Maternity support workers
Enhancing the work of the maternity team

National large scale workforce change
Foreword

During 2005, NHS Employers’ large scale workforce change team was commissioned by the Children and Families Programme Care Services Improvement Partnership (CSIP) to run a national workforce change programme to develop and spread new roles and new ways of working in maternity services, in support of the National Service Framework (NSF) for children, young people and maternity services standard 11. Key elements of the NSF need to be achieved by 2009, emphasising the determination to improve maternity services and provide choice for women antenatally, during birth and labour and postnatally.

This work is also an integral part of the Six Point Plan for Midwifery Recruitment, Retention and Return. This change programme was designed to support speedier implementation and spread of maternity support worker roles that would reduce maternity team time spent on non-clinical tasks, improve the working lives of maternity teams and bring measurable benefits to mothers and their babies.

This report illustrates ways in which the support worker role is helping the maternity workforce provide the improved access, quality and flexibility of care needed to deliver choice by increasing the capacity of the maternity team. Trusts will also be better positioned to meet the markers of good practice outlined in the maternity NSF standard 11, and support compliance with the European Working Time Directive (EWTD).

This programme engaged 57 NHS trusts across 26 strategic health authorities and, building on existing models of good practice, applied adopt and adapt principles to role redesign to spread good ideas and new ways of working across the NHS.

In this report you will find an outline of the methodology used, examples of change ideas from the participating teams and an overview of the impact of the changes on service users and on staff, and measures of the productivity and benefits realisation.

We hope you will find some interesting and useful ideas that you can use to assist you in bringing about some of the key improvements you want to achieve within your local maternity services.

Steve Barnett,
Director,
NHS Employers

Richard Humphries,
Chief Executive,
Care Services Improvement Partnership

Hilary Samson-Barry,
Head of Child Health and Maternity Branch,
Department of Health
Section 1

Background and aims
The Changing Workforce Programme (CWP), NHS Modernisation Agency and subsequently the Change for Children Care Services Improvement Partnership (CSIP) commissioned this piece of work in 2005. The large scale workforce change (LSWC) team, part of NHS Employers, delivered the programme.

The aim of the programme was to spread the maternity support worker roles to facilitate implementation of standard 11 of the National Service Framework (NSF) for children, young people and maternity services\(^1\) and the white paper *Every child matters*\(^2\). Also, the project links closely with the National Six Point Action Plan for Midwifery Retention and Recruitment, the plan funded by the Department of Health’s workforce directorate. It has a strong focus on developing and supporting the midwifery workforce to meet increasing demands, while also improving the working lives of practising midwives. Bedfordshire and Hertfordshire Strategic Health Authority/Workforce Development Directorate have hosted this project and have lead responsibility for co-ordinating and progressing the action plan.

The role of the maternity support worker, integrated into antenatal and postnatal teams, in hospital and community settings is discussed in the recently published NSF for children, young people and maternity services. It is recognised that without the support function, the maternity team can spend a proportion of their valuable time attending to tasks that could be delegated to an appropriately trained and supervised support worker, such as clerical and other duties\(^3\). When developing new roles, the LSWC team places great emphasis on safety while striving to secure improvements in quality and continuity of care. The Royal College of Midwives (RCM) suggests the need to re-conceptualise this role from ‘an extra pair of hands’ to an integral member of the health and social care team\(^4\). The RCM is included on the national reference panel for this project alongside other key stakeholders (see appendix v).

A recent survey, looking at the challenges that lie ahead across maternity and children’s services set out to identify sustainable models of maternity care that could help trusts achieve compliance with the European Working Time Directive (EWTD)\(^5\). The report outlines the part that the maternity support worker role could play in future workforce development initiatives to meet the requirements of the EWTD by 2009. The models discussed within this document could be applied to all sizes of maternity units within the UK.
Aims of the maternity support worker programme

1. To develop and implement maternity support worker (MSW) roles as an integrated part of the team in the ante and postnatal periods across hospital midwifery and community care settings
2. To reduce midwifery time spent on non-clinical tasks
3. To address the retention and recruitment issues of midwives and other related staff
4. To assist in the development of a career/education framework for MSWs in the context of the maternity team
5. To improve the working lives of staff delivering maternity services
6. To support compliance with EWTD.

References

1. National Service Framework for children, young people and maternity services DH, DfES (September 2004)
2. Every child matters: change for children, DfES(November 2004)
How to use this report

The report provides examples of maternity support worker roles that have been developed at each site. These examples are provided in note form, illustrating the local context, specific work setting and highlighting some of the improvements being secured. It outlines the framework used by participating teams to design the roles and implement new ways of working, which deliver measurable evidence of benefit for service users, staff and their organisations.

It is important to note that this work builds on the models of maternity support workers that were already operational in several maternity units. The LSWC team has used some of the best as models. The programme has benefited from the willingness of those heads of midwifery and their services to share their knowledge and experiences so that teams participating in this programme could adopt or adapt some of these existing roles to meet their local needs. There are also some newer roles.

The knowledge and experience gained from this programme will provide focus for those yet to start their improvement journey, and some maternity services will undoubtedly further develop some of the new ways of working discussed here.

While all maternity teams share a need to respond appropriately to national policy drivers such as the NSF, the choice agenda and the EWTD, the participating sites demonstrated a variety of starting points in terms of population profile, local labour market issues, and in terms of the needs specific to their local populations.

The examples from the sites demonstrate how the maternity support worker is affording maternity teams the flexibility to address service problems and deliver improvements in maternity care, that are sensitive to the particular needs of local populations.

The traffic light system will make it easy to identify the operational status of the roles at each site. Some sites have classified their status as ‘pilot’ to enable them to maintain engagement with the programme during local reconfigurations or where competing service pressures interfered with progress. Due to similar local circumstances a small number of sites were unable to complete reporting within the programme timeline, but they continue their implementation plans.

Contact details of the project leads at each site are provided. You can find fuller details about how the sites managed and sequenced their activities by accessing the completed case study templates which are available at www.nhsemployers.org/kb/index.cfm/tab/1
Section 2
Programme design and implementation
In March 2005, all strategic health authorities (SHAs) were invited to submit expressions of interest from trusts wishing to participate in this ten-month programme. Fifty-seven maternity teams were selected to take this piece of work forward; all but two SHAs were represented. A scoping exercise had identified successful MSW roles that already existed. The LSWC team approach built on the strengths of these models already in operation to enable a safe and speedy spread programme across England.

Who was involved at each trust?

Chief executives at each trust and SHA modernisation leads signed a memorandum of agreement committing their support to their local maternity teams in delivering the aims of the project; this high-level backing is seen as an essential and integral part of the programme design.

It was important that the initial team comprised senior people from each organisation: support from human resources, education and finance were essential. Each project team nominated a lead – an individual with clinical expertise and credibility among peers who could also work with board-level colleagues. The role of the team leads was ‘to make things happen’.

It was very clear that for the most part these leads felt empowered, and were driving the initiative forward within their units. Having such leaders for change in place is a key pre-requisite for trusts to deliver on the choice agenda. As the teams drew up their detailed action plans, representation from operational staff increased: these knowledgeable individuals were key to the successful design and implementation of the new ways of working.

LSWC team training and support framework

Staff delivering healthcare are equipped with high levels of skills appropriate to their area of work. Skills to improve their services are often low or absent. The LSWC team methodology supports all participants in applying the most appropriate modernisation tools and techniques to secure measurable improvements against local and national priority areas. Details of the techniques applied are covered in a set of freely available Improvement Leader Guides produced by the NHS Modernisation Agency.
Their bespoke packages ensure trust teams are more favourably positioned to deliver against the key national priority areas for the NHS and partners. The LSWC team builds participants’ understanding of current policy drivers and balances this against the particular targets their organisations need to deliver locally.

As in previous ten-month programmes, participating trust teams designed a new way of working, developed education and training plans and the governance frameworks needed to safely implement the new processes. The emphasis was on rapid, widespread and safe implementation of efficient and sustainable new ways of working.

The programme followed distinct phases. There were set times when all teams came together for two major learning and sharing workshops. Two periods were scheduled for trust teams to work within their host organisations to develop and strengthen the support framework in readiness for smooth implementation of the role and the introduction of new ways of working.

**Reporting formats**

These were designed to enable the LSWC team to monitor progress without adding unnecessary additional demands on clinical teams, who were fully engaged in service delivery. Finally, the LSWC team leaves all teams involved in their programmes with a legacy of basic improvement skills to help those who wish to continue making further changes to enhance their local services.

**Participating teams followed the same structured general approach:**

**Improvement skills development workshop (ISDW)**

All the LSWC team’s spread programmes start with the gathering of up to 60 teams from NHS trusts and 250 to 300 service staff including HR, education, and senior managers. The training package itself starts during the first two or three days as each programme is launched.

The MSW programme was launched with project leads from all participating trusts attending this three-day improvement skills development workshop. They learned or refreshed existing knowledge on the standard modernisation techniques that can be used to develop new ways of working. These included problem analysis, how to redesign a role, process mapping of the patient journey and how to conduct small test cycles on their change ideas to ensure they would deliver improvements. The project leads also learned how they could measure the results of the changes they wanted to make; changes designed to show impact against the key programme objectives and provide evidence that their activities were delivering improvements for service users’ staff and their organisations.
Preparation and diagnostic days

These were held regionally and enabled site leads to convene their full project teams and, with dedicated input from LSWC team facilitators, they focused more sharply on their identified problem areas and were helped to produce more detailed and deliverable action plans.

Identifying the local problem(s) and generating solutions

Defining the local problems was key to creating support worker roles that delivered the improvements required by maternity teams at the local level. Using modernisation tools and techniques, the teams accurately identified points in their respective patient experiences where changes could secure greatest improvements to patient care. Gaining a clear understanding of the problems meant effort was not wasted developing solutions to symptoms rather than root causes of problems. Teams could then focus their energy on those problem areas that would yield the most significant benefits.

Designing the new role or new way of working

With clear understanding of the care processes they wanted to improve, teams undertook analysis of midwives’ daily activities to identify and agree duties which could be safely delegated to their support worker. Data showed which duties could yield the greatest improvements for women, babies and staff. These duties were ranked in order of the potential impact they would deliver. This helped teams understand how to sequence their training plans and what skills were most necessary for the local role to have maximum effectiveness.

Engaging service users

Service user involvement is fundamental to modernisation activities and is reflected in values underpinning the national patient and public involvement strategy and is central to the new patient-led NHS. Details of how maternity service users were involved by each site can be found in their full case studies. These are available at www.nhsemployers.org

Conducting small tests of change

Improvement activity often works best using small ‘tests of change’, which can demonstrate positive impact, sometimes in a matter of days. Using some standard techniques, teams targeted their new role to secure improvement at specific points in their local maternity care pathway. As part of the programme, teams learned how to conduct these small tests without disrupting scheduled service delivery. The quality of care to service users was never compromised, but often improved.
Maternity teams were able to agree which functions could be safely undertaken by the maternity support worker and so make best use of the talents already available within their respective teams. As a result, a number of new support worker roles were created; roles designed to improve efficiency and effectiveness and improve the experience of women and their families. These new maternity roles are viewed as better for service users, better for staff and better for the service.

**Governance**

Patient safety is paramount. All teams were advised to review their existing local protocols and guidelines to ensure the support worker activities were held within a firm governance framework. It was also essential that there was clear communication and understanding at each trust about the remit and boundaries of this support role. Site leads were advised to ensure workforce, trust boards and service users were kept fully appraised of local developments. The fuller individual case studies will provide more detailed information about how the sites attended to this.

**Measuring the improvements**

With all improvement activity, baseline measurements must be taken before any changes are implemented. This is important because the effect of change needs to be assessed. Not all changes yield improvements and if baseline measures are taken, these subsequent variations can be identified quickly. Conversely it identifies the really positive and powerful changes early on in the process and can allow teams to build on that success. A range of additional measures was provided to cover issues of quality, efficiency and waste. Several sites also chose to measure some of these as contributory indicators of improvement (see appendix vii). All teams were asked to report against a minimum of two core measures: the number of maternity support worker roles implemented and percentage of midwifery time released per week by the support worker role. The whole project was predicated on the teams’ ability to release midwifery time from duties that midwives themselves felt were inappropriately diverting their skills away from direct care of women and babies. Teams were then asked to show how they would utilise the released midwifery time, to deliver the desired benefits for service users and staff. During the programme, teams also learned how the collection of simple and informative data could enable them to articulate their business cases and present them in a format that major stakeholders appreciate.
Tracking the changes

As part of the LSWC team approach, a small number of the sites involved in the maternity support worker programme will be invited to continue collecting evidence about the impact of the role they have implemented. This will provide some additional understanding of how the new way of working continues to develop. This information can then be used by all maternity teams to improve on how they choose to design and implement any further support worker roles.

Web-based discussion forum

The LSWC team sets up and manages a web-based, virtual discussion forum for each of its programmes. These ‘smartgroups’ help participating teams share and request information so that they can more speedily progress the design and implementation plans for their new way of working.

Popular contributions include locally devised job descriptions, protocols and training details which teams were then able to choose to adapt for their own use. This openness allowed variations in approach to be freely debated. The LSWC team also ensured major policy documents and guidelines were readily available for viewing. This site – www.smartgroups.com – will remain open for continued use over the next 12 months and will be a ready resource for any future workforce maternity projects.

