MATERNITY SUPPORT WORKERS (MSWs)

KING'S College LONDON

NHS
Health Education England

The deployment, education and development of maternity support workers in England

A scoping report to Health Education England

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A scoping report to Health Education England

Royal College of Midwives
and Kings College London
December 2017

This report presents the findings of a review on the deployment of maternity support roles in England, the education and training they receive and career development opportunities available to them. Examples of innovative practice are presented along with proposals for how the role's capacity could be enhanced in support of safe care for mothers, babies and their families.

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Author

Richard Griffin MBE, Visiting Senior Research Fellow at Kings College London, wrote this report. Particular thanks are due to Lyndsey Wheeler for her support and contributions and Denise Linay (Royal College of Midwives). Dr Suzanne Tyler, (Royal College of Midwives) oversaw the project.

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1. Introduction and background

1.1 Introduction

This section describes the evolution of support roles in maternity services since 2004 and highlights issues raised in previous research and evaluation. The structure of this report and the methods used to gather data are then discussed along with the research's limitations.

1.2 The development of maternity support worker roles

Support worker roles have long been present in maternity services, traditionally undertaking 'housekeeping' and clerical duties such as bed making, stock keeping and cleaning (Griffin *et al*, 2010). The notion of a Maternity Support Worker (MSW) role more explicitly supporting mothers and babies was first introduced in the *National Services Framework for Children, Young People and Maternity Services* published by the Department of Health in 2004. The role was envisaged as receiving-

> *... appropriate training and would work under a midwife...in hospital (or community postnatal care teams) – providing basic care and support for women and their babies. This could include infant feeding advice and general information about the hospital environment including catering, washing and visiting arrangements* (page 31)

The *Maternity Matter* strategy, published by the Department of Health in 2007, while calling for an increase in the deployment of MSW roles in activities such as clinical roles, assisting infant feeding and parenting education; was not prescriptive about the number of MSWs services should employ or the exact duties they should perform. The strategy noted the role's *"potential to release clinical time and improve outcomes"* as well as the need for *"appropriate training"* (2007:43).

A series of early evaluations of the role were undertaken by organisations including NHS Employers, Care Services Improvement Programme (CSIP) and the Kings Fund. The findings of these were summarised by the Royal College of Midwives (no date) as follows –

- The role was supported by a disparate range of learning programmes resulting in a lack of standardisation and transferability
- Learning was often unaccredited
- MSWs experienced problems accessing learning and when they did, the programmes taught did not always meet the needs of their job
- There was a lack of career progression pathways

CSIP, for example, reported that *"training does not always reflect the type of competence required, hence it is not always fit for purpose"* (2006:61). Kings College (2007) called for a managed and consistent approach to MSW learning and development in England. A 2008 review of maternity support roles in London, commissioned by the Strategic Health Authority against a backdrop of rising demand for maternity services in the capital, found that MSWs were–

> *"... supported by a disparate range of learning, ranging from off-the-job classroom based teaching, to in-house training, to learning by doing, coaching and e-learning"* (Griffin, *et al*, 2009:9)

The report found a clear consensus in favour of commissioning maternity specific London-wide education programmes for MSWs.

The RCM (no date) published a series of case studies of NHS trusts that had developed their maternity support roles and the benefits that had resulted (which included release of midwives' time, improved career pathways and improved breastfeeding rates).

In Scotland the role developed following the publication of *A Framework for Maternity Services* in 2001 by the Scottish Executive. Between 2006 and 20010 a maternity support role development framework was published, which included - an indicative job description, skills passport for support workers to record their acquisition of competences (this also included a list of tasks the role could and could not perform) and a linked national education programme (a *Certificate of Higher Education* delivered from 2008 by Robert Gordon University), whose modules included the principles of women-centered care. NHS Education for Scotland identified the following as reasons for developing a Maternity Care Assistant (as the role is largely described in Scotland) national framework-

- Providing midwives with additional support and assistance as their role expands
- Supporting continuity of care
- Assisting effective care planning and delegation

Support roles, NHS Education for Scotland stated, assisted midwives-

> *"... by providing increased face-to-face time and support [to mothers and families], thus enabling the midwife to direct her skills towards those who will benefit most"* (2006:5).

A later evaluation of the programme by London South Bank University (2010) found evidence of the positive impact of the role particularly in respect of postnatal care, breast feeding support, parent education and supporting vulnerable women.

By the end of 2009 the first-higher level maternity support roles were being developed in Northern Ireland through the completion of a 12-month NVQ level 3 programme that included modules on - taking bloods, undertaking observations and assisting mothers with breastfeeding. In 2012 the *Northern Ireland Practice Education Council for Nursing and Midwifery* published a *Review of the Impact of the Maternity Support Role*. This concluded that while –

> *There was some resistance expressed by midwives on the initial introduction of the MSW role, regarding concerns of 'MSWs taking over the role of midwives', these concerns were quickly allayed once the midwives gained confidence in the ability of MSWs to carry out delegated tasks and they could see the potential benefits of the MSWs role in supporting them* (page 21)

At the same time the Strategic Health Authority in London commissioned a Foundation Degree, delivered by London South Bank University to help develop higher-level roles across London. An evaluation of this programme and it impact on services found–

> *... where the role was fully deployed it had a positive impact on a range of service outcomes including breastfeeding rates, lengths of stays and service capacity particularly in the community.* (Griffin et al, 2012:884)

The evaluation did find variable deployment of the role's new learning in the workplace with MSWs in some services returning to band 2 housekeeping roles.

Box 1.1: Scotland Competency Framework

NHS Education for Scotland published the *Maternity Care Assistants in Scotland: A Competency Framework* in 2006. A multi-partner steering group developed the framework. It not only established the key competences[1] MCSWs should possess but also aimed to:

> *"...inform MCSWs about their roles and boundaries"* (NES, 2006:8)

It further provides a framework to flexibly deploy the role to meet local needs. The framework recognised that defining a single all encompassing maternity care assistnt role might be problematical because the exact components of the post will vary by service need and area. The framework was linked to the *NHS Knowledge and Skills Framework* and comprised the following ten competences-

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

The RCM Wales, Skills for Health and the National Leadership Agency for Healthcare published a tool kit for services planning to introduce higher-level maternity support roles (2008a). In the same year, the organisations published the results of an evaluation a pilot in Bro Morgannwg NHS Trust of a band 3 MSW role with a more direct clinical focus that included - parent education, infant feeding and antenatal care (2008b).

A RCM (no date) review of the early reports and studies into the development of MSWs in England and Wales found the following factors identified as initial drivers for it introduction-

- Increasing demands on maternity services
- The need to maximize midwives direct contact with women
- Changing expectations of women and their families
- The need for effective team working
- Shortages of qualified midwives
- Opportunities to enhance support worker roles and development

In 2010 the Department of Health produced a new maternity strategy called *Midwifery 2020. Midwifery 2020* acknowledged the contribution that MSW made to care, but also noted–

> *... there has been a lack of clarity and consistency regarding title, task and training, accountability and governance* (page 31)

1 Competencies may be defined as the ability and means to undertake a task. They bring together knowledge, skills and attitudes (behaviour) to allow safe and effective practice.

In 2010 the RCM produced a *Position Statement on Maternity Support Workers,* which stated that introduction of the role–

> *Should be within a clear framework which defined the role, responsibilities and arrangements for supervision.* (Page 1)

This statement was retained in the revised version of the *Statement* published in 2014.

In 2011 the RCM convened an expert group to address the *"inconsistency and confusion about the tasks that support workers can perform"* (2011:2). The resultant guide provided advice on delegation and listed tasks that MSWs must not perform (such as diagnosing pregnancies, auscultation of fetal heart and delivery of baby) along with 96 tasks that could be performed by MSWs in support of mothers, their birthing partner and baby. The guide drew on NHS Education for Scotland's (2010) Skills Passport and the task list covered the whole maternity pathway, including theatre tasks and postnatal community activities. The guide underwent minor revisions in 2016, for example noting the training that had been delivered in the West Midlands to enhance the ability of MSWs to support midwives at homebirths. The guide stresses the importance of appropriate training, delegation and supervision of support roles.

The guide also made the point that there is no single definition (or title) encompassing the MSW role (2016:5). The RCM define the role as-

> *... with appropriate training and supervision [MSWs are] able to provide information, guidance, reassurance, assistance and support, for example with breastfeeding or recording vital signs that improve the quality of care that midwives are able to provide mothers and families. MSWs are banded on Agenda for Change bands 2,3 or 4* (ibid)

Reports and publications, such as The Kings Fund (2011) and CfWI (2013), have continued, albeit at a slower pace than in the early phase of the role's development. These reports have emphasized the contribution MSWs can make to maternity care, particularly in light of the rising demands and needs of maternity services, including the on-going trend towards older mothers with more complex needs (IFS, 2017). The most recent studies have highlighted how the role can enhance care in public health (RCM, 2017) and potentially supporting homebirths (IVLWR, 2016).

The National Maternity Review of 2016, called *Better Births* set out a five-year vision for improving the quality of maternity care, providing women and their babies with safer and more personalised care. The review stresses the importance of MSWs in supporting maternity transformation, particularly in respect of public health, community postnatal care and intrapartum safety. The review highlights a number of case studies of innovation including in respect of homebirths. *Better Births* stresses the importance of - multi disciplinary team working along with organisational cultures that promotes learning and continuous improvement.

In England the apprenticeship standards[2] that is most applicable to the training and development of MSWs is the *Senior Healthcare Support Worker* (level 3), which has a specific maternity pathway that includes the following knowledge and skills–

- Assist with clinical tasks (e.g. parenting skills, recognition of deterioration, obtaining and testing venous and capillary blood samples and other specimens and supporting women with general personal hygiene)
- Assist with caring for baby (includes - physiological measurements and supporting parents to meet the hygiene and nutrition needs of babies)
- Support mother and birthing partner

2 The Apprenticeship Standard for Assistant Practitioners (Health) does not explicitly mention MSWs in the list of potential occupations that are appropriate for the level 5 standard, however it is possible that the standard could be utilised to support higher-level maternity support roles.

According to Health Education England (HEE), MSWs comprise 5.5% of the total maternity workforce, however the RCM's annual survey of Heads of Midwifery (HoM) suggests that the proportion may be considerably higher. It would appear however that MSWs have remained a reasonably stable proportion of the workforce over time. The RCM's survey suggests the proportion of MSWs has risen by less the 0.4% between 2010 and 2016.

1.3 The purpose of this report

This report summarises the findings of a mixed methods research programme undertaken between October and November 2017 by the RCM and Kings College London. The research was commissioned by HEE to help inform the national maternity transformation workforce programme. The following areas were investigated –

- Duties currently undertaken by MSWs
- Progression and development opportunities
- Training
- The role of MSWs within current service/staffing models
- Innovation practice related to MSWs nationally
- Key challenges and barriers to the future development of the role
- Education and training opportunities and pathways

1.4 Methodology and methods

Data was gathered through a mixed methods research design. The rationale for using multiple methods (for example a survey and focus groups) was the need to gather data about "what' is happening in respect of MSW roles such as the tasks that they perform, but also "why". The specific methods used were as follows –

1.4.1 Rapid review of literature

We conducted a review of the research and policy literature on MSW roles since 2004. The findings are summarised in section 1.2 above.

