NHS
Health Education England

Allied Health Professions' Support Worker Strategy Impact Evaluation

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KING'S College LONDON

Professor Richard Griffin, King's Business School

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1. Introduction

Purpose

This report seeks to provide a formal evaluation of the anticipated benefits and impact of Health Education England's (HEE's) national Allied Health Professions (AHP) support workforce programme. It adds to the evidence base for supporting, developing, and deploying support workers and can be used to support organisations to write business cases aimed at developing and deploying the AHP support workforce.

Background

In 2020 HEE established a dedicated national programme of work aimed at providing national leadership and support for the Allied Health Profession's non-registered, or support, workforce. The programme comprises of several resources including a competency framework and is linked to other developmental interventions. Created collaboratively with NHS England, trade unions, professional bodies and other stakeholders, the strategy has the following objectives:

1. Patients and service users have access to skilled and consistently well-trained support workers who have a defined role within their team
2. AHP support workers have access to development structures that provide opportunities to follow a rich and rewarding career pathway
3. Services can address the current variation in support worker roles, banding and progression
4. Support worker roles can be at the heart of improvements in service delivery and transformation, including new models of care

This report sets out the results of an evaluation that addresses the fourth objective – the impact of the strategy on service outcomes and ultimately for service users.

Evaluation approach

Evaluation allows an assessment to be made of change(s) that results from the introduction of an intervention, in this case the HEE programme. This document presents an ex-ante approach to evaluating it, meaning it assesses the potential impact of the strategy by considering possible costs and benefits. Two methods are deployed to assess this:

1. The development of a Theory of Change that draws on a change narrative, derived from research evidence.

2. A cost-benefit analysis of the Senior Healthcare Support Worker apprenticeship standard. This apprenticeship was selected because it has a specific therapy pathway and is likely to be the apprenticeship that is most extensively used for AHP support staff.

Data to support the evaluation was gathered through a review of the literature and a survey of the members of the National AHP Support Workforce Programme Steering Group, comprising staff from service, including support workers, along with trade union, professional body, and arm's length body representatives.

The primary focus of this evaluation is assessing impact of the programme on employers, although wider costs and benefits are identified including service outcomes. This evaluation follows the guidance set out in HM Treasury's Magenta Book. Central Government Guidance on Evaluation.

2. Change narrative

2.1 The impact of good people management

Certain people management practices, such as effective job design, clear career pathways and access to education, have a positive impact on organisational outcomes, including in health care settings. A summary of the evidence, for healthcare, is shown below.

Box 1: The impact of "good work" practices

People management activities, such as team working, appraisals and effective line manager support, as well as wider organisational culture, have consequences for employees. Collectively they shape employee commitment, health and well-being, effort, and, consequently, organisational performance, including patient outcomes (Kessler, 2017).

The Boorman Review (2009), for example, noted that the health and well-being of NHS staff is linked to them having "productive and rewarding jobs" (page 28). This is not just important for staff Boorman pointed out, but also for patients –

"…improving the health and well-being of staff is key to enabling the NHS to genuinely provide health and well-being for all" (ibid:28).

In their seminal study of the NHS, West and Dawson (2012) analysed data from the 2009 NHS Staff Survey to assess whether there was a link between bundles of people management activities designed to increase employee engagement (such as training) and service outcomes. The study found that the –

"…quality of patient experience…is strongly linked with engagement. Patient satisfaction is significantly higher in trusts with higher level of employee engagement" (ibid:19).

Other positive outcomes identified in the study were:

- Lower absenteeism.
- Lower turnover.
- Lower mortality rates.
- Improved patient safety.

The Boorman Review (2009) found a link between staff well-being and the following outcomes:

- Absenteeism.
- Turnover.
- Patient satisfaction.
- Infection rates.

