The Cavendish Review Ten Years On: Are NHS support workers still 'invisible'?

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Support workers are an important part of wider multidisciplinary teams, enabling more effective and efficient working. They contribute to addressing critical workforce capacity constraints while providing high quality, personalised care to patients. These include assistant practitioner and technician roles, such as occupational therapy assistants, which can be key integrators across health and social care (NHS England (2023) Long Term Workforce Plan)

I worked in two different NHS trusts. They both had different attitude towards support workers...in the first place I felt left out/ forgotten. When I suggested some developmental changes, it was rejected without discussion. In the second trust I feel valued, included, and trusted and encouraged to develop my skills. I have the feeling that this is down to management style (Support worker)

How do support workers' experience work? Everything depends on individual good will and good luck (Education Lead)

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Any errors are the author's own.

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Professor Ian Kessler. After spending over twenty years at the University of Oxford, Ian Kessler joined King's College, London in September 2012. He has been involved in a number of research projects on aspects of employment relations in the British public services. This work has ranged across central government, the health service, and local government, including education and social care, and covered such topics as pay determination, strategic human resource management and work organisation. Over the last few years, he has been exploring nurse support roles in acute health care, and the more general re-structuring of the nursing workforce. He has co-authored two books on aspects of public service employment relations: The Modernisation of the Public Services and Employee Relations (2012) (with S. Bach.) and the Modernisation of the Nursing Workforce: Valuing the Healthcare Assistant (2012) (with Paul Heron). He was a commissioner on the Local Government Pay Commission in 2005 and has acted as adviser to the Royal College of Nursing, the Police Federation, the Audit Commission, and the National Audit Office.

Both Richard Griffin and Ian Kessler were advisors to the original Cavendish Review.

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Foreword

Ten years ago, I had the great privilege of travelling around the country and meeting healthcare assistants and other clinical support workers who are the bedrock of the NHS. These are the people we patients are most likely to see at our bedside; they make up 28% of the NHS workforce; they can be feisty advocates for us in our hour of need; yet their importance is rarely recognised.

This detailed report lets us track how today's support workers are faring in the NHS. It is frustrating to see that so many of the issues and challenges I identified ten years ago still remain. But that makes it all the more important that this report is read widely and acted upon.

The report's findings underline the dedication and commitment of many support workers. A third have been in their roles for more than 15 years. Well over half are aged over 40, bringing a maturity to their work. Many also have aspirations to progress their careers – but there remain too many barriers to doing so. Last year's *NHS Long Term Workforce Plan* included a welcome aspiration to create lifetime career ladders for support workers – but this needs to be made real.

When the NHS faces acute backlogs and staff shortages, it is vital to maximise the potential of all staff. This group are a strategic resource.

Camilla Cavendish

Financial Times Columnist and Contributing Editor Research Fellow, Mossavar Rahmani Center, Harvard Kennedy School

Executive Summary

Background

Comprising 28% of the total NHS workforce, clinical support staff are healthcare employees who work alongside nurses, midwives, physiotherapists, radiographers, orthoptists, and others in patient facing roles performing a wide range of clinical and non-clinical tasks. Their jobs require learning up to, but below, degree level. Their work is not regulated by bodies such as the Nursing and Midwifery Council, but they are frequently the healthcare staff patients, and their families have most direct contact with. Examples of such roles include Health Care Assistants, Maternity Support Workers, Assistant Practitioners, and Therapy Assistants.

In 2013 Camilla Cavendish was commissioned by the government to undertake an independent review of the recruitment, training, utilisation, and development of this group of staff. Published in July of that year, *The Cavendish Review* found a large number of issues and barriers the workforce faced, including poor access to education, a lack of career development opportunities and inconsistent delegation of tasks. These prevented staff from fully utilising their knowledge and skills and progressing their careers. They also meant that employers wasted resources and that patient care was not as effective or always as safe as possible. Cavendish made a series of recommendations to address these issues but only one of them, The Care Certificate, was adopted nationally, although it was not mandated.

This report sets out the findings of a national survey of support staff and a scoping review undertaken by King's Business School in 2024 that has sought to discover whether NHS support workers still experience the issues identified by *The Cavendish Review*, and if so, why that is, its consequences and what might be done to address the issues.

Findings

We found that whilst support workers are enthusiastic about and proud of their work t and strongly believe it makes a difference to patients. However, they feel undervalued. Only one-in-five believe that the NHS values their role and just half would recommend being a support worker to their friends and family. Many (28%) frequently think about leaving their current job and most think they are underpaid for the work they do.

Support workers feel that the NHS is not getting the best from them and that they could contribute more if they had greater access to learning and development. Just a fifth had studied an apprenticeship. One-in ten had not been able to access any formal education

in their whole career with the NHS. Over nine in ten would like to see protected time off for study and protected funding for the continued professional development.

The support workforce experience other barriers to their development such as a lack of information about career progression routes, little support from their managers, poor quality appraisals and Personal Development Plans. Support staff also believe recruitment, induction, and onboarding processes should be improved.

Progress does seem to have been made, since the publication of *The Cavendish Review* in respect of clarity around scope of practice and the quality of supervision, perhaps reflecting the development of competency frameworks for some support staff groups in recent years.

Nearly a third of the support workers in our survey strongly aspire to become registered professionals but need more support to do so. Compared to registered staff, support workers are more likely to be recruited from local labour markets and come from a working-class background.

There is a strong view amongst support workers that NHS workforce policy needs to change to address the issues they face. Many of the changes support workers believe are needed were, in fact, recommended by *The Cavendish Review* such as common job titles, protected time off for study, protected funding for training, clear careers information, representation of support workers at board level, support to access pre-registration degrees, better quality appraisals, and clear task descriptions.

Conclusion

Poor utilisation and deployment of this important healthcare workforce has negative consequences for patients, staff, employers, and the NHS as a whole. Addressing the issues the support workforce face, nationally, regionally, and locally, would benefit patient care, ease staff workloads, improve organisational productivity, safety, and patient satisfaction.

Introduction

Most of us are familiar with healthcare employees such as nurses, midwives, radiographers, and physiotherapists. Employment in these sort of healthcare roles requires the successful completion of an occupationally relevant degree. The practice of qualified nurses, midwives, radiographers, physiotherapists, and other professional healthcare staff are governed by nationally set standards of education, training, conduct and performance. Moreover, to be eligible to practice individuals are required to register with independent regulatory bodies, such as the Nursing and Midwifery Council (NMC) and, throughout their career, demonstrate that they have maintained their knowledge and skills. For a long time, such staff have been represented by professional bodies, such as the Royal College of Nursing (RCN). Less visible, though, are the nearly 400,000 people working in the NHS alongside those nurses, midwives, radiographers, physiotherapists, and other healthcare professionals in what are collectively known as clinical support roles.

Even if patients may not know about them, clinical support staff are often the NHS employee we are most likely to have contact with when we need care. Support workers perform a wide range of crucial tasks, such as assisting with feeding and personal hygiene, carrying out observations, catheterisation, teaching parenting skills or correcting walking gaits, as well as non-clinical responsibilities such as cleaning and stock control. These roles, which include Healthcare Assistants, Maternity Support Workers, Radiography Clinical Support Workers, Assistant Practitioners and Physiotherapy Assistants are not, with one exception[1], regulated by bodies such as the NMC and are subject to surprisingly little national policy in respect of their education, training, and management practices. Employment in such roles does not require qualifications at degree level. It is only recently that they have been permitted to join professional bodies (although they have always been eligible to join trade unions representing healthcare staff). In his review of the tragic events at Mid Staffordshire NHS Foundation Trust, that led to as many as 1,200 unnecessary deaths, Robert Francis pointed out that the taxi driver who took him to the hospital and the security guard that greeted him at main reception were subject to more regulation than clinical support workers we met on the hospital's wards – despite the important bedside role they have.

This report is concerned with the clinical support workforce. Support workers have always been a crucial part of the healthcare workforce – even before the NHS was created. They have also, however, long faced a series of barriers and constraints, such as poor access to training, that have meant their roles can be poorly utilised and deployed

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[1] The Nursing Associate role which was introduced in 2017.

by employers and that they struggle to develop their careers and receive recognition for the work they do.

They have been neglected in terms of national NHS workforce policy. As long ago as 1997 the researcher Carol Thornley captured this by describing them as 'invisible'[2]. 'Invisible' was also the word used to describe them by the journalist Camilla Cavendish who was commissioned by, then, Prime Minister David Cameron in 2013, in the wake of the Francis Inquiry to investigate what could be done to improve their recruitment, management, and development. Over a fourteen-week period through a series of meetings, focus groups, roundtable discussions, hospital visits, a survey, formal consultation (which produced 100 individual and organisational responses) and discussions with key stakeholder, Cavendish sought to understand how support staff experienced work, and what the consequence of that experience was for them, other staff, their employers and patients.