1.4.2 Questionnaires

In 2016 the RCM surveyed MSWs about the training they received, their views on that training and their aspirations (unpublished). Over 500 MSWs completed the survey and we have drawn on the findings from that survey in respect of education and development.

An online survey was promoted to MSWs across the UK through the Autumn 2017. The survey included questions on demographics such as ethnicity, areas of work, years in employment, future employment intentions, job satisfaction, attitudes and aspirations to training and education including the Care Certificate, tasks performed (drawn from the RCM Guide (2011)) and views on supervision, delegation and regulation. In total 557 MSWs completed the survey (471 of whom were employed in England).

1.4.3 Semi-structured telephone interviews

A total of twelve telephone interviews were conducted. Critical case sampling[3] will be utilised to select key stakeholders to be interviewed on their views on the deployment and development of MSW roles including the duties performed, training, challenges and barriers. The following questions were asked –

- How are MSWs currently deployed by services, including the progression and development opportunities available to them?
- What examples of innovation are there in respect of the MSW role?
- What training is provided to MSWs?
- How the role might evolve in the future?
- What are the key challenges and barriers to future development you think the role might face?

Participants included - MSWs, senior midwives involved in implementing national policy including early adoption of *Better Births*, educators, a representative of the RCM and midwives from services utlising the MSW roles, including a Practice Educator.

1.4.4 Focus groups

Three focus group discussions were held with MSWs. In total 54 took part. Focus groups were organised in the North (with community based MSWs), London (hospital and community) and the South West (hospital). Discussions explored in more depth MSW's views of their role, aspirations, challenges and issues, as well as ideas for its future development.

1.4.5 Job Descriptions

Content analysis was undertaken of job descriptions and person specifications for MSW posts advertised on NHS job websites through the duration of this research (n=34). Sites searched were - *NHS Jobs, NHS Scotland Recruitment* and *HSCRecruit*. Half the roles identified were for band 3 roles and 44% for band 2. Of the remaining two one service did not specify its banding and second offered band 2 or 3 depending on experience. The majority (82%) of posts were advertised in England, with four in Scotland and one each in Wales and Northern Ireland. The following information was extracted –

- Title
- Band
- Area of work
- Tasks and duties
- Education and training required for the post

This approach allowed up to date information on the tasks that maternity services across the UK require their MSW posts to perform across the pathway.

1.4.6 Examples of innovation

The RCM issued a call for HOMs to self-nominate their services as being innovative in terms of MSW education and development.

1.5 Limitations

The aim of this report is to provide scoping information about MSWs to support the national maternity workforce board. The key limitation of the research is that it was not possible with the time and resources available to gather data from midwives, other than those interviewed by phone. While it was not a requirement of the research to assess the impact of MSWs on services, in common with other healthcare support worker roles there appears to be a paucity of high-quality impact evaluation research.

3 A critical sampling technique seeks to identify participants with specific insights and understandings of a phenomenon (in this case the training and development of MSWs). While sample size may be small the data gathered is rich.

2. The maternity support workforce

2.1 Introduction

This section sets out the research's general findings in respect of the MSW workforce, such as their age profile and is largely drawn from the on-line survey.

2.2 Characteristics of the MSW workforce

Key features of the MSW workforce identified from the survey were that MSWs are -

- Overwhelmingly female (99.4% of the sample)
- Have personal caring responsibilities such as childcare (58.5%)
- Work part time (56%)
- Aged 40 or over (55.8%). A quarter are aged 51 years or older, and just 15.6% are under 30 years old[4]
- The vast majority of the survey sample described themselves as 'White'. Less than 2% described themselves as black and less the 1% as Asian

2.3 MSW's attitudes to work

The survey asked respondents to indicate their future employment intentions. These are summarised in Table 2.1 below and suggest that the MSW workforce is a stable and loyal one. The survey found that only 5% wished to leave NHS employment and that 43% have worked for their current employer for 10 years or more.

Table 2.1: Future employment intentions of MSWs

Survey question –"What would you like to do in the future?"	% of sample
Stay in current job/with current organisation	47.3
Stay as a MSW but with a different organisation	1.3
Train to be a registered midwife	18.9
Train to be a nurse	4.7
Undertake a non maternity healthcare support role	1.3
Retire	6.4
Leave NHS employment	4.5
Not sure	15.6

A little over one in five of the people who completed the survey stated that they would like to either train to be a midwife in the future (18.9%) or a nurse (4.7%).

4 One interviewee (midwife) did mention she noted a difference between younger and older MSWs in terms of their attitude to work/life balance.

Respondents were asked to state how strongly they agreed or disagreed with a series of statements about their job satisfaction using the following five-point Likert Scale – "Strongly Agree", "Agree", "Neither Agree or Disagree", "Disagree" and "Strongly Disagree". Weighted averages for each statement were calculated and the results are shown in Table 2.2. Responses closer to 1 suggest stronger agreement with the statement and those nearer 5 a stronger disagreement.

Table 2.2: Attitudes to work

Statement	Average
I would recommend my organisation as a good place to work	2.4
I feel my role is valued by my employer	2.7
I **do not** look forward to coming to work	3.5
There is not enough time to do all I need to do	2.2
I am fairly paid for the work that I do	2.2
I feel frustrated in my role	2.5

Only 15% of survey respondents would not recommend their place of work to their friends and family. Asked whether they looked forward to coming to work each day 59% said that they did and only 18% that they did not. A little over half (52%) felt valued by their employer but 58% felt frustrated in their role.

The results of the qualitative research emphasized the finding from the survey that while MSWs enjoy their work they can feel frustrated by elements of it particularly pay, grading, work load, and as will be discussed below, career progression opportunities, as the following illustrate –

> *I absolutely love my this job but I think there is more that could be done to make us competent in our roles* (MSW, focus group)

> *I love my role but sometimes I feel we're stuck* (MSW, focus group)

> *My role has expanded over the years. My band is the same. I do love my job but I find it hard to provide for my family on such a low income* (MSW, focus group)

> *More and more is expected from MSWs due to lack of midwives* (MSW, focus group)

The above quotes are from five different MSWs who participated in the focus groups. It is interesting to note that three used the word "love" to describe their job. We were struck by how frequently this word was used by participants in the qualitative research to describe how they felt about their work[5].

2.4 Titles used to describe the maternity support roles

The survey recorded a total of 22 different titles used to describe the role, although the most common one, (used by 61% of survey respondents, rising to 94% in Northern Ireland) was "Maternity Support Worker".

For Scottish based respondents to the survey the most common title (56%) used was - "Maternity Care Assistant", although 29% of the sample that were based in Scotland described their role as 'Maternity Support Worker'. Box 2.1 lists some of the alternative titles used.

Box 2.1: Titles used to describe support roles working in maternity

Healthcare Support Worker
Clinical Support Worker
Maternity Healthcare Assistant
Advanced Maternity Support Worker
Assistant Practitioner
Practitioner Development Maternity Assistant Practitioner
Obstetric Support Worker
Specialist Maternity Assistant
Maternity Associate Practitioner
Maternity Healthcare Support
Senior Maternity Care Assistant
Community Maternity Support Worker
Associate Maternity Practitioner

Three different titles were used to describe MSWs in each of the three focus groups we conducted ("Maternity Assistants", "MSWs" and "Maternity Care Assistants"). A total of 17 different titles were identified in the 34 job adverts identified during the research period (50% of jobs sampled did use 'Maternity Support Worker" as a title for the role).

2.5 Grading

Table 2.3 shows the proportion of the survey sample from each country (and London) graded at *Agenda for Change* band 2, 3 or 4. Across the sample as a whole over half (54.8%) of all band 4s worked in Scotland and the majority of band 4s in England worked in London.

Table 2.3: MSW Grade by location

Location	Number	Band 2	Band 3	Band 4
Scotland	49	34.0	14.0	46.0
Wales	48	35.4	58.3	2.1
Northern Ireland	59	23.7	61.0	8.4
England (excluding London)	379	44.8	48.3	3.4
London	42	35.7	50.0	14.3

5 One interviewee suggested that there could be negative consequences of this – *I think MSWs can be taken advantage of because employers know they love their job and they won't rock the boat* (RCM, phone interview)

Table 2.4 shows the distribution of grading by work setting (those that MSWs completing the survey stated they 'Always' or 'Mostly' worked in). MSWs are more likely to be graded at band 2 if they mostly or always work on labour ward or in theatres and band 3 if they work in antenatal care, specialist roles (such as public health) or particularly in the community. The highest proportion of band 4 MSWs work in theatres most of the time. It should be noted though, as will be discussed below, that the MSW role in hospitals tends to be deployed across settings (and between clinical and non-clinical tasks).

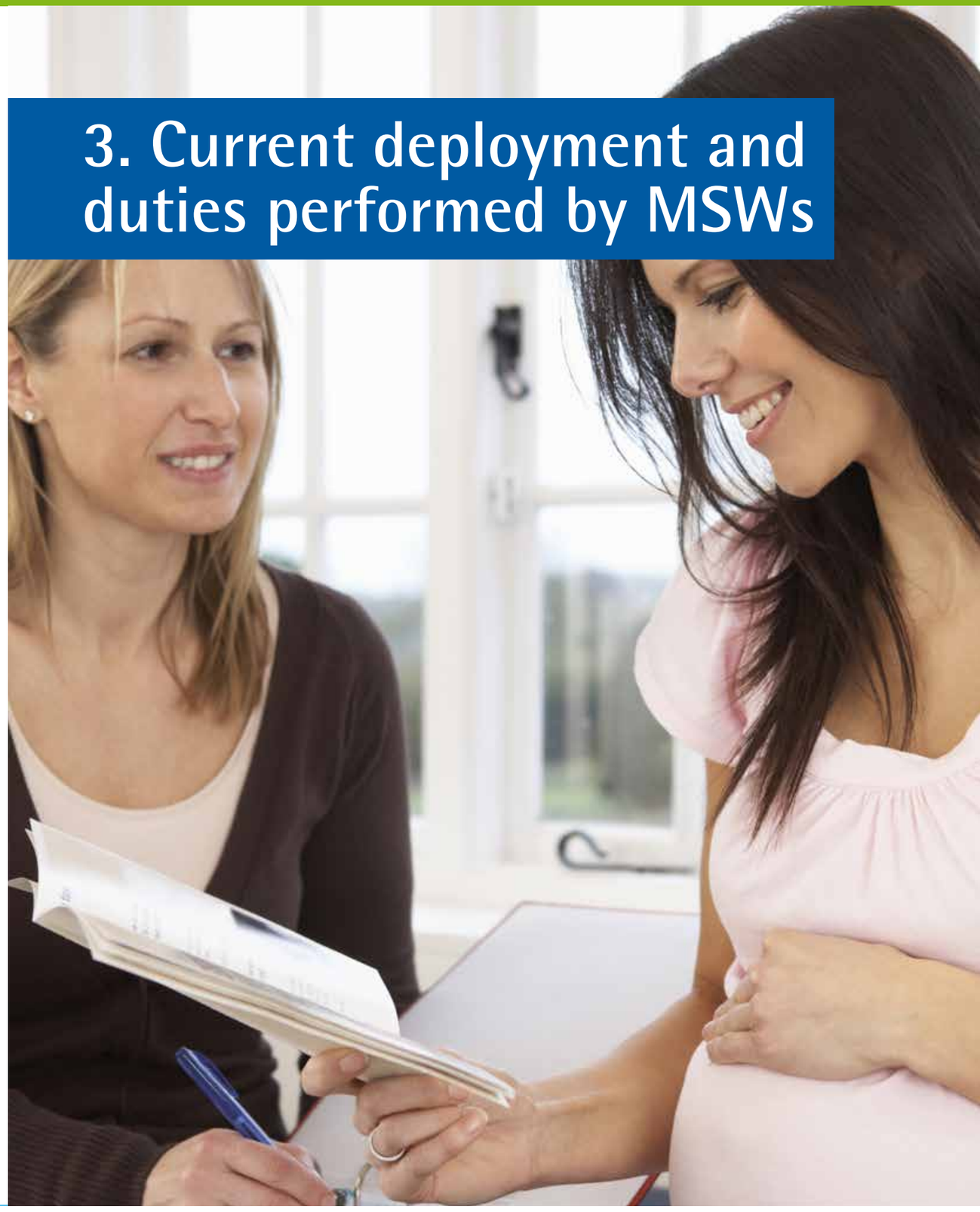
Table 2.4: Grading by setting of work

Work setting	Number	Band 2 (%)	Band 3 (%)	Band 4 (%)
Antenatal	129	40.3	**52.3**	2.6
Labour ward	111	**72.3**	20.5	6.2
Birth centre	72	40.2	**54.1**	5.6
Postnatal ward	176	39.8	**45.4**	10.8
Postnatal community	125	2.4	**82.4**	10.4
Theatre	58	**67.0**	17.0	14.0
Specialist	30	36.6	**60.0**	3.3