Based on self-reported feedback from NHS trusts, a review of the NHS appraisal system conducted by Brown and colleagues in 2010, concluded that appraisals and Personal Development Plans (PDPs) “contribute directly to patient outcomes” with one NHS trust, for example, finding a clear link between the number of complaints it received and the levels of knowledge and skills staff had as identified through appraisals/PDPs (NHS Staff Council, 2010:4).

Griffiths and colleagues (2014) assessed peer reviewed studies investigating the link between nurses and support worker staffing ratios and patient outcomes for the National Institute for Health and Care Excellence review of safe staffing evidence. They identified just eight studies, with mixed results. They did, however, find some evidence for the positive impact of support staff on reducing the risk of falls and incidence of pressure ulcers.

Also reviewing data from the NHS Staff Survey, but more recently, Ogbonnaya and Daniels (2017) found positive links between NHS trusts with extensive people management practices and organisational outcomes. NHS trusts with good people management were:

- More than twice as likely to have staff with high levels of job satisfaction.
- Over three times more likely to have staff with the highest level of engagement, compared to trusts with less extensive talent management practices.
- Over three time more likely to have the lowest level of sickness absence.

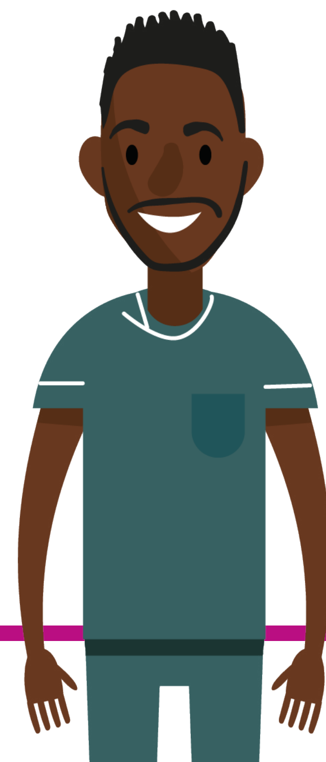
Although NHS trusts with good people management practices were over four times as likely to have the most satisfied patients than those that did not, unlike West and colleagues, (2006), Ogbonnaya and Daniels (2017) found no robust statistical evidence for a link between people management practices and patient mortality.

What are the characteristics of "good work"? Reviewing the wider (non-NHS) literature, Ogbonnaya and Daniels (2017) report that 'good work is characterised by the following factors' (page 6) such as:

- Job security.
- Staffing having input into decisions that affect how, when and what work is accomplished.
- Reasonable work demands and working hours.
- Clear role descriptions.
- Use of skills (and access to learning).
- Variety in tasks.
- Support from co-workers.

Recent research investigating NHS support worker's experience of work (HASKE, (2020) for AHPs and Griffin (2023) more widely) along with official reviews of healthcare support workers conducted by Camilla Cavendish (2013) and Lord Willis (2015), strongly suggest that NHS support workers do not always experience the features of "good work" identified by Ogbonnaya and Daniels (2017). Given the evidence in Boxes 1 and 3, this would suggest that the contribution of AHP support staff is not being fully utilised by the NHS and that employers, as a result, are incurring unnecessary costs (for example avoidable staff turnover) and poorer organisation outcomes than they might.

As outlined in section 1 the HEE AHP support worker programme aims to address long-standing barriers to the full deployment of support workers. There is limited but emerging evidence that implementation of the first explicit support worker strategy developed by HEE, for maternity support workers - which seeks to address similar issues, is resulting in positive change (Griffin, 2019) including improved safety (Griffin, 2022).



