15	1	4
Sole night cover Stand alone Midwife led unit	0	0	0	1	0	1	0	0
Teenage pregnancy advice	0	0	3	3	2	3	1	0

Table 9 has aggregated support worker titles into four main roles, those with a role with the title 'health', those with the title 'maternity/midwifery', assistant practitioners and nursery nurses by task. All support workers are involved with housekeeping, clerical and some generic clinical tasks. Health care assistants were engaging in a wider number of tasks and working in a wider range of settings than auxiliaries and health care support workers. The picture was less clear cut with the staff with 'maternity/midwifery' in their titles. Overall, maternity support workers were engaged in a wider number of roles in a wider range of settings than maternity/midwifery assistants and maternity care assistants.

Five units employed assistant practitioners, who engaged in a more tasks in the hospital and community settings, whereas nursery nurses focused on their work with the newborn bit were still contributing to a wider range of tasks in many units.

Table 9 Summary of roles reporting task ever undertaken

Auxiliary, HCW, HCA	MSW/MCA/MA	Assistant practitioner	Nursery Nurse
Housekeeping and clerical	**Housekeeping and clerical**	**Housekeeping and clerical**	**Housekeeping and clerical**
Cleaning and hygiene	Cleaning and hygiene	Cleaning and hygiene	Cleaning and hygiene
Serving meals	Serving meals		Serving meals
Housekeeping	Housekeeping	Housekeeping	Housekeeping
Stocking up	Stocking up	Stocking up	Stocking up
Clerical duties	Clerical duties	Clerical duties	Clerical duties
Data entry computer	Data entry computer	Data entry computer	Data entry computer
Audit	Audit (not MA)	Audit	Audit
Ordering Pharmacy stock (not auxiliary)	Ordering Pharmacy stock (not MA)	Ordering Pharmacy stock	Ordering Pharmacy stock
Portering	Portering	Portering	Portering
Transfer of emergency	Transfer of emergency	Transfer of emergency	Transfer of emergency

patients (not auxiliary)	patients	patients	patients
Transfer of babies to other departments	Transfer of babies to other departments	Transfer of babies to other departments	Transfer of babies to other departments
Clinical roles	**Clinical roles**	**Clinical roles**	**Clinical roles**
Planning of care	Planning of care	Planning of care	Planning of care
Telephone support	Telephone support	Telephone support	Telephone support
Phlebotomy	Phlebotomy	Phlebotomy	Phlebotomy
Vital sign observation	Vital sign observation	Vital sign observation	Vital sign observation
Administering Medication (HCA only)	Administering Medication (not MA)	Administering medication	Administering medication
Pregnancy care	**Pregnancy care**	**Pregnancy care**	**Pregnancy care**
Advice Smoking cessation	Advice Smoking cessation	Advice Smoking cessation	Advice Smoking cessation
Conducting booking appointment (HCA only)	Conducting booking appointment (not MA)	Conducting booking appointment	
Pre-natal screening counselling (HCA only)	Pre-natal screening counselling	Pre-natal screening counselling	
Running Glucose Tolerance Test clinics (not auxiliary)	Running Glucose Tolerance Test clinics	Running Glucose Tolerance Test clinics	
Recording Foetal CTGs (HCA only)	Recording Foetal CTGs (MCA only)	Recording Foetal CTGs	
Vaginal examination (HCSW only)	Vaginal examination (MCA only)		
	Carrying out Doppler ultrasound (not MA)		
Birth care	**Birth care**	**Birth care**	**Birth care**
Assistance to midwives during labour	Assistance to midwives during labour	Assistance to midwives during labour	Assistance to midwives during labour
Washing women after birth	Washing women after birth	Washing women after birth	
One to one support of women in labour	One to one support of women in labour	One to one support of women in labour	
Operating theatre	**Operating theatre**	**Operating theatre**	**Operating theatre**
Theatre runner	Theatre runner	Theatre runner	Theatre runner
Post-operative care	Post-operative care	Post-operative care	Post-operative care
Theatre scrub (not auxiliary)	Theatre scrub	Theatre scrub	
Theatre assisting (not auxiliary)	Theatre assisting	Theatre assisting	
Newborn care	**Newborn care**	**Newborn care**	**Newborn care**
Infant feeding advice and support	Infant feeding advice and support	Infant feeding advice and support	Infant feeding advice and support
Advice on routine care of the baby	Advice on routine care of the baby	Advice on routine care of the baby	Advice on routine care of the baby
Running baby discharge clinic	Running baby discharge clinic	Running baby discharge clinic	Running baby discharge clinic
Newborn serum bilirubin	Newborn serum bilirubin	Newborn serum bilirubin	Newborn serum bilirubin

blood test (HCA only)	blood test (not MCA)	blood test	blood test
	Doing Newborn hearing screening (not MA)	Doing Newborn hearing screening	Doing Newborn hearing screening
Doing Newborn blood spot screening (Guthrie test) (not auxiliary)	Doing Newborn blood spot screening (Guthrie test)		Doing Newborn blood spot screening (Guthrie test)
Public health/community	**Public health/community**	**Public health/community**	**Public health/community**
Health advocacy	Health advocacy	Health advocacy	Health advocacy
Infant feeding support in home (not auxiliary)	Infant feeding support in home	Infant feeding support in home	Infant feeding support in home
Support vulnerable families in home (not auxiliary)	Support vulnerable families in home	Support vulnerable families in home	
Teenage pregnancy advice (HCA only)	Teenage pregnancy advice	Teenage pregnancy advice	
Assist Antenatal groups	Assist Antenatal groups	Assist Antenatal groups	
	Run Antenatal groups (not MA)	Run Antenatal groups	
Assist Postnatal groups (HCA only)	Assist Postnatal groups	Assist Postnatal groups	
	Run Postnatal groups (not MA)	Run Postnatal groups	Run Postnatal groups
Support to community midwifery (not auxiliary)	Support to community midwifery	Support to community midwifery	Support to community midwifery
Second person at home birth (HCA only)	Second person at home birth		
	Sole night cover Stand alone Midwife led unit (not MA)		

4.5 Training

The range in roles and tasks tended to reflect AFC pay bands where the majority of auxiliaries, health care support workers, health care assistants and maternity care assistants were on AFC Band 2. The majority of midwifery assistants and maternity support workers on AFC band 2/3 and assistant practitioners on AFC band 4. However, there was less congruence of role and responsibility and the minimum level of training required by units. For example, 15/25 units required no training for the maternity care assistants and 9/22 units required no training for their maternity support workers. On the other hand midwifery assistants and assistant practitioners were all required to have NVQ level 2/3 and a foundation degree respectively. Figure 5 shows that units provided a wide range of training for support workers across a range of titles. Specific training included the following.

Figure 5 Range of training offered

UNICEF Baby Friendly Initiative Smoking cessation Child protection Domestic Violence Drills and skills Emergency breech Adult and Newborn Life Support	Cannulation Bereavement CTG B-Tech maternity care Baby massage Safety in the home Newborn bloodspot screening ECG Theatre recovery

Table 10 shows that the majority of units who employed support workers did support training and day release.

Table 10 Employer support for training for support workers

Type of support worker	Fee support	Secondment	Day release	Access
Auxilliairies	16	1	12	
Healthcare support worker	13	4	11	
Healthcare assistant	18	7	19	1
Maternity care assistant	16	7	16	
Midwifery assistant	3	1	3	
Maternity support workers	15	6	9	
Nursery nurse	4	4	7	
Assistant practitioners	4	4	1	

Total 94 maternity units

Table 11 Number of units providing training for support workers

Type of support worker	Generic	Specialist maternity	Accredited	NVQ	Diploma/degree
Auxiliaries	20	16	17	8	0
Health care support worker	15	11	14	5	16
Health care assistant	32	25	28	20	2
Maternity care assistant	30	23	28	14	0
Midwifery assistant	4	4	0	4	0
Maternity support worker	22	19	22	16	1
Nursery nurse	11	6	11	2	11
Assistant practitioner	4	0	0	1	0

Total 94 maternity units

4.6 Management and accountability arrangements

The majority of units reported that support workers were accountable to a specific midwife on a daily basis, although a substantial minority of units stated that support workers were reporting to an operational manager on a daily basis. Thus it is unclear what arrangements existed for delegated accountability of specific clinical tasks within these roles.

Table 12 Management and accountability arrangements

	Person support worker reports to on a daily basis		Person who performance manages support workers	
Type of support worker	Specific assigned midwife	Operational manager	Specific assigned midwife	Operational manager
Auxiliaries	20		18	2
Health care support worker	17		15	1
Health care assistant	24	9	20	13
Maternity care assistant	25	6	16	11
Midwifery assistant	2	3		5
Maternity support worker	18	6	13	8
Nursery nurse	12	2	4	5
Assistant practitioner	4	1	3	1

Total 94 maternity units

4.7 Benefits of new roles

This section highlights the strongest themes that emerged from the discussion part of the interviews, as well as describing some of the new roles. A total of 54% of units reported that they wished to share examples of how innovative roles were benefiting women and babies. Respondents were asked to describe how the use of support workers in their service had improved or enhanced the care of mothers and babies. In addition they were also asked to share examples of new roles and innovative developments. It is perhaps not surprising that the managers who had had the most experience were the most positive about the role. Many of these early developers were confident about the scope of the role and the checks and balances that need to be in place to protect women and babies. This was particularly apparent in small units such as birth centres, where support workers were described as highly valued and important members of the maternity team. Managers described the positive relationship between support workers and midwives and the clarity amongst the maternity team about what the new role could contribute. A number of managers described how the different roles complemented each other well. Appendix 3 provides a comprehensive list of the responses. It also draws heavily on the information that managers shared with us, and this information is summarised below:

More time to support women

A strong theme that emerged from the interviews was that support workers had more time to spend with women, as compared to midwives. For example, a key role of support workers on the postnatal ward of a number of units was to assist women following a caesarean section to wash, remove cannulae and catheters. By allocating the role to support workers more time was spent supporting the women without rushing them and at the same time pressure on the midwives was released. However, few units were able to quantify how much time was released and what midwives were doing instead.

Providing breastfeeding support

Many respondents spoke of the positive contribution that the new role was making towards supporting breastfeeding. Many units had made breastfeeding support a key responsibility of support workers. This was clear from the job descriptions made available. Some units also used the developing role of the support worker around breastfeeding as an opportunity to improve processes and continuity of care. This is illustrated by the example below:

Breast feeding problem on the ward

Old Process

1. Received support from any staff available e.g. support worker, student midwives and midwives. Different staff on each shift.
2. Would prolong stay in hospital and expose to additional staff
3. Seen by community midwife
4. Referred to infant feeding co-ordinators
5. Support worker visit
6. Baby Café or breast feeding support group
7. Health Visitor
8. Possibly prolonged post natal visiting
9. Possible readmission to ward

New process

1. Support worker will check on post natal ward if any breastfeeding problems and help with them on the ward
2. Support worker will arrange to see them at home if necessary and let the midwife know to prevent any duplication of work
3. Inform of available breast feeding support and arrange to meet at Baby café
4. Support worker will support by face to face visits, phone and text

Improving morale and job satisfaction

A number of manager's spoke of the positive effect the introduction of the new role had had on the morale of midwives. Whilst initially, some midwives were sceptical about the role, once established, midwives appreciated the contribution that the support workers made to the team. Real benefits were described in terms of increasing the morale of midwives by enabling them to spend more time on direct care rather than on non-clinical tasks which they felt did not utilise their skills.