2.6 Summary

The MSW workforce is overwhelmingly female, with the majority working part time and having personal caring responsibilities. It is an ageing workforce – while 16% are aged 30 years old or younger, a quarter is aged 51 years old or over. MSWs represent a stable and loyal workforce with just 5% wishing to leave NHS employment and the majority having worked at their current employer for six years or more. MSWs generally enjoy their work but are frustrated by elements of their role specifically – pay, grading, workload and lack of progression opportunities. A large number of titles are used to describe the role – 22 were recorded in the survey and seventeen different ones in the 34 job adverts reviewed between October and November. MSWs in England are graded at either *Agenda for Change* band 3 or band 2.

3. Current deployment and duties performed by MSWs



3.1 Introduction

A key aim of this research was to investigate how MSW roles are currently deployed by maternity services. Data to address this aim were drawn from all the methods deployed. In the survey, respondents were asked which parts of the maternity pathway they worked on, (from antenatal to community postnatal care), and for each are how frequently they worked there (using a five-point scale from "Mostly/Always" to "Never"). The survey further asked respondents to record how frequently they performed particular tasks, such as - "cleaning and making beds", "identifying and reporting faulty equipment", "applying TENS machine", "promoting skin-to-skin contact" and "assisting mothers with postnatal exercises". The tasks were drawn from the RCM's (2016) *The Role and Responsibilities of Maternity Support Workers* guide and included theatre tasks such as "checking swabs and needles". A free-text box allowed respondents to record any tasks not included on the list. Additionally the tasks listed in the job descriptions extracted were reviewed and finally in the interviews and focus groups participants were asked to describe how MSWs were deployed locally.

3.2 Deployment of MSWs across the maternity pathway

The results of the survey suggest that the MSW role is extensively deployed across the whole maternity pathway. Table 3.1 shows the proportions of the survey respondents stating how frequently they worked in each setting. As can be seen only a minority "Never" work on the postnatal ward (19% never do this), in antenatal work (21%) or on the labour ward (30%). While a majority never worked in a birth centre or in theatres or specialist roles, this probably reflects the more limited opportunity to work in these settings. Indeed only 7% of the sample said that they "Mostly/Always" work in a Specialist, for example supporting vulnerable women, (72% said the "Never" or "Rarely" worked in these roles).

Nearly three quarters of the survey sample (61%) stated that they had never worked in community postnatal care. The focus groups conducted in the North and South West included MSWs who were solely community based, supporting midwives to deliver postnatal care to mothers and families. The survey results would suggest that around a quarter of the MSW workforce is primarily deployed supporting postnatal care in the community, one of the areas the role has long been seen as increasing capacity in –

> *Community roles have developed a long way from 2006* (MSW, focus group)

Table 3.1: MSW work setting

Setting	"Mostly/Always" work (%)	"Some of the time" (%)	"Rarely" (%)	"Never" (%)
Antenatal	30	32	17	21
Labour ward	24	27	21	30
Birth centre	16	14	17	53
Postnatal ward	37	29	15	19
Postnatal community	27	7	5	61
Theatre	13	19	13	55
Specialist	7	21	15	57

For hospital-based MSWs it is likely that while staff may be primarily focused on a particular setting, such as the labour ward, they work flexibly in other areas of the pathway as well including theatres. The extensive nature of the role was expressed by one MSW as –

> *There is so much to our job, there is not just the skills that you have, but also your connection to women, the empathy, the compassion, the judgments…there is so much involved* (MSW, focus group)

3.3 The tasks MSWs perform

This section sets out the findings from the survey results in respect of the tasks performed by MSWs.

3.3.1 To what extent does the *RCM's Roles and Responsibilities Guide* determine the tasks MSWs perform?

The survey listed all the tasks contained in the RCM's (2016) guide as being appropriate for MSWs to perform. Respondents were provided with the opportunity to list any other additional tasks undertaken but not included in the survey list. Only a small number (n=15) of respondents provided "Other" example. An analysis of these showed that there were in fact none that fell outside of the guidance. Examples of "Other" tasks listed by respondents included (by a band 4 for example) – "performing venepuncture and providing first postnatal visit", (by a band 3) – "breastfeeding, running the office and parent education" and (by band 2s) – "assisting at a baby clinic and setting up an antenatal class". These, as with all the other tasks listed as "Other", were covered in the survey task list drawn from the guide.

On the basis of the survey results it can be concluded that the RCM's guide[6], is, in fact, setting the broad parameters of the tasks that MSWs undertake locally. The interviews, focus group discussions and job description analysis did not identify any additional tasks being performed by the role.

6 The College report that the Roles and Responsibilities guide is their most accessed publication.

3.3.2 The frequency of tasks performed by MSWs

In addition to stating which tasks MSWs performed in the survey, respondents were also asked to record how frequently they performed each, again on a five-point scale (ranging from "Frequently" to "Never"). We reviewed the tasks that were most commonly performed across the whole sample and those that were less frequently performed (theatre tasks were reviewed separately) and the results are shown in Table 3.2.

Table 3.2: Frequency of tasks performed by MSWs (survey results)

Frequently performed tasks	Less frequently performed tasks
Cleaning and maintenance	Organising and taking part in parent classes (ante and post natal)
Assisting with equipment	Assisting with ultra sound
Restocking	Cannulation
Observing and recording mother's vital signs	Homebirths[7]
Obtaining and performing urinalysis	Bereavement[8]
Promoting and supporting breast feeding	Assisting midwife with neonatal resuscitation
General assistance with new born (such as weighing)	Carrying out newborn hearing screening
Venepuncture	Observation of vital signs (community)
Supporting mother with general personal hygiene	Recognising signs of deterioration (community)
Reviewing vital signs (mother)	
Discussing stool and micturition	
Supporting vulnerable mothers	

The tasks that staff who worked mostly in theatre settings (n=46) undertook were also reviewed. Almost all staff working in theatre (n=46) settings performed the following–

- Checking swabs
- Cleaning the theatre
- Preparing theatre
- Taking samples
- Providing support to mothers and birthing partner

7 24 respondents reported they were "present" at homebirths (eight of these were graded at band 2). No data was gathered on the role they undertook in support of midwives and families.

8 14% of the sample said that the "often" supported families suffering bereavement

The task that was considerably less frequently performed was scrub. Just seven of the sample stated they regularly performed "scrub duties".

The majority of MSWs primarily working in theatre settings also worked in antenatal care and on postnatal wards and10% also stated they worked in community settings – underlying how the role is extensively deployed in hospital settings.

3.3.3 Tasks and grading

The tasks "frequently" performed by MSWs at each grade were compared to assess whether there were clusters of activity more likely to be performed by higher-level bands (because they require additional training such as maternal observations, obtaining venous blood samples and breastfeeding support), compared to lower level ones. We found little rationale for why posts were graded at particular bands. Comparing band 2s and band 3s the following tasks were slightly more likely to be performed by a band 3 than a band 2–

- Discuss changing stools and micturition of normal neonate
- Supporting vulnerable mothers
- Routine baby observations
- Skin and eye care
- Obtaining venous blood samples

MSWs graded at band 2, for example, were as likely as band 3s to perform the following tasks –

- Maternal observations
- Breast feeding support
- Setting up and removal of epidural catheter
- Care of cord

A similar situation pertained for between band 3 and band 4s. Band 4 MSWs were less likely to assist with equipment and health promotion tasks than a band 3 but more likely to assist mother's with their personal hygiene (a surprising observation), review mother and in hospitals baby vital signs, take samples (capillary blood, urine) from babies and recognise signs of deterioration. For all other tasks there was no significant difference in the frequency a band 3 and a band 4 performed them.

Box 3.1: NHS Job Evaluation and MSWs

The NHS Job Evaluation scheme is used to determine pay bands for posts. The Job Statement for a band 2 support role includes the following responsibilities – undertaking personal care and recording patient information (it does not include observations). Typical band 3 duties include observations and undertaking a range of delegated tasks.

While as described above we did find that band 3s were more likely to work in community settings, in birthing centres and in specialist roles, in terms of tasks performed, (with the exception of the broader responsibility of "supporting vulnerable women"), it is hard to discern a clear rationale for grading; a point raised in each of the focus groups and phone interviews -

> *…we've got band 3s and band 2 MSWs, however there are a variety of job descriptions that have been tweaked over the years and when I speak to the [MSWs] themselves there are some band 2s that do additional roles and some band 3s that don't do additional roles, they are paid at band 3* (midwife, phone interview).

Its [task allocation] *is very muddled. There is no clear definition at all between band 2s and band 3s…there's no clear definition at the moment… we know exactly what a band 5, 6 or 7 midwife can do, you know exactly where everyone sits on that structure but with MSWs its just like a pot of people and they don't really know what to do with them…there is no clear structure for them, and because there is no clear structure they* [midwives] *do not know what they can do, so there is a nervousness about allocating some of the roles they can clearly do* (Midwife, phone interview)

Job descriptions are weak, they are variable, they are nebulous, I'm generalisng but we need robust job descriptions embedded in a national framework that's mandated, things would look very different on the ground. (Policy, phone interview)

The way MSWs are deployed is not consistent, you will have some trusts that are deploying them very effectively and then we have others that aren't using them at all well…even where they are being deployed well they are not necessarily being paid correctly. Its something that comes up again and again, they are carrying out high level work but being paid at band 2 …Trusts that are fairly close together are treating the role very differently (RCM, phone interview)

There's no link between tasks and grades. It not fair. It's not right (Midwife, phone interview)

The analysis of job descriptions also suggested that the difference between the expectation of a band 2 and 3 proves difficult for some employers to clarify. Some job descriptions implied a more active role for band 3 staff, for example stating - *"to actively participate in the recognition and prevention of maternal and neonatal illness and respond effectively in an emergency situation"*, compared with "*provide support to the midwife and maternity care assistants by observing and reporting aspects of care promptly alerting the midwife to any issues or risks"* for a band 2 role.