The Cavendish Review an independent review into healthcare assistants and support workers in the NHS and social care was published by the Department of Health on 10 July 2013. It found that although support staff were dedicated*,* indeed "sometimes fierce advocates for the people they look after, many in this group also feel frustrated at what they feel is a lack of recognition from managers, employers and commissioners" (page 83). The review recorded a long list of issues this workforce faced that prevented them from fully utilising their skills, being recognised, and progressing their careers. The lack of national policy, Cavendish concluded, meant the work they could perform, sometimes even within the same hospital, was inconsistent and could risk patient safety.

Ten years after the publication of *The Cavendish Review,* King's Business School, working with an Advisory Group that included healthcare trade unions, professional bodies, representatives from Arm's Length Bodies, support workers and others, with the support of Camilla Cavendish, has undertaken a comprehensive study to investigate whether the issues she identified a decade ago still characterise work for this group of staff and, if so, why and what could be done to improve this. Given the specific issues staff in social care face this study, unlike the original review, is only concerned with NHS support staff, it does though cover all occupational groups not just nursing healthcare assistants who were the sole focus of *The Cavendish Review.*

We publish this report at a time when the NHS is under unprecedented pressure and faces an acute workforce crisis, with over 120,000 vacant posts according to the Kings Fund, (2024). Some, maybe many, of the issues discussed in this report are not just currently experienced by support staff. Registered Nurses, for example, report that they do not feel valued, and this is contributing to them leaving the NHS (RCN, 2023).

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[2] Thornley's reports' full title was - *The Invisible Workers: An Investigation into the Pay and Employment of Health Care Assistants in the NHS*.

However, the issues the support workforce experience that are described in this report, have long characterised their working lives and are unlikely to dissipate even if the current staffing crises is addressed - unless, as Cavendish pointed out, specific interventions are implemented to address them. Indeed, we argue, as Camilla Cavendish did, that support workers are an underutilised resource, that if invested in, could significantly contribute to addressing the capacity and capability issues that the NHS faces. That opportunity was missed in 2013. It should not be missed again.

The Cavendish Review and after

This section describes why *The Cavendish Review* (Department of Health, 2013a) was established, what the review found, its recommendations and what happened, in terms of NHS workforce policy and practice, after its publication.

The Cavendish Review

Between 400 and 1,200 people died unnecessarily at the Mid Staffordshire NHS Foundation Trust due to chronic failures in care. The inquiry into these tragic events, led by Robert Francis, made 290 recommendations, including a number in respect of Healthcare Assistants, who, the inquiry noted, often provided the majority of direct personal care but were subject to very little regulation or training (Department of Health, 2013b). In response to the Inquiry's recommendations the, then, Prime Minister, David Cameron, commissioned *The Times* newspaper journalist Camilla Cavendish, to independently investigate whether the recruitment, retention, training, and development of the nursing healthcare clinical support workforce employed in the NHS and social care could be improved.

The Cavendish review: an independent review into healthcare assistants and support workers in the NHS and social care was published by the Department of Health on the 10th of July 2013. Whilst noting that there were examples of good practice in both the NHS and social care sector, over 93 pages Camilla Cavendish set out the plethora of issues, barriers, constraints, limits, and obstacles she had identified that the support workforce frequently faced in their places of work. These included a –

- Lack of recognition of their contributions to care
- Lack of clarity about their scope of practice
- Plethora of often confusing job titles[3]
- Poor access to occupationally relevant training
- Limited career progression pathways
- Lack of national standards for training
- Under-grading
- Blurring of roles between registered and non-registered staff
- Inconsistent and sometimes inappropriate delegation of tasks

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[3] Cavendish found over 60 titles that services used to describe Healthcare Assistants.

The Cavendish Review Recommendations[4]

1. A standards-based Care Certificate, (originally described as a Certificate of Fundamental Care), should be introduced, and completed by all newly employed patient facing support roles in health and social care.
2. A Higher Certificate, covering more advanced competences, including elements of nursing degrees, should be developed.
3. A framework to quality assure the training available to support staff should be created *"so money is not wasted on ineffective training"* (op cit., page 8).
4. Value based recruitment into posts should be adopted.
5. A national plan to deliver widening participation into pre-registration degrees including bridging programmes and funded work-based progression routes should be agreed.
6. The Nursing and Midwifery Council should make caring experience a prerequisite for students planning to study a nursing degree.
7. A review should be undertaken to consider how the contribution of experiential experience of care possessed by support staff could enable those that wished to, to undertake a 'fast-track' nursing degree.
8. A *"robust career development framework...linked to simplified job roles and core competences"* should be created (op cit., page 10).
9. A common job title of 'Nursing Assistant' should be adopted.
10. A single common data set should be created.
11. Directors of Nursing should have board level responsibility for the recruitment, training, and management of support staff in their organisation.
12. New mechanisms to dismiss 'unsatisfactory' staff (in the absence of a register) should be created.
13. A code of conduct should be agreed.
14. A review of the impact of staff working 12-hour shifts on patients and staff should be undertaken.

Cavendish discovered that the care work undertaken by support staff was often perceived as being of a low status and frequently "taken for granted" (op cit., page 11). The support workforce despite being "frontline" workers, were, she found, "invisible" to policy makers, commissioners, employers, and the public (op cit., page 83). She also used the word 'silo' on nine occasions to describe how workforce planning took place in the NHS. This undermined team building and shared responsibility, she thought. Towards the end of her report, she wrote that whilst the "...best organisations...recognise that this workforce is a strategic resource that is critical to ensuring the safety of patients", many

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[4] Recommendations aimed exclusively at social care workforce are excluded from this list.

organisations did not. (op cit., page 83). The conclusion of *The Cavendish Review* (op cit.,) was clear but stark –

> the system does not currently guarantee public safety...Employers lack of faith in the system has led to duplication and wasted resources. Staff do not always achieve recognised transferrable skills. Training does not always relate to the needs of patients/service users. Training can reinforce professional siloes...Caring does not always feel like a career with clear routes to progression" (op cit., page 82).

The Cavendish Review (op cit.,) made a large number of recommendations to address the issues identified (see box above). Cavendish hoped that these would lead to all health and social care employers implementing workforce practices that would enable this group of staff to fulfil its potential to "improve care", along with improving "staff engagement" and ensuring a degree of standardisation in role deployment and utilisation (op cit., page 83).

What happened after *The Cavendish Review* was published?

In response to the publication of *The Cavendish Review* (op cit.,), Health Education England (HEE), the national Arm's Length Body then responsible for NHS workforce education and development, worked with partners, such as the Council of Deans, trade unions and professional bodies, to produce a workforce strategy called *Talent for Care* (HEE, 2014). This sought to address the issues raised by Cavendish and meet the review's recommendations[5]. HEE also led the development, with Skills for Health, of the Care Certificate, which was launched in April 2015 and Skills for Health produced a *Code of Conduct for Healthcare Support Workers*.

The *Talent for Care* (HEE, 2014) strategy was not, however, mandated, meaning that decisions to implement it were left to individual employers. This ultimately resulted in the strategy having only a limited impact (see Griffin, 2023a for full discussion of the strategy and its consequences). *Talent for Care (op cit.,)* is no longer a strategy focused solely on the support workforce. In April 2024 its web pages stated that –

> More recently the scope of *Talent for Care* has extended to staff at all levels, particularly with the introduction of higher and degree apprenticeships, while also retaining its emphasis on opportunities for the support workforce[6]

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[5] Separately, a short-lived pilot explored the Cavendish recommendation that nursing pre-registration students spend a period of time working as a Healthcare Assistant before entering their formal studies but this was not subsequently implemented (for further information see here).

[6] Source: https://www.hee.nhs.uk/our-work/talent-care-widening-participation [Accessed 25/04/24]

In 2015 HEE commissioned a new review, this time of nursing education, led by Lord Willis of Knaresborough. Called *Shape of Caring* (HEE, 2015), Willis's remit included nursing support workers. Willis endorsed the Cavendish recommendations and added some further proposals, including the need to develop an e-portfolio to record support staff learning. However, other than his proposal to create a new 'bridging' role between the registered and non-registered nursing workforce, which became the Nursing Associate role, none of Willis's recommendations were adopted in respect of support staff.