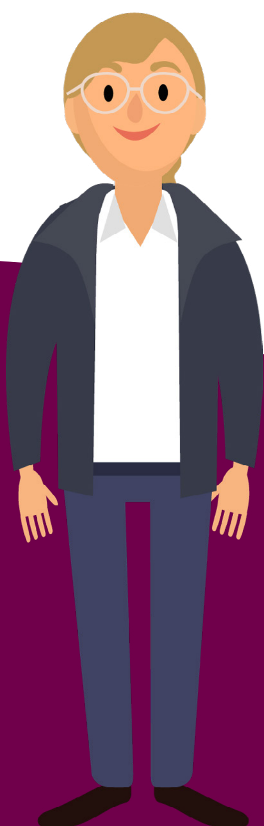
The research evidence suggests that delivering these objectives will result in wider outcomes and impact from the perspective of support workers, other staff, employers, service users and the NHS as a whole[1]. As such the programme meets a key objective of good policy as defined by government–

> "Good policy-making necessitates a thorough understanding of the intervention and how it is expected to achieve the expected outcomes. Good evaluation also requires this understanding" (HM Treasury, 2020:24)

Box 2: Human Capital Theory (HCT)

Although not without its critics, HCT suggests that investment in the knowledge and skills of staff increases their productive capacity (Chartered Institute of Personnel and Development (CIPD, 2017) and that this can be captured through wage premiums enjoyed by trained employees (compared those who have not accessed training). In their review of the research base CIPD (ibid,) found strong evidence to show that investment in employee development had a positive impact on staff retention, performance, productivity, job satisfaction, empowerment, team working and commitment.

Increasing AHP support worker access to occupationally relevant education and training is a key element of the HEE strategy. If achieved, following HCT, this should result in productive gains (see below for a discussion on the return on investment from introducing apprenticeships).



1 There will however be costs associated with operationalising the strategy locally. These include the resources required to plan and organise implementation, possible regradings and backfill for staff who access education. This evaluation takes account of costs as well as benefits.

2.2 Change narrative

It is not difficult to describe a situation where implementation of the HEE programme would result in a clearer and broader scope of practice for a support worker, who, following completion of occupationally relevant education, is able to safely perform a wider range of tasks with a more holistic understanding of care[2]. As a result of this, registered staff would be more confident to appropriately delegate tasks, allowing them (registered staff) to focus on more complex needs. In this narrative the support worker has better appraisals and is clearer on how they can progress their careers. This, in turn, improves retention, commitment, discretionary effort and productivity, resulting in improved service outcomes. This process is captured in the Theory of Change set out in the next section.

Box 3: AHP support workers and service improvements

In a systematic review of the literature, undertaken in 2010, Lizarondo and colleagues found that deployment of support workers in AHP services resulted in improved clinical outcomes, increased patient satisfaction, and released time for registered staff to concentrate on more complex cases. The review also found that a key barrier to effective deployment was blurred support worker role boundaries – one of the key objectives of the HEE programme to address.

HASKE (2020) interviewed several AHP services that had taken the strategic decision to actively develop their support workforce. Participants in the HASKE study reported that extending the scope of their support staff's practice increased capacity and freed up the time of registered staff to focus on "more complex cases" (page 50). This, in turn, enabled the running of more clinics, improved continuity of care, reduced waiting times, and more physiotherapy sessions.

Furthermore, deployment of support workers increased capacity for student placements. In terms of the quality of care, one participant in the HASKE (2020) study believed quality rose because – "you are drawing on utilising the maximum potential of a really expert workforce" (page 58).

Finally, they found that investment in support staff reduced turnover and supported local Grow Your Own approaches which was seen as "particularly beneficial for smaller [AHP] professions" which struggled to recruit (page 50). As an example, HASKE (2020) found that services used Orthoptic Assistants for a range of tasks including setting up clinics, positioning equipment, liaising with patients, assess visual acuity and taking bloods. One "of the main roles of the orthoptic assistant", one participant said, "is to assess vision…that's taking a huge chunk of work away from orthoptists to allow us to do other assessments" (page 53).

2 Camilla Cavendish (2013) wished to see support workers become an 'extra pair of eyes' as well as 'an extra pair of hands' through education, development and support.