In one case a Trust simultaneously advertised for a band 2 and a band 3 MSW. The primary clinical differences between these two posts was an expectation that the band 3 undertakes phlebotomy and is "*able to carry out postnatal care/ home visits making observations, assessments and appropriate referral to the midwife".* The band 2 job description suggests that the post holder take *"appropriate actions such as referral to a band 3 MSW"*. The biggest difference overall is that the band 3 has explicit duties under the headings "communication" and "clinical", but the band 2 has headings for "care giving", "housekeeping" and "clerical". The only clerical work expected from the band 3 is maintaining accurate clinical records, and the role has no housekeeping duties.

Some differences were seen in the clinical elements of the task analysis, with 56% of band 3s listing basic observations, but only 35% of band 2 job roles expecting these tasks. Band 2s are being recruited to take bloods, but it is required in only 18% of band 2 job descriptions compared to 56% of band 3s. The analysis showed that 81% recruited at band 3 are expected to be active in maternal observations during and after pregnancy, and to know how to escalate any concerns. This requirement also occurs in 29% of the band 2s. The task analysis also revealed a greater expectation of active information giving in band 3 roles, with 81% expected to actively give maternal advice, often focusing on breastfeeding, compared with 29% of the band 2 roles analysed.

The role advertised as either a band 2 or 3 stated that grading on appointment would 'depend on the candidate'. Only one job description and person specification was provided for this role, suggesting that there is little or no difference in duties. The implication in the job description was that someone holding an up to date Level 3 qualification would be employed as a band 3. Some job descriptions related the band 3 role to the band 2, for example "the band 3 role includes the following Band 2 duties and responsibilities".

One job description took this route by including **all** band 2 duties plus a list of additional elements (numbering 20 further duties in the clinical care element alone)[9].

3.3.4 A tension between MSW clinical and non-clinical roles?

The survey suggests that a "typical" MSW will undertake a range of clinical and non-clinical tasks regardless of their grade. For example 82% of the sample often carried out cleaning and tidying tasks and 80% stock control. While the tension between clinical and non-clinical roles was a strong theme of the discussions in the focus groups and had also been addressed explicitly in the examples of innovation discussed in section 5, analysis of the job descriptions suggested that at least for the sample advertised during the period of this research, services made some distinction between the roles of band 2 and 3 in this respect. Table 3.3 below summarises those job descriptions that specifically mentioned non-clinical tasks by grade. The results show that while band 3s were expected to undertake some non-clinical tasks like "administration", there is a distinction between levels with no band 3s expected (as far as job descriptions are concerned) to undertake "housekeeping" tasks.

Table 3.3: Job Description Analysis of non-clinical tasks

Band	Administration Tasks	Maintaining Records	Maintaining Stock	Housekeeping	Setting up	Provide information
2	4	9	3	9	3	4
3	3	13	4	0	4	2

In each of the focus groups MSWs highlighted the issues they saw arising from having to undertake clinical and non-clinical roles, as the quotes from one focus group show -

One minute MSWs are cleaning or doing admin tasks, the next they are helping out in theatres, then with breast-feeding support (MSW, focus group)

It's a high-pressured role, I would like to give more time to women but housekeeping tasks take up a lot of my time (MSW, focus group)

The following is a discussion that developed between the MSWs in the North focus group –

At a drop of a hat they [midwives] *will ask you to do something ridiculous like 'go and pick up a box of stores'…is what's in your diary important or not?* (MSW1)

My midwife rang me and said she'd been to her team leader's office to pick up her own stuff and got greeted by 'oh, you didn't have too, you could have got your MSW to do that' but why should that just be me, why should I be made to feel I'm a 'fetcher and carrier' (MSW2)

I think the 'fetch and carry' role is important because if you have seven or eight visits in your diary you prioritise those and get through them. If you have a day when you are in the office and you have time to fetch and carry I would have no issue. Where I do have a problem is being dictated too, when I have a diary full of visits (MSW 3)

9 The full results of the content analysis of the job descriptions and person specifications reviewed are contained in a separate report.

Its not like what you do is appreciated (MSW 4)

Its almost as if our role is not important (MSW5)

It should be noted that when asked directly this group all felt that their midwives valued their role, with one saying –

They [midwives] *are chuffed we exist* (MSW, focus group)

In the South West focus group MSWs again described how they each performed a broad range of tasks ranging from housekeeping to mother and baby supporting roles. This group felt strongly that housekeeping roles should be separated from clinical ones in job design, with band 2s performing non clinical duties like cleaning and making beds, re-stocking and ordering equipment and preparing clinical areas, and band 3s undertaking tasks such as cannulation, breastfeeding support, blood spots and observations, with band 4s having more specialist and autonomous roles such as running clinics.

The South1 case study described in section 5 below has in fact made the distinction and no longer employ band 2 MSWs. Part of the rationale for this was to ensure MSWs could provide holistic support to mothers and babies. A senior midwife we interviewed from a service in the midlands said –

We have stopped band 2's doing baby observations…we redesigned the job descriptions

As will be discussed below some participants did express the view that if band 2 was the entry point for MSWs, then for job satisfaction and future career development staff should be allocated appropriate clinical tasks.

3.4 Clarity about role boundaries, delegation and confidence in the role

The survey contained a series of statements about supervision and delegation and respondents were asked to say how strongly they agreed or disagreed with each. We calculated a weighted average based on the five-point scale ranging from "Strongly Disagree" (= 5) to "Strongly Agree (= 1), the closer an average is to 1 the more respondents agreed with the statement and the closer to 5 the more strongly they disagreed.

The results showed strong agreement by MSWs that they know what is expected of them[10] (1.8), that they know which tasks they should (1.7) and should not (1.7) perform, that they feel adequately supervised (1.4), are responsible for their mistakes (1.7) and are clear about organisational delegation polices (2.0). Linked to this MSWs generally disagreed (3.5) with the statement that "midwives are reluctant to delegate tasks to MSWs" (22.4% did think more tasks could be appropriately delegated to them, however). Over eight in ten MSWs (81%) believed midwives had confidence in their role.

The qualitative research reinforced the view that MSWs were clear about the tasks they could and could not perform. In a number of cases services used local skills passports –

We have a firm list of what you can and cannot do, which makes easer to work too (MSW, focus group)

10 Of the total sample 8.7% were "Not Sure", 5.5% "Disagreed" and 1.9% "Strongly Disagreed" with the statement that they knew exactly what was expected of them.

The survey did record that 40% of MSWs believed they were sometimes *asked* to perform tasks that they felt they should not[11]. This also came up in focus group discussions-

Sometimes we get asked to do things beyond what we should but sometime there is no one else to ask (MSW, focus group)

3.5 Allocation of tasks is not always stable

Examples were found in our qualitative research showing that task allocation is not always stable and that a change of senior leadership or a MSW moving setting within the same service can result in them no longer being able to perform tasks that they were previously able and trained too. In one interview a midwife described to us how the appointment of a new Head of Nursing in her trust led to an instruction that all MSWs stop performing observations (this was later reversed). In a focus group discussion a MSW reported that when she moved from one team within the same trust to another she was no longer allowed to undertake blood spots, saying-

This is a disparity between what you can and cannot do (MSW, focus group)

3.6 Reasons for inconsistent grading and variable utilisation of role

The issue of variable and inconsistent allocation of tasks and grading was a strong theme in the qualitative research and we explored, particularly in the phone interviews, why participants thought this happened. This section briefly summarises the issues, these also provide insights into the factors that are acting as a barrier to the role's full development locally.

3.6.1 Workforce planning is based on historical factors not current need

Services participating in the research that had or were about to systematically audit and review the tasks, grading, learning and job description of MSWs said a motivation for doing so, beyond addressing the increasing service demand, was because of historical inconsistencies in the role's development -

That's how its been for years…its been allowed to happen and no one has done anything about it. (Midwife, phone interview)

Its [task allocation] *historical* (Midwife, phone interview)

This point was also made by one of the Policy participants –

Services have not always thought through how best they can use support staff, it tends to be reactive rather than proactive planning (Policy, phone interview)

11 We do not have data to assess whether MSWs have been asked to do tasks that fall outside of the RCM's (2016) guide or whether they have been asked to undertake tasks they feel exceed their band and/or training but remain within the list of appropriate tasks.

Box 3.2: Example of barriers to role development

A midwife interviewed for this research set out the following factors she felt acted as a barrier to the full development of MSW roles locally-

- Lack of appropriate and comprehensive workforce planning
- Lack of high-quality and consistent formal education and training opportunities
- Absence of a national mandate for the role
- Workload pressures meaning development is frequently reactive
- "Group think – people are not thinking outside of the box"
- Funding constraints

3.6.2 The importance of national guidance and local leadership

A theme emerging from the phone interviews was that in the absence of clear national guidance there was a *"nervousness"* (Policy, phone interview) locally to fully develop the role. Two other participants mentioned this –

> *There is nervousness about giving them greater autonomy to do what they need to do. Not everyone…but they almost have to prove themselves* (Midwife, phone interview)

> *No one has the conviction to make [the role] work* (Midwife, phone interview)

A related theme was the importance of local leadership and champions, particularly at senior levels –

> *If you've got a HoM who believes MSWs can do more then they will develop these roles, whereas others will take the view that they will just use them for housekeeping* (RCM, phone interview)

There was a clear view expressed throughout the qualitative research that there should be national guidance and a linked framework, similar to Wale's and Scotland's, setting out clearly the roles and responsibilities of MSWs at each level (this was mirrored in discussions about education and training, see below). One midwife told us this was important because, amongst other reasons, *"services need to see the potential of the role".* She went on to say –

> *Once we get beyond that* [a clear understanding of the role] *the 'skies the limit', services will understand that this role is embedded in maternity services, where as at the moment its not…someone needs to take ownership of this role nationally and provide guidance, indicators about how services can use the role so everyone knows where we stand* (Midwife, phone interview)

> *… we need a robust JD embedded in a national framework that's mandated* (Policy, phone interview)

Two interviewees also mentioned their view was that more could be done to share best practice and innovation, making the point that some services are developing MSW roles (their role in supporting midwives at homebirths was mentioned) but that this was not promulgated and the knowledge exchanged between services-

> *We need to disseminate understanding of the role across the board*

3.6.3 Remaining concerns about the role

Despite the evidence that the MSW role is increasingly accepted by midwives, participants did mention that the role is not always valued and that some concerns that extending support capacity might jeopardies midwives' roles still existed –

> *Services don't always see MSWs as a valuable asset. This means they are undervalued. There is poor planning we just don't seem to be able to pull it together well* (Policy, phone interview)

> *There can be some concern from senior management that if you develop MSWs you will lose midwifery posts … people don't like change* (Midwife, phone interview)

3.6.4 Funding constraints

The view was consistently raised in the qualitative research that services were unable to afford MSWs working in higher-level grades. The MSW we interviewed by phone, for example, described how MSWs in her trust had left the role because of a lack of opportunity to progress to band 3 (due to funding constraints) –

> *We lost people who had a passion for maternity* (MSW, phone interview)

4. Current learning and development of MSWs

4.1 Introduction

This section summarises the findings in respect of MSWs access to education and training, the nature of learning, participant's views of the learning MSWs acquire and perceptions of learning needs.

