Using support workers to release time for qualified midwives in maternity care

Childbearing women should receive a personalised service that meets their needs. For this to occur, we need to embrace the assistance of well-trained support workers.

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Maternity services must meet the demands of an increasingly diverse and rapidly growing population. Recent policy changes mean midwives are taking on roles formerly performed by doctors, leaving maternity support workers to undertake many traditional midwifery tasks. This article discusses how MSWs can facilitate choice by helping midwives deliver a flexible, personalised service to childbearing women and how the MSW role has developed.

INTRODUCTION

Major changes in healthcare offer an ideal opportunity to change women’s experiences of birth for the better. Healthcare staff are taking on new roles, and services are being commissioned and funded in new ways.

Maternity services need to meet the needs of an increasingly diverse population and practitioners who care for childbearing women must be highly skilled to facilitate choice and provide a positive experience of childbirth. All healthcare professionals need to understand the meaning of informed choice and be able to facilitate it (NICE, 2008).

The role of the maternity support worker may be key to delivering choice in childbirth, and hugely important in making choice a reality. The potential impact of the MSW role on childbirth choices could be direct, through provision of additional skills and supporting the midwifery workforce, or indirect, through the adoption of activities that free up midwives’ time.

One of the most effective ways to facilitate choice in birth is by educating childbearing women and empowering them to make informed choices. Midwives may be responsible for providing evidence-based information needed to do this, but it is the duty of every member of the team, including support workers, to create a culture where this is the norm.

BACKGROUND

Since the publication of Changing Childbirth (Department of Health, 1993) there has been a succession of government and other influential reports making specific reference to choice, in both general healthcare and maternity services.

Reports such as Maternity Standard, The National Service Framework for Children, Young People and Maternity Services (DH and Department for Education and Skills, 2004) and High Quality Care for All (Darzi, 2008) illustrate the main forces governing the settings and contexts in which healthcare staff operate, and in which childbearing choices are made.

One of the most important government reports related to childbearing is Maternity Matters (DH, 2007). This emphasises the need for flexible, personalised maternity services.

PRACTICE POINTS

Maternity support workers can help free up midwives’ time by taking on roles such as clerical work, breastfeeding support and parent education. This allows midwives to spend more time with women who are in labour on a one to one basis.

MSWs can be trained to act as a second person at a home or hospital birth, to take over the scrub role in obstetric theatres, and carry out neonatal blood tests and abdominal examinations.

To deliver Maternity Matters (Department of Health, 2007), midwives need to view the MSW role as an enhancement to the care they provide.

To deliver Maternity Matters, midwives need to see the MSW role as an essential part of a team environment.

Flexible, personalised service that every woman must have to meet her individual needs. The report made a number of “national choice guarantees”. These were:

- Choice of how to access maternity care;
- Choice of type of antenatal care;
- Choice of place of birth;
- Choice of postnatal care.

A number of recent policy developments have had significant impact on the provision of midwifery services. The European working time directive, introduced in August 2009, limits the number of hours junior doctors can work (Department of Health, 2009). Consequently, midwives are taking on some of the tasks formerly undertaken by doctors, such as intravenous cannulation and full newborn examination. The effect of this has been that some traditional midwifery roles, such as breastfeeding support, are being taken on by other healthcare workers, such as MSWs (Griffin et al, 2009).

This shift has led to a loss of role clarity and concerns over whether “role substitutors” have the right educational background to execute the role to the necessary high standards (Tookey, 2008).

The current shortage of midwives in England means recruitment drives and return to practice programmes are high on
the midwifery workforce agenda (Royal College of Midwives, 2008). Nationally, heads of midwifery and lead midwives for education have collaborated to review commissions for both undergraduate and postgraduate midwifery training. Some midwives have been reluctant to pass on midwifery duties to other workers. However, with an increasing birth rate in the UK (Office for National Statistics, 2008), an increase in complex care and the need to deliver Maternity Matters, it is timely to explore roles that can be moved from midwives to support staff (DH, 2007).

At present, there are some 520 whole time equivalent midwives working in community settings across the West Midlands, with establishments ranging from 15.0 to 52.61 WTEs. These figures directly relate to the number of births per year and the type of care available in each trust.

