Skills for Health

Paraprofessional Roles:
A Case Study of Gateway Family Services
Commissioned by Skills for Health

April 2010

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Gateway Family Services Community Interest Company

A report commissioned by Skills for Health

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EXECUTIVE SUMMARY

In June 2009, GHK Consulting Ltd (GHK) was commissioned by Gateway Family Services, funded by Skills for Health, to undertake a piece of research looking at paraprofessional roles. The research was commissioned to inform Skills for Health's work around widening participation; it used Gateway as a case study and had three aims:

1. To provide evidence of the effectiveness of Gateway's model of working;
2. To use this evidence to suggest ways of improving current practice; and,
3. To improve Gateway's ability to collect evaluative evidence on an ongoing basis.

A range of tasks were undertaken to gather evidence to address these aims, including: interviews and focus groups with paraprofessionals, managers, clinicians and stakeholders; a review of related policy and literature; and an analysis of management information collected by Gateway (training sessions and workshops were also held in support of the third aim). The evidence gathered is presented in the main body of this report. This summary presents the key findings, with a particular concentration on those that appear generic to the use of paraprofessionals (rather than specific to Gateway). The main findings are that:

There is a strong policy rationale for using paraprofessionals...

Paraprofessionals exist within a wider policy context and, in broad terms, the rationale for their use is entirely in line with the current direction of policy. Specifically, the current emphasis on health inequality, improving quality and focusing on preventing ill health countenances in favour of the use of paraprofessionals. Related policy concerns include the problems facing the health and social care workforce – the forthcoming 'retirement bulge' and the need for more flexible ways of working for example; again, these concerns count in favour of using paraprofessionals.

...but there are some important practical considerations in their use

This study showed a set of important practical considerations that need to be taken into account when using paraprofessionals; these included:

- Setting clear boundaries when paraprofessional services are established. In the case of Pregnancy Outreach Workers (POWs) and Health Trainers, the clinician–paraprofessional relationships worked best where clear ground rules about referrals and communication had been set out.
- Good communication between paraprofessionals and clinicians is vital. This may include regular phone calls / letters to confirm that referrals have taken place, sharing information about the clients' history, and letting clinicians know what support has been given.
- The ability of a paraprofessional to manage their own caseload and workload is a key attribute of being successful in their work. Moreover, strong line management is vital.
- Continuity of service is valued by paraprofessionals, clinicians and beneficiaries. Where clients may have had difficulties engaging with professionals and where there is a lack of trust, it seems to be important that a single paraprofessional is able to re-engage them and see them throughout, allowing for a trusted relationship to be built.

Paraprofessionals should not be seen as a quick route to reduced cost...

Paraprofessionals do not appear to provide gains in efficiency in terms of immediately reduced costs (i.e. cashable savings), despite often being viewed as such. Instead, it

seems more likely that they offer an additional service, rather than an alternative; also, this additional service often attracts a 'management cost' for clinicians in terms of overseeing the paraprofessional's work. Paraprofessionals should not therefore be seen as an unambiguous route to reducing costs and much more work would need to be done to establish the true changes in cost.

...and the current funding crisis presents a risk in this respect

To date, the UK's public services have been largely protected from cuts in funding arising as a result of the deficit in public finances. But the 2009 Pre-Budget Report marked a change here and the challenge facing the NHS has also become clearer: 2010/11 is the final year when the NHS will see a growth in funding; thereafter, for the foreseeable financial future, growth will be zero or close to it. The approach to addressing this challenge is to be achieved primarily through improved Quality, Innovation, Productivity and Prevention (QIPP). This presents a challenge for those advocating the use of paraprofessionals, since the focus of the NHS may well (despite the best intentions of QIPP) turn to short-term saving at the expense of longer-term investment.

Used properly, the main benefits of paraprofessionals relate to widening participation and (possibly) reducing health inequalities...

Accepting practical considerations in their use, paraprofessionals can offer the health and social care workforce a younger, more diverse and appropriately skilled supply of labour. There are two issues of note here:

- Firstly, that there is a need to consider the career route for the paraprofessional (is it optimal for them to leave these services to begin other career routes, or can progression be built in?); and,
- Secondly, on a related point, this supply of labour is trained at the 'expense' of individual commissioners, who may simply (and understandably) regard high levels of turnover as a purely negative feature of these services. There is a need therefore to recognise the wider value of investment in paraprofessional services – Social Return on Investment (see below) may help here.

Paraprofessional services also offer a means for the NHS to address its own 'corporate social responsibility' aims, and work towards other government aims around social justice, by training and employing the unemployed.

On a related point, paraprofessionals improve the quality of services for vulnerable groups. They are more able to relate to, communicate with and tailor services to those most likely to suffer poor health outcomes. They also appear to increase and improve access to mainstream services. They should therefore be considered as a means of addressing health inequalities.

...and the paraprofessionals considered in this study generate a positive Social Return on Investment

This study also identified return on investment ratios for two of Gateway's paraprofessional services (Health Trainers and POWs) in order to give an example of the possible wider social value that can be generated from investing in paraprofessionals. Social Return on Investment – a form of cost-benefit analysis – was used, drawing on management information held by Gateway and a range of financial proxies to establish the likely value of paraprofessionals from a broad, societal perspective, over a five-year period. The use of conservative assumptions in the modelling allows us to be clear that the wider benefits to society of paraprofessionals exceed the monetary cost of running such services, and that such returns are in the region of £3 to £5 for every £1 invested.

1 INTRODUCTION

In June 2009, Skills for Health commissioned a report of Gateway Family Services Community Interest Company (Gateway) into paraprofessional roles, with the aim of identifying lessons from Gateway's experience and applying them to future developments in this field. This report presents the findings of this study.

The project used a **case study approach,** examining Gateway against the broader context of developing paraprofessional roles and their impacts upon NHS resources and services, the wider workforce, paraprofessionals themselves, and the clients that they work with. The primary research for the study – in-depth interviews and focus groups with Gateway employees and learners, as well as interviews with wider stakeholders – was supplemented by an analysis of Gateway's management information; and a review of literature and policy relating to the delivery of paraprofessional services. The report also provides a **social return on investment (SROI) analysis**, which helps to explain the wider social value and the likely value of the benefits to society generated by investment in Gateway's paraprofessional services.

One of the main features of the study was the high degree of congruence between the findings from the various sources used (the issues in the literature accorded with those found in the fieldwork for example). This gives us a reasonable degree of confidence that – although following a case study approach (with all the inherent limitations on the ability to generalise findings) – the issues raised here are likely to be common to other organisations and perhaps other types of paraprofessional.

1.1 Gateway Family Services and Paraprofessional Roles

Gateway Family Services is a Community Interest Company (a form of social enterprise) whose stated aim is to, "*reduce inequalities in learning, employment and health*". It is a provider of community-based health and social care services, and of tailored training programmes aimed at helping NHS and social care organisations to recruit from traditionally poorly represented groups – such as the recently unemployed or people lacking qualifications.

Among the **services that Gateway provides** (recruiting and managing staff) under contract to Primary Care Trusts (PCTs) are:

- Pregnancy Outreach workers (POWs);
- Health Trainers (HTs); and
- Size Down workers (community weight management workers).

These are often called '**paraprofessional**' roles, meaning that they are assistant practitioner roles (usually at bands 3 or 4), supporting and working with professional clinicians – but operating autonomously in a management structure that is separate from mainstream clinical services. These roles have a focus on prevention and tackling the wider determinants of health; the interventions they provide aim to address clients' social and environmental barriers to better health, motivate clients to access mainstream services and set health goals, or signpost / inform clients about mainstream services.

Gateway's **training programmes** include:

- Pre-employment programmes aimed at recruiting and training local people, the unemployed or people with local skills into NHS employment for a range of entry level roles;

- Community Family Worker training, aimed at producing paraprofessionals that deliver a full range of support and advice to families, in partnership with multi-agency teams and relevant professionals;
- Year In Industry (YINI) programmes; and
- Apprenticeships in health and social care.

Both service provision and training programmes are marketed to NHS Trusts and other employers – predominantly around the West Midlands region.

Paraprofessional roles are increasingly seen by employers as a solution that can help to address a number of workforce issues that they face. Such new roles have been promoted by Skills for Health, the NHS Institute for Innovation and Improvement, Strategic Health Authorities (SHAs) and others as a way of[1]:

- **tackling skills shortages** (e.g. the shortage of trained midwives);
- **delivering more / higher quality preventative services**, which are more tailored to people in deprived or socially excluded communities than existing mainstream services – and with which people in disadvantaged groups are more likely to engage;
- **widening participation** to non-traditional recruits – this is defined variously by different stakeholders, from:
  - a form of corporate social responsibility and engagement with local communities;
  - giving an opportunity for employees employed in entry-level or support roles to move up a 'skills escalator' into more highly skilled roles;
  - taking advantage of a wider pool of skills and talent from which employers can recruit; to
  - a way of changing the 'mindset' of health services so that they adopt models of care that are more appropriate for diverse groups.
- **making cost savings** by increasing flexibility in the workforce, breaking down barriers to multi-agency working, and allowing clinicians and professionals to focus on work where they add the most value (saving time).

While paraprofessional roles are increasingly being implemented by health and social care employers, the evidence base for their use (and in particular their effectiveness) is still being built. As discussed later in this report, it is important that employers and providers of such services know more about the outcomes of such services and their wider impact on society; as well as how to commission and operate such services effectively. As a study of the wider literature will show, all the above statements can provide more or less valid arguments for expanding the scope of services provided by paraprofessionals, but more study is needed in order to quantify the extent to which such benefits are realised in practice, and under what circumstances they are most likely to be realised. Building the evidence base is further complicated because many of the outcomes and health benefits of paraprofessionals' interventions may only become apparent in the long-term. Because paraprofessionals are intended to work closely with other health and social care staff, there are also questions of the degree to which clients' behaviour change can be attributed to such interventions[2].

This study aims to contribute to the evidence base by using the data already collected by Gateway – as an exemplar of such a service provider – in order to examine the impact of

[1] These issues are discussed more fully in section 3 of this report.

[2] A forthcoming randomised controlled trial of the Pregnancy Outreach Workers will build the evidence base in this respect.

paraprofessionals on health and social care employers and wider society; highlighting the key issues encountered in delivering paraprofessional services for employers and providers to consider; and through providing some indication of the likely the return on investment in such services.

1.2 Report Structure

This report continues in the following sections:

- **section 2, 'Aims of the Study and Research Method Used'** introduces: the aims and objectives of the study; the final scope of the study; the key issues considered; the activities undertaken and the rationale for them, including sampling and recruitment; and, the strengths and limitations of the approach used;
- **section 3, 'Review of Literature and Policy'** gives the findings from a review of the key sources of evidence on paraprofessionals, identifying the intentions behind using paraprofessionals and how these relate to the major trends affecting the NHS workforce and the extent to which organisations such as Gateway can meet the challenges ahead;
- **section 4, 'Gateway Family Services – Findings'** describes the case study of Gateway and the qualitative evidence for how its services are meeting the various expected outcomes;
- **section 5, 'Gateway Family Services – A Return on Investment Analysis'** describes the methods used for this part of the study, the findings and how they ought to be interpreted (in particular by readers who wish to know more about value for money);
- **section 6, 'Issues Raised and Lessons Learnt'** summarises the learning from this study and outlines some future issues to consider for providers such as Gateway, as well as NHS commissioners and employers.

Two annexes support this:

- Annex A: Discussion guides; and
- Annex B: Bibliography

2 AIMS OF THE STUDY AND RESEARCH METHOD USED

This section introduces:

- the aims and objectives of the study;
- the final scope of the study that was decided upon and the key issues considered;
- the research method used; and,
- the strengths and limitations of that method.

2.1 Aims and Objectives

Three aims were agreed with Gateway for this study:

1. To provide evidence of the effectiveness of Gateway's model of working;
2. To use this evidence to suggest ways of improving current practice; and,
3. To improve Gateway's ability to collect evaluative evidence on an ongoing basis.

As an organisation, Gateway has grown rapidly, and the number of contracts secured suggests that they are valued by commissioners. However, Gateway managers identified a need for the organisation to be able to:

- produce robust evidence for commissioners demonstrating the added value of paraprofessionals to clinical services;
- build its own internal capacity to evaluate and monitor impact.

Gateway therefore commissioned GHK, using funding from Skills for Health as part of their work looking at widening participation.

It was agreed that a **case study approach** would be used, which could not only to fulfil the aims listed above, but would also focus on the identification of lessons from Gateway's experience that could inform future developments in this field. Hence, while the evidence and data gathered during this study largely relates to Gateway, it was agreed that this would be situated within a broader set of issues derived from a limited review of policy and literature in order to support the broader application of learning.

The research questions and the most important issues that were considered in defining the study are outlined below.

2.2 Scope of the Study and Research Questions

In order to give a clear focus to the study, key questions that the study should address were agreed between Skills for Health and Gateway Family Services:

What effect has involvement with Gateway had on learners?

- What were they doing before involvement with Gateway?
- What has the nature of their involvement been?
- Has this led to gains in skill levels and / or employment?

How has Gateway changed the way services are delivered?

- Have clinicians / social workers / health professionals changed the way they deliver services because of the support of the paraprofessionals?
- Have clinical or other services changed the way they deploy their workforce because of the support of the paraprofessionals?

- What do clinicians, social workers and public health professionals think about any changes made? (and are these changes quantifiable, in monetary terms?)
- Is there any evidence that the use of paraprofessionals has led to better outcomes for vulnerable and hard-to reach groups?
- What additional needs of vulnerable and hard-to reach groups have been met as a result of paraprofessionals' involvement?
- Is there any evidence of increased engagement with hard-to-reach individuals and communities?
- Has the involvement of paraprofessionals informed the strategic development of services (e.g. the Joint Strategic Needs Assessment)?
- Can paraprofessionals 'grow' and take on more advanced roles within services?

Lastly, it was agreed that **the study should equip Gateway with evidence showing commissioners' likely return on investment.** It was agreed that the research should take into account the types of outcomes achieved by Gateway and – as far as possible – place a monetary value on them (e.g. what is the value of someone gaining an accredited qualification? What are the typical savings from moving someone out of unemployment?).

2.2.1 Working collaboratively with Gateway Family Services

The resources available for this study were comparatively modest and in addressing this issue, Gateway and GHK agreed to work together to gather evidence to fulfil the study aims. It was agreed that such **a collaborative approach would also help to improve Gateway's ability to collect evaluative evidence** and build its internal capacity to monitor impact. Therefore, **GHK provided training to Gateway staff in gathering evaluative evidence** (see below) throughout the duration of the contract.

It was also agreed that the study **should draw on existing resources held by Gateway**, including data and management information concerning outcomes for clients and the recruitment and progression of paraprofessionals, in order to inform the final report and an analysis of social return on investment (SROI).

Finally, **the budget for this study was supplemented by resources from GHK**. This represents an in-kind contribution to Gateway and this was made as part of GHK's commitment to corporate social responsibility.

2.2.2 Defining 'paraprofessionals'

To further define the study, it was agreed that the focus should be on paraprofessionals as a single group and that services other than those provided by paraprofessionals lay outside the scope of the study. In support of this, as part of the scoping phase for the study (see below), we interviewed a range of stakeholders to discuss their perspective on paraprofessional services and the rationale for using them. It was generally agreed that paraprofessional roles in healthcare share the following characteristics:

- despite their role of providing support autonomously (under supervision) to clinicians, they all work on a 'social' or 'family support' model, i.e.:
  - they work with clients to identify and address multiple, often complex and largely social, barriers to engaging with mainstream services; and,
  - 'hand-holding' (i.e. more 'active' and supported referrals) where necessary, working to increase clients' ability to access other services.
- their main 'outcomes' are therefore based around referrals to other, more specialised services, but there will also be some direct health-related outcomes from services provided; and,

- they all have a core, generic skill set centred on an ability to engage with, and develop trusted relationships with people with multiple needs.

It was agreed that the study would focus on those paraprofessionals employed by Gateway in order that the researchers could study groups of paraprofessionals who are commissioned to work alongside different clinical services (or within a clinical pathway). Moreover, the costs of delivering commissioned services in this way can also be more easily defined for the purposes of a return on investment analysis. This means that the paraprofessional groups covered in this study include Pregnancy Outreach Workers (POWs), Health Trainers (HTs) and (to a far lesser extent) Size Down workers, but Community Family Workers and trainees on other Gateway programmes were not a focus of this study.

2.3 Research Method Used

This sub-section describes the research activities undertaken and the rationale for them, including sampling and recruitment, and the limitations of the study design. All the main study tasks are described below.

2.3.1 Scoping phase and baseline research

The research began with a scoping phase in order to define the research brief more tightly, determine how Gateway's paraprofessional services are provided, and find out what outcomes are expected by Gateway staff and the commissioners / stakeholders of Gateway. The tasks undertaken were as follows:

Interviews with Gateway managers and staff

We carried out six face-to-face, semi-structured interviews with the relevant Gateway managers of different paraprofessional services, including those managers responsible for POWs, Heath Trainers, Size Down and Learning. These included discussions about:

- the rationale for using paraprofessionals;
- the perceived benefits and issues surrounding the introduction of paraprofessionals as part of clinical services and family support;
- their perspectives on workforce redesign and the role of paraprofessionals in future;
- the measurement of outcomes for service users;
- costs of the paraprofessional services and Gateway's business model;
- lessons learned as these services have developed over time; and
- their views on the focus of this research.

Interviews with external stakeholders and commissioners

We carried out seven semi-structured interviews (face-to-face and telephone) with seven external stakeholders and commissioners. These respondents were chosen purposively in order to reflect the wide range of stakeholders and commissioners that Gateway works with, and who could give a range of perspectives about their experience and expectations of paraprofessional services. These included discussion about:

- the rationale for using paraprofessionals;
- the perceived benefits and issues surrounding the introduction of paraprofessionals as part of clinical services and family support;
- their perspectives on workforce redesign and the role of paraprofessionals in future;
- their perspective on Gateway as a partner and service provider, including why / whether they would choose to work with Gateway or other social enterprises;

- the measurement of outcomes for service users, including links between the monitoring of activity / outcomes and the commissioning process; and,
- future needs for the kind of services that paraprofessionals can provide.

Literature and policy review

We carried out a limited review of literature on paraprofessionals and recent NHS workforce policy, in order to identify the wider intentions for using paraprofessionals in service design. We also reviewed recent NHS workforce policy in order to identify the major issues that are having an impact on the workforce and to identify the extent to which organisations such as Gateway Family Services can meet the challenges ahead.

Workshops

Four workshops were carried out with Gateway staff in order to fulfil the component of the study brief aimed at increasing Gateway's capacity to gather evaluative evidence and monitor impact. This included workshops on:

- how to produce case studies; and
- identifying and working with sources of data to monitor outcomes.

Production of a 'theory of change'

In order to research the effects of Gateway's paraprofessional services on service delivery, service users and the paraprofessionals themselves, it was agreed to use a '**Theory of Change**' approach to summarise our understanding of the expected outcomes and how Gateway's activities are expected to produce, or contribute to, these outcomes. This is represented by a 'logic model' which is illustrated and explained more fully in section 4 of this report.

A theory of change approach allows us to describe the inputs and activities carried out by paraprofessionals, and how these are expected to lead to outcomes. During the scoping phase for this work, the outcomes that are important to Gateway and its stakeholders were defined.

Six expected outcomes were identified for Gateway and its paraprofessional services. These are described in greater detail in section 4.

The six key outcomes for Gateway Family Services

1. Improved access to mainstream services for service users;
2. Reduced health inequalities / health benefits for service users;
3. Improvements for paraprofessionals as individuals;
4. Benefits to NHS organisations and the NHS workforce;
5. More efficient use of services' resources; and
6. Changes in services provided for disadvantaged communities.

These were then used as the focus for evaluative activity, and allowed for the collection of evidence under each of these headings, through qualitative research and the use of Gateway's existing data.

The scoping phase therefore concluded with an interim findings report, which set out the theory of change and a logic model with the expected outcomes for Gateway's paraprofessional services; this provided a framework for the data gathering phase.

2.3.2 Data gathering phase

The scoping phase was followed by the gathering of evidence and data, using the six outcomes identified as a framework, to examine the effectiveness of Gateway's model of working.

Interviews with clinicians

We carried out seven semi-structured telephone interviews with frontline clinicians that worked with paraprofessionals or had working relationships with them (e.g. referral relationships).

The original sample frame for this task envisaged that ten clinicians would be interviewed; sampling was purposive and it was intended that the sample would be broadly representative of:

- the different professional groups who work with the three types of paraprofessional studied (POWs, Health Trainers and Size Down workers); and
- the three different PCTs in Birmingham, where Gateway provides paraprofessional services.