4.2 Current education and training

Table 4.1 below shows the types of learning MSWs identified that they were currently undertaking in the survey broken down by formal qualification (e.g. those that are regulated such as NVQs) and informal (non regulated) learning. Where more than one person stated a particular type of education or training the total numbers citing are shown.

Table 4.1: learning undertaken by MSWs

Formal learning	Informal learning
NVQ level 3 (n=17)[12]	Breastfeeding (n=6)
Foundation Degree (n=10)	Hypnotherapy (n=2)
Access to Higher Education (n=8)	Cannulation
GCSE Math's (n=5)	Nutrition
GCSE English (n=2)	Mental health awareness
NCQ level 2 (n=2)	Understanding diabetes
OCR text processing	
'Level 4 professional support'	
Care Certificate	
'Level 2 team leadership'	

Asked whether they had received any training in the last two years, excluding statutory and mandatory, 79% said that they had, although as will be discussed below most of this is likely to be informal learning. Participants in the phone interviews and MSWs in the focus groups described how they perform a number of tasks that they had not received formal training for, and that acquisition of these tasks had been ad hoc rather than the result of formal workforce planning –

> *It's information we have just picked up* (MSW, focus group)

> *Lots of training is very patchy* (RCM, phone interview)

12 A number explicitly stated that this was the Maternity and Paediatric programme and a number that it was being studied as part of an apprenticeship

4.3 The results of the Job description and Person Specification Analysis

The analysis of the 34 new jobs advertised during the study period suggests a generally common expectation for educational attainment for applicants Where specified in job descriptions, the appropriate education level for band 2 and band 3 is largely agreed upon - a Level 2 qualification (i.e. an NVQ level 2 equivalent) is usually identified for a band 2 post and a Level 3 qualification is specified for a band 3. Some of the jobs were advertised as development opportunities for those working towards the appropriate qualification, including one, which was advertised as an apprenticeship role. From the job description analysis, at band 2, 35% of posts require an existing level 2 (one of which required a level 3), 29% required a successful candidate to work towards a level 2, while 18% listed a level 2 as desirable, and another 18% did not specify an educational level. At band 3, an existing level 3 qualification was expected in 56% of cases, and 31% needed a successful candidate to work towards a level 3. The remaining 13% did not specify a level.

Typically, the job descriptions examined feature a phrase like this –

> *[the post holder must] participate in personal and career development plan to maintain skills and develop personal growth in order to maximise contribution to service delivery*

Little information was provided at the application stage about ongoing training and opportunities. There were some exceptions to this; the most notable being the job explicitly advertised as an apprenticeship opportunity and one band 3 role that expected the post holder to enroll in a Foundation Degree.

There was no discernible pattern in the requirements for literacy and numeracy. One job at band 3 and one at band 2 specified level 2 functional skills. Others asked for various things ranging from "basic skills" to "excellent skills".

Box 4.1: An example of workforce development and learning

A London-based senior midwife interviewed by phone reported how her service had previously used NVQs level 2 and 3 to train their MSWs, along with a Foundation Degree, but that inconsistencies in task allocation between the bands had resulted in the service reviewing the role and the education provided –

> *The challenge is to develop this role and let it be a role in itself, so if they want to deliver postnatal care that would be good and they should all be trained for it, but at the moment its like 'she should do that and I am not sure about her' and that's a huge challenge because MSWs cannot prove themselves*

In respect of the band 4 roles, she said, *"the foundation degree came before we were ready for it".*

4.4 The majority of training MSWs receive is workplace based

The survey results suggest that the vast majority of training MSWs received was delivered at the work place (86%, compared to 6% at an education establishment). It is reasonable to assume that the bulk of training provided to MSWs is either statutory mandatory training or training provided by maternity practice educators and other midwifery staff.[13]

This also suggests that MSWs currently have limited access to formal training, which may explain why relatively few recorded that they were currently undertaken formal training (Table 4.1), indeed the MSW we interviewed by phone said, echoing the issue noted above about the informal nature of much learning –

> *... there is no opportunity for accredited learning...learning is frequently –'I will show you, you copy me and I will sign you of as competent'*

Box 4.2: Access to pre-registration midwifery degrees

An European Directive specifies that the education required to become a competent midwife must comprise three-years (full time) study at undergraduate degree level (level 6). This Directive bars the application of APEL for staff who have completed a vocational qualification such as a Foundation Degree.

4.5 Views about the Care Certificate

Box 4.3 summarises the results from the survey in relation to the Care Certificate (this question was asked to MSWs employed in England only). The results show that only a minority of MSWs had completed the Care Certificate. For those staff that had worked in their current employer for three years or less, 22% had not heard of the Care Certificate and a further 28% stated that they had completed it. This suggests that a proportion of maternity services in England are not using the Care Certificate when recruiting new staff[14].

The job descriptions for new roles were examined for references to the Care Certificate. The Care Certificate was mentioned explicitly in only 4 job descriptions (12%), plus one reference to an employer's own academy training.

Box 4.3: MSWs and the Care Certificate

The survey asked MSWs in England about their experience of the Certificate:

- 27.8% had completed the Care Certificate at the time they responded to the survey
- 5.2% were completing the Care Certificate
- 43.4% had not completed the Care Certificate
- 23.5% had not heard of the Care Certificate

Concerns about the relevance of the Care Certificate as it is currently delivered were raised by participants in the qualitative research –

> *The Care Certificate has not worked for MSWs. What was developed wasn't particularly relevant to maternity settings and I think that has been borne out by the experience of MSWs doing the Care Certificate in that they cannot complete it because they are not getting the experience they need to complete it* (RCM, phone interview)

13 As part of this research we attended two such days and witnessed the high quality of training delivered 'in house' as well as the commitment of practice educators to MSW learning and development. We also found two examples of services developing MSWs into educator roles locally (both at band 4). We believe Practice Educators are a resource that should be supported to help enhance MSW roles.

14 We are aware, however, of trusts that have their own maternity-specific standards based induction training that they utilise instead of the Care Certificate but which provide the same level of knowledge.

4.6 Apprenticeships and Talent for Care

Across the whole survey sample 68.1% of MSWs were aware of apprenticeships but only 5% of respondents in England had heard of *Talent for Care* – the national HEE support worker strategy. Only one of the job descriptions analysed specifically mentioned apprenticeship training. Through the focus group discussions we did find examples of MSWs who had previously undertaken the Maternity and Paediatric apprenticeship framework, and two MSWs who were currently studying a level 3. Both these however raised the issue that the training they were receiving was not directly relevant to their maternity roles –

> *It has nothing to do with the skills needed to be a MSW whether in the community or the hospital … it's a waste of time when I could be helping people, helping my team* (MSW, focus group)

> *Doing an apprenticeship has no bearing on maternity* (MSW, focus group)

In a phone interview with a senior midwife who had explicitly developed their MSW roles at band 3 and 4 (described in the next section), the participant was asked whether she was considering utlising the level 3 *Senior Healthcare Assistant Apprenticeship Standard* (training was currently delivered in-house). While she said - *"there was no reason why we shouldn't"* she did make the point that there were no education institutions locally planning to deliver the programme. Lack of local education provider capacity had in fact driven the decision to provide training in-house, a not uncommon finding in this research.

We explicitly sought to identify services that were planning or were actually using the level 3 standard but with one exception[15] we were unable.

4.7 The effectiveness of the learning MSWs receive

Findings from the survey suggested that MSWs were generally content with the training they received and felt it was effective. MSWs were asked to assess how effective they thought the most recent training they had received was, by stating on a five-point scale how strongly they agreed or disagreed with a series of statements about training. The weighted average (mean) for each statement was calculated, averages closer to 1 suggest stronger agreement with the statement and those closer to 5 greater disagreement. The results are shown in Table 4.2.

The survey results show there was a strong perception that the training MSWs had taken was not a waste of time (only 15% thought that it was). It is also worth noting that 18% strongly agreed and 52% agreed that their manager supported their learning, and that 13% strongly agreed and 47% agreed that the training they had completed was linked to their personal development needs. However less than half (41%) felt that they had enough training to use their skills as effectively as possible and over three quarters (77%) would like to access more training - only 9.3% of respondents stated that they would not like to receive more training. Some 15% said that they felt they "could access all the training" they needed.

15 A London LMS has agreed in principle to use the standard across the system to extend the contribution that MSWs can make, particularly in post natal care, however progress has been delayed due to lack of education provider (and the need for the LMS, which is an early adopter of Better Births, to implement the review particularly in respect of continuity of carer.

Table 4.2: The effectiveness of MSW training

Statement	Weighted average
The training helped me perform my job better	2.4
The training improved care and support (for mothers/babies)	2.4
The training met a training need	2.6
The training was supported by my manager	2.2
The training was a waste of time	3.7
The training was linked to personal development	2.5

The qualitative research did find examples of views that training was not consistent or always high quality -

> *You have a once a year mandatory update, where you are talked at in a room – that's the new girls and the ones that have been there for ten years. Its very mixed and I would say unsuccessful. What that ends up with is support workers on the ward that don't have the competences or ability to do the job as well as they should; they are not in a position to support the midwives or the women and we lose them* (MSW, phone interview)

4.8 Barriers to learning and current training needs

The main barriers to training identified in the survey were organisational - cost (identified by 44% of the sample), lack of opportunity (41%), workload (39%), time off (31%) and lack of management support (25%). These issues were also raised in the focus groups, with MSWs in one group mentioning the challenges not having protected study time –

> *Time off for study leave is not supported, shifts aren't planned, it left to MSWs [to arrange cover for study]* (MSW, focus group)

In a survey conducted by the RCM in 2016 (unpublished), the College asked MSWs to identify areas they believed they would benefit from extra training in. The results are set out in Table 4.4. It is interesting to note the proportion identifying basic skills, such as numeracy, as a need along with service related knowledge and skills.

Table 4.4: Training topics identified by MSWs

Training topic	Percent
Mental health	66
Bereavement	61
Breast feeding/tongue tie	56
Health promotion	49
Transitional care	40
Statement writing/documentation	30
Work/life balance	26
Computer skills	23
Numeracy skills	19
Verbal communications	17
Literacy	15
Dyslexia awareness	14

The need for, but lack of training around supporting families who had experienced a bereavement and mental health concerns were consistently raised by MSWs in the focus groups. In one focus group we spoke to two MSWs who had directly supported families who had lost their child.

Not only had they not been provided with any specific training, they also reported that they were not provided with any personal support. The 2016 survey also asked respondents their motivation for wanting to train. The responses are shown in Table 4.5 below.

