Joined Up Careers Derbyshire

# Evaluation of Integrated Health and Social Care Support Worker Apprenticeship Scheme

February 2020

CordisBright

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# 1 Executive summary

## 1.1 Introduction

This report presents the findings of an independent evaluation of the pilot Integrated Health and Social Care Support Worker Apprenticeship Scheme in Derbyshire. The evaluation was commissioned by Joined Up Careers Derbyshire (JUCD)[1] and delivered by Cordis Bright[2], an independent research and consultancy organisation.

## 1.2 About the Scheme

The Scheme aims to raise the profile of careers within the sector and to secure a workforce of an adequate size and with the required skills needed to meet current and future health and social care needs, particularly in social care. The pilot ran between September 2018 and January 2020, providing an opportunity to explore the practicalities and merits of providing training, facilitating working, and creating integrated roles across health and social care in Derbyshire.

Apprentices who completed the Scheme undertook five placements in different health and social care settings in Derbyshire over 15 months, alongside gaining a Care Certificate and a Level 2 Diploma in Care covering both health and social care competencies. Placements were hosted by JUCD partner organisations and other local service providers.

## 1.3 Key achievements

Many of the intended outcomes and impacts of the Scheme were ambitious, large-scale and longer-term. Achieving them also relied on a range of other factors and initiatives outside of the scope of the Scheme itself. This reflects positively on the high aspirations of JUCD and key partners in Derbyshire to deliver greater integration and efficiency. However, it also means that it was not feasible to deliver, embed and evidence all of these outcomes and impacts within the timescales and resources available to the pilot.

Nevertheless, the Scheme made a number of key achievements over the pilot period, providing evidence of the commitment of local health and social care organisations to work together to develop and implement the Scheme. For example, delivery partners were engaged to recruit and employ apprentices, deliver training and host placements and they signed up to joint working protocols. Equally, a training package was developed for apprentices and the process of developing it enabled partners to increase their understanding of the

[1] JUCD is a partnership organisation whose aim is to improve health and social care services by focusing on workforce recruitment and development and sharing best practice. JUCD is part of Derbyshire's Sustainability and Transformation Partnership (STP). It comprises local authorities, NHS organisations, and private, voluntary and independent sector employers across Derbyshire and Derby City.

[2] Please see https://www.cordisbright.co.uk/ for more information about Cordis Bright.

training requirements for an integrated Scheme of this nature. This could be built upon in future iterations of the Scheme.

JUCD provided a coordinator role which offered administrative, pastoral and employability support to apprentices, as well as support to partner organisations. Eight apprentices commenced the Scheme and seven[3] of these went on to achieve their care certificate and complete at least three placements. Two apprentices then left the Scheme but the remaining five all successfully completed it, gaining the Level 2 Diploma in Care and experiencing five different placements. Of these, four had confirmed employment in health and social care by the end of the Scheme and the fifth was making applications to work in the sector. This provides strong evidence that those apprentices who completed the Scheme gained the required skills to work in health and social care roles.

In addition, the Scheme acted as a catalyst for local partners to increase the level and effectiveness of their collaboration around integrated training and working. It provided a concrete example of an integrated training scheme in action. The relationships, pathways and learning resulting from the Scheme are likely to be transferable to wider work to integrate health and social care recruitment and retention activities, and to explore other opportunities for developing and delivering integrated training and roles.

The remaining intended outcomes and impacts targeted system-level changes which would require resources and activities outside of the scope of the Scheme and which would always take time to achieve, embed and evidence. As such, the evidence of progress towards these impacts is relatively limited though there is some evidence that it has contributed to progress in some areas, or that it might contribute positively if it were delivered on an ongoing basis and scaled up.

## 1.4 Areas for future development

The Scheme aimed to contribute towards sector improvement, the professionalisation of integrated health and social care roles and improved progression routes within these. Yet the pilot did not result in the development of a specific integrated progression route for apprentices, such as a designated post-qualification integrated health and social care role[4]. This limited the extent to which it could contribute to more integrated delivery of health and social care, beyond trialling a more integrated training scheme for a specific cohort. It also potentially impacted on apprentices' satisfaction with the Scheme, and could contribute to recruitment difficulties or attrition in future iterations of the Scheme if prospective participants are attracted by the idea of a specific progression route.

[3] The eighth apprentice to commence the Scheme was aged under 18. After they had begun it transpired that they were ineligible to undertake placements at some placement hosts as a result of their age and would therefore be unable to complete the Scheme. They were transferred to a generic apprenticeship programme at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB NHS FT).

[4] The proposal for extending the Scheme to a second cohort refers to an enhanced community centred worker role, which is currently being explored across Place and Primary Care Networks. This would be an integrated role and, if established, could provide a progression route for apprentices who complete the Scheme.

It was likely challenging to develop this type of role within the timescales and resources available for the Scheme. In particular, it might be hard to see where best to situate such a role within the system in order to maximise its utility to existing providers and its impact on integration. Therefore work would be required beyond the scope of the Scheme itself in order to identify demand, gaps and opportunities to introduce specific integrated health and social care roles. In addition, the training requirements for different integrated roles are likely to vary substantially. This means it will be important to determine and map the particular training requirements for each role once the roles are identified and agreed.

## 1.5 Sustainability

Local partners have decided to extend the Scheme to a second cohort of apprentices in 2020-21, indicating that they are supportive of the Scheme in principle and willing to continue to fund it in the short-term. The longer-term prospects for Scheme continuation are not known at present. However, its delivery for a second cohort provides an opportunity to further shape the programme, to achieve further outcomes and impacts and to progress towards longer-term outcomes and impacts. Ongoing monitoring of the outputs, outcome and impacts of the Scheme will be crucial in determining whether there is a business case for its longer-term continuation.

The key challenge to continuing the Scheme on an ongoing basis is gaining and maintaining buy-in to participate and direct funding inputs from different local partners. A revised approach to apportioning the provider share of funding will be implemented in 2020-21, which may mitigate this challenge. It is also possible that delivering the Scheme to larger cohorts on an ongoing basis would result in economies of scale. Yet even if this is the case, it is likely that additional work would be required to build in and articulate direct benefits to partner organisations. It will also be important to outline ways in which the Scheme can contribute to positive system-wide outcomes and obtain partners' commitment to supporting these outcomes.