Maternity service provision in the region varies enormously, accommodating between 1,659 and 6,176 births a year in hospitals and between 173 and 1,367 births a year in midwife led units. Home births range from 13 to 139 per year – 0.4% to 3.7% of the total number of annual births (Kuypers, 2008). These figures demonstrate the varied patterns of work for midwives in the region.

The population has also become more diverse, which had a significant impact on midwives and maternity services. Planning the workforce to meet the demands of maternity services is becoming increasingly difficult for commissioners.

**TABLE 1. PLANNED AND NEWLY IMPLEMENTED RESPONSIBILITIES OF THE MATERNITY SUPPORT WORKER AT WEST MIDLANDS TRUSTS (N=7)**

<table>
<thead>
<tr>
<th>Responsibility of the maternity support worker</th>
<th>Number of trusts where MSWs have the responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant feeding support</td>
<td>2</td>
</tr>
<tr>
<td>Breastfeeding support groups</td>
<td>2</td>
</tr>
<tr>
<td>Assist in antenatal clinics, acts as chaperone</td>
<td>3</td>
</tr>
<tr>
<td>Booking appointments</td>
<td>2</td>
</tr>
<tr>
<td>Support parent education sessions</td>
<td>3</td>
</tr>
<tr>
<td>Glucose tolerance test clinics (under supervision)</td>
<td>1</td>
</tr>
<tr>
<td>Advising on breastfeeding, diet, smoking</td>
<td>2</td>
</tr>
<tr>
<td>Hotel duties</td>
<td>1</td>
</tr>
<tr>
<td>Administration/clerical duties/limited data entry</td>
<td>2</td>
</tr>
<tr>
<td>Assist at young parents’ group</td>
<td>1</td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>4</td>
</tr>
<tr>
<td>Recording temperature, pulse and blood pressure</td>
<td>4</td>
</tr>
<tr>
<td>Calculation of body mass index</td>
<td>1</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>3</td>
</tr>
<tr>
<td>Support midwife at home birth</td>
<td>1</td>
</tr>
<tr>
<td>Reduce lone worker attendance (attendance with midwife)</td>
<td>2</td>
</tr>
<tr>
<td>Assist midwife at delivery</td>
<td>1</td>
</tr>
<tr>
<td>Postoperative support</td>
<td>1</td>
</tr>
<tr>
<td>Cares for and supports postnatal women and babies</td>
<td>0</td>
</tr>
<tr>
<td>Take, label and process specimens</td>
<td>1</td>
</tr>
<tr>
<td>Assess, implement and evaluate a programme of care</td>
<td>1</td>
</tr>
<tr>
<td>Support women in early labour</td>
<td>0</td>
</tr>
<tr>
<td>Community clinics</td>
<td>1</td>
</tr>
<tr>
<td>Second person at aquanatal sessions</td>
<td>0</td>
</tr>
<tr>
<td>Works with midwives to support vulnerable families</td>
<td>0</td>
</tr>
<tr>
<td>Replaces the midwife in the scrub role in maternity theatre</td>
<td>0</td>
</tr>
</tbody>
</table>

**The West Midlands**

Historically, the national maternity workforce has been made up of midwives, GPs, obstetricians and auxiliary workers. Midwives make up the greatest proportion and 2,771 midwives notified their intention to practise in the West Midlands in 2008 (Kuypers, 2008).

Between 2002 and 2008, the annual birth rate across the West Midlands increased by 7,000 each year (Kuypers, 2008). This increase equates to more than the number of births each year in one large maternity unit in the West Midlands, or in several midwifery led units around the region.

**Literature review**

To gain a full picture of childbirth choices across the West Midlands, as well as the implications for the future education and training of healthcare workers, a literature review was commissioned in 2008 by the workforce deanery of NHS West Midlands. This was conducted by a team from the faculty of health and life sciences at Coventry University and the University Hospitals Coventry and Warwickshire Trust.

The literature suggested that both intrinsic and extrinsic factors influenced the ability of women to make choices during childbirth. Intrinsic factors included the characteristics of the women themselves, many of which cannot be changed. Extrinsic factors are the outside influences on childbearing women, including the knowledge and attitudes of healthcare professionals and the policies of the institutions in which they operate. These are factors that potentially could be changed.