There have been a number of other developments in both NHS workforce and wider employment and skills policy that have impacted on this workforce. Key amongst these have been –

- The changes in the apprenticeship system implemented in 2017 with the introduction of apprenticeship standards and the employer Apprenticeship Levy. There are now apprenticeships for many (but not all) NHS support worker roles, which was not the case in 2013
- The creation of occupationally specific national education and competency frameworks and associated resources developed by HEE. The first was developed in maternity in 2018, the next for the Allied Health Profession support workforce in 2021 and most recently for staff supporting people affected by cancer[7]
- A number of professional bodies and trade unions have created resources aimed specifically at support staff

 The most significant policy change since 2013 has been the publication of *NHS Long Term Workforce Plan* (LTWP) by NHS England in 2023[8]. The *NHS LTWP* contains a number of aspirations directly focused on support staff[9]. These include a –

- Proposal to increase the size of this workforce from 389,000 currently, to between 636,000-662,000 by 2036/37[10]
- Growth in the proportion of registered staff educated through Degree Apprenticeships, from 7% currently to 22% by 2031/32
- Greater recruitment into support roles from local communities including by working with skill and employment partners such as colleges and councils

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[7] The development of these were not part of *Talent for Care* (HEE, 2014).

[8] The previous *NHS People Plan* published by NHS England in 2019 made few direct references to support staff.

[9] Other proposals in the *NHS LTWP* addressing the whole workforce, such as those concerned with employee wellbeing, will also benefit support staff.

[10] Analysis we have undertaken of the projected workforce increases modelled by NHS England in the NHS LTWP suggests that – excluding Nursing Associates – skill mix between registered and unregistered clinical staff will actually fall slightly over the life of the Plan.

- The creation of life time career ladders
- Continued focus on the maternity, Allied Health Profession, and cancer care strategies for support staff

Discussion

Despite the findings of *The Cavendish Review* (ibid.,) and the extensive set of recommendations it set out, which were reaffirmed and extended upon two years later by Willis (HEE, 2015), subsequent NHS workforce policy and practice has not specifically focused on support staff and the issues they face. The occupationally specific strategies developed by HEE, (now NHS England Workforce, Training and Education), for maternity, Allied Health Professions, and cancer care are significant and welcome developments that do explicitly seek to address issues, such as inconsistent job design and lack of transferability of acquired learning. However none of these are mandated which means, again, that local employers can chose not to adopt them. The *NHS LTWP* (NHS England, 2023) does include a number of aspirations that will, if implemented, assist the support workforce, but it is silent on many issues this workforce faces, particularly in respect of in-work development and progression (Griffin, 2024). The next sections of this report will consider what we found has, and has not changed, for support workers since 2013.

Why does the support workforce matter?

- **Support workers comprise a significant proportion of the NHS workforce.** According to *The NHS Long Term Workforce Plan* NHS (England, 2023)*,* support staff represent 28% of the total NHS workforce - some 389,000 people, with plans to recruit a further 204,000 by 2037 to meet rising demand for healthcare
- **Support workers are often the key "bedside presence".** Research has identified, as *The Cavendish Review* (Department of Health, 2013a) did, that support staff often provide the majority of direct personal care, spending more time with patients and their families than registered staff do (see for example HEE, 2015; Kantaris et al., 2020; Palmer et al., 2021, Wood et al., 2023)
- **The support workforce brings distinctive qualities to care.** Support staff are more likely to be recruited from and be representative of local communities. Many have previous experience of employment, frequently in people-focused roles in retail and hospitality
- **The support workforce delivers critical services to patients.** Across occupations support staff perform a huge range of tasks and responsibilities, such as the provision of information and guidance including health promotion, crucial to safe and effective care

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Do NHS support workers still face the same workplace issues *The Cavendish Review* identified in 2013? Survey results

This section sets out findings from this study's on-line survey which was completed by 5,255 clinical support staff employed by the NHS in England between November 2023 and January 2024 (see Appendix 1 for more information). The survey's aim was to explore whether the issues identified by *The Cavendish Review* (Department of Health, 2013a) still typify how NHS support staff experienced work. As a result, questions were constructed based on the findings of *The Cavendish Review's* (op cit.,), supplemented by insights from subsequent research studies and reviews. A later section of this report will discuss the survey findings in respect of whether support staff felt the recommendations made by Cavendish would still be beneficial to them today.

Job satisfaction and recognition at work

Survey respondents felt enthusiastic about the work they did (75%)[11], felt pride in their work (85%) and that they made a positive difference to patients (83%). However -

- Only half felt that their contributions at work were recognised
- Just 20% agreed that the NHS valued support workers
- A third *did not* agree that they felt full members of their team at work
- Only a little over half (53%) would recommend becoming a support worker to their friends and family
- Over a quarter (28%) frequently thought about quitting their job.

The survey did reveal that perceptions of being valued varied depending on the level of organisation, with perceptions being more positive the closer to where staff worked -

- 20% thought the NHS valued support workers.
- 49% thought their employer valued them
- 58% felt the team they worked valued their role

Asked whether they thought support staff were still 'invisible' only 27% thought that they were not. Most, but not all, felt they had a voice at work. A fifth (21%) felt that they were not able to share their views at work.

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[11] The percentages reported are the proportion of survey respondents to a topic.

Deployment, development, and progression

Support staff felt that they would be able to contribute more to patient care if they had better access to training (56%). Over half (60%) had, though, accessed some form of training in the previous year, in addition to statutory and mandatory training. Just under half (49%), though, felt they had been given enough time to engage with their learning. Two thirds reported that they would like more opportunities than they currently had to develop in their role. The box below sets out the survey's findings in respect of the formal training that respondents had accessed <u>throughout</u> their NHS career.

Education and training

The survey asked respondents to indicate all the work-related qualifications they had acquired or learning they had accessed since they began working in the NHS.

Learning	% of respondents
The Care Certificate	50
e-Learning modules	41
National Vocational Qualifications	33
Functional skills training	22
Clinical apprenticeship (level 3)	17
Clinical apprenticeship (level 2)	16
Foundation Degree	9
Clinical apprenticeships (level 5)	3
Degree Apprenticeship	3
Higher Development Award	3
Clinical apprenticeship (level 4)	1
Non clinical apprenticeship	1
Have not accessed any formal learning	13

Support staff are career aspirant but experience barriers to career progression. Two thirds (66%) reported that they would like more opportunities to progress their careers, with the same proportion (66%) wishing to remain working in a support role - although 47% of those wished to work in a different occupation to their current one. Less than half (45%) agreed that they had sufficient information to plan their career development and 46% reported that they were frustrated because they lacked opportunities to develop. Only 37% agreed that their manager helped them to develop their career.

Appraisals and Personal Development Plans (PDPs) were not always perceived as being effective by support staff. Whilst most (80%) survey respondents had participated in an appraisal during the previous year, only 32% of them felt that it had been "helpful". Just

49% of those who had undertaken an appraisal also had a PDP, meaning that half of appraisals did not result in a development plan for support workers. Of those that had agreed a PDP only 38% felt that it was "helpful".

Grading and pay

Support staff felt strongly that they were under-paid for the work they did. Just 26% believed that they were fairly banded (graded). Dissatisfaction about levels of pay was also the issue most frequently raised in the free text question (below).

Scope of practice, delegation, and supervision

The survey results suggested that there is some clarity around scope of practice and delegation of tasks as Table 1 shows.

Table 1: Scope of practice

Statement	Per cent Strongly Agreeing	Per cent Agreeing
I am clear about the tasks I can and cannot perform	37.2	41.1
Registered staff are confident to delegate tasks to me	38.6	39.9

The majority of respondents were generally satisfied with the supervision they received. Only 18% indicated that they would like more supervision, although only just over a half (53%) felt they received constructive feedback from their manager and 48% felt that their supervisor helped them solve issues they faced at work.

How do people find out about clinical support careers?

Most of the support staff completing the survey had not found out about their role through structured career information, advice, or guidance. Just 6% had been told about opportunities through careers talk at their school or college, about the same proportion who had found out via social media (7%). The most common way respondents said that they found about the potential of a career as a support worker was through –

- Searching the internet (33%)
- Information provided by friends (21%)
- Information provided by family (15%).

Other issues

The survey included an open text question that allowed respondents to raise any issues or suggestions about how their work could be improved that they wished. A full analysis of the 1,531 replies received will be presented in this study's future qualitative findings report. Comments did though endorse the issues highlighted elsewhere in the survey and summarised above. Two new common themes emerged -

Recruitment, induction, and onboarding

After pay levels, the issues most frequently raised related to the quality of the recruitment process, selection interviews and the need for improved induction and onboarding processes as the following comments highlight–

> Have concise descriptions of what the job entails, as I've found that a lot of people really didn't know what to expect when the applied for a job as a support worker

> [The]recruitment process was hard to navigate. too many questions and not much clarity on time frame and what to expect when going through checks and final allocation

> New employees [should be] given time to complete the huge amount of training before starting the job. It puts them off

Access to development and career opportunities for support staff are depended on individual employers.