## 1.6 Learning from implementation

The evaluation identified several key strengths and enabling factors in delivering the Scheme, which should be replicated in delivery for the second cohort of apprentices and in any future iterations of the Scheme, as well as by other local areas planning to introduce similar initiatives. The most important enabling factor was the provision of a designated role by JUCD to offer support to apprentices and partners, which greatly facilitated the day-to-day operation of the Scheme. Other significant enabling factors were high buy-in, flexibility and responsiveness from local partners. The primary strengths were the quality of placements and training and the variety of experiences and learning offered.

The Scheme also encountered challenges and areas for development in implementation. Some of these were predominantly a facet of the pilot nature of the Scheme and there was evidence that delivery was improved and adapted during the course of the pilot. The challenges and areas for development have been translated into recommendations, which are summarised in Chapter 2.

# 2 Summary of recommendations

The evaluation identified eleven recommendations for the future development of the Scheme, which could be considered during delivery for the second cohort of apprentices. They may also be of use to stakeholders in other geographical areas with an interest in implementing an integrated apprenticeship scheme or similar initiative. These are summarised in Figure 1, which also highlights the sections of the main report in which the evidence for each recommendation is discussed in more detail.

*Figure 1: Recommendations*

| Recommendation | Explanation | Section reference |
|---|---|---|
| **Scheme design** | | |
| **Developing a robust logic model or Theory of Change**. Any future logic model or theory of change for this Scheme, or similar local programmes, should include SMART[5] outcomes and impacts which are directly connected to the inputs, activities and outputs of the Scheme. It should also aim to reflect other factors and initiatives outside of the Scheme which might contribute to or enable achievement of the Scheme's outputs, outcomes and impacts | Many of the intended outcomes and impacts of the Scheme were ambitious, large-scale and longer-term. It was also likely that their achievement would be related to a range of other factors and initiatives outside of the Scheme. This is a positive reflection of the high aspirations of JUCD and key partners in Derbyshire to deliver greater integration and efficiency. However, in practical terms it means that it was unlikely that a number of outcomes would be achieved and evidenced within the initial funding and delivery period of the pilot Scheme, and with a pilot of this relatively small scale. In any future iteration it would be useful to develop a logic model or Theory of Change which a.) is limited to outcomes/impacts that can be achieved within the Scheme's resources and activities and/or b.) acknowledges factors outside of the Scheme itself which might impact on the same outcomes and impacts. | 4.2 |
| **Inclusion of a coordinator role**. It is important to identify resource and responsibility for delivering a coordinator role to offer administrative, practical and pastoral support to apprentices and partner organisations involved in delivery. In particular, the | The coordinator role introduced during the pilot proved to be a key strength of the Scheme and invaluable in ensuring that apprentices and partner organisations received the administrative, practical and pastoral support they needed. A | 6.3.4 |

[5] SMART stands for Specific, Measurable, Achievable, Relevant and Timebound.

| Recommendation | Explanation | Section reference |
|---|---|---|
| co-ordinator would need to have significant capacity and appropriate training and support to provide the pastoral element of the role, which proved to be an extensive component of the role during the pilot | similar role would therefore be important in the effective delivery of any continuation of the Scheme or a similar programme. | |
| **Set-up and preparation** | | |
| **Recruiting partners to the Scheme**. To help to recruit partners to the Scheme, it might be useful to signpost potential partners to the role of the Scheme in improving collaboration between partners around integrated training and working, and the benefits of this for partners. These outcomes and benefits are discussed is more detail in section 5.4.3. | Stakeholders identified that the key challenge to continuing the Scheme in its current form was gaining ongoing buy-in to participate and direct funding inputs from different local partners, which related to a difficulty identified by stakeholders in articulating the direct benefits of participation in the Scheme for partners. The evaluation identified benefits for partners as a by-product of improved collaboration around integration. These findings could be shared with (prospective) partners to encourage participation in any future iteration of the Scheme. | 6.5.3 |
| **Producing a comprehensive training schedule and overview**. It would beneficial to develop a full training overview and schedule if this is not already available. This could be shared with applicants, apprentices, Scheme delivery partners, and any other stakeholders with an interest in integrated health and social care training. | The Scheme documentation shared with Cordis Bright did not include a document mapping out all the selected training units and a training schedule for the whole Scheme in one place. This would have been helpful in providing an accessible overview of the training component of the apprenticeship, useful to (prospective) apprentices, partners involved in scheme and wider stakeholders with an interest in the Scheme | 5.3.2 |
| **Mapping training modules alongside placement opportunities**. It would be beneficial to map training modules alongside placement | During delivery of the Scheme, the sequencing of placements and training modules for the Level 2 Diploma in Care did not always align. This created challenges for apprentices when | 6.4.6 |

| Recommendation | Explanation | Section reference |
|---|---|---|
| opportunities in order to develop a schedule where placement-based learning aligns as closely as possible with off-placement training for the Level 2 Diploma in Care and with the expectations and timings for assessment. This links to recommendation 2 in Section 5.3.2. | synthesising their learning and for placement hosts in understanding the key competencies which should be covered during the placement. Mapping out placements alongside training modules might service to improve alignment and thereby streamline the programme. | |
| **Production of accessible and comprehensive Scheme summaries for key partners**. All partner organisations should be provided with an accessible and comprehensive summary of the Scheme and their roles and responsibilities within it. This could be based on the FAQ documents which were already developed during the pilot period. | A comprehensive Scheme summary for partner organisations would support the consistency of the offer and delivery across training and placement providers (recommendation 7) by reinforcing key roles and responsibilities and ensuring all partners are aware of these. | 6.4.5 |
| **Ensuring the Scheme aligns with apprentices' expectations.** It is important to provide prospective apprentices with accessible and transparent information about the requirements, structure, opportunities and progression routes involved in the Scheme. Ideally, this would include written information that they could review in advance and verbal information via a meeting or presentation during which they could ask questions and seek clarification as required. | The evaluation found a number of instances where the delivery or outcomes of the Scheme did not meet apprentices' original expectations or where they were unsure of what to expect from the Scheme. This was an understandable by-produce of the fact that the Scheme was still in development during the recruitment and induction period. However, in some instances, it might have reduced satisfaction with the Scheme and/or contribution to attrition from it. Therefore providing more detailed information to apprentices during recruitment and induction will be important in any future iterations of the Scheme. | 6.4.3 |