In practice, clinicians were difficult to contact and interview, and just seven interviews were achieved, with:

- 3 midwives, who work with POWs
- 2 GPs, who work with Health Trainers
- 2 family support workers in Children's Centres who work with Size Down workers

Our lines of enquiry enabled us to examine clinicians' views of:

- the context for their involvement with paraprofessional services;
- how they came to work with paraprofessionals;
- key success factors for the relationship and how difficulties were overcome;
- outcomes achieved for clients; and
- broader benefits for NHS services, the workforce and the wider community.

Full discussion guides for all the interviewing tasks for this study can be found in the annexes to this report.

Interviews / focus groups with paraprofessionals and learners

We carried out five semi-structured, face-to-face interviews with the three different types of paraprofessionals employed by Gateway. This was in line with the planned sample of five paraprofessionals; the sample covered 2 POWs and 3 Health Trainers (who comprise the largest proportion of Gateway's paraprofessional workforce). Access to paraprofessionals was brokered by Gateway staff.

The interviews were supplemented by focus groups, which allowed for a discussion of the main issues concerning paraprofessionals' working relationships and career paths, and a comparison of different experiences. The focus group with learners also enabled us to examine the expectations and recruitment of individuals to a particular Gateway training programme (in Stoke-on-Trent). We carried out:

- 1 focus group with 10 learners; and
- 1 focus group with 5 paraprofessionals currently in employment (POWs and HTs)

Both interviews and focus groups with paraprofessionals used the same discussion guide (which can be found in the annexes to this report). Our lines of enquiry allowed us to examine:

- paraprofessionals' experiences prior to employment with Gateway;
- their current role and working relationships;
- engagement with Gateway and the training received;
- the role of Gateway staff in supporting paraprofessionals into employment;
- key success factors for their relationships with clinicians and how difficulties were overcome;
- outcomes achieved for clients; and
- broader benefits for NHS services, the workforce and the wider community.

Review of management information

We reviewed the existing data collected by Gateway on the outcomes of paraprofessional services; as well as data on the costs of delivering its various paraprofessional services to PCTs. We reviewed data concerning:

- throughput;
- contract management;
- activities carried out;
- outputs (e.g. referrals and signposting);
- outcomes (e.g. weight loss, satisfaction with service);
- costs of delivering the service.

This review was carried out in order to inform the assumptions contained in the social return on investment analysis (see section 5); some of the data is also used in the section in findings (section 4).

2.3.3 Strengths and limitations of the research method used

The case study approach adopted and the use of Gateway as an exemplar for other paraprofessional services has both advantages and drawbacks which have been considered in the writing of this report.

A case study approach enables researchers to examine the workings of a subject in some detail – in this case it enables us to identify particular issues that are relevant for Gateway and its commissioners. The main drawback is that there is a limited ability to generalise from the findings (although, to a greater or lesser extent, this is a limitation of all social research – including those studies with the strongest designs[3]). The literature and policy review was therefore used to place these findings in content, and they indeed show that many of the issues identified in the case study of Gateway are not uncommon or unusual, suggesting some potential for wider application.

In addition, the analysis of the case studies identified a diverse range of participant and stakeholder experiences; we found that interviewees were able to reflect on both experiences that had gone well – and difficulties from which they had learned. Rich and varied information was therefore gathered about the personal experiences of participants

[3] See Chapters 1 and 2 of Pawson and Tilley (2007) *Realistic Evaluation* (London: Sage) for a full discussion of this issue.

along the establishment of paraprofessional services, or participants' 'journey' to employment.

Finally, although the total numbers of interviewees was small, there was sufficient breadth of coverage to identify the key thematic issues that overlapped between the three paraprofessional services that were studied. Future studies could build on this review by considering a longer-term approach where larger cohorts of paraprofessionals of different types are tracked.

3 THE BROADER CONTEXT: A REVIEW OF POLICY AND LITERATURE

This section presents the findings from the review of policy and research literature on paraprofessionals. It identifies the rationale to the use of paraprofessionals and how this relates to the major trends affecting the NHS workforce. The section begins by setting out a broad context in relation to the policy and funding environment, before moving on to describe a set of possible benefits and practical issues in the use of paraprofessionals.

3.1 The Policy and Funding Environment

While this report is not the place to undertake a through-going description and analysis of health and social care policy, it is nonetheless possible and useful to pick out some of the main themes and features of the recent developments in this area. Taken as such, and focusing slightly more upon healthcare, there has been:

A drive to improve quality

A decade ago, the health service was under-resourced relative to the services of most developed economies; this is no longer the case and spending on the NHS has more than doubled in real terms over this period. Having largely addressed the problems of accessing services through this significant increase in funding[4] (coupled with the use of national service frameworks and targets), the 2008 Next Stage Review, led by Lord Darzi, established quality as the organising principle for the future development of the NHS. By 'quality' Lord Darzi meant improvements in clinical effectiveness, safety and patients' experience.

"Improving quality will continue to be at the heart of everything the NHS does. Improvements will be led by NHS clinicians at the local level, based on what is best for the public and patients in their area."[5]

More recently, '*NHS 2010 – 2015: From Good to Great*' sets out the Department of Health's vision for the future of the NHS; this confirms Darzi's view that quality ought to remain the focus.

A focus on prevention

A critical area of focus for health and social care is to shift services onto a more preventative (as opposed to restorative) approach. This was set out in 2002 by Lord Wanless in the report *Securing our future health: Taking a long-term view*, who presented a vision for a 'health' service instead of a 'sickness' service. This was re-affirmed in the 2008 Next Stage Review:

"Every primary care trust will commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations."[6]

We return to this issue below in relation to the change in financial context and the 'QIPP' (Quality, Innovation, Productivity and Prevention) agenda, but here we note that the rationale for this focus has been around the more optimal use of resources – that by focusing more on prevention and early intervention, there ought to be a consequent fall in the use of more expensive restorative services. On this reading, prevention represents an

[4] NHS spending increased from about £35bn in 1997 to £103bn in 2009/10.

[5] Darzi (2008) *High Quality Care for All – NHS Next Stage Review Final Report.* London: Department of Health

[6] Ibid

important route to productivity – helping people to stay healthy as well as reducing their use of NHS services, to save resources.

An increased emphasis on choice, competition and personalisation

Choice, competition and personalised care have been central mechanisms used by government to drive improvement for patients. These mechanisms were used by Conservative administrations in the 1990s, and came back into vogue from around 2004/05. Various commentators have written on this issue, for example Christopher Ham notes in 'Health Policy in Britain' (2004):

"…there is no doubt that the wheel had turned, if not full circle, then at least part of the way back to new Labour's 1997 inheritance."

Some have cited this as the biggest transformation in NHS history (Kings Fund, 2006) and the result has been a shift towards a model delivered by a variety of localised independent and voluntary organisations, with a greater focus on more patient-centred model which involves patients in discussions and decisions about their own health.

For example, as the White Paper *Our Health, Our Care, Our Say* (2006) argued, by giving patients a greater say over the way they receive health and social care services, they ought to benefit through being more engaged in their own care, more likely to stick to appropriate treatments – and with money (through individually-held budgets) following the patient - commissioners and providers are more likely to respond to patients' wishes. In essence, the intention behind these policies has been to try and apply the disciplines and benefits of a free-market system to health and social care services[7].

A concern with health inequality

In the UK, the lineage of policy to improve the health of the poorest in society can be traced back into the Industrial Revolution[8] and the 1848 Public Health Act. Understanding has evolved through a series of key enquires, reports, and policy papers[9]; but, in essence the key issue has remained the same: poorer people die sooner and suffer more ill health than wealthier people.

It is worth noting that many of these interventions have been outside of the mainstream 'health' policy area and 'joining-up' across policy domains and their respective government departments has been an essential feature of this government's approach[10]. Addressing these problems therefore requires careful targeting of services and a multi-faceted approach (perhaps based upon prevention, as set out above).

A desire to deliver care closer to home and to have better health / social care links

Partly in response to demographic challenges (an aging population with an increased prevalence of long-term conditions) and rising 'consumer' expectation, moving care 'closer to home' was a major theme of the 2006 White Paper *Our Health, Our Care, Our Say.* The emphasis here is on approaches such as: improving the use of community services,

[7] The evidence for the effectiveness of these polices is, to date, at best ambiguous; see Civitas (2010) *The impact of the NHS market: An overview of the literature*

[8] See, for example, Edwin Chadwick's 1842 *Report on the Sanitary Condition of the Labouring Population of Great Britain*.

[9] See *The Black Report* (1980); *The Health Divide* (1987); *The Acheson Report* (1998); *Saving Lives: Our Healthier Nation*, and *Our Healthier Nation: Reducing health inequalities* (both 1999); *Tackling Health Inequalities: Summary of the 2002 Cross Cutting Review* (2002); *Securing Our Future Health: Taking a Long-Term View* (2002).*Tackling Health Inequalities: A Programme for Action* (2003); and the recent work of the '*Post-2010 strategic review of health inequalities*' (the Marmot Review).

[10] For examples in more recent government policy, see the work of the Social Exclusion Unit and its successor the Social Exclusion Task Force.

increasing the range of services available in community settings, improving facilities in local communities, and making use of assistive technologies (to support care at home in some cases). Overall, the approach is to design care pathways that reduce the use of hospital settings; the aim is to make more effective use of resources and provide care in a more personalised fashion.

This theme also ran through the Next Stage Review. The commitment here was for the NHS to support this shift in resources by providing capital investment to build new community hospitals, polyclinics and other settings where patients can access a range of care (as well as, potentially, other local services they may need).

There has also long been a focus on the links / divides between health and social care systems. Patients may come to professionals with one particular problem, and resources are distributed accordingly, but in fact these may be as a result of multiple issues which need to be addressed equally. For example, a health issue may be linked to housing, finance and/or poor diet. These links have received additional scrutiny recently in the July 2009 Green Paper *Shaping the Future of Care Together*, and also through the possibility of efficiency gains through the better integration of health and social care provision; although there is evidence to suggest that the greater use of choice, competition and a mixed market of providers (see above) introduces greater transaction costs between individual organisations[11].

3.2 Specific Workforce-Related Issues

The above summary of broad policy trends has a series of implications for the health and social care workforce. In relation to the NHS, the Next Stage Review noted that:

"Just as patients deserve high quality care, so NHS staff deserve high quality work. If frontline staff are going to focus on improving the quality of care provided by the NHS, they need the right working environments and the right training and education."[12]

And the King's Fund gives some notion of the scale of the challenge:

"The NHS in England employs approximately 1.3 million staff and the independent sector a further 0.5 million, giving a total workforce of 1.8 million spread across more than 1,000 separate employers. The supply pipeline to the health care workforce is significant, with more than £4 billion spent annually on staff training. Given the shift towards more integrated working between health and social care, it is interesting to note that the social care workforce is of a similar size, at 1.4 million, but distributed over a much larger employer base – estimated at around 35,000 separate employers."[13]

There is therefore a particular need to invest in a change of workforce skills in health and care services in response to the policy direction set out above. However, there are also a number of challenges and difficulties in doing so; for example:

There is an upcoming 'retirement bulge' in the current workforce

Over the next decade it is widely anticipated that 150,000 of the 1 million NHS staff (15%) nationwide are set to retire, which will leave a large skills gap. Indeed, a national survey of 23,000 GPs showed reported that one in four intended to retire between the ages of 55 and 57, and that eight in ten would retire before they are 60 years old[14]. In addition to this, it is reported that around two thirds of South Asian GPs who came to the UK in the 1960s were set to retire before 2007, leaving some areas with a loss of one in four of their GPs (ibid).

[11] Civitas (2010) op cit

[12] Darzi (2008) *High Quality Care for All – NHS Next Stage Review Final Report.* London: Department of Health

[13] Kings Fund (2009) *NHS Workforce Planning: Limitations and possibilities*

[14] White, C (2002). *Ageing workforce will exacerbate NHS staffing crisis*. BMJ, 325 (7377):1382

A report by the King's Fund (2002), *Great to be Grey*, states that to prevent this 'staffing crisis' a more sensitive and imaginative approach to encouraging older staff not to leave earlier than planned is needed, and that the key to this is to tackle some primary drivers for seeking early retirement which include: increased workload; compromises to the quality of the patients' experience brought about by a lack of time to reflect on practice, to provide support and to train up junior colleagues; and, a lack of staff[15].

Reductions in funding (and the QIPP agenda) may dominate other reforms

Between 2004 and 2008 the NHS pay bill rose by £7.5 billion (35%)[16] and salary costs represent a very significant part of the overall cost of the health service. As the Health Foundation's 2006 report *'Value for money in the English NHS: Summary of the evidence'* notes:

"...since 2001/02, an average of £5.7 billion each year extra has been spent in the NHS. Of this, 43 per cent has been spent on extra staff, activity and drugs, 33 per cent on pay rises, 18 per cent on additional expenditure and staff training and 7 per cent on increases in prices and negligence costs."

The NHS briefing *Leading the NHS workforce through to recovery* (NHS Employers, 2009) reports that the NHS is set to go through some very lean times in the next four to five years as a result of the economic downturn, where there is likely to be zero growth in the NHS budget, if not cuts to overall spending. The service will be looking to make around £20bn in savings between 2011 and 2014 (ibid) so a focus on creating a more efficient and flexible service will be a priority – especially given that (by most measures) productivity has fallen as resources have increased.

There is a need for greater flexibility and improved planning

At national level, the problems of skills shortages, and consequent need for changes in skill mix and improved planning have long been noted[17]. More recently, it was noted in *The House of Commons Health Committee report* (2007) that in response to slow funding growth the NHS needs a more productive and flexible workforce that can efficiently meet the health service requirements of the future. This need was repeated by the *NHS Workforce Planning: Limitations and possibilities report* (2009) which suggested that greater workforce flexibility is needed which could mean *"new working patterns, new ways of working, new work locations and new roles"* (c.f. Imison et al, 2009[18]). In essence, the significant additional investment in the NHS (which makes these jobs more attractive) has come after a protracted period of underinvestment[19] (which made these jobs less attractive) and has thereby led to skills shortages in some areas[20].

[15] Meadows, S (2002). *Great to be Grey: How can the NHS recruit and retain more older staff?* London: Kings Fund

[16] Kings Fund briefing note: http://www.kingsfund.org.uk/topics/workforce_and_professionalism/#background

[17] See, *inter alia*, Department of Health (1999) *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare* and Department of Health (2002) *HR in the NHS Plan: more staff working differently*

[18] Imison, C., Buchan, J. & Xavier, S. (2009). *NHS Workforce Planning: Limitations and Possibilities.* London: Kings Fund.

[19] Department of Health (2010) *The NHS Quality, Innovation, Productivity and Prevention Challenge: an introduction for clinicians*

[20] See the Royal College of Midwives 'Evidence to the NHS Pay Review Body 2008' and the 'Return to Practice' programme for midwives as one response to this problem in the area of maternity services.

At regional level, in the West Midlands *Investing for Health*, the regional strategic framework for health services[21], stated that, *"training can be used to move tasks and skills down the skills escalator so that highly-skilled staff may concentrate on more complex care"*. As part of the implementation of this strategy, 'Investing for Health' *Project 9: Workforce Transformation*[22] has been developed to produce a suitably trained and equipped workforce that is flexible enough to adapt to meet these challenges. The project is important in order to plan and deliver the necessary the large scale workforce and skills changes.

3.2.1 A Change in Financial Context and the 'QIPP Agenda'

Lastly in relation to the broader environment, it is crucial to note the change in funding context. Between the second half of 2007 and the middle of 2008, a serious crisis in the financial sector and the subsequent public 'bailout' left the UK's public finances in serious deficit and the economy in recession. Reducing this deficit means reducing the resources available to all public services, including health and social care.

To date, the UK's public services have been largely protected from cuts in funding, but the 2009 Pre-Budget Report marked a change here. The challenge facing the NHS has also become clearer: 2010/11 is the final year when the NHS will see a growth in funding; thereafter, for the foreseeable financial future, growth will be zero or close to it[23]. The NHS Chief Executive has cited total necessary savings of £15-20bn and the 2009 Pre-Budget Report announced savings of around £10bn a year for the NHS, to be delivered by 2012-13. In August 2009, in a letter to the most senior managers of the NHS, the Chief Executive of the NHS, David Nicholson, described the funding constraints facing the NHS as:

"…the most important challenge facing the NHS for the foreseeable future."

The letter is clear that the approach to addressing this challenge is to be achieved primarily through improved Quality, Innovation, Productivity and Prevention (QIPP). This choice of approach has further been recognised through the 2010-11 Operating Framework for the NHS and also in the recent five-year strategy '*NHS 2010 – 2015: From Good to Great*'. These issues and approaches are likely to frame the development and delivery of health and social care services for the short and medium term.

3.3 Possible Benefits to using Paraprofessionals (and associated issues in their use)

Having set out some of the main features of the wider policy environment, we now turn to consider the use of paraprofessionals. We do so by summarising some of the themes raised during the stakeholder interviews conducted as part of this study, backed by the main findings from a brief review of existing literature. These are presented as a set of possible benefits and related issues; namely that paraprofessionals might offer:

a) A greater ability to serve the hard-to-reach and address health inequalities

Stakeholders reported that paraprofessionals are most appropriate where there are high levels of social need and where health inequalities are a particular problem. For instance, specific social problems (e.g. alcohol or substance misuse, mistrust and disengagement with services, domestic violence) can be difficult barriers for clinicians to overcome in order to engage effectively with their patients (for reasons of time, knowledge and expertise).

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[21] See in particular the annexes in the strategy on workforce planning in *Investing for Health. A Strategic Framework for the West Midlands. Appendix 12: Investing for the Workforce 2007 – 2012*

[22] Investing for Health. Project 9: Workforce Transformation. http://ifh2.westmidlands.nhs.uk/ifh-projects/workforce-transformation.html. Last accessed 1st January 2010.

[23] Kings Fund & Institute for Fiscal Studies (2009) *How cold will it be? Prospects for NHS funding: 2011–17*

These needs influence the ability of multiply disadvantaged groups to access health services, and the challenges faced by 'mainstream' services to address these needs could thereby exacerbate health inequalities. For clinicians, solving such problems and referring onto appropriate services – knowledge of which often lies outside their core area of expertise – can take up large amounts of time and is unproductive. Stakeholders cited this as providing a rationale for paraprofessionals with good generic skills in family or social support, who have specialist knowledge of disadvantaged communities and local services that can support them.

Uta and Christopher (2006, 461) support this view and also note that paraprofessionals brought with them qualities such as *"enthusiasm, positive expectations, openness to innovative strategies, knowledge and position in the community, and lack of the professional role and technique armour which often distances the helper from the client"*[24], that made them better able to carry out certain roles in the community. This view is supported by Mackenzie (2006), which notes that paraprofessionals' ability to communicate with hard-to-reach beneficiaries was an important factor in their favour[25].

Dawson et al (2007) noted that the paraprofessionals they examined often forged highly effective partnerships with health visitors as result of them bringing insight into the community from which they were recruited[26]. In Gateway's case, the ability to speak community languages was also thought by stakeholders to be critical to using paraprofessionals in Birmingham – as professionally-led services found it difficult to respond to the rapidly changing needs of disadvantaged (and sometimes transitory) populations.

b) Improved quality of services

As the policy review above noted, effective preventative services rely heavily upon the development of multidisciplinary teams and joined-up working between health and social care teams - recognising that most patients have numerous health and social issues that cannot be dealt with by a single service. Stakeholders interviewed also noted this issue, citing a role for paraprofessionals in spanning this gap, as well as often having a wide knowledge and understanding of available services.

Use of paraprofessionals could also therefore be considered as a means of enhancing the quality of services, rather than solely being about improved productivity. Some of the literature supports this, providing evidence for impacts on clients' 'soft' outcomes and satisfaction with services. For instance, Rosenberg et al (2002) and Vogler et al (2002) point out that paraprofessional roles could lead to improved 'softer' outcomes through providing information and emotional support[27]. One such outcome was an improved rapport between services and the families that they worked with.

