The Impact of Maternity Care Support Workers in NHS Scotland

Faculty of Health and Social Care
London South Bank University

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Richard Griffin
Christine Blunt
Prof. Jacqueline Dunkley-Bent
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Contact address for further information:

Richard Griffin
Faculty of Health and Social Care
London South Bank University
K2 Building
23 Keyworth Street
London, SE1 6NG

T: +44 (0)20 7815 8350
E-Mail: Griffir3@lsbu.ac.uk
Web: www.lsbu.ac.uk/hsc

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The Impact of Maternity Care Support Workers in NHS Scotland

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The Impact of Maternity Care Support Workers in NHS Scotland: an evaluation

EXECUTIVE SUMMARY

- In 2008 NHS Scotland began introducing a higher-level maternity support worker role called a Maternity Care Assistant, a title that was later changed to Maternity Care Support Worker (MCSW). The role is supported by a dedicated national Competency Framework and associated learning programme currently delivered by two higher education institutions. To date 82 MCSWs have been trained or are being trained through these programmes. In 2010 London South Bank University was commissioned to undertake an impact evaluation of the role.

- The MCSW role has been introduced in response to service demands such as reduced lengths of stay for women with healthy births and workforce challenges including the ageing profile of the qualified midwifery workforce.

- The evaluation found very high levels of satisfaction with the training programme from support workers, midwives and national stakeholders. The programme delivers learning relevant to MCSW’s jobs in an appropriate style. MCSWs and midwives believe that the training programme provides the support workers with the necessary skills and knowledge to undertake their role.

- There was no evidence of learning ‘overload’ or of any omitted knowledge and skills from the programme. Some MCSWs are non-traditional learners and require additional learning support and study skills particularly at the beginning of the programme. This is likely to be even more the case if future cohorts are recruited from non-maternity support staff or non-NHS employees.

- Attrition rates from the programme are extremely low and all the support workers so far that have completed the programme have passed. Around 70 trained MCSWs have been deployed by NHS Health Boards. Boards wish to substantially increase the numbers of MCSWs they currently employ.
The programme has resulted in a range of proximal benefits for MCSW staff including increased confidence, commitment to the NHS and job satisfaction. These benefits are likely to result in lower absence and staff turnover.

MCSWs perform a wide range of tasks that were previously undertaken by midwives. These include: antenatal and postnatal parenting skills education, Venepuncture, breastfeeding information, guidance and support and the monitoring of maternal and baby vital signs. MCSWs also though continue to carry out traditional support worker housekeeping and administrative duties. The extent to which MCSWs are able to fully utilise the knowledge and skills they have acquired does vary by Board, however.

MCSWs work in all settings and across the whole maternity pathway. There is also evidence of the development of a specialist MCSW role focusing on assisting women with specific or higher-level support needs.

Support workers are freeing-up the time of midwives who, as a result of the training the MCSWs have received, are able to delegate tasks to them. This has increased capacity and improved the quality of care to mothers and their families.

The programme has successfully addressed accountability and governance issues. The majority of maternity staff have accepted and integrated MCSWs into their teams and feel confident to delegate tasks to them. The Skills Passport has been particularly effective in supporting safe and appropriate delegation of tasks.

While the majority of midwives and other maternity staff, including non-MCSW support workers, accept the role, there is some evidence of limited resistance to MCSWs. This largely stems from concerns that the role will dilute midwives’ skills or even replace midwives. Such resistance seems to dissipate once the role is established and where staff’ concerns are directly addressed.

The MCSW programme learning outcomes are commensurate with Scottish Credit and Qualifications Framework (SCQF) level 7, which equates to level 3 on the NHS Career Framework. There is, however, some inconsistency in the Agenda for Change banding of the role across boards with some MCSWs graded at band 3 and some at band 4. This has inhibited the full deployment of the role locally in a small number of cases.

The MCSW role has largely been developed in isolation to overall workforce planning. No labour force data is collected nationally on maternity support workers. To ensure the
effective deployment of the role MCSWs need to be more fully integrated into workforce planning processes.

- The MCSW programme has successfully provided clarity and consistency in respect of the higher-level maternity support roles, clearly codified the tasks that the role can – and cannot - undertake through the Competency Framework and Skills Passport. It has also raised the profile of the role amongst maternity services.
1. Introduction

1.1 Background

Maternity services and practices in Scotland are changing with, for example, a much greater emphasis on encouraging women to exercise choice and control in the type of care they receive during their childbearing period. Lengths of stay in hospitals for women with healthy births are falling. An older average maternal age, however, is resulting in a greater number of complications and adverse outcomes (Maternity Services Action Group, 2008). These and other changes in service delivery have in turn driven changes in the Scottish maternity workforce. In 2008, following three years of scoping and developmental work, NHS Education for Scotland commissioned a national education programme linked to a core Competency Framework in order to establish a higher-level support worker role now called Maternity Care Support Workers (MCSWs). In total 82 maternity support workers have either been trained or are being trained as MCSWs. We estimate that around 70 of these have been deployed by services as MCSWs.

In August 2010, London South Bank University (LSBU) was commissioned by NHS Education for Scotland (NES) to undertake an independent evaluation of the impact of the role. The evaluation addresses the following research questions:

- To what extent have MCSWs changed workforce planning?
- To what extent have MCSWs impacted on service delivery?
- How are MCSW roles meeting the career and developmental aspirations of MCSW post holders?
- How do other members of the maternity team, other staff and service users perceive the role?
- What is the overall cost and benefit of MCSW posts?

1.2 Roles and responsibilities in maternity services

Registered midwives are the key professionals responsible for the provision of care to women through low risk pregnancies, birth and postnatal care (NES, 2006; Midwifery 2020, 2010; RCM, 2010a). The role and training requirements of qualified midwives are defined by the European Union¹ and by The International Confederation of Midwives. Midwives are responsible for the delegation of tasks to support workers and are required to ensure that adequate supervision and

support is available for safe care (Midwifery 2020, 2010). Support workers are accountable for accepting any tasks delegated to them (NMC, 2008). The Midwifery 2020 Programme Final Report points out that:

“Delegation must always be for the benefit of women and families and where aspects of care are delegated this must not disrupt the provision of holistic care or reduce the quality of care” (2010: 31).

In February 2010, the Royal College of Midwives (RCM) published a Position Statement on maternity support workers. The statement recognises the valuable role support workers can play helping women, their families and healthcare professionals. The RCM states that support workers are able to directly and indirectly benefit midwives, mothers and their families through the undertaking of:

“work for which midwifery training and registration are not required either by statute or by professional guidelines” (RCM, 2010b: 2).

The RCM guidance further establishes clear principles in the respect of role boundaries in order:

“to ensure consistency in standards of care, to protect the public and sustain a defined body of midwifery knowledge” (RCM, 2010b:1).

An earlier RCM Position Paper published in 2006, set out examples of duties that midwives can appropriately and safely delegate to support workers. These included:

- Advice and information on nutrition, exercise, smoking and other lifestyle factors associated with a healthy pregnancy.
- Facilitating fathers’ and partners’ involvement.
- Information and support with infant feeding.

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2 http://www.rcm.org.uk/EasySiteWeb/getresource.axd?AssetID=118790&servicetype=Attach
2. Evaluation methodology

2.1 Introduction

This impact evaluation uses a quantitative and qualitative mixed method research design to measure the difference MCSW posts are making to mothers, their families, midwives and others. Impact measures include the extent to which support workers are freeing up the time of midwives to allow them to meet the needs of women (Hunter, 2005). The evaluation further seeks to investigate:

- The effect MCSW posts are likely to have on future maternity workforce planning.
- The extent to which MCSWs have been accepted and integrated into maternity teams.
- The perceptions of MCSW staff themselves of the role and the extent to which it is meeting their career aspirations.

Mixed methods allow, via the collection of multiple evidence from different sources: greater validity of findings, a more in-depth understanding and picture of the role’s impact. Mixed methods also allow an investigation into the multifaceted nature of the role’s development and deployment (Mason, 2006). Finally mixed methods allow descriptive and empirical evidence to be presented (Onwuegbuzie and Leech, 2005). Each method has been utilised separately and treated equally. The overall research design is shown in Figure 1 below.

2.2 Evaluation methods

2.2.1 Literature Review.

We sought to identify English-language peer-reviewed studies and other reports concerned with maternity support workers. Searches have been made in a range of health, management and educational electronic library databases including: Intermid3, Health Management, Maternity and Infant Care and Education Resources Complete along with websites of organisations such as the RCM, NHS Employers and the Kings Fund.

Our search identified just three non-descriptive articles that had been peer reviewed. Others have recently noted the paucity of research on maternity support workers (Kings Fund, 2011). A greater number of non peer-reviewed reports (such as Kings College, 2007) were identified. These reports however largely focus upon the initial creation of higher-level support worker roles and as

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3 The Intermid database is the largest source of articles on midwifery. Back issues of the British Journal of Midwifery were also searched.
such highlight normative issues such as the need to create coherent and standardised education programmes (see for example Kings Fund, 2005; NHS Employers 2006). These issues are now beginning to be addressed (RCM, 2010a). Moreover, while these reports identify potential benefits often based on anecdotal evidence they do not include robust assessments of the role’s impact on service delivery (Kings Fund, 2011) ⁴.

Figure 1: Review Stages and Methods

The effective deployment or extension of any role in the healthcare workforce is contingent on a range of processes, structures and cultural issues (Nancarrow and Borthwick, 2005). In order to gain insights into the broader issues that might inhibit or enable the application and impact of MCSW competences we extended our literature search to include studies concerned with the development of health care support workers more generally.

⁴A number of impact evaluations are though currently being undertaken across the UK. These will allow a more evidence-based assessment of the role to be made. In addition to this evaluation, NHS London has commissioned an evaluation of a Maternity Support Worker Foundation Degree provided by LSBU (due to be published in January 2012) and NLIAH are evaluating the All-Welsh NVQ-based MSW learning programme. Where possible evidence and insights from these evaluations have been included in this research.
2.2.2 Document Review.
We gathered and reviewed policy documents and educational material produced by NES and others relating to the development of MCSWs in Scotland. Scottish maternity workforce and birth rate data was also been gathered in order to provide background and contextual information particularly in respect of future labour force supply and demand.

2.2.3 Semi-structured interviews.
Between October and November 2010 we carried out a series of semi-structured one-to-one telephone interviews with a range of stakeholders including heads of maternity services, workforce planners, education providers and professional body representatives (n=9). The results of these interviews are reported in Section 6.

2.2.4 Self-completion questionnaire results.
Two self-completion surveys were designed – one for MCSWs and one for midwives. The surveys were designed on the basis of our literature review, stakeholder interview findings and feedback from NES. The objective was to gather information on staff’s perceptions of the role, the relevance of its learning, and the extent to which acquired knowledge has been applied in the workplace and to what effect.

The surveys were distributed to those Boards employing two\(^5\) or more fully trained MCSWs. This purposeful sampling frame sought to ensure that a sufficient number of MCSWs had been in post for a long enough duration (at least a year) to allow an appropriate assessment to be made of the role’s impact locally either by the MCSWs themselves or by midwives who worked with them. Surveys were only distributed to midwives\(^5\) that had direct experience of working alongside support workers. This allowed information to be gathered on actual experience of the role rather than perceptions of it.

Eight Boards agreed to participate. One Board approached to participate was excluded because they had not deployed any MCSWs although staff had been trained on the programme. Paper based surveys were distributed directly to MCSWs (n=34). Participation was voluntary and survey results anonymous. MCSWs were asked to return surveys directly to LSBU in prepaid envelopes. In total 52% of surveys were returned (n=18). An on-line survey was designed for midwives to complete. Heads of Midwifery were asked to identify midwives who had direct experience of

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\(^5\) In one Board a MCSW had resigned meaning that they only had one left in employment. The remaining MCSW was invited to participate.
working with MCSWs and an email was sent to these staff inviting them to complete the survey (n=55). In total 13 completed the survey (23.6%). Both surveys were analysed using Microsoft Excel 2007.

The surveys utilised self-report measures based on employee’s perceptions of the MCSW role. It is possible that responses may reflect respondent’s psychological state on the day they completed the survey or what they consider to be socially desirable answers. As completion of the survey was voluntary we have no data on those MCSW and midwives who did not return surveys.

2.2.5 Additional qualitative research

Whilst undertaking this study the opportunity arose to undertake further qualitative research as follows:

- A semi-structured telephone interview was held with a maternity lead whose staff have completed the MCSW programme but have not yet been employed in the role locally.

- A focus group was held at the Scottish Lead Midwives Group’s meeting in January 2011. This explored views on the role and future commissioning intentions.

- A telephone discussion was held with a senior midwife who was leading a skill mix review of her Board’s community maternity service and planned to expand employment of MCSWs.