| Recommendation | Explanation | Section reference |
|---|---|---|
| **Delivery** | | |
| **Providing advanced notice of placements**. It is important to provide all apprentices and placements hosts with advanced notice of placement schedules. This should include, as a minimum: placement start and end dates, location, working days and hours. | During the pilot, delivery partners and apprentices were not always notified of placement timetables and requirements far enough in advance. Again, this was linked to the fact that Scheme was still under development during the pilot delivery period. Nevertheless, it impacted on apprentices' and placement hosts' ability to prepare for placements and on apprentices' sense that they understood their trajectory across the apprenticeship. It also affected consistency and continuity across placements. Giving adequate advanced notice of placements in any future iteration of the Scheme could address this. | 6.4.4 |
| **Increasing the consistency of the training and placement offer**. It would be beneficial to explore and agree an employment, training and placement offer which is as consistent as possible across organisations. Key considerations are likely to include consistency of: employment terms and conditions, training provision (on- and off-placement), placement structure and support offered by placement hosts. This should include a single point of contact within each placement host, as well as allocated mentors/buddies for individual apprentices. | During the pilot it proved challenging to ensure consistency of the apprenticeship offer and delivery across employers, placement hosts and training providers. Again, this related in part to the Scheme being a pilot and having limited set-up time prior to the first cohort of apprentices starting, and also to necessary variations related to different setting and providers. However, if greater consistency of the overall offer and experience of apprentices could be achieved this would likely represent an improvement to the Scheme. | 6.4.5 |

| Recommendation | Explanation | Section reference |
|---|---|---|
| **Monitoring performance and outcomes** | | |
| **Monitoring performance and outcomes on an ongoing basis**. It would beneficial to develop approaches to monitoring performance against its intended outcomes and impacts, and particular those which will only be evident in the longer-term. Key steps include:<br>• Ensure that the outcome or impact is SMART and directly linked to the inputs and activities of the Scheme.<br>• Determine indicators which would capture data on the outcome or impact.<br>• Review the best approaches to collecting data against these indicators, and to isolate the impact of the Scheme from other factors which might impact on them.<br>• Allocate responsibility for collating and monitoring this data. | In order to understand the outcomes and impact of the Scheme or a similar programme it is important to monitor these on an ongoing basis, and to develop mechanisms for capturing data about the extent to which they have been achieved. | 5.6 |
| **Additional work to build integration initiatives** | | |
| **Consultation and/or needs assessment to explore integrated roles**. Whilst outside of the scope of the Scheme itself, if there is appetite and resource to develop integrated roles, partners may | A key area for development for the Scheme was in developing a specific and integrated role into which apprentices could progress following completion of the Scheme. This would likely have required a longer timescale than the pilot period and a key | 6.4.7 |

| Recommendation | Explanation | Section reference |
|---|---|---|
| wish to undertake a consultation and/or needs assessment exercise to identify and map the demand, gaps and most appropriate opportunities to introduce integrated roles within the health and social care system | component would be wider strategic work by partners to determine where and how integrated roles might best be introduced into the system. | |

# 3 Introduction

## 3.1 Overview

This report presents the findings from an independent evaluation of the pilot Integrated Health and Social Care Support Worker Apprenticeship Scheme run by Joined up Careers Derbyshire (JUCD). The pilot scheme ran between September 2018 and January 2020.

The evaluation was conducted by Cordis Bright, an independent research and consultancy organisation specialising in health, adult social care, children and young people's services and criminal justice[6]. It took place between June 2019 and February 2020.

## 3.2 About the Scheme

The Scheme involves apprentices earning a Care Certificate and a Level 2 Diploma in Care, whilst gaining experience and training in a range of health and social care settings over 15 months. This is through five rotating placements each lasting three months. Apprentices are supported throughout by JUCD and receive training for their Level 2 Diploma in Care from an external training organisation. For the pilot scheme, there were two different cohorts of apprentices. Each cohort was employed and line managed by a different organisation, both of which were also placement hosts. The employer organisations were:

- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB NHS FT), for a cohort based in the south of Derbyshire.
- Derbyshire County Council, for a cohort based in the north of Derbyshire.

## 3.3 About Joined Up Careers Derbyshire

JUCD is a partnership organisation whose aim is to improve health and social care services by focusing on workforce recruitment and development and sharing best practice. JUCD is part of Derbyshire's Sustainability and Transformation Partnership (STP). It comprises local authorities, NHS organisations, and other partner organisations across Derbyshire and Derby City. For a list of the organisations involved in the partnership, please see Appendix A.

## 3.4 Evaluation aims

This evaluation aimed to:

- Clearly and succinctly describe the pilot Scheme.

[6] For more information about Cordis Bright, please see: https://www.cordisbright.co.uk/.

- Outline outputs, outcomes and impacts achieved.
- Describe high-level findings on implementation.

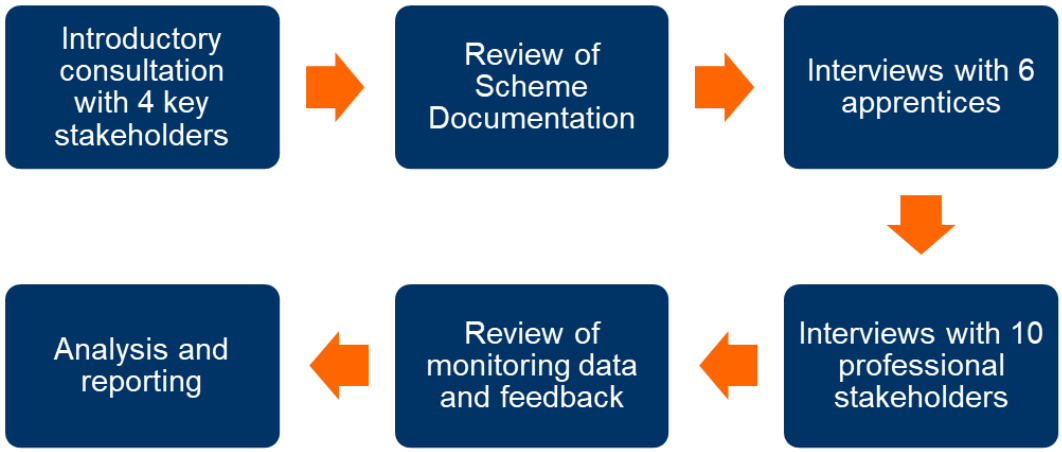
It did not intend to outline process in detail.

## 3.5 Evaluation methodology

### 3.5.1 Summary of methodology

Figure 2 summarises the evaluation methodology. Each method is outlined in more detail in sections 3.5.2 to 3.5.7. The methodology and research tools were proposed by Cordis Bright and agreed in advance by JUCD.