Improving continuity of care

Many units felt that support workers were helping to provide more continuity of support. For example a number of units reported the benefits to mothers of having support workers in antenatal clinics, where prior to the introduction of the support worker role women would rarely see a familiar face in clinic because midwives rotated within the service. In a number of units medical staff also reported the positive impact of having the same support worker in the antenatal clinic.

Supporting vulnerable women

Some units used the support worker role to help them support socially excluded and deprived mothers and babies, with a number of them linking this work to the Sure Start programme and Children's Centres. Managers reported positive developments around supporting vulnerable teenagers and mothers from Black Minority Ethnic groups, with many units describing how well the support workers related to women and the positive effect that this was having on women's' self esteem. Recruiting local people to the support worker role had helped this.

Running groups

In some units support workers were running antenatal and postnatal groups, or in areas where two midwives had previously run such groups support workers were taking on the role of the second midwife. One unit estimated that this saved 8 hours per week of midwifery time where this had occurred at Aqua natal and evening parenting classes. Details of this calculation are provided in Appendix 4.

Attending home births

In a number of units (N=7), support workers had taken on the role of the second person attending home births. In two units, support workers were staffing (alone) a freestanding birth centre at night. In one unit support workers were improving continuity of care for women. This is illustrated by the process outline below and in Appendix 4.

Home Birth Support

Old process

1. Home visit by midwife to deliver equipment
2. When in labour named midwife if possible attends, supported by any available midwife
3. If out of hours could be "On Call" midwife plus second "On Call" midwife
4. Visited next day by named midwife or replacement if midwife has been up all night
5. Support worker for baby care and infant feeding support
6. Post natal support visits by support worker or midwife

New process

1. Visit in the antenatal period by support worker at approximately 37/52 to deliver equipment and introduce her, if not already met
2. Attend home birth with midwife
3. Care for mother and baby following delivery (delegated care)
4. Infant feeding support
5. Postnatal support visits

Advanced clinical skills

Support workers were developing advanced clinical skills in some units. To facilitate this, local training programmes had developed to supplement the NVQ 3. New roles that were being introduced and that require careful evaluation regarding safety of women and babies included:

- Receiving babies in low risk deliveries
- Undertaking cord gas analysis
- Foetal blood sampling

Scrub role in obstetric theatre

A number of units had, or were in the process of developing a scrub role in operating theatre for support workers.

Reduction in complaints

A number of the units highlighted the positive feedback from users, with some reporting a reduction in complaints since the role has been introduced.

Releasing midwifery time and developing capacity

A strong theme to emerge from the interviews was the way in which the role was helping to relieve pressure on midwives by releasing midwifery time so that they could spend more time delivering direct care to women. For many units, demonstrating that midwifery hours were being released was an important part of the business case to support the further development of the role, but many managers were struggling to do this. Only one respondent submitted a business case that reported outcome data. Those who made progress in this area appeared to have done so with additional support, for example, through the NHS Employers Maternity Support Worker Programme, and focused on quantifying the time saved in specific areas. For example, one community antenatal team used an audit tool to quantify the impact of the new role. They found that during an antenatal clinic lasting 135 minutes, the support worker undertook 86 minutes of nursing and clerical tasks, which previously the midwife undertook. The unit reported that this equated to a 64% saving in time spent on non-midwifery tasks, that midwives would have previously undertaken. In another unit, the amount of midwifery time released since the introduction of support workers enabled them to increase the number of Baby Cafes and breastfeeding support Groups from three to five sessions. Figure 5 summarises benefits reported by respondents for mothers and babies, the organisation (Full details are provided in Appendix 3).

Figure 5 Reported Benefits

Benefits for mothers & babies

More time spent with mother by support worker
Aromatherapy
1 to 1 Breastfeeding support from support worker
Aqua natal classes and birth preparation
Continuity of care from support worker
Bereavement support from support worker
Reduced waiting time
Support to vulnerable mothers
Mothers feel valued
Transitional care for babies, preventing separation from mother
Running community postnatal cafes

Benefits to organisation

Jobs are done smoothly
Quality of care maintained
Clinical governance improved
Motivated workforce, more job satisfaction
Fewer complaints
Good retention of staff
More recruitment opportunities
Quicker discharges
Better skill mix
Utilising resources more effectively
Fewer turnovers of staff
More flexible workforce
Better service delivery
Meets public health agenda
Devolved management, organising their own off duty and meetings
Starting a newsletter
Running a range of clinics including pre-discharge from hospital assessment
Second member of team at a home birth and improves capacity in midwifery workforce
Stresses, pressure and strains are reduced
Good team spirit/ethos
Frees up midwife time
Strengthens team with extra skills
Starting a newsletter
Running a range of clinics including pre-discharge from hospital assessment
Second member of team at a home birth and improves capacity in midwifery workforce
Stresses, pressure and strains are reduced
Good team spirit/ethos
Frees up midwife time
Reduced workload
Midwives can do the jobs they were trained to do
Strengthens team with extra skills

Financial savings made

More appropriate use of resources
Cheaper service provided
No cost saving
Skill mix saves money

4.8 Risks of new roles

Two units reported that they had received a clinical incident or complaint regarding support workers in the previous year. A total 14 units had employed a qualified nurse or midwife as a support worker. The majority were nurses, or newly qualified midwives/midwives from abroad, awaiting PIN numbers. Some managers were concerned about support workers working outside their role and there is clearly a potential issue if a nurse or midwife on the NMC register would be required to act in an emergency that is outside their role as a support worker.

From an analysis of the job descriptions provided (N= from 25 units), some were clearly defining the role of the support worker in clinical practice outlining boundaries and accountability, while others were unclear and not specific about the role limitations. For example, support workers employed at AFC Band 1 were undertaking tasks that required clinical competencies but these were not listed within the job description. In two job descriptions, the maternity support worker was expected to put women on the Cardiotocograph (CTG) after competency training, however, this

intervention requires a complex set of skills that may require further discussion as to whether this can be delegated by a midwife to a support worker. It is unclear from documentation in one unit around receiving babies, blood gas analysis and fetal blood sampling whether the intent was for support workers to assist or conduct such tasks, if the latter, this is a cause for concern.

Figure 6 summarises potential risks reported by respondents for mothers and babies, and the organisation (Full details are provided in Appendix 3).

Figure 6 Potential risks for women and babies

Poor team preparation
Lack of knowledge by support worker
Inconsistence advice
Support workers working outside their boundaries
Poor communication
Need clear lines of accountability and clarification of role

Risks to organisation

Potential for under/over utilisation
Confusion of roles
Policies and guidelines need are unclear
Legal implications from clinical errors
Duplicated roles
Staff concern over losing jobs
Over reliance on support workers
Midwives role undermined
Lack of respect
Confusion of roles
Difficult in delegating if support worker competency is unknown
Wary of giving up responsibilities

When job descriptions were analysed in terms of day-to-day supervision arrangements and performance management, a wide range of people were identified including the senior midwife, matron and head of services. It was unclear how this operated in practice, and warrants further investigation. In addition, it is unknown whether professionals were aware of their responsibilities regarding delegation of work to support workers. Overall, there was a lack of standardisation and consistency of all the job descriptions received. Support workers in this study were engaged in tasks that are deemed within the scope of midwifery practice, requiring specialist knowledge and training. These were prenatal screening counselling, newborn bloodspot screening, conducting booking appointments, foetal CTGs, abdominal palpation and vaginal examination. It is unknown what level of training and supervision was in place, and this is a concern for women using maternity services and their understanding and expectations of the support workers they encounter.

5.0 Discussion

This scoping study has provided a snapshot view of the range in roles, tasks undertaken and levels of training provided in a representative sample of NHS Trusts providing maternity care in England. This study has not provided any detailed insights into the actual training received either initially or on an ongoing basis. In addition, of necessity it relied on reports from managers about the way the role was operating in practice, and the job elements that were currently undertaken. It did not collect data directly from observation of practice or directly from women and their families about their experiences.

Potential of support workers in maternity services

We found that managers were enthusiastic about the contribution that support workers were making, and that the contribution to the organisation and delivery of maternity care and the wider team could grow substantially in areas where activity is currently low in community based settings, Sure Start and Children's Centres. There is clearly the potential for the support workforce to be engaged in a far wider range of activities, such as midwife led units, the home and the community. Maternity support workers who were working in units who had been involved with the NHS Employers Programme were already working in these more innovative roles.

There was very little routinely collected data available within maternity units to quantify the actual and potential contribution of the support workforce. Managers who had achieved used structured observation rather than staff diaries, which were difficult to compare. There is little evidence regarding the impact of support workers for women and babies and whether such roles are cost-effective. Carr-Hill et al's [18] review of skill mix in secondary care found many schemes aiming to expand the role of support workers in healthcare, but found little evidence, on the role of support workers, what they do, the impact of their deployment on other staff, quality of care delivered to the patient, or on the release of qualified nursing/midwifery time. They suggest that although substitution can make sense at a task level by increasing the proportion of less qualified and non-professionals in the workforce providing the routine care, it may be possible that the quality of care falls. Arguing that the level of surveillance or sensitivity to signs and symptoms suggestive of complications, or the capacity to respond to an emergency, is diluted to a level that impact negatively, with a danger that some of the holistic and patient-centred aspects of care get neglected.

Carr- Hill et al conclude that substitution may not be as efficient as anticipated because of the extra time that staff in new roles (e.g. maternity support workers) may take to carry out the same tasks, the costs of supervision and also the uncertainty about how those released by substitution (e.g. Midwives) are using their time. They highlight that there is little evidence on the extent to which this increases productivity and that measurements of quality and safety need more sophisticated attention than has been received in many studies. This view has generally been reiterated, and the associated issue of developing new roles remains relatively unexplored[19]. What should not be forgotten is that the greatest potential is for more support workers to be employed in areas where they have traditionally provided support. This may have the greatest cost-benefit in terms of freeing up midwives' time rather than training support workers to take on complex new roles. Generally, there is a dearth of research, particularly for role changes involving workers other than doctor/nurse, and there is little work published since the current modernisation of the workforce on support workers, and specifically focusing on British maternity settings.

However, there is evidence for some of the interventions that support workers do, such as breastfeeding support, running postnatal groups and support in labour. We found a substantial number of support workers were providing one to one support to women in labour, which can both reduce intervention rates and improve maternal and neonatal outcomes[20.] Lay health worker (LHW) interventions also show promising benefits in promoting the uptake of immunization in children, and promoting breastfeeding when compared with usual care, however there is insufficient evidence to assess which LHW training or intervention strategies are likely to be most effective, and whether support workers would have the same impact[21]. There is less evidence to support a postnatal home visiting based on a Dutch model of maternity aides. Although women valued the service, there was no evidence of any health benefit at the 6-week or 6-month follow-up, no difference in use of NHS services, and the additional cost of the service provision was around £180 per woman[22].