External evaluation

An external evaluation of the programme commissioned by CSIP’s research directorate, is in progress and will report its findings in late spring 2006. The outcome will be openly available and the learning from this exercise will be shared to compliment the focus and detail of this LSWC team progress report.
Section 3

Results and benefits
Results

This section outlines details of the coverage achieved across England during the ten-month spread programme designed and managed by the LSWC team. There is a breakdown of the training levels and work settings of the support worker posts being implemented.

Maternity support worker posts being implemented: 218 whole-time equivalent (WTE)
Spread: 26 SHAs
55 NHS trusts

This table shows the operational status of 218 WTE maternity support worker posts being implemented across 55 NHS trusts (England)

<table>
<thead>
<tr>
<th>Total WTE maternity support worker posts</th>
<th>218</th>
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<tbody>
<tr>
<td>Operational</td>
<td>162</td>
</tr>
<tr>
<td>Ready to ‘go live’</td>
<td>46</td>
</tr>
<tr>
<td>Pilot</td>
<td>10</td>
</tr>
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</table>

There are two outstanding trusts where work is reported as stalled or delayed. In one organisation this has been caused by local service reconfiguration and, in the other, the delay is compounded by a recent decision to adopt a sector-wide approach to the development of this role.

Where posts are categorised as ready to ‘go live’, trust teams are ready to implement the roles as funding is secured or released in the new financial year.

Some trusts preferred to adopt ‘pilot’ status as part of the local approach to change management.
When maternity teams discussed or reported on matters related to training, they universally understood the categories of National Vocational Qualification (NVQ) levels. For this reason, the training level of the roles is represented in these terms.

Where trusts report functioning between L2 and L3, this means that they have either a number of part-time support workers who are being trained to work at level 2 and level 3 or level 2 workers training towards level 3.

*There are four assistant practitioner posts which sit at level 4 on the Career Framework for Health.

Where NHS trusts are deploying their maternity support workers

Note: Many organisations are implementing the support roles in several work settings.
Benefits

How do these results improve the service and benefit women, staff and organisations?

A core objective in introducing appropriately trained support workers into maternity teams was to release highly skilled midwifery time from duties such as administration, clerical and where agreed appropriate, from some indirect care activities. This released midwifery capacity was then to be used to help secure the improvements wanted at the local level.

All participating sites were asked to measure the percentage of midwifery time released per week with the support worker in place. The following sets of examples were chosen to illustrate the benefits achieved in acute and community settings, to demonstrate how this translated into quantitative benefits for service users, staff and organisations and finally to share some qualitative feedback from both service users and staff.

Examples of midwifery time released

Community

**Countess of Chester District General Hospital:** When the MSW works as the second person at antenatal sessions, this saves eight hours (50 per cent) of the midwifery time previously spent on this activity per week.

**Wycombe and Stoke Mandeville Hospitals:** In a clinic where 12 patients are seen, the MSW releases one hour of midwifery time when she inputs the data and retrieves information from the computer. This is 33 per cent of midwifery time in each clinic session. (48 hours a week support provided by 1.29 WTE MSWs divided between two community teams).

**Kingston Hospital:** 0.6 WTE maternity support worker releases 25 hours (16 per cent) midwifery time per week, when working in a team of 4.2 WTE midwives.

**Mayday NHS Trust:** Three WTE MSWs support four community teams. 7.5 hours (9 per cent) of midwifery team time is being saved per day when one MSW works as part of a team.

Acute setting

**Salisbury NHS Trust:** The MSW independently runs glucose tolerance testing clinics releasing six hours midwifery time per week.

**Good Hope Hospital:** Antenatal day assessment unit. 25 hours (22 per cent) midwifery time released per week.

**Surrey and Sussex NHS Trust:** Almost 30 per cent less time being spent by midwives on clerical work and computing.

**United Bristol Healthcare NHS Trust:** 12 per cent of midwifery time released on postnatal ward shift when one MSW supports three midwives.
Examples of how benefits are being delivered

United Bristol Healthcare NHS Trust
12 per cent midwifery time released on postnatal wards redirected to high-risk women, supporting women in making appropriate choices in pregnancy and birth, improving one-to-one care in labour including induction of labour, training for extended roles such as neonatal examination.

The Whittington Hospitals NHS Trust – postnatal ward and community
2.5 WTE MSWs received UNICEF Baby Friendly initiative training; they subsequently trained eight breastfeeding peer supporters.

Birmingham Women’s Hospital – community scanning clinic
One WTE MSW working alongside the midwife at scanning clinic releases: five per cent = one midwifery day per team of 3.6 WTE midwives. Released time enables community midwives to undertake community visits, attend safeguarding children meetings and update professionally.

Barnet and Chase Farm Hospitals NHS Trust – antenatal clinic
When the MSW assists at antenatal clinic, women receiving breastfeeding information increased from 28 per cent to 100 per cent.

Walsall NHS Trust – two community teams
Midwives no longer need to exceed their contractual hours and feel less stressed.

Portsmouth District General – community teams
Analysis of activities undertaken by MSWs showed that women received 145 hours additional breastfeeding support from five MSWs during October and November 2005.
Women’s views

‘The maternity support worker helped me get over the problems I was having with breastfeeding my baby and certainly this encouraged me to continue breast feeding’

Salisbury NHS Trust

‘I had not planned to breastfeed but the midwife in recovery gave me information that made me want to try. With help of the MSW I am breastfeeding now’

Bedford Hospitals NHS Trust

‘She was one of the most helpful carers that I had. She was supportive, knowledgeable and encouraging’

Queen Elizabeth Hospital – Woolwich

‘It is so nice to have the support when you need it, especially when you are unable to move well because you are sore’

Mayday NHS Trust

‘I was told what I need to know and more’

Barnet and Chase Farm Hospitals NHS Trust

‘I have been able to breastfeed successfully this time as I had much better support and the midwife spent more time with me.’

The Royal Wolverhampton Hospital NHS Trust

‘My baby needed to be fed every three hours and it was helpful to have the same person performing the blood sugar tests all the time and helping me to deal with looking after such a small baby’

Women’s Health Unit, Mid Cheshire Hospitals NHS Trust

Maternity team views

Improved quality of care

‘Following caesarean section, women are cared for in a calm and safe way, one midwife can now supervise the care of a number of women with the help of the maternity support worker.’ (Midwife)

‘It meant that the mother could get a visit at a time when the baby was due to feed, rather than when I could make it.’ (Midwife)

‘Clinics flow well now, with no time delays, which is nice for the women.’ (Midwife)

‘Fewer clients get irritated because they are seen so quickly especially at discharge.’ (MSW)

‘I never realised the scope of midwives’ role.’ (MSW)

Improved IWL indicators

‘I had my doubts, but have been proven wrong; time saved at antenatal clinic meant I got home on time.’ (Midwife)

‘If I go to a clinic I have never been to before to cover a colleague, the MSW knows the computer system and how the clinic is set up and so I am more efficient.’ (Midwife)

Retention and recruitment

‘Having the MSW has been a fantastic help. I was able to spend more time with the women who really needed my support. I look forward to helping develop this role further.’ (Midwife)

‘I’m really enjoying the community clinics, my skills can be used positively there.’ (MSW)

‘I now feel I am a useful member of the team.’ (MSW)
A legacy of improvement skills

In addition to the benefits described so far, this programme aimed to leave members of local project teams with a more personal legacy in terms of improvement skills. At the second national learning workshop all attendees were asked to complete a simple questionnaire. These are the results:

<table>
<thead>
<tr>
<th>Participants rated their confidence against the following areas:</th>
<th>Very</th>
<th>Quite</th>
</tr>
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<tbody>
<tr>
<td>in their ability to communicate the benefits of the MSW programme across their organisation</td>
<td>50%</td>
<td>49%</td>
</tr>
<tr>
<td>that their involvement in the programme has enhanced their personal development and effectiveness</td>
<td>44%</td>
<td>55%</td>
</tr>
<tr>
<td>that the experience and learning will be an asset to them in their future work</td>
<td>67%</td>
<td>32%</td>
</tr>
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<table>
<thead>
<tr>
<th>Participants rated their new understanding of role redesign and implementation*:</th>
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<tbody>
<tr>
<td>62%</td>
<td>well enough to analyse service problems themselves</td>
</tr>
<tr>
<td>35%</td>
<td>well enough to teach how to analyse service problems</td>
</tr>
<tr>
<td>61%</td>
<td>well enough to take steps in redesigning roles themselves</td>
</tr>
<tr>
<td>35%</td>
<td>well enough to teach how to take steps in redesigning roles</td>
</tr>
<tr>
<td>53%</td>
<td>well enough to deal with blocks and challenges</td>
</tr>
<tr>
<td>43%</td>
<td>well enough to teach how to deal with blocks and challenges</td>
</tr>
<tr>
<td>48%</td>
<td>well enough to know how and where to obtain baseline data</td>
</tr>
<tr>
<td>49%</td>
<td>well enough to teach how and where to obtain baseline data</td>
</tr>
<tr>
<td>47%</td>
<td>well enough to measure the impact of new or amended roles or new ways of working</td>
</tr>
<tr>
<td>51%</td>
<td>well enough to teach the impact of new or amended roles or new ways of working</td>
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</tbody>
</table>

*Participants could select more than one category
Maternity support worker roles being implemented

Leads at each trust were asked to supply a brief description of the MSW role being implemented and to provide some key information about the nature of their local population, their service priorities and any pertinent workforce issues. This information should help colleagues looking at maternity workforce issues, identify profiles and roles which most closely match their own situation. Much more detail can be found in the full case studies available at www.nhsemployers.org/kb/index.cfm/tab/1 or by contacting the trust directly. Where views of staff and service users are available, examples have been included. Trusts are listed according to SHA.

- **Operational:** Worker in post, part time or full time. This staff member could be newly recruited or a health support worker being ‘upskilled’ from the existing support staff establishment.
- **Ready to ‘go live’ early 2006:** The preparatory work has been undertaken at these sites. The work setting, job description and training needs have been identified in readiness for the recruitment process. Many in this category await decisions on or release of funding in the new financial year.
- **Stalled/delayed:** Towards the end of the ten-month programme, progress at several trusts was being affected by local service reconfigurations. Two trust teams were unable to progress their work through to implementation in the agreed timescale.
- **Pilot:** This status was adopted by some trusts as part of their general approach to the change management process, while for others it allowed them to remain engaged with the programme during local service reconfigurations.

We also provide in appendix iv one example of the fuller case study produced by each of the participating teams. The full case studies contain a wealth of valuable information about the actions and decisions that helped teams successfully implement their new way of working. All case studies can be found on the website where each site gives details about their starting points, in terms of local improvements that were sought. The accounts provide insight into how the teams brought about the changes they wanted and further examples of the benefits delivered for service users and the team. Project leads also report on how their new ways of working are addressing the objectives of the programme as a whole. Where teams have submitted copies of their local job description and protocols these are also available at www.nhsemployers.org/kb/index.cfm/tab/1
Salisbury NHS Trust
A district general hospital delivering care in a semi-rural area, pockets of deprivation. Birth rate 2,000 per year. Transient population, high numbers of army families.

Work area
Generic role acute and community
7 WTE 12 posts
Level 2 and 3

Improvements sought and delivered
• reduced discharge waits
• improved immediate post birth care
• improved breast feeding support
• midwifery time released redirected to one-to-one care in labour, public health and high-risk women.

What the MSW does
• support postoperative women (including management of intravenous infusions) and low-risk postnatal mothers and babies
• clerical role to aid timely discharge from postnatal ward
• support women in early labour under guidance of midwife
• independently run glucose tolerance testing clinics. Releases six hours midwifery time per week
• community: attached to a specific group practice. Releases eight hours time per midwife, per week
• NICU – breastfeeding support, clinical observations of babies, heel prick for blood samples and Guthrie tests.

Impact
• discharge waits reduced by 50 per cent to average four hours
• midwifery time released eight per cent.

User views
‘The maternity support worker helped me get over the problems I was having with breastfeeding my baby and certainly this encouraged me to continue breastfeeding.’

Staff views
‘I don’t know how we managed to run the postnatal ward without the clerical support.’

Lead contact
shirley.kinsey@salisbury.nhs.uk
Tel: 01722 425 189

United Bristol Healthcare NHS Trust
Inner city maternity unit with a diverse ethnic population (25 per cent). Areas of extreme deprivation, many vulnerable groups and rising teenage pregnancy rates. As a regional referral unit for maternal and foetal health, case mix complexity means increased volume of work within the unit. Shortage of midwives. Birth rate 4,800 per year.

Work area
Postnatal wards
Level 2
WTE 13.6

Improvements delivered for women and maternity team
• improved user satisfaction by reducing discharge delays
• more support and advice for parents, particularly breastfeeding
• more staff available to offer basic care and support to low-risk mothers and babies.

What the MSW does
• postnatal wards: basic care to low-risk mothers and babies
• administration duties including low-risk maternal and baby discharge, advice on cot death, sterilisation of equipment
• at community antenatal clinics: clerical duties and signposting to other agencies
• support visits for vulnerable women, antenatally and postnatally
• breastfeeding support
• accompanying teenage parents to contraceptive clinics to help reduce second pregnancies.