Increased satisfaction may also be due to paraprofessionals having greater time to devote to clients' or patients' needs. Dawson et al (2007, op. cit.) highlight that patients reported

[24] Uta, M. W. and Christopher, G. P. (2006). *Lessons from the Research on Paraprofessionals for Attendant Care in Children's Mental Health*. Community Mental Health Journal, 42 (5) p459-475

[25] Mackenzie, M. (2006). *Benefit or Burden: Introducing paraprofessional support staff to health visiting teams: the case of Starting Well.* Health and Social Care in the Community 14 (6), p523-531

[26] Dawson, S., Morris, Z. S., Erickson, W., Lister, G., Altringer, B., Garside, P. And Craig M. (2007). *Engaging With Care. The Nuffield Trust Empowerment Among Paraprofessionals Within Human Service Organizations*, Administration in Social Work,30 (1) p95 — 115

[27] See Rosenberg, S. A., Robinson, C., & Fryer, G. E. (2002). *Evaluating paraprofessional home visiting services for children with special needs and their families*. Topics in Early Childhood Special Education, 22(3), 158–168 and Vogler, S. D., Davidson, A. J., Crane, L. A., Steiner, S. J., & Brown, J. M. (2002). *Can paraprofessional home visitation enhance early intervention services delivery?.* Journal of Developmental and Behavioral Pediatrics, 23(4), 208–216.

higher satisfaction levels with the service they received when paraprofessionals gave them treatment, perhaps as a result of the longer consultation time and additional needs being met in a more comprehensive, supportive and empathetic way than a professional perhaps has the time to do. They also note that in some cases paraprofessionals uncover previously untreated conditions. Paraprofessionals are generally chosen for their emotional competences and their ability to empathise with patients. Newton (2000) states that personal and interactional skills such as empathy and interpersonal warmth, flexibility and the ability to be firm without being controlling, are more important than educational background and credentials when recruiting paraprofessionals[28].

However, the practical challenges faced in attaining these benefits are also important and the relationship between paraprofessionals and clinicians is a central factor here. Removing ambiguity from paraprofessional roles was also thought by stakeholders to be very important to establishing trust with clinicians. One commissioner mentioned that paraprofessionals need to be clearer about "*what they ought not to do"* when engaging with clinicians. Newton (2000) stressed the importance of good communication between professionals and paraprofessionals in order to maintain clear role definitions. Furthermore, both Pazaratz (2000a, b)[29] and Vance (2002)[30] stated that in general, training is an important part of defining the paraprofessional role, in order to create clear boundaries that prevent them from falling into roles of therapist, crisis worker or parent. These points are summarised by Walter and Petr (2006)[31] in their review of the literature as follows:

"With respect to the roles and responsibilities of paraprofessionals, the literature indicates that these are characterized by high flexibility ranging from monitoring and accompanying children, providing concrete services, to lending emotional support or efforts to teach new skills. Paraprofessionals' tasks tend to change over time and according to field, program and individual client. This flexibility in roles and responsibilities is at once an advantage and a difficulty. At best it grants a versatility that allows the tailoring of a paraprofessional's role to a specific program or individual. At worst the ambiguity leads to confusions and tensions between involved parties, overwhelms paraprofessionals, or alienates the paraprofessional from his or her work."

Mackenzie (2006, op. cit.) also notes the challenges of relationships between clinicians and paraprofessionals. Specific issues here relate to: the challenges of 'managing across organisations' (clinicians employed within the NHS, paraprofessionals by a voluntary / community sector organisation); clarity around the paraprofessional role; the threat posed to traditional roles; and the problems of assuming that individual clinicians would have a commitment to the philosophy of widening participation.

Some studies extend this point by noting that clear boundaries need to be set up between paraprofessional and patient. Dealing with clients' emotional needs may lead to paraprofessionals requiring high levels of support themselves and advice on maintaining clear boundaries. For instance, Noelker (2001) states that both paraprofessionals and clients may experience the negative consequences of developing relationships that are too

[28] Newton, N. A. (2000). *Issues in in-home psycho-social care*. In N. A. Newton, & K. Sprengle (Eds.), *Psychosocial interventions in the home* (pp. 38–66). New York : Springer

[29] Pazaratz, D. (2000a). *Training youth workers in residential settings*. Residential Treatment for Children and Youth, 18(1), 35–56.

Pazaratz, D. (2000b). *Youth worker job description and self-evaluation compendium*. Residential Treatment for Children and Youth, 18(1), 57–74.

[30] Vance, J. E. (2002). *Mentoring to facilitate resiliency in high-risk youth*. In Burns, B.J. & Hoagwood, K. (Eds.), *Community treatment for youth* 139–153 New York : Oxford University Press

[31] *Lessons from the Research on Paraprofessionals for Attendant Care in Children's Mental Health* Community Mental Health Journal, Vol. 42, No. 5

close, such as emotional distress and lack of personal time[32]. Mackenzie (2006) supports this view from a case study of paraprofessionals working alongside health visitors; the study suggests that the problem of maintaining 'professional' boundaries was especially pronounced amongst paraprofessionals who were themselves 'vulnerable'.

However, empowering paraprofessionals is also important: some studies point to a lack of acceptance by professionals[33]. Wallack and Mueller (2006) found that peer support and working collaboratively with supervisors to clearly set out key tasks, goals and responsibilities lead to paraprofessionals becoming more empowered, which can be associated with more effective practice, diminished role stress, innovation, job satisfaction, organizational commitment and performance[34].

Stakeholders and commissioners interviewed stated that where clinicians had 'bought into' the benefits of using paraprofessionals, relationships were effective and referrals were high. The importance of supportive individuals was frequently emphasised. As well as developing good relationships with senior managers, working with middle managers to persuade them of the potential that using paraprofessionals could bring to their services was thought to be important. Often, this was described as a joint responsibility, between Gateway and its commissioners. Feeding back more data about ('harder', clinical) outcomes to frontline clinicians was thought to be important; other stakeholders thought that GPs in particular would always be difficult to work with – even as practice-based commissioners, they have a 'menu' of options for different local services that they can call on for their populations and there may be few systemic incentives for them to engage with paraprofessionals.

Finally, another important and related issue raised by stakeholders was clinical governance systems. For instance, one stakeholder said that integrating paraprofessionals into patient group directives might be a good way to persuade clinicians that paraprofessionals are working appropriately, although this might lead to the (possibly) undesired effect of making paraprofessionals more 'clinical' than 'social' in their focus.

c) Improvements in efficiency / productivity

As noted elsewhere in this section, there is an increased policy and funding imperative for more productive services. Several stakeholders raised this issue as being an important part of the reason for considering the use of paraprofessionals. They noted that there are many elements of professionals' roles that could be performed equally competently (and more cheaply) by a paraprofessional; this therefore provides an opportunity to buy the same outcomes for a reduced cost and / or greater outcomes for the same cost[35].

Yet the evidence on this point is ambiguous. This is noted in Mackenzie (2006), which cites the opportunity to 'backfill' as staff move up the skills escalator in response to higher-level skills shortages as a key part of the rationale for using paraprofessionals; although the study also found examples of the displacement (rather than reduction) of cost, with some health visitors seeing an increase in their management responsibilities. Dawson et al (2007), also suggest that it is not clear whether the introduction of paraprofessionals decreases professional workloads and calls for further research; one possible reason was that paraprofessionals may uncover previously unidentified conditions or problems, which

[32] Noelker, L. S. (2001). *The Backbone of the Long Term Care Workforce*. Generations. 25 (1) p85-91

[33] Brawley, E.A., and Schindler, R. (1988) *The front-line paraprofessional in social development: An international perspective*

[34] Wallach, V.A., Mueller, C.W. (2006) *Job characteristics and organizational predictors of psychological empowerment among paraprofessionals within human service organizations: an exploratory study*, Administration in Social Work, 30(1), 95-113

[35] This is a line currently being pursued by Lord Nigel Crisp (ex-Chief Executive of the NHS) in thinking what the NHS workforce might learn from less developed nations; see Health Service Journal 25th March 2010.

then require the attention of professionals. Similarly, an article in Community Care[36] notes that the use of paraprofessionals in teaching may have increased teachers' workload through the increased line management responsibilities.

In summary, this is a difficult case to make convincingly either way. The rationale is compelling in theory, but the evidence from practice is ambiguous. Moreover, there are a very complex set of factors in play; chiefly that achieving this benefit relies upon:

- a strong and clear division of roles and responsibilities between professional and paraprofessional;
- good relationships between these two groups, which means that professionals' resistance to change / perceived erosion of 'their' roles must be surmounted[37];
- a weighing of the different costs of recruiting, training and retaining professionals in comparison to paraprofessionals; and,
- assumptions about likely staff turnover, relative effectiveness of services[38] and changes in management costs.

d) A younger and more diverse workforce

The challenge of the 'retirement bulge' in the current workforce is described above. One stakeholder in particular noted that the use of paraprofessionals may be an effective response to this issue. This would be in terms of developing new career pathways into the NHS so people with non-traditional backgrounds are recruited. This interviewee noted that organisations like Gateway can fulfil this role by recruiting people from local communities and training them in community development so that they can gain the skills and qualifications needed to be employed by the health and social care sector. This supply of workers would enable NHS organisations to utilise a pool of local people to supply their workforce of the future and therefore help to fill the workforce and skills gaps created by the mass retirement of older professionals. This view is supported in the literature by Mackenzie (2006), which also noted that voluntary sector organisations would be more likely (relative to the NHS) to succeed in this type of recruitment.

Supplementing this approach to delivering services that are patient-centred and locally led is the NHS widening participation agenda which both acknowledges that the development of skills is a key driver for success[39] and that there is a need for a more structured approach to developing these particularly for those who are employed in bands 1 to 4 in the NHS workforce[40]. Here employees are encouraged to develop their own skills and knowledge and thus move up the NHS 'skills escalator'. This agenda also seeks to be inclusive of underrepresented groups in communities such as, *"those on low incomes, those without qualification, the unskilled, part-time and temporary workers, older adults, those with literacy, numeracy or learning difficulties, disaffected youth and some minority ethnic groups"*[41].

[36] Hunter, M (2008) *Social care paraprofessionals feel out of their depth* Community Care, 9th April 2008

[37] An issue noted in The Scottish Government (December 2005) *Insight 25: The Role Of The Social Worker In The 21st Century - A Literature Review*

[38] In very broad terms, the evidence on the effectiveness of paraprofessional services is somewhat supportive, but generally ambiguous – see Walter and Petr (2006) op cit.

[39] Leitch, S. (2006) *Prosperity for all in the global economy- world class skills. Final Report*. London: HM Treasury

[40] Fryer R, (2006) *Learning for a Change in Healthcare* London : Department of Health found at http://www.wideningparticipation.nhs.uk/pages/framework.html

[41] Tight, M. (1998) *Education, Education, Education! The Vision of Lifelong Learning in the Kennedy, Dearing and Fryer Reports*. Oxford Review of Education 24, pp479-480.

Stakeholders noted that Gateway also aims to contribute to widening participation by ensuring that the local workforce is more representative of the local community. This approach is supported by Dawson et al (2007), which cites the creation of confidence and satisfaction in the community as the workforce is empathetic and understanding of their needs and difficulties; it also provides a fuller range of pathways into the sector (Mackenzie, 2006), where they do not initially have sufficient qualifications, or where they have relevant qualifications which are not recognised in the UK. Indeed Newton (2000) states that personal and interactional skills such as empathy and interpersonal warmth, flexibility and the ability to be firm without being controlling, are more important than educational background and credentials when recruiting paraprofessionals.

Lastly, two studies (Hunter, 2008; Mackenzie, 2006) note that use of paraprofessionals might help to stay the retirement of some older workers by offering support with tasks that paraprofessionals might be better suited for.

e) The NHS as a good corporate citizen and broader, societal gains

Stakeholders with strategic responsibilities for workforce development pointed out that paraprofessionals can play an important part in the widening participation agenda. Some of our respondents cited instances where previously low-skilled or economically inactive people had gone on to higher education or training to become a professional, as a result of working as a paraprofessional. This may have a significant impact on wider workforce development because it allows people with a wider set of competencies to enter professional work. Recruiting paraprofessionals can therefore contribute to NHS organisations' drive to reduce social exclusion and promote local jobs by enabling low-skilled people from vulnerable communities the opportunity to move up the skills escalator, a point emphasised by Mackenzie (2006).

Brawley and Schindler (1991)[42] summarise this argument as follows:

"...we need to continue to recognize that paraprofessional social service jobs are a way out of poverty, unemployment, underemployment and other forms of deprivation for large numbers of people around the world. Having recognized that, we must avoid the danger of maintaining paraprofessionals (most of whom are women and many of whom are members of disadvantaged minority groups) in marginal positions in society by locking them into low-status and low-paying jobs. Appropriate opportunities for advancement (promotion, better pay and other forms of recognition for increased skills and experience) must be provided if we are to live up to principles of social and economic justice."

In *Working for a healthier tomorrow* (2008) Dame Carol Black highlights that employers (and especially those in the public sector) are increasingly being asked to consider their corporate role in promoting health and drawing on the pool of disadvantaged people who are marginalised by the benefits system, and who, with the right support, could benefit from returning to work[43]. The NHS has a key role to play in this agenda, from changing the way that occupational health is practiced, to becoming aware of its social role as a major UK employer. From this point of view, it makes sense for employers serving disadvantaged areas to recruit and train locally, as demonstrated, for example, by the pre-employment programmes delivered by the Skills Academy for Health North West, and Gateway Family Services who seek to address health inequalities through a social enterprise model.

However, it is easy to overstate the value placed on this particular benefit; the debate on giving paraprofessionals their own career ladder towards higher bands in the NHS (so they can 'move up' without 'moving on') is far from settled. Based on the views of respondents

[42] *Strengthening Professional and Paraprofessional Contributions to Social Service and Social Development*. Br. J. Social Wk. (1991) 21, 515-531

[43] Black, C (2008). *Working for a Healthier Tomorrow*. London : Department of Health.

interviewed for this study, few of the clinical service providers and commissioner organisations seem to place particular value on the positive effect of paraprofessionals coming from disadvantaged communities and joining the NHS ‘skills escalator’. Stakeholders said that staff turnover (people being recruited and trained as a paraprofessional, but then moving on to further training / better paid employment) was typically viewed negatively, instead of looking at the numbers of paraprofessionals who had moved on to jobs in higher bands in different organisations.

For commissioners, widening participation may be important; but not as important as buying a stable, cost-effective service. Moreover, the incentives facing commissioners may lead them to consider the effectiveness of the services they commission in ‘isolation’ – gains to the health service or state more generally are not typically considered. This is arguably even more likely to be the case with practice based commissioners, and other types of micro-commissioner being created around the personalisation agenda (see above).

Lastly, and thinking about the full set of possible benefits listed above, it is vital to note that using paraprofessionals must be considered relative to some alternative. Their use need only be a practical (rather than theoretical) best option, since alternatives – such as the recruitment of additional midwives or health visitors – may (for reasons of labour market shortages / deficiencies in planning / specific issues facing local providers) not be available.

Having set out the broad policy context and summarised the rationale to the use of paraprofessionals, we are now in a position to consider the case of Gateway - to ask to what extent these theoretical benefits have been realised in practice and to see to what extent Gateway’s experiences can be described as ‘typical’. This is the subject of the next section.

4 GATEWAY FAMILY SERVICES – THE FINDINGS

The following section describes the case study of Gateway and the qualitative evidence for how its services are meeting the various expected outcomes.

4.1 Gateway's Six Outcomes

As noted in section 2, we used the information gathered during the scoping phase of interviews with Gateway staff and stakeholders to set out our understanding of the expected outcomes and how Gateway's activities are expected to produce, or contribute to, these outcomes. These broad outcomes were then used to structure the evidence by using them as a framework for reporting, as described below.

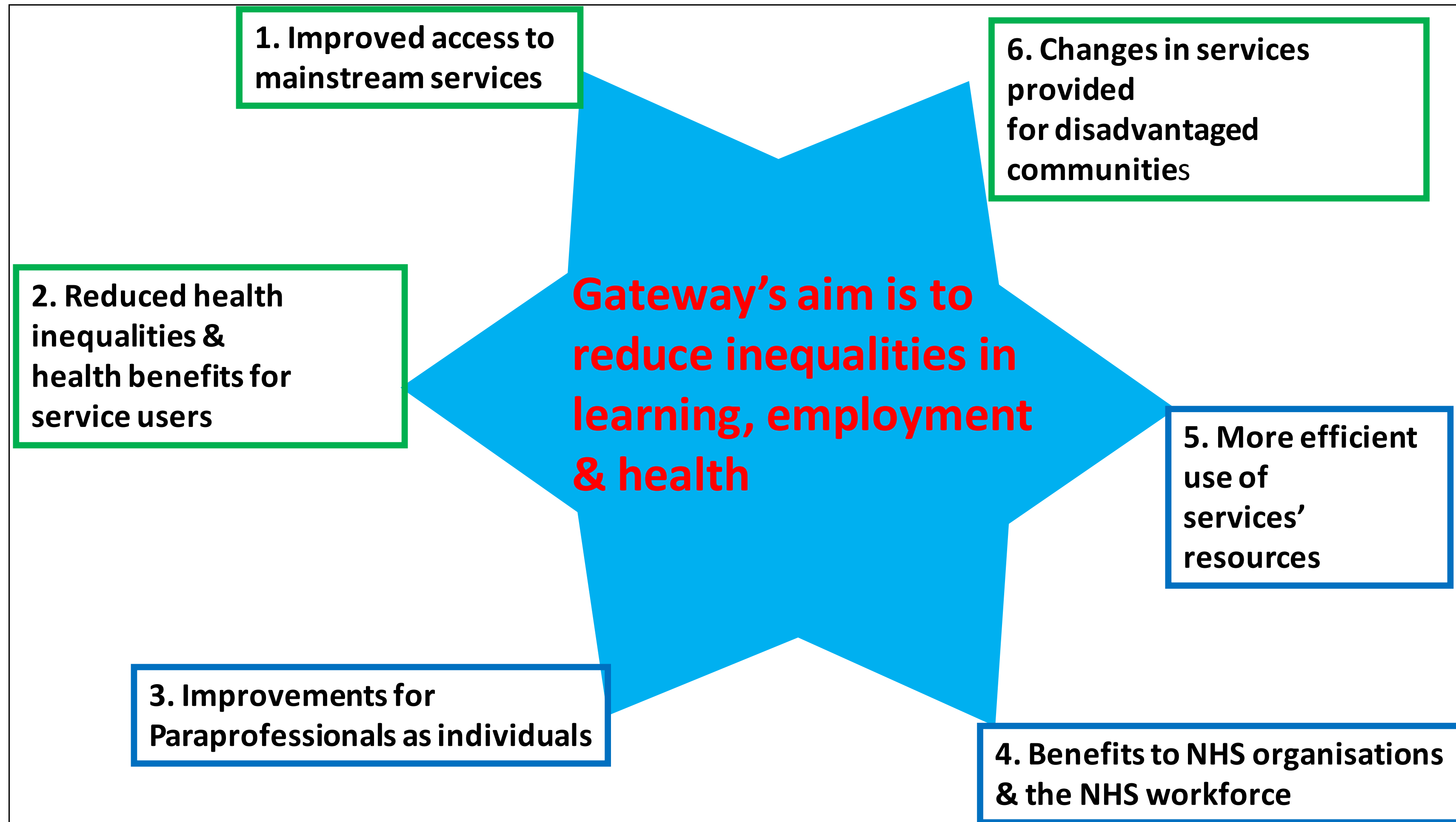
This is illustrated as a 'logic model' – which was refined and tested as the evidence below was gathered. A final version of this can be found at the end of this section. Such a logic model also helps us to frame the return on investment analysis (section 5).

The **six outcomes** that are used to structure this section are common to each type of paraprofessional; these are:

1) **Improved access to mainstream services for service users** (e.g. service users are referred to appropriate services as a result of paraprofessionals' intervention; service users have the skills and confidence to engage with mainstream services as a result of paraprofessionals' intervention);
2) **Reduced health inequalities and benefits for disadvantaged service users** (e.g. service users feel safer or less isolated; improvements in levels of physical activity / diet; reductions in smoking);
3) **Improvements for paraprofessionals as individuals** (e.g. paraprofessionals gain new skills and move up the skills escalator);
4) **Benefits to NHS organisations and the NHS workforce** (e.g. paraprofessionals contributing to a wider pool of shared skills and competencies in engaging with disadvantaged communities, or supporting professionals in their local area);
5) **More efficient use of services' resources** (e.g. clinicians are able to concentrate their time on clinical tasks more effectively as a result of paraprofessional support); and,
6) **Changes in services provided for disadvantaged communities** (e.g. commissioners alter service provision as a result of intelligence from paraprofessionals).

They are also illustrated in the diagram overleaf. Outcomes 1, 2 and 6 (shown in green) are those outcomes which are beneficial to service users and the wider public, while outcomes 3, 4, and 5 (blue) are those that are beneficial to paraprofessionals, service providers and the NHS.