2.2.6 Case study research.

Permission was granted to undertake field research at a NHS Board. This was conducted in March 2011. This research allowed a more in-depth enquiry into the difference MCSWs have made within a maternity service. The case study research consisted of four focus groups discussions with MCSWs and midwives. The focus groups were digitally recorded with participant’s permission and transcribed verbatim. The transcripts were analysed thematically in order to identify common themes and experiences.
3. The Development of MCSWs in Scotland

3.1 The creation of higher-level maternity support roles in UK maternity services

Support workers have been a feature of UK maternity services since the inception of the NHS. Traditionally such roles have performed general housekeeping, clerical and administrative duties such as bookings, cleaning, bed making, stocktaking or as a ‘runner’ during theatre procedures (RCM, 2010a). Recent years though have seen the evolution of a new higher-level support worker role often described as ‘Maternity Support Workers’ (MSW) in England, Wales and Northern Ireland and ‘Maternity Care Assistants’ or ‘Maternity Care Support Worker’ (MCSW) in Scotland. The evolution of this role has been in response to a range of factors reshaping maternity services across the UK (Lindsay, 2004; NES, 2006; Griffin et al, 2009; RCM Wales et al, 2008; Midwifery 2020, 2010; Kings Fund, 2011):

- Future staffing shortages as the professional maternity workforce ages.
- Changing expectations of mothers.
- Reducing the workload of midwives.
- Social changes including the trend towards older mothers and the additional demands placed by lifestyle challenges.
- Clinical safety.
- Productivity.
- Retention of midwives.
- Continuity of care, effective care planning and delegation.
- Capacity and maximising midwives direct contact with mothers and their babies.

While there has been an expansion in the number of higher-level support workers in recent years the Kings Funds' review of staffing levels in maternity units notes that compared to midwives:

"Much less is known about the significant and growing numbers of maternity support workers. What we do know is that their evolution and development is variable across the United Kingdom, along with job titles used and training provided" (2011: 6)

6 There is a third maternity support role which has been developed to assist in Obstetric theatres but these posts are outside of the scope of this research (RCM, 2010a).
What evidence there is suggests that higher-level roles undertake more advanced duties than traditional support workers. Working under the supervision and direction of midwives, they perform tasks such as helping mothers with personal hygiene, removal of catheters, parenting skills education, taking of bloods, cannulation and breastfeeding support (Griffin et al, 2009; National Nursing Research Unit, 2010). As a result higher-level roles tend to be graded at (AfC) band 3 or more rarely 4; compared to band 2 for traditional roles.

In Scotland, the development of MCSWs, underpinned by a national Competency Framework, has been in response specifically to the need to ensure services are woman and family centred; deliver value for money and address potential future staff shortages (NES, 2006). The actual genesis for the role’s creation was the Scottish Executive’s 2002 review of maternity services. A scoping exercise undertaken in 2004 showed a clear commitment from maternity services to the need to standardise and enhance the role. In 2005 NES was commissioned to undertake a four-phase project to:

- Develop the MCSW role.
- Scope existing educational opportunities.
- Design a core Competency Framework.
- Commission a national educational programme.

### 3.2 The MCSW Core Competency Framework

The *Maternity Care Assistants in Scotland: A Competency Framework* was published by NES in 2006. A multi-partner steering group developed the framework. It not only established the key competences MCSWs should possess but also aimed to:

“… inform MCSWs about their roles and boundaries” (NES, 2006:8).

The Framework recognises that defining a single all-encompassing MCSW role is problematical because the exact components of the post will vary by service need and area. The Framework is linked to the NHS Knowledge and Skills Framework and comprises ten competences (see Box 1 below). In 2010, NES published *A Guide to Healthcare Support Worker Education and Role Development*. This document set out three levels of support worker linked to the Scottish Credit and Qualification Framework (SCQF)⁷:

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⁷ Qualifications in Scotland exist within the Scottish Credit and Qualifications Framework (SCQF). The English, Welsh and Northern Ireland equivalent is the Qualifications Credit Framework (QCF). There are twelve levels in the SCQF starting at Access level 1 and progressing to Doctoral Degree at level 12. The MCSW learning programme is at the same level, for example, as SVQ level 3 qualifications. The programme is equivalent to QCF level 3.
MCSWs have been developed at Senior HCSW level. In Scotland the exact banding of MCSWs is a matter for local determination through AfC job evaluation. Some Boards have graded MCSWs at band 3 and others at band 4. The academic attainment achieved through the completion of the education programme is at Scottish Credit and Qualification Framework level 7, which is commensurate with preparation for senior support workers.

Box 1: MCSW Competences

1. Recognise the importance of ethical and legal issues within maternity care.
2. Respect the principle of woman-centred care.
3. Communicate effectively.
4. Maintain standards of record keeping appropriate to the role of MCSW.
5. Function effectively as a member of the multidisciplinary team.
6. Support the creation and maintenance of environments that promotes the health, safety and well-being of women, babies and others.
7. Participate in the provision of care, monitoring and support for women and their babies.
8. Review, develop and enhance own knowledge and skills.
9. Recognise and respond to emergencies in order to meet the needs of women, babies and the team.
10. Assist the midwife to support parent’s transition to parenthood.

3.3 The MCSW Education Programme

Following the creation of the Competency Framework an associated 42-week education programme - a Certificate of Higher Education with an award equating to SCQF level 7 was developed by Robert Gordon University (RGU) in partnership with NHS Grampian in 2008. The course aims:
“to produce MCSWs with knowledge, skills and attitudes which will enable them to support women, their families and midwives working within the maternity services in Scotland” (Gibb et al, 2008: 5).

The course is delivered through a blend of face-to-face teaching and online learning. Workplace-based mentors provide trainees with guided learning in a range of placements, which is recorded and signed off in the programme’s Skills Passport. The Passport supports the achievement of the competencies MCSWs require and which are contained in the programme’s Competency Framework (NES, 2006). It also sets out through a traffic light system - skills that may be undertaken by MCSWs, those that require further training and those that must not be carried out by support workers. As a result the Passport defines and codifies the limits and boundaries of the role. This is reinforced through the programme’s learning.

The RGU course modules comprise:

- The role of the MCSW
- Communication
- Delivering holistic care.
- Practice education.
- Meeting the needs of women and their families.

To date 69 MCSWs have completed or are currently studying on the RGU programme. A second education provider - The University of the West of Scotland introduced a MCSW education programme linked to the Framework in September 2010. They currently have 13 staff on the programme drawn from four health Boards. A total of 82 support workers then have joined MCSW training programmes. Since 2008, MCSW student cohorts have been drawn from across Scotland’s Health Boards and have been recruited following nomination by Heads of Midwifery, from the existing pool of health care support staff employed in maternity services.

Learning programme design and delivery style has been shown to have an effect on the acquisition, transfer and application of learning into the workplace (Burke and Hutchins, 2007; Giangreco et al, 2010). It has been estimated that on average as little as 10-15% of classroom learning is actually transferred into improved job performance (Kontogiorghes, 2004). Ensuring that learning programmes are relevant to a trainees’ work, are delivered via an appropriate

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8 May 2011
pedagogy and that there are no barriers to the transfer of learning into the workplace allows effective transfer and retention of knowledge and skills over time (Arthur et al, 1998).

Formative evidence of the effectiveness of the learning programme was undertaken by RGU through an internal evaluation of the pilot course, the results of which are reported in Gibb et al, (2008). The first cohort of students positively evaluated all the theory-based sessions. In addition, Gibb and colleagues state:

“... mentor feedback was ... without exception highly complementary of the developing competence and skills of the MCSW students” (page 21).

The external examiner’s report highlighted the following positive features of the programme and stated according to Gibb and colleagues that it was ‘excellent’:

- Students are able to develop their reflective skills.
- Individual progression is encouraged.
- Students are able to apply theory into the practice environment.
- Standards are above what is expected at the academic level.
- Students demonstrate empathy, insight and individual growth.

Table 19 shows that the course delivered at RGU has had low attrition rates and high pass rates. The majority of staff withdrawing from the programme (n=3) are from one Board and as discussed in Section 10, left for reasons unrelated to the programme. Table 2 provides a comparison of the various maternity support worker-training programmes introduced to date10 across the UK. Table 2 shows that the MCSW programme is at the same educational level as the Northern Ireland and Welsh programmes. The LSBU Foundation Degree is at a higher level, equivalent to SCQF level 8. In respect of duration the MCSW is broadly the same length as the Northern Ireland NCQ level 3 programme but shorter than the Welsh NVQ and LSBU Foundation Degree. The cost of the MCSW is slightly less than the annual cost of the LSBU course.

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9 Source: Gibb et al, (2008) and email communication.
10 Further MSW Foundation Degree programmes are currently being developed in England.
### Table 1: Robert Gordon University Course Details

<table>
<thead>
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<th>April 2007</th>
<th>April 2008</th>
<th>April 2009</th>
<th>April 2010</th>
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<tr>
<td>Number of students starting</td>
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<td>20</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td>Number withdrawing</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Attrition rate (%)</td>
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<td>10</td>
<td>18.7</td>
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<td>Numbers passing</td>
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<td>5</td>
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<tr>
<td>Pass rate (%)</td>
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<td>100</td>
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<tr>
<td>Cost per student (£)</td>
<td>1750</td>
<td>1750</td>
<td>1870</td>
<td>1870</td>
</tr>
</tbody>
</table>

### Table 2: Maternity support worker programmes

<table>
<thead>
<tr>
<th>Programme</th>
<th>Qualification</th>
<th>Education Level</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Gordon</td>
<td>Certificate of Higher Education</td>
<td>SCQF 7</td>
<td>42-weeks</td>
</tr>
<tr>
<td>LSBU</td>
<td>Foundation Degree</td>
<td>QCF 4</td>
<td>Two years</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>National Vocational Qualification</td>
<td>QCF 3</td>
<td>10 months – two years (max for part time)</td>
</tr>
<tr>
<td>All Wales</td>
<td>NVQ, OCN Level 3, Edexcel BTEC</td>
<td>QCF 3</td>
<td>70 weeks</td>
</tr>
</tbody>
</table>
4. Scottish demographic and maternity workforce information

4.1 Scottish birth rates

The most recent population review in Scotland shows that the country’s birth rate is presently stable (The Registrar General for Scotland, 2010). There were a total of 59,064 registered births in 2009, a 1,000 fewer than 2008 but 1,200 more than in 2007. This figure however is well below the peak of over 100,000 recorded in the 1960s and Scottish birth rates are expected to fall in the future (Midwifery 2020, 2010). By 2030 birth rates are forecast to have fallen to 50,300 per annum although rates will vary by Health Board (Maternity Services Action Group, 2008).

In common with other parts of the UK the average age of mothers in Scotland is rising from 27.4 years old in 1991 to 29.4 in 2009 (Midwifery, 2020, 2010). Nearly half of all new Scottish mothers in 2009 were over 30 years of age. Older maternal age is more associated with pre-existing ill-health, multiple births, complications of pregnancy and increased risk of adverse outcomes (Maternity Services Action Group, 2008).

4.2 Scottish skills policy

Scotland’s workforce is the most skilled in the UK – 33.4% have a qualification equal to a SVQ level 4 or above. The Scottish Government (2010) sees the development of a skilled workforce as the key driver of employment and productivity growth. In respect of the country’s public sector the Government’s aim is to:

“… ensure a flexible responsive approach to skills development …[to create] more confident, motivated and relevantly skilled individuals, aware of the skills that they possess and how best to use them, engaged in workplaces that provide meaningful and appropriate encouragement, opportunity and support to develop and use their skills effectively” (2010: 38, 41)

4.3 Scottish maternity workforce

In 2008 Scotland employed 2,670 whole time equivalent (wte) qualified midwives - 51.4 wte midwives per 100,000 population and 45.4 wtes per birth – the highest proportion in the UK (Midwifery 2020, 2010). Latest workforce data shows that in 2009 the ‘on the day’ vacancy rate for

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11 This is higher than the overall UK average of 27.5 years (ONS, 2009).
midwives in hospital settings was just 1.4% and in community settings 2.3% (NHS Scotland Workforce, 2010). From 2011 newly qualified midwives in Scotland who are unable to secure permanent employment have been guaranteed an internship for one year in clinical practice12.

While midwifery vacancy rates are low, the peak age of employed midwives has increased in the last five years. Workforce statistics gathered for the Midwifery 2020 Programme show that 39.1% of all midwives in Scotland are due to retire by 2020. Moreover the proportion of midwives working part time has risen from 50.6% in 1998 to 62.4% in 200913. Alongside this trend the population of Scotland as a whole is ageing. It is estimated that the number of people over 75 years of age will grow by 84% between 2008 and 2033 (The Registrar General for Scotland, 2010). An ageing population may cause labour supply constraints in the future.

4.4 Skill mix and grading

There are currently between 70-8014 MCSW staff in training or deployed in Scottish maternity service. They comprise just over 2% of the total maternity workforce headcount15.

In Wales the National Leadership and Innovation Agency for Healthcare (2009) estimate that support workers comprise some 20% of the maternity workforce. Unfortunately the Agency does not distinguish between traditional and higher level roles. Around 40 MSWs in Wales are currently studying or have completed the All Wales Curriculum. This suggests a similar proportion of higher-level support workers as Scotland. Research conducted in London found that on average higher-level maternity support workers comprised 25% of the total maternity workforce although that ratio varied between services from 4.4% to 37.5% (Griffin et al, 2009). There are presently 44 students enrolled on the foundation degree programme at LSBU and a third cohort is being recruited16. Northern Ireland has only recently begun introducing higher-level MSW roles17 through the piloting at the Southern Health and Social Care Trust of a regional 12-month NVQ Level 3 programme. To date 21 MSWs have been successfully trained through this programme, which is now being introduced in each of the region’s five trusts.