Table 4.5: MSW's motivation for learning

Reasons for wanting to be trained	Per cent
To develop new skills	89.0
Personal development	79.8
To increase confidence	54.0
Promotion	49.8

4.9 The lack of clear career progression pathways including into midwifery

The lack of clear career progression pathways for MSWs to develop their careers was a consistent theme across the qualitative research –

> *They cannot see it, they cannot see what the pathway is* (MSW, focus group)

> *I don't see how you can progress, there isn't progression for us* (MSW, focus group)

> *I sometimes feel we are stuck* (MSW, focus group)

Nearly one in five MSWs stated that they aspire to be a midwife. This represents a potentially significant 'grow your own' talent pool for the future registered workforce, particularly if linked to apprenticeship standards. While we did not explicitly investigated barriers to widening participation into pre-registration degrees, the issue was raised by a number of participants in the research particularly the need to provide clear support and pathways for existing staff to enter education-

> *There are many support workers who would like to train as a midwife and have the appropriate skills and experience, however due to funding, there are a lack of places at university due to lack of bursary.* (MSW focus group)

> *Its really difficult to progress, which is why so many people move on; lots of the girls went into nursing…nursing seemed a lot more on the ball.* (MSW telephone interview)

The withdraw of secondments and the bursary was mentioned by participants as a barrier to MSWs progressing into midwifery degrees. One service we held a focus group in provided basic skills training for their MSWs who wished to apply for midwifery degrees.

5. Examples of innovation

5.1 Introduction

This section summarises the examples of innovation in the deployment of MSWs, we identified through the interviews, the focus group discussions and RCM's call for services to nominate good practice. These are reported below, however it should be noted that we were unable to extensively review these examples to assess their efficacy. Fuller case studies are being investigated separately to this report.

5.2 Examples from the focus group discussions

In the focus groups MSWs reported (unprompted) a number of examples of innovative practice. These were –

- MSWs running a clinic at weekends for vulnerable women
- MSWs running a community based 'drop-in' clinic to support women that breast feed. The MSWs involved in the clinic reported that they identified issues such as tongue-tie and undertake more general observations such as weight and looking for signs of infection. They said that they also spoke to mothers about their wellbeing and, if they thought it appropriate, signposted mothers to further support
- One group reported that it was planned to extend the number of postnatal visits made by community based MSWs to two of three following normal birth
- A MSW who was the smoking cessation lead in her service

5.3 Other examples of innovation

Three examples were found of services that had developed a band 4 Practice Educator role to support the education and development of the service's support staff. In one case this role was explicitly focused on apprenticeships. The boxes below summaries services that nominated themselves as innovative, following the RCM's call in October 2017. In addition to the sites being investigated for this research, we are aware of others that are innovating the role, for example the maternity service is developing a band 4 role focused on primarily public health.

Box 5.1: London1 service

A service in London reported that they employ twelve band 3 MSWs in the community and also has two band 4s who lead on **breastfeeding support**. Working with a local university the service is co-designing a Foundation Degree and plan to deploy band 3 MSWs on the **postnatal ward** and **at the birth centre.** The service is also planning to develop a band 4 MSW role to work within its **safe guarding team**. The service is considering deploying the role on two pathways of care – low risk and high-risk, with MSW band 3s supporting the **low risk pathway** and band 4s the **high risk**. Training is mandatory and delivered in-house. A **skills passport** is being created, with midwives signing off competences.

Box 5.2: South service

A maternity service in the south of England originally employed band 2 and band 3 MSWs, with band 2 undertaking mainly housekeeping roles with some support to mothers, but not babies –

> *They weren't having much to do with the baby and its not helpful to have someone who just does one, it is much easier to run an organisation where you see birth as a partnership – mums and babies*[16]

Partly driven by increasing demands on local maternity services and a shortage of midwives, a decision was taken to stop MSWs performing non-clinical tasks, (other roles like Bed Makers perform these tasks but do not provide support directly to mothers or families). All MSWs in the service are now band 3s and **provide care to both mothers and babies across the pathway**. These posts were trained in-house because there was no external training programme and provider available – *"it just seemed to make sense".*

A band 4 role is currently being developed supported by a maternity pathway delivered by a local university –

> *[This] role is very much around a person who can be there with the midwife throughout the pathway, so that they have a much bigger knowledge about public health, smoking cessation, breast feeding, domestic violence, mental health, a much broader understanding…our vision is that they will be able to be the second person at a homebirth or in a midwifery-led birth centre and they would play an active role for example on the postnatal ward looking after babies that are more of a challenge – 2.5 or below*

The higher-level roles would be trained in all these activities (**public health, postnatal ward and supporting homebirths**). The rationale for extending the role on postnatal wards was that more babies who would once be transferred to a neonatal ward were now staying and being supported on the maternity ward.

The service see value in training these higher-level roles through a Foundation Degree not just because of the maternity-relevant knowledge and skills but also other skills such as higher-level communications, research and governance – *"the sort of things that maternity support workers probably had less of in the past".*

The service is commencing a five-year review of staffing needs that includes the MSW role's contribution.

The service had invested in MSW development for a considerable period of time, initially utilising a regionally designed **skills passport**. This long-term and strategic approach meant –

> *We don't have a problem with acceptance, [MSWs] have been here long enough for people to accept them… it was a problem but it isn't a problem, we are in a good place - we are in a place were people feel safe*

16 All quotes are from the senior midwife interviewed for this research

Box 5.3: South West service

The service currently employs around 50 MSWs, most graded at band 3. Their role is being reviewed to assess how MSWs can contribute to the implementation of *Better Births* but also how MSW job satisfaction can be improved. Band 2 roles work solely in antenatal care. To extend beyond that area they can enter a **progression pathway** into band 3. Band 3s work across the maternity pathway in the hospital including at the birthing centre, and in community (postnatal) settings.

Role development is supported through a combination of formal and in-house learning. The service has utilised the maternity and pediatric apprenticeship framework and are currently working with an university to utilise their Foundation Degree. MSWs received work-based learning that includes an **annual skills update** and 'Prompt' training with doctors and midwives teaching staff how to react to emergency situations. The service has also involved MSWs in the design and delivery of human factors training.

All MSWs employed by the trust have **competency framework,** which follows them throughout their career in the service and specifies the learning they require to be competent in the areas they work. The service is considering implementing **rotations** across the pathway so MSWs can move flexibly between settings including into the community.

The service sees the MSW role as playing an important role in helping to deliver the aspirations of *Better Births* particularly focusing on **personal** and **postnatal care.** The service is reviewing how roles might be deployed at band 3 and band 4 and see MSWs, for example as able to **provide the bulk of postnatal care following discharge** as well as **mental health support** and encouraging **smoking cessation,**

Box 5.4: London2 service

The second London service is seeking to clarify the difference between band 2, 3 and band 4 roles (which were developed in response to the London-wide Foundation Degree programme, see also Appendix 3 for the roles job description), in response to **rising demands on services** and **staff shortages**. The service lead notes *"the historical disparity between roles".* The service, in response to *Better Births* plan to develop the role so that it more explicitly focuses on the following activities – **public health, mental health** and **postnatal care.**

5.4 Models of care

The examples above illustrate services that have comprehensively considered the role of MSWs holistically and explicitly alongside the needs of mothers, babies and families. We found examples where this had been done for elements of the pathway but not as fully as the examples above illustrate. This may well be a reflection of the poor workforce planning, noted earlier but also perhaps because services are still planning implementation of *Better Births* and developing principles such as continuity of carer.

Of particular interest is the approach being considered by the London1 service, where the future deployment of MSWs could be linked to assessments of risk, with band 4s supporting high risk mothers and families and band 3s low risk. Given the demands on maternity services arising from increasingly complex case loads, working with midwives supporting high-risk women is likely to be an area where the contribution of MSWs can be enhanced.

6. The future of maternity support roles

6.1 Introduction

This section sets out activities and areas that participants in this research identified MSW roles might be more fully deployed in, in the future. All the suggestions build on existing activity. Views from participants about how the learning and development of the role might be made more consistent are also presented. We did not ask directly what participant's thought the future drivers for change might be, however we note that 'shortages of midwives' was frequently mentioned. Participants were clear that developing MSWs in response to staffing pressures was not a matter of substituting midwives for the MSWs, but rather maximizing the contribution support roles could make within the parameters set up in the RCM's (2016) *Roles* guide –

> *There's a tipping point where you realise you don't have enough qualified midwives and you have to do something … you have to develop MSWs or else you are relying on agency staff* (Midwife, phone interview)

> *Due to shortages of Registered Midwives we need to focus midwifery skills into labour but there's a lot that MSWs can do for example supporting vulnerable women and public health, which midwives will never have the capacity to cover properly* (RCM, phone interview)

The role was seen by the policy participants as essential to helping deliver the aspirations of *Better Births* and help address service pressures –

> *To be able to deliver this policy [Better Births] we have to be able to acknowledge all roles within maternity services and that includes MSWs and maximizing the contribution that can make to mothers and babies* (Policy, phone interview)

6.2 Increasing MSW capacity to support midwives and families

In the phone interviews participants stated that they believed there was considerable scope to expand the contribution of MSWs across the whole maternity pathway (although their contribution to postnatal care and public health[17] were consistently mentioned as areas where the role could be deployed more fully). MSWs in the focus groups were also clear that they could contribute more, particularly if they had access to more and better quality training –

> *If we are adequately trained, we can step up* (MSW, focus group)

> *I think the role is invaluable to women* (MSW, focus group)

Participants in the interviews and focus group were asked to identify areas in which they thought the current contribution of MSWs could be expanded. These are shown in Box 6.1.

17 The MSWs in two of the focus groups we conducted identified public health as a specific area they felt the role could make a greater contribution in, with one group using supporting women with alcohol issues as an example.

Box 6.1: Activities that MSW contribution could be enhanced

Community postnatal care	Homebirths
Breastfeeding support	MSW support for neonates on postnatal ward
Recognition of neonate deterioration on ward	Mental health support
Public health such as smoking cessation	Bereavement care
Leadership	Practice Education Development
Phlebotom[18]	Supporting vulnerable women/safeguarding

6.3 Being clear about the difference between responsibilities and bands

A number of participants, including the MSWs in the focus groups, suggested that band 2 roles should focus solely on non-clinical tasks such as bed making, stock control and cleaning, and that band 3s should perform maternal and baby facing activities-

> *Ideally we would do away with band 2s* (MSW, phone interview)

> *Band 2s – a housekeeping and admin role. Band 3s – clinical and hands-on* (Practice Educator, phone interview)

> *There should be a generic core MSW role with options to progress into specialist support roles* (Policy, phone interview)

A midwife interviewed said that band 3 roles should be characterized by clinical tasks such as phlebotomy, bloods/sugars, daily maternal and baby observations and blood spots.

Participants we interviewed who had or were planning to review their MSW roles, saw a clear need for higher-level roles with more autonomy and responsibility supporting midwives –

> *The ones that run the clinics, can co-ordinate and be autonomous, able to run part of a service like public health* (Practice Educator, phone interview)

Box 6.2: Grow your own

A midwife reported that her service sometimes struggled to retain newly qualified midwives, as they did not wish to stay in the area for long after graduating. One advantage, she saw, of supporting MSWs on a Foundation Degree was that *"it also has the added value of growing local midwives who stay in the area"* for those MSWs who progress on to the same university's degree[19].

A MSW in a focus group told us –

> *There are people who could probably make amazing midwives with the knowledge and experience that they have but I think it's a waste of talent that they can't get trained further*

18 One participant stated that all MSWs should be trained in phlebotomy to free-up time of midwives

19 While not explicitly explored in this research three interviewees reported that they had no difficulty in recruiting from local labour markets into MSW role, indeed the key challenge were the large number of applicants received.

6.4 Career progression and development – the need for national guidance

We found support throughout the qualitative research for the development of a national career and education framework (linked to clear task delineation between bands) for MSWs. A number of participants also mentioned support for a version of the Scottish Skills Passport in England. We also found examples of services that had developed their own competency booklets.