One support worker explained –

> I worked in two different NHS trusts. They both had different attitude towards support workers. Meanwhile in the first place I felt left out/ forgotten. When I suggested some developmental changes, it was rejected without discussion. In the second trust I feel valued, included, and trusted and encouraged to develop my skills. I have the feeling that this is down to management style and for this reason I think managers could be supported to support, support worker

Who are support workers?

The survey elicited demographic and other information about the sample-

- 84% were female, 14% male, 0.2% were non-binary and 0.2% preferred to self-define

- 82% described themselves as White, 7% as Black/Black British, 6% Asian, and 2% as Mixed heritage.

Table 2 shows the age distribution of the sample.

Table 2: Age

Years of age	Per cent
16-20	1.2
21-30	14.2
31-40	20.1
41-50	23.0
51-65	37.4
Over 65 years of age	1.7

The survey asked respondents to state how long they had been employed by their current employer and how long they had worked in the NHS. Responses are shown in Table 3.

Table 3: Length of employment in the NHS

Years employed	Per Cent
Less than 1 year	9.9
Between 1-5 years	30.0
Between 6-10 years	18.9
Between 11-15 years	10.4
Over 15 years	30.5

In terms of length of employment with their current employer, 35.1% of respondents had worked for between 1-2 years (15.1% for less than 1 year), 37% for between 3-10 years, 8% for between 11 and 15 years and 17.7% had worked for their employers for over 15-years.

Asked whether or not they currently worked near to where they went to school, 53% said that they did – suggesting that the workforce is primarily recruited from local labour markets. Asked whether their parents/guardians had attended university just 21% said they had. A significant minority (43%) of the respondents were the sole or main earner in their household. The answers to these questions suggest that this workforce may be more likely from working class backgrounds than their registered staff colleagues, as others have suggested (see Griffin, 2023a). Over half (57%) of the respondents were a member of a trade union or professional body.

Are there differences between occupational groups?

Analysis was undertaken to see if there were significant differences in responses between occupational groups, specifically from those employed in one of the Allied Health Professions (AHP), or in nursing or maternity. The comparative results are shown in Table 4. This shows that AHP support staff are less likely to think about quitting their job compared to the other occupations. They were also more likely to recommend working as a support worker to their friends and family. Both AHP and maternity support staff are half as likely to think about quitting NHS employment than their nursing colleagues. AHP support workers are more likely to be clear about the tasks they are able and unable to perform, feel full members of the team and have their work recognised by their manager. They are also more likely to feel that they are more fairly banded (although only 32% do feel they are fairly banded) and that the NHS values them (although 58% do not think that the NHS values them).

Table 4: Results by different occupation

Statement	AHP	Nursing	Maternity
I frequently think about quitting my job	18.8	32.5	29.3
I plan to leave NHS employment	9.8	21.9	11.7
I am clear about clinical tasks I can and cannot perform	84.0	76.2	79.3
Registered staff are confident to delegate appropriate tasks	84.7	81.9	82.4
I could contribute more with additional training	53.5	57.7	51.1
I feel I am a full member of my team at work	74.8	60.4	59.0
I would recommend becoming a support worker to friends/family	62.2	49.6	48.4
I have access to the information I need to progress my career	48.6	45.4	39.4
My work is recognised by my manager	73.6	55.8	53.7
I am fairly banded for the work that I do	32.0	23.2	11.2
The NHS does not value support workers	58.0	62.0	66.0

Discussion

The findings of the survey suggests that most of the issues identified by *The Cavendish Review* (Department of Health, 2013a) still typify how many NHS support staff experience work. For example, the majority of the survey's respondents wished to develop themselves, both within their role and into registered roles, but experienced a range of barriers preventing them doing so. These included: poor quality or non-existent appraisals and PDPs, a lack of access to learning, no information about how to develop and only limited support from their managers. Despite the reforms to apprenticeships uptake of these programmes was low. Moreover, just half of support staff had completed the Care Certificate. Support staff still felt undervalued, particularly nationally with just one in five believing that their role was valued by the NHS.

Despite these findings support staff enjoyed, in fact, were proud of the work they did and felt that it made a difference to patients. There do appear to have been improvements in terms of understanding of scope of practice, delegation, and supervision. This may reflect the introduction, since 2018 of specific occupational competency frameworks. This possibility is strengthened by the finding that AHP support staff report somewhat more positive than their nursing and maternity colleagues. The AHP support workforce strategy has received considerable national and regional focus, and investment in the last three years.

The development and utilisation of support workers: A scoping review

Details of the strategy adopted to undertake the scoping review for this study is contained in Appendix 1, which also includes a short discussion of the issues associated with this body of research. In this section we set out the themes we identified when reviewing recently published academic research focused on the clinical support workforce.

Drivers explaining the growth of the support workforce

Three factors are consistently identified together in the literature to explain the international growth in the clinical support workforce: shortages of registered staff, the growing demand for healthcare and government concerns around costs (Sarre et al., 2018; Fee et al, 2020; Blay and Roche, 2020; Sarigiovannis et al., 2021; Shore et al., 2022; Crevacore et al., 2023; Etty et al., 2024). Crevacore and colleagues note that "there has been an increased use of unregulated healthcare workers due to rising demand for healthcare, escalating costs and nursing workforce shortages" (2023: 885). Etty and colleagues (2024) observe that the COVID-19 pandemic "worsened staff shortages" meaning "that activity focused on workforce redesign", including utilisation of support workers, had become "ever more crucial" (page 2251). Referring to the growth in NHS support roles from the 1980s, Dent (2020) sees the "more extensively [utilisation] of lower paid support workers, including HCAs, relative to the number of registered staff" as a means of cutting costs (op cit., page 63). Dent (2020) also points to another issue that historically has been deployed to explain the increased use of support roles – the closure of professional boundaries.

The undervaluing of support workers and their contribution to healthcare work

A number of studies have observed that support staff do not always feel valued at work (Fee et al., 2020; Saks, 2020; Dent, 2020; Wood et al., 2023; Deady et al., 2023). Fee and colleagues (2020) note that despite the fact that "healthcare assistants play an important role in providing community based palliative care, questions remain as to why they are so rarely recognised as integral team members and are mainly unrecognised in policy" (page 985). Sarre and colleagues (2018), in the context of their review of the issues influencing healthcare staff's access to training, also note the absence of national policy focused on this group of staff resulting in inconsistent local employer approaches. They suggest this is due to support staff's "place in the work hierarchy" (page 152). The subtitle of Saks' (2020) edited collection about support workers is - *The Invisible Providers of Health Care*.

In that book's introduction the editor notes that despite "their relative invisibility health support workers are vitally important to enhancing health" (Saks, 2020:2). Etty and colleagues (2024) quote examples of support workers being deliberately excluded from key decisions.

What makes support workers feel valued – or not?

Parallel to this study, Dr Hall undertook a qualitative exploration using semi-structured interviews to explore the factors that influence AHP support worker feelings of being valued at work (forthcoming). Twenty-nine AHP support workers from diverse backgrounds and experiences, working across various settings and alongside different professions, were recruited in England. The study found that a sense of belonging, recognition of skills and abilities, and empowerment within a role, (including opportunities for role development), were pivotal factors contributing to a feeling of being valued. Conversely, when support workers perceived themselves as "just a support worker" with underutilized skills, their sense of value diminished. Feeling valued led to enhanced job satisfaction and performance. Notably, there was considerable variation in the extent to which support workers felt valued, impacting both their personal well-being.

Deployment

Two studies in this review noted that the deployment of the support workforce is context dependent, resulting in inconsistency in task allocation and lack of standardisation of roles (Nancarrow, 2020; Blay and Roche, 2020). Lack of standardisation varies by setting, (for example urban or rural areas), team structure, circumstance (such as staff absence) and occupation (Etty et al., 2024). A survey of Assistant Practitioners working in radiography services found variations in practice between services (Snaith and Harris, 2018). Etty and colleagues (2024), in their scoping review of peer reviewed research on the Allied Health Profession (AHP) support workforce, noted that "uncertainty around how best to deploy this workforce, underpinned by international variations in their skills and knowledge" was a feature of his workforce internationally (page 2251). Sarigiovannis and colleagues in a systematic review of tasks that were delegated to AHP support staff found "there is considerable variation in their duties and tasks" (2021:1, see also Sarigiovannis, 2022). Inconsistency "around roles and responsibilities and unclear expectations about the healthcare assistant role from other team members and others continues to be identified as a workplace constraint for support staff" (Fee et al., 2020:984). This is also the case for Nursing Associates, despite registration and the setting of national standards for this role, (Blay and Roche, 2020; Kessler 2021a).