3. Theory of Change

A Theory of Change (TOC) seeks to capture how an intervention is meant to work and the steps, or links, that result in it achieving its desired outcome(s), along with any assumptions and, particularly important prior to full implementation, the strength of evidence it is based on. TOC is commonly used in evaluation (Mayne, 2017; NHS England, 2017 and HM Treasury, 2020).

Typically, TOC considers the following steps:

1. Inputs – resources and activities undertaken.
2. Outputs – what is delivered.
3. Outcomes – early and medium-term results.
4. Impact – long term results.

Using the evidence summarised in section 2 and the insights obtained from the HEE national steering group (the full responses from which are set out in Appendix 1), the diagram below seeks to set out inputs required to operationalise the HEE strategy both nationally and locally, the outputs expected such as clearer job descriptions, the outcomes implementation is likely to being in the short and medium term, such as reduced turnover and the long term impact on organisations and service users.

Clearly not all of these will occur in every situation where the strategy is introduced. For example, not every employer may introduce apprenticeships for the AHP support workforce. However, what the TOC illustrates is the potential impact of the strategy and the benefits it could deliver if fully implemented.

The TOC is from the perspective of an individual employer, because employers such as NHS trusts are key in terms of implementation. The evidence, though, also points to NHS-wide benefits that should specifically accrue from the HEE strategy[3], such as:

- Supporting the NHS to fulfil its role as an 'anchor institution' in local communities.
- Effective use of the apprenticeship levy.
- Transferrable skills between employers reducing internal labour market frictions.
- Grow your own workforce supply strategies.

3 Clearly individual employer benefits such as improved safety or better access to services will aggregate across the NHS.

The TOC includes potential costs and issues that might arise from implementing and managing the strategy. These were identified by the HEE national steering group. There may, for example, be re-grading costs, and support staff may have an increased expectation that they can progress their careers, but posts may not be available for them to do so (this may be a particular issue for those who wish to enter pre-registration degrees/degree apprenticeships). Conversely some staff may feel anxious, particularly, for example, if they have not accessed formal education for some time. Overall, though, the evidence suggests that employers, support workers and the NHS should benefit substantially from the strategy, more than offsetting any costs (many of which will be short term).

Inputs	Outputs	Outcomes	Impact
National Development & production of national strategy (Framework, Guides,) Funding for trusts Raising awareness and engagement (webinars, regional meetings) **Employer** Mapping workforce and job redesign Mobilising of learning Delivery of learning (backfill, supervision, loss of productive capacity) Cost of developing resources (portfolio)	Improved job design Job relevant knowledge, skills and behaviours Occupationally relevantly trained workforce Clear job descriptions More rewarding jobs Pay (fairer pay/ regrading costs) Improved supervision Review of skill mix Delegation of tasks by registered staff Career pathways (internal promotions/ Grow Your Own capacity)	Overall increased job satisfaction resulting in lower absenteeism Improved morale Lower turnover Greater engagement Better team working Innovation and creativity Discretionary effort Time released for registered staff Some staff may feel anxious about having to access formal learning Insufficient posts for support staff to progress (frustration)	**Organisational** Lower staff costs (e.g., lower turnover and less use of agency staff) Increased capacity Productivity gains **Service** Lower mortality Improved safety Higher patient satisfaction Reduced infection rates Reduced waiting times Better continuity of care

4. Cost and benefit analysis of the Senior Healthcare Support Worker apprenticeship for AHP support staff

4.1 Introduction

It is possible to model the potential return on investment accruing to employers from delivering apprenticeships for their workforce by allocating costs and benefits solely attributable to the apprenticeship. Apprenticeships are an essential element of the HEE AHP support worker strategy and therefore provide a useful indication of benefit and costs. They do not, however, represent the totality of benefits that will arise particularly in respect of service delivery or the freeing up of time to optimise registered staff to focus on complex clinical decision making, planning and complex interventions.

4.2 Assumptions

This Cost Benefit Analysis (CBA) is based on the introduction of the Senior Healthcare Support Worker (SHCSW) apprenticeship standard (which has a therapy and theatres pathway), by an employer for an AHP support worker working full time.