> *A clear career pathway, similar to what a midwife has that is what I would like to see; that the MSW role is entrenched services – 'this is what the role is, this is its career pathway and that they can move through those pathways so a 2 can become a 4…clear and standardised…trusts need guidance* (Midwife, phone interview)

> *We need a clear career ladder, particularly at band 4* (MSW, phone interview)

> *If not mandatory good employers will use it but poor ones won't* (RCM, phone interview)

> *I think there needs to be a clear career progression – 'I want to be a band 3' or 'I want to be a band 4' or 'I want to progress and go to university to study midwifery' but there is no clear banding in the pathway* (MSW, focus group)

> *I don't want to be a midwife, I want to be a good MSW but I want that career pathway for everybody* (MSW, focus group)

Participants mentioned the need for more higher-level opportunities, including assisting MSWs to access pre-registration degrees –

> *We need the maternity equivalent to the Nursing Associate or Assistant Practitioners with recognised and accredited training* (MSW, phone interview)

One participant felt strongly that more should be done to ensure that student midwives understood MSW roles –

> *Midwives at the point of graduation should categorically know what a MSW does* (Midwife, phone interview)

This echoed by a MSW in one of the focus groups who aspired to be a midwife –

> *If I achieve my dream of being a midwife, I feel I will never ever forget I was a HCA* (MSW, focus group)

6.5 Design of education programmes for MSWs – guiding principles

Through the qualitative research participants identified a number of principles they felt should underpin MSW education and career progression. A key issue raised was the need for education and training programmes for MSWs to be consistent and transferrable –

> *There is a need for consistency in training so we move away from a situation where you can be trained in one trust move to another and have to be trained again because it is not recognised* (RCM, phone interview)

Participants, both midwives and MSWs, emphasized the importance of learning for MSWs to be holistic-

> *If we get better training as to understand the rationale for what we do, we do understand tasks but in a deeper sense if we are adequately trained we can step up* (MSW, focus group)

> *We don't want a task-based workforce* (Educator, phone interview)

The need for the training accessed by MSWs to be directly relevant to maternity settings was also raised. This was not just in the context of content but also delivery method–

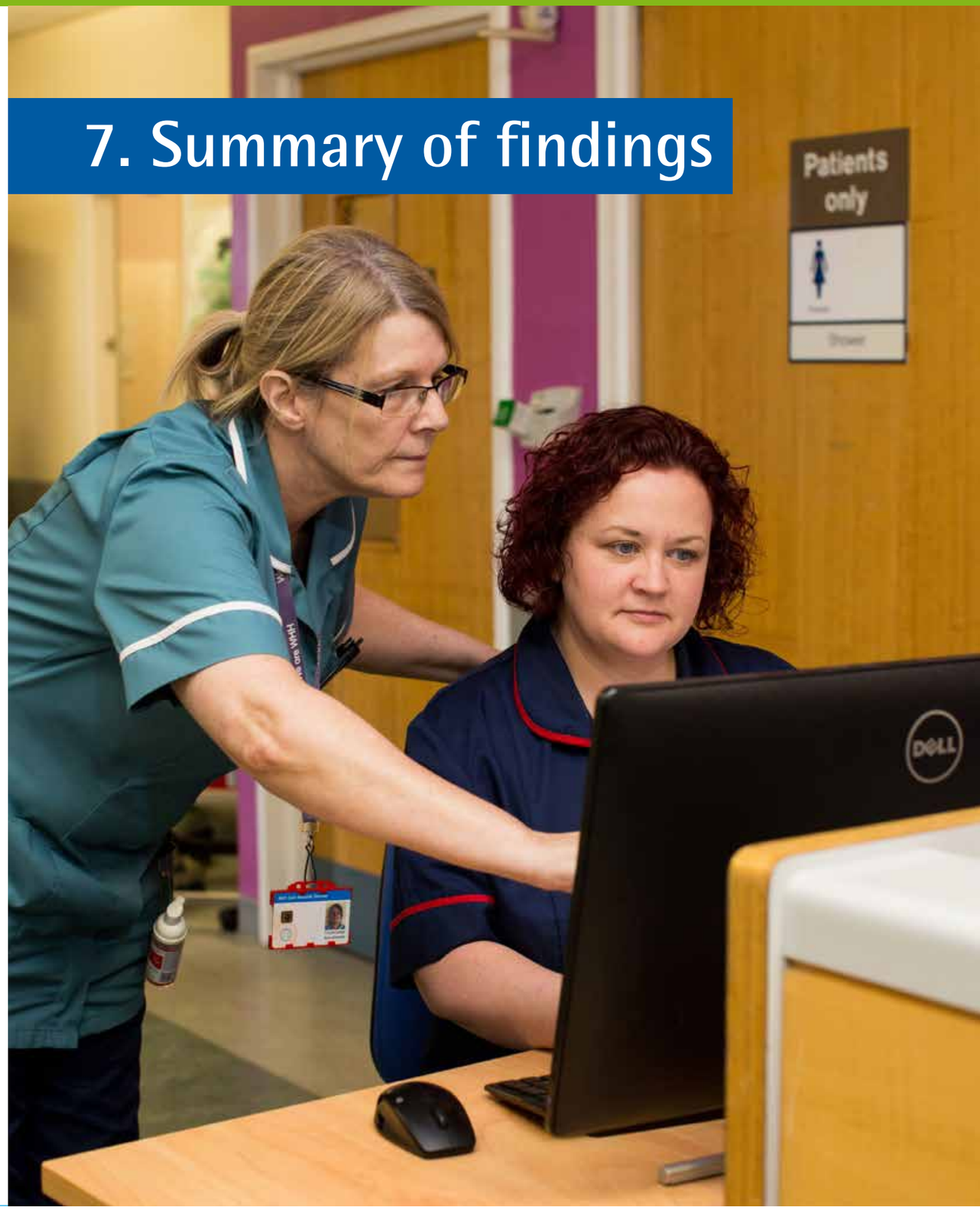
> *Its important training is made more relevant* (MSW, phone interview)

> *We are very much 'hands on.' We would like to learn like that* (MSW, focus group)

This was raised as a particular issue in respect of the Care Certificate –

> *We need to look at the Care Certificate and ensure its relevant to maternity* (Midwife, phone interview)

7. Summary of findings



7.1 Introduction

This report summarises the findings of a mixed methods research programme designed to investigate the deployment and development of MSW roles in England. This section sets out the key findings, and their implications.

7.2 The current deployment and training of MSW roles

The MSW workforce is a stable and loyal one; almost all of who wish to remain in NHS employment and of whom three quarters (63%) have worked for their current employer for six years or more. One in five would like, in the future, to train to be a midwife (18.9%) or nurse (4.7%), according to the survey results.

The maternity support workforce is an ageing one; a quarter are aged 51 or over. This means in the next decade a significant proportion of experienced MSWs will retire. In addition to the need to ensure this capacity is replaced, these staff, as the focus group discussions demonstrated, can frequently act as role models, mentors and informal teachers for new MSWs.

Across all methods participants reported that MSWs enjoyed their work, indeed the most frequently used term to describe how they felt about their job was that they *"loved"* it. 64% would recommend their place of work to their friends or family – this is a slightly higher proportion than in the NHS Staff Survey. A consistent finding across the methods, however, was that MSWs are frustrated with their pay (just 13% reported that they felt fairly paid for the work that they did), grading (most in England were graded at *Agenda for Change* band 2 or 3) and career progression opportunities. A key theme from the qualitative research was a lack of clarity around grading which was also reflected in the view that job descriptions were, as one interviewee described them -*"weak"*.

This research found a total of 22 different titles used to describe support roles in maternity, although "maternity support worker" is now the most common one used in England (by 61% of the survey sample). The lack of a universal title is likely to be a consequence of the *ad hoc* development of the role locally, a strong theme from the interviews (below). We would also note the plethora of titles may result in confusion amongst the public. A similar finding was recently observed for nursing (Leary *et al,* 2017).

We found that hospital-based MSWs are deployed across the pathway, moving between settings. Community-based MSWs tend to focus on postnatal care, although like their hospital colleagues they undertake a range of clinical and non-clinical tasks – sometimes a cause of frustration and tension.

MSWs are clear about their role boundaries, delegation and feel appropriately supported and feel valued by midwives. While we found no evidence of tasks being performed that were not set out as appropriate in the RCM's 2016 guide on *Roles and Responsibilities of Maternity Support Workers*, allocation of tasks and consequently deployment of the role was inconsistent (see below).

We consistently found participants reporting that the MSW role was 'accepted' by the profession –

> *I think that the resistance we saw (from midwives) to MSWs eight to twelve years ago has declined. The majority of midwives are very supportive of what MSWs can do. A lot of barriers that had been put up to MSW development have been broken down…Midwives were fearful that MSWs would take over their jobs and that just has not happened* (RCM, phone interview)

Perhaps related to the variable deployment and grading of the role we found few examples of MSWs who were engaged in formal training programmes (just 6% of the survey sample). Overwhelmingly training was delivered in-house through a plethora of learning and while MSWs were positive about that training, it is non-standardised and transferrable. MSWs reported that they had attended training that was not relevant to their role. The analysis of the jobs advertised during this research suggests that most services feel band 2s should have a level 2 qualification such as a diploma[20] and band 3 a level 3 qualification.

MSWs, the majority of whom would like to access more training, felt that they could contribute more to service delivery with additional learning. Two areas frequently mentioned by MSWs they would like more training in was – bereavement and mental health.

There was strong support for a national career and competence framework to guide the development of the role locally.

7.3 How could the contribution of MSWs to care be enhanced?

Our impression, drawn from this research, is that since its inception the MSW's role and contribution has evolved and developed but in an uneven and *ad hoc* way. This view was expressed well by a MSW in one of the focus groups who had worked for her trust for over 15-years–

> *I have seen a lot of changes, but its very slow* (MSW, focus group)

There was consensus that the contribution of MSWs could be enhanced. Linked to this was a debate about the extent to which MSWs should be required to carry out housekeeping tasks like bed making and stock control, alongside clinical ones such as breastfeeding support and maternal/baby observations. The consensus was that MSWs should not perform such roles, however some participants including MSWs felt the combined role offered 'entry-level' opportunity to start acquiring experience. One participant interviewed by phone felt that staff should enter at band 2, spend some time acquiring knowledge and skill through a formal maternity related education programme as well as experience that included clinical and non clinical tasks and following completion of the programme they should progress to a band 3 role.[21] This is the model being used by one trust we investigated however other services we spoke too have dispensed with band 2 MSWs undertaking non-clinical tasks. The tasks defined as 'General' in the RCM's (2016) guide on page 12, with the exception of contributing to education classes should form the basis of discussions about the boundary of a housekeeping role. This is clearly one area that warrants further discussion.

Our research suggests that the allocation of 'core' MSW tasks, which we would define as those directly supporting mothers, babies and families are variably and inconsistently allocated. Establishing a clear definition of these core tasks and related competences, which should be supported by a formal education programme would enhance capacity, improve care and free-up the time of midwives.

20 The level 2 Healthcare Support Worker Apprenticeship Standard while including the Care Certificate does not require a formal qualification.
21 Another pointed to the position with newly qualified midwives who spend a period of time as a band 5 before progressing to band 6.