*Figure 2: Evaluation methodology*




### 3.5.2 Introductory consultation with key stakeholders

At the beginning of the evaluation period, Cordis Bright consulted with four key stakeholders in the Scheme, either in person or by phone[7]. These stakeholders were closely involved in designing, setting up and/or delivering the Scheme. They provided an outline of the purpose and structure of the Scheme, as well as information about early implementation, including areas of strength and challenges encountered. They also provided insight into the priority areas of focus for the evaluation.

### 3.5.3 Review of Scheme documentation

To complement the introductory consultation with key stakeholders, Cordis Bright reviewed documentation relating to the Scheme, which was shared by JUCD.

[7] The roles and organisations of consulted key stakeholders are included at Appendix B.

This provided further detail on the Scheme's purpose, design and early implementation, as well as the local structures within which it operated. Documentation included:

- A provisional logic model for the Scheme, developed by the public health team in Derbyshire County Council.
- Information on the financial inputs to the programme.
- An overview of JUCD and the partners involved in it.
- Information on organisations involved in delivering the Scheme, including JUCD, employers, placement hosts and training providers.
- Documentation to support partnership working in the Scheme delivery, such as Memoranda of Understanding.
- A role description for the apprentices.
- An anonymised version of the placement schedule for apprentices.
- Details of the training modules and units for the Care Certificate and Level 2 Diploma in Care.
- Minutes from monthly meetings of the Working Group overseeing the design and implementation of the Scheme, and from a specific Working Group overseeing the development of the training and curriculum.
- Pro formas and information sheets provided to apprentices and/or Scheme delivery partners.

### 3.5.4 Face-to-face interviews with participating apprentices

Six apprentices who participated in the Scheme were interviewed in person on a 1-to-1 basis by a Cordis Bright researcher[8]. Interviews with the Derbyshire County Council cohort took place in July 2019 and those with the UHDB NHS FT took place in November 2019. Interviews were semi-structured, using a topic guide which focused on their experience and satisfaction with the Scheme and the impact of the Scheme for them. Apprentices were provided with an information sheet about the interview and evaluation and their informed consent was established prior to the interview.

[8] The seventh apprentice who was still participating in the Scheme at the time of the interviews was also offered an interview slot but was unavailable on the agreed interview date. They were offered the option of a phone interview but elected not to participate.

After the interviews with the Derbyshire County Council cohort, a summary of key themes was produced to provide JUCD with an indication of emerging themes prior to the completion of the Scheme.

### 3.5.5 Telephone interviews with professional stakeholders involved in the pilot

10 professional stakeholders involved in the design, implementation or oversight of the pilot were interviewed by phone on a 1-to-1 basis by a Cordis Bright researcher[9]. The interviews took place in November and December 2019, to enable stakeholders to reflect on the entire delivery period for the Scheme. They were semi-structured and the topic guide focused on the purpose and delivery of the programme, its efficacy and impact, learning from implementation and views on potential future development of the Scheme or similar initiatives. Informed consent was established prior to the interviews.

### 3.5.6 Review of monitoring data and feedback

In January 2020, following the end of the Scheme, Cordis Bright reviewed data and feedback covering the entire delivery period for the Scheme. This aimed to, assess the scheme's performance against key outputs and outcomes and to supplement the qualitative data on implementation and apprentices' experience which was generated during interviews. Data and feedback included[10]:

- Data summarising applications, uptake and throughput of the Scheme.
- Data on employment outcomes for apprentices and employment support offered by the Scheme.
- Appraisals, reviews and handover notes for specific placements.
- Placement feedback and exit questionnaires completed by apprentices.

### 3.5.7 Analysis and reporting

Data gathered via the consultation and documentation and data review was drawn together to produce a draft evaluation report outlining the evaluation's key findings and recommendations. This was shared with JUCD colleagues and their feedback was incorporated in order to finalising the report.

## 3.6 Evaluation challenges

The primary challenge for the evaluation was in commenting on the extent to which the Scheme is achieving its intended outcomes and impacts. Many of

[9] The roles and organisations of interviewed stakeholders are included at Appendix B. Stakeholders from two further placement hosts – Derbyshire Health United and Milford Care (which hosted a placement at Ashbourne Lodge) were also invited to participate in interviews but were not available within the timescales for interviews.

[10] Where possible this information was shared in anonymised form. Any information shared which contained personal or identifiable data about apprentices was only shared with their prior consent.

these outcomes and impacts were ambitious, large-scale and longer term. It was also likely that their achievement would be related to a range of other factors and initiatives outside of the Scheme. As such, it was unlikely that they would be achieved and evidenced within the initial funding and delivery period of the pilot scheme, and with the relatively small number of apprentices who participated in the Scheme.

The evaluation therefore focused mainly on the extent to which the Scheme is achieving its intended outputs and shorter-term outcomes. Where possible, it also commented on the trajectory towards longer-term outcomes and impacts, and the feasibility of these being achieved or contributed to by a continuation of the Scheme or similar integration initiatives.

## 3.7 Report structure

The remainder of the report is structured as follows:

- Chapter 4 outlines the rationale, design and structure of the Scheme.
- Chapter 5 explores the extent to which the Scheme has achieved its intended outputs and outcomes
- Chapter 6 details key findings on the implementation of the Scheme, including recommendations for the future development for this or similar initiatives.

# 4 Background, design and structure

## 4.1 Introduction

This chapter outlines the key elements of the Scheme and the reasons for its introduction, drawn from a review of relevant documentation and consultation with a range of stakeholders.

## 4.2 Key findings

Figure 3 provides an overview of the Scheme, in the form of a logic model. This is based on a draft logic model produced for internal use by JUCD, which has been amended and supplemented based on additional documentation and consultation with key stakeholders.