Supervision and delegation

There is some evidence that the quality of supervision can be an issue for some support staff (Sarigiovannis et al., 2021; Shore et al, 2022). Shore and colleagues review of twenty studies on this topic found that "multiple studies reported that supervision did not always occur as expected" (2022: 10-11). Blay and Roche's systematic review of studies considering the tasks delegated to Nursing Associates (NA) found that "nurses considered NA supervision to be time consuming, challenging and adding to their workload" (2020: 1543).

A number of studies have addressed the factors that appear to enable safe and effective delegation of tasks to support staff, as well as the consequences of not enabling appropriate delegation. The factors underpinning safe delegation identified in this literature we reviewed are set out in Table 5. Etty and colleagues (2024) identified eleven separate studies that recorded underutilisation of AHP support worker due to inconsistent delegation, with one academic article they identified reporting that only 10% of support workers in their study were performing all the duties that they could actually have performed. There is evidence from Australia that registered AHP staff are undertaking a significant number of clinical and non-clinical tasks that could safely and more appropriately be delegated to their support staff colleagues. Performing these tasks represent as much as a quarter of their time (Somerville et al., 2018).

Poor delegation "may lead to [support staff] not being able to be fully utilise their clinical skills, which may result in job dissatisfaction as well as disparity in the clinical service provided to patients of equal clinical need" (Sarigiovannis et al., 2021:17). Another study found that when "nurses fail to delegate it may result in missed care" (Crevacore et al, 2023:890). Shore and colleagues (2020) observe that "support workers were generally receptive to taking on new tasks and learning new skills particularly if they would benefit patient care, ease pressure on the wider team or free registered nursing time" (page 11). Their review found that error rates were linked to whether or not appropriate delegation processes and support had been established, for example training.

Titles

Crevacore and colleagues (2023) reported that, internationally, support worker roles are known by more than 300 separate titles. Sarigiovannis and colleagues (2021) also noted the plethora of titles used to describe support roles, (as have recent non-academic reviews such as that by Palmer and colleagues (2021) which found over 90 titles used to describe support staff employed in mental health services). Etty and colleagues (2024) point to the fact that the "wide variation in job titles ... suggest that role content varies widely" (page 2252).

Table 5: Factors influencing effective delegation of tasks to support workers

Factor	Studies
• Understanding of support roles	Blay and Roche, 2020; Crevacore et al., 2023; Sarigiovannis et al., 2022; Shore et al, 2022; Etty et. al, 2024.
• Unambiguous scope of practice	Blay and Roche, 2020; Crevacore et al., 2023; Sarigiovannis et al., 2022; Shore et al, 2022; Etty et. al, 2024.
• Experience and confidence of registered staff	Sarigiovannis et al., 2021; Crevacore et al., 2023; Etty et. Al, 2024
• Availability of training	Blay and Roche, 2020; Sarigiovannis et al., 2022; Etty et al, 2024
• Appropriate delegation processes (clinical governance)	Sarigiovannis et. al, 2021; Sarigiovannis et al., 2022; Etty et al., 2024
• Effective team working	Blay and Roche, 2020; Sarigiovannis et al., 202; Shore et. al, 2022; Etty et. al. 2024
• Frequency of supervision	Shore et al., 2022
• Time to discuss tasks and review practice	Shore et al., 2022; Etty et. al, 2024
• Effective communications between registered and support staff	Shore et al., 2022; Etty et. al, 2024
• Registered staff's attitudes towards support staff (such as perceptions of competence, whether support workers seen as 'cheap substitutes' for registered staff) and perceptions of the impact of delegation (scope creep, loss of job satisfaction)	Etty et. al, 2024
• Working across professional boundaries or not	Sarigiovannis et al., 2022

Support workers motivation to learn, access to education and training and progress their careers

Kessler and colleagues (2021b and 2022) found that support staff were keen to access learning, with the majority of those responding to their survey stating they were motivated by a desire to progress their careers (50%) and perform their job better (33%). However, whilst support workers may be keen to learn, their ability to access the education and training they require, continues to be identified as a constraint in the literature (Wood et

al., 2023; Sarigiovannis et al., 2021; Blay and Roche, 2020 and Kessler et al., 2021b and 2022). Sarre and colleague's (2018) study of the provision of education opportunities in three NHS trusts included a consideration of the experience of support workers and found variation in practice between the trusts, with one, for example, offering protected time for learning but the other two not. Specifically, barriers to support worker's access to learning were reported to be staff shortages, "variability in ward manager's enthusiasm", problems with IT infrastructure or lack of IT literacy (ibid, page 146). This study was, however, based on just ten interviews. The more comprehensive investigation of nursing support staff undertaken by Kessler and colleagues (2021b and 2022) identified the following significant barriers –

- Training not offered during working hours
- Lack of knowledge about available training
- The cost of training courses
- A lack of personal return (e.g., higher pay) from completing training
- Lack of flexibility to balance work and domestic responsibilities
- Lack of protected study time

Etty and colleagues (2024) also identified a range of barriers that prevented support workers progressing their careers. These were –

- The absence of career frameworks
- Lack of a defined pathway into registered roles
- Limited opportunities for progression
- Limited opportunities for gaining experience
- Lack of formal training plans
- Limited access to training
- Lack of recognised qualifications

Evidence of impact

Etty and colleagues' (2024) review of the research on the deployment of AHP support workers found seven studies that considered the impact that more effective deployment of support workers could have –

> a shorter length of stay for patients, reduced costs...increased service capacity and the release of registered practitioner [time]...Additionally a clinically and statistically significant improvement in all dimensions of patient satisfaction was observed following the implementation of a nutritional support role (page 2263).

A review of twenty studies considering the efficacy of delegating medicine administration found that "predominantly patients were happy with the care provided by non-registered support workers...rating care as excellent or good" (Shore et al, 2022: 11). Delegation of responsibilities to support staff increased "visits by non-registered support workers" which "resulted in fewer nurse visits for patients requiring medication support for low complexity long term conditions" (op cit., page 11). Other benefits identified by this review were -

- Improved care planning resulting in earlier detection of problems
- Increased continuity of care
- More timely administration of medication

Schwatz and colleagues (2018) found that using support staff to undertake mealtime observations was as effective as having a registered member of staff undertake them. Farell (2020) found that the development of a band 4 role in a fall's clinic led to a 54% reduction in onward referrals. Moreover, service users were "well informed and engaged" and received more timely interventions through utilisation of the support role (op cit., page 148). More generally Davison and Lindqvist (2020) note "the importance of HCAs in fostering compassionate care" on wards (page 384). Assessing the contribution support staff make in general practice Dakin and colleagues (2023) point to the pivotal role support staff play interacting with patients helping to guide and "navigate the patient through the healthcare system and appropriately allocate resources" (page 3). Support staff deliver culturally competent care "due to experiences of particular cultures, languages, social classes, government structures and disabilities" (op cit., page 3).

Discussion

The lack of a substantial body of research - in terms of both volume and quality – investigating the clinical support workforce is a challenge. However, the literature we have reviewed does support our conclusion that the original issues identified by *The Cavendish Review* (Department of Health, 2013a) not only continue to characterise the support workforce employed in the United Kingdom but also internationally (Etty et. al., 2024). The research consistently identifies a number of common themes in respect of the perception, deployment, utilisation, and development of this group of staff. Although not included in our review, recent non-academic investigations into support roles in particular healthcare occupations, (Griffin, (2018) for maternity, Snell and Grimwood, (2020) for Allied Health Professions and Palmer et al., (2021) for staff employed in mental health services), have also found similar issues, again suggesting they remain characteristics of how staff experience employment.

Significally there is emerging evidence that the underutilisation of this workforce may have a detrimental impact on patient care and the workload of registered staff. This suggests, as some studies have quantified (Sommerville et al, 2018, Griffin and Fordham, 2023), that there is scope to increase workforce capacity and capability through better deployment of support staff, and the findings in respect of the factors underpinning effective delegation suggests issues that need to be addressed to ensure support staff contribution is optimised.

What do support staff think needs to change?

This study's survey asked respondents to identify what, if anything, they thought could be done to improve their experience of work. A series of potential workforce practices, including all of those that were recommended in *The Cavendish Review* (Department of Health, 2013a), along with others identified in the *Shape of Caring* (HEE, 2015) review and subsequent research, were set out and respondents asked whether they felt each would be beneficial to them or whether they felt that they were not needed. Respondents were also able to highlight any other changes that thought should be implemented in the free text question.

Workforce interventions that would improve the development and utilisation of support staff

Table 6 sets out the proportions of survey respondents who strongly agreed or agreed (combined) that a particular intervention would be beneficial. As can be seen there was strong support for every suggested intervention.