In respect of education careful consideration needs to be given to the supply of the level 3 Apprenticeship standard and the extent it meets service need. The application and relevance of the level 5 Assistant Practitioner should also be reviewed, particularly in light of the examples found of services designing higher-level MSW roles across the pathway. We note at the time of writing a Trailblazer group has not yet been set up by employers to create a maternity degree Apprenticeship standard. This research suggests that in many cases the MSWs received training informally in the sense they have not acquired a regulated qualification.

The RCM's (2016) *Roles and Responsibilities* guide sets out a range of clinical-tasks that support the mother and birthing partner and care of baby. The clear evidence from this research is that the RCM's guide has allowed services to define the overall boundaries of the MSW role – the issue has been inconsistent between grading. An area where the role is particularly expanding is in providing postnatal community care. We found a number of examples of community based MSW teams undertaking the bulk of home visits where there was a low risk.

While the RCM's (2016) guide mentions public health and supporting vulnerable women, further work could be undertaken to establish the exact activities MSWs can and cannot be deployed in, to assist in these area. The recently published *Stepping Up to Public Health* (RCM, 2017) report, which included MSWs' contribution to public health, is an opportunity to clearly define the MSW contribution to public health, safeguarding and supporting vulnerable mothers.

The research found examples of services that were actively considering the deployment of higher-level (band 4) MSW roles, particularly but not exclusively in respect of supporting vulnerable and higher-risk women for example with infant feeding, parenting skills and family adjustment. The following examples were provided of MSW higher-level activities –

- Providing care for sick babies on the postnatal ward
- Supporting higher-risk and vulnerable mothers postnatally
- Supporting midwives at birth centres
- Supporting midwives at homebirths
- A public health role

In each of the examples of services developing higher-level roles, we researched links had been made with a local university to utilise a Foundation Degree to support the role's development. Participants stressed the importance of soft skills such as communications, research and leadership. The need for higher-level roles to be able to work more autonomously was mentioned by a number of participants.

This research would suggest that there is considerable scope to enhance the contribution of MSWs through improved workforce planning, centered on the roles' support for mothers and babies, and a clear national definition of what MSWs can do at each level/grade linked to formal maternity relevant education programmes, and complementary in-house training. As one participant said –

> *We should put everyone from [band] 8 to 2 into a pot and see what we really need to deliver a service that is better for the woman. We need that clean sheet and ask 'what do we need to provide a service…we need a career pathway that the MSW is entrenched in, 'this is what the role is, this is the career pathway* (Midwife, phone interview)

Access to high-quality and transferrable education and training to support the MSW role has been an issue from its inception and remains so. The research found that that very few MSWs access formal education programmes and where they do they are not always relevant to maternity. A *potential* education framework does now exist (assuming that band 3 roles undertake clinical tasks only) with the apprenticeship standard at level 3 and the redesign of Foundation Degrees to support higher-level roles (which could be mapped to the level 5 standard). In respect of the level 3 standard we were unable to find any examples of services accessing this programme, indeed concerns were expressed about the lack of education institutions providing training for MSWs. This was a major reason the services we researched had taken a 'in-house' route to develop their staff. While we were impressed with the commitment and quality of in-house training we observed, as a number of participants noted this approach meant learning was not portable, leading to MSWs having to be retrained when they moved service (or sometimes within services). While a minority of MSWs had completed the Care Certificate there was a strong view that the standards needed to be made relevant to maternity-based staff and that this was not always the case.

Drawing on the findings of this research we would suggest the following broad framework could be discussed –

- A maternity-services relevant 'Care Certificate' that is national and standardised
- Band 2 roles that undertake general house keeping roles
- Band 3 roles performing care of the mother and baby tasks across the pathway including observations, recognising ill health and deterioration, venepuncture, phlebotomy and cannulation.
- Band 4 higher-level roles particularly supporting high-risk and vulnerable women but also leading on activities such as public health and more directly supporting midwives at home births and at the birth centre

Uniquely amongst NHS support roles, the roles and responsibilities that MSWs can (and cannot) perform have been defined by an expert group and set out in the 2016 RCM guide. The profession has clearly embraced the guide and we suspect it has contributed to the growing acceptance of the role by the profession. This guide should form the basis of the discussion of what distinguishes the different levels of the role. Linked to this should be a consideration of emerging models of care being designed in response to *Better Births* and, for example, the extent MSW roles can be designed to support families in high-risk models.

This scoping exercise has focused on what MSWs currently do and the plans and innovation's being developed. However we are aware more generally that maternity services continue to evolve and grow to meet the needs of mothers and their families and in response to national policy. The Secretary of State has, for example, set an ambitious aspiration to half the prevalence of stillbirths. Initiatives such as ATTAIN, the Maternal Mental Health strategy and others are changing the patterns and working relationships of midwives and obstetricians. As a result and in addition to the aspirations of *Better Births,* there is a need for the contribution and voice of MSWs to be more centrally located in these initiatives. This is not always the case. MSWs can sometimes, to borrow Camilla Cavendish's phrase, feel like the 'invisible workforce'

7.4 Conclusion

It appears clear from our research, that much progress has been made in terms of deploying and utlising the MSW role. We found examples of, what one interviewee described as *"pockets of excellence".* It is also clear that many see the role as critical in helping to deliver the aspirations of the national maternity review, including supporting continuity of carer, and that there is scope to safely utilise the role further than is often the case. However barriers and issues persist for support workers in maternity services. The initial conclusions we have drawn from the data is that in most services development of role has been *'ad hoc'*. We found little evidence that design and deployment of the role had resulted from context dependent diagnostics and clinical leadership. This is not an uncommon situation in resect of support roles as the Cavendish review identified (Department of Health, 2013). The consequences of a lack of systematic workforce planning are-

- Poorly designed roles (albeit with tasks being delineated by the RCM's *Roles* guidance) and job descriptions
- Variable and inconsistent utilisation of the role
- A lack of clear career progression pathways from entry level into pre-registration degrees
- Low levels of access to formal education which is standardised and transferrable

As the review of literature in section 1 illustrated these issues have been identified from the beginning of the role's development. The HEE review and implementation of the national maternity review creates an opportunity to address these issues. This will not only benefit MSWs, many of whom feel frustrated, but also free-up the time of midwives and, most importantly enhance the care that mothers, babies and families receive across the pathway.

> *If we get it right, it's a job for life…a MSW told me – 'this is the best job in the world* (Practice Educator, phone interview)

8. Recommendations

1. **Clear national guidance should be produced to ensure consistency in deployment, training and grading of MSW roles in England.** Such a framework would underpin **career progression** opportunities for support roles not only up to band 4, but also for those able, into pre-registration degrees. A national framework, which should be based on the RCM's (2016) *Maternity Support Worker Roles and Responsibilities* document and designed by an expert group that includes MSWs, would allow full utilisation of existing roles capacity as well as extending the role's scope to support midwives and families. This group would also determine whether MSW roles should undertake non-clinical tasks, (it is our view is that they should not perform a housekeeping role), and specifically in light of *Stepping up to Public Health* (RCM, 2017) clarify more fully the contribution MSWs can make to public health. Consideration should also be given to the **relationship between higher-level MSWs and Nursery Nurse roles** given the increasing support provided on maternity post-natal wards with neonatal care. National framework must be linked to NHS Job Evaluation guidance and profiles.
2. **Competences** linked to the levels and tasks in a new national framework should be clarified. Some participants mentioned that they would like to a see a **national skills passport** produced, as is the case in Scotland and a number of services we investigated. Participants have suggested that band 3 MSWs should perform maternal/baby-facing tasks across the pathway for low-risk women and that band 4s could deliver more autonomous tasks under the supervision of a midwife including for higher-risk and vulnerable women. Such an approach should be embedded in the **models of care** being developed to implement *Better Births* including continuity of carer (see below).
3. Once the national guidance is produced **maternity services working as a Local Maternity System (LMS) should review the current allocation of tasks, training, banding and job descriptions** of their MSWs**.** This might also be an opportunity for services to be encouraged to **generically describe the role as a 'maternity support worker'** as well as ensuring the role's capacity can be fully utilised to support implementation of the aspirations of *Better Births*.
4. There is an opportunity for HEE, RCM, NHS England and other partners to **promote best and innovative practice in deployment and development** of the role. Best practice needs to be shared not just to spread innovation but also to build awareness of the contribution support worker roles can make to care, build confidence in the role and increase capacity.
5. In light of national role and competence guidance, **the level 3 and level 5Apprenticeship Standards** should be reviewed to ensure it meets the needs of service. LMS should work with local education providers to ensure **sufficient and high-quality provision of training for MSWs** that takes account of how they work (for example reflecting that they work across the pathway and many work shifts) and maximises the opportunities the **apprenticeship levy** creates. Two training needs consistently raised by MSWs were – **bereavement** and **mental health.**
6. A national education programme at **Foundation Degree** level should be agreed (building on the work being undertaken by services and universities we investigated) to underpin a higher-level support role (band 4), this should include tasks linked to public health, vulnerable women and an enhanced postnatal role (including supporting transitional care babies) along with leadership, communications, governance and research skills.
7. There is a need to encourage employers to create a **Trailblazer** group to develop **a midwifery apprenticeship degree.**
8. We found no support for a maternity equivalent of a Nursing Associate.

9. Participants were clear that formal apprenticeships should not be the only means of training MSWs and that local, flexible shorter-term training programmes were also needed (for example on mental health, recognising deterioration and bereavement). Practice educators are a key resource in supporting the development of MSW roles. **Consideration should be given to how workplace education capacity for MSW training and development could be enhanced.** We found examples of services developing MSW as Practice Educators for example.
10. The most effective services we researched not only ensured that MSW roles were clearly defined and appropriately trained but also that tasks were undertaken were supported by **local practice frameworks** for example to guide baby and maternal observations.

Appendix 1: The Development of MSW roles (Institutional Model)

In 2017 Kessler and colleagues published an article in *Human Resource Management Journal* based on research they conducted with nursing HCAs in the NHS revising a model first developed by Reay et al, (2006) that seeks to described three stages associated with the development of a new role. The table below summarises the features of each stage.

The Institutional Model of New Roles

Stage	Features
1. EMERGENCE (Old ways of working dominated)	• Need established for the role • Champions for the role • Organisational concerns 'calmed'
2. LEGITIMACY (Isolated examples of new ways of working	• Opportunities to advance the role are identified and created • New role is fitted into the established structures, processes and systems • The 'value' of the new role is proved to others
3. ACCEPTANCE (New role is 'taken for granted')	• Role is routinely used • Trust in the role is creates • Others come to depend on the new role

In 2010 in *British Journal of Midwifery* Griffin et al, set out a hypothetical model to describe the evolution of MSW roles. The model has four-stages-

- Initial stage: social, policy, workforce and service pressures result in innovation and pathfinders
- Development stage: initial research, identification and discussion of issues ("making the case")
- Consolidation stage: hearts and minds won, role accepted but issues remain
- Established stage: coherent and consistent role, career pathways established, routinely included in workforce planning and dedicated training programmes

While this research has not explicitly sought to assess the extent to which MSW have been accepted by the profession, there would appear to be good evidence that the role has progressed from the Emergence/Initial stages to the Legitimacy/Consolidation ones and in some cases to full Acceptance/Established. Participants reported that while there had been initial concerns about the role, these had dissipated on the whole.

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