**A note on the Scheme's intended outcomes and impacts**

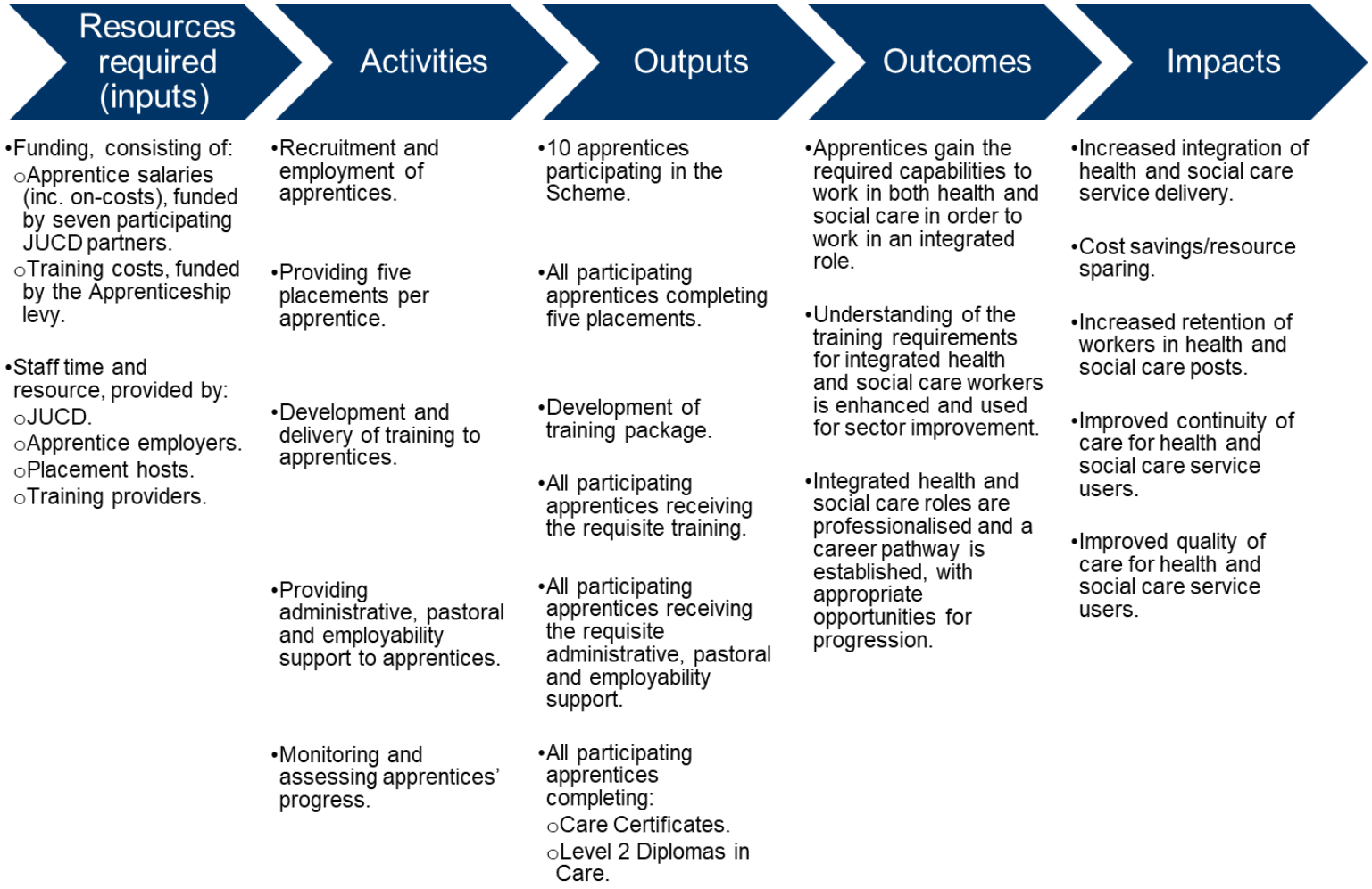
Many of the intended outcomes and impacts of the Scheme were ambitious, large-scale and longer-term. It was also likely that their achievement would be related to a range of other factors and initiatives outside of the Scheme. This is a positive reflection of the high aspirations of JUCD and key partners in Derbyshire to deliver greater integration and efficiency. However, in practical terms it means that it was unlikely that a number of outcomes would be achieved and evidenced within the initial funding and delivery period of the pilot Scheme, and with a pilot of this relatively small scale.

The evaluation therefore focused mainly on the extent to which the Scheme is achieving its intended outputs and shorter-term outcomes. Where possible, it also commented on the trajectory towards longer-term outcomes and impacts, and the feasibility of these being achieved or contributed to by a continuation of the Scheme or similar integration initiatives.

**Recommendation:** Any future logic model or theory of change for this Scheme, or similar local programmes, should include SMART[11] outcomes and impacts which are directly connected to the inputs, activities and outputs of the Scheme. It should also aim to reflect other factors and initiatives outside of the Scheme which might contribute to or enable achievement of the Scheme's outputs, outcomes and impacts.

[11] SMART stands for Specific, Measurable, Achievable, Relevant and Timebound.

*Figure 3: Logic model for the Integrated Health and Social Care Support Worker Apprenticeship Scheme Pilot*



## 4.3 Aims of the Scheme

The Scheme had multiple aims, which were to:

- Build capacity to meet the health and support needs of an ageing population (including improving hospital discharge processes).
- Increase efficiency across health and social care and reduce duplication in order to meet demand.
- Raise the profile of careers in health and social care (for instance by educating people about the range of opportunities within the sector, routes into the sector, and progression opportunities).
- Secure a workforce with the clinical, technical, and personal skills to make a real difference and improve quality of care. The integrated nature of the apprenticeship Scheme was intended to prepare apprentices to deliver both health and care tasks, a high standard of basic care, and person-centred care.
- Contribute to meeting recruitment and retention challenges in social care.

## 4.4 Cohorts of apprentices

The Scheme involved two distinct cohorts of apprentices, as outlined in Figure 4. The cohorts had different employers and training providers, although they completed the same qualifications. They completed the majority of the same placements, with some differences in the ways in which the Scheme was delivered. Having distinct cohorts made it possible to run the Scheme across the whole of Derbyshire whilst keeping travel times manageable for apprentices living different parts of the county.

*Figure 4: Characteristics of the two cohorts of apprentices in the Scheme's pilot*

| Cohort | Derbyshire cohort | Derby City cohort |
|---|---|---|
| Employer | Derbyshire County Council | UHDB NHS FT |
| Training provider | Derbyshire County Council's Adult Community Education Service (DACES) | Derby College |
| Level 2 Diploma in Care qualification | City & Guilds Level 2 Diploma in Care | Pearson BTEC Level 2 Diploma in Care |
| Time spent with training provider | 1 day per week | 1 day per fortnight |
| Contracted hours | 37 hours per week | 37.5 hours per week |

## 4.5 Resources required (inputs)

### 4.5.1 Direct funding

Direct funding was required for two key aspects of the Scheme:

- **Apprentices' salaries[12] and other associated costs (e.g. recruitment).** The salary costs (including on-costs) were funded collectively by JUCD partners participating in the Scheme, except for private, voluntary, and independent organisations (who were not asked to contribute). The total funding contributed by partners was £65,122, with each partner contributing an amount of funding which was proportional to the size of their organisation relative to other contributing partners[13]. Other associated costs were generally borne by the employers or by JUCD.