Figure 4.1: The six key outcomes



We now take these outcomes in turn and consider the evidence gathered in relation to each one.

4.2 Outcome 1: Improved access to mainstream services

Improving access to mainstream services is seen by both paraprofessionals and the clinicians that they work with as a key part of the paraprofessional role. The paraprofessional is expected to signpost or refer clients to other services, which include not only mainstream health services, but also ESOL (English as a second language), housing and other services where relevant to the needs of the client. These onward referrals are generally monitored as part of Gateway's reporting to commissioners. An important part of the role is motivating and encouraging clients to access mainstream services, and helping them tackle barriers to access.

For instance, POWs offer support to clients with housing issues (e.g. helping clients to write letters to housing managers); accessing benefits; making clients aware that they have a responsibility to book their own anti-natal appointments; and helping clients in emergencies by helping them find the most appropriate care. POWs that we interviewed described how their clients were more likely to speak to them about particularly difficult social issues because they were seen as more empathetic, and this could lead to problems being identified at an earlier stage in pregnancy: "*there are things that [clients] really should be telling their midwives but they don't know how they are going to react…It's not that the midwives aren't nice, it's just that they are professionals"* (POW). POWs were then able to share this information with midwives: *"Mostly its practical [support] but sometimes it's emotional. And picking up things that the midwives might miss, like someone might say in a clinic that their nan has died today, and you might speak to the midwife afterwards and she'll say 'oh she never mentioned that'. They tend to divulge different things to them than to us. That happens a lot"* (POW).

Some of these issues are unlikely to be picked up by other professionals, whose focus is necessarily on the clinical aspects of pregnancy. Paraprofessionals interviewed thought this was because they were able to build up a relationship with their clients, which was seen as more supportive. As one midwife said, "*in addition to the pregnancy, often there are financial, ESOL, housing, mental health - stress and depression – and DV [domestic violence] issues to deal with. The women do not necessarily come to the midwife with these issues*". Nevertheless, close cooperation between clinicians and paraprofessionals was considered to be an important success factor in getting the most appropriate help for clients' multiple and complex needs: "*If you've got somebody who has got housing and finance problems they are likely to be depressed as well, [and then I have to consider whether] she needs to be assessed clinically, does she need to be referred, who's the most appropriate person to be referred to. So there's all those things"* (Midwife).

Understanding minority languages and cultures is seen by both paraprofessionals and the clinicians as critical to paraprofessionals' role in improving access. Language barriers are seen by clinicians as a major barrier to engaging with services: *"the main problems that I will refer patients [to the POW] for is because [their] first language isn't English as this disadvantages the patient. With the POW going they can at least direct the patient to English classes"* (Midwife).

Besides tackling issues of language and communication with clients, paraprofessionals may also have a greater understanding of cultural barriers to health and be able to promote good health in a culturally sensitive manner, as a children's centre worker that had worked with a Size Down worker stated: *"[the Size Down worker was] excellent at their role, very flexible with delivery and had a lot of knowledge which catered for vegans, vegetarians and non English speaking people".*

Although Gateway keeps good records of the numbers of clients that are referred onto other services, it is still difficult to know the exact degree to which paraprofessionals'

intervention has led to long-term outcomes (such as reduced depression, or quitting smoking) because the paraprofessional is the first step in a longer process of engagement for the client. This is an important consideration when considering the return on investment and the extent to which outcomes can plausibly be said to have been ‘because of’ the paraprofessional service (see section 5). In addition, the Gateway referral data indicates that there are variations between local areas in Birmingham, but interviewees attributed this to local factors – such as the level of engagement between clinicians’ managers and POWs, and the different ways in which the paraprofessional services were promoted. For instance, one POW stated that about half of the midwives that she worked with *“really embraced the service…and always return [my] calls”*, while the others were dismissive.

4.3 Outcome 2: Reduced health inequalities and benefits for disadvantaged service users

Notwithstanding the issue of attributing long-term health benefits to the actions of paraprofessionals, evidence from the interviews pointed to shorter-term benefits for disadvantaged clients with complex needs.

Emotional or social support is the most important and obvious additional benefit of paraprofessional support. Motivating a client to think about their behaviour and explaining good health in terms that clients can understand was viewed as a key part of the intervention by paraprofessionals themselves: *“[What Health Trainers do is] essentially getting the service put over to the client and explaining the four areas that we work in which is diet, alcohol, smoking and physical activity. [We provide] a support network – we give the client the support and the motivation to make these changes and to show that it doesn’t have to big changes; it is simple changes that will lead to a better lifestyle really” (Health Trainer).*

Paraprofessionals will usually tailor the frequency of their visits around clients’ needs; in the case of POWs, there seems to be a great deal of emotional support to help clients deal with isolation, depression, or other mental health issues (which in turn led to the POWs monitoring their boundaries carefully): “*in other cases, [we are] a shoulder to cry on as well, even a friend almost, whilst keeping it, as much as we can, professional”* (POW). This function of paraprofessional support was also viewed as important by clinicians: *“I had a patient a few months ago who was feeling a bit low and was having no end of problems. She didn’t really want a professional dressed person going into the house, but she thought a person without a uniform going in [would] perhaps talk to her and [the client would be able to] share her concerns with her”* (Midwife).

Health Trainers also gave many examples of clients whose confidence had increased, and said that this was the key factor behind the behaviour change: *“I think it’s…mainly getting people out and about. A lot of the time people know what changes they need to make but they need somebody to tell them, and that’s what we’re doing… just supporting and motivating people, sometimes people just need a bit of a confidence boost and that’s what our service has done”* (Health Trainer).

The impact of this emotional support is hard to quantify[44] as it is only recorded in the case notes. It should be noted also that some of the paraprofessionals did not always feel trained to deliver it and neither is it viewed as a key outcome by Gateway’s commissioners. Nevertheless, paraprofessionals thought this was an important part of establishing a successful relationship that would enable them to tackle other issues.

Paraprofessionals are viewed as an important part of the team by clinicians where multiple lifestyle issues that contribute to a health problem may need to be addressed at the same

[44] Although this is necessary for the purposes of estimating a return on investment (which, moreover, then requires a proxy monetary value); see section 5 for our approach to this.

time: *"Anything that improves [clients'] outcomes, whether it's housing or financial, it's a whole picture - without it they are very isolated"* (Midwife).

Paraprofessionals were also viewed by clinicians as being more approachable and therefore able to provide care that was holistic – an important element of this was paraprofessionals being able to take the time to listen to clients' concerns (for instance, an 'average' community midwife will have a caseload of 90 clients[45]; a POW will have approximately 30). Health trainers also noted that in a short GP consultation, there is not the time for lifestyle issues to be addressed – whereas Health Trainers are able to spend an hour (and sometimes longer) with their clients at the first meeting. This gives them an opportunity to empathise with the client, and while the Health Trainers' highlighted enthusiasm and professionalism as being important qualities needed for the role, shared experiences and interests were also important too as Heath trainers are knowledgeable about what is going on in the community: *"they realise that you are part of the community so it's an easy communication"* (Health Trainer).

Likewise, community workers working with Size Down workers stated that part of the reason for their effectiveness was their ability to explain the importance of wider habits and eating adjustments to having a healthy weight: *"the course offers their services users small tips on changing their cooking, looking for healthier options, being aware of the salt content of the food they eat, cutting down on snacks and portion sizes and watching carbohydrates. They even showed their users how to do basic exercises whilst watching TV… the course wasn't just about losing weight, in some instances it was about gaining weight too, as well as giving energy and improving people's outlook on life"* (Children's centre worker).

Finally, both clinicians and paraprofessionals thought that an important success factor for the relationship between paraprofessional and client was continuity of service – for instance, clinicians generally thought it made a big difference if the same POW saw their client all the way through. Both GPs and midwives thought it was helpful if the paraprofessional that had 'recruited' the client continued to offer the service: "*Most women would tell you that, they'd hate seeing someone else. You are vulnerable when you are pregnant anyway so when you have got a named contact it's a positive thing"* (Midwife).

4.4 Outcome 3: Improvements for paraprofessionals as individuals

There are also benefits for paraprofessionals that are also benefits to wider society. For instance, some of Gateway's paraprofessional workforce are purposely recruited from disadvantaged groups in order to fulfil the requirements of Gateway's contracts with employers. This is the case with the group of learners in Stoke that we interviewed as part of this study; they were a group of people undertaking pre-employment training with Gateway that were unemployed, and had a number of other barriers such as low skill levels or a lack of formal qualifications that excluded them from potentially being employed in the NHS.

However not all paraprofessionals are recruited from disadvantaged groups per se, and for POWs and Health Trainers, they considered it unlikely that they would have been unemployed. For instance, some were educated to degree level. Nevertheless, the paraprofessionals that we interviewed saw a job with Gateway as being a route into working in healthcare or as a way to fulfil a chosen career goal (e.g. working with people) that could not be easily obtained by any other route: "*It was really good of Gateway because not many people want to give people who don't have much work experience a job, so I think that's where Gateway have done really well, it's given people lots of opportunities to work"* (Health Trainer).

[45] This can be contrasted with levels recommended by Birthrate Plus, which is a maternity-specific workforce planning tool and recommends a ratio of one midwife for every 29.5 women as the minimum standard necessary to achieve one-to-one care in established labour.

Therefore although it is not possible to argue that Gateway's recruitment always reduces unemployment, it can be said that employees' skills are now more relevant to health and social care as a result of working in Gateway. In general, learners and employees gain new skills and knowledge through their work; some gain qualifications and while they are with Gateway, employees have opportunities to progress; moreover, some of the POWs that we interviewed were studying for a foundation degree in family support work.

Recruits' reasons for applying to Gateway were varied. Reasons given by the learners at the focus group in Stoke included:

- *"I've got a long gap in my experience because I'm a single parent… I want to do level 3 here [and'] get my foot in the door at the NHS"*
- *"I was made redundant in January after working for 15 years. I found it very difficult because of my age to get another job, I have no qualifications either… I was looking for an admin job in health… my advisor through the Job Centre put me through to Gateway and I was lucky enough to get it"*
- *I've been unemployed for about three and a half years. I took time out to look after my child, getting back into work wasn't as easy as I thought"*
- *"You can move around within the NHS. With some organisations if your job goes than there's nowhere to move to because they've got nowhere else to go but with the NHS you can move around"*
- *"I know someone who's worked in the NHS and she's always raved about how much she enjoys the job and how good it is. She got quite high up after starting in an admin role. She's done NVQ's and stuff"*
- *"It's a people contact thing for me really. All my work has been customer facing"*

Paraprofessional employees had similarly varied reasons for wanting to work for Gateway: *"I like the idea of reaching out to people that maybe wouldn't have the resources to come in for counselling themselves"* (POW).

Good line management was seen by the paraprofessionals as an advantage of working in Gateway; this seems to be an important success factor: *"In every one-to-one we are always asked if there is any training we require or if there are any problems. We are always given the opportunity to say 'I'm finding this difficult could you please help me', so the opportunity is always there"* (Health Trainer).

4.5 Outcome 4: Benefits to NHS organisations and the NHS Workforce

Both paraprofessionals and commissioners thought that paraprofessional services helped to widen participation in employment to non-traditional groups (by giving experience to people who might be overlooked – as described above).

Paraprofessionals at Gateway can and do move on into NHS employment. There is a high staff turnover at Gateway, which some human resources staff attributed to employees being recruited from disadvantaged communities. For instance, annual staff turnover in the Health Trainer service varied from 7% to 40% a year[46]. However, many paraprofessionals move on to other careers in the NHS – for instance some went into nursing training or became paramedics – because as the service design currently stands, paraprofessionals hit a 'ceiling' and to fulfil their ambitions they move on. This means that, while there is a loss to the paraprofessional service itself, there are wider benefits to local NHS organisations – as they benefit from a wider pool of skilled, local people from whom they can potentially recruit (and indeed, as pointed out above, NHS employment is the ultimate objective for some).

[46] By way of comparison, the Information Centre non medical workforce census turnover statistics of all Non Medical staff in England for 2007-2008 showed an average leaving rate of 8.5%.

For example, as one Health Trainer stated: *"I've been in a very similar position for three and a half years… I'm happy with what I'm doing, I'm happy with the management and the team and everything and I get on with everyone, so I want to stay but then… I can't see any progression at the moment or any other options, then that kind of forces me to look elsewhere".* Gateway therefore clearly plays a role in supplying the local labour market with skilled staff.

One of the questions for the study was to examine the possibility that paraprofessionals might also change clinicians' skills or competences through working with them. We did not find any evidence of this with the group of paraprofessionals in this study. However, Gateway's paraprofessionals do work autonomously from clinicians and they do bring other benefits to clinical care (see below).

4.6 Outcome 5: More efficient use of services' resources

While noting real ambiguity in the evidence, the literature noted that paraprofessionals may help to 'save clinicians' time'. From the interviews that were carried out with clinicians, there is some limited evidence of this; moreover the Health Trainer team consider that they do reduce use of GP services.

However it seems that in general, clinicians mostly valued paraprofessionals because they brought additional benefits, and increased the quality of care – rather than relieving them of specific tasks. Paraprofessionals also enabled clinicians to make better use of the short time that they had with each client.

Midwives were particularly clear about POWs being able to take care of issues that were important for the standard of care, but which fell outside of their core remit. For instance, as one midwife stated: "*if you'd have come to me and asked me what I want and needed I would have come up with a role like a POW. They take a lot of pressure off us as we are supposed to be delivering a holistic service but we don't have time. It means now when I get those issues it's nice to be able to say [to the client] look here's a POW, and then they can work with me".* Or as another midwife said, *"there's a limit to what I can do; I have to stop somewhere so I can't get very involved in housing issues, benefit issues, asylum seekers, so I have to signpost. So they're taking that pressure off me in a 15 minute consultation; it makes life easier for me to do what I'm trained to do".* One midwife also said that POWs helped to take the pressure from families and carers too: *"They [POWs] are also able to go along with the woman to the hospital which is really appreciated by the women. In some cases the woman may need to go to the hospital once a week and that's a hell of a commitment for a family or partner to give"*.

To an extent, it can be argued that paraprofessionals may be filling a gap in existing services – for instance, all of the midwives and GPs that we spoke to talked of the lack of time that they had in consultations, and the midwifery service was particularly short-staffed: *"[there is] quite a demand on the midwives' time as they have to deal with a large number of issues such as helping with breastfeeding, smoking cessation, safeguarding issues, signposting, mental health, support with young children etc. The POWs alleviate this up to a point"* (Midwife).

4.7 Outcome 6: Changes in services provided for disadvantaged communities

While the benefits for clinicians and clients of paraprofessionals have already been described above, there is little evidence from the interviews carried out to suggest that paraprofessionals are leading to wider cultural changes in the way that mainstream services are delivered or the ways in which service planning takes place (making them more tailored to the needs of disadvantaged communities and people with complex needs).

More often than not, paraprofessionals depend on clinicians to make referrals into their services. Unless paraprofessionals are doing their own recruitment through outreach, they are still dependent on the skills / willingness of clinicians to refer to them. However Gateway

have been developing methods of reaching out directly to people that are most in need: for instance through 'community mapping' and generating referrals in the community. This has led to POWs setting up local steering groups with clinicians in certain parts of Birmingham, so that they can explain the service in person to midwives and inform them about what is taking place. Moreover, by responding to an invitation to tender, Gateway in effect co-designed the POW role; thereby substantively influencing the services provided, which also evolved through close working with the original commissioner[47].

Finally, working together with clinicians on a face-to-face basis was also thought to be beneficial by both paraprofessionals and clinicians, and it helped to break down professional barriers and improve communication: *"She [the POW] has a room and she see's almost everyone that I see, so when they are waiting she'll see them [the clients] or I'll introduce her. She'll then come and talk to me about them, we have quite a close liaison. I just wish she was here more".*

4.8 A Theory of Change for Gateway

Having set out the findings from our research with paraprofessionals and clinicians, we can set out a 'theory of change' for Gateway's paraprofessional services. This is illustrated as a 'logic model', which can also help us to begin the production of a return on investment analysis (see section 5).

4.8.1 Definitions used

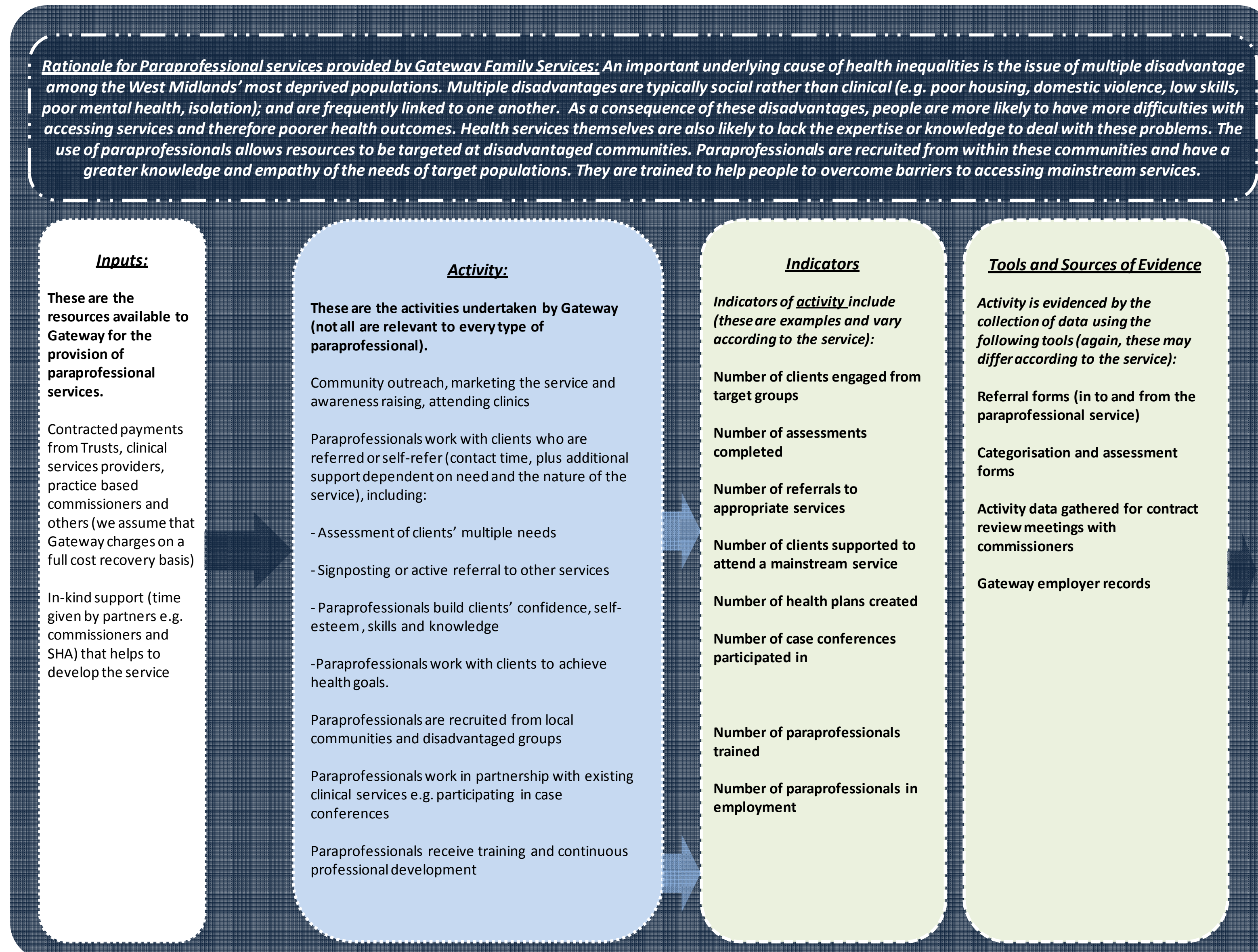
Inputs: These are the resources available to Gateway for the provision of paraprofessional services. These are essentially the costs of delivering the service, as well as the external support received (from partners and commissioners) which contribute to the development of the paraprofessionals' services. Inputs illustrate the full 'cost' of purchasing the activities provided by Gateway.