Scope of practice

McKenna et al's review shows how the scope of practice for health care assistants has grown in the UK, and now includes a wide range of clinical tasks with varying levels of supervision. Some tasks being undertaken by support workers in our study have been regarded as midwifery duties (reordering of pharmacy stock, transfer of emergency patients and babies, giving drugs and taking blood) [23]. Raising concerns about the lack of statutory duty for training, suitability of NVQ training and the type of training on offer resulting in wide variation, as the role often varies depending upon the country and the clinical area in which the person is employed [24 25]. Due to these wide variations, there is also the distinct possibility that nationally, support workers carrying similar job profiles will be differently rewarded in terms of grade and pay.

Quality and safety

There is no current statutory requirement for support workers to undertake training, nor, any level of regulation to ensure public protection, although recommendations are currently under review in England [26]. Previous research has recommended that health care support workers should be regulated [27], and the consideration of statutory regulation for assistant practitioner roles at levels 3 and 4 on the Skills for Health Career Framework is reassuring [28]. The Scottish pilot of employer-led regulation of healthcare support workers (HCSWs) is testing arrangements for those who have met agreed national standards. The Scottish model is that induction standards focus on generic public protection concepts such as confidentiality, dignity, advocacy, and apply to all HCSWs employed in the NHS, regardless of their role [29].

The NMC code of professional conduct: *standards for conduct performance and ethics (2004)* states that registrant nurses/midwives remain accountable for the appropriateness of the delegation, for ensuring that the person who does the work is able to do it and that adequate supervision or support is provided. Thus a potential situation may arise where registrants have the legal responsibility for the delegated work of MSW without the supervisory mechanism in place. In maternity services, the delegation of clinical tasks to non-trained support workers is of significance and midwives have identified the need for education on delegation of skills, particularly in relation to accountability and legal responsibility.

The NMC states "*you (the registrant) remain accountable for the appropriateness of the delegation and for ensuring that the person who does the work is able to do it and that adequate supervision and support is provided…..if the HCSS has not been assessed and signed as competent, the registrant has the responsibility to countersign any entries made*" [30].

In 2006, the Royal College of Midwives (RCM) in response to pressures to expand midwives' sphere of practice outlined essential midwifery responsibilities and tasks that could be delegated to a support worker (Appendix 6) [31]. The RCM has set out the role of the maternity care assistant as "undertaking limited clinical duties for which midwifery training and registration is not required (either by statute or professional training) under the direction and supervision of the midwife" and developed a training package[32].

The issue as to who is accountable for support workers has been debated by the National Practitioner Programme (Appendix 7). The responsibility of the support worker is to be clear on what is expected in their role and to be confident that they have received the requisite training required for their work. We also found large variation and overlap between the type of support worker and scope of practice. For example, there was substantial variation in title, range of activities, required entry level of training and pay. This wide variation may leave women and their families, managers and midwives with uncertainty as to the role and competency of the individual support worker. Appendix 4 provides an example from a job description that highlights clear role boundaries, which require both the support worker and the midwife to work together in the postnatal area of one NHS Trust.

Figure 7 Modelling proposed development of accountability in practice for support workers – from supporting the service to supporting women

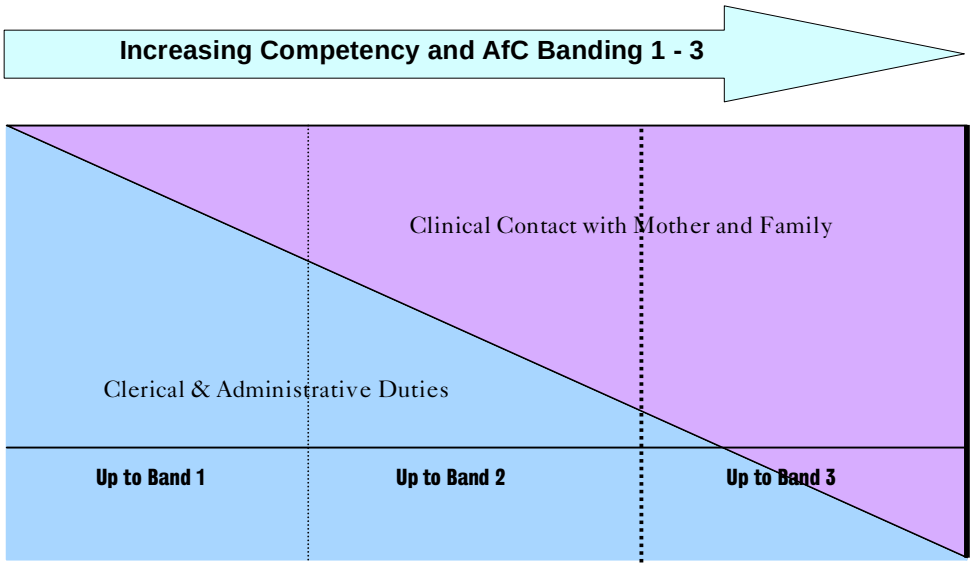


Figure 7 outlines a simple model of accountability in practice. At the lowest level of support worker role, (Band 1), the emphasis is on developing a familiarity with the way a maternity service operates and at this point the role is generic and not dissimilar to the traditional "auxiliary" or health care assistant. Understanding the principles of public safety, boundary limitations and role accountability would be introduced here. As the support worker undertakes further theoretical and practical training (currently this is through NVQ 1-3), a fundamental component is proposed to include public protection and personal and professional accountability. The key to accountability is that the support worker recognises his/her own practice limitations and if presented with tasks that fall outside their training repertoire, are clearly able to identify the necessary person to refer to. As the support worker develops skills and competencies up to NVQ 3 and Band 3, their interface with the public is increasing and culminates in the role fulfilling a greater component of the maternity service delivery requirements i.e. supporting midwives at a home-birth, undertaking independent home visits.

Skill mix and substitution

Both the RCOG and RCM have exercised serious concerns regarding inadequate labour ward coverage and critical midwifery staffing levels, with resultant impacts on quality and care[33]. The annual survey of UK heads of midwifery identified that in over 70% of maternity units, midwifery establishments were felt to be inadequate of the level of activity undertaken, confounded further by a 3% increase in birth rate [34]. In such a climate, there is a danger that support workers could cease to become "another pair of hands" freeing the midwife and other members of the maternity team from administrative and routine duties to look after women (a perfectly reasonable objective) and instead, substitute care provided by midwives, and fall outside the professional structures that enable full accountability, and (apart from the NHS Employers MSW programme) without overmuch investment in their training or development - a much less desirable situation.

For example, 14 units had employed qualified nurses or midwives as support workers. The majority of these were nurses, in the case of midwives, some were newly qualified or overseas midwives awaiting registration, or retired midwives. In addition, since support staff are not required to be regulated, any professional staff that may have been removed from their respective professional register, can freely work within the healthcare setting without regulatory checks that may have otherwise limited or prohibited their employment within a similar healthcare setting. The implementation of an adequate screening function is fundamental to ensure the safety upon which public protection is based and as such has been identified by the NMC as "*a priority waiting for implementation*" [35].

6.0 Recommendations

For Policy makers

- If improving the quality of care is to be fully realised, it seems to be essential that there is a national framework for entry requirement, training and competencies determined by job profile for roles in different settings, and a national framework for pay, and appropriate arrangements for governance.
- Due to the degree of overlap with clinical role of the midwife, the development of advanced clinical roles needs careful management at a local level to ensure public safety. There is an urgent need to identify the skills and tasks that can and cannot be delegated to a support worker.
- Workforce and service developments should reflect the needs of women and their families and aim to improve quality and safety of care.

For future data collection

Information is needed to assess nationally the impact (cost benefits / productivity) of support workers in maternity care, and to inform decisions made locally about the make-up of the workforce.

A standard tool to assist managers with collating economic information on actual midwife and managerial time saved or required by the support worker role is needed. The proposed impact measures in the NHS Employers Programme would be extremely helpful if routinely collected in Stage 2 of the roll out (Appendix 5).

The information required should include:

Midwifery time released through the use of support workers - what task was undertaken by support worker and how much midwifery time did this release?
How was the freed up time redirected? - What did midwives do with the time released through the use of support workers?
In what settings did support workers work, and what tasks do they undertake?
How did what they are doing impact on service improvements?
Process mapping of old and new processes of care.

For future research

In sum, there is a need for a more sophisticated approach that is able to model the likely effects of workforce scenarios on expected outcomes and costs. Potential areas for future research in England should include:

- Investigation of the impact of the support worker role on outcomes for mothers and babies.
- Assessment of the cost-effectiveness of the support worker role at different levels of training and scope of practice.
- Exploration of the views and experience of women receiving care from support workers.

Appendices

Appendix 1

Internal Reference Group External Reference Group

Heather Mellows	Medical Adviser - Gynaecology and Obstetric Women's and Maternal Health Team, Department of Health	Susanne Trutterro	LSA Midwifery Officer
Caroline Simpson	Professional Advisor Maternity/ Family Health CNO Professional Leadership Team, Department of Health	Prof Cathy Warwick	King's College Hospital NHS Trust
Janis Stout	Senior Workforce Adviser, Care Services Improvement Partnership	Cathy Devonport	Programme lead Large Scale Workforce Change Team
Jane Verity	Team Leader, Women's Health and Maternity Team, Department of Health	Gail McConnell	National Childbirth Trust
Claire Corneille	Workforce Directorate DH NHS & Social Care Workforce Supply	Frances Day-Stirk Mervi Jokinen	Royal College Midwives
Bryn Shorney	Economic Adviser Workforce Delivery Analysis Team	Dr Lindsay Smith	Royal College of General Practitioners
Sandra Williams	Chief Research Officer - Child and Maternal Health, Sexual Health Research & Development Standards and Quality Group Department of Health	Prof Paul Lewis Susan Way	Nursing and Midwifery Council
		Sue Eardley	Health Care Commission
		Ruth Young	King's College London
		Maggie Redshaw	National Perinatal Epidemiology Unit

Appendix 2

Cover letter and questionnaire

Department of Health

Care Services Improvement Partnership CSIP

Children and Families Programme

Dear Colleague

Rapid scoping audit of support workers in maternity services in England

A team of researchers from Kings College, University of London have been commissioned by the Department of Health to undertake a rapid scoping audit of the role of support workers in maternity service (including Maternity Support Workers in order to help provide future guidance as to areas for future research, future service delivery and routine data collection.

This quick scoping study aims to provide an overview of numbers, scope and range of practice, skill mix and service model arrangements of support workers working in maternity services England. Data to be collected will include number of midwives and support workers, training, supervision arrangements, scope and range of practice of support workers. We will also be looking at sites where there is innovative practice to that the Care Services Improvement Partnership (CSIP) are keen to share.

All responses will be treated in confidence, and we will be following ethical and good practice research guidelines. We would very much welcome your help and support during the audit should you be contacted by one of the research team.

If you have any queries regarding the audit please contact

Janis Stout
Senior Workforce Advisor
Children,Young People and Families Programme Division
Care Service Improvement Partnership
Janis.Stout@dh.gsi.gov.uk
Tel: 0161 903 9826

Or the study team lead
Professor Jane Sandall
Health and Social Care Research

King's College, London
150 Stamford Street, London, SE1 9NH
Telephone Number: 0207 848 3605
Email address: jane.sandall@kcl.ac.uk

Yours faithfully

Jane Sandall

Gwyneth Lewis
National Clinical Lead for Maternal Health and Maternity Services

NHS Gateway reference: 7364

National Clinical Lead for Maternal Health and Maternity Services

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Dear Colleague

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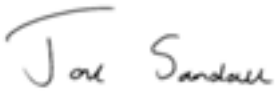
A team of researchers from Kings College, University of London have been commissioned by the Department of Health to undertake a rapid scoping audit of the role of support workers in maternity services (including Maternity Support Workers) in order to help provide future guidance as to areas for future research, future service delivery and routine data collection.