Impact
• 12 per cent midwifery time released on postnatal wards
• time redirected to high-risk women, supporting women in making appropriate choices in pregnancy and birth, improving one-to-one care in labour including induction of labour.

Staff views
‘It should make a huge difference to the care offered to new mums and babies.’

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Watford General Hospital

Maternity unit with a 12-bed delivery suite, two obstetric theatres and a two-bed obstetric HDU, a 29-bed postnatal ward, a 14-bed antenatal ward, a seven-bed integrated midwife-led birthing unit, a combined triage/foetal day assessment unit and a stand-alone midwifery-led birthing unit at Hemel Hempstead General Hospital. The catchment area is extensive. Birth rate: 5,500 per year.

Work area
29 bedded post natal ward
Level 3
8 WTE

What the MSW will do
• release midwifery time from data input, clerical duties, non-clinical telephone enquiries, co-ordinating routine discharges
• increase direct patient contact, thus identifying and addressing issues that arise on the ward.

Impact (predicted)
• released midwifery time: predict at least two hours a day (working a 12-hour shift) for each midwife.

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Tel: 01923 217 377

Bedford Hospitals NHS Trust

Provides a community midwifery service to a rural and urban, culturally mixed, community with small pockets of deprivation, increasing drug and alcohol issues, economic migrants and language issues. Eighty-six WTE midwives with no vacancies. Birth rate 2,876 per year.

Work area
Attached to community teams of 4–6 midwives
Level 2 and 3
2.6 WTE (four posts)

What the MSW does
• clerical role to aid timely discharge
• support women in early labour under guidance of midwife
• independently run glucose tolerance testing clinics. Releases six hours midwifery time per week
• community: attached to a specific group practice, assist in antenatal clinics, low-risk home visits, support visits for vulnerable women, parent craft and breastfeeding. Releases eight hours time per midwife, per week.

Impact
• eight per cent midwifery time released = ten working days
• one to two days redirected to acute intrapartum care, delivery suite and one-to-one care in labour.

User views
‘The maternity support worker helped me get over the problems I was having with breastfeeding my baby and this encouraged me to continue breastfeeding.’

Staff views
‘The MSWs are great but they are not on duty every day. When can we appoint some more?’

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Sandwell Primary Care Trust

This community-based project is within the deprived Borough of Sandwell, population 282,904 (2001 Census), of whom one in five are of minority ethnic origin. Income is ninth lowest in England and Wales with unemployment at five per cent. Life expectancy is in the lowest 20 per cent in the country and infant mortality is higher than national comparators.

Work area
Community/Sure Start
Not yet operational
Level tbc
WTE (tbc)

Improvements sought for women and the maternity team
• support for vulnerable women
• improved recruitment and retention through improved working lives of midwives
• improved capacity to deliver service
• recruiting to the support role from the local labour market (with a vision of a career in maternity services) this already occurs within one Sure Start Programme
• plans are underway to link the standardisation of the basic role to the development of the health trainer role.

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The Royal Wolverhampton Hospital NHS Trust

The maternity unit serves a multi-ethnic population with high levels of deprivation, pre-war and high-rise homes. There are eight Sure Start areas with high rates of unemployment, teenage pregnancy, smoking, low-birth weight babies and low breastfeeding rates. Birth rate 3,500 per year.

Work area
Post natal wards and community (Pilot) Operational role delayed
3.8 WTE (four posts)
Level 2 and 3

Improvements delivered for women and the maternity team during pilot
• breastfeeding rates improving from 53.6 per cent in April to 60.8 per cent in September 2005
• numbers abandoning breastfeeding at eight weeks is falling
• mothers happier with the service
• midwives able to spend more time with mothers.

What the MSW does
• supports women in their chosen method of feeding in hospital and their home
• supports breastfeeding promotion events locally
• supports the community midwifery team at home confinements
• ward duties in the maternity unit
• supports at parent craft classes and breastfeeding support groups in Sure Start villages.

Impact of pilot
• 20 per cent midwifery time released across two teams of midwives on two postnatal wards
• maternity services able to provide specialists for teenage pregnancy and bereavement
• it is anticipated that if all roles are recruited to, additional midwifery posts may also be filled
• no further complaints about feeding support during the trial.

User views
‘I have been able to breastfeed successfully this time as I had much better support and the midwife spent more time with me.’

Staff views
‘I always knew that the support worker role would return as they were such a valuable resource and now it’s proven how brilliantly they work.’

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Birmingham Women’s Hospital

A tertiary unit delivering 6,700 babies. Provides maternity services to South Birmingham and surrounding areas. West Midlands has the highest perinatal mortality rate. A growing black and minority ethnic community has diverse needs. Birmingham Women’s Hospital is working with the primary care trusts and the West Midlands Perinatal Institute to implement the NSF and the Reducing Perinatal Mortality project. Early access, before the 12th week of pregnancy is a key target for reducing perinatal mortality. Midwife-led community clinics, some with midwifery-led scanning service, provide women the choice of an early scan.

Work area
Community scanning clinic
Level 2
1 WTE

Improvements delivered for women and maternity team
• improved access to community scanning clinics for pregnant women
• developing maternity support workers skills to work alongside the scanning midwife, releasing midwifery hours
• release of midwifery hours will enable the midwives to spend time with women in the community especially those with special needs.

What the MSW does
• meet and greet
• phlebotomy
• blood pressure
• BMI
• testing urine
• appointments.

Impact
Midwifery time released:
• five per cent = one midwifery day per team of 3.6 midwives
• released time enables community midwives to undertake community visits, attend safeguarding children meetings and update professionally.

User views
‘Enough time to discuss issues and concerns with midwife, less waiting times in community, less travelling time.’

Staff views
‘This is great. It means that midwives can be doing things that we have been trained to do.’ (Midwife)

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Good Hope Hospital

Provides a full range of maternity services. There is some deprivation with significant areas of high perinatal mortality of 11.8 per 1,000. Stable workforce with few recruitment and retention issues. Birth rate 3,200 per year and home birth rate two per cent.

Work area
Antenatal day assessment unit: 1 WTE at Level 2 and 0.80 WTE at Level 3
Postnatal wards, delivery suite: 12 WTE at Level 3
Community teams: 0.64 WTE at Level 3

Improvements delivered for women and maternity team
• reduction in waiting times in antenatal clinic and antenatal day unit
• reduction in complaints regarding antenatal clinic waiting times and lack of breastfeeding support
• midwifery staffing costs saved in antenatal clinic redirected to ward areas, reducing bank/agency usage.

What the MSW does
• hotel and clerical duties, including information management
• limited clinical duties
• support post-operative women and low-risk postnatal mothers and babies
• glucose tolerance testing clinics under supervision of a midwife
• community: attached to a specific group practice, breastfeeding, smoking cessation support and parent craft. Assisting in antenatal clinics.

Impact
• 22 per cent midwifery time released = 25 hours midwifery time released per week (antenatal and day assessment unit)

• time redirected to high-risk areas, delivery suite, postnatal wards, targeted antenatal surveillance to reduce perinatal mortality.

User views
‘I am seen quicker in clinic since they changed the system.’

Staff views
‘My dual role gives me the best of both worlds, hospital and community working. I will be able to see the women all the way through from pregnancy to postnatal and have more job satisfaction.’ (MSW)

Lead contact
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Good Hope Hospital
Provides a full range of maternity services. There is some deprivation with significant areas of high perinatal mortality of 11.8 per 1,000. Stable workforce with few recruitment and retention issues. Birth rate 3,200 per year and home birth rate two per cent.
Walsall Hospitals NHS Trust

The acute work setting is a town with a multicultural and socially diverse population with high deprivation levels. High rates of teenage pregnancy, smoking, drug use, domestic violence, and asylum seekers and low breastfeeding rates. Birth rate 3,700 per year.

Work area
Two community midwifery teams covering a local improvement group project to improve maternity care and reduce perinatal mortality.

2 WTE
Level 2

Improvements delivered for women and maternity team
• women have increased dedicated time with midwife
• clinics are finishing on time and are reported to run more smoothly
• every woman’s urine is now tested at every attendance at clinic
• growth charts have been implemented.

What the maternity support worker does
• prepares antenatal clinics and packs
• takes bloods for screening
• supports parent education
• reduces lone working through attendance with midwives
• producing growth charts
• blood pressure and urinalysis
• future training for advising family units on breastfeeding, diet and smoking cessation.

Impact
• predicted 33 per cent released midwife time per clinic session per midwife
• midwives no longer need to exceed their contractual hours
• midwives feel less stressed.

Staff views
‘Will we be working with the maternity support workers?’ (future community midwives at interview)
‘Feel a valued member of the team.’

Lead contact
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Countess of Chester NHS Foundation Trust

District general hospital providing midwifery-led care and shared care across mixed rural, urban population, predominantly white middle class, affluent area with under three per cent ethnicity, and 6.2 per cent teenage pregnancy rate. No recruitment problems. Birth rate 3,200 per year.

Work area
Community-based geographical areas (obstetric theatre role under development)

0.6 WTE x 3
Level 3

Improvements delivered for women and maternity team
• improved access for vulnerable women
• increased access to breastfeeding support. Support groups on postnatal ward set up for breastfeeding support
• additional support at baby café and other breastfeeding support groups. Peer support training completed (La leche)
• more efficient use of team skills, support for midwives in antenatal clinics
• clerical support for midwives
• improved information given to women about health promotion.

What the maternity support worker does
• second person at aqua natal sessions
• breastfeeding advice and support
• releases midwife from a range of non-clinical tasks
• works with midwives to support vulnerable families on a one-to-one basis
• works with teenage pregnancy midwife on one-to-one basis with isolated teenagers.

Impact
• 25 per cent midwifery time released, indirect and direct care
• eight hours midwifery time released from aqua natal sessions weekly
• two hours midwifery time released from evening parent education classes.

User views
‘Your support has changed my life.’
‘You kept me breastfeeding.’

Staff views
‘Would not want to be without them.’

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South Sefton PCT

The work setting is community linked to local Sure Start programmes and the developing children's centres. Focus is on key public health areas such as breastfeeding and smoking, working with and supporting vulnerable families. The post supports the delivery of the children's NSF, Delivering Choosing Health and Every Child Matters. Discussion with colleagues across services to identify gaps and need to develop a role that fits across health and local authority.

Work area
Community health visiting/midwifery teams
Level 3
1 WTE

Recruitment in progress and funding has been secured for first six months through Sure Start. Further funding may come through Neighbourhood Renewal Funds.

Improvements to be delivered for women and the maternity team
- reduce pressure on health professionals workload with vulnerable families
- improve attendance and compliance.

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Women's Health Unit, Mid Cheshire Hospitals NHS Trust

Ante/postnatal wards, in a 54-bed consultant unit. Semi-rural area with low deprivation indices. Birth rate is 3,000 per year. Staffing comprises 95.4 WTE midwives and 24.8 WTE healthcare assistants. Skill mix varies, averaging 3:1 on early shift, 1:1 on late and night shifts. No recruitment problems. Requests for home births usually granted.

Work area
Ante natal and postnatal wards
Level 3
1 WTE

Improvements delivered for women and maternity team
- more support for women in the postnatal period with feeding, bathing and parenting
- reduced complaints about support on postnatal ward
- staff can take meal breaks 85 per cent of the time
- extra hours worked reduced by 50 per cent within one month of implementation, reducing claims for extra pay.

What the maternity support worker does
- an additional member of the ward team, supporting postnatal women with breastfeeding, nappy changing, bath and bottle feed demonstrations
- assist mothers with the care of small babies.

Impact
- 25 per cent midwifery time released (average)
- Hours redirected to support antenatal women and early labourers on the ward.

User views
'The midwives are always so busy it was good to know there was someone else I could go to ask for help with breastfeeding my baby.'
'My baby needed to be fed every three hours and it was helpful to have the same person performing the blood sugar tests all the time and helping me'

Staff views
'It allows me to care for antenatal patients and those with complications.'

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**Liverpool Women’s Hospital NHS Foundation Trust**

A level three neonatal unit – tertiary referral with medical intensive care, caring for 800 babies per year, covering some deprived city areas, increasing numbers of asylum seekers, mothers using drugs, teenage pregnancies, child protection and domestic violence cases. The neonatal community midwifery team (two full-time midwives) supports mothers and vulnerable babies after discharge from NICU. Recruitment is difficult because of more attractive community posts.

**Work area**

Community neonatal midwifery team  
Level 2  
0.6 WTE x 2

**Improvements expected for women and maternity team**

- review visits by appointment, reducing current time lost on unplanned, no access visits, including unproductive time currently spent travelling
- earlier discharge for agreed categories of infant

**What the MSW will do**

- reduced LOS on NICU
- release of NICU cots for more complex cases
- improved breastfeeding rates in the community.
- home visits to low-risk babies and mothers
- breastfeeding support
- capillary blood samples, check weights
- nasogastric tube feeds at home
- clerical and administration work currently done by midwife.

**Impact (predicted)**

- 40 per cent midwifery time to be released
- time to be redirected to care planning and more complex cases.