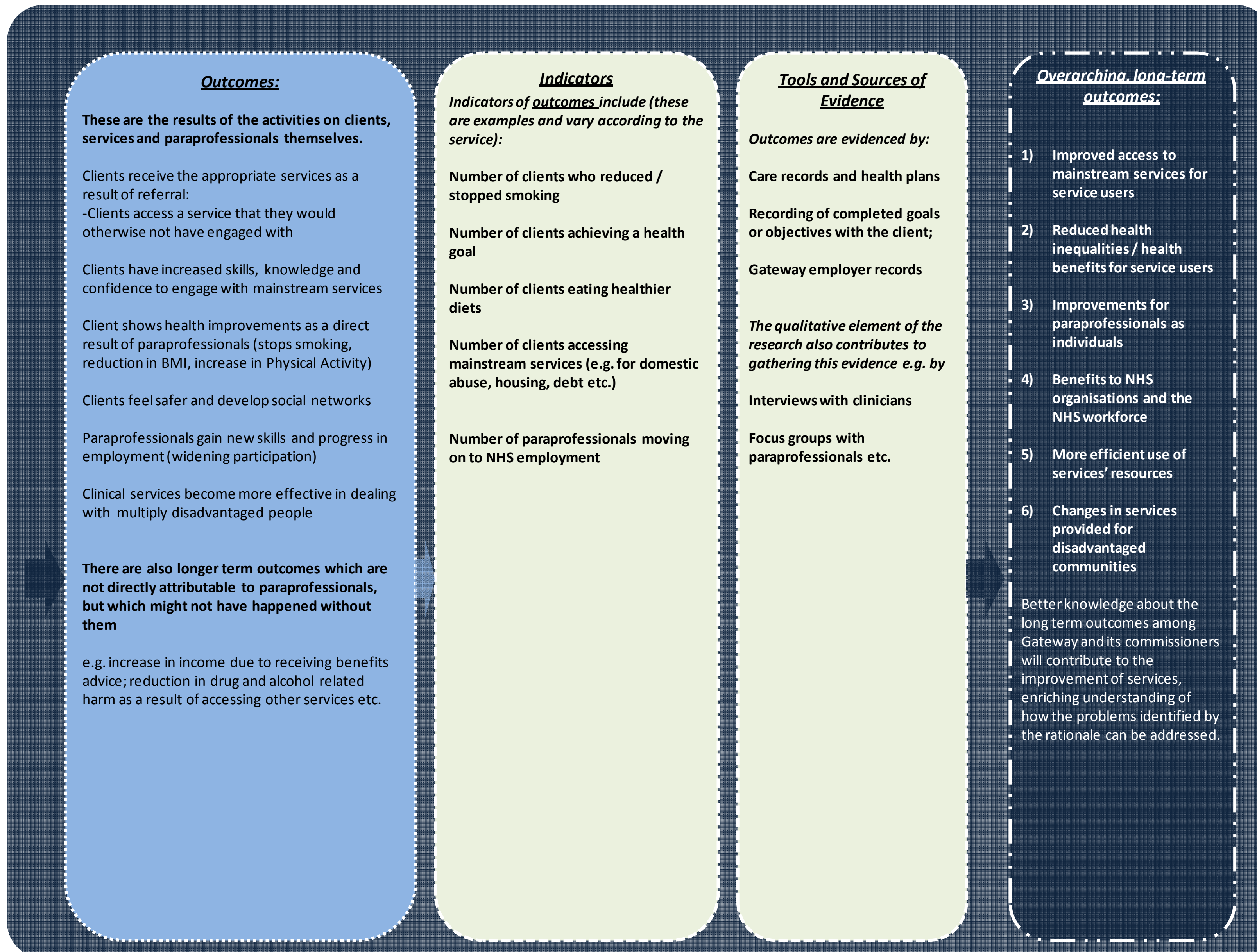
Activities: These are the activities undertaken by Gateway. Our list is not exhaustive and as the list is meant to reflect all the different types of paraprofessional together, not all are relevant to every type of paraprofessional. As well as the activities provided to service users / clients, activities relating to the broader development of services and the paraprofessionals themselves are included. Mostly, NHS commissioners tend to commission by 'activity': in some cases this term seems to encompass both set throughput / output targets (e.g. numbers of specific interventions / numbers of beneficiaries); as well as short term outcomes. The Health Trainer targets are illustrative of this approach, as they allow providers to be paid against a mix of process targets or milestones (appointment of HT coordinator; number of HTs in post); what we would call activities (number of clients; number of assessments completed); and clinical outcomes (number of clients achieving goals). In our definition, activities are a description of what commissioners are buying; the effects of what they are buying are considered as outcomes.

Outcomes: These are defined as the results or effects of the activities on clients, services and paraprofessionals themselves. Some will be common to all paraprofessional services; others will be specific to one type of paraprofessional. As activities or interventions will affect individual clients in different ways, not all clients, services or paraprofessionals will experience the same outcomes. Therefore, in the return on investment analysis, attribution will need to be considered, as in some cases it will not only be the paraprofessional service alone that contributes to a positive outcome for a client (for instance, the paraprofessional refers to a domestic abuse service, which then removes the client from the violent situation). In this case, the indicators tell us about progress towards, or the achievement of an outcome.

[47] This was documented in GHK's evaluation of the Reducing Infant Mortality Programme: http://www.bhwp.nhs.uk/AssetLibrary/Infant%20Mortality/IM%20Evaluation%20-%20Phase%202%20Report.pdf (p.7)

Figure 4.1: A Theory of Change for Gateway




Outcomes:
These are the results of the activities on clients, services and paraprofessionals themselves.
Clients receive the appropriate services as a result of referral:
-Clients access a service that they would otherwise not have engaged with
Clients have increased skills, knowledge and confidence to engage with mainstream services
Client shows health improvements as a direct result of paraprofessionals (stops smoking, reduction in BMI, increase in Physical Activity)
Clients feel safer and develop social networks
Paraprofessionals gain new skills and progress in employment (widening participation)
Clinical services become more effective in dealing with multiply disadvantaged people
There are also longer term outcomes which are not directly attributable to paraprofessionals, but which might not have happened without them
e.g. increase in income due to receiving benefits advice; reduction in drug and alcohol related harm as a result of accessing other services etc.
Indicators
Indicators of outcomes include (these are examples and vary according to the service):
Number of clients who reduced / stopped smoking
Number of clients achieving a health goal
Number of clients eating healthier diets
Number of clients accessing mainstream services (e.g. for domestic abuse, housing, debt etc.)
Number of paraprofessionals moving on to NHS employment
Tools and Sources of Evidence
Outcomes are evidenced by:
Care records and health plans
Recording of completed goals or objectives with the client;
Gateway employer records
The qualitative element of the research also contributes to gathering this evidence e.g. by
Interviews with clinicians
Focus groups with paraprofessionals etc.
Overarching, long-term outcomes:
1) Improved access to mainstream services for service users
2) Reduced health inequalities / health benefits for service users
3) Improvements for paraprofessionals as individuals
4) Benefits to NHS organisations and the NHS workforce
5) More efficient use of services' resources
6) Changes in services provided for disadvantaged communities
Better knowledge about the long term outcomes among Gateway and its commissioners will contribute to the improvement of services, enriching understanding of how the problems identified by the rationale can be addressed.

5 GATEWAY FAMILY SERVICES – A SOCIAL RETURN ON INVESTMENT ANALYSIS

This section provides an assessment of Gateway's work using a Social Return on Investment (SROI) analysis. It begins by setting out the main features of SROI – relative to other forms of economic analysis – before moving on to present the results of the exercise.

5.1 Social Return on Investment (SROI)

This sub-section sets out some of the main features and limitations of SROI.

5.1.1 What is SROI?

Economics views humans as creatures of unlimited want, constrained by the limited resources available to them. This situation is known as the 'economic problem'; from this problem flows the concepts of:

- trade-offs, where we have to decide upon a course of action from a range of competing alternatives; and,
- opportunity cost, where, by choosing, we forgo the value of the next best alternative.

The economic problem is ever-present in public policy. Decision makers have to work out how to achieve the greatest good with the finite resources available to them – i.e. to get the best possible value for the public purse. There are a range of means available to them in doing so (e.g. use of the political process), but one of the main means – and arguably the most rational one - is through the use of economic analysis.

This analysis comes in many forms. The most common of which are:

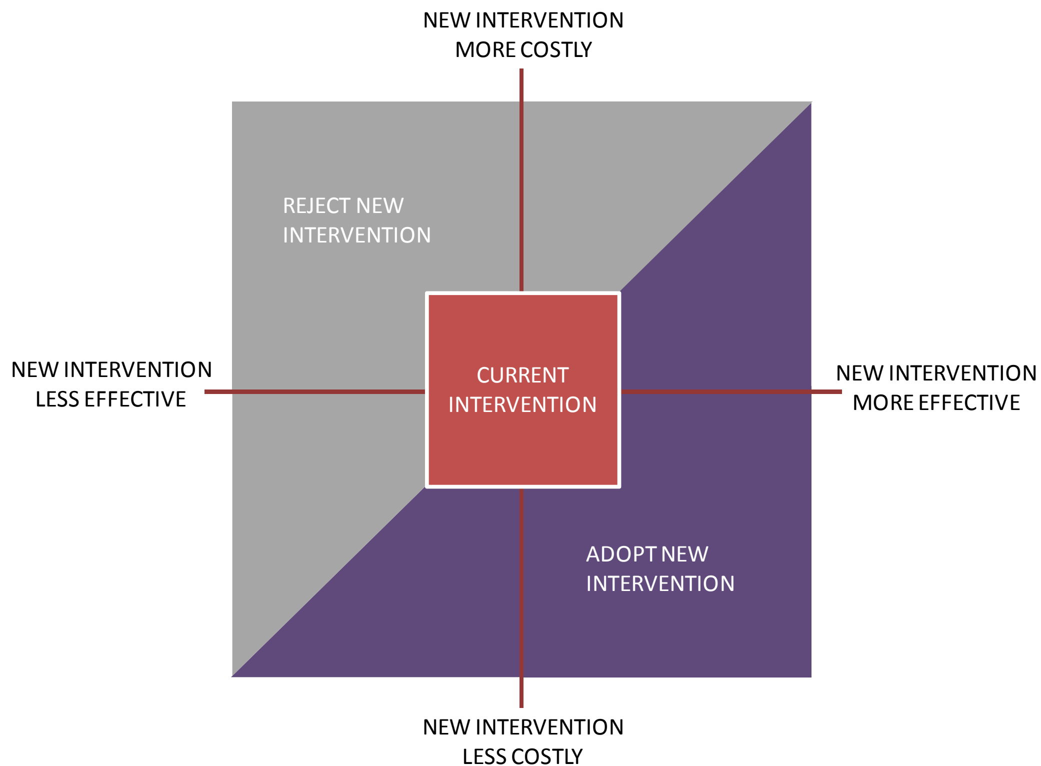
1) Cost-Effectiveness / Cost-Utility

These types of analysis measure costs monetarily, but benefits are measured in different units:

- For cost-effectiveness, benefits are measured in their natural units (e.g. lives saved, symptom-free days etc) and results are expressed as a cost per unit.
- Cost-utility analysis is an attempt to get around the challenge of having to decide upon the different types of benefit shown by cost-effectiveness studies. It uses a common measure of benefit – typically Quality Adjusted Life Years (QALYs). Results are then expressed as cost per QALY, and – theoretically – a wide variety of different interventions can then be compared to find the best use of resources. This has been the chosen approach of NICE in its health technology assessments.

Cost-effectiveness is framed by the cost-effectiveness plane (shown below), which offers a set of decision rules based around the two notions of cost and effect:

Figure 5.1: Basic Cost-Effectiveness Plane



2) Cost-Minimisation

In this type of analysis the effectiveness of the alternative interventions is assumed (ideally known) to be equivalent. Costs are measured monetarily and there is no consideration of benefits other than to show why they are the same. The aim of the analysis therefore is to show that the intervention in question achieves the same effects at lower cost – i.e. spending less for the same. So, if two interventions have the same effect on beneficiaries the optimal choice is the one with the lowest cost per beneficiary.

This type of analysis is likely to be attractive given the QIPP agenda (described elsewhere in this report) and would seek to place interventions in the bottom right quadrant of the cost-effectiveness plane.

3) Cost-Benefit

Cost-benefit analysis measures both costs and benefits in monetary terms. Results are then expressed as a ratio between costs and benefits. This has the advantage of not always needing a comparison in order to make an evaluative judgement, since if costs exceed benefits then the action should not be pursued.

The main challenge here is placing monetary values on intangible / ethically difficult benefits, e.g. lives saved, improvements in mental health, reductions in pain or symptom-free days. There is also an important issue in deciding upon the perspective to take in the analysis e.g.: should we consider them from one commissioner's / provider's perspective / the NHS as a whole / all public services? The state? Society as a whole? Very different answers can be gained by varying this perspective.

In essence, **SROI is a type of cost-benefit analysis**. The distinction made (typically by its promoters) is that it values a broader set of benefits than cost-benefit analysis would; but, for all theoretical and practical purposes, the distinction is a tight one. In the analysis that follows, we draw upon the Cabinet Office's 2009 Guide to SROI; it defines SROI as follows:

“Social Return on Investment (SROI) is a framework for measuring and accounting for this much broader concept of value; it seeks to reduce inequality and environmental degradation and improve wellbeing by incorporating social, environmental and economic costs and benefits...SROI is about value, rather than money. Money is simply a common unit and as such is a useful and widely accepted way of conveying value.”

5.1.2 What are its benefits? What are its limitations? How should it be used?

The main benefits of SROI are those of all types of economic analysis; chiefly that a decision maker has a more rational and informed means of allocating resources and making trade-offs between competing claims. This ought to lead to more optimal use of these resources (reduced opportunity cost) and better outcomes will be achieved for the resources consumed.

In common with the cost-benefit analysis, one of the results of a SROI analysis is a ratio showing the likely value of the return on the investment made. This provides some ‘at a glance’ reason for interest in the approach under consideration in that, as a minimum, if benefits exceed costs then there is a prima facie case for choosing that approach (if used prospectively) or continuing with it (if used retrospectively). Conversely, a more practical and immediate use would be to stop the activity if costs appear to outweigh benefits.

The arguably more distinctive benefit to SROI relative to other approaches is that it explicitly seeks to take account of some of the more ‘intangible’ social and environmental benefits than perhaps a more traditional cost-benefit appraisal would.

SROI’s limitations are therefore somewhat similar to those of other types of analysis (e.g. its reliance upon the strength of the evidence fed into the models used), but are in the main related to its key strength; notably that - because of the desire to include intangible and difficult-to-monetise benefits - it relies upon the use of assumptions, proxies and informed estimates. These are serious limitations: they render SROI necessarily indicative and certainly unscientific. Serious though these limitations are, they do not fatally undermine the case for SROI since we would still be left with (more) imperfect alternatives. Rather, a mature use of SROI is to minimise the use of assumptions (and be explicit and clear as to what they are), rely upon the most defensible (i.e. conservative) proxies available, and to use results alongside the clear health warning set out here.

5.1.3 How is a SROI analysis carried out?

In essence, and following the main steps in the Guide referenced above, the main stages of a SROI analysis are:

- Define the main costs and benefits (see the logic model in section 4 for our starting point for this);
- Value these costs and benefits (using proxies to place monetary values on intangible benefits);
- Decide upon a perspective for the analysis (usually a broad, societal, perspective is taken) and a suitable time period over which costs and benefits will be weighed; and,
- Conduct the analysis (including a sensitivity analysis, where the main assumptions used are varied to establish their effect on results) and report the findings, including all appropriate caveats and limitations.

Having set out the main features, strengths and limitations of SROI we are now in a position to apply this approach to the paraprofessional services offered by Gateway.

5.2 Headline Results of the SROI Analysis

We examined both the Health Trainer and POW paraprofessional services provided by Gateway, using a common approach to making assumptions about costs and benefits as described below.

The total value of the social impact *per WTE paraprofessional* for a year's investment is:

- for **Health Trainers, £162,000**;
- for **POWs, £105,000**.

This means that for the total investment in one paraprofessional, the following approximate returns are generated:

- for **Health Trainers, £4.80 for every £1 invested**;
- for **POWs, £3.20 for every £1 invested**.

These ratios are the results of dividing the total present social value generated, by a year's investment in each paraprofessional service.

It should be noted that the methods used in this report could be used for Size Down paraprofessionals also; but less data was provided by Gateway for the outcomes of this service. We have therefore focused on POWs and Health trainers in this section of the report.

5.3 Methodology and Assumptions Used

5.3.1 Overview

As noted above, SROI rests on giving the most accurate monetary value possible for the wider costs and benefits of a service or project. An SROI analysis may be a *forecast* or *evaluative* analysis:

- a forecast SROI looks at planned costs and attaches a value to anticipated benefits, with a view to deciding what data to collect in order to evidence those benefits. Therefore any calculation of social return is predictive and dependent on assumptions of the numbers of outcomes that might be achieved (for instance, by comparison with similar projects), as well as the use of financial proxies;
- evaluative SROI draws on analysis of data about outcomes, where the data has been collected in order to inform a calculation of social value. While still reliant on financial proxies, an evaluative method is more definitive than a forecast.

This study draws on elements of both forecast and evaluative SROI. We have analysed the existing data on outcomes provided by Gateway. However, this was mainly collected for the purposes of contract reporting, and in the form of 'snapshots' which we have aggregated in order to gain an overview of each paraprofessional service.

We also drew on the findings of the stakeholder and paraprofessional interviews in order to structure the analysis of outcomes, identify which stakeholders experience the returns, and inform our assumptions about the degree to which impact can be attributed to paraprofessional intervention and how long these impacts last.

The findings above have identified a number of economic and social outcomes of the programmes, such as:

- for paraprofessionals, e.g. increases in skills as evidenced by qualifications;
- for the State, e.g. reduced costs to NHS services because of improved health and better access to mainstream services, cost savings where previously unemployed paraprofessionals are no longer claiming benefits;

- for service users, e.g. improved health and wellbeing (especially mental health, through the emotional support given by paraprofessionals), and reduced spending on items harmful to health such as cigarettes (e.g. as a result of quitting smoking).

It can be seen that while some of these benefits are reductions 'hard' outcomes that have an obvious value (e.g. the value of skills gains can be monetised by looking at likely gains in income or the cost of such a qualification in market), other benefits such as the value of health gains are 'softer', and thus more difficult to measure with accuracy. We have therefore made **conservative assumptions** about outcomes based on the provided management information and exercised caution in the choice of financial proxies used (in order to prevent over claiming the social benefits) and the number of different outcomes (in order to focus on those that represent tangible impacts, and avoid the risk of double counting). Therefore the figures we have given in our 'base case' for social return should represent a conservative view of the likely value generated.

We have been transparent in our description of those assumptions (as described below), in keeping with the principles of SROI.

Finally, the timescales used for costs and benefits should be described at the outset. The convention we have adopted is that:

- **costs per paraprofessional for a full year** are used;
- the **benefits then accrue to all the service users that worked with paraprofessionals during the year** (i.e. the annual caseload). Some of those benefits are only realised once – while others last for longer (e.g. improved mental health); and
- to take account of benefits that endure over time, **we have assumed a horizon of five years** over which the present value of the social impact (i.e. its value to stakeholders at the current time) diminishes. Different SROI studies use a timescale of between two and 20 years for valuing benefits; we have used five years as this is relatively conservative.

There is more information about timescales and valuing benefits over time in the sections below.