- **Apprentices' training and assessment**, which was funded through the apprenticeship levy[14]. This training includes both the Care Certificate and the Level 2 Diploma in Care. The average cost per person of a Level 2 Diploma in Care is approximately £3,000, whereas the approximate cost for training per person on the Scheme is £4,000. Tutors and assessors from the different training providers deliver and assess the training, and apprentices are assigned an assessor to ensure training is completed[15].

### 4.5.2 Staff employed for the Scheme

An **apprenticeship coordinator** was employed by JUCD in order to deliver the Scheme. Key aspects of this role were organising the Scheme, providing administrative support, offering pastoral support to apprentices and handling queries from apprentices, staff at placement hosts, and JUCD partners.

### 4.5.3 Staff time provided by other organisations

A range of other organisations provided resources to support the delivery of the Scheme. In the main, this took the form of staff time provided by staff in existing roles[16]. The key staff roles involved in delivering the Scheme were:

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[12] Apprentices were paid National Minimum Wage for their age. This is a different rate from other apprenticeships due to the Scheme being a pilot.

[13] This proportional approach to funding by contributing partners has been revised for the 2020 cohort. More detail is provided in section 6.5.3.

[14] If unspent, 25% of the Levy could be transferred between organisations if it is to be spent on apprenticeships and if the organisation which is transferring the funding acts as an advisor to the recipient organisation.

[15] Apprentices employed by Derbyshire County Council were also assigned a DACES Personal Development Worker to assist with their training.

[16] As this work was incorporated into staff member's existing roles, there were no direct additional salary costs for this element required by organisations. However, it is likely that staff members supporting the apprenticeship delivery will have needed to reduce other elements of their workload or manage this alongside an already-full workload.

- **Strategic and operational leads in JUCD partner organisations**, involved in developing and/or agreeing to participate in the Scheme and in providing organisational oversight.
- **Project leads or apprenticeship leads within employers and placement hosts**. These staff coordinated their organisation's involvement in Scheme delivery. They also attended monthly JUCD working group meetings to discuss progress, feedback, and any adaptations to the Scheme.
- **Line managers within employers**, namely:
    - Derbyshire County Council.
    - UHDB NHS FT.
- **Line managers and designated mentors at placement hosts**[17]. Figure 5 details the placement hosts.

[17] Due to shift patterns, apprentices' designated mentor sometimes shifted to whichever line manager was working at the time.

*Figure 5: Placement hosts for the Scheme*

| Placement host(s) | Host description | Placement setting or type |
|---|---|---|
| Chesterfield Royal Hospital NHS Foundation Trust | Secondary care provider | Elderly or rehabilitation wards for example the Robinson Ward. |
| Derby City Council | Adult social care provider | Perth House, a short-term rehabilitation centre. |
| Derbyshire County Council | Adult social care provider | Predominantly residential care but also domiciliary care for example the Staveley Centre. |
| Derbyshire Community Healthcare Services (DCHS)/Derbyshire Healthcare NHS Foundation Trust (DH NHS FT)[18] | DCHS – community care organisation.<br>DH NHS FT – mental health provider running both the Radbourne Unit and the Hartington Unit | Placement settings included:<br>• Killamarsh Health Centre, a mental health setting for adults of all ages.<br>• Okeover Ward at St. Oswald's Hospital, a rehabilitation ward.<br>• Audrey House, a mental health rehabilitation and recovery inpatient service. |
| DHU Health Care CIC | Out-of-hours health service provider which runs the NHS 111 service and employs staff in A&E. | Placement settings included:<br>• A&E minor injuries streaming.<br>• Advance nurse practitioner home visiting. |
| UHDB NHS FT | Secondary care provider | Medical wards, including medicine for the elderly wards.<br>Placement settings included:<br>• Royal Derby Hospital.<br>• London Road Community Hospital. |

[18] These are two separate organisations managed under a single HR function.

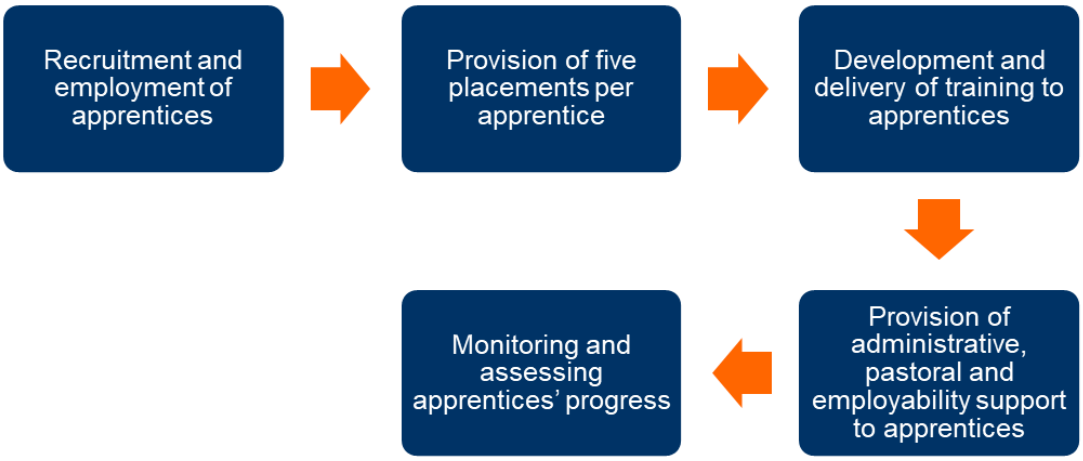
| Placement host(s) | Host description | Placement setting or type |
|---|---|---|
| • Cherry Tree House<br>• Derby Private Health<br>• Derwent Lodge<br>• Inspirative Arts<br>• Langdale Lodge | Private, voluntary and independent providers delivering a range of different services. | Placement settings and types vary by PVI provider. |

## 4.6 Activities

### 4.6.1 Summary

Figure 6 summarises the main activities delivered by the Scheme. Each activity is described in further detail in sections 4.6.2 to 4.6.6.