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**North Cumbria Hospitals NHS Trust**

A rural setting covering 20,000 square miles, mixed population profile. Busy midwifery clinics, clerical duties and basic assessments diverting midwifery skills from patient care. Early discharges from birthing centre and delivery mean women need more home support. High demand for parent craft classes is difficult to meet. Shortage of applicants for support worker/HCA and social service care roles. It is important to develop a career escalator within health and social care to aid local recruitment and retention.

**Work area**

Community and birthing centre  
Level 4 assistant practitioner (AP)  
3 WTE Full time (undertaking two-year foundation degree in health and social care).

**Improvements delivered for women and the maternity team**

- 80 per cent success with breastfeeding – due to continued support at home
- reduced delays in antenatal clinics
- more parenting support, especially for vulnerable women.

**What the trainee AP does**

- taught how to do basic assessments such as blood pressure, urinalysis, venepuncture, retrieve investigation results
- built upon existing knowledge regarding breastfeeding support
- some parenting skills classes independently
- contributes to antenatal clinics releasing midwives time.

**Impact**

- on average 50 minutes midwifery time released per three hour clinic.

**User views**

‘Mothers are very grateful for the flexible service provided by the AP’s, less time wasted at antenatal clinics.’

**Staff views**

‘The trainee assistant practitioners are more confident and appreciate having underpinning knowledge; now not just performing tasks and they have a clearer appreciation of the importance of governance and a need for a defined scope of practice. They are committed to support the midwives to improve the overall quality of care for women and their babies.’

**Lead contact**

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North Cumbria Hospitals NHS Trust

Rural setting covering 20,000 square miles. Population profile includes affluence, pockets of urban deprivation, farming communities. Within Cumberland Infirmary a consultant/midwifery-led unit delivers approximately 1,600 women per year. Midwives and MSWs had highlighted factors that inhibited the provision of effective direct patient care. An audit undertaken on three key areas: housekeeping, clerical and clinical duties identified inappropriate use of both midwifery and MSW time, demonstrated the need for increased MSW presence on delivery suite and showed the opportunity for the introduction of a housekeeper to release midwives and MSW to provide more patient care.

**Work area**

**Acute setting**

**Housekeeper role**

**Improvements to be delivered for women and the maternity team**

- free up registered midwifery time
- free up maternity support workers time.

**Impact (predicted)**

- 12 hours of direct midwifery time could be saved if there was a change in skill mix on delivery suite
- introducing a housekeeper to the unit could help release 18 hours per day, of midwifery and MSW time
- this information will be considered in the current maternity services review.

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Taunton and Somerset NHS Trust

District general hospital covering a wide geographical area with some pockets of deprivation. SCBU is on site. Birth rate 3,000 per year.

**Work area**

**Acute setting, main maternity unit, concentrating initially on postnatal/antenatal ward and antenatal clinic.**

**15.2 WTE**

**Level 2**

**Improvements delivered for women and maternity team**

- support workers already in post now up-skilled
- increase in postnatal observations completed (post caesarean) from 50 per cent to 75 per cent
- static breastfeeding rates at transfer to community 69 per cent to 71.4 per cent
- improved morale and teamwork.

**What the MSW does**

- in antenatal clinic: works alongside the doctor, releasing midwifery hours
- chaperoning, phlebotomy, blood pressures
- on the postnatal/antenatal ward: will become an integral team member providing holistic care to women, feeding support, postnatal observations, applying TENS, removal of urine catheters and intravenous cannulae, mother and baby hygiene, parent education within the postnatal wards and some administration work
- enhanced training ensures understanding of observations and importance of reporting all results to midwifery staff.

**Impact (predicted)**

- 16 per cent midwifery time released = six hours in antenatal clinic
- time will be redirected to antenatal home visits and home births.

**User views**

‘The MSWs were available to listen to my problems. They had time to help me feed my baby.’

**Staff views**

‘Maternity support workers appear happier.’

**Lead contact**

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**Mid Essex Hospitals NHS Trust**

Serves a largely affluent urban, rural area with a 2.28 per cent minority ethnic population. Two PCTs commission within the area. Staff spread across a consultant unit, two birthing units (11 and 13 miles from the consultant unit) and the community. Shortage of midwives and extensive recruitment drives. Birth rate 3,725 per year. Home births supported.

**Work area**
Community and postnatal ward
Level 3

3 WTE predicted from existing funding. Initially this will be three MSWs before further roll-out

**Improvements expected for women and the maternity team**
- community pilot just finished, data being analysed
- one MSW worked alongside one team for four weeks
- any initial midwifery apprehension disappeared as they were able to finish their clinics on time.

**What the maternity support worker will do**
- an MSW will support each team
- community: assist at antenatal clinics, duties include blood pressures, urinalysis clerical
- postnatal visits include breastfeeding, show baths, baby checks
- postnatal ward: increase breastfeeding support.

**Impact**
- midwives not working over their daily hours
- quality of care enhanced as MSWs spending time in the home with breastfeeding problems
- the released midwifery time will be spent in providing more time with their women in labour and reducing the number of bank hours to cover the service.

**User views**
‘I had not planned to breastfeed but the midwife in recovery gave me information that made me want to try. With help of MSW I am breastfeeding now.’

**Staff views**
‘What a difference she made to a large clinic. We actually managed to finish on time.’

**Lead contact**
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**Southend Hospital NHS Trust**

Commuter belt seaside town, largely middle class with outlying rural areas. Women choose home birth, domino or delivery in consultant unit. Community service, four locality teams of six to nine midwives. Birth rate 3,500–4,000 per year.

**Work area**
Community
Level 3

1 WTE community (business case for six more 2006/07, followed by two posts on labour ward 2007/08 – all full time)

**Improvements to be delivered for women and maternity team**
- improve breastfeeding rates beyond the first four weeks of life
- increased 1:1 care in labour
- increased time for provision of parenting skills education.

**What the MSW does**
- bridges gap between HCAs and trained staff
- undertakes non clinical tasks delegated by midwife
- 1:1 coaching in the postnatal period and antenatal group sessions
- supports smoking cessation and breastfeeding women
- releases midwifery time for listening visits to women with mental health issues.

**Impact**
- 20 per cent midwifery time released = seven and a half hours per midwife
- time redirected to improve 1:1 care in labour and supporting vulnerable women.

**User views**
‘The service user within the project group felt women would feel more comfortable contacting a MSW than thinking they may be disturbing the midwife.’

**Staff views**
None yet available.

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Portsmouth NHS Trust

A large district general hospital covering a socially diverse population and wide geographical area. Portsmouth is a very densely populated city, 23rd on the indices of social deprivation, with high teenage pregnancy rates and a growing number of refugees and asylum seekers. Birth rate 5,300 per year. There are 282.3 WTE midwives and healthcare support workers; approximately 70/30 ratio and 12 community midwifery teams. Four maternity outreach workers (2.8 WTE) are funded by three local Sure Start programmes.

Work area
Community
Level 2 and 3
7.4 WTE

Improvements delivered for women and the maternity team
- enhances the quality, flexibility and amount of care given by the midwives
- MSWs will undergo health trainers training enabling expansion of outreach.

What the MSW does
- supports vulnerable hard-to-reach families at home giving health information and advice on parenting
- extra postnatal support and breastfeeding support groups
- parenting education, one to one or in groups
- assists at specialist and antenatal clinics.

Impact
- women received 145 hours extra breastfeeding support from five MSWs in October and November 2005.

User views
'The maternity support worker helped me get over the problems I was having breastfeeding my baby and certainly this encouraged me to continue breastfeeding.'

Staff views
'It's really going well. It's so nice to know that someone will be visiting who has the time to spend with women.'
(Midwife)

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Maidstone and Tunbridge Wells NHS Trust

Eight community teams (40 WTE) across catchment area. The home birth rate is currently 3.7 per cent. Mixed town and rural with two ‘hot spots’ of teenage pregnancy and social deprivation. Working with social services and education in the development of a new children's centre. Ten per cent of clients identified as ‘vulnerable’ requiring additional support and resources (mental health input, drug and alcohol dependency, child protection issues). Trust comprises two maternity units 14 miles apart, both delivering 2,500. Plan to open birthing centres in 2008.

Work area
Community
Level 2
2 WTE (three posts)

A pilot linked to two community teams in most deprived areas, running from 7 November 2005 to end April 2006. Plan to increase to eight if funding available by mid 2006.

Improvements expected for women and the maternity team
- reduction in number of different people involved in a care pathway
- more continuity of care given
- improved rates for initiation of breastfeeding and reduce drop off rate at six weeks

What the MSW does
- earlier booking – by one week
- introduction of teenage pregnancy education/contraception service.

What the MSW does
- the MSW will reduce the number of different people involved in a care pathway for example giving/supporting breastfeeding/undertaking support visits.

Impact (predicted)
- 20 per cent midwifery time released = five hours per week
- time redirected to vulnerable client groups.

User views
Survey underway.

Staff views
‘Having the MSW has been a fantastic help. I was able to spend more time with the women who really needed my support. I look forward to helping develop this role further.’
(Midwife)

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The Queen Elizabeth Hospital NHS Trust

District general hospital in King’s Lynn, covering large rural area and two significant areas of urban deprivation with an influx of asylum seekers. The area has been reported as having a high teenage pregnancy rate. Retention of staff is good however recruitment of midwives has become difficult. Birth rate 2,000 per year. Caesarean section rate 23–28 per cent.

Work area
Delivery suite and obstetric theatre
Level 3
2 WTE (several part time posts)

Improvements to be delivered for women and the maternity team
- more capacity to target groups with special needs
- improved skill mix and efficient use of team skills.

What the MSW does
- replaces the midwife in the scrub role in maternity theatre.

Impact
- 12 per cent midwifery time released per week
- released midwifery time redirected to caring for women in labour.

Staff views
‘I now feel I am a useful member of the team.’ (MSW)

Lead contact
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West Suffolk Hospitals NHS Trust

The maternity services have changed recently, responding to the changing needs and expectations of women and their families, government reports and increasing clinical activity. While women are now being offered improved and extended services, this has increased the pressure on midwives and other staff roles and responsibilities. Birth rate for 2004 was 2,536.

Work area
Community – in each integrated midwifery team
Level 3
9.0 WTE (proposed)

Improvements expected for women and the maternity team
- IWL: appropriately trained support workers will reduce pressure on midwives
- increased midwifery time for essential midwifery duties and support for vulnerable women.

What the maternity support worker will do
- clerical duties
- provide health promotion such as smoking cessation
- assist at antenatal clinics
- support breastfeeding women and those choosing to bottle-feed.

Impact (predicted)
- releasing 10–12 per cent of total midwifery time = 10–12 days per month
- time redirected to continue to implement recommendations from the NSF standard 11.

Staff views
‘It will make such a difference to the amount of support we can provide to vulnerable women.’

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York Hospitals NHS Trust

Acute trust serving a mixed socio-economic, rural and urban population over a large geographical area. There is minimal ethnic diversity but an increasing population from eastern Europe. Integrated maternity services provide for 3,000 births per year. Midwifery establishment is 91 WTE with no vacancies. The home birth rate is two per cent. The caesarean section rate of 27 per cent impacts on all areas, especially the postnatal wards.

Work area
Postnatal ward role
Level 2 and 3
WTE (tbc)

Improvements expected for women and the maternity team

- release midwifery time for direct care
- improve breastfeeding and infant feeding support
- support the development of parenting skills while in hospital
- reduce length of stay and support earlier discharge to community
- improve and enhance the clinical care provided to women and their babies
- develop and enhance the role of the support worker.

What the MSW will do

- support women and staff on the postnatal wards.

Impact (predicted)

- a small test cycle indicates that 350 hours of midwifery time per year, could be released if the maternity support worker undertook the single task of ‘topping and tailing’ babies whose mothers were compromised after caesarean section.

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North Middlesex University Hospital NHS Trust

Serves a diverse population. There is high socio-economic deprivation, language barriers, increased numbers of HIV/Aids and teenage pregnancy. The total number of referrals to maternity is around 3,500. The majority of antenatal and postnatal care is provided in the community setting. Birth rate 3,300 per year.

Work area
Community geographically based team of six midwives
Level 2 and 3
1 WTE (one post)

Improvements delivered for women and maternity team:

- improved job satisfaction
- more time available to mentor students
- seen on time
- more contact time
- finish work on time.

What the MSW does

- recording workload
- phone calls
- replying to queries
- form filling
- makes changes appointments
- DNA follow-up
- maternity database IT
- filing
- support mothers and babies.

Staff views

‘Enjoying working in the community and would like to continue. Colleagues friendly and supportive, I feel useful to the team.’ (MSW)

‘Clinic was a joy. MSW had prepared the equipment required and obtained blood results for each client prior to clinic. I was able to listen to the women and enjoy my time with them. I had time to practice midwifery.’ (Midwife)

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University College London Hospitals Foundation Trust

Wide cultural and ethnic population mix, with some pockets of deprivation. Birth rate 3,200 per year.

Work area
Generic role. Maternity unit and community. Level 2
17.4 WTE Six within community group practices (in post as programme started). Remainder rolled out within the maternity unit.