12 http://www.employabilityinscotland.com/jobguaranteeformnurses.aspx
13 One senior midwife who participated in this research said she needed to recruit two people to fill most midwifery vacancies.
14 While 82 MCSWs have or are being trained not all these have been deployed locally.
15 Headcount is 3231
16 A second London HEI is planning to introduce a MSW foundation degree from January 2012, as are at least two others outside London.
When considering relative staffing ratio’s some caution needs to be exercised. Accurate labour force data is not gathered for maternity support workers (see Section 5). Moreover there is no single agreed UK definition of the maternity support worker roles\(^{18}\). It should also be noted that Scottish maternity services might be employing higher-level support roles that have not undergone the MCSW training programme\(^{19}\).

Most higher-level maternity support workers in England, Wales and Northern Ireland are graded at *Agenda for Change* (AfC) band 2 or 3, although there are a small number at band 4 posts in England. In Scotland the exact banding of MCSWs is a matter for local determination through AfC job evaluation. Some Boards have graded MCSWs at band 4. The academic attainment achieved through the completion of the education programme is at Scottish Credit and Qualification Framework level 7, which is commensurate with preparation for senior support workers.

### 4.5 Conclusion

While vacancy rates for midwives in Scotland are low, an ageing and increasingly part time registered workforce is likely to place capacity pressures on services. Demand for maternity services, despite predicted overall falling birth rates, is likely to grow in the acute sector in response to more complicated births and in the community as the overall length of stay falls and home birth rates rise. In addition maternity services will need to respond to new policy priorities and service pressures.

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\(^{18}\) The RCM are planning to produce guidance on higher-level support worker roles and tasks in autumn 2011.

\(^{19}\) As discussed in Section 10 we found examples of extended traditional support roles.
5. Effective healthcare role development

This section briefly sets out a conceptual framework that seeks to identify the factors that may influence the effective development and deployment of new or extended roles in healthcare.

**Factor 1: Rationale for role development – appropriately meeting health and service needs.**

Dussault and Dubois (2004) have argued the need for human resource interventions to be aligned with service and health needs. Too often, they report workforce development has been an ‘afterthought’ rather than an integrated element of service development. The RCM have recently drawn attention to the need for a coherent and appropriate rationale for the introduction of higher-level maternity support roles. The College makes clear that support workers should not be used:

“as substitutes for midwives or to cover shortfalls in midwifery staffing numbers”

(RCM 2010a: 2).

Kessler et al’s (2010) recent research on nursing HCAs identified four ways in which support workers are utilised:

- **Substitute** – support workers are seen as a ‘cheap labour’ substitute for qualified staff.
- **Apprentice** – the support worker role is part of a pathway the leads to becoming professionally qualified.
- **Co-producer** – support workers complement and directly support the work of qualified staff.
- **Relief** – support workers relieve qualified staff of routine tasks.

Nationally NES (2010) has made it clear that NHS support workers as a whole should be used to release professional staff from non-core activities by taking on work previously within the remit of registered practitioners and providing complementary capacity.

Applying Kessler et al’s typology to the intended rationale for MCSWs, it would appear clear that the aim of introducing the role in Scotland was to develop ‘Co-producer’ and ‘Relief’ type posts. Given the clearly regulated task boundaries required in midwifery ‘Substitute’ or ‘Apprentice’ roles would be inappropriate rationales for role development. The rationale for the development of MCSWs in Scotland has clearly been to provide complementary support for the maternity team directly linked to health and service needs:
“The introduction and development of maternity care assistants has been identified as one way of developing and modernising maternity services in order to be responsive to current and future need” (NES, 2006: 2)

While the intended rationale for the development of MCSWs in Scotland nationally is clear and appropriate, actual perceptions of the role locally may differ with, for example, some midwives fearing that MCSWs will be used as ‘Substitutes’.

**Factor 2: The need to clearly define roles and boundaries**

There is a need to ensure roles are clearly defined and have appropriate professional boundaries. Research in England shows the ad hoc evolution of maternity support roles has resulted in a lack of clarity and consistency in responsibilities, deployment and grading (Kings College, 2007; Griffin et al, 2009; Midwifery 2020, 2010; Kings Fund, 2011). In August 2008 NES published A Skills Passport for maternity support workers that seeks to set out the tasks that are ideal for support workers with appropriate training and those that are not to be undertaken. The Passport reminds support workers to focus on the skills that they can undertake in their area of work, that they should work within their sphere of responsibility and that all clinical tasks should be delegated and reported back to a qualified midwife. This document clearly defines the parameters of the MCSW role.

**Factor 3: Workforce planning: the ‘invisible’ workers**

While acknowledging the importance of maternity support workers, the workforce Final Report of the Midwifery 2020 Programme (2010) noted that there is limited labour force data available on such roles, describing them as ‘largely invisible’ in terms of workforce information. The Kings Fund has recently made a similar point:

“... much less is known about the significant and growing numbers of support workers, who play a valuable role within the maternity care team and could take on additional tasks. This makes it difficult to model requirements for the future workforce” (2011: vi)

While NHS National Services for Scotland’s Information Services Division\(^ {20} \) website contains labour force data on midwives, no data is currently collected on MCSWs.

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\(^ {20} \) http://www.isdscotland.org/isd/1.html
As the Midwifery 2020 Programme (2010) Final Report states maternity workforce planning is multifaceted and influenced by a wide range of variables. These affect the capacity and quality of care. In the case of maternity services workforce numbers and skill mix should be driven by a focus on the needs of women and families. The report further notes that as the MCSW role develops:

“greater understanding will be required in regard to how the future workforce model may evolve” (2010: 3).

“The composition and skill mix within maternity teams needs to be considered as new roles such as maternity care assistants emerge” (2010: 7).

The RCM has also noted the importance of ensuring that workforce planning takes account of the development of support workers (2010a; 2010b). Effective workforce deployment requires effective workforce planning, which in turn requires accurate workforce supply and demand intelligence linked to service needs.

**Factor 4: The need to win ‘hearts and minds’**

Previous reports have highlighted that the introduction of higher-level maternity support roles can result in concerns amongst existing staff in respect of possible changes in role, skill mix (including replacement) and changed working patterns (RCM Wales et al, 2008). There is also some evidence that midwives may perceive support posts as devaluing the role of midwives. An evaluation of the introduction of maternity support workers at NHS Addenbrooke’s in 2003 reported concerns from midwives that the post would erode their position (Lindsay, 2004). Such concerns can heighten during periods of public sector funding constraint when professional staff may also be less willing to ‘give up’ tasks (Nancarrow and Borthwick, 2005).

The RCM’s (2010b) *Guidance Note on Maternity Support Workers* sets out the importance of ensuring support workers are fully integrated members of the maternity team. There is some evidence, however, that support workers can experience barriers that prevent them from fully integrating, for example a reluctance by other team members to delegate tasks (Griffin et al, 2010). This issue is not unique to maternity. It has also been highlighted for example, in developing Health Care Assistant roles in primary care (Bosley and Dale, 2008; McDonald et al.,

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21 Including women’s choice, geography, models of care, midwives working patterns, student numbers and retirements.
The Impact of Maternity Care Support Workers in NHS Scotland

2009)\(^{22}\) and for acute sector nursing HCAs (Kessler et al, 2010). Fears about the introduction of new roles may stem from a range of factors. Lindsay (2004) reported that the concerns she identified at Addenbrookes:

“… may have been driven by the psychological discomfort which accompanies any change in working practice” (page 653).

Interestingly, Lindsay believed attitudes towards the support workers improved once they actually carrying out their role because midwives were able to see the benefits they were able to provide.

**Factor 5: Providing relevant and effective educational support**

The lack of appropriate educational support, career pathways and life long learning opportunities has been previously identified as a barrier to the development of maternity support workers (Kings College, 2007; RCM Wales et al, 2008). In common with other support workers this can result in frustrations and thwarted career aspirations (Kessler et al, 2010). It can also mean that the NHS is not fully utilising the skills and contributions of its workforce (Fryer, 2006).

**Factor 6: Assessing the impact of a role**

Systematic measurement of the quality of maternity service provision is a vital element in driving improvements (Midwifery 2020, 2010). To date there has been a paucity of research available on the roles’ impact in maternity services (Kings Fund, 2011). A range of potential benefits has been proposed associated with the introduction of higher-level maternity support roles, often based on anecdotal evidence. These include:

- Midwives may, due to staff shortages, be overloaded with administrative duties (Kings Fund, 2007). This can also be a cause of frustration for midwives who feel they do not have sufficient time to spend with women and babies in direct care. This in turn contributes to decreasing job satisfaction which the effective use of support workers can help address.\(^{23}\)

- Maternity support workers provide the potential to release clinical time for healthcare professionals for example through reducing the ‘burden’ of data collection (Department of Health, 2007; Midwifery 2020, 2010)

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\(^{22}\) Such issues are not unique to support role development in health and social care or to the United Kingdom. Pearce et al, (2010) report on the challenges primary care nurses encountered in Australia integrating into local practice teams.

\(^{23}\) It is debatable to extent to which higher-level MCSWs should be undertaking a substantial portion of administrative work. We found an example where a service manager had to intervene to stop midwives delegating what she regarded as excessive amounts of administrative work, which then prevented MCSWs from carrying out other tasks.
The Impact of Maternity Care Support Workers in NHS Scotland

- Effective deployment of support workers allows a review of appropriate skill mix to provide safe and quality services to women and their families (Midwifery 2020, 2010).

This study only found three examples of actual evaluations of maternity support roles. Lindsay’s review of the introduction of higher-level maternity support workers\(^ \text{24} \) at NHS Addenbrooke’s reported a number of benefits accruing from the role including positive feedback from women who “appreciate kindly care from an informed support worker” (2004:653), improved continuity of care support and better utilisation of support workers by professionals.

The Kings Fund (2011) reports the findings of an impact evaluation of maternity support workers in the East Midlands. Key findings were:

- More than 90% of midwives felt that they had more time to spend with high-risk women and on their essential roles.
- Half of the midwives’ felt well supported by the support workers.
- Mothers were often unable to tell the difference between MSWs and midwives.

\(^{24}\) While a distinct new role within maternity supported by a bespoke NVQ training programme, the roles were at level 2 in educational terms.
6. Stakeholder interview findings.

6.1 Introduction

Semi-structured telephone interviews were conducted with Heads of Midwifery (HOM), educators, national policy representatives, workforce planners and a professional body representative (n=9). The interviews took on average 30-40 minutes and were, with permission, digitally tape-recorded. The findings reported below are anonymised.

6.2 Results

6.2.1 Role definition and boundaries

The HOM who were interviewed stated that they felt the national definition of the MCSW role was clear. The Skills Passport was seen as the key element in ensuring the role boundaries were appropriately and unambiguously set. Participants did however feel there was less certainty about the role’s definition and boundaries locally. It was mentioned for example, that not all health professionals referred to the Passport. One HOM commented that there was a lack of clarity surrounding the difference between traditional support workers in maternity services and MCSWs. It was also suggested that whilst the role’s function was clear for postnatal care this was not the case for delivery care. Another respondent believed that while organisations may be clear about the role and function of MCSWs particularly because of the national NES Framework for support roles this was not necessarily the case with service users, particularly in the acute sector.

6.2.2 The rationale for and benefits of introducing MCSW posts

All but one of the participants supported the introduction of MCSWs into Scotland’s maternity services. The main reason they believed that the role had been introduced was to free-up midwives time to allow them to enhance one-to-one support for mothers and babies.

Whilst very positive about the role participants did identify a range of challenges that the introduction of the post created locally. These included ‘jealously’ from the MCSWs’ previous peer groups and ‘suspicion’ from midwives.

The particular role MCSWs play supporting postnatal care was highlighted. Indeed some participants felt that there was a danger the role may become, in their words, ‘pigeon-holed’ in this area particularly providing women with breastfeeding support and advice.
As women’s length of stay in hospital, following a healthy birth, became shorter there was an opportunity, participants in this research believe, for MCSWs to provide substantial amounts of postnatal information:

“Women are in hospital an average of 1.8 days now. A lot has to be crammed in education and support for the women and baby”

“I think the community is the place for them to be. Not the only place of course, but the women’s hospital stay is so short. First time mothers in particular need somebody. Not a midwife but somebody to support and guide them”

Further benefits identified in the interviews are set out in Box 2, below.

<table>
<thead>
<tr>
<th>Box 2: MCSW role impact</th>
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<tr>
<td>Cost savings through delegation</td>
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<tr>
<td>Increased contact time for women</td>
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<tr>
<td>Workforce flexibility</td>
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<tr>
<td>Increased capacity through undertaking of parent skills education</td>
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<tr>
<td>Public health including smoking cessation</td>
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<td>Allowing midwives to focus on their core role</td>
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<tr>
<td>Providing holistic care to women</td>
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<tr>
<td>Continuity of care</td>
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<tr>
<td>Improved quality of care</td>
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</table>

6.2.3 Delegated tasks

The types of task delegated to MCSWs differed according to individual midwives and Board area. The most common task delegated, according to five of the interviewees, was breastfeeding advice. Others tasks specified were:

- General observations
- Parenting advice
- Neonatal screening
- Transition care.

It was suggested that inappropriate tasks were sometimes delegated. An example given was of a MCSW being used for obtaining bloods when a phlebotomist was available. At the other extreme some participants felt that the level of tasks MCSWs were directed to perform were often too low for the competences they have acquired.
More generally the manner in which delegation took place was considered problematic by all those interviewed. Respondents’ reported ‘suspicion’ from some midwives who were unconvinced of the need for MCSW posts rather than a lack of confidence in individual support workers. Interviewees suggested some midwives do not delegate at all, whilst others do so only under very close supervision:

“It’s all about role identification. Some of the older school midwives in particular find it difficult to delegate.”