Table 5.1 Key features of this analysis

Type of analysis	Social Return on Investment
Perspective	Broad, societal benefits across a range of stakeholders
Duration of costs / intervention considered	1 year
Duration of benefits	up to 5 years
Unit of analysis	value of outcomes per paraprofessional, per year
Key considerations	Deadweight and attribution Drop-off Net Present Value (at 3.5%)
Main factors (uncertainty) affecting results	Choice of proxies Value of proxies Caseload

The Cabinet Office (2009, ibid) Guide describes seven key principles of SROI. The table below describes these and the degree to which our methodology meets these standards:

Table 5.2 Key principles of SROI

Principle	Description
Involve stakeholders	Inform what gets measured and how this is measured and valued by involving stakeholders *We carried out detailed discussions with Gateway staff and stakeholders in the initial phases of this study in order to define the scope of the study and define the expected outcomes (see section 3 above)*
Understand what changes	Articulate how change is created and evaluate this through evidence gathered, recognising positive and negative changes as well as those that are intended or unintended *SROI recommends the use of a Theory of Change to map the impacts of the subject of research against the inputs. A Theory of Change for Gateway paraprofessionals can be seen in section 5 above.*
Value the things that matter	Use financial proxies in order that the value of the outcomes can be recognised. Many outcomes are not traded in markets and as a result their value is not recognised *We have highlighted the origin of the financial proxies used to value each outcome achieved by Gateway and used further assumptions about their reliability in order to give a conservative estimate of the total impact.*
Only include what is material	Determine what information and evidence must be included in the accounts to give a true and fair picture, such that stakeholders can draw reasonable conclusions about impact *Materiality is key to any accounting or auditing process. We have highlighted what we consider to be the material outcomes (i.e. those that can be clearly defined and distinct from each other) below so that we only value outcomes whose existence is the most likely.*
Do not over claim	Only claim the value that organisations are responsible for creating *We have been conservative in our assumptions and conducted a sensitivity analysis on the results in order to be sure that our results are as reliable as possible.*
Be transparent	Demonstrate the basis on which the analysis may be considered accurate and honest, and show that it will be reported to and discussed with stakeholders *We have set out the method for the SROI in this section of the report, in a step by step manner that can be understood.*
Verify the result	Ensure independent appropriate assurance *Although we have observed the ‘best practice’ literature in SROI methods, independent assurance of this report lies outside the scope of our brief.*

5.3.2 *How were the costs measured?*

The costs of the two paraprofessional services (Health Trainers and POWs) are based on the data given by Gateway. We added the total pay costs for a fixed number of WTE paraprofessionals claimed by Gateway in its main paraprofessional contracts, and added assumed percentages for overheads and other costs, based on estimating the amount claimed for these costs across all the relevant contracts. The costs are therefore assumed to be composed of:

- total pay costs for delivery staff (paraprofessionals, administrators, and programme managers)
- to which a cost is added for:
    - management (HR, chief executive time);
    - overheads (tax and NI);
    - training costs that are explicit in the contracts;
    - additional costs (cost pressures) that are NOT recovered by Gateway for interpreting and other expenses. The additional costs are based on interview evidence given by Gateway staff.

In order to give a fuller picture, we have also considered that there are likely to be additional costs associated with the time that clinicians liaise with paraprofessionals e.g. midwives take time to liaise with POWs; and this also has a cost attached. However we have assumed that the value of this is equal to the midwives' time saved through working with POWs (indeed those midwives that liaise most often with POWs are likely to be the ones that use them the most), or working more efficiently as a result of working with a POW, for which there is some limited evidence. Therefore no cost is given for this.

The costs of the paraprofessional services were then further broken down by the number of WTE staff to give a *cost per paraprofessional*. This is important because all the outcomes given are also valued per paraprofessional for ease of understanding.

The **cost per paraprofessional, per year** used is:

- £34,080 for each Health Trainer; and
- £32,500 for each POW.

We have also stated the annual 'active' caseload of paraprofessionals in the tables below, as this is a key assumption for calculating the **cost per client** and the number of outcomes. We have assumed that referrals which are inappropriate or from which no ongoing actions arise are *not* counted. Therefore, the caseload assumptions only take into account and assumed number of clients with personal health plans (for HTs) and clients that are booked with the POW (for POWs). These assumptions are based on the outcome data given by Gateway; they should represent an average of all the caseloads across the PCTs in which Gateway works, as the figures vary significantly between the different sites in which paraprofessionals work (as noted in section 5 above).

The **caseload assumptions** were:

- each HT works with 200 clients per year;
- each POW works with 50 clients per year.

5.3.3 *How were the benefits measured?*

Materiality of outcomes

Using the framework provided by the Theory of Change, the six defined outcomes of Gateway paraprofessional services, and evidence given by stakeholders and staff, the following ***measurable* outcomes** were defined for each paraprofessional service.

Each outcomes has an **indicator** which allows us to look up how many people are likely to have had gained an outcome. This allows us to assign, at a later stage, a total value per paraprofessional, per year, for each outcome.

The rationale for including each outcome is given in the tables below, in order to describe why we considered these outcomes to be material. Outcomes that were included are shown in bold; those that were excluded are shown in normal text.

Table 5.3 Outcomes and evidence included

Stakeholder	Outcome	Indicator	Rationale
Paraprofessionals	**New qualifications gained**	**Number of qualifications gained**	**The value of qualifications is a useful proxy of the added value of the skills that Gateway imparts to its paraprofessionals. Although we have included commissioners' contribution to training in the costs, they do not pay the full cost – the value of which they realise when paraprofessionals move into NHS employment**
	Increase in paraprofessionals' income	**Average increase in earnings (before and after employment with Gateway)**	**Given that part of the policy rationale for the use of paraprofessionals relates to disadvantaged groups gaining entry to the labour market, we have included average gains in income as a benefit. Data were derived from Gateway's HR records using a small random sample of employees.**
State	**Reduction in unemployment (all)**	**Number of previously unemployed people taken on by Gateway as PPs**	**If unemployed people are employed by Gateway, the State makes savings because of reduced unemployment and other benefits paid out; and recouping the taxes from employment. An estimate can be made of the number of previously unemployed paraprofessionals and the likelihood of their having found a job without Gateway's intervention.**
	Recruitment savings from paraprofessionals		NHS employers that employ former paraprofessionals experience the benefit of having a skilled pool of local labour from which to recruit. Although we know how many paraprofessionals do move on into the NHS, the benefit to Trusts is too diffuse to measure as the local labour pool is large.
	Reduction in GP appointments for public health (HT)	**Number of GP appointments that are replaced by the HT (to make 'health promotion' referrals)**	**We have assumed that because people are being supported by a Health Trainer that they would reduce their use of the GP. This is based on the views of those managing the service.**

Stakeholder	Outcome	Indicator	Rationale
Clients	Reducing alcohol consumption (HT)	Number of people with 'alcohol' as primary goal that achieve in full or part	Gateway management information shows the number of clients that wanted to reduce alcohol consumption and achieved this goal.
	Improving diet (HT)	Number of people with 'diet' as primary goal that achieve in full or part	Gateway management information shows the number of clients that wanted to improve their diet and achieved this goal.
	Increasing physical activity (HT)	Number of people with 'physical activity' as primary goal that achieve in full or part	Gateway management information shows the number of clients that wanted to increase physical activity and achieved this goal.
	Quitting smoking (HT)	Number of people with 'smoking' as primary goal that achieve in full / Number of women quitting smoking	Gateway management information shows the number of clients that wanted to stop smoking and achieved this goal (we have assumed that HT clients that reduce smoking do not receive a benefit that is significant enough to monetise – nor do we know the degree to which they reduced their smoking). For pregnant women, quitting smoking reduces the chances of their children suffering from jaundice or low birth weight (key factors in infant mortality)
	Reducing smoking (POW)	Number of women reducing smoking in pregnancy and reducing harm	There is a benefit from reducing smoking (and reducing harm to the foetus) during pregnancy, which we have assumed is less than the benefit of quitting.
	Women with improved English language abilities (POW)	Number of referrals to English classes or peer groups	A large number of POW clients are referred to English classes or other groups. There are likely to be significant economic benefits (e.g. access to employment) for clients learning English, even though the POW referral will only be a small part of the process (which we take into account in our other assumptions). The benefits of improving English language ability are also likely to endure.
	Increasing breastfeeding rates after birth (POW)	Number of referrals to Breast Buddies	Some POW clients are referred to breastfeeding support services – which has clear health benefits for the child in the months / years after birth, including a cost saving to the parent from not buying formula milk.
	Increasing uptake of antenatal care (POW)	Number of women supported to receive antenatal care	Early booking and facilitating access to antenatal care is one of the main roles of the POWs and key to reducing infant mortality.
	Increasing uptake of	Number of women with	A large number of POW clients have been referred to income maximisation sessions, which indicates that

Stakeholder	Outcome	Indicator	Rationale
	benefits (POW)	**evidence of income maximisation**	**they may not be receiving all the benefits that they are entitled to. The value of unclaimed benefits can be monetised (although we have to make assumptions as to how many women are not claiming their entitlements, and how much they are not claiming).** ***It should be emphasised that although this could be considered as a cost transfer (i.e. from a societal perspective, individuals benefit at the expense of the wider State, so the overall effect can be considered to be 'no overall change in value'); however, it can also be argued that there has been a gain in utility by this transfer (which must be the assumption of the policy), we have therefore included it.***
	Reducing housing problems (POW)	**Number of women supported with housing issues**	**A large number of POW clients have varied housing issues and POWs may help them with accessing services, writing letters and advocating on clients' behalf. The cost of housing problems can be monetised in the form of alternative visits from other professionals (although displacement effect on such services has to be considered at a later stage)**
	Reducing incidence of domestic violence (POW)	**Number of women that no longer live with domestic violence**	**A small number of women are removed from domestic violence (DV) as a result of POW intervention. DV has a high cost for individuals and services.**
	Improving diet (POW)	**Number of women referred to dietician**	**A large number of women are referred to a dietician. Obesity in pregnancy can lead to pre-eclampsia and other birth complications. As a result of accessing support that they would not otherwise have received until later in their pregnancy, women are also less likely to have an underweight and premature baby that requires paediatric intensive care.**
	Increasing social and emotional support and reducing isolation (POW / HT)	**Number of clients receiving support**	**All clients receive social and emotional support, as the interviews evidenced – the value of the benefit will vary according to the client so assumptions must be made about the social impact of this.**

The value of outcomes

Tables 5.4 and 5.5 overleaf show the descriptions of the indicators and financial proxies that represent the value (calculated in the right hand column on a per paraprofessional, per year basis) for each stakeholder, along with all the quantities achieved. The quantity of outcomes is illustrated:

- numerically, i.e. the number of outcomes for the service;
- as a percentage of the whole annual cohort; and
- for some of the quantities, further adjustments have been made to define the number of clients for which an outcome applies. These assumptions are made clear in the tables.

The assumptions on quantity are based on the management information provided by Gateway. In many cases they represent estimates or forecasts of the quantity of outcomes achieved, because the data gives quarterly snapshots (and outcomes vary from quarter to quarter) and because outcomes differ according to the client group in each PCT and the relationships that POWs have with local midwives, for example. For the POWs, we have used data from the Heart of Birmingham contract and assumed that these outcomes apply across the whole POW service. The figures given below for outcomes are based on the number of people that are estimated to have received an impact.

Additionally, we have used the numbers of outcomes gained with caution. For example, we have only counted the outcomes of Health Trainer clients that chose a particular issue (e.g. diet) as a health goal.

For **financial proxies**, various sources from the existing literature (e.g. NICE cost-effectiveness models, PSSRU) have been used. There are a number of types of proxy, for instance:

- actual increased income to the client through income maximisation, or cost savings such as quitting smoking;
- Cost savings or the *avoided cost* to health services (e.g. the cost of a complex delivery due to pre-eclampsia, or the costs associated with intensive care for premature births);
- Estimates of what would be the 'market value' of certain outcomes. This is the most difficult element of the valuation of benefits. There are a range of ways of getting these data (e.g. willingness to pay / accept studies) and one of the main approaches taken in this analysis is to use a form of 'revealed preference', by establishing what commissioners typically pay for a given outcome. For example, we use the cost of CBT as a proxy value for an assumed similar gain in mental health. This is done on the assumption that the value of the benefit is similar to the cost paid. In doing so, we recognise the potentially circular nature of this argument; nevertheless we consider these values to be the most defensible (and available) for this analysis.
- Value of staff time (e.g. the cost of a GP consultation).

The value of financial proxies and what health benefits they include / exclude also varies from study to study. We have been conservative in our choices to ensure that benefits are not over claimed. Finally, wherever possible we only included proxies that were derived from studies that could show the value of each impact on an individual, per-outcome basis. For instance, there are many studies which measure the cost of obesity to the whole of society, but it would be difficult to extrapolate the avoided cost to the local NHS from such figures. The reader should also treat the value of individual outcomes with caution; the value of each outcome is not intended to be contrasted to the value of others – rather it is the sum of value that is important in SROI.

N.B. For ease of understanding of the tables below, **green** cells show where assumptions have been made; **purple** cells show values which are calculated.

Table 5.4 The value of outcomes for the Health Trainer service

Outcomes	Indicator	Quantity	Quantity (any %)	Comments	Data source	Financial proxy	Source	Value per outcome	Total value per PP / year
New qualifications gained (HT)	Number of Health Trainer Level 3 quals gained	16 PPs			Gateway MI	Cost of externally purchased course	Typical cost of L3 HT Cert, taken from college websites	£250	£250
Increased Income (HT)	Average Increase in income (pre-post employment)	16 PPs		We have assumed an average increase in income per paraprofessional, based on a sample of HR records	Gateway HR Records	N/A	N/A	£2,100	£2,100
Reduction in unemployment (all)	Number of previously unemployed people taken on by Gateway as PPs		33% of all HTs = 5 HTs	Data suggests 1/3 were previously unemployed	Gateway HR Records	Cost of ESA (£64/wk assumed) + CT and housing benefits (c£70/wk assumed)	DWP Benefit Rates Guide, 2009; + assumption	£6,968	£2,299
Reduction in GP appointments for public health (HT)	Number of GP appointments that are replaced by the HT (to make 'health promotion' referrals)	4160 appt's saved		We assumed that each client would have made two appointments to see their GP	Interviews	Cost of a GP consultation (upper limit)	PSSRU 2009	£35	£9,100
Reducing alcohol consumption (HT)	Number of people with 'alcohol' as primary goal that achieve in full or part		53% of clients with this primary goal achieve	We assumed (based on management information) that 4% of clients chose this primary goal	Gateway MI - data snapshot, 2nd qtr 2009 (rounded figures)	Cost of voluntary sector residential rehabilitation for people who misuse drugs/alcohol. Assume that such a program is 1wk in length	PSSRU updated to 08/09 figures	£808	£3,426
Improving diet (HT)	Number of people with 'diet' as primary goal that achieve in full or part		72% of clients with this primary goal achieve	We assumed (based on management information) that 60% of clients chose this primary goal	Gateway MI - data snapshot, 2nd qtr 2009 (rounded figures)	Cost of or list at for one year per patient	NICE	£537	£46,397

Outcomes	Indicator	Quantity	Quantity (any %)	Comments	Data source	Financial proxy	Source	Value per outcome	Total value per PP / year
Increasing physical activity (HT)	Number of people with 'physical activity' as primary goal that achieve in full or part		56% of clients with this primary goal achieve	We assumed (based on management information) that 30% of clients chose this primary goal	Gateway MI - data snapshot, 2nd qtr 2009 (rounded figures)	Cost saving of getting a person 'active'	Swinburn 1998 in NICE, Modelling the cost-effectiveness of physical activity interventions	£88	£2,957
Quitting smoking (HT)	Number of people with 'smoking' as primary goal that achieve in full		41% of clients with this primary goal achieve	We assumed (based on management information) that 6% of clients chose this primary goal	Gateway MI - data snapshot, 2nd qtr 2009 (rounded figures)	Annual cost saving to the individual of not smoking 20 cigarettes a day	NHS Smoke Free Calculator	£2,200	£10,824
Increasing social and emotional support and reducing isolation (POW / HT)	Number of people given social and emotional support	2080		Each client with a personal health plan is given support	All clients with PHPs	Cost of one course of CBT	Layard 2006	£750	£150,000

Table 5.5 The value of outcomes for the POW service

Outcomes	Indicator	Quantity	Quantity (any %)	Comment	Data source	Financial proxy	Source	Value per outcome	Total value per PP / year
New qualifications gained (POW)	Number of FSW Level 3 quals gained	27 PPs			Gateway MI	Cost of externally purchased course	Typical cost of Nat Cert L3 H&SC	£2,000	£2,000
New qualifications gained (POW)	Number of FdA Family Support Quals supported	2 PPs			Interviews with POWs	Cost of externally purchased course	Typical cost of P/T FdA, internet search	£3,000	£222
Increased Income (POW)	Average Increase in income (pre-post employment)		50% of all POWs = 14 POWs	We have assumed an average increase in income per paraprofessional, based on a sample of HR records	Gateway HR Records	N/A	N/A	£2,800	£2,800

Outcomes	Indicator	Quantity	Quantity (any %)	Comment	Data source	Financial proxy	Source	Value per outcome	Total value per PP / year
Reduction in unemployment (all)	Number of previously unemployed people taken on by Gateway as PPs	7 PPs			Assumption (1/2 of HTs were previously unemployed)	Cost of ESA (£64/wk assumed) + CT and housing benefits (c£70/wk assumed)	DWP Benefit Rates Guide, 2009; + assumption	£6,968	£3,484
Quitting smoking (POW)	Number of women quitting smoking		2% of clients		Gateway MI - data snapshot of outcomes in HoB, 1st qtr 2009	Annual cost saving to the individual of not smoking 20 cigarettes a day	NHS Smoke Free Calculator	£2,200	£2,200
Quitting smoking (POW)	Number of women quitting smoking		2% of clients		Gateway MI - data snapshot of outcomes in HoB, 1st qtr 2009	Cost of all complications per smoking pregnant woman	Miller et al 2001, Birth and first-year costs for mothers and infants attributable to maternal smoking – cost originally in dollars	£910	£910
Reducing smoking (POW)	Number of women reducing smoking in pregnancy and reducing harm		6% of clients		Gateway MI - data snapshot of outcomes in HoB, 1st qtr 2009	Cost of all complications per smoking pregnant woman	Miller et al 2001, Birth and first-year costs for mothers and infants attributable to maternal smoking - cost originally in dollars; have assumed the impact is less	£910	£2,730
Women with improved English language abilities (POW)	Number of referrals to English classes or peer groups		9% of clients		Gateway MI - data snapshot of outcomes in HoB, 1st qtr 2009	Cost penalty of not speaking English in employment	20% of median female wage (ONS); the 20% 'pay penalty' is taken from Jongsung (2005).	£4,430	£19,935
Increasing breastfeeding rates after birth (POW)	Number of referrals to Breast Buddies		3% of clients		Gateway MI - data snapshot of outcomes in HoB, 1st qtr 2009	Annual medical cost of not breastfeeding v's breastfeeding	Ball and Wright (1999)	£300	£450

Outcomes	Indicator	Quantity	Quantity (any %)	Comment	Data source	Financial proxy	Source	Value per outcome	Total value per PP / year
Increasing breastfeeding rates after birth (POW)	Number of referrals to Breast Buddies		3% of clients	Healthy Start tokens are worth £3.10/wk. Assume that parents would otherwise spend £2 of this sum on formula milk.	Gateway MI - data snapshot of outcomes in HoB, 1st qtr 2009	Cost saving to parent of not purchasing formula, per child	Healthy Start website	£104	£156
Increasing uptake of antenatal care (POW)	Number of women supported to receive antenatal care		20% of clients		Gateway MI - data snapshot of outcomes in HoB, 1st qtr 2009	Cost saving from reducing infant mortality	Based on an assumption that early access reduces infant mortality by a 1000th; and the value of a 'statistical life' (Department of Transport, 2002 prices uprated to 2010 prices)	£140	£1,400
Increasing uptake of benefits (POW)	Number of women with evidence of income maximisation		35% of clients		Gateway MI - data snapshot of outcomes in HoB, 1st qtr 2009	Increase in weekly income	Assumption of £5 a week increase through update of tax credits, etc	£260	£4,550
Reducing housing problems (POW)	Number of women supported with housing issues		42% of clients		Gateway MI - data snapshot of outcomes in HoB, 1st qtr 2009	Cost saving of housing department informal intervention	DCSF Think Family Toolkit - assume PP intervention saves 3 other interventions from their LA	£180	£3,780
Reducing incidence of domestic violence (POW)	Number of women that no longer live with domestic violence		1% of clients	We have assumed that 1% of each POW's clients benefit from intervention; as the data given is already conservative and may underestimate the number of women that receive help	Gateway MI - data snapshot of outcomes in HoB, 1st qtr 2009	Cost of one domestic violence case	Australian Domestic and Family Violence Clearinghouse Topics Paper (2001). This is a one-off cost.	£55,000	£27,500

Outcomes	Indicator	Quantity	Quantity (any %)	Comment	Data source	Financial proxy	Source	Value per outcome	Total value per PP / year
Reducing the number of babies being treated in paediatric intensive care	Number of women with a baby that was born healthily (as opposed to needing intensive care). Premature birth due to underweight is the main reason for treatment.	2		The POW service is likely to save 2 babies per year (across the whole service) going to special care.	Evidence given by senior stakeholder	Total healthcare costs associated with one premature birth	Mangham, Petrou et al (2009), "The Cost of Preterm Birth Throughout Childhood in England and Wales" in Pediatrics Vol. 123 No. 2 February 2009, pp. e312-e327	£22,885	£1,695
Improving diet (POW)	Number of women referred to dietician		6% of clients		Gateway MI - data snapshot of outcomes in HoB, 1st qtr 2009	Cost of medical care in pre-eclampsia pregnancy including delivery	NICE paper on Weight Management In Pregnancy Economic Modelling Report	£9,952	£29,856
Increasing social and emotional support and reducing isolation (POW / HT)	All women given social and emotional support		100% of clients		Caseload	Cost of one course of CBT	Layard 2006	£750	£37,500

The calculation of impact

The calculations of the total value of impact for each outcome must take into account a further assumption: that of **deadweight and attribution**.