Training costs and benefits are calculated for an 18-month period – the minimum duration of the SHCSW apprenticeship, including End Point Assessment (EPA). Benefits are more widely distributed than costs, including to the apprentice and service users. Moreover, benefits mostly accrue over a longer period than costs – namely the duration of time that the employee remains in their role[4].

There are several ways that apprenticeships can be delivered. For example, if an NHS trust has achieved 'Main' provider status on the Register of Apprenticeship Training Providers, they could deliver the apprenticeship themselves, thereby retaining the full levy. However, such cases are likely to be rare based on the number of NHS trusts listed as main providers on the register, although co-delivery may be more common (which under certain circumstances will allow some of the levy to be returned to employers).

4 If the employee leaves one NHS employer to work for another, the NHS as a whole and that new employer continues to benefit from the training.

To be sensitive to the different approaches that could be adopted to deliver the apprenticeship the following two scenarios have been modelled-

1. The apprenticeship is fully delivered by an external provider. This is described as the “Maximum” scenario.

2. Half of the apprenticeship is delivered by the employer through a co-delivery model, allowing 50% of the levy to be returned. This is described as the “Minimum” scenario. Given that few external education providers are likely to employ AHP lecturers such as radiographers or dieticians, as with delivery of the maternity framework (Griffin, 2019), a co-delivery model seems the most likely approach, in order to ensure that the clinical elements of the apprenticeship can be taught appropriately.

The “Minimum” scenario represents the lowest costs that an employer might face and the maximum benefits that might accrue. The “Maximum” scenario represents the highest costs and lowest benefits. Employers are likely to be at some point between these two positions.

Procurement costs associated with securing a provider are not included, as it is likely that NHS trusts will already have procured their SHCSW apprenticeship provider and HEE are undertaking a national procurement exercise.

4.3.1 Costs

This section sets out the assumptions underpinning the costs employers incur when delivering the SHCSW apprenticeship to AHP support staff.

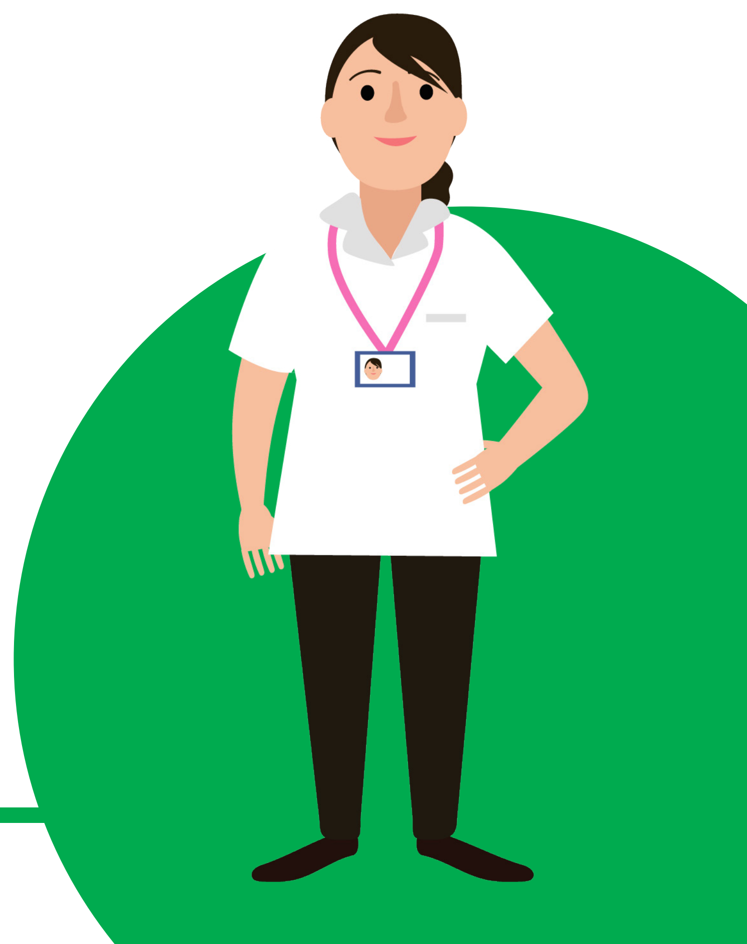
1. **Wages.** Apprentices are employees who receive a wage whilst training. In the NHS a wide range of approaches appear to be used by employers to pay their apprentices from Spot Pay to Agenda for Change terms (Alma Economics, 2019). For the purpose of this CBA, it is assumed that the apprentice is paid at the minimum of band 2 (£18,870[5]) for the duration of their training (18-months). Employers also incur other wage costs including National Insurance Contributions. These are calculated at 29.1% (Alma Economics, 2019). An important point in terms of apprenticeships is that apprentices spend the bulk of their time (80%) working with their employer and only 20% of time ‘off-the-job’ learning. Whilst working, apprentices are making a productive contribution, however it is assumed that the 20% of their working week spent learning off of the job is covered by backfill (which represents a further cost). Once training is completed employers may incur a regrading cost if apprentices are an existing employee. New staff will be recruited and trained into band 3 vacancies (but only graded at band 3 once they have completed training).