*Figure 6: Overview of Scheme activities*




### 4.6.2 Recruitment and employment of apprentices

JUCD aimed to recruit 10 apprentices for the Scheme, with five employed by each employer.

The following activities were used to advertise the Scheme to applicants:

- Open adverts.
- Careers events (such as a Princes Trust event).
- The National Apprenticeship Service which was linked to NHS Jobs.

### 4.6.3 Provision of five placements per apprentice

Apprentices who completed the Scheme undertook five placements on a rotating basis[19], with each placement lasting three months[20]. The first placement undertaken by apprentices was with their employer. The final placement was with a private, voluntary, or independent organisation. Other than this, the placements

[19] In addition to the five placements, some apprentices also had the opportunity to 'ride along' with East Midland Ambulance Service.

[20] The dates on which apprentices moved between placements were synchronised within each cohort but not across cohorts.

did not follow a set pattern of rotation and were sequenced according to the capacity of placement hosts, so each organisation did not host more than 1-2 apprentices at any one time.

### 4.6.4 Development and delivery of training to apprentices

Training consisted of a Care Certificate which apprentices were required to complete in the first three months of the apprenticeship[21], and a Level 2 Diploma in Care which was completed throughout the apprenticeship[22].

The Level 2 Diploma in Care requires 46 credits for a pass. 24 credits come from mandatory units and 22 from optional units, which were pre-selected by JUCD and partners with the aim of providing a good spread of training across both health and social care[23].

Training for the Level 2 Diploma in Care is a combination of:

- **On-the-job observation**. This accounts for 80% of apprentices' time[24] and involves:
    - Direct delivery of care and support to patients/clients.
    - Shadowing staff.
    - Completing any training which is normally completed by staff at placement organisations.
    - Asking any questions to assigned mentors.
- **Off-the-job training**. This accounts for 20% of apprentices time and involves taught sessions and independent study. For apprentices employed by Derbyshire County Council, weekly off-the-job training days consisted of sessions at which assessors were present to provide support with independent study when apprentices are not being delivered taught training. For apprentices employed by UHDB NHS FT, weekly off-the-job training days alternated each week between taught training and support from assessors and completely independent study.

### 4.6.5 Providing administrative, pastoral and employability support to apprentices

Administrative and pastoral support to apprentices was provided by JUCD, whilst support with matters such as annual leave and absence was provided by employers. Support to apprentices with training, policies, and procedure relevant to specific placement hosts was provided by those placement hosts.

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[21] Appendix C lists mandatory training modules for the Care Certificate.

[22] In addition, apprentices were offered support to attain the required level of functional skills competence in English, mathematics, and ICT as required.

[23] Appendix D lists the mandatory and optional modules included in the Leve1 2 Diploma in Care.

[24] The total time the diploma should take is 460 hours. Just under 70% of this time is intended to be guided learning.

Whilst the apprenticeship did not include any guarantee of end employment for apprentices, JUCD provided support to apprentices to increase their chances of gaining employment in health and social care for after the apprenticeship. This entailed providing information, advice, optional support, and events towards the end of the apprenticeship such as:

- Insight days into careers in the sector, with JUCD partner organisations presenting.
- Optional support with CV and application-writing skills.
- Information about current job vacancies.

### 4.6.6 Monitoring and assessing apprentices' progress

Apprentices' progress with training was assessed. In addition, their performance and progress on placements was monitored via:

- Handover/review meetings involving the apprentice, the current placement line manager, the new placement line manager, and the apprentice coordinator, which took place towards the end of each placement.
- Written appraisals completed by the placement line manager with input from other staff at the placement host.

A digital system called OneFile was used to record training activities, feedback from assessors and placement hosts, and assessment progress.

## 4.7 Intended outputs

The intended outputs of the Scheme corresponded to the activities outlined in section 4.6 and included:

- 10 apprentices participating in the Scheme.
- All participating apprentices completing five placements completed in different health and social care settings by apprentices.
- The development of a training package.
- All participating apprentices receiving the requisite training.
- All participating apprentices receiving the requisite administrative, pastoral and employability support.
- All participating apprentices gaining Care Certificates.
- All participating apprentices completing Level 2 Diploma in Care.

The extent to which these outputs were achieved is considered in Chapter 5.

## 4.8 Intended outcomes

The intended outcomes of the Scheme included:

- Apprentices gain the required capabilities in both health and social care in order to work in an integrated role.
- Understanding of the training requirements for integrated health and social care workers is enhanced and used for sector improvement.
- Integrated health and social care roles are professionalised and a career pathway is established, with appropriate opportunities for progression. This entails several sub-outcomes, including:
    - An improved recruitment process, reaching a wider and more diverse pool of candidates.
    - Roles for integrated health and social care workers are established in Derbyshire.
    - The profile of the apprenticeship Scheme is raised, indicated by the Scheme being embedded in regular training options, being attractive to candidates, and being valued and accepted by health and social care provider organisations across Derbyshire.

The extent to which these outcomes were achieved is considered in Chapter 5, alongside the feasibility of achieving and evidencing them within the timescales for the Scheme.

## 4.9 Intended impacts

The intended impacts of the Scheme included:

- Increased integration of health and social care service delivery.
- Cost savings/resource sparing.
- Increased retention of workers in health and social care posts.
- Improved continuity of care for health and social care service users.
- Improved quality of care for health and social care service users.

The extent to which these impacts were achieved is considered in Chapter 5, alongside the feasibility of achieving and evidencing them within the timescales for the Scheme.

# 5 Achievement of outputs, outcomes and impacts

## 5.1 Introduction

This chapter considers the extent to which the Scheme achieved its intended outputs, outcome and impacts. It draws on evidence from consultation with stakeholders and apprentices, as well as monitoring data and documentation relating to the Scheme.

**A note on evaluating progress against outcomes and impacts**

As discussed in Section 4.2, a number of the intended outcomes and impacts of the Scheme were always destined to be challenging to achieve and evidence within the initial funding and delivery period of this Scheme.

This report seeks to comment on the extent to which each outcome and impact has been achieved and on the trajectory towards achieving those outcomes and impacts which could not be fully achieved within the funding and timescales.

It is important to note, however, that not achieving the longer-term outcomes and impacts is not necessarily an indication that the Scheme has not been successful. Rather it indicates that the reach and influence of the Scheme across the whole system may have been over-estimated within the initial documentation and logic model for the Scheme.