Deadweight and attribution refer to a number of phenomena which our model has taken into account:

- the measure of the amount of outcome that would have taken place if the activity had not taken place (e.g. some unemployed people would have found other jobs in health and social care);
- the extent to which the outcome was caused by agencies other than Gateway;

This is expressed as a % reduction from the 'gross' value of the outcome, resulting in the actual social **impact**. A zero reduction means that the paraprofessional / Gateway is entirely responsible for that outcome, and no other agencies were involved. A 90% reduction means that we judge, based on the available data about the intervention, that it is very likely to have happened without paraprofessional intervention, or that other agencies gave the greatest contribution to the achievement of that outcome.

Where there is a straightforward referral relationship that means that the client is accessing another service as a result of paraprofessional intervention, a 50% deduction has been made from value of outcome, to the final impact.

Table 5.6 Deadweight and the final impact of HT interventions

Outcomes	Indicator	Total value per PP / year	Deadweight (0=entirely due to PP intv'n)	Comment	Impact
New qualifications gained (HT)	Number of Health Trainer Level 3 quals gained	£250	0%	This would not have taken place without Gateway.	£250
Increased Income (HT)	Average Increase in income (pre-post employment)	£2,100	70%	Most of the paraprofessionals would have found other work.	£630
Reduction in unemployment (all)	Number of previously unemployed people taken on by Gateway as PPs	£2,299	70%	Most of the paraprofessionals would have found other work.	£690
Reduction in GP appointments for public health (HT)	Number of GP appointments that are replaced by the HT (to make 'health promotion' referrals)	£9,100	80%	Assumes that there is a HT contribution	£1,820
Reducing alcohol consumption (HT)	Number of people with 'alcohol' as primary goal that achieve in full or part	£3,426	50%	Referral to another service	£1,713
Improving diet (HT)	Number of people with 'diet' as primary goal that achieve in full or part	£46,397	50%	Referral to another service	£23,198
Increasing physical activity (HT)	Number of people with 'physical activity' as primary goal that achieve in full or part	£2,957	50%	Referral to another service	£1,478
Quitting smoking (HT)	Number of people with 'smoking' as primary goal that achieve in full	£10,824	50%	Referral to another service	£5,412
Increasing social and emotional support and reducing isolation (HT)	Number of people given social and emotional support	£150,000	80%	The Health Trainer group is generally considered by Gateway staff to have fewer emotional needs than the POW clients	£30,000

Table 5.7 Deadweight and the final impact of POW interventions

Outcomes	Indicator	Total value per PP / year	Deadweight (0=entirely due to PP intv'n)	Comment	Impact
New qualifications gained (POW)	Number of FSW Level 3 quals gained	£2,000	0%	This would not have taken place without Gateway.	£2,000
New qualifications gained (POW)	Number of FdA Family Support Quals supported	£222	0%	This would not have taken place without Gateway.	£222
Increased Income (POW)	Average Increase in income (pre-post employment)	£2,800	70%	Most of the paraprofessionals would have found other work.	£840
Reduction in unemployment (all)	Number of previously unemployed people taken on by Gateway as PPs	£3,484	70%	Most of the paraprofessionals would have found other work.	£1,045
Quitting smoking (POW)	Number of women quitting smoking (cost saving)	£2,200	50%	Referral to another service	£1,100
Quitting smoking (POW)	Number of women quitting smoking (pregnancy complications)	£910	50%	Referral to another service	£455
Reducing smoking (POW)	Number of women reducing smoking (smoking in pregnancy and reducing harm)	£2,730	50%	Referral to another service	£1,365
Women with improved English language abilities (POW)	Number of referrals to English classes or peer groups	£19,935	90%	Referral to another service. In addition most of the women would have improved their English without intervention, or accessed ESOL services themselves	£1,994
Increasing breastfeeding rates after birth (POW)	Number of referrals to Breast Buddies (health benefit)	£450	50%	Referral to another service	£225
Increasing breastfeeding rates after birth (POW)	Number of referrals to Breast Buddies (cost saving)	£156	50%	Referral to another service	£78
Increasing uptake of antenatal care (POW)	Number of women supported to receive antenatal care	£1,400	50%	Referral to another service	£700

Outcomes	Indicator	Total value per PP / year	Deadweight (0=entirely due to PP intv'n)	Comment	Impact
Increasing uptake of benefits (POW)	Number of women with evidence of income maximisation	£4,550	80%	Referral to another service; not all women will have unclaimed benefits	£910
Reducing housing problems (POW)	Number of women supported with housing issues	£3,780	50%	Referral to another service	£1,890
Reducing incidence of domestic violence (POW)	Number of women that no longer live with domestic violence	£27,500	50%	Referral to another service	£13,750
Reducing the number of babies being treated in paediatric intensive care	Number of women with a baby that was born healthily (as opposed to needing intensive care). Premature birth due to underweight is the main reason for treatment.	£1,695	50%	Referral to another service	£848
Improving diet (POW)	Number of women referred to dietician (pre-eclampsia avoided)	£29,856	80%	Referral to another service; and the high % reflects the difficulty of reducing weight in pregnancy	£5,971
Increasing social and emotional support and reducing isolation (POW / HT)	All women given social and emotional support	£37,500	20%	The POW client group is generally considered by Gateway staff to have much higher emotional support needs than the HT clients, in particular Category A clients	£30,000

Accounting for benefits over time

The final step in SROI analysis is to consider the value of enduring benefits over time. Such benefits might include benefits in mental health, the health benefit of being a non-smoker, and so on. Not all benefits accrue over time in this way, and it is important to make the distinction between one-off benefits and those that are longer-term.

We have assumed a horizon of five years over which some benefits continue. Different SROI studies use a timescale of between two and 20 years for valuing benefits; we have used **five years** as this is relatively conservative. Going further into the future, the benefits become less clear, because people's situations change and predicting the continuation of outcomes becomes more uncertain.

There are three important considerations with measuring benefits over time:

- **duration** – it is important to distinguish between one-off benefits, those benefits which a defined life (e.g. very few mothers will breastfeed a child for more than two years), and those which can be assumed to continue (e.g. the benefit of learning English);
- **drop-off**, which measures how outcomes deteriorate over time and is expressed as a percentage. For instance, the evidence base for the long-term impact of interventions to improve diet is poor, so we might assume a higher rate of drop-off for such outcomes; and
- **net present value (NPV)**, which is a way of expressing how to value future outcomes in today's currency; it is also expressed as a percentage. Even if there is no drop-off, people will always be 'willing to pay' less for a benefit that is postponed, as opposed to a benefit they can get in the present. NPV is a well-known concept in accounting and hence its value is fixed for the purposes of SROI and government accounting purposes by the Treasury at 3.5%.

Hence, it can be seen that in each future year, the value of social impact decreases. The total social impact (again, expressed in this study for each paraprofessional, per year) is the sum of the values of social impact in each year. This is seen in the example below:

Worked example of drop-off and NPV

The impact associated with the 'number of women with evidence of income maximisation' is measured by the assumed increase in income experienced by all the women in the care of a POW for the duration of a year.

- After deadweight and attribution, the **annual social value of this outcome is £910**.
- If we assume **a drop off of 60% and NPV of 3.5%**, the value in the second year is **£332** (36.5% of £910).
- The value in the third year is **£121** (36.5% of £332).
- The value in the fourth year is **£44** (36.5% of £121).
- The value in the fifth year is **£16** (36.5% of £44).

So the total social value of this outcome, over five years, is **£1,424, per paraprofessional, per year**.

The tables below list the duration, drop off and the final social value of each outcome for HTs and POWs.

Table 5.8 Duration, drop-off and the final social value for Health Trainer outcomes

Outcomes	Indicator	Impact	Duration (years)	Drop off	Comments	Total NPV (net present value) per PP
New qualifications gained (HT)	Number of Health Trainer Level 3 quals gained	£250	1	n/a	Health trainers do not do the same qualification year after year, so the benefit is a one-off	£250
Increased Income (HT)	Average Increase in income (pre-post employment)	£630	5	0%	Increase in income is likely to be an enduring benefit (even if HTs move on to be employed elsewhere)	£2,937
Reduction in unemployment (all)	Number of previously unemployed people taken on by Gateway as PPs	£690	5	10%	Very few people employed by Gateway would leave over time to return to unemployment	£2,635
Reduction in GP appointments for public health (HT)	Number of GP appointments that are replaced by the HT (to make 'health promotion' referrals)	£1,820	1	n/a	This benefit to GPs only lasts as long as the intervention (we have assumed, conservatively, that clients do not pay fewer visits to the GP in the future)	£1,820
Reducing alcohol consumption (HT)	Number of people with 'alcohol' as primary goal that achieve in full or part	£1,713	5	20%	20% represents the people who return to previous habits over time.	£3,497
Improving diet (HT)	Number of people with 'diet' as primary goal that achieve in full or part	£23,198	5	20%	20% represents the people who return to previous habits over time.	£47,354
Increasing physical activity (HT)	Number of people with 'physical activity' as primary goal that achieve in full or part	£1,478	5	20%	20% represents the people who return to previous habits over time.	£3,018
Quitting smoking (HT)	Number of people with 'smoking' as primary goal that achieve in full	£5,412	5	20%	20% represents the people who return to previous habits over time.	£11,047
Increasing social and emotional support and reducing isolation (POW / HT)	Number of people given social and emotional support	£30,000	5	50%	50% represents the people who return to previous level of mental health over time.	£54,856

Estimated total social value (rounded to three significant figures) = £162,000

Table 5.9 Duration, drop-off and the final social value for POW outcomes

Outcomes	Indicator	Impact	Duration (years)	Drop off	Comments	Total NPV (net present value) per PP
New qualifications gained (POW)	Number of FSW Level 3 quals gained	£2,000	1	n/a	POWs do not do the same qualification year after year, so the benefit is a one-off	£2,000
New qualifications gained (POW)	Number of FdA Family Support Quals supported	£222	1	n/a	POWs do not do the same qualification year after year, so the benefit is a one-off	£222
Increased Income (POW)	Average Increase in income (pre-post employment)	£840	5	0%	Increase in income is likely to be an enduring benefit (even if POWs move on to be employed elsewhere)	£3,916
Reduction in unemployment (all)	Number of previously unemployed people taken on by Gateway as PPs	£1,045	5	10%	Very few people employed by Gateway would leave over time to return to unemployment	£3,993
Quitting smoking (POW)	Number of women quitting smoking (cost saving)	£1,100	5	20%	Very few people employed by Gateway would leave over time to return to unemployment	£3,454
Quitting smoking (POW)	Number of women quitting smoking (pregnancy complications)	£455	1	0%	A complex delivery is a one-off cost.	£455
Reducing smoking (POW)	Number of women reducing smoking (smoking in pregnancy and reducing harm)	£1,365	1	0%	We have assumed there is no longer term benefit of reducing smoking vs continuing smoking	£1,365
Women with improved English language abilities (POW)	Number of referrals to English classes or peer groups	£1,994	5	0%	Once learned, English language skills should not deteriorate over time	£9,294
Increasing breastfeeding rates after birth (POW)	Number of referrals to Breast Buddies (health benefit)	£225	2	60%	Breastfeeding does not endure beyond two years and sustained breastfeeding is notoriously difficult to promote	£307
Increasing breastfeeding rates after birth (POW)	Number of referrals to Breast Buddies (cost saving)	£78	2	60%	Breastfeeding does not endure beyond two years and sustained breastfeeding is notoriously difficult to promote	£106
Increasing uptake of antenatal care (POW)	Number of women supported to receive antenatal care	£700	1	n/a	The value of a statistical life year is a 'one-off' proxy.	£700

Outcomes	Indicator	Impact	Duration (years)	Drop off	Comments	Total NPV (net present value) per PP
Increasing uptake of benefits (POW)	Number of women with evidence of income maximisation	£910	5	60%	The high drop-off assumes that people's benefit circumstances change frequently	£1,424
Reducing housing problems (POW)	Number of women supported with housing issues	£1,890	1	n/a	We have assumed that this benefit lasts no longer than the duration of the intervention	£1,890
Reducing incidence of domestic violence (POW)	Number of women that no longer live with domestic violence	£13,750	1	n/a	The avoided cost of a domestic violence case is a one-off cost (although this is being conservative and it can be argued that were the DV relationship to continue, multiple cases would have occurred)	£13,750
Reducing the number of babies being treated in paediatric intensive care	Number of women with a baby that was born healthily (as opposed to needing intensive care). Premature birth due to underweight is the main reason for treatment.	£848	1	n/a	Treatment in SCBU is a one-off cost (and the financial proxy already takes account of future value)	£848
Improving diet (POW)	Number of women referred to dietician (pre-eclampsia avoided)	£5,971	1	n/a	A complex delivery is a one-off cost.	£5,971
Increasing social and emotional support and reducing isolation (POW / HT)	All women given social and emotional support	£30,000	5	50%	50% represents the people who return to previous level of mental health over time. .	£54,856

Estimated total social value (rounded to three significant figures) = £105,000

Calculating SROI – the return on investment

The formula for calculating the return on investment is:

$$\text{SROI ratio} = \frac{\textbf{Total social value generated per paraprofessional per year}}{\textbf{Total cost of one paraprofessional per year}}$$

A value greater than 1 indicates a positive return on investment.

The following **approximate** returns are generated:

- for **Health Trainers, £4.80 for every £1 invested**;
- for **POWs, £3.20 for every £1 invested**.

It should be reiterated that these are estimates and had different proxies or assumptions been used, the outcome would have been different – there is no universally accepted way to value every outcome! Rather, the reader can engage with, and critique the choice of proxies and the assumptions, and use the same method to determine results – the key to this entire exercise is that it should be transparent and open to comment.

Neither should the SROI analysis be used as a way of planning operating costs or planning detailed returns on investment for specific commissioners: it takes a broad societal perspective of 'value' generated and a narrower analysis would not be useful for an organisation such as Gateway, which as impacts on multiple stakeholders.

Finally, as noted elsewhere in this report, the case study, in common with all approaches to research, has strengths and weaknesses. The most commonly cited weakness is the problem of transferring findings. As a final note of caution, the findings presented above relate to Gateway (a specific organisation, proving specific services in a specific context) and should not be taken as representing a SROI analysis of the use of paraprofessionals per se.

5.4 Sensitivity analysis

A sensitivity analysis was undertaken as part of the development of the tool to test the assumptions used as the base for calculating returns, and to see how changes in each variable can affect the final outcome for return on investment. For example:

- if we assume that the drop-off assumed for 'improved mental health' is greater than 20%, the value of returns will decrease; or
- if the caseload is decreased, the value of returns will increase.

A sensitivity analysis examines which changes produce the greatest effects. For the purpose of this analysis, we have taken all the variables that we have assumed are subject to change (in green) and worked out the changes in ROI if these values are increased or decreased by 20%, relative to the 'base case'.

We found that:

- the **annual caseload** is the most significant factor in the value of the eventual return of both paraprofessional services. For example, if the caseload of HTs is increased by 20%, the SROI ratio rises to 5.7 (an additional 90p of return for every £1 invested). Similarly, a 20% decrease results in an SROI of 3.9 (a decrease of 90p for every £1 invested).
- for the **Heath Trainers, the number of people assumed to have benefited** in relation to each of the primary goals is also significant. For instance, if we assume that all the HT clients experience an improved diet (with the same rate of success as those clients that had diet as a primary goal), the SROI rises to 6.2 (an additional £1.40 of return for every £1 invested).

- the **POW model tends to be much more 'stable'**, because there are many more variables. There are no 20% changes that lead to more than a 0.2 change in SROI. Even when some of the bigger assumptions are challenged - for instance, if the % of women helped to access ante-natal care or avoiding a complex delivery is doubled, the change is no greater than 0.2.

6 SUMMARY OF ISSUES RAISED IN THIS REPORT

6.1 The role of paraprofessionals

The evidence gathered for this report suggests that:

- **Paraprofessionals exist within a wider policy context** and, in broad terms, the rationale for their use is entirely in line with the current direction of policy. Specifically, the current emphasis on health inequality, improving quality and focusing on prevention countenances in favour of the use of paraprofessionals.
- **They also exist within a set of more immediate practical concerns, notably the current funding 'crisis' facing health and social care services**. Other related concerns facing the health and social care workforce – problems with a forthcoming 'retirement bulge' and the need for more flexible ways of working – again count in favour of using paraprofessionals.
- **Paraprofessionals have a greater ability to serve the hard-to-reach**. Accepting some ambiguity over the evidence of effectiveness, they may therefore be considered as a possible means of addressing health inequalities. At a more minimal level, and slightly side-stepping questions of effectiveness, they appear to increase and improve access to mainstream services.
- On a related point, **paraprofessionals improve the quality of services for vulnerable groups**. They are more able to relate to, communicate with and tailor services to those most likely to suffer poor health outcomes. However, this comes with a need to establish clear boundaries between service users and paraprofessionals (to provide professional support, not friendship), and clinicians and paraprofessionals (to be clear about relative roles and responsibilities).
- **Paraprofessionals do not appear to provide gains in efficiency in terms of immediately reduced costs**. It seems more likely that they offer an additional service, rather than an alternative; it also seems likely that this additional service attracts a 'management cost' for clinicians in terms of overseeing the paraprofessional's work. Paraprofessionals should not therefore be seen as an unambiguous route to reducing costs and much more work would need to be done to establish the true changes in cost.
- **Paraprofessionals can offer the health and social care workforce a younger, more diverse and appropriately skilled supply of labour**. There are two issues of note here: firstly that there is a need to consider the career route for the paraprofessional (is it optimal for them to leave these services to begin other career routes, or can progression be built in?); and, secondly, on a related point, this supply of labour is trained at the 'expense' of individual commissioners, who may simply (and understandably) regard high levels of turnover as a purely negative feature of these services. There is a need therefore to recognise the wider value of investment in paraprofessional services – Social Return on Investment ought to help with this.
- **Paraprofessional services also offer a means for the NHS to address its own 'corporate social responsibility' aims**, and to work towards other government aims around social justice, by training and employing the unemployed.

6.2 Practical considerations in using paraprofessionals

The interviews carried out with paraprofessionals and the clinicians that they work with also enabled us to identify a set of practical concerns that ought to be taken into account in the use of paraprofessionals, which are also reflected in the wider literature:

- **Setting clear boundaries** is important when paraprofessional services are being established; in the case of POWs and Health Trainers, the clinician – paraprofessional relationships seemed to work best where clear ground rules about referrals and communication had been set out.
- **Good communication** between paraprofessionals and clinicians is vital. This may include regular phone calls / letters to confirm that referrals have taken place, sharing information about the clients' history, letting clinicians know what support has been given.
- The ability of a paraprofessional to **manage their own caseload and workload** is a key attribute of being successful in their work.
- **Continuity of service** is valued by paraprofessionals, clinicians and beneficiaries. Where clients may have had difficulties engaging with professionals and where there is a lack of trust, it seems to be important that a single paraprofessional is able to re-engage them and see them throughout, allowing for a trusted relationship to be built.
- **Effective line management** was also viewed as being very important by paraprofessionals.

6.3 The monetary value of paraprofessionals

This study also identified return on investment ratios for two of Gateway's paraprofessional services (Health Trainers and POWs) in order to give an example of the possible wider social value that can be generated from investing in paraprofessionals. Whilst a theoretical model, the Social Return on Investment (SROI) methodology – a form of cost-benefit analysis – aims to be of practical benefit to commissioners and stakeholders, and our study drew on the existing management information held by Gateway and the financial proxies in established literature to model and test the potential value of paraprofessionals from a broad, societal perspective, over a five year period.

Furthermore, the use of conservative assumptions in the financial modelling allows us to be clear that the wider benefits to society of paraprofessionals exceed the monetary cost of running such services, and that such returns are in the region of £3 to £5 for every £1 invested.

ANNEX A: DISCUSSION GUIDES

A) Discussion Guides – Scoping Phase

Topic Guide for Managers

The purpose of these meetings is to gain early views as to:

- Their areas of service in terms of the main research questions;
- The data available to the evaluation from their area of service; and,
- Their needs for the ongoing collection of evaluative evidence to inform the capacity building remit of the evaluation.

Background & Involvement

1. Please summarise your role within Gateway *[including job title]*.
2. Please describe the services you are involved in / responsible for.