5 All salaries are for 2022/2023.

2. **Apprenticeship levy.** At the time of writing the cost of the SHCSW apprenticeship was £5,000 including EPA. It is assumed that employers pay this full cost, although it is possible for them to negotiate a lower cost with providers within the national funding bands. As described above, two scenarios are modelled; one where external provider delivers the whole apprenticeship, and one where the employer delivers 50%. The apprenticeship levy is gathered from every NHS trust regardless of the number of apprenticeships they provide. Although the levy is included as a discrete cost in this evaluation, it is one incurred whether AHP support workers are trained or not. Unspent levy can be transferred to other employers or is returned to HM Treasury.

3. **Supervision.** Apprentices require supervision and guided learning from colleagues whilst training. This represents a cost to employers, as such supervising staff will not be able to provide direct care whilst supervising. Each year the Department of Health and Social Care and HEE publish their Education and Training Tariff guide. This sets out the amount NHS employers are compensated for in respect of the cost of supporting degree students on clinical placement, (for example for the time-spent overseeing students, teaching, administration, and facilities costs). The latest (2022) guide sets - for non-medical education and excluding High Cost Area Supplements - a tariff of £5,000 per student. The tariff does not apply to apprenticeships delivered to support workers but can be used as proxy for costs employers are likely to face. It is not known how much time supervision of apprentices takes but the full tariff value may be excessive[6] compared to undergraduate students. Further it is assumed that this cost includes others that might be associated with organising and delivering an apprenticeship such as the cost of recruitment and learner travel costs (if recompensated). For this CBA-

   i. In the Minimum scenario 20% of the tariff is calculated as supervision costs.
   ii. In the Maximum scenario 80% of the tariff is calculated.



6 The cost of planning and delivering training in the Minimum scenario will be compensated for directly through return of levy funds.

4.3.2 Benefits

1. **Direct Productive Contribution (DPC).** DPC measures the contribution apprentices make to their organisation whilst training. It is calculated as follows: The salary of the apprentice (in this case the minimum of band 2- £18546) is subtracted from the salary maximum of the role they are being trained to fill – in this case the maximum of band 3 (£21,777). The difference (£ 3231 per annum) between the two reflects the tasks that the apprentice cannot yet perform because they have not fully completed their training. Following HCT (Box 2) it is assumed that the maximum of band 3 represents the full value of a productive worker in that grade. This is called the Fully Productive Wage. The productive contribution of the apprentices applies to the 80% of the time they are in the workplace and over the 18-months of training.