This quick scoping study aims to provide an overview of numbers, scope and range of activities, skill mix and service model arrangements of support workers working in maternity services England. Data to be collected will include number of midwives and support workers, training, management arrangements, scope and range of activities of support workers. We will also be looking at sites where there is innovative practice that the Care Services Improvement Partnership (CSIP) are keen to share.

You are being approached because we are sampling 50% of small, medium and large NHS Trusts who provide maternity services in England. All responses will be treated in confidence, and we will be following ethical and good practice research guidelines. We would very much welcome your help and support during the audit when you are contacted by one of the research team. It would be helpful if you are able to read the questionnaire in advance so that you are prepared for the telephone interview and have the data that is required to hand. Where you manage more than one unit i.e. standalone unit and consultant unit, we will require a separate questionnaire for each unit, and advise that you complete as much as is possible before your scheduled interview.

Yours faithfully



Jane Sandall

Professor of Midwifery and Women's Health

Health and Social Care Research Division
Waterloo Bridge Wing, 150 Stamford Street,
London, SE1 9NH
Tel: 020 7848 3605 Fax: 020 7848 3764
email:jane.sandall@kcl.ac.uk

Maternity Unit No					

The use of support staff within maternity is standard practice with the most common roles being healthcare assistants and nursing auxiliaries. A more recent and different role is that of maternity support worker or maternity assistant. We have defined support worker as *'A worker who provides face-to-face care or support of a personal or confidential nature to patients and/or service users in clinical or therapeutic settings, community facilities or domiciliary settings, but who does not hold qualifications accredited by a professional association and is not formally regulated by such a body' (Saks 2000).*

SECTION A: Demographics of Unit and Contact Details

PLEASE COMPLETE A SEPARATE QUESTIONNAIRE FOR EACH MATERNITY UNIT CONTACTED

Q1	Name of Strategic Health Authority (SHA)	
Q2	**Name of NHS Trust**	
Q3	**Name of Maternity Unit**	

Q4	**Name of Head of Midwifery of Trust Contact Details and Email Address**		
Q5	**Name of Midwifery Head of Unit (if more than one Unit in a Trust). Contact Details and Email Address**		
Q6	**Name of Respondent Contact Details and Email Address**		
Q7	**Name of Respondent Contact Details and Email Address**		

Q8	Name of Respondent Contact Details and Email Address	

SECTION B: About your Maternity Service

Q9	How many deliveries did you have in your service in April 2005- March 2006?	
Number		

Q10	What is your current Whole Time Equivalent (WTE) establishment of midwives?	
Number		
Q11	How many midwives (WTE) do you currently employ in your service?	
Number		

Q12	What was your Whole Time Equivalent (WTE) establishment of midwives in November 2005?	
Number		
Q13	How many midwives (WTE) did you employ in your service in 2005?	
Number		

Q14	Is there a gap between (WTE) established posts and midwives currently employed?	
No	Yes	If yes, Specify reasons why and number WTE

Frozen posts		
Unable to recruit midwives		
Other, please specify		

Q15	**How is this gap being managed?**	
Conversion to support worker posts	**If Yes, specify number**	
Employment of other professionals ie nurses	**If Yes, specify number**	
Frozen posts	**If Yes, specify number**	
Other, please specify	**If Yes, specify number**	

Q16	**How many midwives (WTE) do you currently employ on each Agenda For Change pay band**	
5 Midwife entry level 17,475 – 24,803	WTE	
6 Midwife community/hospital/ integrated 20,970 – 31,004	WTE	
7 Midwife higher level 24,803 – 36,416	WTE	
8 Midwife Consultant/manager A-D 32,921-73,281	WTE	
9 Senior Midwife Manager 63,417 - 88,397	WTE	

Q17	What is your current Whole Time Equivalent (WTE) establishment of support workers in maternity services? (include information on Health Care Assistants, Health Care Support Workers, Auxiliaries, Maternity Support Workers, Maternity Care Assistants, Midwifery Assistants, Nursery Nurses, assistant practitioners and others)	
WTE		
Q18	How many support workers (WTE) do you currently employ in your service? (include HCAs, Auxiliaries, MSW, Maternity Care Assistants, Midwife Assistants, Nursery Nurses, Assistant Practitioners)	
WTE		

Q19	In November 2005, what was your Whole Time Equivalent (WTE) establishment of support workers in maternity services in November 2005? (include information on Health Care Assistants, Health Care Support Workers, Auxiliaries, Maternity Support Workers, Maternity Care Assistants, Midwifery Assistants, Nursery Nurses, Assistant Practitioners and others).	
WTE		
Q20	In November 2005, how many support workers (WTE) did you employ in your service? (include HCAs, Auxiliaries, MSW, Maternity Care Assistants, Midwife Assistants, Nursery Nurses, Assistant Practitioners)	
WTE		

Q21	Have you employed any support workers with a nursing or midwifery qualification?	
Yes	If yes, specify number	
No		
More information		

Q22	How many support workers (WTE) in your maternity service are employed with the current title, and what pay band? (specify hospital or community).			
	WTE on AFC pay band 1	**WTE on AFC pay band 2**	**WTE on AFC pay band 3**	**WTE on AFC pay band 4**
Pay range	11,782 - 12,853	12,177 - 15,107	12,853 -16,799	15,107-19,730
Auxiliaries				
Health care support worker				
Health care assistant				
Maternity care assistant				
Midwifery assistant				
Maternity support worker				
Nursery nurse				
Assistant practititioner				
Other				

Q23		How many midwives and support workers (WTE) work in each area ?						
	Hospital Antenatal clinic/ Day Assessment Unit Antenatal ward	**Hospital Delivery suite**	**Hospital Postnatal ward**	**Rotates in hospital areas**	**Operating theatre**	**Community team/ practice**	**Stand alone Midwife Led Unit**	**Children's centre/ Sure Start**
Midwives								
Auxiliaries								
Healthcare support worker								
Healthcare assistant								

Maternity care assistant								
Midwifery assistant								
Maternity support worker								
Nursery nurse								
Assistant practitioners								
Other								

BELOW ARE A RANGE OF TASKS AND ROLES THAT MIGHT BE UNDERTAKEN BY SUPPORT WORKERS. SOME ARE COMMON, AND SOME WOULD BE VERY UNUSUAL.

Q24		**Indicate tasks undertaken (ENTER)1 Usual 2 Sometimes 3 Never**								
		Auxilary	**Health care support worker**	**Health care assistant**	**Maternity care Assistant**	**Midwifery assistant**	**Maternity support worker**	**Nursery nurse**	**Asst Practitioner**	**Other**
Housekeeping and clerical										
Cleaning and hygiene										
Serving meals										
Housekeeping										
Stocking up										
		Indicate tasks undertaken (ENTER)1 Usual 2 Sometimes 3 Never								
		Auxilary	**Health care support worker**	**Health care assistant**	**Maternity care Assistant**	**Midwifery assistant**	**Maternity support worker**	**Nursery nurse**	**Asst Practitioner**	**Other**
Clerical duties										
Data entry computer										
Audit										
Ordering Pharmacy stock										
Portering										

Transfer of emergency patients									
Transfer of babies to other departments									
Clinical duties									
Planning of care									
Pre-natal screening counselling									
Conducting booking appointment									
Phlebotomy									
Running Glucose Tolerance Test clinics									
Advice Smoking cessation									
Abdominal palpation									
Recording CTGs									
Carrying out Doppler ultrasound									
Vital sign observation									
Administering medication									
Assistance to midwives during labour									
One to one support of women in labour									
Vaginal examination									
Washing women after birth									
Theatre runner									
Theatre scrub									
		Indicate tasks undertaken (ENTER)1 Usual 2 Sometimes 3 Never							
		Auxilary	**Health care support worker**	**Health care assistant**	**Maternity care Assistant**	**Midwifery assistant**	**Maternity support worker**	**Nursery nurse**	**Asst Practitioner**	**Other**
Theatre assisting									
Post-operative care									

Infant feeding advice and support									
Advice on routine care of the baby									
Running baby discharge clinic									
Doing Newborn hearing screening									
Doing Newborn blood spot screening (Guthrie test)									
Newborn serum bilirubin blood test									
Telephone support									
Public health roles									
Health advocacy									
Support vulnerable families in home									
Infant feeding support in home									
Assist Postnatal groups									
Run Postnatal groups									
Assist Antenatal groups									
Run Antenatal groups									
Second person at home birth									
Support to community midwifery group practice/team									
Sole night cover Stand alone Midwife led unit									
Teenage pregnancy advice									
Other									

Q25	Do you have any data on average hours spent by midwives and support workers on the above tasks that you can share with us? If yes, please complete Question 25a which is a supplementary question. An example of what is required is entered below in grey. If data is not available in this format, please tick no.

	Yes	No	N/A	

INTERVIEWER INSTRUCTION.

FOR EACH OF THE TYPE OF SUPPORT WORKER RECORDED IN Q24, FILL IN A SEPARATE SHEET OF Q25a.

Q25a Example						
Note: Support worker type: IE Maternity Support Worker Healthcare assistant	**(a) Undertaken by support workers (Y/N)**	**(b) Average hours per WTE support worker per week (IF (a)= Y)**	**(c) Undertaken by midwives (Y/N)**	**(d) Average hours per WTE midwife per week (IF (c)= Y)**	**(e) Previously undertaken by midwives In sites where maternity support workers have been introduced (Y/N)**
Clerical duties	Y	2.5	N		N

Q26			What level of training is required on appointment for each type of worker?				
	NVQ 1	NVQ 2	NVQ 3	Other	None	Foundation degree
Auxiliaries						
Healthcare support worker						
Healthcare assistant						
Midwifery assistant						
Maternity care assistant						
Maternity support worker						
Nursery nurse						
Assistant practititioner						
Other						

Q27	What training opportunities are provided to support workers by your organization? Please give average hours per training activity if you are able.					
	Generic In house (fire, moving, handling)	In house Specialist maternity	In house Accredited training First aid, UNICEF BFI breastfeeding, Smoking cessation, Neonatal and adult resuscitation. PLEASE NOTE WHAT SPECIFICALLY	NVQ	Diploma/ degree	Other
Auxiliaries						
Healthcare support worker						
Healthcare assistant						
Maternity care assistant						
Midwifery assistant						
Maternity support worker						
Nursery nurse						
Assistant practititioner						
Other						

Q28	What level of employer support is provided for support workers training and development ? Please give average costs per activity if you are able.				
	Fee support	Secondment	Day release	Other	None
Auxiliaries					
Healthcare support worker					
Healthcare assistant					
Maternity care assistant					
Midwifery assistant					
Maternity support worker					
Nursery nurse					
Assistant practitioner					
Other					

Q29	Who does the support worker report to on a daily basis?				
	Specific assigned midwife	Operational Manager (SPECIFY TITLE)	Other		
Auxiliaries					
Healthcare support worker					
Healthcare assistant					
Maternity care assistant					
Midwifery assistant					
Maternity support worker					
Nursery nurse					
Assistant practitioner					
Other					

Q30	Who performance manages the support worker?				
	Specific midwife	Operational Manager (SPECIFY TITLE)	Other	Does not happen	
Auxiliaries					
Healthcare support worker					
Healthcare assistant					
Maternity care assistant					
Midwifery assistant					

Maternity support worker					
Nursery nurse					
Assistant practitioner					
Other					

Q31	Do you have a job description or job profile you can share with us? Email or fax to Jane Sandall at jane.sandall@kcl.ac.uk			
	Yes	No	N/A	Average length of time in post
Maternity care assistant				
Midwifery assistant				
Maternity support worker				
Assistant practitioner				
Other				

Q32	Do you have an evaluation that you can share with us? Email or fax to Jane Sandall at jane.sandall@kcl.ac.uk				
	Yes	No	N/A		
Maternity care assistant					
Midwifery assistant					
Maternity support worker					
Assistant practitioner					
Other					

Q33	Do you have a business case that you can share with us? Email or fax to Jane Sandall at jane.sandall@kcl.ac.uk				
	Yes	No	N/A		
Maternity care assistant					
Midwifery assistant					
Maternity support worker					
Assistant practitioner					
Other					

Q34	How recently has your unit undertaken Birth-rate Plus™				
	Date	N/A			

Q35	What were your overall findings?
Did you find a gap between birthrate plus staffing figure and your established number? Please specify.	