Rationale for using Paraprofessionals

3. Please describe your understanding of the rationale to using paraprofessionals to deliver the services we just discussed.

including discussion of broad aims and objectives for the service.

how the idea for the service was developed?

discuss the roles of paraprofessionals and why / how they have taken on these roles.

how much variation is there between different types of paraprofessional roles and between different settings where they work?

Practicalities of using Paraprofessionals

4. Please outline the main issues in relation to recruiting and training people to work as paraprofessionals.

target groups for recruitment and why those groups are targeted?

including characteristics such as age, gender, prior qualifications (if any), employment status, benefit status.

how is the programme marketed (including links with other programmes or agencies e.g. JCP)?

how does recruitment and selection take place (what skills are you looking for?); what have the challenges been?

discussion of the training received and the extent to which this meets the needs of the services they will work in?

to what extent do trainees' needs vary, and what impact does this have on the training delivery?

what share of trainees do not complete the programme or do not find work? (and for what reasons?)

4. What are the main issues you have in relation to paraprofessionals delivering services? *[e.g. as they relate to allied health professionals and other clinicians]*

how are paraprofessionals managed within their services? (degree of autonomy / supervision).

what ongoing support do they receive in relation to their roles? (from Gateway or from the settings in which they work?)

what is their remit and have there been any instances where clinicians and paraprofessionals have had to adapt in order to deliver services more effectively?

view on key factors for effective delivery of paraprofessional support.

Outcomes Achieved

5. Thinking about the paraprofessionals, what benefits (if any) do you think they have had? e.g. in terms of:

What they were typically doing before they became involved in Gateway?

Gains in skills / qualifications.

Any wider improvements, such as improvements in employability and career progression, their family / household situation, health situation, confidence.

discuss career progression over time – what are the barriers and facilitators in relation to paraprofessionals advancing up the 'skills escalator'?

ask for examples.

6. What benefits (if any) have there been to the health / social care services; in terms of:

Have clinical or other services changed the way they deploy their workforce because of the support of the paraprofessionals? (i.e. are clinicians being 'freed up' to focus on clinical tasks – thereby making the service better and/or cheaper?)

Have clinical or other services changed the way they deliver their service because of the support of paraprofessionals (e.g. are clinicians also more sensitive to the needs of hard to reach groups?)

Has the involvement of paraprofessionals informed the gathering of health intelligence or the strategic development of services? (e.g. the Joint Strategic Needs Assessment, or getting a better sense of what is needed 'on the ground')

What communication around health intelligence takes place between paraprofessionals, Gateway and commissioners?

ask for examples.

7. What benefits (if any) have there been to beneficiaries of the services provided; in terms of:

Is there any evidence of increased engagement with hard-to-reach individuals and communities?

What additional needs of vulnerable and hard-to reach groups have been met as a result of paraprofessionals' involvement?

Is there any evidence that the use of paraprofessionals has led to better outcomes for vulnerable and hard-to reach groups?

ask for examples.

Future Developments for Paraprofessionals

8. How might existing paraprofessionals 'grow' and take on more advanced roles within services (establishing the relationship with National Occupational Standards)?

9. What are your general views as to the way in which the use of paraprofessionals will develop in this area (health and social care)? What are the main drivers of these developments and how do you see the role of Gateway in facilitating such change?

Costs

10. What are the costs associated with delivering the training programme? (for future studies of return on investment) Explore:

costs along the whole of the delivery model.

discuss what elements of cost are not usually considered e.g. management time, partners / stakeholder contributions, inductions and ongoing training once in post.

discuss variations in cost to Gateway of taking on and training different types of paraprofessional (are these significant?)

11. What is the throughput of trainee paraprofessionals in each year or cohort?

Monitoring & Evaluation, Data & Documents

12. Please describe your current approach to monitoring and evaluation of your service.

What **data** are currently collected by the service? *[and can we have access / how do we get the data?].* Similarly, are there any key **documents** that describe the service that you think would add to this research?

on the training programme.

on paraprofessionals once in post.

what is the purpose of collecting this data?

how is it collected?

are there any gaps or difficulties in collecting data?

what improvements in data collection do you feel would be useful for monitoring progress?

13. GHK is going to be working with Gateway to improve the way it collects and uses evaluative information. Do you have any specific requests in this respect?

Lessons, Recommendations & Final Reflections

14. What do you consider to be the major lessons to be learnt from the use of paraprofessionals in this area to date?

15. Are there any recommendations you would like to make – either to Gateway, or to other organisations thinking of using paraprofessionals?

16. Discuss how we can gain access to paraprofessionals in training or employment (what considerations are important?)

suitable groups of people for focus groups or paraprofessional employees for in-depth interviews?

17. Finally, do you have any other comments in relation to any of the issues raised in this interview - or are there any other issues that you would like to discuss?

Thank interviewee for their time and close

Topic Guide for commissioners

The purpose of these interviews is to discuss:

- The services currently delivered by Gateway – what works well and what could be improved;
- The key target groups for the interventions delivered by Gateway and how these link to commissioning strategies to reduce health inequalities;
- How they see the future role of paraprofessional workers in adding value to clinical services and encouraging hard-to-reach groups to access services?
- How they monitor the quality and safety of services commissioned from social enterprises such as Gateway?
- What information and evaluation they would require in order to commission further services from Gateway? and

Their expectations of this study.

Background & Involvement

1. Please summarise your role and your involvement with Gateway (and its services).

Rationale for using Paraprofessionals

2. Please describe your understanding of the rationale to using paraprofessionals to assist in the delivery of health / social care services.
3. (How) is this reflected in commissioning strategies / workforce development?

ask about how commissioning from social enterprises is managed and whether there is a strategy or plan for increasing the share of services commissioned from social enterprises?

e.g. Compact agreements.

workforce development strategies (use of KSF, development of new roles, workforce redesign?)

Practicalities of using Paraprofessionals

4. Please outline the main issues, as you understand them, in relation to recruiting and training people to work as paraprofessionals.
5. What are the main issues you have in relation to paraprofessional delivering services?

(see above)

also:

links to reducing health inequalities.

monitoring the quality and safety of services provided by social enterprises.

Outcomes Achieved

6. Thinking about the services delivered by Gateway, what benefits (if any) do you think they have had for the delivery health / social care services; in terms of:

   Have clinical or other services changed the way they deploy their workforce because of the support of the paraprofessionals? (i.e. are clinicians being 'freed up' to focus on clinical tasks – thereby making the service better and/or cheaper?)

   Have clinical or other services changed the way they deliver their service because of the support of paraprofessionals? (e.g. are clinicians also more sensitive to the needs of hard to reach groups?)

   Has the involvement of paraprofessionals informed the gathering of health intelligence or the strategic development of services? (e.g. the Joint Strategic Needs Assessment, or getting a better sense of what is needed 'on the ground').

   What communication around health intelligence takes place between paraprofessionals, Gateway and commissioners?

   ask for examples.

7. What benefits (if any) do you think there have there been to beneficiaries of the services provided; in terms of:

   Is there any evidence of increased engagement with hard-to-reach individuals and communities?

   What additional needs of vulnerable and hard-to reach groups have been met as a result of paraprofessionals' involvement?

   Is there any evidence that the use of paraprofessionals has led to better outcomes for vulnerable and hard-to reach groups?

   ask for examples.

Future Developments for Paraprofessionals

8. What are your general views as to the way in which the use of paraprofessionals will develop in this area (health and social care)? What are the main drivers of these developments?

9. Are you able to describe any future commissioning plans that may entail the use of paraprofessionals?

Monitoring & Evaluation, Data & Documents

10. What information do you ask for / receive in relation to the services provided by Gateway?

11. Does this tell you what you need to know? If not, what other information would you like to be provided with?

Lessons, Recommendations & Final Reflections

12. What do you consider to be the major lessons to be learnt from the use of paraprofessionals in this area to date?

13. Are there any recommendations you would like to make to Gateway in terms of making improving their services?
14. Finally, do you have any other comments in relation to any of the issues raised in this interview - or are there any other issues that you would like to discuss?

Thank interviewee for their time and close

B) Discussion guides – Main phase of fieldwork

Topic Guide for Clinicians

Interviews should be understood as 'a conversation with a purpose'. We have some core questions that we are interested in, grouped here with prompts. The interviews should be tailored to what we know about the clinician and their role (from Gateway), and who the paraprofessionals concerned are (e.g. POW, Health Trainer). The guide is not intended to be used verbatim.

The purpose of these interviews is to gather clinicians' views on:

- How they work with paraprofessionals;
- Their views and expectations of the paraprofessional role;
- What has changed about service delivery as a result of working with paraprofessionals;
- If there have been improvements, how can these be evidenced or quantified?
- The difference that external support (from Gateway, commissioners or others) has made to their experience of working with paraprofessionals and why.

Introduce yourself, GHK and the study – what the study has involved so far, that the purpose of the interview is to find out about what has worked well and what could be improved in relation to paraprofessionals, benefits and outcomes of using paraprofessionals, and how working with paraprofessionals might have changed their role. As part of this study our qualitative work involves interviewing clinicians who work with paraprofessionals.

Remind the interviewee or group that the research is confidential (although we may use anonymised quotes).

Background & Involvement

1. Please summarise your role and the clinical services that you are responsible for [including job title].
2. Please describe the patient groups you work with most [including any particular disadvantaged groups or groups with specific support needs].
3. Have you ever heard of Gateway and what, if any, contact have you had with them? [ask about their awareness of the services that Gateway provides]

Context

4. Please describe your understanding of the main challenges in relation to your role – in reaching out to particular groups:

including discussion of overcoming health inequalities and why these might arise (wider determinants of health).

issues with particular patient groups (e.g. who are hard to reach or engage with?)

what are the main barriers with these groups?

5. When did you first hear about [HTs, POWs or other service] and how was the idea introduced to you?

what did you expect initially? What improvements did you expect / want to see?

did you know what health needs that paraprofessionals were expected to address?

did you make a conscious decision to 'get involved' (why?) or were you just 'told' that the service was being introduced?

6. How did you expect the paraprofessional role to fit with yours?

what sort of role(s) did you think the paraprofessional was going to perform?

how did you think it might change your role?

did you see the need for this role?

7. What activities are the paraprofessionals undertaking now? Does this differ to what they did at the beginning?

how much variation is there between the paraprofessionals and between different settings where they work?

has your view on the need for paraprofessional roles changed as a result of working with the paraprofessional(s)?

Practicalities of using Paraprofessionals

8. Please describe your relationship with the paraprofessionals (e.g. HTs or POWs)

prompt for day to day contact.

sharing of workloads and division of tasks.

Communication.

case conferences or other multidisciplinary team meetings.

what ongoing support do they receive in relation to their roles? (from Gateway or from the settings in which they work?) Does this model work?

9. What is your view of this relationship? Does it work well?

has the relationship changed over time?

how were any initial difficulties overcome? (e.g. clarity of professional boundaries, clinical governance).

were you or the paraprofessional able to draw on external support or guidance to improve the working relationship?

what do you think of the training that paraprofessionals have received? Has it led to them becoming effective in post? Why / why not?

ask to describe instances where it may have led to changes in practice or workload.

view on key factors for effective delivery of paraprofessional support.

Outcomes Achieved

10. What benefits (if any) have there been to the health / social care services **as a result of paraprofessionals becoming involved**? (What if they weren't there?):

Have clinical or other services changed the way they deploy their workforce because of the support of the paraprofessionals? (i.e. do clinicians have more time to on clinical tasks (and how much?) – thereby making the service better and/or cheaper).

Have clinical or other services changed the way they deliver their service because of the support of paraprofessionals? (e.g. are clinicians more responsive to the needs of hard to reach groups?)

Has the involvement of paraprofessionals informed the gathering of health intelligence or the strategic development of services? (e.g. the Joint Strategic Needs Assessment, or getting a better sense of what is needed 'on the ground').

What communication around health intelligence takes place between clinicians, paraprofessionals, Gateway and commissioners?

Has there been a reduction in health inequalities or disparities in access to services as a result of paraprofessionals?

ask for examples, data or evidence - do you have any data / evidence to support that? (because we are collecting evidence, not because we doubt what they are saying).

11. What benefits (if any) have there been to **patients and the wider community**; in terms of:

Is there any evidence of increased engagement with hard-to-reach individuals and communities?

What additional needs of vulnerable and hard-to reach groups have been met as a result of paraprofessionals' involvement? Are these people more able to access the right services for them?

Is there any evidence that the use of paraprofessionals has led to better outcomes for vulnerable and hard-to reach groups?

ask for examples, data or evidence.

12. Have there been any benefits to the NHS workforce?

e.g. paraprofessionals going on to train as professionals.

is there a better skill mix across the workforce?

is the workforce more reflective of the communities it serves?

ask for examples, data or evidence.

Lessons, Recommendations & Final Reflections

13. What do you consider to be the major lessons to be learnt from the use of paraprofessionals in this area to date?
14. Are there any recommendations you would like to make – either to Gateway, or to other organisations thinking of using paraprofessionals?
15. Finally, do you have any other comments in relation to any of the issues raised in this interview - or are there any other issues that you would like to discuss?

Thank interviewee for their time and close

Topic Guide for Paraprofessionals

The purpose of these interviews is to discuss:

- The role and who they work with
- Improvements for the paraprofessionals themselves
- Improvements to services as a result of their employment
- What they learned and how they improved, in terms of how to deliver an effective paraprofessional service

- What works well / badly in their relationships with NHS clinicians, and why?
- The value of engaging with Gateway (particularly for unemployed learners) and what paraprofessionals received through their training.

For focus groups, we will use the broad question headings below, prompting with other specific questions (in purple) where necessary.

Remind the interviewee or group that this is entirely confidential (although we may use anonymised quotes), and for groups, that participants should not talk about what happened to other people who did not take part.

Background

1. When did you first find out about Gateway and the paraprofessional programme (POW, HTs) and how?
2. Can you tell me more about your situation when you heard about the programme? Discuss:

Were you employed / in training / unemployed / receiving benefits (which benefits, and how long for?)

Previous experiences of training and education. This could include their education history, training as well as any previous experience of working in health.

Previous experiences of employment (sector, job type, why left work, etc).

Previous experience of looking for a job (did they have any problems?)

Family responsibilities - do they have to look after children or other people at home?

[N.B. Not all these prompts may be appropriate for focus groups e.g. detailed prompts about unemployment or benefits should not be used]

3. Can you describe your current role to us?

briefly, what it is that they do?

which patient groups they work with?

which clinicians they work with?

Engagement with Gateway and training received

4. Tell me more about how and why you decided to train as a paraprofessional.

What did you expect the role would involve at the start?

Discuss the support they received from different sources at the start to get into employment (e.g. JCP adviser, Gateway trainer) how did this compare to your expectations? On reflection, was this support appropriate?

Why did you want to take part? Was it anything about wanting to work with disadvantaged groups in particular? (perhaps making use of a language skill, or using sports skills in a job..?)

If unemployed – did you think you could get back into work? How confident were you that you could get back into work?

5. Confirm training received on the programme (from existing knowledge relating to what qualification / level?)

Explore what they learned.

How was it assessed? [explore how challenging this was, what they gained from it, who supported them]

How did it fit with being 'on the job' – were there advantages / disadvantages in learning while working?

What was missing? Looking back is there anything you felt that you ought to have been taught, but weren't?

6. Who was supporting you throughout the programme? What role did they play? Ask about:

mentors in their workplace or in college.

line managers at Gateway.

What was it like learning with other people in a similar situation? How did you benefit from that?

How did the ongoing support compare to your expectations? On reflection, was this support appropriate?

7. What was the best thing and what was the most difficult thing about your experience of the training? After the training, how did you feel about your achievement?

8. If you hadn't have done this, what would you have done? (If unemployed, were you thinking about any other ways of getting back into work?)

Practicalities of using Paraprofessionals

9. Please describe your relationship with clinicians:

prompt for day to day contact.

sharing of workloads and division of tasks.

Communication.

case conferences or other multidisciplinary team meetings.

prompt for any variations – is the role different between you and your colleagues and across different settings where you work?

10. What is your view of this relationship? Does it work well?

has the relationship changed over time?

how were any initial difficulties overcome? (e.g. clarity of professional boundaries, clinical governance) Do you have any views on 'what works' in engaging clinicians in your work?

were you able to draw on external support or guidance to improve the working relationship?

ask to describe instances where it may have led to changes in practice or workload for the clinician.

view on key factors for effective delivery of paraprofessional support.

Outcomes Achieved

11. What do you see as the main benefits to the health / social care **services as a result of your role?**

Have clinical or other services changed the way they deploy their workforce because of the support of the paraprofessionals? (i.e. do clinicians have more time to on clinical tasks (and how much?) – thereby making the service better and/or cheaper).

Have clinical or other services changed the way they deliver their service because of the support of paraprofessionals? (e.g. are clinicians more responsive to the needs of hard to reach groups?)

Has the involvement of paraprofessionals informed the gathering of health intelligence or the strategic development of services? (e.g. the Joint Strategic Needs Assessment, or getting a better sense of what is needed 'on the ground').

What communication around health intelligence takes place between clinicians, paraprofessionals, Gateway and commissioners?

Has there been a reduction in health inequalities or disparities in access to services as a result of paraprofessionals?

ask for examples, data or evidence - do you have any data / evidence to support that? (because we are collecting evidence, not because we doubt what they are saying).

12. What benefits (if any) have there been to **patients and the wider community (beneficiaries)**; in terms of:

prompt for increased engagement with hard-to-reach individuals and communities.

What additional needs of vulnerable and hard-to reach groups have been met as a result of paraprofessionals' involvement? Are these people more able to access the right services for them?

Can you point to any evidence that [HTs or POWs] has led to better outcomes for vulnerable and hard-to reach groups?

ask for examples, data or evidence – perhaps by asking them to describe someone that they have helped.

13. What do you think are the benefits to the NHS workforce?

e.g. paraprofessionals going on to train as professionals.

is there a better skill mix across the workforce?

is the workforce more reflective of the communities it serves?

ask for examples, data or evidence.

14. What are your plans for the future? How do you see your role developing? How long would you stay in your current role?

Lessons, Recommendations & Final Reflections

15. What do you consider to be the major lessons to be learnt from the [HT, POW or other paraprofessional service] to date?

16. Are there any recommendations you would like to make – either to Gateway, or to other organisations thinking of working with paraprofessionals?

N.B. In focus groups, this question could be phrased in more general terms "Do you think there are any ways in which the support that you receive could be improved?"

17. Finally, do you have any other comments in relation to any of the issues raised in this interview - or are there any other issues that you would like to discuss?

Thank interviewee for their time and close

Topic Guide for Learners

This topic guide gives a broad indication of the question areas and prompts to cover with new learners:

- Their experience so far of recruitment and training;
- Any barriers encountered in the process so far; and
- Hopes and aims for the future;

For focus groups, we will use the broad question headings below, prompting with other specific questions (in purple) where necessary.

Remind the interviewee or group that this is entirely confidential (although we may use anonymised quotes), and for groups, that participants should not talk about what happened to other people who did not take part.

Background

1. When did you first find out about the programme offered by North Staffordshire Hospitals and Gateway Family Services, and how?
2. Can you tell me more about your situation when you heard about the programme? Discuss:

Previous experiences of employment (sector, job type, why left work, etc).

Family responsibilities - do they have to look after children or other people at home?

Previous experience of looking for a job (did they have any problems?)

Prior qualifications.

[Not all these prompts may be appropriate, ask them what they had been doing and see if anyone raises any specific stories]

3. Why did you want to join the programme?

Motivations and interest in working in the health service, providing support to families.

[N.B. for focus groups e.g. detailed prompts about unemployment or benefits should not be used]

Engagement with the programme

4. Tell me more about how you found out about the programme and what happened then?

prompt for how different people might have been involved in the recruitment process (e.g. Job Centre Plus)

what sort of support or guidance did you receive – who from?

was this support useful?

5. And what was your experience of being chosen for the programme?

experiences of interviews and selection, including any initial assessment.

what were the difficulties and challenges they had to overcome?

who did they meet and how did they found out more about what the programme involved?

now that you've started, do you feel that you know enough about the programme and what your future job might involve?

6. What are your hopes for the future?

ask about where they might find satisfaction in their job (helping people, talking to people…?)

where do you see yourself in the future (do you have a longer term plan to work in the health service?)

tell me more about what you think the job will be like? Why do you think so?

7. What are your expectations of the training?

Have you been told what your training is going to be like?

Who is going to be supporting you and how?

What do you think your main support needs would be, and how would you expect to see these met?

Thank interviewee for their time and close

ANNEX B: BIBLIOGRAPHY

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