Table 6: Interventions

Intervention	Per Cent Agreeing
Nationally agreed common job titles	80
Protected time for studying	97
Dedicated and protected Continuing Professional Development funding	96
Representation of support staff on Trust and ICB boards	93
A national Skills Passport to record learning	93
Greater support to access pre-registration healthcare degrees	91
Improvements in the quality of appraisals and setting of PDPs	89
Creation of competency frameworks for all patient-facing support roles	94
Nationally agreed descriptions of roles and responsibilities	94
Support staff should have access to mentors to assist their development	95
Support staff roles should be formally regulated	87
The impact of twelve-hour shifts should be reviewed	82
There should be a dedicated national support workforce plan	93

Analysis of the open text responses identified a number of further changes respondents thought would improve the position of support staff –

- Recognition of prior and experiential learning

- Regular reviews of Job Descriptions
- Regular reviews of pay banding
- Opportunities to gain work experience outside of existing roles
- Greater flexible working
- The creation of more higher-level support roles focused on the education, research, and leadership pillars of practice

Discussion

It is striking the extent to which support workers still perceive the recommendations made by *The Cavendish Review* (op cit.,) as being needed. For example, only 1.5% of respondents thought there was *no need* to protect study time, only 1.6% thought that there was no need for a national NHS workforce policy focused on the support workforce, and just 4.2% did not see the continuing need for clear descriptions of tasks that support staff could perform. The intervention that the largest proportion felt was not needed was a review of shifts, but even here only 10.3% of respondents felt this was not necessary. These findings also suggest that many of the interventions needed to improve support worker employment conditions, most of which were, in fact, included in the *Talent for Care* (HEE, 2014) strategy, have not been implemented by employers locally, but, in the view of support staff, should be.

In terms of the additional interventions proposed in the survey, recognition of prior and experiential learning for staff seeking to enter pre-registration healthcare degrees, was, in fact, a theme raised by *The Cavendish Review* (op cit.,) and would still appear to be a barrier for those wishing to progress their careers in that direction. As will be discussed in the next section the lack of recognition of acquired learning may be a signal of how support roles are perceived. Not a feature of the original review, is the demand for the creation of higher-level support workers (non-registered roles often graded at *Agenda for Change* band 5) that have specific non-clinical responsibilities that warrant their higher banding, such as organisational responsibilities, leadership, and educational support. Although such roles have begun to emerge in recent years, particularly in the Allied Health Professions (see [here](#) for examples from orthoptics), they are few in number, but this perhaps points to the future potential to create career pathways along non clinical pillars of practice for support staff. Finally, it is worth noting that nine out of ten respondents believed that support roles should be regulated.

Why are support staff 'invisible' and what are the consequences of this?

This study's survey and scoping review has found that the issues identified in 2013, to a large extent, still characterise the working experience of NHS clinical support staff. Decisions about this workforce's recruitment, educational requirements on entering employment, job titles, allocation of tasks, skills acquisition, banding, access to learning and career progression still remain primarily in the hands of individual employers. A lack of mandated policy results in inconsistencies, underutilisation, under deployment and wasted resources. A "lack of central coordination" is, in fact, an international characteristic of how this workforce is treated (Nancarrow, 2020:102). This begs the question: why are decisions about the management of support staff so context dependent? This section will briefly explore a number of possible answers. This is, though, an under researched area which warrants further investigation. This section will also draw on research to describe the cost to the NHS of underinvesting in its support workforce.

Managerial and Professional explanations of the position of support staff

Classically two, sometimes opposing; sometimes linked, explanations have been put forward to explain the relative position of healthcare support workers within the wider healthcare clinical workforce. One approach sees their situating as a consequence of specific approaches to public sector management that were first introduced in the 1980s and are often described as New Public Management (NPM). NPM sought to "contain the costs of public sector health and care" by introducing "business concepts, techniques and values" into the public sector including "an emphasis on performance and outcome measures" (Dent, 2020:60). In terms of support staff specifically, NPM meant ensuring–

> the high cost of professional work is minimised by substituting qualified nurses with unqualified *(sic)* and lower paid support workers where ever possible in order to contain costs (Dent, 2020:66)

The other explanatory approach focuses on the role that professional interest groups play in shaping the work of those close too, but outside of their scope of practice. According to this explanation–

> the main driver for the creation of the modern generation of healthcare support workers was the further professionalisation of nurses which fits well into a neo-

> Weberian analysis of social closure. It was initiated with the policy of Project 2000[12] (Dent, 2020: 62)

This approach stresses that groups, such as nurses, have sought to protect their professional status by closing and protecting their scope of practice and restricting access to their profession[13] resulting, amongst other things, in the shedding of tasks they do not feel fall within their remit, such as so-called 'dirty work' which can explain the growth in support roles as necessary to undertake such tasks(Daykin and Clarke, 2000)[14].

There are, though, reasons to question the validity of both of these explanations. The signposting of the 1980s as a 'pivot' point in the development of the support workforce ignores the long history of the support roles in the NHS (and before). This history has long been characterised by the sort of issues Cavendish (Department of Health, 2013a) described. The 1972 review of nursing chaired by Asa Briggs, for example, highlighted that nursing support staff, such as nursing auxiliaries, worked under a variety of titles and struggled to access training once substantively employed (Griffin, 2023a). It should be recalled that after the implementation of *Project 2000*, which is referenced by Dent (2020) as a key moment in the history of support staff, it was the old auxiliary roles and State Enrolled Nurses that were replaced by the newly introduced Health Care Assistant role, not registered nurses. In terms of professional closure, a complex picture emerges of the tasks that nurses and others do and do not discard (Kessler et al, 2015). Finally healthcare professions are now graduate-only and governed by clear standards and regulation suggesting the need to protect professional boundaries is unlikely to be driving development and condition of support roles, even if it was previously.

Turning to NPM, it is arguable in England whether cost cutting through skill mix has occurred "where ever possible" in a comprehensive and systematic way as the NPM explanation proposes (Dent, 2020:66). Whilst skill mix ratios have ebbed and flowed in the NHS, there is no evidence of substitution of registered staff, (although such fears do appear to remain, at least, in the nursing profession). Although the *NHS Long Term Workforce Plan* (NHS England, 2023) predicts an increase in support staff numbers; this increase is matched by an equivalent rise in the number of registered staff, meaning that overall skill mix ratios will not change. NPM is also often framed as conflictual approach to public policy, which in part sort to weaken the power of organised labour. In reality the majority of significant policy developments in terms of the support workforce, such as

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[12] Published in 1986, *Project 2000* resulted in, amongst other things, a greater emphasis on the academic training of nurses reducing the time they spent on wards whilst studying. The loss of capacity this created led to the creation of a new support role in nursing (albeit with very little national guidance on the role's scope of practice or educational requirements) called the Health Care Assistant (Griffin, 2023a).
[13] Nursing became an all-graduate profession in 2010.
[14] The issue of delegation of menial tasks was encapsulated in the 'debate' two decades ago about whether nurses were "*too posh to wash*" patients.

the development of the Care Certificate and, more recently, competency frameworks, have been designed in partnership with trade unions and professional bodies. Social partnership has been the dominant characteristic of the small amount of policy that has developed in this space. Where there have been deliberate decisions and guidance nationally to develop specific support roles, for example in maternity or radiography, the stated rationale has been to improve patient care, not to cut costs or substitute registered staff. Commenting on the introduction of Assistant Practitioners in radiography, which first occurred in 2003, Snaith and Harris (2018) state the rationale was to "invigorate a career structure, improve staffing levels and deliver high quality care" (page 1). This contrasts with both the managerial and professional approaches which see support worker growth and situating as being the result of external factors: the consequence of cost cutting or protection of boundaries. The possibility that supports roles exist because they provide necessary knowledge and skills to assist patients is not considered by either approach.

If the managerial and professional approaches do not adequately explain the position and experience of support staff, are there any other explanatory frameworks that might?

Dual labour market theory

Dual labour market theory (Doeringer and Piore, 1970) posits that labour markets, whether within individual businesses, whole industries or nationally, are characterised by segmentation, with some workers being employed in a relatively privileged, (in terms of job security, pay, access to education, status, and career development opportunities), 'primary' market, and others employed in a less privileged 'secondary' market with lower pay, job security, opportunities and status. A worker's market position is not determined by their productive contribution, as classic economic theory suggests it should be, but rather by characteristics such as their gender, ethnicity, whether they have a disability or not and/or social class (Bradley, 2015 and Warhurst et al., 2017). Workers are segmented in the workplace by these characteristics (or a combination of them) and this, rather than the objective needs of a job and the individual employed in it, determines, for instance opportunities to acquire skills and how acquired skills are perceived and recognised by others (Warhurst et al., 2017)[15].