Q36	Can you share this data with us? Email to Jane Sandall at jane.sandall@kcl.ac.uk				
	Yes	No	N/A		

SECTION C: Further information

Q37	We are interested in innovative roles for support workers. Do you have examples that you would like to share with us?				
	Yes	No			
Further details					

Q38	Which of the following measures are already in place within your organisation to ensure that the public is protected when support workers are employed in maternity services?		
	Yes	No	
Pre-employment checks			
Unit Guidelines (Role, activities, confidentiality, record keeping etc)			
Day to day monitoring			
Line management by qualified staff			
Continuing staff development opportunities			

other (please describe)

Q39	**We are interested in your experience of how the greater use of maternity support workers / midwifery assistants / maternity care assistants has improved or enhanced the care of mothers and babies?** **For example, whether pressure has been taken off midwives and in what way? How has the time released been identified and re-allocated?** **Please could you share with us your experience if you have received positive feedback.**

Benefits for mothers and babies

Benefits for the organisation

Benefits for the maternity team

Financial savings made (measured how)

Q40	**We are interested in your experience of how the greater use of maternity support workers / midwifery care assistants / maternity assistants can adversely affect or detract from the care of mothers and babies and in what way?** **Have had any clinical incidents or complaints involving support workers in the last year?**
Yes	
No	

Risks for women and babies

Risks to organisation

Risks for members of maternity team

Other comments

Many thanks for your time in completing this survey. The findings will be anonymised, and a study summary returned to you.

INTERVIEWER INSTRUCTION.

FOR EACH OF THE TYPE OF SUPPORT WORKER RECORDED IN Q24, FILL IN A SEPARATE SHEET OF Q25a.

Q25a Supplementary						
Note: Support worker type: ie Healthcare assistant or Maternity Support Worker		**(a) Undertaken by support workers (Y/N)**	**(b) Average hours per WTE support worker per week (IF (a)= Y)**	**(c) Undertaken by midwives (Y/N)**	**(d) Average hours per WTE midwife per week (IF (c)= Y)**	**(e) Previously undertaken by midwives where maternity support workers have been introduced (Y/N)**
Housekeeping and clerical						
EXAMPLE CLERICAL DUTIES		Y	2.5	N		N
Clerical duties						
Housekeeping and cleaning						
Transfer of mothers and babies						
Organising clinics						
Clinical duties in hospital and community						
Health Advice Ie Smoking cessation Teenage pregnancy						
Assist/run antenatal and postnatal groups						
Phlebotomy						
Vital sign observation						
Assistance to midwives during labour						
One to one support of women in labour						
Second person at home birth						
Washing women after birth						
Theatre duties/ Post-operative care						
Newborn screening including hearing & Guthrie test						
Infant feeding and baby care advice and support in health facility						
Infant feeding and baby care advice and support in womens' home including support to vulnerable families						
Support to community midwifery group practice/team						
Sole night cover Stand alone Midwife led unit						
Other						

Appendix 3

Qualitative responses

Q39 We are interested in your experience of how the greater use of maternity support workers/midwifery assistants/maternity care assistants has improved or enhanced the care of mothers and babies?

ID#	Benefits for mothers and babies	Benefits for the organisation	Benefits for the maternity team	Financial savings made
5	-Project workforce plan in progress with MCAs in the community settings which is beneficial for mothers and babies -Breast feeding support has improved breastfeeding figures and more time can be spent with mother	-MCAs are an asset -Risk is reduced when appropriate person is performing care duties -They release time for MWs to attend to women at high risk -Cost effective	-MCAs undertake an excellent education programme with units that relate to maternity services. This helps to improve care -They help to meet stresses & strains	-Cost effective
6	-More timely care in hosp & comm. Settings. - SWs cam respond quickly to problems esp. on postnatal ward	-More flexible use of MWs -SWs provide care as long as it has been planned by MW -Has helped in recruitment of MWs by SWs initially starting off as SWs but train to be MWs -Positive user satisfaction of SWs	-Helped MWs focus on things that only MWs can do -Good team spirit with skill mix provided -SWs look after MWs and are pivotal in the team -Provide morale within the unit	-No -SWs taken on with additional funding -But now they demonstrate skill mix it may be financially beneficial
7	-Care pathway longer -Better constructs of care	-Value for money -Experience -Pick them up and drop them into any service	-Role differentiation issues initially -2 years to cement in -Scope of practice	-Probably cost a bit more -Converted twice
9	-Feeding support -Postnatal support		-Initial resistance from MWs	-Saves 5 hrs per day of MW time
11	-MCAs recognise problems and can bring them to MW attention -Alert MWs to situations such as post-partum haemorrhage	-More people means more hands on the ground and more general care for women and breastfeeding	-Freeing up time for some MWs but not for others -Some skill practice but are MWs unwilling to hand over responsibility to SWs esp. in community -Stress lowered among staff as work is shared out	
12	-Breast/infant feeding support gives greater continuity of care as more time can be spent with each mother/baby	-Frees up time -Less pressure on MWs	-More awareness of individual members of team	-No savings made but has prevented Trust from spending any more money
13	-Improves role of MW -Better quality of care -Frees up MW role -Career pathway for unregistered employment for people who otherwise may be unemployed	-Improve quality of care -Better use of resources -We have a limited pot of money -Maintains service safely -Represents new ways of working	-More politically aware -MWs do not feel so threatened	-No savings made -Not established for activity
15-19	-All got a lot to offer -All got breastfeeding training -They are dedicated to maternity & get really involved -I wouldn't be without them	-Worried that developing role of SW may be perceived by Trust as cheaper option to MW	-SW highly valued	
21	-SWs help with bereavement, sometimes attend funerals	-Retention of MWs has improved -Around 5 SWs were funded by Trust through MW training with 5/6 more girls currently going through training	- Lots of opposition in 1st yr for SWs working in comm. but no more -SWs provide continuity of care because lots of MWs are PT -SWs very involved in clinical tasks Helpful to get SWs helping with phlebotomy -Complement each other well -MWs always asking for more SWs	-Cheaper than MWs but must be careful of skill mix
20	-Invested in training, spend more quality time with women -SWs got things done for women rather than wait for a MW	-Quicker turnover of staff -Input into computer	-Free MWs up to devote to MW care -Midwifery becoming more high tech	-Perhaps in the long-term
4		-Meets public health agenda -Cheaper posts -Local employer foundation trust	-Scrubbing in theatre -Free up time for MWs -We may have gone through the "over my dead body will anyone else do that"	-More people around, you can have 2 SWs for the same cost of a MW
3	-No benefits as SWs play a limited, traditional role and have not taken many roles from MW		-Once changes are in place (next yr) MWs time will be freed so they can target women with needs while SWs	-Substantial -Unit is looking to lose 4 MW posts as part of

			provide basic care, this will ensure MWs are not thinly spread	changes over next yr and these will be replaced by 4 SW posts
23	-SWs very interested in becoming part of the birth experience -Lots of time spent in postnatal ward, more time for care of mothers & babies	-Reduced complaints, increased client satisfaction -NN discharge programme improved	-Reduced workload of community MWs	
39	-Community based SWs have more time with mothers -Team MWs can focus on high risk mothers	-Marketing, greater support -Assisting 10 steps to baby friendly -CNST, going for level 2		
25	-SWs providing continuity of care -Support to vulnerable families with parenting skills & baby care	-'Skill mix' gives an appropriate level of staff for duties -Increased establishment of workers without using all professional grades	-Frees up time -Takes pressure off MWs -SWs are team players	-No cost savings
26	-Provide continuity for the women esp. in postnatal care -Mothercraft, showing mum how to change nappies etc. -Very good support to women in early labour		-SWs have taken on more clinical roles which reduces the pressure -Frees up MW time	
27	-AP supportive to women during caesarean	-Cheaper -Fewer MWs employed		
33	-Extra support for women	-Release MW time -Fewer complaints -Can meet other needs -83 SWs have gone onto MW training so working within a team of MWs has been a positive role model so may help with recruitment	-SW have contributed to team because their roles are clear -MW can focus on labour -Will transfer equipment etc that MW may not have time to do -SW can multi-task	
34	-Underpinning knowledge that they have from NVQ3 which enables them to provide explanations for women -Defining more support for women		-Raises profile of SW -Help clarify MW what SW role is	-Saves MW time -Used to have 25 WTE in community and now have 24 WTE and 3 MAs no financial saving but a skill mix
35	-Women get better continuity of care with breastfeeding -Women can come in at any day or night	-Retention of staff, MCAs going on to be MWs	-Observations done by MCAs so frees up MW time -MWs don't work nights and are called in by MCAs only if birth -MCAs staff the unit at night time	-Cut costs because no need for MWs at night because MCAs are responsible
36	-Reduced waiting time in postnatal discharge -Increased time spent supporting breastfeeding -Continuity of care for high risk women -SWs easier access than MW for teenagers needing advice	-Do not require Band 6 MW for clerical work -Reduced average length of stay -Reduced number of antenatal over night stays -Better access	-Increased training time for MW and SW -Increased level of training -Increased time with women -Extra members of staff to get more work done	-Community relieve saved £647.20/wk -Theatre role saved £339/wk
37	-Breast feeding initiative and supporting mums with parenting	-Clerical support maintains good quality data -Prepare packs and make appts to make things run smoothly	-Working at night, reduced MW night shifts	
39	-MWs wont work without SWs in community	-Give better quality of care		-Cost effective
ID#	Benefits for mothers and babies	Benefits for the organisation	Benefits for the maternity team	Financial savings made
40	-Piloted 4 MSW 12 months ago, was brilliant and mothers appreciated it	-Job satisfaction	-Strengthens team by giving additional skills -MW less stressed and more time is given to students -"Students see midwifery care as it should be"	-No cost saving
44 & 45	-Continuity of care -Meet and greet	-More efficient use of skill mix and MW time	-Allow MWs to do what they have been educated to do	-Low birth to MW ratio, convert posts
46	-Community quality and continuity of care, -Doing clerical work gives MWs more time to spend with mother and babies	-Value for money	-SWs Enhance team activity	-Cheaper than a MW
47		-MW workforce more efficient -Less turnover of staff	-MW can set the care plan while SW physically carry it out, reducing	