2. **Wider Productivity (Spillover) Gains.** A broad range of benefits accrue to employers that introduce apprenticeships compared to those that do not. For example, the National Apprenticeship Service (2018) found that 78% of employers believed apprenticeships increased productivity and 73% that they improved staff morale. The method to calculate these 'spillover' gains, building on HCT (see Box 2), is to firstly identify the wage premium apprentices receive compared to people who have not completed an apprenticeship. Research shows that apprentices enjoy a premium because they are more likely to be in work and be earning more than people who have not undertaken an apprentice (Department of Education, 2018). The Department of Education (2018), in a review of the evidence, identified a 16% premium for people completing a level 3 apprenticeship. Once the premium is identified, it is uplifted. HM Treasury (2013) suggested an uplift of 200% and National Audit Office (2012) 125%. The 200% uplift is applied to the Minimum scenario and the 125% to the Maximum. The uplift is applied to the Fully Productive Wage (the maximum of band 3). Such gains flow to the employer for as long as the trained employee remains working for them. Data is not available for AHP support worker retention rates, but it is assumed a trained apprentice will remain in their new role for between 5 and 10 years. One of the benefits of the strategy identified in the TOC is that it should improve retention.

Tables 4.1 and 4.2 below set out a simulated CBA for the SHCSW apprenticeship based on the above assumptions.

Table 4.1: Costs and benefits during training

	Min (£)	Max (£)
Costs		
Apprenticeship fees	2500	5000
Wages	7182	7182
Backfill	7182	7182
Supervision costs	1500	6000
Total costs	**18364**	**25364**
Benefits		
Direct productive contribution	3877	3877
Wider productivity spillover effect	10452	6533
Total benefits	**14329**	**10410**
Net cost/benefit (to employer)	**-4035**	**-14954**

In Table 4.2 the Maximum scenario again shows the greatest costs (in this case upgrading the member of staff from band 2 to band 3) and minimum benefits employers might enjoy over a five-year period. The spillover effect is based on a 125% uplift of the wage premium. The Minimum position assumes that the apprentices is required to a vacant band 3 role (i.e., the post is already funded). The spillover effect is based on the 200% uplift and is enjoyed by the employer for 10-years. Both scenarios show net gains.

Table 4.2: Costs and benefits post training

	Min 10 years (£)	Max 5 years (£)
Costs		
Regrading band 2 to band 3	0	16155
Wider productivity spillover effect	69684	21777
Net benefit (to employer)	**69684**	**5622**

5. Potential full benefits of the strategy

The benefits set out in Section 4, arising from more extensive use of apprenticeships are not the only way that the HEE AHP support workforce strategy and programme will impact on staff, employers, and services. Indeed, not all AHP support workers will need to complete an apprenticeship. Implementation of the strategy will however still benefit them and their services. Boxes 1 and 3 above set out the characteristics of 'good work' such as good job design and clear progression pathways. An organisation implementing the strategy would meet the definition of providing 'good work' and it would be expected that they and their service users would benefit from the associated outcomes such as reduced staff sickness absence, improved patient satisfaction and reduced falls[7].

Using the measure of spillover gains, set out in the previous section, as a proxy for the wider non-apprenticeship benefits of implementation, this would suggest the full implementation of the strategy by an employer could produce a maximum benefit of £5,622 a year per employee who does not require additional training. The TOC did identify some potential costs – the time employers spent delivering the strategy, (although NHS trusts benefited from central funding to support this activity) and the potential that turnover (and perhaps retirements) might[8] increase amongst staff who felt either anxious that they would have to access training that they did not wish to, or from other staff who were frustrated that posts were not available for them to progress their careers. Even assuming that this would be equivalent of third of the benefit, which is a very cautious assumption, that still suggests a net gain of £3,710 a year per support worker. This is alongside a (best case scenario) of a £5,622 gain per year for a newly trained apprentice.