Improvements delivered for women and the maternity team
• community MSW role releasing 60 minutes per antenatal clinic in preparation and support
• role in birthing centre releases 30–35 per cent time from non-midwifery tasks
• 100 per cent MSW trainees planned to attend breastfeeding training – two already completed Baby Friendly (UNICEF training)

What the MSW does
• meet, greet and settle women to the ward and commence admission procedure
• support women in the birthing centre in early labour under guidance of midwife
• clerical and administrative duties when in birthing centre/wards
• community: attached to a specific group practice, prepare and assist in antenatal clinics, conduct low-risk home visits and support visits for vulnerable women, parenthood education and breastfeeding support.

Impact
• 35 per cent midwifery time released (diary of days events)
• time redirected to increase midwifery time spent with women
• increase support visits to those in more vulnerable groups.

Staff views
‘After initial uncertainty couldn’t be without them.’ (Midwife)
‘I really appreciate the new training and career development this offers.’ (MSW)

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Barnet and Chase Farm Hospitals NHS Trust

Community maternity service spanning three hospital sites. Mixed profile population with Sure Start area, many vulnerable groups with majority of care provided in the community. Ten teams of approximately 5.8 WTE midwives. Vacancies across the service, but 25 per cent in community. Birth rate 6,000–6,500 per year. The MSW will support one community team, recently linked with the first children’s centre in the London Borough of Barnet.

Work area
Community and children’s centre
0.1 WTE role in weekly antenatal booking clinic in children’s centre. Recruitment to whole-time post due within next three months, and will absorb the above operational role.

Improvements to be delivered for women and maternity team
• IWL: midwives can rest before and after on call duties.

What the MSW does
• clerical and minor clinical duties
• postnatal breastfeeding support
• selected postnatal home visits

Impact
• 64 per cent midwifery time released during one antenatal clinic = 86 minutes; each community team conducts between eight and ten antenatal clinics per week

User views
‘I was told what I need to know and more.’

Lead contact
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The Whittington Hospitals NHS Trust

Serves a community with wide social, cultural, ethnic and economic mix, comprising affluence and some of the most deprived areas in the country. Over 170 languages and dialects are spoken. There are high levels of asylum seekers. Five per cent of births are to women under 18. Three per cent of births are at home, with home birth being encouraged. Birth rate 3,400 per year.

Work area
Postnatal ward/community team
Level 2
2.5 WTE (further two proposed)

Improvements to be delivered for women and the maternity team
• MSWs introduced into high deprivation area through joint working with local Sure Start
• all MSWs received UNICEF Baby Friendly initiative training; they subsequently trained eight breastfeeding peer supporters
• Sure Start report almost 100 per cent uptake of registration in women receiving antenatal/ postnatal ‘listening visits’ from MSWs. This will facilitate engagement with smoking cessation and breastfeeding support.

What the MSW does
• provide extra antenatal/postnatal visits for social support
• attached to children’s centre supporting women needing extra support
• set up and run breastfeeding peer support groups.

Impact
• 12.5–15 per cent of the team’s time is saved = 31–37 hours per week
• time redirected to setting up services in a new children’s centre, including a drop in clinic covering pre-conception to late postnatal advice and conducting more antenatal bookings in the community.

User views
Major Sure Start evaluation spring 2006.

Staff views
‘Team leader factored MSW roles into launch of children’s centre.’

Lead contact
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Barking Havering and Redbridge NHS Trust

Two hospital sites provide care for women from all ethnic mixes and in some areas of extreme deprivation. Our focus for change surrounds efficiency, safety and choice for women. Birth rate 9,200 per year – predicted to rise to 10,000 for 2005/6.

Work setting
Antenatal clinic, post natal, labour, community, new birth centres and supporting home births
Level: 2 and 3
4.0 WTE

Improvements expected for women and the maternity team include
• increased of 1:1 care in labour
• increased breastfeeding rates and satisfaction in support levels
• reduction in clinical risk and enhancing women centred approach achieving standard 11
• IWL: focus on professional care delivery from midwives enhancing job satisfaction

What the maternity support worker does
• antenatal clinic: the MSW role has been developed by training in clinical observation
• reducing waiting times and releasing midwife time
• the other new roles will incorporate advanced competencies and assist with clinical and clerical support, Guthrie clinics, breastfeeding support, assistance at home births and normal births within any setting, taking babies in theatre at LSCS and assisting with parent craft and booking procedures.

Impact
• antenatal clinic role: reduced non-clinical midwifery time by ten per cent
• data analysis predicts midwifery time released across other work settings: 35 and 40 per cent non-clinical duties per shift.

Staff views
‘I would love to be more involved and work as part of a team.’ (MSW)

User views
Awaiting interview outcomes.

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Barts and The London NHS Trust

Provides maternity services in Tower Hamlets, an ethnically diverse, socially and economically deprived borough in East London. Birth rate 4,054 per year is expected to continue rising following the Thames Gateway expansion (projection for 2016 – 5,261).

Planned work area
Attached to six community teams
Level 2 and 3
7.4 WTE – (one MSW per team seven days per week)
Roles not yet in place. Planned start April 2006 – business case outcome pending.

Anticipated improvements expected for women and the maternity team
• reduced waiting time in antenatal clinics
• improved quality of parenting support
• released midwifery
• increase midwifery capacity in antenatal clinics.

What will the MSW do?
• practical care and support in the postnatal period at home including infant feeding
• facilitate parent craft sessions and assisting in hospital tours
• undertake clinical observations, interpret abnormal findings and report immediately to midwife
• assist in community-based antenatal clinics

Impact (predicted)
• 13 hours per midwife per week released (34 per cent)
• redirected into community midwifery care.

Lead contact
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Queen Charlotte’s and Chelsea Hospital

A tertiary referral unit with a diverse client group. It has a 31 per cent caesarean section rate and a level three neonatal unit with 49 cots. The 23-bed postnatal ward has high numbers of transitional care babies whose mothers may also have decreased mobility due to maternal complications. Birth rate 5,000 per year.

Work area
Postnatal ward
Level 3
5 WTE

Improvements expected for women, their babies and the maternity team
• timely neonatal observations carried out for transitional care babies
• increased feeding support for mothers
• individual feeding plans for transitional care babies implemented appropriately
• postnatal bed occupancy reduced preventing delays in the transfer of women from delivery suite
• increased support and continuity by MSW leading to increased maternal satisfaction and reduction of complaints
• increased sense of responsibility and job satisfaction for MSWs.

What the MSW will do
• assist the midwife, primarily in transitional care of babies, including observations and feeding
• provide breastfeeding support, undertake routine maternal observations and provide basic postnatal care to mothers.

Predicted impact
• eight per cent midwifery time usually spent performing neonatal observations redirected to enable timely discharge/reduced length of stay.

User views
‘I really appreciated that there was always someone nearby that I knew and could ask for help with my baby.’

Staff views
‘At last I feel like a valuable member of the team.’

Lead contact
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Chelsea and Westminster NHS Trust

Adopted a systematic, planned approach to support worker development within maternity services. This links this project with the other three service development working parties, introduced in June 2005, thus adopting a whole-systems approach to service development in maternity.

The team decided on two generic job descriptions, supported with detailed competency tables. Audits undertaken on delayed postnatal discharging and MDAU ICP appointments show that the MSW role could release a substantial amount of midwifery time, although it is acknowledged that the audits were very basic and small. Competency tables have been developed for the following roles, developed in line with the following maternity working parties: high dependency unit/recovery, breastfeeding, and drugs (the drugs group specifically highlight discharge issues). The team went live in January 2006 in line with the other service development projects.

**Impact (predicted)**
- postnatal discharge co-ordinator will help to reduce the postnatal length of stay
- releasing five per cent of midwifery time, or 6.79 WTE per year.

<table>
<thead>
<tr>
<th>Specific MSW roles that are fit for purpose for Chelsea and Westminster</th>
</tr>
</thead>
<tbody>
<tr>
<td>All posts are full time</td>
</tr>
<tr>
<td>MSW recovery assistant</td>
</tr>
<tr>
<td>MSW PN discharge co-ordinator</td>
</tr>
<tr>
<td>MSW nursery nurses</td>
</tr>
</tbody>
</table>

**Lead contact**
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St Mary’s NHS Trust

An acute trust situated in central London, providing health services for 350,000 people from all social classes, nationalities and cultures who live and work in West London. Maternity care is delivered through various models including caseload, community and hospital teams, and includes all levels of dependence, from home birth to complex tertiary referrals.

**Work area**
- Postnatal ward
  - 2 WTE
  - Level tbc
  - Funding secured for two WTE posts, appointments made and commenced in February 2006, when they will undertake a specific training package focusing on meeting the needs of women on the postnatal ward.

**Improvements expected for women and the maternity team**
- recent user satisfaction surveys suggested that the postnatal ward was the area in greatest need of improvement.

**What the MSW will do**
Specific aspects of care where the maternity support worker will help to improve the postnatal experience are:
- regular linen changes
- careful fluid balance
- help with hygiene needs.

**Impact (predicted)**
- a better postnatal experience for women.

**Lead contact**
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Maternity support workers

Enhancing the work of the maternity team

The North West London Hospitals NHS Trust

An acute trust situated in Brent and Harrow. The maternity unit deliver approx 5,200 births per year from a diverse population comprising the full range of nationalities and cultures.

Work area
Acute and community services
34.98 WTE maternity support worker at Band 3.

Improvements expected for women and the maternity team
• increased breastfeeding rates at six weeks following birth
• greater satisfaction levels from women/clients
• improved morale of maternity services team.

What the MSW will do
• undertake a range of support roles in the clinic from taking weights, urine, blood pressure, baby care and breastfeeding support
• booking appointments.

Impact (predicted)
• improved patient care to both women and babies
• more effective and efficient use of scarce midwifery skills through skill mixing.

The role of the maternity support worker has been key in ensuring that scarce maternity skills are used appropriately. MSWs have increased the quality, support and time available to be spent with mothers with emphasis on fundamental care.

It is anticipated that the trust will continue to invest in MSW roles across the acute community setting in the future.

User and staff views
‘Both mothers and staff have made positive comments about the role of maternity support workers.’

Lead contact
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Shrewsbury and Telford Hospitals NHS Trust

The largest geographical inland county in the country at over 1,300 sq miles. There is one consultant obstetric unit and five peripheral midwife-led units within the county. Diverse population profile. One of the highest teenage pregnancy rates in the country and two of the most deprived wards in England and Wales (Index Multiplication Score). 252 midwives employed. Four WTE midwifery vacancies. Birthrate Plus identified a further deficit of 15. Birth rate 5,000 per year.

Work area
Seven community midwifery teams.
One MSW per team Level 2

Improvements delivered for women and the maternity team
• high-risk pregnant teenagers now receive individualised care pathways, involving at least 14 antenatal visits and daily postnatal visits
• more home visits and midwifery care provided for this vulnerable caseload.

What the MSW does
• assists two specialist midwives carrying caseloads of 90–100 teenage women in providing specialised health promotion visits at 20 and 37 weeks and three postnatal visits (day 4, 5, 7).

Impact
• 40 per cent of midwifery time released from non clinical work
• 58 per cent midwifery time released from administration (teenage identified midwife).

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Note, a full case study from this site is included on page 58.
Burton Hospitals NHS Trust
Provides maternity services for approximately 3,500 births per year. This includes 350 at the stand-alone midwifery-led unit at Lichfield and approximately 60 home births. There are rural and urban areas with pockets of deprivation.

Work area
Community Level 2
Maternity support workers were introduced into the community in a pilot study in January 2006, where a traditional model of care is currently employed.

0.4 WTE

Improvements expected for women and the maternity team
- increased breastfeeding support
- support for vulnerable women and families
- releasing midwifery time
- reducing delay in antenatal clinic
- clerical support for community midwives
- provision of basic parenting skills.

What the MSW does
- visit women to give breastfeeding support
- provide basic parenting skills and education
- support midwife in antenatal clinic
- limited clerical role with data entry and support to midwife.

Lead contact
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University Hospital, North Staffordshire
Delivers over 5,000 babies per year in an acute trust. The community is both rural and urban with the urban element falling into the lowest 30 per cent of UK deprivation indices. Rates of teenage pregnancy, smoking, drug misuse and domestic violence are comparatively high. Stoke-on-Trent is also an appeal centre for people awaiting asylum or refugee status.

Work area
Community Level 2
Healthcare support workers were rotated out of the community maternity unit (low-risk unit) to support four community teams. Some community clinics were large, or lengthy due to complex social needs of the caseloads.

Improvements delivered for women and the maternity team
- reduced waits in clinics
- reduced parent craft costs by £6,829–£8,404
- additional staff resources to support midwives with very demanding caseloads such as asylums seekers, refugees, homelessness.

What the MSW does
- set up the room for antenatal care and parent craft
- blood pressure, urinalysis, phlebotomy
- book ultrasound scans, induction of labour and appointments
- data input
- second person at parent craft: in order to meet ‘lone worker’ guidelines.

Impact
- waiting times by an average of 17 minutes per patient
- midwifery time redirected to plan care women with complex needs.

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Mid Staffordshire General Hospitals NHS Trust

Serves a mixed rural and urban environment with pockets of social deprivation and diverse needs. Birth rate 3,000 per year.

Work area
Hospital and community
Level   2
3 WTE. Commenced training in October 2005.

Improvements expected for women and the maternity team
• delivering the public health agenda
• increasing parenting education with parental involvement
• decreasing caesarean section rates, promoting normal birth and opening of a birthing unit
• reducing work-related stress in midwives.