		-Reduction in re-admission rate -Reduction in # complaints	MW stress	
48	-More time to support women -Drop in very popular	-Convenience of drop in and home visits	-Massive benefits -Extra support for MWs	
49	-Continuity of care -Post delivery hygiene, the MSW can remove all cannulas and do baseline observations - Help mother breastfeed baby	-MW are doing their proper duties	-Help make a cohesive team and in the understanding of roles, expectations and skills required	
50	-Huge scope from parenting point of view -Skill mix in community means more MW freed up for 1-1 care in hospital and community setting	-Proud of theatre roles (MWs have not scrubbed into theatre for 10-12 yrs) -MSWs are very flexible when needed	-Freeing up time -Low turnover of staff and wealth of extremely experienced MWs and MSWs (no problems with recruitment) -MWs keen to keep MSW role as long as it is done safely -Performs roles that a MW doesn't need to do -Delegation	-Investing in quality with MSWs (20% increase in activity but no increase in establishments) -MSWs can be used more economically -Much more would be saved if we implemented national defined training programmes for MSWs now
51	-Women relate to them very well, perhaps because SWs don't wear a uniform	-Workforce recruited from local area	-Release MW team -MW free to give support to high risk women	-Skill mix will save money without changes to the care
52		-Can deliver same care	-Free up MW time to concentrate on the job at hand -Job satisfaction	
54	-Breastfeeding support, parenting skills -Continuity of care - More accessible to women	-Flexible workforce	-NN have enabled babies with more complex needs to stay in ward -Public health role support safe guarding children	
55	-Individual healthcare	-Better service delivery	-Shared workload	-Reduced NHSP
56	-Continuity of care -Reduced risk when appropriate person is performing the duties		-Release time for MWs for women with increased risk	-Cost effective
57	-Maternal observation -Computer work means faster rate of discharging women from ward	-Motivated workforce -Career progression -Better utilisation of MW hours	-Better utilisation of maternity developments such as community work, PN visiting, and parent education	
58	-Quality underpinning women feeling valued, supported and helped and not having to wait for a bossy MW		-Gives MWs time to perform midwifery duties -Unfortunately we don't have enough of them!	
61	-SWs have directly helped increase breastfeeding rate in community setting	-SWs have been brought into areas where help was most required, esp. in poorer areas -SWs will cover different areas which will take pressure off other areas	-Releases ~ 20% MW time -Allows MWs to be doing what they should be doing -More hands on = more help -Initially struggled with acceptance but now is working well esp. in community	
60	-More visible and hands on support in close proximity to mothers -Increased breastfeeding rates -Mothers have more support and this doesn't necessarily have to come from a MW	-Reduction in complaints -Utilising resources -Better skill mix	-SWs delegated duties so MW can spend more time with women	
61	-"Have the time to talk to women"		-SWs held back by MWs, seen as "domestic cleaners" and are treated badly	
63	-Give extra care to mothers and babies when MWs are busy	-Quicker discharges -Improved standards for organisation because there are increased levels of trained people on ward -Better recruitment	-"An enhanced extra pair of hands for MWs"	
64	-"Some women prefer to talk to MSW as MW is perceived to be too busy"		-Takes pressure off MW teams -MCA very flexible, esp. dealing with community visits if MW was busy	
65	-MCAs have vast knowledge and experience of infant feeding -MCAs provide the majority of direct postnatal care which is very relaxed and allows a great deal of disclosure for women in hospital	-MCAs do most of the admin work which leaves time for the MWs to support the women -Without MCAs providing the bulk of postnatal care in hospital we would not function	-Only 1 team has an MCA in community but they say she takes away 30 hrs of admin work from them leaving them to be with the women	

	-When questioned, women found the MCA role very supportive	-MCAs self roster and manage it better than MWs -There is a great deal of ownership on their part to cover the service area		
67	-More breastfeeding support -More available to women -Help with parenthood classes -Community support, visiting vulnerable teenagers	-Increased skill mix -Improved recruitment and retention -Improved working lives of MWs	-Improved personal development of team -Better/healthy team ethos -MWs can focus on where they are skilled	-Covert financial saving
68	-NN employed specifically to focus on well-being of babies, more breastfeeding support for mothers	-Fewer complaints	-More MW time	-Frees up 2.2 WTE MWs when SWs work in antenatal clinic/perform phlebotomy
82	-Important for mothers to have someone there that is not too busy and has time to help	-Reduced complaints	-MCAs ensure tests are followed up, increases team efficiency	-Cheaper service
81	-"Consistency of person around the postnatal areas"		-HCAs are an essential part of the care and team	
80			-MW spend their time doing what they should be doing rather than non-clinical task-oriented activities that take them away from direct care of the women	
96		-MW workforce more efficient -Less turnover of staff -Reduced readmission rate -Reduced complaints	-MW can set the care plan and SWs physically help with providing the care -Reduces MW stress	
83	-Continuity of care		-MWs have downtime and less clerical work	
29	-Day to day contact with mothers and babies -Mums do not really discriminate between the SW and the MW	-Stand alone birth centre would not be able to function well at all without SWs, they coordinate all the admin tasks -Low turnover of staff	-Team bonding increased -MWs do not feel threatened and SWs are very clear about where their role finishes and the MWs roles begin	
71	-Extra time spent on support Sure Start arrangement is fantastic, very good relationship with mothers and supporting vulnerable women		-Clerical, admin and data input	
53	-Continuity of care for mother -Decreased waiting time in community clinics -Support women with more complete needs and who require more postnatal care e.g. women with disability	-Reduction in MW hours -Allows MW to do job smoothly -There is a massive scope to develop these roles		-£8000 per yr saved for antenatal evening classes -Reduction in waiting time by 15 mins
22			-Less MW stress	
92	-Breastfeeding support and parenting improved	-Quality of postnatal care is maintained	-Shared workload	
69	-Free up MW time so that MWs spend more time supporting women, helps MWs pick up on postnatal depression -MWs able to prioritise their time in the community so they can show support to vulnerable mums -Could increase home births if SW was second person at the delivery	-Clinical governance -If MWs are released from antenatal, they are more likely to provide better care in the labour ward		
79	-SWs look after women who need more 1-1 support for breastfeeding -Reduced waiting times for women		-Esp within the community, SWs have been helpful in getting appointments -Frees MW time	
78	-Mothers get focused home visits -SWs can take the time to sit and talk with women, get to know them	-A happy workforce	-Some teams of MWs do not have SWs but now they are requesting them because they have seen the benefits they have brought to other teams	-Difficult to prove
20	-Spend more quality time with women -Reduced waiting time			
76	-Some mothers like to talk to non-professionals	-Increased number of MWs in the high risk clinical areas	-MW improved job satisfaction	
73	-Continuity of care and women can get to know the SW instead of MWs who rotate		-Enhanced roles have released MW time -Multiple benefits -NN helpful because she is providing a link with paediatricians	

88		-Reduced complaints and better patient satisfaction		-Trust will gain financially as highly paid and highly trained MWs will no longer be carrying out tasks that can be done by an appropriately trained SW
38	-Provide transitional care to babies enabling mums and babies to stay together, preventing early separation in the early days following delivery	-SWs are retained in-house so there are career development opportunities -Good retention of staff	-Unit cannot function without them, there is even frustration they are being under-utilised -MWs delegate work well	-More appropriate use of resources, must think more critically with NHS budget cuts -Need to develop role of MW, not end it. Should aim for a balance between MWs and SWs
70	-Mothers and babies have benefited from SWs support in labour under guidance of MW -Currently, band 3 role is being developed to include community work for breastfeeding advice and baby care support under the care plan of MW	-Has enabled service to remain viable -Supportive friendly environment	-SWs seen as integral part of team -Sometimes considered as equals to MWs if their knowledge (esp about breastfeeding) is developed -SWs contribute positively to team dynamic -Admin support and stocking ensures smooth running of service	-Financial benefit from skill mix

Q. 40
We are interested in your experience of how the greater use of maternity support workers/midwifery care assistants/maternity assistants can adversely affect or detract from the care of mothers and babies and in what way?

ID#	Risks for women and babies	Risks to organisation	Risks for members of maternity team	Other comments
6			-Initially MWs were wary and unwilling to give up roles but now SWs have been in unit for a while and it is not as problem -Still some wariness when SWs take on roles such as recording CTGs, vital sign observation -Essentially it is the MWs who plan the care but the support workers who carry it out.	-SWs are worth their weight in gold!
9				-Competency book -Mobile phone -Weight babies
10				-Water births
12	Need to ensure SWs are adequately trained for their role & supervised when necessary			
13	After birth, HSWs look after low risk women, Stand alone MWs not in unit manned by support workers who are trained		-MWs may become 'de-skilled' and their roles as sitting and talking with mothers may be lost -Role is changing, some have said they may leave because of SWs	
20				-There is potential for problems if SW not aware of all the markers and does not pick up on relevance of women's complaints or comments due to lack of knowledge
3	-Some women may prefer MW expertise and may not have faith in competency of support worker -This can be overcome by ensuring that women understand the role of SWs and level of training they have		-Some MWs conservative in their views and are suspicious of changes (they are wary of giving up some of their responsibilities	-This unit is behind other units in country but changes are to happen next yr (are involved in maternity support worker project) -Restructuring has recently taken place with conversion of 1 MW post into 2 SW roles -Trying to phase out Band 1 MUA

				roles -Looking to revamp how MWs work and expanding SW role (2nd person at home birth, clerical duties, all Band 3 duties) -SWs are badly supported in training and career development and hopefully this will change as part of MSW project involvement
24			-Unfinished workforce & retention, may go onto other roles -MWs to accept the structure within the profession -Changing roles in next 3 yrs, internship and how it is financed, superannuation	
25	-Poor team preparation because they fail to recognize role of HCAs -Possibility of HCAs doing the wrong thing if they do not know -Possibility of poor preparation in community roles which may affect their reputation	-Potential for over/under utilisation -Inappropriate allocation of workload	-Need to make sure SWs are treated are valued and treated as fair players, not as "dogs bodies" -Poor orientation, vulnerability when working in dangerous places in community	
26	-Only risk of the MSW programme is that it has been implemented without paper checks	-Initially concerns/anxiety about invasion of MW role but this is overcome by having clear lines of accountability and clear roles outlined	Caesarean	-It is very important to recruit well, we need SWs who really understand the role
27		-HCAs difficult to define -Need clarity between roles -Need to train properly -Not clear who is responsible for HCAs, solution is regulation -Confusion of roles -Financial strain to pay APs at Band 4	-Need a housekeeper role as MWs do more Dr role & HCAs are stepping up to do MWs role which leaves a gap in housekeeping -MWs cant delegate because there is a lack of clarity in HCA role (housekeeping vs. clinical)	-I don't like training the AP role, I was told I had to do it; we had enough in place to develop own HCA to level 2 and 3. -I would rather have a band 5 MW or employ postnatal nurses because of the number of surgical cases
31	-Women neglected because we do not have enough SWs			-SWs need to be regulated and appropriately trained for maternity services
33				-Think it is a valuable role and can add to MW role rather than detracting from it -Would help if there was common training -Need standardisation
34			-Initially resistance from MWs, but now very popular	-Very successful, would invite all MAs rather than HCAs because of extra knowledge and learning, which enables them to offer a lot more support to women and MW team
35	-MCAs staff the unit at night time but call MWs if emergency -There was one occasion when the MW arrived after the birth but the MCAs dealt with it well		-Initial concern from MW, but everyone appreciates MCAs now	
36	-Potential for SW to work beyond boundaries and wrongly refer to GP		-Staff and patients unclear of who's who -MW perceived as poorest communicators of who they are	-SW used to be called MSW which denoted them as part of the support unit and Drs ordered them to do things, now they are MWA meaning they are attached to midwifery, belong to MW.
37		-Only if they work outside their role		
47				-Agenda for change has been a nightmare -Don't believe in MSW replacing role of MW
49	-Can be inconsistent advice			