Whilst these figures should be treated with some caution, the evidence of the impact of good people management strategies summarised in Section 2 strongly suggests that the HEE AHP support worker strategy and programme should be cost beneficial for employers (and consequently the NHS).

Conclusion

This report seeks to provide a formal evaluation of the anticipated benefits and impact of HEE's national AHP support workforce programme. The HEE team will continue to support integrated care systems and employers in relation to the evidence for supporting, developing, and deploying support workers to enable them to deliver high quality patient care, whilst also focusing on the needs and benefits for improving diversity and widening participation.

7 Falls, for example, are estimated to cost the NHS £435 million a year (Office Health Improvements and Disparities, 2022).
8 No research appears to have been taken to explore this issue.

Appendix 1:

Results of the National AHP Support Workforce Programme Steering Group survey

A HEE national steering group was established in 2021 to oversee and advise on the implementation of the national strategy and programme. It comprises a range of stakeholders including support workers, university representatives, employers, and professional bodies.

A survey was sent in March 2022 to all the members of the Steering Group asking them to describe the costs and benefits that they thought would arise from implementation of the strategy. In total nine of the twenty-two members responded and the results, which were incorporated in the TOC, are set out below. 'Incidence' refers to how many respondents mentioned a cost or a benefit.

Table A.1: Costs

Cost	Incidence
Backfill	6
Education support (e.g. supervision)	5
Loss of productive contribution	5
Study leave	2
Regrading	2
Cost of bridging programme	1
Administrative costs	1
Cost of developing a portfolio	1

Many of the costs in Table A.1 relate to education. There is a presumption, (probably correct), that the HEE strategy will result in an increase in training activity. As one respondent said –

> "Initially staff training might increase as organisations are working to meet the standards within the framework"

Table A. 2: Benefits (employer)

Benefits	Incidence
Improved retention	8
Increased capacity including support staff working at top of practice	7
Improved safety	3
Improved job satisfaction	3
More competent staff	3
Opportunity to review skill mix	2
Reduced sickness absence	2
Better career pathways	2
Helps trusts be 'good employers'	2
Better supervision	1
Better delegation	1
Effective use of apprenticeship levy	1
Improved recruitment	1
'Grow you own' registered staff	1
Innovation	1
Transferrable skills	1
Helps NHS as an 'anchor institution'	1
Improved quality	1
Reduced use of agency staff	1

Table A.3: Benefits (support workers)

Benefits	Incidence
Career progression	7
Feeling more valued	3
Improved job satisfaction	3
Clear role boundaries	2
Fair pay	1
Standarisation	1
Access to qualifications	1
Safe working practices	1
Improved morale	1
Improved clinical care	1
Relevant competences	1
Improved access to HE	1
More innovative	1

Respondents were also asked if they thought implementation of the strategy would result in any disadvantages for support staff. Interestingly, most answers related to potential frustrations the support workforce might feel if the strategy was not fully implemented:

- Lack of posts available for staff to progress.
- Employers not supporting development.
- Lack of backfill.
- Support staff unable to progress into pre-registration.

Three respondents did point out that not all support workers wish to progress their careers and that these staff might feel "left behind". In a response to another question a respondent said that support workers may risk being downgraded as a result of the strategy, suggesting that some staff may be graded at a higher level than their roles and responsibilities warrant. It should be noted that HEE has stressed that the Framework and the NHS job evaluation process are separate. NHS job evaluation takes account of factors, such as physical and mental effort, that are not included in the Framework and also places more weight on some factors than others. The extent to which under or over grading is an issue in the NHS is not known.

Finally, respondents were asked to list the positives and negatives of the strategy from the perspective of patients. No negatives were identified. In terms of positives three people mentioned safety, and others highlighted-

- Patients "will gain appropriately and consistently qualified staff providing their care".
- Increased confidence in the care provided.
- A more satisfied workforce leading to "better care'.
- Consistency.
- Lower waiting times.
- Equality of access.
- More timely care provision.
- Improved access to care.
- Improved quality of care.

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