What the MSW does
• act as an assistant to midwives to ensure patient’s needs are met
• act as a chaperone in antenatal clinics
• be responsible for the assessment, implementation and evaluation of programmes of care under the supervision of the primary midwife
• basic clinical observations, temperature, pulse and blood pressure, reporting findings to the primary midwife
• venepuncture
• take, label and process specimens required for investigations
• take routine urine samples
• assist midwife at delivery
• set up equipment used at deliveries, including preparation for suturing.

Impact
• five per cent midwifery time released = 25 hours per week.

User views
‘Provided they have been given the training, I can’t see any problems.’

Staff views
‘It will enable us to give quality care to women that really need us.’

Lead contact
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Queen Elizabeth Hospital – Woolwich

Provides care for approximately 4,000 women per year. The borough of Greenwich has pockets of high deprivation and has a high number of women whose first language is not English.

Work area
37 bedded (+37 cots) mixed postnatal and antenatal ward
Level 2 and 3
2 WTE. (Five posts) funded from existing establishment.

Improvements expected for women and the maternity team.
• more support for women and babies following a normal pregnancy and birth, under the supervision of a midwife
• increase numbers exclusively for breastfeeding
• facilitate early transfer home for healthy women and babies
• reduce number of women allocated to midwives enabling midwives to care for women and babies requiring midwifery care
• improved support for women’s choice of feeding
• reduced complaints regarding postnatal care.

What the MSW does
• provides total care to low-risk women, including education on feeding and parenting skills
• transfers women to care of community midwife.

Impact
• length of stay reduced by 0.5 days for well women and babies
• improved quality of postnatal care: reduced number of women allocated per midwife.

Users views
‘I am honestly impressed with the professionalism and kindness of the maternity support worker.’

Staff views
‘I have far more time now to spend with women who require my midwifery skills.’

Lead contact
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**Guy's and St Thomas’ Foundation Trust**

Serving a population of high ethnicity, many non-English speaking women, high teenage pregnancy rates, some refugees and asylum seekers alongside increasing drug, alcohol and domestic violence issues. Birth rate is 6,000 per year. The community has different systems in place for caring for women, caseload, team, group practice and traditional midwifery. Midwifery vacancy rate is 1.5 per cent.

**Work area**

**Community**  
Level 3  
3 WTE Attached to community group practices of 6 midwives.

**Improvements expected for women and the maternity team**

- reduce midwifery time spent on non-clinical duties  
- address retention and recruitment issues  
- increase the breastfeeding rates  
- improve parenting support for vulnerable clients.

**What the MSW will do**

- antenatal clinics: preparing clinics, leaflets, booking notes, ensuring laboratory results available and follow-up appointments arranged  
- assisting midwife with phlebotomy and baseline observations; following up non-attendees  
- antenatal classes: setting up the classes and relevant leaflets; assisting in health education  
- postnatal visits: home visits to support breastfeeding, bath demonstration and health education  
- Postnatal support groups: health education, breastfeeding support groups, postnatal exercises.

**Impact (predicted)**

- 20 per cent midwifery time released per week.

**User views**

‘This will be something very positive for the women within our local area.’

**Staff views**

‘Plan welcomed with open arms – this will help us spend more time with the women.’

**Lead contact**

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**St George’s NHS Trust**

A tertiary referral centre provides care and support in a multicultural/race community of mixed socio-economic background, stigma and disadvantage ranging from domestic violence, mental health, language difficulties and drug and alcohol use. This role will help the trust develop improved ways to enhance flexible, women-centred services with earlier access to maternity services. Birth rate 4,500 per year.

**Work area**

**Community services**  
Level 2 (during training) becoming Level 3 on satisfactory completion  
2 WTE (to be increased).

**Improvements expected for women and the maternity team**

- decreased waiting times in antenatal clinics, improved relationships with prospective parents  
- routine antenatal blood tests, blood pressure checks and urine testing

**What the MSW will do**

- improved continuity of care for vulnerable, disadvantaged women  
- decreased social visits not requiring midwifery skills  
- IWL: midwives more able to focus on midwifery care.

**Midwifery time released per week**

- provide parenting skills, bathing baby: ten hours approximately  
- blood tests including Guthrie and blood glucose monitoring: eight hours approximately.

**Staff views**

‘Managers feel that this role is vital in providing continuity of care. Many midwives fully support this role.’

**Lead contact**

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Kingston Hospital NHS Trust

A local district general hospital. Four teams cover mainly urban areas. The population is diverse, mainly Caucasian, age profile over 30 years. A home birth service is offered to low-risk mothers. The midwives work in traditional teams with approximately four WTE midwives per team, supported by one MSW. Birth rate 5,000 per year.

**Work area**
- Community (one per team)
  - Level 3
  - 0.6 WTE x four

**Improvements to be delivered for women and the maternity team**
- user questionnaire shows improved satisfaction for mothers requesting help with breastfeeding
- midwives have the opportunity to increase the home birth rate
- midwifery time released is being used to develop postnatal drop in centres.

**What the MSW does**
- works as part of the team for five hours per day providing postnatal support.

**Impact**
- 16 per cent midwifery time released = 25 hours in team of 4.2 WTE midwives
- time redirected to provide care for antenatal women in local centres.

**User views**
- ‘She was one of the most helpful carers that I had.’
- ‘She was supportive, knowledgeable and encouraging.’

**Staff views**
- ‘Very reluctant to hand over care initially, now can’t manage without the MSW.’

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Mayday NHS Trust

Provides maternity services for the London Borough of Croydon and surrounding areas. Included are deprived and prosperous communities. The population is multicultural including refugee women. Clinics provided include: smoking cessation, teenage pregnancy, breastfeeding, perineal care, and drug abuse. Projected birth rate for 2005 is 4,300.

**Work area**
- Postnatal 1 WTE
  - Level 2 and 3
- Community 3 WTE (attached to 4 teams)
  - Level 2 and 3

**Improvements delivered for women and the maternity team were**
- reduced waiting times for discharges
- increased one to one midwifery care
- reduced non-midwifery work load
- improved breastfeeding support.

**What the maternity support worker does**
- administration
- show baths
- chasing blood results
- Guthrie test
- clerical duties
- bottle feeding advice
- observations
- baby weight checks
- phlebotomy
- urinalysis.

**Impact**
- postnatal – 16.9 per cent (3.8 hours) midwifery time released/day by one MSW. Time redirected to caring for high-risk patients, one-to-one care, and breastfeeding support
- community – nine per cent (7.5 hours) midwifery team time released/day by each of three MSW. Time redirected to breastfeeding support, greater focus on high-risk cases.

**User views**
- ‘It’s nice to have the help, especially when you are unable to move well because you are sore.’

**Staff views**
- ‘Fewer clients get irritated because they are seen so quickly especially at discharge.’

**Lead contacts**
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Cornwall and Isles of Scilly NHS Health Community

Maternity services care for over 4,000 women during their pregnancy and following the birth. There are pockets of high home birth rates, especially in North Cornwall 30 per cent and the far west 12 per cent. The acute unit in Truro delivers 3,400 babies; a midwifery-led birth centre in central Cornwall delivers 300. The newly appointed director of midwifery for the whole of Cornwall is leading integration of the service.

Work area

Area one: postnatal care, acute unit with skills transferable to the community setting. Level 3

Area two: Integrated midwifery team, working from a birth centre. Level 3

Three WTE (four posts).

Improvements expected for women and the maternity team
• significant reduction in complaints from the postnatal ward
• improved support for breastfeeding

What the MSW does
• breastfeeding support and general care of women and their babies, including home visiting
• MSW will run consultant-led antenatal clinic from January 2006.

Impact
• Ten per cent midwifery time released per week on postnatal area.

Impact (predicted)
• 20 per cent midwifery time released to work either in the birth centre or in the community.

Lead contact
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Plymouth Hospitals NHS Trust (working in partnership with Sure Start)

Covers inner city and rural areas, some pockets of deprivation child protection, domestic violence issues and asylum seekers. Large consultant-led unit with midwifery-led care. Teenage pregnancy rates 1.8 per cent. Audit on postnatal ward revealed improvements required as 18 per cent of midwifery time spent on non-clinical duties around admission, 11 per cent spent transferring care to the community, and ten per cent bed occupancy was women awaiting discharge. Birth rate 4,500 per year.

Work area

Early discharge lounge, central delivery suite
Level 2

2.4 WTE needed to cover Monday–Friday 8am to 8pm. No MSW currently employed specifically for early discharge suite, as yet.

Improvements expected for women and the maternity team
• more time for midwives to spend on clinical care
• reduced discharge waiting time
• improved breastfeeding initiation and support

What the MSW does
• will ‘run’ this suite under the guidance of the midwife, ensuring that women choosing an early discharge receive the necessary information, support and care.

Impact (predicted)
• 29 per cent midwifery time released into delivering midwifery care.

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Sheffield Teaching Hospitals NHS Foundation Trust

Jessop Wing maternity unit with its regional neonatal tertiary referral unit, is the country’s second largest, providing services to a large major UK city with diverse cultural needs, large areas of deprivation, high minority ethnic and asylum seeker/refugee population, as well as having a large university student population and a ten per cent cross-border population. Midwifery establishment WTE 229, four community teams of 72 WTE midwives. No recruitment and retention issues. Birth rate 7,000 per year.

Work area
Community ante natal clinics
Level 2
Six support workers from current staffing establishment. Funding agreed for a further six posts.

Improvements to be delivered for women and the maternity team

- markedly reduced waits in community antenatal clinics
- midwives able to give to women improved quality of care, for example discussion time, birth planning, breastfeeding, health promotion
- IWL: midwives now likely to finish shifts on time

What the MSW does
- basic observation
- venepuncture
- clerical duties
- sets up and ensures clinics run smoothly.

Impact (predicted)
- 50 per cent midwifery time released in three antenatal clinics used in test cycle = 90 minutes per three hour session

- within Sheffield, community midwives have 107 antenatal clinic sessions. Six WTE support workers could attend 72 sessions per week. 72 x 90 = 6,480 minutes released of midwifery time
- this would equate to 2.88 WTE midwives.

Staff views
‘More time to answer women’s questions, frees midwife up to concentrate on the woman.’ (Midwife)

Lead contact
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Surrey and Sussex NHS Trust

Acute setting, mixed social class, and between urban and rural. All care delivered locally. Twenty-eight-bed postnatal ward, six antenatal beds, one-day assessment unit. Crawley has one of the highest teenage pregnancy rates in the country. It has two teenage pregnancy and one Sure Start midwife. The trust is 19 FTE midwives short-staffed. Staffing complement per shift: 11-bed delivery suite has six or seven midwives. Twenty-eight bed postnatal ward has two midwives, one staff nurse and two health care assistants /maternity support workers. Antenatal ward has one midwife. Antenatal day unit open 9–4 has two midwives and one healthcare assistant and sees 25 women daily. Birth rate 4,000 per year.

Work area
Community and postnatal wards
Level 2
14 WTE seven in each setting, rotating

There is a clinical skills facilitator 0.6 WTE overseeing the training of all the MSWs.

Improvements to be delivered for women and the maternity team

- better continuity of care and consistent advice
- increased communication.

What the MSW does
- assists with clerical work and baby and mother examinations
- provides breastfeeding support and parent education
- baseline observations.

Impact
- 30 per cent midwifery time released from clerical duties
- time redirected to high-risk cases.

User views
‘Report increased satisfaction with breastfeeding.’

Staff views
‘Happy to delegate work to MSWs. They are responsible but know limitations of their role.’ (Midwife)
‘Never realised the scope of midwives’ role.’ (MSW)

Lead contact
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Buckinghamshire NHS Trust, Wycombe and Stoke Mandeville Hospitals

Mixed urban and rural communities include areas of deprivation and ethnic mix. Birth rate approximately 5,600 per year. Average four midwives per team, average caseload 177. Majority of homebirth requests are met. No retention issues.

**Work area**

**Community**

**Level 2**

1.29 WTE (two posts)

**Improvements to be delivered for women and the maternity team**

- midwives now able to focus totally on the woman during a consultation
- longer consultation time available for women with queries and problems prevents scheduling another appointment
- reduced waiting times
- improved numbers sustaining breastfeeding
- more time spent with vulnerable families

- IWL : reduced additional midwifery hours worked.

**What the MSW does**

- in a clinic where 12 patients are seen the MSW can release one hour of midwife time from clerical duties
- build up relationships with women during regular clinics
- follow up non-attenders
- outside clinic: administration, arranges appointments, books classes
- additional breastfeeding and smoking cessation support
- longer visits to a small number of families.

**Impact**

- 33 per cent midwifery time per clinic = 16 per cent of all midwifery time across the team
- time redirected to improving number and quality of home visits.

**Staff views**

‘It takes the pressure off me in a busy clinic and I have more time to give to the mothers.’ (Midwife)

**Lead contacts**

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Milton Keynes General Hospital NHS Trust

City with rural fringes. Ten per cent increase in minority ethnic groups of diverse origin, above average teenage pregnancy rate. Low vacancy rate. Birth rate 3,500 per year.

**Work area**

**Four community teams**

**Level 3**

3.8 WTE (four posts) one per team

**Improvements to be delivered for women and the maternity team**

- women will have more choice of where they give birth as released midwifery time is redirected to support home births and domino scheme
- more timely and accessible breastfeeding advice available. Improved user satisfaction.