	relating to infant feeding and care- addressed individually			
50	-MSWs working outside their boundaries	-Concern with some courses developing APs in midwifery where there isn't a need for an in between role -Cannot develop a role that isn't there to fit a budget		
54	-Need for robust training skills based competencies -Must be overseen by professional -Communication can sometimes be challenging			
58				-Something positive needs to move this forward, there is pressure needed to let Trusts address the issues in midwifery as it is always the poor relation
60			-Undermines MW role, some are unwilling to let go of what they think are their responsibilities	
61	-SWs maybe think they can do more than they could but they have protocols so this is minimised			
62		-Not utilising their time effectively	-Lack of respect for MW, "made to feel they are put in their place"	
			-Lack of embracement for MCA model	
66	-What the maternity unit lacks are full-time housekeepers to enable the MSW to have time to support mother and baby further			
67	-Only if inadequately trained	-Policies, procedures and guidelines -Need to be clear of roles and responsibilities	-If not managed on a day to day basis confusion could be caused on who is doing what	
68	-May not recognise boundaries of the role		-Lack of clarity for what SWs should be doing, confusion caused -MW reluctant to give up responsibility and feel threatened -Difficulty in assigning/delegating tasks, not sure what level of competency SW has	
82	-Should be none because HCAs are trained to know their limitations and what they are/are not allowed to do -Risks only if they act outside their level of responsibility			
80	-There are risks of employing unqualified MCAs but we have reduced this by setting up our own program		-Only poor communication in team -MWs are desperate to handover tasks and are in need of support	-There should be a National Programme for Maternity Support Workers, we have asked for national training but have been ignored -A generic NVQ is not good enough nor helpful to women and babies -Has been a "dog's dinner" right from the start -Professionals are being replaced by those that are not qualified and the public is at their mercy
71			-Only if you push the role too far -Would like to push the training for SWs and get them to do more	
83			-Accountability, the SWs are not to do MW duties	
22	-No risks if right guidelines are provided			

ID#	Risks for women and babies	Risks to organisation	Risks for members of maternity team	Other comments
69	-Am worried if there is no clear line of accountability and lack of clarity re roles -I am sure families are not happy with SWs carrying out postnatal checks- they feel it should be done by a pro	-Only if lines of accountability are not clear	-There are risks that roles are duplicated which is not time or cost efficient	-It is difficult to put a price on the quality of services -It is difficult to demonstrate the impact of health improvement in the future
84			-Previously, SW roles were anonymous (when they were auxiliaries) but now the MW team are "singing their praises"	
				-There is potential for problems if SW is not aware of all the markers and do not pick up on relevance of women's complaints or comments made due to lack of knowledge
76			-Concern about losing MWs to SWs	-Concern about the rapid roll out of SWs without any clarifying from the top about measurable standards (being transferable across all different trusts)
38		-Immediate risk if scope of practice, need clear guidelines so they don't overstep the mark -Legal implications for Trust, over-reliance on SWs and wrong skill mix may increase clinical error	-Need to be careful of over reliance on SWs	

Appendix 4

Information submitted by Trusts

Cornwall and the Isles of Scilly
Healthcare Community

Distribution of work between the Midwife and the Maternity Care Support Worker on the Postnatal Ward

Chris Joyce, Director of Midwifery & Kim Hewlett, Postnatal Ward Lead Midwife

Midwife	Activity	Maternity Care Support Worker
	NORMAL BIRTH	
	Receive on ward	
	Check baby labels	
	Initial Maternal examination	
	Orientation to ward	
	Food/Drink/Bell	
	1st feed & discussion re: expressing & establishing feeding	
	Breastfeeding support	
	Hand expressing – show how & help	
	Artificial feeding support	
	Discussion re: milk, equipment, sterilising	
	Lead on issues re: feeding problems	
	Support on issues re: feeding problems	
	Help to toilet & shower	
	Daily Maternal examination	
	Daily Baby examination	Must be able to recognise deviations from normal
	Baby BMs	At the request of the Midwife
	Baby care: bath, top & tail, nappy changing	
	Bed making	
	Refreshments in absence of house keeper	
	Discharge bed & room clean	
	Data entry & discharge paperwork	
	Completion of documentation in medical notes	
	Completion of documentation in midwifery notes	
	Discharge advise to mother	
	Co-ordinate Medical staff activities	
	Collect notes, blood, drugs	
	Counselling of Women	
	Baby Resuscitation	Able to deal with initial mucousy baby, take to midwife & resuscitative
	Baby weighing	
	Topping up in rooms	
In addition to above	INSTRUMENTAL / EPIDURAL	In addition to above
	Catheter care; clean, empty, fluid balance, advise mother, document	

	Catheter removal at request of Midwife	
	CAESAREAN SECTION	
	Temp, Pulse & Blood Pressure – report abnormal results, document in notes & mews	
	Manage IV fluids & Drugs	
	Undertake Blood Transfusion obs.	
	Remove IV Cannula at request of Midwife	
	Observations of Hypertensive/epileptic women	At request of Midwife
	Help out of bed	
	Remove dressings – advise re shower	
	Remove Sutures	
	Help with all baby care	
	Measure for, put on and remove TEDS	
	Phlebotomy at request of Midwife	
	TRANSITIONAL CARE	
	SBR	
	IV Antibiotics (1 – 3 babies per day BD)	

	Most appropriate member of the team to undertake this activity
	May be undertaken by this member of the team
	Not expected to be undertaken by this member of the team

The Hammersmith Hospitals NHS
NHS Trust

QUEEN CHARLOTTE'S AND CHELSEA HOSPITAL
DIRECTORATE OF WOMEN'S AND CHILDREN'S SERVICES

Job Description

Post:	Infant Feeding Support worker
Grade:	HCA2
Hours of Work:	37.5 (hours as required)
Responsible to:	Infant Feeding Specialist
Accountable to:	Director Midwifery/ General Manager

Required to work day and night shifts on a rotational basis.

Key Result Areas

1. Promote a safe, supportive and caring environment for women and their families within the unit, working to Trust guidelines and policies.

2. Assist the Infant Feeding Specialist in supporting women and families as regards breastfeeding to achieve Baby Friendly Initiative.

3. Participate in the effective running of the department.

4. Maintain efficient documentation.

Scope and Purpose of Job Description

A job description does not constitute a 'term and condition of employment'. It is provided only as a guide to assist the employee in the performance of their job. The Trust is a fast moving organisation and therefore changes in the employee's duties may be necessary from time to time. The job description is not intended to be an inflexible or finite list of tasks and may be varied from time to time after consultation /discussion with the post-holder.

Key duties and Responsibilities

1. <u>Promote a safe, supportive and caring environment</u>
   - Support and promote each mother's right to dignity and privacy, respecting individual beliefs and cultures.
   - Welcome women, their families and other visitors to the department.
   - Give clear advice on the ten steps to successful breastfeeding.
   - Report any problems or incidents to Infant Feeding Specialist and Lead Midwife as soon as possible.
   - Following appropriate training, make clear emergency calls when requested to do so by qualified staff.
   - Offer all mothers contact details of support groups and Infant Feeding Specialist and ensure they are referred for ongoing care with a midwife or health visitor in the community.
   - Promote skin to skin contact.

1. Support Infant Feeding Specialist

- Support mothers with infant feeding under the guidance of the Infant Feeding Specialist according to Baby Friendly and Trust guidelines.
- Assist mothers to breast feed in their own time, encourage breastfeeding on demand and support mothers with positioning, attachment and hand expressing.
- Assist mothers with the care of their babies, under the supervision of a midwife. Refer any concerns to the Infant Feeding Specialist and midwife in charge.
- Check and unpack supplies of breastfeeding information leaflets and other documents.
- Ensure mothers' comfort and access to food and fluids.
- Ensure that all feeding equipment is clean, report any faults to Infant Feeding Specialist.
- Undertake general clerical duties that may be associated with breastfeeding. This may include computer date entry, using ICHIS. Ensure documentation of care and breastfeeding is completed efficiently.
- Assist with the transfer of mothers and babies to other departments as necessary.

3. Participate in the effective running of the department

- Answer the telephone in a friendly and helpful manner, taking messages and referring callers when necessary.
- Assist in the general cleanliness of the department.
- Participate in departmental meetings as required.

General

1. Confidentiality

The post holder must maintain confidentiality of information about staff, patients and health service business and be aware of the Data Protection Act (1984) and Access to Health Records Act (1990)

2. Health and Safety

The post holder should be aware of the responsibility placed on employees under the Health and Safety at Work Act (1974) to ensure that the agreed safety procedures are carried out to maintain a safe environment.

3. Management of Violence/Crime

The Trust had adopted a security policy in order:

a) To help protect patients, visitors and staff
b) To safeguard their property.

All employees have a responsibility to ensure that those persons using the Trust and its services are as secure as possible.

4. Equal Opportunities

The Trust is aiming to promote equal opportunities. A copy of our policy is available from the Human Resources Department.

As an employee you are expected to treat all colleagues and clients equally regardless of colour, race, sex or disability.

If you believe that you have been treated unfairly due to colour, race sex or disability you should either discuss it with your manager, or if more appropriate, with your trade union representative, a friend or a member of the Human Resources Department.

5. No Smoking

The Trust operates a non-smoking policy. Anyone who wishes to smoke may do so only in one of the designated smoking areas at a time agreed with their line manager.

6. Medical Examinations

All appointments within the National Health Services are subject to pre-employment health screening.

Business Case Study Template 1 (MSW) Barnet and Chase Farm Hospitals NHS Trust

Area of Focus Community Midwifery (ante-natal clinics)

Delivered improvements against: please tick

R&R	User Satisfaction	IWL	Public Health	Metrics	Implementing NSF Standard 11	WTD
Some clinical duties currently performed by midwives, clerical and administrative duties will be supported and carried out by MSW Release of midwifery time will enable midwives to fully utilise their midwifery skills, knowledge and expertise thus improving morale and job satisfaction	Involvement of MSW at antenatal clinics will reduce delays for women and improve consultancy quality for women MSW working with midwives antenatally can be involved in the postnatal care thus providing continuity for the women	By performing non-clinical duties the MSW will provide support for the midwife, and time released can be used for providing quality midwifery care, thus improving job satisfaction Reduction in stress levels thus improving sickness rates	MSW will be trained in breast feeding advice and will contribute to supporting women with breast feeding during the postnatal period, also to give information in the antenatal period regarding breast feeding, thus meeting WHO Baby Friendly guidelines MSW will contribute to caring and giving advice on the general care, health and hygiene of both mothers and babies thus contribute to supporting healthy outcomes	MSW trained to provide breast feeding advice will contribute to improvement in the quality of care and advice given to women MSW involvement in antenatal clinics will contribute to improved quality of focused midwifery care provision	Working under the direction of midwives in small community teams, the MSW will undertake selected postnatal visits which will allow midwives to focus on providing midwifery care to vulnerable women	Role redesign and change in working patterns will assist midwives to delegate effectively therefore allow rest-time before/after community on-call commitments

			for women and their babies.			