The review also found that healthcare workers were taking on new roles and that services were being commissioned and funded in new ways.

**Maternity Support Workers**

There have been many suggestions regarding the future role of the MSW. Maternity Standard, National Service Framework for Children, Young People and Maternity Services (DH and DfES, 2004) stated that MSWs should have important roles in future maternity care, such as working in postnatal areas under the supervision of midwives.
In 2006, the DH commissioned work to examine the role that support workers could play in maternity services. The role was also referred to in Maternity Matters, when the skill mix was reviewed to release the clinical time of other staff. Examples of ways to achieve this included MSWs undertaking tasks such as clerical work, breastfeeding support and parentcraft classes (DH, 2007).

NHS Employers (2006) reported on a large scale workforce change programme in which models of the role of the MSW were explored with a view to the dissemination of good practice. MSW roles had been developed or were being implemented across 55 trusts in 26 strategic health authorities. In total, 218 WTE posts were implemented over a 10 month period. The report gave demographic and outcome data for each trust. This included the new responsibilities of MSWs (Table 1), where they worked, the range of roles, the improvements being delivered for women and the maternity team, the impact of midwifery time being saved and the views of users and staff.

The report showed that significant numbers of midwifery hours were being released in acute and community settings. Reported benefits included midwives being able to spend more time with women in labour on a one-to-one basis and being able to update themselves professionally. Views of childbearing women were positive, midwives were less pressured and MSWs felt valued and satisfied with their new roles (NHS Employers, 2006).

Role development
Stout (2007) described 14 examples of how the MSW role has developed in maternity services in England. One of these, a birth centre in St Austell, Cornwall, provided additional training for MSWs to enable them to take on roles such as breastfeeding support and new baby care, in both the birth centre and the community.

In this instance, choice for women has been supported through more efficient use of staff resources and increasing the viability of a midwife led community based service. This has also allowed flexible appointments for women, including evening and weekend working. Other new roles taken on by MSWs and described in the report include clerical and administration duties, extra support in labour, and parent education.

Sandall et al (2007) surveyed a 50% representative sample of maternity trusts in England to examine the numbers, scope and range of practice, skill mix and service model arrangements of MSWs. Using a telephone questionnaire, the researchers interviewed 94 maternity unit managers. Analysis of the data showed a wide variation in the activities undertaken by MSWs, from carrying out housekeeping duties to booking appointments, neonatal blood tests and abdominal examination. Employment bands awarded also varied and MSWs in similar roles were often paid different rates.

In January 2009, NHS West Midlands funded a project to enable MSWs to take over the scrub role in the obstetric theatre. An in-depth theoretical and practical programme has produced high quality, trained workers, which has released midwives and registered nurses from the scrub role. The project is ongoing and other areas have also adopted this position.

MSWs are being developed to act as a second person at a home or hospital birth (with the midwife remaining accountable for care) or to provide enhanced breastfeeding support and support to the community midwifery service (NHS Employers, 2006).

An evaluation of a 2006 rapid rollout programme in the South East of England found the MSW to be an invaluable addition to maternity teams (NHS Employers, 2006).

DISCUSSION
Midwives need to delegate some of the roles that can be undertaken by those without a professional midwifery qualification, and MSWs need to develop additional skills to take on these roles.

The rapid development of the MSW role has led to some anxiety among midwives that their role might be eroded and they could be replaced by a cheaper alternative (Ackerman and Maycroft, 2008). As such, clarification of the responsibilities of the MSW and their interface with the statutory midwife role is required. In addition, while midwives are required to work within a professional code, there is no regulation of support workers. This raises issues of accountability, which require further debate.

CONCLUSION
Changes due to the European working time directive and national policy have expedited the need for health professionals to review their roles. Midwives and nurses have enhanced and developed their skills over the past decade but remain somewhat reluctant to give up traditional tasks that can be done by others.

The increased birth rate, diverse population and the need to implement national policy mean that midwives need to embrace the assistance of well trained support workers. Whatever the job title – maternity support worker, maternity care assistant or maternity assistant (Stout, 2007) – the support worker role is seen as essential to the future of maternity services and in enabling midwives to make choice a reality for childbearing women.

REFERENCES