- Responds more flexibly to provide 1:1 support where it is most needed.

**What the MSW does**

- visit in tandem with midwife for three months then alone, as part of a team. This could be offered for six weeks after discharge where needed
- provides support for breastfeeding, administration, parenting skills, performing PKU tests
- attends parent craft sessions and runs sessions on breastfeeding
- provides ongoing contact via breastfeeding support groups, timely intervention helps continuance of breastfeeding
- Available to provide extra support with transition and adjustment to a new family member improving client satisfaction

**Impact**

- up to eight per cent midwifery time released.

**User views**

‘The majority of women asked, feel the MSW helped most with breastfeeding and emotional support.’

**Lead contact**

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The Oxford Radcliffe NHS Trust

Services are based on five sites, three providing midwifery-led care. The John Radcliffe unit has 5,800 births per year, including foetal maternal medicine activity. The Horton Maternity Unit is a small obstetric unit 23 miles north with 1,580 births per year. The service supports a diverse population including high teenage pregnancy rates, deprivation, drug addiction, contrasting with academia and affluence. In 2005, MSW establishment increased by eight WTE deployed to the ante/postnatal wards. Now keen to develop MSW scrub role.

Work area
Community, delivery suite, ante/post natal
Level 2 and 3
Additional funding application plus report submitted to Thames Valley Health Authority to further develop MSW role (awaiting outcome).

Improvements anticipated for women and the maternity team
• improved accessibility for vulnerable
• releasing midwives from scrub role to improve intrapartum care continuity
• reduction in clerical and administration duties.

What the MSWs do
• work alongside midwives undertaking a range of basic duties to help deliver the above priorities.

Impact (predicted)
• theatre: with a 22 per cent LSCS rate, significant midwifery time released to improve continuity of care in labour.

Lead contact
bev.bennett@orh.nhs.uk
Tel: 01865 221 672

Derby Hospitals NHS Foundation Trust

Provides maternity service for over 6,500 women of whom 4,800 women give birth at Derby City General Hospital. There are significant areas of deprivation within the city of Derby. A home birth rate of four per cent. A stable workforce with minimal recruitment issues and a low turnover of staff.

Work area
Community
Level 2
Piloted in a community team with two X 0.8 WTE.
Second pilot from January 2006 with additional two X 0.8 WTE.

Improvements delivered
• reduction midwifery time spent on non-midwifery tasks
• maintenance of breastfeeding rates
• more efficient use of midwifery time
• increased quality of care and information for women.

What the MSW does
• phlebotomy, blood pressure checks, urinalysis, aqua natal support, newborn blood spot screening, general health promotion, stock control, booking appointments.

Impact
• non-midwifery tasks reduced by 30 per cent
• antenatal clinic waiting time reduced
• breastfeeding rates maintained at 85 per cent
• 100 per cent MSWs trained in breastfeeding advice/support.

User views
‘After days of sleepless nights, Sarah pinpointed the breastfeeding problem and my baby fed much better.’

Staff views
‘More continuity of care as they are known to many of the women.’

Lead contact
sandra.orton@derbyhospitals.nhs.uk
Tel: 01332 785 415
George Eliot Nuneaton NHS Trust and North Warwickshire PCT

The population profile is predominantly white low socio-economic groups. It has a combination of industrialised urban and rural poor. It is a spearhead PCT with nine wards of deprivation. Demographics include army barracks and a large non-English speaking population, four travellers’ sites, and a three per cent ethnic population. Breastfeeding rate is 42 per cent. Birth rate 2,800 per year.

Work area
Community   (Pilot)
Level: 3
1 WTE

Improvements expected for women and the maternity team
• allows for consistency of staff to cover the breastfeeding café, young parents group, breastfeeding postnatal visits and individual parenting preparation
• antenatal clinics keeping to time and give quality time to women. Improved, quality time for breastfeeding support.

What the MSW does
• helping to establish a further breastfeeding café in a deprived area
• parenting skills, helps run the young parents group.

Impact
• 17.5 per cent of team time (29 hours) per week
• midwives can focus on vulnerable groups, undertake a 36-week antenatal home visit for birth planning, time allocated for 28–32 weeks breastfeeding discussion.

User views
‘She said she was fine. She had the MSW direct line if she had any problems with breastfeeding.’

Staff views
‘It meant that the mother could get a visit at a time when the baby was due to feed, rather than when I could make it.’ (Midwife)

Lead contact
deborah.garrett@geh.nhs.uk
Tel: 02476 865 012

Calderdale and Huddersfield NHS Trust

The area is both urban and rural with a high percentage of ethnic minorities including asylum seekers. Birth rate 5,500 per year.

Work area
Antenatal/postnatal/ labour wards
Level 2
7 WTE  (Eight posts) recruited from the existing workforce.

Improvements delivered for women and the maternity team
• the MSWs completed competency training based on the knowledge and skills framework
• these competencies have been mapped against the National Workforce Competences for skills for health.

What the MSW does
• training included parent education, emotional support in labour, lifestyle factors associated with a healthy pregnancy, detecting and monitoring anxiety and postnatal depression, information and advice on self-care and infant care, neonatal resuscitation, breast feeding, smoking cessation advice, PN exercises, basic observations and computer skills, emotional support to women in labour.

Impact
• the training and role complements the skills of midwives without compromising care, either in terms of quality or safety. This allows midwives time to spend with high risk women.

Staff views
‘Its great when the MSW is on, she does all the discharge letters for us.’

Lead contact
kathryn.kershaw@cht.nhs.uk
Tel: 01422 224419
Maternity support workers

Enhancing the work of the maternity team

The Leeds Teaching Hospitals NHS Trust

Maternity services provides care to women and their families in both acute and community midwifery settings. The service also provides tertiary care to women from outlying district general hospitals. There are two hospital sites and approximately 8,300 deliveries a year across the whole of the city. The service provides care to a diverse community that includes a great emphasis on specialist social support as well as providing care to women with complex medical conditions.

Work area

- Planned for all care settings including theatre
- Level tbc

Improvements expected for women and the maternity team

- support the implementation of the maternity NSF
- enhance women centred care
- support improvements in breast feeding rates
- improve one-to-one care for women in labour
- support midwives in the nursing care of critically ill obstetric women
- release midwives from house keeping/administrative tasks.

Impact

- eight per cent – it is anticipated that the first wave of the programme will release up to 180 hours of midwifery time each week.

Staff views

‘Enhancing care in the community setting.’

Lead contact

julie.scarfe@leedsth.nhs.uk
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Section 5
Appendices
Appendix i

About the large scale workforce change team

The purpose of the large scale workforce change team, developed from individuals with skills gained in the NHS Modernisation Agency, is to promote service improvement and development through a series of top-down, nationally-led programmes designed to develop local capacity by facilitating large scale workforce change. Its work focuses on the development of an adaptable and flexible workforce, reducing unnecessary boundaries and enabling the effective use of staff skills, creating benefits for patients as well as healthcare staff.

Aims and objectives

- to design and deliver large scale national programmes that support clinical and support staff in the delivery of local healthcare services
- to spread new roles, new ways of working and improvements in retention and recruitment systems known to have impact on key service improvement areas
- to build HR capacity within the service to deliver the four pillars of HR in the NHS
- to deliver programmes that reflect national priorities, take account of service needs and that are based on the adopt and adapt principle.

Key deliverables 2005/6

Including the maternity support workers programme, there are four large scale workforce change programmes running during 2005/6.

Retention and recruitment collaborative

A programme that brings organisations together with the common purpose of reducing agency and temporary staffing costs in the NHS through the identification and spread of good practice. This programme targeted the highest agency spend trusts across London.
Rapid roll-out programme – children’s services

This programme has engaged 45 NHS trust teams and local authorities in working together to develop and implement a new skill mix of roles and new ways of working to support delivery of the NSF for children, young people and maternity services, targeting particularly, community paediatric services. New roles and new ways of working from previous national new ways of working (NWW) programmes are being shared, adopted and adapted and spread as appropriate.

Rapid roll-out programme – long-term conditions

Building on the work of the NWW Accelerated Development Programme for new roles in Intermediate Care for Older People, this programme is rolling out the learning, new role profiles and new ways of working to further spread the adoption of good practice. We have engaged some 37 NHS trust/local authority teams to work together in supporting implementation of the NSF for Older People.
Appendix ii

Workforce issues

This large scale workforce change programme is set firmly within the context of a national movement of workforce development that looks to develop capacity to meet both present and future demand for healthcare across all areas of the service. Healthcare delivery is changing in many ways as procedures are refined, care processes are streamlined in response to gathering evidence about what works well, and new technology improves both diagnosis and treatment. Staff are working differently and often more productively. This LSWC team programme has made a significant contribution to the development of an educational and career framework for the maternity team by implementing new roles that will position maternity services with a more sustainable, flexible and responsive workforce in readiness for the challenges that lie ahead.

In 2004/5 2,374 students entered midwifery training: 44 per cent more than in 1996/7, evidence highlights that the midwifery workforce is ageing; 20 per cent are over 50 years of age, and that 50 per cent of all midwives choose to work part time.

Current demand and expectations of service users is increasing. Imperatives such as the choice agenda and the European Working Time Directive are compounded by significant issues with recruitment and retention in the midwifery workforce. An accurate assessment of the baseline-funded establishment required for service delivery is essential if one is to ensure the right mix of skills is available to support service delivery and discourage the delivery of less complex direct and indirect care by the midwife. Introduction of maternity support workers (MSWs) into the maternity team will help develop a more sustainable workforce by improving the working lives of practising midwives and enhancing retention rates, while at the same time providing opportunities for recruitment from the local workforce to enable maternity teams to attract and ‘grow their own’.

The Career Framework for Health

The career framework is important because it will form a common language and currency that has not been present before. It illustrates the concept of skills escalation based on competence. It has been developed to support organisations by improving workforce planning and modelling. It will help succession planning and illustrates the workforce implications of service redesign. It integrates personal development, organisational development and service improvement. It has been developed to support the service by illustrating and enhancing career opportunities as well as highlighting anomalies and informing workforce issues and challenges, for example regulation, assessment, quality assurance and employability.

A populated maternity career framework will be a useful tool to workforce modernisers for referencing levels of roles, and the accompanying competence statements and KSF outlines that may be used for a role of that type. (Job
titles have repeatedly been found to be an unreliable basis for creating a career framework). Work is currently underway to test a more robust process for consistently populating the career framework. For maternity services, this work started in February 2006.

**Developing quality assured roles with national transferability**

The roles devised and implemented at each site matched and responded to local needs and teams were asked to underpin them with clear competences, to assist consistency, quality and national transferability. Skills for Health was asked to define a set of National Occupational Standards/National Workforce Competences (NWCs) that would be appropriate for MSWs working in a variety of settings. These can then be used alongside KSF post outlines as evidence for the areas of application relevant to the particular post, and for a variety of purposes including:

- individual development/appraisal
- team development
- role design
- service design
- education programme/curriculum design.

The Royal College of Midwives has developed a set of core role competencies for maternity support workers (Prepared to Care: Fit for Purpose Programme RCM Trust 2004) which were used as the basis for this work.

A workshop was undertaken at which potential NWCs were reviewed by a group of project managers from sites involved in this project, and a set of 20 competences were selected.

Members of the workshop felt that this set of NWCs was appropriate as a core for MSWs working in both hospital and community settings, and that local differences in the roles are likely to lead to the need for additional NWCs within individual job descriptions. More consultation is needed to ensure that sufficient competences appropriate to MSWs working in operating theatre settings are included.

During the first half of 2006, the set of selected competences will be subject to both an electronic consultation and a consultation workshop for teams taking part in the project, to ensure wide agreement before final dissemination. The selected competences can be viewed, linked with KSF dimensions and levels, at www.skillsforhealth.org.uk

**Resourcing the MSW roles**

It is important to understand that many of the improvements discussed here were secured by the maternity teams working ‘smarter’, using existing staff
resources differently; a principle fundamental to the success of the NHS Plan. Some teams took the decision to convert existing long-term midwifery vacancies, some decided to seek alternative funding to support this new way of working. Towards the later stage of the programme, reconfiguration of PCTs left certain trusts unable to give firm commitment to fund the MSW role being developed.

**Accountability issues for the maternity team**

In designing the MSW roles, the teams will have given serious consideration to responsibilities and relationships of the other team members readers are directed to do the same. Maternity teams implementing the support worker role should be fully aware of the guidance produced by the Nursing and Midwifery Council on this matter* www.nmc-uk.org

**The maternity support worker in theatre**

When women require caesarean section, many highly skilled midwives are called away from busy labour wards and delivery suites to undertake theatre duties including the ‘scrub’ role. Appropriately trained, the MSW can help prevent this. In assisting maternity teams to develop these roles, the programme has benefited from the advice and learning of three important groups: the National Practitioner Programme, (hosted at North West London SHA developing a variety of new ways of working in surgery, anaesthetics and primary care), a project scoping the role of the assistant/support worker role in theatre (hosted by Norfolk, Suffolk and Cambridge SHA), and from the National Perioperative Care Collaborative group.**

Participating maternity teams appreciate that developing the MSW scrub role must involve close working with colleagues in main theatre and for quality assurance purposes the training provided must in every way meet the nationally agreed standards and competence.