There are consequences arising from the existence of dual labour markets –

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[15] An enduring issue raised by support workers, highlighted by Cavendish (ibid.,) and in this study's survey is the fact that their experiential learning is frequently not valued, for example when support staff seek to access pre-registration degrees. This points to a lack of equivalence in perceptions of the value of skills, a feature of dual labour markets (Warhurst et al, 2017). Support worker acquired skills could be said to be 'invisible'. *The NHS Long Term Workforce Plan* (NHS England, 2023) explicitly states on page 32 that a rationale for increasing the number of support roles is to increase *"skilled"* roles higher-up the grading structure. Are support workers, though, also not skilled? The word 'skilled' here is being used to delineate job segmentation.

- Duality is "detrimental to productivity growth...leading to higher turnover rates" (Bentollia, 2019:2) which leads to a loss of organisational knowledge and unnecessary selection, recruitment, and onboarding costs (Fuller and Raman, 2023)
- Worker access to work-related education and skills acquisition is not linked to their role's needs but rather perceptions of the subjective quality of their work leading to exclusion (Warhurst et al., 2017).
- Duality results in higher absenteeism, unnecessary levels of overtime, and an over-reliance of agency and temporary staff (Fuller and Raman, 2023).
- It is difficult for employees to move from one segment to the other reducing employer scope to develop work-based talent pipelines (Turbin et al, 2014).

Does the NHS have a dual labour market and if so, why?

Turbin and colleagues (2014) have pointed to the probable existence of duality within the NHS's internal labour market. The evidence we have gathered about how the support workforce experiences work suggest that they do, in fact, often experience many (but not all) of the characteristics of workers employed in secondary markets. For example: their roles can be perceived as being of a low status, they have truncated career structures, are underinvested in and experience difficulties progressing into the primary market. Sarre and colleagues (2018), in the context of their review of the issues influencing healthcare staff's access to training, suggest that the limited access to learning support staff experienced was due to their "place in the work hierarchy" (page 152). Camilla Cavendish herself noted that the NHS workforce systems created siloes "between different groups of staff "(ibid., page 42). It should be noted, however, that one of the key signifiers of duality – relative job security – does not apply to support staff who are covered by the same collective agreements as their registered colleagues.

Although more research is needed, it does seem that a case can be made that dual labour market theory might be a useful lens through which to understand the employment conditions of support staff working in the NHS, certainly more fruitful than the managerial or professional approaches. Those groups working in a secondary market often feel marginalised and excluded (Warhurst et al., 2017), which is how support workers often report that they feel. The NHS dual labour market for clinical staff is, then, split between those staff who are registered with a regulatory body and those that are not; between those who need to acquire a formal qualification to be eligible to practice, and those that have what are often seen as 'acquired skills' (Warhurst et al., 2017) rather than formal qualifications. Until recently (2001 in the case of the Royal College of Nursing), duality could also be identified in terms of eligibility for professional body membership.

If duality can be said to exist, a further question that needs to be consider is: what underpins this duality?

Given the gendered nature of both the registered and unregistered clinical NHS workforce it would seem unlikely that gender-based discrimination drives duality. Data on the ethnicity of the support workforce also suggests that there are not significant differences between it and the primary segment (Griffin, 2023a)[16]. This leaves the possibility of social class being a significant determining factor. The formal educational attainment of people from working class backgrounds often means they enter organisations at a lower entry point than people from middle class backgrounds (Warhurst et al., 2017). Subsequent poor access to development opportunities means, even when employed, working class employees struggle to progress their careers. This study's findings point to the fact that support staff are more likely to come from working class backgrounds than registered staff. Class, then, could explain NHS labour market duality.

Good work or bad? Realising the potential of support staff.

There has been a renewed interest in what is described as 'Good Work' (Taylor, 2017): those employment practices that workers perceive as being "fair and decent" (Williams, et al., 2020:4). These practices include well-designed jobs, access to training and clear career progression opportunities (Ogbonnaya et al., 2017). Providing conditions of Good Work results in benefits for staff, employers, and customers (Achor et al., 2018). Research in the NHS, for example, suggests that trusts who have deploy such working practices experience a range of benefits including lower turnover, increased employee engagement and greater staff satisfaction (Ogbonnaya et al., 2017). Outside of the NHS others have pointed to the benefits of delivering Good Work particularly for those who might be described as 'low status or waged workers'-

> [Investment] results in greater productivity...a drop in turnover rates, improvements in customer service and an increased ability to attract frontline staff. And promoting internally helps companies meet their diversity goals, because the low wage labour pool is disproportionally drawn from under-represented groups (Fuller and Raman, 2023)

The insights of this study lead to a conclusion that many support staff *do not* experience conditions and practices that might be described as characterising Good Work and as described above, this may be due to the existence of a dual labour market. The findings of this study suggests that there are specific costs associated with this for the NHS, for example-

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[16] Which is not to say that racial discrimination does not exist in the NHS (Kline, 2014).

- Nearly a third of this study's survey respondents (29%) strongly agreed that they aspired to become registered professionals. Given the enduring and worsening staff shortages the NHS faces, and the inability of traditional workforce interventions to address this, this represents a significant talent pipeline that could be mobilised to build capacity amongst registered staff. However, support staff still struggle to access work-based routes into pre-registration programmes. Degree Apprenticeships may help address this if existing staff are allowed to enter them. Early research suggests widening participation through apprenticeships could deliver significant benefits (Griffin 2023c). The NHS is though missing an opportunity to increase the supply of registered staff through work-based routes
- Registered staff are undertaking both clinical and non-clinical tasks that could be safely delegated to appropriately trained and supervised support staff. More effective delegation could increase workforce capacity by as much as 24% (Somerville et al., 2015)
- Modelling of the potential return to employers arising from implementation of the full AHP support worker strategy suggests a possible return of 150-200% (Griffin and Fordham, 2023). This study's scoping review (above) also provides examples of how better utilisation and deployment of support staff can improve productivity and the quality of care

This section has very briefly considered what might explain the situation of support staff in the NHS. We have suggested that dual labour market theory may provide a useful lens to explore further the drivers and consequences of the way this workforce experiences employment. This theoretical framework also points to the potential upsides of addressing the long-standing issues that *The Cavendish Review* (ibid.,) first articulated and this study has identified as still enduring. Unequal treatment at work can rightly be seen as socially unjust, which they are. They are also, as Cavendish pointed out, wasteful of a strategic resource.

Maximising the contribution of the NHS support workforce: conclusions and recommendations

NHS employees working as Assistant Practitioners, Orthoptic Clinical Support Workers, Dietetic Assistants, Maternity Support Workers, nursing Healthcare Assistants, Radiography Clinical Support Workers, Cancer Support Workers, Care Assistants, and in many, many other support roles are committed, engaged and aspirant members of clinical teams who work in all healthcare settings including in primary care and for mental health services. Over a decade ago, T*he Cavendish Review* (Department of Health, 2013a) identified a series of workplace issues that meant that this important workforce was frequently underutilised, undervalued, inconsistently deployed and often unable to progress their careers. Collectively this meant that care was not as effective, efficient, or as safe as it could or should be. Cavendish pointed to the lack of national regulation of this workforce as a key reason for the issues she identified.

Over ten years after the publication of *The Cavendish Review* (op cit.,) we have revisited its findings to ascertain whether they still describe the experience of most support staff working in the NHS. This report presents the evidence we have gathered through a major national survey and a review of the recent academic literature. Our conclusion is that it is reasonable to say that, whilst some progress has been made in the years since Camilla Cavendish undertook her review - not least the development of occupational relevant competency and education frameworks, most of the issues she identified are still typical of how this important, diverse, and growing part of the healthcare team experience working in the NHS in 2024. Progress for this group of staff has been slow, intermittent, and partial.

The strong support for all the proposed changes in workplace practices this study suggested (based largely on those Cavendish recommended the NHS adopt in 2013), shows how little practice has actually changed locally. Many of the interventions proposed, such as protected time and funding for learning, common job titles or access to mentors, are not addressed by the *NHS Long Term Workforce Plan* (NHS England, 2023).

There are many factors that can influence how an individual feels about their work. So-called 'hygiene' factors include status, job security, working conditions and pay. 'Motivating' factors include leadership, meaning and purpose, recognition, and organisational culture. For some factors, such as meaning and purpose, the survey would suggest support staff feel positive, for others including recognition and pay the picture is

less positive. This may explain why support workers are positive about the work they do but feel undervalued and may think about quitting their job. What does seem clear is that much has not changed in the last decade for this group of staff.