Respondents felt that there was ‘still some way to go’ before many professional staff fully accepted the role. It was commented by one HOM that MCSWs are often not included as team members but rather they are used to ‘plug’ gaps in service.

6.2.4 Impact on workforce planning and skill mix

All those interviewed had concerns regarding the impact of MCSWs on skill mix ratios particularly given the current context of constrained public finances and the need to delivery productivity improvements. Respondents reported that they were aware of concerns that MCSWs would be utilised as a cheap substitute for professional staff because:

- MCSWs are cheaper to train than midwives
- Boards are looking for ways to reduce costs and midwives who rapidly attain Band 6 are expensive.
- As nursing funds are used to employ MCSWs their increasing numbers will impact on nurse employment.

However, when asked all the service leads interviewed thought that the numbers of MCSWs employed in Scottish maternity services should and would increase. Specifically, all the service leads interviewed wanted to employ more MCSWs at their Boards.

6.2.5 General comments

Respondents made many positive comments about MCSWs generally and particularly the MCSWs employed in their services. As all MCSWs are trained using the same programme, participants felt there is a consistency in competences. This contrasted to the different training programmes in England. Furthermore, as MCSWs have a research base component to their education it was felt that this will assist them to keep their skills up to date.
It was seen as an ‘immense’ success that the programme enabled auxiliaries who previously may have had few qualifications to progress their career and personal development. The programme also addressed the skills gap that participants perceived to have existed between traditional maternity support workers and registered staff.

The cohorts who had finished the course to date were seen as extremely motivated. This continued to be shown in the low attrition rates upon qualifying. It was also commented that the MCSWs showed great empathy towards women. The letters of thanks frequently received from mothers was evidence of this.

A number of other issues were highlighted:

- Concerns were expressed that some Boards wanted what they saw as an inappropriate’ skill mix at a home delivery by using a midwife and MCSW rather than two midwives.
- When future cohorts were no longer drawn from an exclusively maternity auxiliary base or even from staff with an experience of the NHS the quality of trained MCSWs may be reduced.
- A concern expressed by one respondent was that once trained MCSWs cannot accredit their learning to accelerate progression into pre-registration midwifery programmes. This it was feared might result in MCSWs being lost to midwifery because they can RPL to nursing programmes25.
- MCSWs were unlikely to be able to progress further within existing support staff structures.
- Respondents expressed differed views regarding length of course. Some felt that the course should be two years in duration.
- Participants felt that the AfC banding locally could be too high. One respondent said they were: “Not convinced a MCSW needs to be a band 4, a band 3 can do a lot of the work an MCSW does”.
- As the ratio of MCSWs increased accountability issues for midwives might occur.

25 There is some evidence to suggest that a significant proportion of higher-level maternity support workers would like to become qualified midwives but that this proportion does not change as a result of higher-level support worker training (LSBU unpublished research).
A financial anomaly had now arisen. At present there are not enough MCSWs to provide 24-hour cover. Therefore after qualifying a MCSW may earn less than they previously did.

6.2.6 How do MCSWs benefit mothers?

Box 3 lists the various benefits highlighted by participants that they felt MCSWs were providing mothers. The most frequent benefit arising from the role were seen as the provision of education for breastfeeding along with MCSWs ability to spend more time with individual women than midwives could.

<table>
<thead>
<tr>
<th>Box 3: MCSW’s Impact on women</th>
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<tr>
<td>Provision of education and information</td>
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<tr>
<td>Continuity of care</td>
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<tr>
<td>Ability to spend more time with mothers than midwives are able to</td>
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<tr>
<td>Supporting vulnerable or young mothers in the community</td>
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<tr>
<td>Supporting higher risk groups</td>
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<tr>
<td>Postoperative care for women</td>
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7. Results of Scottish Lead Midwives Group discussion

7.1 Introduction
A semi-structured discussion was held with the 26 participants at the Scottish Lead Midwives’ Group meeting held in Edinburgh in January 2011. Data was gathered via two sources. Firstly, a short survey was handed to participants. This was designed to focus thoughts on the MCSW role, to gather data on future commissioning needs and perceptions of the role’s impact. Secondly, a semi-structured discussion was held to explore views on the role, which was digitally recorded with participant’s permission.

7.2 Survey results
The Board representatives and others present employed a total of 44 MCSWs (including three in training) – 53% of all MCSWs. One Board representative was uncertain how many MCSWs they employed. When asked whether they would like to employ more MCSWs in the future, nine Boards stated ‘yes’ and one was ‘unsure’. Overall Board representatives indicated that they would, if possible, like to employ an additional 122 support workers – almost three times the current number they employ.

Participants were then asked to rate the overall effectiveness of the training programme on a Likert scale from 1 (effective) to 10 (ineffective). Nine Board representatives responded. The weighted mean response was 3.44, suggesting a high level of satisfaction with the programme. One participant rated the programme at ‘1’, four at ‘2’ and one at ‘3’.

The survey also asked participants to write in their own words what they thought the biggest difference MCSWs had made to their services. Whilst one respondent said that there were: “not enough in service to make a judgement”, the majority were able to identify a range of benefits. The most frequently mentioned (by six people) was the ‘freeing-up’ midwives’ time:

“They have freed up midwife’s time with clinical and administrative support which reduces stress.”

“… allowed the midwife to increase their case-load while retaining the quality of care.”

The full list of self-reported benefits is shown in Box 4 below.
Participants however, also raised a handful of negative issues in their survey responses. One mentioned that there were fears that MCSWs would replace midwives, another that there was a lack of clarity of the role and a third that the role reduced experiences for student midwives.

7.3 Semi-structured discussion findings

A semi-structure discussion was held to explore: perceptions of the role, deployment and impact. A number of linked themes emerged. These were:

- Grading
- Workforce planning
- The role’s deployment
- Delegation
- ‘Hearts and minds’

7.3.1 Grading

The educational level of the MCSW programme implies an AfC band 3 grading (Senior Health Care Support Worker), however it is for local Boards to determine the exact banding of their MCSWs following deployment. Despite the lack of prescription the discussion showed some confusion as to whether the post should be graded at AfC band 3 or band 4, (Assistant Practitioner) levels. The view that the role must be graded at band 4 appears, in some cases, to be resulting in a reluctance to deploy MCSWs and more fundamentally is creating scepticism about the cost benefit of the role. There was a consensus amongst the group that maternity services require senior support roles (at band 3) but that there was substantially less need for a dedicated maternity Assistant Practitioner role at band 4. Some participants argued that Nursery Nurse posts could undertake, with additional training, higher-level requirements and these presented better value for money.
7.3.2 Deployment

There were mixed reports of the extent to which MCSWs roles were being fully deployed locally. One participant reported that she had seen contrasting examples within her own Board where the role was, on one hand, fully integrated into the maternity service and undertaking higher-level activities delegated by midwives, alongside other examples where the role was performing essentially little more than standard house keeping tasks such as bed making. She said:

“It is all about how we utilise them as part of the bigger team.”

Participants believed that reluctance to fully utilise is linked to concerns about its potential impact of the role on midwives and delegation issues. More positively participants believed that the role’s greatest impact to date had been in supporting postnatal care:

“The biggest feedback that we have had from women - and we have had a lot of feedback … is around breastfeeding and general parenting support in the early days of postnatal care. We have had a lot of ‘thank you’ letters in both the community and acute.”

More generally it was felt that the full potential of the role had yet to be realised, perhaps reflecting the small number of posts currently embedded in service:

“Over the years midwives have taken on more and more tasks without giving any up. We have the opportunity if we utilise our trained support workers appropriately to deliver some of the things that we have taken on which are seen as tasks. So, if you are running a busy clinic and have lots of bloods to do and you can’t do them all if you only have 10-15 minutes in a room and have to be out of the surgery in two hours.”

Areas identified for future development included:

26 In addition we separately interviewed (by telephone) the Head of Midwifery at a Board that had trained MCSWs but not deployed the role. The Board’s intention had been to develop the role to support postnatal care with midwives leading the care and identifying mother’s needs, which MCSWs would, where appropriate, provide (for example, breastfeeding). The reason, however, why MCSWs had not been utilised was because of capacity constraints. Developing postnatal MCSWs would require reducing capacity in the acute team, which would threaten the service’s ability to provide 24-hour care. Despite the fact that MCSWs had not yet been deployed as intended, the HOM had observed benefits following the training. It was reported that support workers were more aware of issues for mothers and babies: “they are able to pick things up more quickly”. They provide more detailed & in-depth reports to midwives. Support workers were also performing tasks more accurately. We were told that Board would like all their support workers trained on the programme.
• Supporting the interface between acute and primary care.
• Public health provision including the interface with health visitors.
• Supporting midwives to increase home birth rates through the freeing up midwives’ time in the immediate postnatal care period.

Overall, it was recognised that service delivery is dynamic and that the training programme needed to be flexible to take account of new agendas such as vulnerable women.

Some participants believed that the post was unable to provide ‘holistic’ care and that it was ‘task orientated’. Other participants did not feel that this was the case, noting that the NES Competency Framework and associated learning programmes aimed to develop ‘rounded’ workers. One participant suggested that perceptions around the narrow focus of the roles’ work might have stemmed from the initial creation of the role and the need to carefully define boundaries to ensure public safety.

7.3.3 Workforce planning

There was a consensus amongst the group that the development and deployment of MCSWs should not be undertaken in isolation but rather that services:

“… should consider the role generally: in terms of what is the support required for maternity services.”

“… the key thing is the interface between acute and primary care and in maternity quite often we can suffer from doing things in isolation.”

The current debate in NHS Scotland on the appropriate ratio of qualified midwives to births was seen as central to deciding overall skill mix within services. It was though noted that this review was creating concerns amongst qualified midwives fearful of losing their jobs. This in turn was impacting on how MCSWs were being perceived and potentially deployed:

“There’s a danger of using them instead of midwives in the current financial climate.”

Participants did value the fact that the creation of the MCSW role had created career opportunities for support staff - a group of staff that they said frequently experienced high turnover and sickness absence.

27 No actual examples were provided of this issue.
7.3.4 Delegation

There were concerns28 raised by some participants that tasks were being inappropriately delegated to MCSWs. It was though recognised by others that the national Framework and particularly the Skills Passport if appropriately used, safeguarded against inappropriate delegation. However it was clear from the discussion, that participants felt midwives, in the words of one:

“… can feel very vulnerable delegating tasks. Concerns are very real.”

One participant pointed out that Job Descriptions did not always make clear where responsibility for the safe delegation of tasks lay. Another said:

“I don’t think we have done enough work around what we mean by delegation.”

7.3.5 ‘Hearts and minds’

Linked to the above issue participants indicated that there remains some work to be done to convince staff that MCSWs are appropriate and non-threatening roles:

“Its how we work to dispel the myths that are around … that’s a problem that’s rehearsed every time you bring a maternity support worker in to help the team.”

There was however positive evidence that initial concerns can dissipate over time. One lead midwife explained how her Board had introduced the role. When initially allocated to a community team:

“… the midwives were not happy, saying ‘this is a dilution of skills, this is not for them.’”

Three-months later, she reported, these fears had disappeared. Midwives had become highly supportive of the roles and the contribution they could make to the team. The key issue she felt was that the support workers were explicitly introduced as an additional and complementary resource for midwives rather than as a potential substitution.

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28 No actual examples were provided of this issue.
7.4 Conclusion

The majority of participants were positive about MCSWs and the training programme, believing the role was contributing to improved services for women and freeing midwives time by relieving them of tasks that they did not professionally need to perform. The area that the role appears to be making the biggest impact was in acute and community postnatal care; specifically breastfeeding support and parent skills education. A number of issues were raised in respect of delegation and role boundaries, however it was recognised that this is likely to be a local issue rather than a weakness of the national framework and training:

“If there is a challenge … then perhaps we have just got to go back to the competency documentation and Framework for the development of the role because issues of delegation and accountability are articulated there.”
8. MCSW questionnaire findings

8.1 Introduction

This section reports the findings of the self-completion survey distributed to MCSWs. The aim of the survey was to gather data from support workers who had completed the programme and were fully deployed in the role, rather than support workers still undergoing training. Surveys were distributed by post to 34 MCSWs, 52.9% (n=18) of which were returned. All responses relate to the RGU programme.

8.2 Findings

Table 3 shows the average (mean) results from the survey items asking support workers the extent to which they agreed or disagreed with a series of statements in respect of the effectiveness of the training programme, its application and impact in the workplace. A four point Likert scale was utilised: 1=Strongly Agree, 2=Agree, 3=Disagree and 4=Strongly Disagree.

Table 3 shows very strong agreement from MCSWs that the training provided them with the knowledge and skills required to perform their job (mean response: 1.1). Perhaps not surprisingly, there was also strong agreement with the statement: *I am able to do my job better following the training* (1.1). This is a potentially significant finding as the respondents are now actually applying the knowledge and skills they acquired in their workplace and in some cases have been doing so for over a year. There was also agreement that the training MCSWs received was relevant to their job.

Midwives have, MCSWs report, delegated tasks to them *following* the training (see Table 3 below). There was strong agreement with the statement: *As a result of the training I am clear which tasks as a MCSW I am able to carry out safely and those that I am not* (1.2). Most respondents agreed that the *Skills Passport* was effective (1.6).