**The maternity support worker and newborn screening**

Although many maternity teams across England have developed their support workers to include newborn screening, trusts must be aware of their responsibilities in respect of vicarious liability and the need to consult the clear national guidelines about which health professionals are deemed appropriate to undertake this activity. www.newbornscreening-bloodspot.org.uk/

*The NMC code of professional conduct: standards for conduct, performance and ethics. (clause 4.6) 2004

*Guidance on provision of midwifery care and delegation of midwifery care to others. NMC Circular 1/2004

**The Perioperative Care Collaborative. Delegation: the support worker in the scrub role. Position Statement June 2004
Appendix iii

Participating NHS trusts

Avon and Gloucester SHA:
- Salisbury NHS Trust
- United Bristol Healthcare NHS Trust Maternity Services & Sure Start Bristol.

Bedfordshire and Hertfordshire SHA:
- East and North Hertfordshire NHS Trust
- Bedford Hospital NHS Trust
- West Herts Hospital NHS Trust.

Birmingham and the Black Country SHA:
- Sandwell and West Birmingham Hospitals NHS Trust and Sandwell Primary Care Trust
- Royal Wolverhampton Hospitals NHS Trust
- Birmingham Women’s Healthcare NHS Trust
- Good Hope Hospital NHS Trust and North Birmingham Primary Care Trust
- Walsall Hospitals NHS Trust.

Cheshire and Merseyside SHA:
- Countess of Chester Hospital NHS Foundation Trust
- South Sefton PCT and Sure Start
- Women’s Health Unit, Mid Cheshire Hospitals NHS Trust
- Liverpool Women’s NHS Foundation Trust.

Cumbria and Lancashire SHA:
- Cumbria and Lancashire SHA Working Differently Programme and Cumbria and Lancashire Health Economy.

Dorset and Somerset SHA:
- Taunton and Somerset NHS Trust.

Essex SHA:
- Mid Essex Hospitals Services NHS Trust
- Southend Hospital NHS Trust.
Hampshire and Isle of Wight SHA:
- Portsmouth Hospitals NHS Trust and ABC Sure Start.

Kent and Medway SHA:
- Maidstone and Tunbridge Wells NHS Trust.

Norfolk, Suffolk and Cambridge SHA:
- Queen Elizabeth Hospital NHS Trust
- West Suffolk Hospitals NHS Trust.

North East Yorkshire and North Lincolnshire SHA:
- South Tees Hospitals NHS Trust
- York Hospitals and Hull and East Yorkshire NHS Trust.

North Central London SHA:
- North Middlesex University Hospitals NHS Trust
- University College of London Hospitals
- Barnet and Chase Farm Hospitals NHS Trust
- Whittington Hospitals NHS Trust.

North East London SHA:
- Barking, Havering and Redbridge NHS Trust
- Barts and the London NHS Trust.

North West London SHA:
- Hammersmith Hospitals NHS Trust,
- Chelsea and Westminster NHS Trust
- St Mary's Hospital Paddington NHS Trust
- North West London Hospitals NHS Trust.

Shropshire and Staffordshire SHA
- Shrewsbury and Telford Hospital NHS Trust
- Burton Hospital NHS Trust
- University Hospital of North Staffordshire NHS Trust
- Mid Staffordshire General Hospitals NHS Trust.
South East London SHA:
- Queen Elizabeth NHS Trust
- Guy’s and St Thomas’ NHS Foundation Trust.

South West London SHA:
- St George’s NHS Trust
- Kingston Hospital NHS Trust
- Epsom and St Helier Hospital
- Mayday Healthcare NHS Trust.

South West Peninsula SHA:
- Cornwall and Isles of Scilly NHS Health Community
- Plymouth Hospitals NHS Trust (in partnership with Sure Start).

South Yorkshire SHA:
- Sheffield Teaching Hospital NHS Trust.

Surrey and Sussex SHA:
- Surrey and Sussex Healthcare NHS Foundation Trust.

Thames Valley SHA:
- Buckinghamshire Hospitals NHS Trust
- Milton Keynes General NHS Trust
- Oxford Radcliffe Hospital Trust and Sure Start Oxford.

Trent SHA:
- Derby Hospitals NHS Foundation Trust.

West Midlands South SHA:
- George Elliot Hospital. Nuneaton NHS Trust and North Warwickshire Primary Care Trust.

West Yorkshire SHA:
- Calderdale and Huddersfield NHS Trust
- Leeds Teaching Hospitals NHS Trust.
Appendix iv

Full ‘case study’:
Shrewsbury and Telford Hospitals NHS Trust

Shropshire is the largest geographical inland county in the country at over 1,300 sq miles. There is one consultant obstetric unit and five peripheral midwife-led units within the county, with a delivery rate of 5,000 births per year. The population profile is diverse with one of the highest teenage pregnancy rates in the country and two of the most deprived wards in England and Wales (Index Multiplication Score).

At present there are 252 midwives employed. Currently there are four WTE midwife vacancies, and the recent application of the workforce management tool, Birth-rate Plus identified a further deficit of 15 midwives. This deficiency has not yet been addressed.

Work area

Seven community midwifery teams
One MSW per team  Level 2

Seven maternity support workers allocated to five teams in Shrewsbury working 15 shifts per week.

Two in Telford working eight shifts per week. (One MSW works three shifts per week with the teenage identified midwife, and the other works five shifts per week).
Starting point: improvements sought by this team

- improve teenagers access to midwifery care
- increase breastfeeding support
- reduce waiting times in clinics
- improve the scope and function of the midwife.

Changes that made it happen

The role redesigning process initially commenced in August 2004. We undertook training needs analysis and devised three distinct competency-training packages aimed at increasing knowledge and skills. The MSWs undertook study days and received ongoing midwifery mentorship to promote clinical competency. We recruited additional maternity assistants to back fill this role. Involvement of stakeholders and the media was pivotal in moving the project forward, from a financial and customer perspective (chief executive, maternity liaison committee, NCT and the strategic health authority, Staffordshire University).

<table>
<thead>
<tr>
<th>Retention and recruitment</th>
<th>User satisfaction</th>
<th>IWL</th>
<th>Public health</th>
<th>Metrics: breastfeeding and smoking cessation</th>
<th>Implementing NSF standard 11</th>
<th>Working Time Directive</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ This role development will provide a structured and diverse career framework to which MSWs can aspire. This will have a positive impact on recruitment and retention.</td>
<td>✓ The MSW assists midwives at antenatal clinics reducing waiting time, and improving access to service.</td>
<td>✓ The process of redesigning the role has contributed to a career framework for maternity support workers and has impacted positively on standard 6 of the IWL.</td>
<td>✓ MSWs have increased the breastfeeding support within the community setting, thus ensuring that more babies receive the health benefits of breastfeeding.</td>
<td>✓ The county breastfeeding rate is 63 per cent decreasing to 39 per cent at the discharge visit. Additional breast support, should improve this (it could influence a further six per cent who are mixed feeding).</td>
<td>✓ A quality improvement in the provision of women-centred care.</td>
<td>✓ With an MSW in the community team the midwives can fulfil their role within contracted hours, reducing overtime worked.</td>
</tr>
</tbody>
</table>
Improvements delivered for women and the maternity team

- 58 per cent midwifery time released from administration
- the maternity support worker assists two specialist midwives carrying caseloads of 90–100 teenage women. Considered high risk, these teenagers receive individualised care pathways, involving at least 14 antenatal visits, and in addition, they receive daily postnatal visits. The time released has allowed the midwives to improve access to care, for example more home visits and to improve the quality of care provided for this vulnerable caseload. Working alongside the midwife, the MSW provides specialised health promotion visits at 20 and 37 weeks, and three postnatal visits (day 4, 5, 7) to these teenagers
- increase in breastfeeding support undertaken by maternity support worker
- in antenatal clinic the MSW improves efficiency and reduces waiting times – saving 50 minutes. Clinics now finish on time
- the midwife is able to keep on schedule for other visits, thereby, improving access and improvements to the quality of care, NSF standard 11).

Impact

- 40 per cent of midwifery time released from non-clinical work time ploughed back into direct care, much needed health promotion activity
- this helps the team meet indicators of NSF standard 11 by focusing on providing quality midwifery care, for example increasing the breastfeeding support available to mothers
- 58 per cent midwifery time released from administration (teenage identified midwife)
- maternity support workers providing breastfeeding support and supporting the midwife with 30 per cent of the postnatal care, particularly the sixth day visit
- teenage identified maternity support worker providing 19 per cent health promotion to teenagers
- reduction in the claimed overtime.
**Staff views**

**MSW**
‘We chatted about breastfeeding and the loss of a child.’
‘Positive comments make me feel good and it makes my new job of value and worth while.’

**Midwives**
‘I’m actually finishing clinics on time, rather than an hour later.’
‘We work as a team; instead of the sixth day visit taking 40 minutes it now takes 20 minutes.’
‘Clinics flow well with no time delays which is nice for the women.’
‘I feel safer to have the support of the maternity assistant in an area of social deprivation with high crime rates.’

**User views**
‘The visit helped me.’

**Lead contact**
angela.hughes@rsh.nhs.uk
Tel: 01743 261 000 ext 1675
## Appendix v

### National reference panel membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Role</th>
<th>Organization/Department</th>
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<tbody>
<tr>
<td>Catherine McCormick</td>
<td>Professional Advisor Midwifery/Family Health</td>
<td>CNO Professional Leadership Team</td>
</tr>
<tr>
<td>Until Aug 2005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caroline Simpson</td>
<td>Lead for Nursing</td>
<td>Unison</td>
</tr>
<tr>
<td>From Jan 2006</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gail Adams</td>
<td>Associate Director Midwifery Services</td>
<td>Southampton University Hospitals NHS Trust</td>
</tr>
<tr>
<td>Karen Baker</td>
<td>Team Leader Maternity and Women’s Health Policy Team DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Anne Barker</td>
<td>Midwifery and Women’s Health Advisor</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>Carolyn Basak</td>
<td>Associate Director Workforce Development</td>
<td>Beds and Herts SHA, Lead SHA for midwifery</td>
</tr>
<tr>
<td>Karen Bloomfield</td>
<td>National Lead; Midwifery Retention, Recruitment and Return</td>
<td>Bedfordshire and Hertfordshire SHA</td>
</tr>
<tr>
<td>Susan Cole</td>
<td>Workforce Designer and ECP Lead</td>
<td>Skills For Health – Career Framework</td>
</tr>
<tr>
<td>Belle Connell</td>
<td>WTD, Lead Maternity and Paediatrics</td>
<td>CSIP</td>
</tr>
<tr>
<td>Susanne Cox</td>
<td>MSW Programme Lead</td>
<td>NHS Employers large scale workforce change team</td>
</tr>
<tr>
<td>Cathy Devonport</td>
<td>Lead Workforce Designer</td>
<td>National Practitioner Programme</td>
</tr>
<tr>
<td>Mervi Jokinen</td>
<td>Regional Manager South</td>
<td>Royal College of Midwives</td>
</tr>
<tr>
<td>Lynda Scott</td>
<td>Junior Vice President</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>Professor Shaughn O’Brien</td>
<td>Head of LSWC team</td>
<td>NHS Employers, large scale workforce change team (LSWC)</td>
</tr>
<tr>
<td>Frances Evesham</td>
<td>Programme Manager</td>
<td>Skills for Health</td>
</tr>
<tr>
<td>Mervi Jokinen</td>
<td>Practice Development Advisor</td>
<td>Royal College of Midwives</td>
</tr>
<tr>
<td>Lynda Scott</td>
<td>Senior Workforce Advisor</td>
<td>Change for Children Care Services Improvement Partnership (CSIP)</td>
</tr>
<tr>
<td>Mervi Jokinen</td>
<td>Junior Academic Practice Advisor</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>Lynda Scott</td>
<td>LSA Midwifery Officer</td>
<td>London</td>
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<tr>
<td>Cathy Warwick</td>
<td>Director of Midwifery</td>
<td>King’s College Hospital NHS Trust</td>
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<tr>
<td>Alan Watkins until Sep 2005</td>
<td>NWWW Project Lead</td>
<td>NW London SHA</td>
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<tr>
<td>Susan Way</td>
<td>Professional Advisor Midwifery</td>
<td>Nursing and Midwifery Council (NMC)</td>
</tr>
</tbody>
</table>
Appendix vi

Acknowledgements

• Skills for Health
  – Career Framework for Health
  – Knowledge and Skills Framework

• Norfolk Suffolk and Cambridge SHA Assistant Theatre Practitioner Scoping Project

• Improving Children’s Services: NHS Employers Large Scale Workforce Change Team

• Bedfordshire and Hertfordshire SHA ‘ Workforce Development Directorate

• National Midwifery Recruitment and Retention Six Point Plan Working Group

• Southampton University Hospitals NHS Trust, Maternity Services

• Hope Hospital, Salford NHS Trust, Maternity Services

• Leicester University Hospital NHS Trust, Maternity Services

• Liverpool Women’s NHS Foundation Trust, Maternity Services

• National Practitioner Programme NW London SHA.
## Appendix vii

### Impact measures used in the programme and their definitions

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