Describe your work setting .eg Acute, community, population profile –rural, deprived, mixed

50 Words

Community Maternity Service spanning three hospital sites. Mixed profile population with pockets of deprivation. One Sure Start area.
Majority of ante-natal and post-natal care carried out in the community by 10 established midwifery teams, each team having approximately 5.8 WTE.
Birth rate within the Trust 6000 - 6500 per annum.
Vacancy rate in the whole Midwifery Service currently 10%, but in Community Midwifery the vacancy is 25%.
Vulnerable groups of women include teenagers, alcohol and substance misuse and child protection issues. Community midwives are involved in all aspects of their care.

Starting Point /local problems/Improvements sought

Describe what you needed to improve 3-5 key points

1. Provide ante-natal breast feeding information at ante-natal clinic to meet WHO Baby Friendly Guidelines
2. Reduce delays in antenatal clinics
3. Improve quality of midwifery information given by midwives by MSW undertaking non-midwifery tasks during consultation

Changes that made it happen

Describe the new role/ process changes -how you made it happen locally
100 words

Discussed introduction of MSW in community ante-natal clinics with community midwifery team leaders.
Audit tool developed in conjunction with community midwifery team leaders.
Audited midwifery activities in 2 antenatal clinics.
Introduced MSW into 1 clinic.
Funding for 1 G grade post converted into 1 WTE MSW and 0.6 WTE F Grade midwife to support 1 community midwifery team.
This community midwifery team is now linked within the first Children's Centre in the London Borough of Barnet.
Introduction of a weekly antenatal booking clinic at the Children's Centre with involvement of the MSW to carry out non-clinical duties.
On-going involvement with Strategic Health Authority to develop working guidelines and training requirements for MSW.

RESULTS

Improvements delivered (supported by NUMERICAL data where appropriate e.g. Minutes released, % reduced etc)

3-5 key improvements NB (Results should mirror 'improvements sought)

1. Provision of breast feeing information – % of women receiving information:
   Prior to introduction of MSW - 28%
   With MSW at antenatal clinic - 100%

2. Reduce delays in antenatal clinic

Women continued to be seen on average at 20 minute intervals, however, taking into account improvement (3) midwife able to provide total midwifery care and information giving

3. MSW undertaking non-midwifery tasks during consultation

During an antenatal clinic lasting 135 minutes, the MSW undertook 86 minutes of nursing and clerical tasks, which previously the midwife undertook. This equates to a release of 64% of non-midwifery duties that the midwife would have carried out. As a result, this time was spent focusing on improved midwifery consultation with the woman thus improved quality of care provision. In addition, the midwife was able to conduct the consultation in an unhurried manner thereby allaying the woman's anxieties and reducing stress to the midwife.

IMPACT

Number of roles	1 WTE for 1 community midwifery team
Released midwifery time	64 % during one antenatal clinic, each community team conducts between 8-10 antenatal clinics per week
User views	'I was told what I need to know and more' 'everyone that attended to me were so nice and they explained everything so clearly' 'lovely and welcoming- thank you'
Quality	Improved midwifery consultation Improved breast feeding information
Staff	'could I have Cathy (MSW) one more time' (while undertaking audit)
Efficiency/reduced waste	Redirected hours (86 mins) meant midwife spent time discussing with the woman midwifery related matters and was able to answer any queries/allay any anxieties, thus improved the quality of the ante-natal consultation

Lead Contact: Cyndy Bagan, Senior Midwifery Manager, Outpatients and Community Services, Barnet & Chase Farm Hospitals NHS Trust, Email: cyndy.bagan@bcf.nhs.uk, Tel.no: 0208 216-5414/ 5417

Appendix 5

Impact measures used in the programme and their definitions

Number of MSW roles introduced/anticipated
As above
Percentage of midwifery time spent on non-clinical duties
Time spent on non-clinical duties as a percentage of total work time per week.
Length of stay
Date of admission to unit to date of discharge measured in days
Waiting time or delay to schedule
Time taken to see mother/baby from time of arrival in clinic. Waiting time after appointment time (both measured in minutes)
Time taken for procedure to be completed
Time taken for identified procedure from start to finish measured in minutes
Time from referral to test performed
Time taken from referral source to test performed measured in days
Percentage of mothers known to have initiated breastfeeding
Number of mothers who initiate breastfeeding as a percentage of the total number of live births per week
Number of MSWs trained in breastfeeding
Number of MSWs who have completed training in breastfeeding as a percentage of total number of MSWs
Percentage of mothers smoking during pregnancy
Number of mothers smoking during pregnancy expressed as percentage of all pregnant mothers seen per week
Number of MSWs trained in smoking cessation
Number of MSWs who have completed training in smoking cessation as a percentage of total number of MSWs
Percentage of mothers given smoking advice
Total number of smoking mothers who have been given smoking advice as a percentage of all smoking mothers measured on a weekly basis
Number of patient complaints received
Number of complaints received measured on a weekly basis
Qualified hours/visits/sessions released due to new/changed roles
Total number of above released on a weekly basis
Number of hours lost through sickness
Total number of hours lost due to sickness measured on a weekly basis
Number of hours lost due to vacancies
Total numbers of hours lost through vacancies measured on a weekly basis
Number of follow up sessions covered by MSW previously carried out by midwife
Total number of above measured on a weekly basis
Number of extra hours worked per week
Total number of extra hours (such as overtime, time in lieu) worked by staff per week
Number of shifts covered by bank/agency staff
Number of above measured on a weekly basis
Number of unplanned movements of staff per week/as above

NHS Employers/CSIP (2005) Maternity support workers, Enhancing the work of the maternity team:National large scale workforce change, London, NHS Employers.

Appendix 6

Essential midwifery responsibilities

RCM (2006) Guidance Paper: Position Paper 26, Refocusing The Role Of The Midwife, London, and RCM.

All midwives should be competent in these areas of activity, and should carry the primary responsibility. It will not be suitable for delegation.

- History-taking of health, social and psychological factors, including full clinical assessment to determine individual health status
- Planning and delivery of evidence-based care in partnership with the woman
- Appropriate referral to other professionals, care givers and agencies
- Monitoring the progress of pregnancy, including maternal and foetal health, emotional, psychological and social wellbeing; providing primary advice and information and referring as appropriate
- Diagnosis of the onset of labour
- Monitoring the progress of labour and maternal and foetal wellbeing
- Facilitating and supporting physiological labour and birth
- Maximising normality for women in high dependency care
- Management of emergencies such as resuscitation, haemorrhage, shoulder dystocia, foetal malpresentation
- Recognising deviations from the normal, making appropriate referral, and working as equal partners in a multidisciplinary team
- Examination, monitoring and care of the newborn, including resuscitation
- Assessment, monitoring and care of the woman after birth
- Pain management and analgesic support
- Maintaining perineal integrity and undertaking perineal repair
- Appropriate postnatal care and transfer
- Monitoring and supporting maternal and infant well-being in the postnatal period
- Notification of birth
- Discharge and transfer of care to appropriate professional
- Record keeping
- Supervision and support of students
- Development of service provision that is appropriate for, and responsive to, individual and community needs.

Tasks that can be delegated

All midwives should be competent in these areas, and carry primary responsibility for ensuring that these tasks are carried out. Some may be carried out by support workers, under the supervision of a midwife, others may be augmented by other professionals or volunteers, where appropriate, and with due regard to issues of continuity, quality and accountability. Examples of such activities include:

- Advice and information on nutrition, exercise, smoking and other lifestyle factors associated with a healthy pregnancy
- Facilitating fathers' and partners' involvement
- Providing information and advice on self care and infant care
- Information, advice and support with initiating and maintaining breastfeeding
- Information, advice and support with infant feeding

Responsibilities of the maternity care team

All midwives should be competent in these activities, and contribute to their realisation. However, they may also be undertaken by others under their own responsibility, either within the maternity care team, by other professionals or agencies or by the woman herself.

Examples include:

- Diagnosis of pregnancy
- Development and delivery parenting information and education
- Assistance with transition to motherhood/parenthood
- Facilitating and supporting mother-infant interactionSupporting women and their partners to care for each other; providing appropriate information, advice and referral as necessary
- Advice on the resumption of sexual activity
- Advice on sexual health and family planning

Appendix 7

Greater Manchester NHS
Workforce Development Confederation

Delivering the Workforce

Non-Registered Staff Accountability

What You Want to Know

You are expected to:

- Always make the care and safety of patients your first concern.
- Ensure your level of practice is of the standard that is expected of your role / tasks that you perform.
- Keep your practice and knowledge up to date
- Always respect the public, the patients, the clients, carers, NHS staff and partners in other organisations.
- Demonstrate your commitment to team working by cooperating with your colleagues in the NHS and in the wider community.

What you are responsible for:

- Once assessed as able to do you job - your own practice.
- Reporting any concerns, changes, & developments, about the patients / clients to the registered professional members of the team.
- If you supervise the work of other junior members of the team you need to be sure that what you ask them to do is within their capability & that you are accessible & supportive.
- If you supervise the work of other junior members of the team that you report any concerns about their performance to your line manager.

Delegation – What Does it Mean?:

'*Delegation*' means '*entrusting a task to another person*'.

Delegation to others - You will at times 'delegate' some tasks to other members of the team. When you do that you need to be sure that the person who you are giving a task to is:-

- able to do what you are asking them.
- is clear about the role / task to be done.
- is competent to undertake that role / task.
- that you provide the person with the appropriate:-

Delegation to you -There are many occasions when tasks will be 'delegated' to you by other members of the team.

When you are asked to do something by other team members you must always be sure that you:-

- understand exactly what they are asking you to do – if you are uncertain ask for clarification.
- are confident that you have been trained to do the task and are able to do the task to the standard that you know they expect.
- have the time and proper equipment to do the job.
- the task is part of the patients / clients plan of care.
- the task is appropriate for that patient / client and if you have any concerns or queries (for example the task has already been done) then inform the person of your information or concerns.

Legal Liability and Duty

All organisations have what is called vicarious liability. Vicarious liability applies to all employees employed in the organisation. The organisation is responsible for protecting patient and client safety and employers will be liable for any negligence or battery committed by an employee so long as the employee was acting within the domain of employment. The organisation has a duty to ensure that all staff are competent to perform the roles for which they are employed

Chris Mullen - Project Director
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Florence Nightingale School of Nursing & Midwifery
at King's College London
Waterloo Bridge Wing
Waterloo Campus
150 Stamford Street
London SE1 9NH

Tel 020 7848 3605
Email jane.sandall@kcl.ac.uk

www.kcl.ac.uk/nursing