The majority of respondents strongly disagreed with the statement that the training had not lived up to their expectations (3.7). There is research evidence to suggest that successful learning outcomes are linked to the extent to which training meets learner’s expectations (Chiaburu and Lindsay, 2008). Most MCSWs have been able to transfer and apply the learning they have

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29 This is also a measure of knowledge and skills retention which is likely to be at least partly linked to the finding that MCSWs found that training relevant to their work (Arthur et al, 1998).
received in their workplace although there was a range of responses to this answer suggesting that there is some variance across Boards.

**Table 3: Training Effectiveness**

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>The training has given me the knowledge and skills I need to do my job</td>
<td>1.1</td>
</tr>
<tr>
<td>The training failed to meet my expectations</td>
<td>3.7</td>
</tr>
<tr>
<td>I am able to do my job better following the training</td>
<td>1.1</td>
</tr>
<tr>
<td>The training was not relevant to the work I do</td>
<td>3.7</td>
</tr>
<tr>
<td>I am more positive about learning as a result of the MCSW training</td>
<td>1.2</td>
</tr>
<tr>
<td>I have been unable to apply what I learnt in the workplace</td>
<td>3.6</td>
</tr>
<tr>
<td>As a result of the training I am clear which tasks as a MCSW I am able to carry out safely and those that I am not</td>
<td>1.2</td>
</tr>
<tr>
<td>Midwives are now able to delegate tasks to me that they were not able to before I became a MCSW.</td>
<td>1.1</td>
</tr>
<tr>
<td>I am more confident at work because of the programme</td>
<td>1.3</td>
</tr>
<tr>
<td>I am more motivated as a result of the programme</td>
<td>3.7</td>
</tr>
<tr>
<td>As a result of the training I am more likely to remain working for the NHS</td>
<td>1.3</td>
</tr>
<tr>
<td>How effective have you found the programme’s Skills Passport?</td>
<td>1.6</td>
</tr>
</tbody>
</table>

There is evidence of the training providing proximal benefits for the MCSWs and services. There was strong agreement with the statement: *I am more positive about learning as a result of the MCSW training* (1.2), the programme had resulted in MCSWs being more confident at work and it had made it more likely that staff would remain working in the NHS (1.3). There was though no evidence that the programme had improved staff’s motivation, although this finding may simply reflect the fact that staff were already motivated prior to entering the programme. All had worked in the NHS for six or more years - fourteen for ten years or more.

Table 4, below, shows the average (mean) level of agreement to a range of statements related to the work MCSWs carry out. It shows that most agree that they are satisfied with the work that they do (1.4). All the support workers either ‘strongly disagreed’ or ‘disagreed’ with the
statement: *I do not feel I am a full member of the maternity team at my Board* suggesting that they feel integrated into their team. However, while most MCSWs felt that they were able to work at their full potential, some did not. All but one MCSW strongly agree or agreed with the statement: *My colleagues see the MCSW role positively.* There was also strong agreement that the role was improving services to mothers (1.3).

### Table 4: Attitudes to work

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>I am satisfied with how I do my work</em></td>
<td>1.4</td>
</tr>
<tr>
<td><em>I do not feel I am a full member of the maternity team at my Board</em></td>
<td>3.5</td>
</tr>
<tr>
<td><em>I am unable to work to my full potential at work</em></td>
<td>3.2</td>
</tr>
<tr>
<td><em>As a MCSW I am able to improve services to mothers</em></td>
<td>1.3</td>
</tr>
<tr>
<td><em>My colleagues see the MCSW role positively</em></td>
<td>1.6</td>
</tr>
<tr>
<td><em>I will be able to develop myself at work in the future</em></td>
<td>1.4</td>
</tr>
<tr>
<td><em>I report to the midwife any concerns/worries about parenting issues</em></td>
<td>1.0</td>
</tr>
<tr>
<td><em>I am properly supported in my workplace</em></td>
<td>1.6</td>
</tr>
<tr>
<td><em>I am confident in how to deal with emergency situations</em></td>
<td>1.6</td>
</tr>
</tbody>
</table>

Most MCSWs believe that they will be able to develop themselves in the future (1.4). All of the MCSWs strongly agreed that they would report any concerns about parenting issues to a midwife. There was also agreement that MCSWs were confident about how to deal with emergency situations (1.6).

Unfortunately, because of the duration of this evaluation we were unable to gather pre and post evaluation data to assess the extent to which the training programme had changed MCSW attitudes and approaches to their work although this was explored in the focus group discussions. The evidence of proximal effects noted above, for example the view that the programme has increased MCSW's confidence, suggests that the training has had an effect. MCSWs also agreed with items referring to positive changes following the training they had received.
8.3 Delegated tasks

MCSWs were asked to self-reported tasks that had been delegated to them following the completion of their training. These are shown in Table 5 below. These tasks were previously undertaken by midwives but are now being performed by support workers. The tasks carried out by most frequently by the MCSWs who completed the survey are: breastfeeding support and advice, baby care tasks such as monitoring vital signs, administrative tasks and parent skills education. As well as asking MCSWs to self-reported examples of tasks that have been delegated to them respondents were also asked, from a range of seventeen tasks linked to the MCSW curriculum, to record whether they performed these on a: daily, weekly, monthly or yearly basis or never. The results set out in Table 6 suggest MCSWs are more frequently undertaking tasks related to general housekeeping, breastfeeding, parent education, baby care, catheter, administrative tasks, venepuncture and healthy life style tasks. Less frequently MCSWs undertake tasks assisting with cannulation, smoking cessation and ‘umbilical cord pH’. The data gathered on the frequency with which MCSW deployed particular tasks also allowed an assessment to be made of the extent to which individual support workers are able to apply the range of knowledge and skills that they have acquired in their daily work. Chart 1 below shows the frequency with which each respondent performed on a daily basis the seventeen tasks.

![Chart 1: MCSW Task Deployment](image)

30 Two respondents were excluded as they did not fully complete the survey.
Table 5: MCSW Self-reported Delegated Tasks

<table>
<thead>
<tr>
<th>Task</th>
<th>Frequently Performed</th>
<th>Less frequently performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Baby care (vital signs, weighing, blood pressure, hearing)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Bloods (spots, processing samples)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Healthy lifestyle promotion (exercise, smoking cessation)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Administrative tasks (telephone messages, note taking)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Parent craft (bathing, nappy changing)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Catheter care</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Assist in emergencies</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Urine samples</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Admitting/discharging patients</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Maternal care (vital signs, BMI)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Venepuncture</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Wound care</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Removal of sutures</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Contraception advice</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Assisting at deliveries</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>PKU</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>AFP</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Antenatal classes</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Table 6: Frequency of task performance

<table>
<thead>
<tr>
<th>Task</th>
<th>D</th>
<th>W</th>
<th>M</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>General housekeeping duties such as cleaning and making beds</td>
<td>15</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of women tasks</td>
<td>14</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take and record maternal vital signs</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Assist mothers with breastfeeding</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assist with parenting skills</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of healthy term baby</td>
<td>17</td>
<td>1</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make and receive telephone calls and pass key information to midwife</td>
<td>17</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assist with smoking cessation</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Assist awareness of healthy diets</td>
<td>11</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removal of a catheter</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Venepuncture</td>
<td>17</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Assist with cannulation</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Umbilical cord pH</td>
<td>3</td>
<td></td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Assist with transfer/discharge</td>
<td>14</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assist with theatre duties</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Nasogastric tube feed</td>
<td></td>
<td>1</td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Assist with postnatal exercises</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Key: D=Daily, W=Weekly, M=Monthly, Y=Yearly, N=Never

8.4 Has any learning been omitted?

MCSWs were asked whether they thought the training programme had omitted any knowledge or skill that they thought they should have been taught based on their actual experience of undertaking the role. Just three participants indicated that they thought it had. Two suggested the following could be added:

"Why bloods are taken at the antenatal booking clinic and the reasons behind investigations"

"Information on the management of jittery babies."
8.5 Overall effectiveness

MCSWs were asked: Overall from your point of view how would you rate the effectiveness of the MCSW programme? Respondents rated that programme as either: very effective (n=8) or effective (n=10).

8.6 Open text questions

The surveys provided MCSWs with an opportunity to state any other views on the programme, positive or negative, that they wished. Nine provided responses. Three themes emerged: increasing capacity (n=4), barriers to learning and transfer (n=5) and workforce planning (n=3). One respondent chose to state that they were confident of the boundaries their role worked within and another pointed to the importance of mentors. Respondents were very positive about the programme:

Respondent 31: “This course has been a brilliant opportunity for us all. To say that I am delighted and grateful is an under-statement.”

Respondent 6: “Enjoyed the course.”

Respondent 31: “My views are all positive.”

Increased Capacity

Respondent 1: “I am very much integrated into the midwifery team, the training covered most aspects of my role but was foundational, my role has evolved greatly since I have been in post. The midwifery team have found the support very beneficial. Most of all the women I care for benefit from another tier of support.”

Respondent 28: “I feel that the MCSW course was very worthwhile. It boosted my confidence with my learning. I do feel a valued member of the midwifery team.”

Respondent 25: “I feel that as time has gone by my role as an MCSW is now being more recognised by midwives. In the beginning they appeared to feel threatened but through time they now realise that we are there to enhance and support their role.”
**Barriers**

Respondent 11: “I found it hard working full time and studying with very little support at work especially at the start. Since I finished the colleagues that have done the course have not got any support at all even though I had been through it.”

Respondent 31: “The negative comment I have to make is about my workplace. Midwives are still unsure about what our job role is … Ward being too busy to be taught properly.”

Respondent 6: “Not a lot of support was given by midwifery members of staff, as they didn’t understand any thing about the course.”

Respondent 15: “It has taken a long time to convince some midwives that my role … is to support them and not be in place of them.”

**Workforce planning**

Respondent 31: “One day I am a CSW, the next day a MCSW. This has caused confusion.”

Respondent 15: “The trust I work for were unsure of the role and where best it would work for maternity services.”

Respondent 12: “I found that being employed as a CSW for a number of years enabled me greatly with communication skills and able to work effectively alongside midwives as a team. I have heard that a trainee MCSW who hasn’t had the experience as a CSW does not communicate with parents or other staff members effectively.”

Respondent 27: “I do not feel as if the MCSW role is fully effective or defined at this point in time.”
9. Midwives’ survey findings

9.1 Introduction

This section reports the findings from an online survey using midwives who work with MCSWs. Its aim was to elicit information regarding midwives’ views of the MCSW role including delegation of tasks and the impact on service users and midwives. Replies were obtained from midwives working in Highlands, Tayside, Grampian and Forth Valley (n=18).

9.2 Views of the MCSW role

All of the midwives who responded worked with and delegated tasks to MCSWs. Eight of these reported they ‘strongly agreed’ they were comfortable delegating tasks to MCSWs and the remainder that they ‘agreed’. Within their workplace, seven of the respondents indicated they ‘strongly agreed’ that the MCSWs they delegated to were properly supported and supervised, four that they agreed, whilst one was not sure. This would appear to indicate overall, that midwives consider the MCSW role is accepted and working well and that processes to develop and support MCSWs are also working.

Table 7 shows the results from the survey items asking the extent they agreed or disagreed with a series of statements regarding their view of the MCSW role. A four point Likert scale was utilised 1= Strong Agree, 2= Agree, 3= Disagree and 4= Strongly Disagree. Mean responses are shown.

From Table 7’s results it can be construed that the majority (92%) of the midwives polled considered the role of the MCSWs had: ‘a positive impact on the delivery of maternity services’. One was not sure (mean response 1.6). Midwives also mainly agreed (82%) that: ‘MCSWs improved the quality of care’ and all but one (who was unsure) ‘disagreed’ or ‘strongly disagreed’ that: ‘MCSWs increase the number of complaints the service receives’. Furthermore, they believed that the NHS should: ‘employ more MCSWs’. Surprisingly, although midwives seemed happy to delegate, not all indicated that the employment of MCSWs: ‘reduced the workload of midwives’. While ten agreed, two were not sure and one disagreed.
Table 7: Midwives’ views of MCSWs

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean response</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCSWs are having a positive impact on the delivery of maternity services</td>
<td>1.6</td>
</tr>
<tr>
<td>MCSWs will increase the number of complaints the service receives</td>
<td>3.6</td>
</tr>
<tr>
<td>I am satisfied with the level of skills and knowledge MCSWs have to deliver safe support to mothers, babies and families</td>
<td>1.5</td>
</tr>
<tr>
<td>MCSWs have not improved the quality of care</td>
<td>3.2</td>
</tr>
<tr>
<td>MCSWs reduce the workload of midwives</td>
<td>2.5</td>
</tr>
<tr>
<td>I am not confident that MCSWs will report to the midwife any concerns/worries about parenting issues they have</td>
<td>3.7</td>
</tr>
<tr>
<td>I am clear about the tasks MCSWs carry out and those that they cannot</td>
<td>2.0</td>
</tr>
<tr>
<td>I am confident that other health professionals are clear about the MCSWs role</td>
<td>2.7</td>
</tr>
<tr>
<td>I am confident that MCSWs know how to appropriately deal with emergency situations</td>
<td>2.5</td>
</tr>
<tr>
<td>MCSWs should only undertake housekeeping and clerical duties</td>
<td>3.7</td>
</tr>
</tbody>
</table>

There was agreement with the statement: ‘I am clear about the tasks MCSWs carry out and those that they cannot’. Eleven of the midwives agreed or strongly agreed with the statement. One was not sure, whilst another strongly disagreed. There was slightly less agreement with the statement: ‘other health professionals are clear about the MCSWs role’. Four agreed or strongly agreed, the remainder either disagreed (one strongly) or in two responses were not sure (mean response 2.7). All the midwives agreed or strongly agreed that they were ‘satisfied with the level of skills and knowledge MCSWs have to deliver safe support to mothers, babies and families’. Importantly though, whilst nine responded agreed, other midwives expressed they were unsure whether: ‘that MCSWs know how to appropriately deal with emergency situations’.