The NHS is under more even pressure today than it was in 2013. Support staff represent an underutilised resource that could help address those pressures in a sustainable but also cost-effective way. In 2020 Dr Katherine Halliday and colleagues, as part of the national *Getting It Right First Time* (GIRFT) programme undertook a review of radiography services. This review found that support workers were "underutilised even when the rest of the team were extremely busy" (page 20). "Few trusts" the report went on to say, "benefit from the opportunities [of support workers] to increase capacity" (page 36). As our findings show the situation found by GIRFT team in radiography is not unique[17]. Across the NHS in England, and indeed internationally, the potential capacity and capability of the support workforce is not being fully utilised. The findings of the scoping review we undertook, not only echo the issues our survey identified but also point to the potential productivity and patient care benefits of investing is support staff. Palmer and colleagues (2021) rightly described the potential of support staff as 'untapped'.

It is impossible to know for sure what would have happened if *The Cavendish Review* (ibid.,) recommendations had been mandated a decade ago. What is clear, though, is that failure to address them now will mean the NHS continues to miss out on the full potential of this critical, dedicated, and loyal part of the workforce. Fundamentally as Camilla Cavendish rightly observed, this is bad for patient care.

Recommendations

Camilla Cavendish pointed to the problem of NHS workforce planning and practice happening in silos (ibid.,) There is no question that there are issues that need to be addressed across the whole NHS workforce. However, the history of the NHS's frontline support staff is one of enduring barriers and constraints, first formally recorded in 1972 by Briggs and his committee but still persisting to this day. As such there is a need to consider the requirements of the support workforce specifically, albeit with the context of wider NHS workforce policy. This study's findings point to a large number of specific practices that would assist utilisation, deployment, development, and job satisfaction such as improved on-boarding, access to mentors and recognition of prior learning. All these should be considered by national stakeholders.

Drawing on *The Cavendish Review's* (ibid.,) original insights we think there is a need for the following high-level strategic actions -

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[17] Since the GIRFT report, the Society of Radiographers supported by HEE and now NHS England have developed a series of resources to address the issues their support workforce can face.

1. As soon as possible after the election, a **national stakeholder** summit should be organised to build a policy agenda for the recruitment, training, development, deployment, and management of support workers in health and care, with the end product an **Agenda for Action** to be taken forward by a dedicated NHS England team.

2. Senior leaders at all organisational levels of the NHS, including on trust boards and Integrated Care Boards should be identified and given responsibility for support staff recruitment, deployment, and development.

3. Local implementation of workforce interventions already developed for this workforce, such as the Care Certificate, the Higher Development Award and national competency frameworks should be **mandated** and appropriately supported. It should also be ensured that these interventions are appropriate to all occupations.

4. Local employers working with others in their Integrated Care Boards, should be required to **audit their support staff Job Descriptions** to ensure that they are up-to-date and, where applicable, are mapped against national competency frameworks.

5. Any national **NHS Job Profiles** for support staff that have not been recently reviewed should be reviewed by social partners to ensure that they reflect current practice and any national frameworks.

6. **Continuing Professional Development** (CPD) funding should be allocated to employers based on their whole clinical workforce numbers, both registered and non-registered staff. CPD funding for support staff should be **ringfenced** and **study time protected**. Consideration should be given by national partners to the creation of dedicated **Learning Allowances** for support staff to enable the support of non-apprenticeship training. Building on current good practice, such as the [ACCEND](#) programme, a **national support worker hub** should be established that provides information about roles, career opportunities, training and development needs. A national transferrable **e-portfolio** should be introduced based on [best practice](#).

7. **The Care Quality Commission** should consider training, development, voice, and management of all staff, including support staff, in their inspections, and to report back in a dedicated section in all inspection reports.

8. A standing national support worker **infrastructure fund** accessed on application by trusts and regions should be established to develop systems and roles to promote and underpin training & development of support workers.

9. A taskforce should be established that includes patient, employer and staff representatives, Council of Deans (Health), Association of Colleges, Independent Training Provider representatives and NHS England to address how barriers to **widening access to pre-registration healthcare degrees** can be comprehensively addressed to mobilise work-based routes into registered roles.

Appendix 1: The approach used in this study

The original *Cavendish Review* (Department of 2013a) focused on *nursing* health *and* social care support workers employed in England. This study investigates support staff employed in the NHS only but widens the focus to all patient-facing occupations not just nursing. The rationale for this is that the issues faced by social care support staff are considerable, context and path dependent and worthy of their own study. Researching beyond nursing is though, justified as numerous studies suggest that the issues healthcare support workers can face are common across all occupations (for example see Griffin, (2018) for maternity, Snell and Grimwood, (2020) for Allied Health Professions and Palmer et al., (2021) for staff employed in mental health services).

This report sets out the findings of two of the methods utilised in this mixed methods study seeking to assess whether support staff still experience conditions at work as Cavendish (ibid.,) observed – a national survey and a scoping review. Separately the results of the third method - the semi-structured interviews we undertook will be published. The results of the qualitative exploration, however, strengthens the finding that support staff still experience barriers to their development.

An electronic survey

An electronic national survey was designed. The aims of the survey were to assess -

- Whether respondents perceived that the conditions identified by Cavendish still characterised their working lives
- Whether respondents felt that a series of proposed changes to working practice, most recommended by Cavendish, were still needed or not

Statements in the survey were identified from the literature, including *The Cavendish Review*. Views were also sought from the study's Advisory Group and a small number of support workers from that group, assessed the survey before it was published. Likert-scales were deployed to assess attitudes to items. Demographic data was also gathered, and a free text question was included allowing respondents to raise any issues that they wished. The survey was promoted via social media and through the various media of partners including trade unions and professional bodies.

A scoping review of the academic peer reviewed published research.

Scoping reviews aim to explore the extent of literature in respect of a topic in order to provide an over view of the topic through summarisation, as well as to identify issues and gaps (Munn et. al, 2018). Scoping reviews appear to be the main approach adopted by researchers when assessing the available literature on support workers although this may actually reflect the more general popularity of scoping reviews (op cit.,) Other than ensuring studies were published in academic peer review outputs no assessment of relevant quality was used as an inclusion criterion (this was in order to capture the breadth of the literature).

The following inclusion criteria was adopted: article had to be peer reviewed, in English, focus on healthcare support workers/workforce roles, their experience of work, recruitment, effectiveness deployment, supervision, task allocation, training, development and career progression, and published between 2018 and 2024. Articles that focused solely on social care, or unpaid carers or volunteers were excluded. In total 115 articles were identified, and following review 22 were extracted and reviewed, although a number of these were scoping reviews themselves.

The invisibility of support workers to the healthcare research community

Healthcare support staff remain under researched. Sarigiovannis and colleagues (2021) note where research is carried out "studies were of mixed quality and the majority had methodological shortcomings" (page 18). Etty and colleagues (2024) also note "many studies are of low quality, small in scale and rely on gathering staff perceptions rather than conducting objective observations" (page 2265). Reviews also tend to draw conclusions about the workforce by conflating research published over a long-time scale and from different countries. Given the importance of the support workforce and the safety critical nature of healthcare there is a need for more high-quality and longitudinal research.

Appendix 2: Definitions

Stop calling us support workers! I find it very rude. Registered nurses could be called 'Dr's support', but they are given respect. Other thing - do not call us unqualified (Support worker)

How the clinical support workforce should be collectively described has long been a contentious subject (see, for example, Edwards, 1997). Often terms deployed, such as 'unqualified', which was recently used by a national newspaper (Raynor, 2021), signal the perception of this workforce being of a low status and/or frames their description in terms of what they appear to lack, in this case qualifications. A recent academic study described the workforce as follows – "[they] **do not** hold a qualification accredited by a professional association and **are not** formally regulated by a statutory body*"* (Shore et al., 2022:2, emphasis added). Such definitions might be described as 'deficit' approaches to nomenclature. They ignore not only the qualifications the workforce hold, but also the complex patient-centred and often physically demanding tasks it performs (Davison and Lindqvist, 2020)[18].

Whilst this study has used the collective noun 'support' throughout to describe this group of staff; even this term is problematical. As Kessler and colleagues (2012) have pointed out the word 'support' begs the question - 'who' do support workers, actually support? Frequently 'support' is framed as meaning supporting registered staff, rather than patients (Griffin, 2023a). A common theme of the Francis (Department of Health, 2013b), Cavendish (Department of Health,2013a) and Willis (Health Education England, 2015) reviews was the need to standardise titles. We still think this is necessary and that any discussion to do so should focus on the patient-focused care role staff perform as part of the team, rather than their relationship to other staff or perceptions of deficit.

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[18] They are also inaccurate: Nursing Associates are formally regulated, and some professional bodies have voluntary registers for their support staff members, such as the Society of Radiography.

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