Views on the usefulness of the role of MCSWs play were very positive, with twelve of the midwives disagreeing that MCSWs should ‘only undertake housekeeping and clerical duties’ and one not sure. Table 8 below shows midwives’ views on the impact of the role of MCSWs directly upon midwifery.
The Impact of Maternity Care Support Workers in NHS Scotland

### Table 8: The impact of MCSWs

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean response</th>
</tr>
</thead>
<tbody>
<tr>
<td>The development of MCSW roles is a positive thing for midwifery</td>
<td>1.7</td>
</tr>
<tr>
<td>MCSWs are a threat to midwives</td>
<td>3.2</td>
</tr>
<tr>
<td>MCSWs allow me to spend more time with mothers</td>
<td>2.3</td>
</tr>
</tbody>
</table>

The majority of the midwives who responded considered: ‘the development of MCSW roles as a positive thing for midwifery’ and only one was unsure. However, whilst 46% strongly disagreed that MCSWs were a threat to midwives, 23% thought they were, including one person who thought this strongly. When asked if: ‘the NHS needs to employ more MCSWs’ the variation in responses was pronounce, although no one strongly disagreed (mean response rate 3.8) as shown in the diagram below.

### Diagram 1: Responses to whether the NHS should employ more MCSWs

The statement ‘MCSWs allow me to spend more time with mothers’ also produced some differences in responses, although no one strongly disagreed. When asked: ‘in which setting do you think MCSWs are most effectively deployed?’ nearly 70% said both acute and community. However 23% favoured the community only, whilst one midwife (7.7%) indicated only acute settings. There was stronger agreement to the statement: ‘MCSWs are effective in providing postnatal support’ (mean response: 1.5) than to the statement: ‘MCSWs are effective in providing antenatal support’ (mean response 2.2).
9.3 The impact of the MCSW role

Respondents to the survey were asked to think about the range of duties performed by the MCSWs in their workplace and how effective they thought the role has been in improving services in the following using the following categories: Very Effective (VE), Effective (E), Not Very Effective (NE) Not Effective at all (NEA), Not sure (NS)

<table>
<thead>
<tr>
<th>Duties performed by MCSWs</th>
<th>VE</th>
<th>E</th>
<th>NE</th>
<th>NEA</th>
<th>NS</th>
</tr>
</thead>
<tbody>
<tr>
<td>General housekeeping duties e.g. cleaning &amp; making beds, ordering equipment, dispatching laboratory specimens &amp; preparing clinical areas</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Care of women tasks e.g. calculation of BMI, assisting woman with shower/bath/bed bath, personal hygiene, obtaining urine specimens &amp; performing urinalysis, understanding, taking &amp; recording maternal temperature, pulse &amp; blood pressure and assisting women with post natal exercises</td>
<td>5</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Assisting mothers with infant feeding e.g. promoting breastfeeding, assisting mothers to breastfeed, providing mothers with advice &amp; support (for example positioning &amp; attachment) and preparing artificial feeds</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Assist with parenting skills e.g. demonstrating baby bath, helping parents understand baby cues, promoting bonding &amp; skin-to-skin contact</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Care of healthy term baby e.g. identification &amp; security of baby, daily toileting of baby, weighing of baby, eye &amp; cord care of baby &amp; undertake heel prick</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Make &amp; receive telephone calls &amp; pass key information to midwife</td>
<td>6</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Assist with smoking cessation &amp; awareness of healthy diets during pregnancy and the postnatal period</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Assist with admission/transfer/discharge procedures</td>
<td>5</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Assist with theatre duties</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

These responses indicate that midwives see most of the duties performed by MCSWs as improving services. The two duties that seemed less effective were assisting with ‘smoking cessation, healthy diets pre and post natal’ and ‘assisting with theatre duties’. The response to ‘assisting with theatre duties’ may be due in part to the fact that few midwives have experienced MCSWs in a theatre setting.
Midwives were asked about the effectiveness of specific tasks carried out by the MCSWs using the following categories: Very Effective (VE), Effective (E), Not Very Effective (NE) Not Effective at all (NEA), and Not sure (NS). Table 10 sets out the responses.

<table>
<thead>
<tr>
<th>Specific tasks undertaken by MCSWs</th>
<th>VE</th>
<th>E</th>
<th>NE</th>
<th>NEA</th>
<th>NS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal of a catheter</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Venepuncture</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Assist with cannulation</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Umbilical cord pH</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Nasogastric tube feed</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 10 shows that six respondents thought catheter removal was ‘very effective’ or ‘effective’, MCSWs undertaking venepuncture was considered an even more effective task undertaken by MCSWs (12).

### 9.4 Delegation

Midwives were asked if: ‘Since the employment of MCSWs in your maternity service have you personally delegated any tasks to MCSWs? All but one of the thirteen respondents answered yes. Types of tasks given as examples of delegated work included:

- Formula feeding
- Sterilisation of equipment
- Hearing tests
- Unique identification numbering (CHI) for babies
- Antenatal m/w, consultant appointments
- Supporting women in labour
- Heel tests
- Weights
- Home visits to support new mums with practical care, bathing etc also breastfeeding.
- Venepuncture
- Urinalysis
• Blood Pressure.
• Health promotion information.
• Demonstrating bathing for parent craft
• Admission/discharge of patients (computer)

Finally, when asked if there were any other views negative or positive, two midwives replied they considered the MCSW role as very positive. One midwife did however comment that: ‘as far as intrapartum care whether in hospital or home situation’ they would still prefer ‘to have a second midwife present at delivery’.
10. Field Work at a NHS Board

10.1 Introduction and background

Field research was undertaken at a Maternity Hospital in March 2011. Four focus group discussions with staff were conducted as follows:

- Focus group 1: midwives who work with MCSWs (n=11)
- Focus group 2: MCSWs (n=7)
- Focus group 3: non MCSW maternity support workers (n=6)
- Focus group 4: midwives who do not work with MCSWs (n=3)

The semi-structured questions were utilised. In addition, the MCSWs were asked to complete a contingent valuation survey to assess the degree to which the value the programme.

10.2 Contingent valuation exercise

Contingent valuation (CV) is an economic evaluation method that aims to assess the amount an individual values a service they receive, but do not have to purchase (Drummond et al, 2006). CV is measured by asking the individual to place a hypothetical monetary value equivalent to the maximum they would be willing to pay for the service, programme or intervention (Bala et al, 1999). Surveys suggest that individuals are likely to overstate how much they would actually pay for a service. In order to reduce this bias the CV survey utilised in the field research support workers were asked the extent to which they were sure that they would actually pay the amount they stated (Blumenschein et al, 2008).

The CV survey was distributed to all the MCSWs in the second focus group (n=7). They were asked whether they would hypothetically be willing to pay for the programme if it had not been available (to them) for free. If they stated that they would be willing to pay, they were then asked to select an amount up to £1000 and state how certain they were that they would pay this.

The results are shown in the chart below. All seven MCSWs responded. One (a MCSW who had completed the programme but had not been deployed) stated that they would not be willing to pay, one stated they would pay £900 and the remainder £1000 – the maximum amount. The aggregate valuation of the MCSWs in our focus group sample was £5200.
While hypothetical, the CV does suggest, with one exception, that the MCSWs perceive the programme as providing a significant benefit to them. Given that six of the seven participants were performing their role as MCSWs the valuation is likely to reflect the extent to which the RGU programme has impacted on their daily practice and job satisfaction.

**10.3 Focus group findings**

The following sections set out the main themes that emerged from the focus group discussions.

**10.3.1 Midwives who work with MCSWs**

**Tasks delegated to MCSWs**

When asked to describe the tasks they had delegated to MSCWs the midwives said that these differed across the Board and depending upon the individual MCSW:

‘It can be different in different areas, different MCSWs that are working.’

However the midwives were able to identify a substantial range of tasks that MCSWs were now performing that they had previously undertaken:

- Parenting skills
- Helping with bathing
- Sterilising equipment at home
- Basic observations on the babies and mums
- General baby checks
- Hearing checks
- Blood sugars
- SBRs (although the appropriateness of performing these estimations was not agreed upon by all participants)
- Blood tests on the babies
- Neonatal resuscitation (if a further midwife is not available)
- Setting up screening packs
- Antenatal classes.

**Freeing-up of midwives’ time**

The midwives though found it ‘difficult to quantify’ how much time MCSWs freed up. However, one midwife did comment that when their MSCW was off on long-term sickness:

> ‘it was a huge miss … we have seen their role enhancing the midwife from beginning to end’.

There was a consensus that the MCSWs had made a significant impact by freeing-up midwives’ time.

**Initial suspicion of the role**

There were some reservations amongst the midwives about using MCSWs as a means to reduce or drastically change midwifery employment or to save money:

> ‘I would dread to see the midwife just in the office, that is my fear.’

The majority though felt positive about the role:

> ‘I think an MCSW in every team would enhance the team.’

> ‘They have been a better support than we thought they were going to be but I do think that we have to be really careful that we don’t allow the role to extend into the midwives role, you can almost see that happening with the money shortage all the time’.

> ‘I remember us thinking these girls were going to be out there doing the job and we were going to be stuck behind a computer moving the trained midwives but it hasn’t really panned out like that.’
‘It hasn’t encroached on me as a midwife, it has merely enhanced us as well. At first I thought it was going to be threatening, another tier of nursing but no, I’ve actually been pleasantly surprised.’

**What does the MCSW role bring?**

- **To midwives**
  
  The midwives were clear that the MCSWs acted as additional support and capacity to them:

  ‘An extra pair of hands to help women breastfeeding which is time consuming sometimes so that’s a huge help and they are following the same policies and procedures that we are so it is very helpful.”

  ‘We as a midwife are thinking about the next thing we need to get on to but they can be focused on what they are doing.’

- **To women**
  
  All the midwives were clear that the MCSWS were benefiting women including more vulnerable mothers:

  ‘They are getting extra support because the midwives do not have time’.

  ‘They have got more time to spend with the ladies for that and they can go back to them often because they have not got any clinic commitments like the rest of us so they can go back a second visit that day if they needed it.’

  ‘They are getting a longer one to one experience. They don’t mind who that person is as long as they are getting support from somebody who is knowledgeable, the mother doesn’t mind if it is an MCSW.’

  ‘They give the power to that person whereas we are thinking of the rest of the ward work that we have to do and all the rest of it, I think they have the patience and the time to give to the woman.’

  ‘The young mums don’t like to come to the classes because they feel they are the odd ones out and if that’s the case we offer one to one and that’s an MCSW. The same with substance misuse, they don’t come to classes and so we do one to one either in the unit or at their home.’
Holistic care

Following the discussion at the Lead Midwives’ Group meeting about the possible task-orientated nature of the role this issue was explored in the focus group. None of the midwives considered the MCSWs as task driven role and provided examples:

‘One of ours looked at a family in a holistic way, she went in to do the baby check and the mum had a headache, so she took her blood pressure and phoned the midwife who had delegated her the job so I think that was her being really sensible.’

The MCSWs strongly believed that they acted in a holistic rather than task orientated way:

“I think that every post you’ve got tasks that have to be done, but we’ve also go the time to spend and build up with mums and especially like last year we had two mother’s with learning difficulties so they needed one to one and you built up quite a rapport with that lassie and her family, so I wouldn’t class that as just task orientated.”

Delegation boundaries

The midwives all stated they felt the MCSWs were good at referring back to them and aware of their boundaries:

‘If they stumble on to something they are quite good at phoning it through and running it past you there and then on the spot, this is the decision I’ve made, are you happy with that?’

‘it was very clear what they were supposed to do and what they weren’t.’

All of the midwives stated that they were not in agreement with MCSWs attending homebirths as the secondary rather they:

‘… would rather have two midwives at a home birth.’

‘We find the boundaries are being pushed and pushed and pushed and you have to go through the consultant midwife for a home birth, that’s how uncomfortable we feel about it so certainly having an MCA for the birth wouldn’t be an option.’
'I know myself as a midwife, no matter how good they are, I as a midwife still prefer a midwife to be there.'

‘And it makes you think about your own registration if you are a qualified midwife with an MCSW, if anything goes wrong it is your head that’s on the chopping block. It is your registration and your job at the end of the day.’

MCSW Training

The midwives were complementary about the MCSW training programme but also recognised that it had ‘stretched’ the support workers:

‘I felt in a way it was a difficult course, the way they did it, because they didn’t just do one module at a time, they had to start three modules.’

‘Some of our auxiliaries were panicking about it because they don’t even use a computer yet all this was online.’

‘You can’t pigeon hole them. They have to be able to be adaptable to provide the care that is needed.’

Future supply of MCSWs

Not recruiting from auxiliary staff was seen as more problematic using the current model of training and that ‘nine months would not be long enough training for that’. Though one midwife did feel it could be advantageous to start with a ‘clean sheet’:

‘They are all very experienced auxiliaries, …… so they have a good grounding of knowledge and experience already. Maybe if it was just someone coming off the street with no experience then it would be more task orientated.’

‘Someone coming in blind is better than someone coming in with bad habits. Some auxiliaries could be ingrained in a way that is actually harder to retrain them than them just coming in fresh.’

Deployment of MCSWs

Some midwives commented that MCSWs did not always have the posts they had trained for, stating ‘it’s a waste such a waste’ whilst others who did felt they would at least get the recognition for their role:
‘You go back as an MCSW and get paid for doing exactly the same as that person’s been doing who is still an auxiliary.’

‘She is there as an auxiliary, not as an MCSW. She is not getting paid for that role.’

‘I remember there being some auxiliaries who came from that role into the MCSW and they said it was basically the same, this is what we do anyway but we are going to get paid for it now, acknowledged and signed off as long as you are trained for that.’

Community and hospital based MCSWs

There was agreement that:

‘It’s not always 100% positive on community’

‘It is more clear cut on the wards’

‘Some of our cases are quite spread out and if you are travelling 15 miles to do one visit and there is another visit next door which the MCA could do, does it justify that two of you drive 15 miles to go and do a visit? Sometimes it is easier taking those two visits by one midwife rather than taking the MCSW.’

10.3.2 The MCSW Focus Group

Perceptions of the learning programme

The MCSWs were extremely positive about the learning they had received which was seen as directly relevant to their role. The MCSWs believed the content of the programme was: appropriate, covered all the knowledge required for their role and that they have been able to carry out most of the new skills in the workplace:

“99 per cent of the content we’ve used”

Two issues were raised. The first was in respect of the duration of the programme. They said they would have liked the programme to be delivered over a longer period of time. The 42-week
duration MCSWs felt had put pressure on them, particularly at the start when most of them were adjusting to a formal education process:

“Because it was condensed into ten months, you didn't have a breaking in period to it, you had to start really hard from the very beginning and I think if it had been a year or even up to a year and a half it would have been spread out more and you would maybe have got into it gentler and you could have coped with it. To me, at my age, to suddenly have to start thinking again and having to do research and write things, it was so alien from what I'd ever done before.”

“I didn't know how to start.”

“I'd never switched [a computer] on.”

“Well for me it was the time factor with being full time and I had to utilise two weeks of my annual leave to get modules in and I was sitting every hour just doing it that week to keep in track with everyone because I was full time.”

The second issue raised in the focus group was support during training from the Board particularly with placements and study time. Lack of support it was reported had resulted in some staff withdrawing from the programme in recent years:

“I didn't get any study time, I didn't even get placements, I was four months on the course and I still hadn't had a placement.”

The MCSWs thought the lack of support they perceived resulted from the time pressures midwives faced along with a lack of recognition, confidence or support amongst some of the higher-level MCSW role. This continued in some instances once staff had been deployed:

“I think it’s the time factor, the midwives haven’t got that time to sit with you and go through things because they think: why do you need to know that?”

“Yes definitely, they did not accept that you’re now trying to move on from being an auxiliary.”

“…99% of them have been really supportive, really good but there are still times and this is now many years down the line and very recently I had another instance of: ‘you’ve done it but will you go back and check it.”
Transformation

Effective learning has the potential to transform individual identities and attitudes to work, learning and the self (Billet and Sommerville, 2004). The MCSWs were asked to describe how they felt before starting the learning programme and after they had completed it. Many of them had not participated in formal education for some time. Before the programme began the MCSWs described their feelings variously as: “frightened”, “terrified” and “stressed”. Following the learning the MCSWs universally described the sense of achievement they felt:

“… to be honest because it was 33 years since I’d been in the classroom and never realising, I did much better than I actually thought I would do, so for me it was a big boost for self-confidence.”

“… it was unbelievable the difference.”

“I thought – ‘did I really write that?’”

Deployment of the role and impact

Overall the MCSWs believe that their role has been accepted and in many cases embraced by the majority of midwives and other maternity staff in the Board. They did report that a small number of staff had remained resistant to the role, although this situation had in some cases changed over time, as the following exchange illustrates:

MCSW 1: “I think that one or two feel threatened”.

MCSW 2: “Yes”.

MCSW 3: “You’re encroaching on their remit and ‘oh this is mine’”.

MCSW 4: “I had an instance when one said: ‘I’ll help you on your placement but I wouldn’t want you here’... some midwives would say that, ‘it’s fine to do the course but won’t ask you to do any of my work’”

MCSW 5: “I must say I’ve had nothing like that”

MCSW 1: “For start they were a bit apprehensive to accept us but now they’re quite accepting”

MCSW 2: “...overall our midwives now have found the benefits and they’re mad when we’re not there”.

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Later in the discussion the MCSWs said:

“There are one or two who have completely turned the other way around”.

“Some went the other and they will give you everything and they will absolutely bombard you”.

“I certainly feel that my role is appreciated on the ward”

“When we started a lot of them thought we were going to be replacing them, but now they realise that we’re here to assist them and support them, we’re not there to take their jobs”.

Overall MCSWs were clear that they are undertaking a wide range of duties that were previously performed by midwives. The Board has extensively deployed the role in community settings:

“We get out in the community now, before we were just working in the ward and we weren’t really going out into the community but now we go out ourselves to do postnatal visits to babies”.

“We’re in the community all the time, we will go and help in the clinics if the midwife was requested but there’s so many visits”

The MCSWs were able to identify the following tasks that they were undertaking which midwives had previously undertaken:

- Blood spot tests
- Hearing screening
- Parent skills education
- Breast feeding support and advice
- Maternal observations
- Supporting home births

The MCSWs felt that the learning programme had helped establish the role and resolve any ambiguities around boundaries and responsibilities:

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31 MCSWs were clear that in their view two qualified midwives should be present at all home births.
“I think they’ve realised as well that we’ve got boundaries and we’re not going to step outside of them and once they realise that then they appreciate what we do, that we’re not going to encroach on their territory, that there are certain things that we don’t do.”

The work MCSWS were performing was having in their experience a positive impact on midwives through the freeing up of time:

“[We have] just taken the burden from the midwives”.

“It takes pressure off for them as well and they can spend more time doing other things”.

The impact of MCSWs on mothers

The MCSWs reported that they always made it clear to mothers that they are not midwives although they believed that women were not always clear in practice of the difference between the roles. The MCSWs felt that mothers could feel more comfortable with them than midwives:

Researcher: “So do you think that you have a different relationship with mothers than they do with midwives?”

MCSW 1: “Yes”
MCSW 2: “I think so”
MCSW 3: “More relaxed”
MCSW 4: “You get their life history”
MCSW 5: “Oh yes”
MCSW 4: “An more, too much more”

The key reason MCSWs believed they were able to build empathy with mothers was that they are able to spend more time with women that midwives are:

“… We spend longer with the women”.

“We’ve got more time than the midwife”.

Other issues

The MCSWs believed that any future recruits to the programme drawn from outside of the NHS and maternity services would struggle:
“… if you were totally green I think it would be quite daunting”

A number of proximal benefits from the training were identified including increased job satisfaction and greater integration into teams.

The issue of grading was raised by the MCSWs. All had the expectation that they would be graded at AfC band 4. The support workers had had to wait in some cases for two years to be graded and in one case the MCSW had not been deployed in the role because of financial constraints.
Focus group with non-MCSW maternity support workers

A focus group discussion was held with six non-MCSW maternity support workers. These support workers carried out a range of traditional support worker roles including: cleaning, stores, stock keeping, checking instruments, assisting with collecting and transferring mothers, delivering meals and clerical work. A number though carried out additional duties such as taking bloods and blood pressure. The knowledge to undertake these tasks had been supported by specific training programmes (in the case of bloods) and more generally SVQ level 3. The support workers believed that extended roles, short of MCSWs, would become more common in the future:

“They’re going to make us take on an extended role…I feel they will extend our role to train you up to do more things”

“You’re right because there are some of the auxiliaries that are very experienced, they can take bloods, they can help with breast feeding and they can do the babies’ blood and sugar levels and they can do heaps of stuff, probably what an MCSW could do but on a band 2”

Two of those present in the focus group had joined the MCSW programme but had withdrawn because they were unable to get sufficient time off or support locally to complete the Skills Passport. The problems these staff experienced had discouraged another support worker from joining the scheme:

“The reason why I wouldn’t go for the MCSW course is just because of lack of support the girls have had in previous years”

The support workers were however positive about the MCSW role particularly as a future career step. They were also clear that the MCSW role was a different one to theirs:

“Just a totally different job role to what we’re doing”
11. The impact of MCSWs in Scotland

11.1 Introduction

This evaluation addresses the following questions:

- To what extent have MCSWs changed workforce planning?
- To what extent have MCSWs impacted on service delivery?
- How are MCSW roles meeting the career and developmental aspirations of MCSW post holders?
- How do other members of the maternity team, other staff and service users perceive the role?
- What is the overall cost and benefit of MCSW posts?

11.2 Overall effectiveness of the learning programme

Evidence was gathered from a range of sources to assess the overall effectiveness of the MCSW training programme. The results are presented in Table 11 below. Participants consistently rated the programme’s effectiveness across all methods very highly. The training programme appears to be effective because its content is relevant to MCSW’s jobs, appropriate to their current learning needs, helps support future development and is delivered in an appropriate style. Acquired knowledge and skills have been transferred into the workplace.

Excluding staff from a single Board that have withdrawn from RGU’s programme, attrition rates are very low and the pass rate 100%. The MCSW learning programme is of a shorter duration than the All Wales Maternity Support Worker Curriculum (70 weeks) and LSBU’s Foundation Degree (two years). Its cost is less than half the cost of a Foundation Degree.

Whilst overwhelmingly positive a number of issues were raised about the programme:

- Additional study skills support (including use of ICT) should be made available to staff who require such support prior to their commencement of the programme.

- An appropriate local learning infrastructure and support is essential to the success of the programme. Lack of support has resulted in a handful of staff withdrawing from the programme and has also acted as a barrier to entry for some in at least one Board. As pressures on services grow provision of support may become increasingly challenging.
• Consideration could be given to allowing some maternity support workers access to specific units rather than the full programme. This would provide a sound educational basis for band 2 support workers that extend their roles but will not develop into full band 3/4 MCSWs.

**Table 11: Overall effectiveness ratings**

<table>
<thead>
<tr>
<th>Source</th>
<th>Effect Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi structured interviews</td>
<td>All participants positive &amp; supportive of role</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Scottish Lead Midwives Group</td>
<td>Average: 3.44</td>
<td>Likert scale range: 1 (effective) to 10 (ineffective)</td>
</tr>
<tr>
<td>MCSW survey</td>
<td>All respondents rated programme ‘effective’ or ‘very effective’</td>
<td>Likert scale: Very effective, effective, not very effective or not effective at all.</td>
</tr>
<tr>
<td>Midwives’ survey</td>
<td>High levels of satisfaction</td>
<td>Likert scale: Very effective, effective, not very effective or not effective at all.</td>
</tr>
<tr>
<td>Field Research MCSWs</td>
<td>Contingent valuation: £0 (n=1), £900 (n=1) &amp; £1000 (n=5)</td>
<td>Maximum valuation possible: £1000</td>
</tr>
<tr>
<td>Field Research focus groups</td>
<td>All participants (midwives and support workers) positive</td>
<td>Qualitative</td>
</tr>
</tbody>
</table>

**11.3 To what extent have MCSWs changed workforce planning?**

**Demand and Supply**

MCSWs currently represent 2% of the total Scottish maternity workforce. Maternity services wish to see an expansion in the number of trained MCSWs they employ. Discussions with representatives at the Lead Midwives meeting revealed a demand for 122 further posts – almost three times the existing number of MCSWs employed by those present. The main drivers for this are: an ageing qualified midwifery workforce (which is increasingly working part time) and the need to improve services, particularly, but not exclusively in respect of post-natal care.

While participants supported the expansion of band 3 MCSWs they saw less need for Assistant Practitioner roles in maternity services. It was though suggested that Nursery Nurses’ roles might be extended to address any band 4 role requirements.
Participants, including MCSWs, did raise issues in respect of future labour supply. The current cohorts have been drawn exclusively from the existing maternity workforce. Many have worked for the NHS for over ten years. This was seen as a considerable strength. These support workers possess pre-existing embedded skills and knowledge of the NHS and maternity services processes, procedures and teams. It was recognised that an expansion of the role would require wider recruitment including potentially from non-NHS employees. It was felt that future programmes would need to be flexible enough to address the skill and knowledge gaps along with NHS and maternity service orientation and socialisation issues that may inevitably arise from such recruitment.

**Workforce planning processes**

Workforce planning requires the linking of health and service needs with workforce numbers and competences to ensure the employment of the appropriate number of staff with appropriate skills. It was felt by participants in this evaluation that the development of MCSW roles had largely been undertaken in isolation to overall maternity workforce planning processes.

Discussions are currently being held in NHS Scotland in respect of maternity skill mix. MCSWs need to be fully integrated into any future workforce planning. This includes not only technical matters such as the gathering of workforce data on support worker numbers, roles, working areas and banding but also organisational cultural issues, such as addressing concerns about the impact of the role on midwifery employment.

Workforce planning should take account of different ways in which maternity support roles may develop in the future. The potential extension in the role of non-MCSW support workers (see below) needs to be considered, for instance. Moreover as well as considering the duties MCSWs can undertake, explicit consideration needs to be given to the implications for qualified staff of the freeing-up of midwives time from roles such as breastfeeding and parentcraft. It is recommended that:

- Consideration is given to developing workforce-planning guidance for maternity services that explicitly address the potential impact of maternity support workers.
- If in the future, as is anticipated, recruits to MCSW roles are drawn from outside the current maternity support workforce consideration should be given to extending the programme to include an ‘induction’ element. This would allow new staff to orientate themselves to the NHS and acquire foundational skills.
• National workforce intelligence data should include information on maternity support workers.

11.4 To what extent have MCSWs impacted on service delivery?

Current deployment

Following a review of the processes, training, material and guidance associated with the development of MCSWs in Scotland it is clear that particular account has been taken nationally of the need to ensure MCSW posts appropriately support and complement the role of midwives as set out by the International Confederation of Midwives, the RCM and defined by the European Union. The Skills Passport, for instance, makes clear the competences that MCSWs are able to work within and those that they are not. Across the methods deployed in this research stakeholders consistently reported that they believe and are confident that the role has been designed and developed appropriately at a national level and that its boundaries are clear. This has allowed most midwives to delegate tasks to MCSWs.

There are limited instances of MCSWs being used to ‘plug gaps’ or being ’overwhelmed’ by housekeeping and routine administrative tasks. There are also cases following training where the post has not been deployed. There appear to be a number of reasons for this:

• Budgetary and capacity constraints partly arising from the decision by some Boards to grade the role at AfC band 4 rather than band 3.
• Fears from midwives that the role will replace them and/or dilute their skills.
• Uncertainty about the role and delegation issues.

Concerns about the potential impact of the role however appear to dissipate once the role is introduced and shown to deliver benefits. Individual MCSW motivation and engagement can be a factor here. Overall however, MCSWs have been able to apply and indeed extend the full range of knowledge and skills they have acquired and are integrated into maternity teams.

While there is a perception amongst some that the role is currently, in the words of one participant, being ’pigeon holed’ within postnatal care this evaluation suggests that in fact it is being deployed to a greater or lesser extent across all the tasks and activities anticipated by the curriculum, as Table 12 illustrates.

32 We found examples of support workers who individually ‘convinced’ their midwifery team of the value and benefit of the role. Another said: “I felt that I made the role”.
Table 12: Tasks undertaken by MCSWs

<table>
<thead>
<tr>
<th>Blood spots</th>
<th>Hearing Screening</th>
<th>Basic baby observations</th>
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<tbody>
<tr>
<td>Breast feeding support</td>
<td>Blood sugars</td>
<td>Maternal observations</td>
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<tr>
<td>Maternal observations</td>
<td>Supporting home births</td>
<td>Bathing demonstration</td>
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<tr>
<td>Vital signs monitoring</td>
<td>Equipment sterilisation</td>
<td>Venepuncture</td>
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<tr>
<td>Smoking cessation</td>
<td>Blood pressure</td>
<td>Data inputting</td>
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<tr>
<td>Removal of catheter</td>
<td>Assistance with cannulation</td>
<td>Urine samples</td>
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<tr>
<td>Note taking</td>
<td>Assisting in emergencies</td>
<td>Nappy changing demonstration</td>
</tr>
<tr>
<td>Telephone messages</td>
<td>Contraception advice</td>
<td>Antenatal classes</td>
</tr>
<tr>
<td>BMI</td>
<td>Catheter care</td>
<td>Exercise</td>
</tr>
<tr>
<td>Wound care</td>
<td>Removal of sutures</td>
<td>Supporting high risk groups</td>
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<tr>
<td>Formula feed</td>
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One of the most apparent ways that MCSWs are directly impacting on services is by providing mothers with breastfeeding information, guidance and support. MCSWs are able to spend a longer time with mothers than busy midwives are, allowing early and extensive support for women. This is likely to increase breastfeeding initiation and duration. Improved breastfeeding rates are a key maternity quality measure (Midwifery 2020, 2010). Of the tasks taught MCSWs the areas where the role could be more extensively utilised appear to be in respect of public health activities such as smoking cessation and dietary advice.

Despite the small number of MCSWs in post participants in this evaluation were able to consistently identify service benefits that have resulted from the deployment of role such as:

- Cost savings through delegation
- Increased contact time with women
- Increased service capacity
- Provision of holistic care
- Continuity of care
- Freeing up of midwives’ time to focus on core midwifery responsibilities
- Improved quality of care
Future development of the support roles

Currently MCSWs are utilised in both hospital and community settings undertaking an extensive range of tasks. There is a perception that the role will develop in the future in two ways. First, that it may increasingly focus on a broad range of postnatal care tasks and secondly that some MCSWs will become more specialised for example supporting mothers with specific needs.

The evolution of a specialist MCSW role may help to address the question raised by some participants in this research of: where next for MCSWs once they have completed the programme? The foundational nature of the MCSW learning programme provides an opportunity for services to develop the role in this direction, although there will be the requirement for on-going training and development. Participants including MCSWs highlighted the importance of training across the full set of competencies.

An issue raised in this evaluation was how existing non-MCSW maternity support staff might be utilised in the future. Although evidence is limited discussions with support staff at the Maternity Hospital suggested that non-MCSW support roles may begin to be ‘extended’ through the taking on of a range of tasks within the MCSW curriculum such as bloods swabs. It is recommended that:

- The relationship between MCSW tasks and other support workers is considered further in light of the extension of traditional roles. Consideration might be given to making individual MCSWs training modules available to maternity support workers.
- Consideration should be given by NES to developing competences for all levels of maternity support worker roles.

11.5 How are MCSW roles meeting the career and developmental aspirations of MCSW post holders?

There was universal agreement from the participants that the MCSW programme, in the words of one Head of Midwifery is:

“A great career opportunity for support workers”

The MCSW survey showed strong evidence that the training had resulted in increased confidence amongst support workers, the majority of whom felt that they would be able to develop themselves further in the future. MCSWs at the Board field research was undertaken at

33 Examples of this role were identified in NHS Grampian. There is evidence of a similar development with MSWs in London (LSBU unpublished research).
reported high levels of satisfaction with their role. The midwives corroborated this finding. Staff were keen to keep their knowledge and skills up to date and were accessing local training days and resources. There was no evidence that the training had changed the proportion of MCSWs who wished to become qualified midwives.\(^{34}\)

Workplace learning has the potential to transform (positively or negatively) individuals, their work and wider identities along with attitudes to work such as increased commitment (Billet and Sommerville, 2004). In the focus group discussion at the Board MCSWs were asked to describe how they felt before and after the RGU learning programme. The results are shown in Figure 2 below.

**FIGURE 2: TRANSFORMATIVE LEARNING**

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Scared&quot; &quot;Terrified&quot; &quot;Stressed&quot;</td>
<td>&quot;Confident&quot; &quot;Achievement&quot; &quot;Satisfied&quot;</td>
</tr>
</tbody>
</table>

There is evidence from this evaluation that the MCSW programme has had a positive impact on the participant’s self-efficacy and attitudes to work. For example the survey results show that most MCSWs are more likely to remain working for the NHS as a result of the programme. MCSWs have mastered skills, such as ICT, that have ‘spill over’ benefits for them and their families. We found little evidence that MCSWs who had been deployed felt other than positive about their role and future opportunities.

**11.6 How do other members of the maternity team, other staff and service users perceive the role?**

- **MCSWs**

  The MCSWs in our focus groups clearly saw their role as, in their words:

  "Providing an extra pair of hands for the midwife"

  "Lifting the burden for midwives"

  "Providing support and assistance for midwives"

\(^{34}\) The evaluation of LSBU’s MSW programme reveals a similar finding.
“The role of the MCSW is to assist, support and enable to midwife to complete and deliver a holistic and sustainable service to all women and their families. Therefore making their experience during pregnancy, labour and postnatal care that of one in which they will treasure, enjoy and recount on many occasions for all the correct reasons”.

The MCSW survey results showed that MCSWs were clear about the tasks that they are able to carry out safely and those that they cannot. Midwives and MCSWs reported that any concerns would be reported to midwives.

- **Non-MCSW support workers**

While it was reported in the stakeholder interviews that some non-MCSW support staff were ‘jealous’ of the role we found no further evidence of this. No MCSWs or midwives reported this issue in any of the focus groups or via the questionnaires' open questions. In the focus group discussion at the Board with non-MCSW support workers, staff raised no negative issues in respect of the MCSW role. Support workers in fact appreciated the developmental opportunity MCSWs created.

- **Midwives**

With just one exception there were no direct examples in the qualitative research of any midwives who were negative about the role or did not support its development. Participants in the focus groups and interviews did though report that they were anecdotally aware of other midwives in their Boards and elsewhere who were not supportive or who were uncertain of the role. Some midwives it was reported were restricting or opposing the role’s full utilisation. MCSWs reported that they had and some in cases were still encountering midwives that were unsure of the role and were resistant to the delegation of tasks to MCSWs. Significantly though the midwives who worked most closely with MCSWs were overwhelmingly positive and confident about the role. Midwives reported examples of where there had been opposition to the role at first but that this had disappeared over time. Such concerns are common when new roles and boundaries are being introduced in healthcare systems (Nancarrow and Borthwick, 2005; Pearce et al, 2010). Key to ensuring acceptance of the role appears to be: firstly clearly explaining its purpose, secondly directly addressing any staff concerns and thirdly the demonstration of MCSWs' positive impact on service delivery.
Service users

Across all the methods deployed in this evaluation, participants believed that MCSWs were having a positive impact on mothers many of whom did not distinguish between support workers and midwives. MCSWs, as reported above, were supporting mothers with particular needs. One senior midwife had specifically utilised her MCSW to provide postnatal support for a mother with learning difficulties. Participants – midwives and MCSWs alike – felt that the support workers were able to build empathy with mothers. The extra capacity the MCSWs provided also helped with continuity of care.

11.6 What is the overall cost and benefit of MCSW posts?

Cost benefit analysis (CBA) requires the valuation of programmes’ consequences compared to its incremental costs (Drummond et al, 2006). There is evidence from this evaluation that MCSWs are undertaking a wide range of tasks previously undertaken by midwives, many of who are likely to be graded at a minimum at Agenda for Change band 6. Table 12 lists the range of tasks that this evaluation has identified MCSWs regularly undertakes. Undertaking a full CBA for MCSWs is though challenging for a number of reasons. Firstly pre and post evaluation activity data is not available.

A second challenge is that in terms of time there is not likely to be a ‘one-to-one’ swap between midwives and MCSWs when tasks are delegated. For example, midwives are trained to support women to breastfeed their babies and this is one area where MCSWs have been extensively deployed. MCSWs are however, spending longer with mothers than busy midwives were able too. While this is increasing the quality of care it makes direct cost comparisons challenging. Finally, there are challenges in costing maternity outcomes attributable to MCSWs.

What is clear though, as Table 12 shows, is that MCSWs are undertaking a wide range of tasks and as the surveys, focus groups and interviews reveal are ‘freeing-up’ the time of midwives. This represents a cost saving, as a number of participants in the evaluation identified.

Below we have estimated the cost of developing a MCSW (based on 2010/2011 rates):

- RGU Programme cost: £1870
- Salary increase from maximum of band 2 (£16753) to maximum of band 3 (£18827): £2074
- Total direct cost: £3944
The costs associated with developing MCSWs represents 11% of the cost of a band 6 midwife (£34189) if the initial course programme cost is included. This is though, a one-off cost and, of course, there is a cost associated with delivering undergraduate programmes. Given the extensive range of tasks undertaken by MCSWs and the evidence of midwives delegating tasks to the support workers, it is likely that the time freed-up for midwives represents a substantial direct cost saving to services. The MCSW role also provides additional less readily costable benefits such as improved quality of care, increased retention and commitment and ‘Grow Your Own’ workforce strategies.

11.7 Conclusion

The Kings Fund (2011) and final report of the Midwifery 2020 Programme (2010) noted the importance of developing higher-level support roles in maternity but have also pointed to some of the enduring issues associated with the role including the lack of clear and consistent boundaries and high quality education. This evaluation strongly suggests that the MCSW programme in Scotland has addressed these issues and successfully developed a much-needed role that is able to safely and appropriately supports midwives.

In summary the MCSW programme has delivered:

- A high quality, relevant and comprehensive learning programme for MCSWs that allows flexible deployment and transferable skills.
- Unambiguous and consistent role boundaries with clearly defined and appropriate tasks.
- Increased understanding of the MCSW role in maternity services.
- Confidence amongst the majority of midwives to delegate a wide range of tasks to the role.
- The foundations to develop the role further in the future.
- Improved job satisfaction and confidence for MCSWs

MCSWs are contributing a range of services to mothers, their babies and families. They are increasing capacity, delivering improved productivity and better quality of care. The majority of midwives have accepted and integrated the role; although some resistance does remain which along with banding issues had inhibited the full deployment of the role in some cases. Overall however, Boards wish to see an expansion in the number of MCSWS they employ to support midwives and improve services to mothers.
References


CQC (2010), Maternity services survey, 2010. CQC


NMC (2008), *Advice in delegation for nurses and midwives*