## 5.2 Key findings

Figure 8 summarises the evidence for progress against the intended outputs, outcomes, and impacts of the Scheme, using the rating system outlined in Figure 7. It indicates that:

- The Scheme was broadly delivered as planned and key milestones were achieved in terms of setting it up and implementing it. The main reasons why the Scheme did not fully achieve all of its intended outputs were the lower-than-anticipated level of recruitment to the Scheme and subsequent attrition of apprentices.

- The Scheme achieved those of its intended outcomes which could feasibly be achieved within the timescales for the pilot and evaluation. These related to supporting apprentices to gain the required capabilities in both health and social care and enabling partners to gain a better understanding of the training requirements for an integrated role at this level. In addition, the Scheme supported improved collaboration between partners in relation to integrated training and working. This represents an additional and unexpected positive outcome of the Scheme.

- It was always relatively infeasible to deliver the remaining intended outcomes and all intended impacts during the pilot timescales. This is because the outcomes at impacts targeted system-level changes which would require resources and activities outside of the scope of the Scheme and which would always take time to achieve, embed and evidence. As such, the evidence of progress towards these outcomes and impacts is relatively limited though there is some evidence that the Scheme has contributed to progress in some areas, or that it might contribute positively if it were continued at a larger scale.

*Figure 7: Ratings used in assessment of progress on outputs, outcomes and impacts*

| Colour | Description |
|---|---|
| ✓ | Evidence that the output/outcome has been achieved. |
| ● | Evidence that the output/outcome has been partially achieved or that there is progress indicating that it is likely to be achieved in the near future. |
| - | Evidence that the output/outcome has not yet been achieved and that it was not feasible to achieve this outcome within the Scheme's funding period and scale. |
| ? | Difficult to make a judgement on the basis of the available evidence about the extent to which this output/outcome has been achieved. |

*Figure 8: Evidence of progress against outputs and outcomes of the Scheme*

| Output/outcome | Progress rating | Evidence of progress |
|---|---|---|
| Outputs | | |
| 10 apprentices participating in the Scheme. | ● | • Monitoring data indicated that nine apprentices were originally recruited to the Scheme, and eight of these went on the participate in the Scheme. However, one apprentice had to transfer to an alternative apprenticeship due to being under 18 and ineligible to undertake placements with some placement hosts. A further two apprentices chose to leave the Scheme partway through and thus did not complete it. |
| All participating apprentices completing five placements completed in different health and social care settings by apprentices. | ● | • All five apprentices who did not leave the Scheme completed five placements in different health and social care settings, however programme leads reported that the two apprentices who chose to leave the Scheme had completed three placements each.<br>• Documentation about the Scheme's delivery indicated that placements were completed in a range of health and social care settings, such as a mental health setting, a rehabilitation setting, residential care, medical wards, and a wellbeing service. |
| The development of a training package. | ✓ | • The training package for apprentices was successfully developed and delivered to participating apprentices, and was perceived as a strength of the Scheme by both apprentices and stakeholders. |
| All participating apprentices receiving the requisite training. | ✓ | • All participating apprentices receive the requisite training, including both classroom-based training and practical training completed through placements. This was evidenced through consultation with stakeholders and feedback and appraisal forms for apprentices. |

| Output/outcome | Progress rating | Evidence of progress |
|---|---|---|
| All participating apprentices receiving the requisite administrative, pastoral and employability support. | ✓ | • There was evidence from a range of sources that support was provided to apprentices during their time on the Scheme and that this included administrative, pastoral and employability support.<br>• Apprentices and stakeholders emphasised that the pastoral support provided to apprentices by the apprentice co-ordinator was a vital strength of the Scheme.<br>• Other support was provided with administrative matters by JUCD, and employability support was provided by JUCD and participating organisations in partnership through a careers event, job vacancy updates, and optional further support with careers skills. |
| All participating apprentices gaining Care Certificates. | ✓ | • Evidence provided by programme leads indicates that all seven participating apprentices who were eligible to complete the Scheme gained Care Certificates during their time on the Scheme, or evidenced having already done so. |
| All participating apprentices completing Level 2 Diploma in Care. | ● | • The five apprentices who completed the Scheme achieved Level 2 Diplomas in Care. However, as the remaining apprentices left prior to completing the Scheme they did not achieve their Level 2 Diplomas in Care. |
| Outcomes which could be achieved within the pilot and evaluation timescales | | |
| Apprentices gain the required capabilities in both health and social | ✓ | • There was a range of evidence that participating apprentices gained the required capabilities, including confidence and skills, to work in both health and social care.<br>• In particular, the majority of apprentices who did not leave the Scheme (four out of five) subsequently secured roles in health and/or social care[25]. |

[25] The fifth apprentice who completed the Scheme also expressed their intention to gain for a position in health.

| Output/outcome | Progress rating | Evidence of progress |
|---|---|---|
| care in order to work in an integrated role. | | • However, it was not possible to determine whether these capabilities specifically equipped apprentices to work in an integrated role, as integrated roles were not established for apprentices to fill following the Scheme. Establishing such roles was not an outcome which was expected by stakeholders within the timeframe of the pilot. |
| Understanding of the training requirements for integrated health and social care workers is enhanced and used for sector improvement. | - | • Evidence from consultation showed that developing and delivering the Scheme increased understanding of integrated training requirements specifically for entering at apprentice level and helped local partners to agree and articulate these.<br>• However, the intended outcome of using this increased understanding for sector improvement was likely to be challenging to achieve within the timescales for the pilot. This is because further work would be needed outside of the scope of the Scheme to understand the key training requirements across different integrated roles, and that further work and a longer time period would be required for this understanding to translate into sector improvement. |
| Improved collaboration around integrated training and working | ✓ | • Stakeholders highlighted a number of ways in which collaboration between local partners in health and social care had improved during the process of developing and delivering the Scheme. |
| Outcomes and impacts which could not be achieved in the pilot and evaluation timescales | | |
| Integrated health and social care roles are professionalised and a career pathway is established, with | - | • Evidence from a range of sources showed that this outcome was not likely to be achieved within the timeframe and the scale of the pilot.<br>• There is nevertheless some evidence that the Scheme has supported progress towards elements of this outcome or has provided an example of how similar Schemes might support delivery of elements of this outcome in the future. |

| Output/outcome | Progress rating | Evidence of progress |
|---|---|---|
| appropriate opportunities for progression | | • On the whole stakeholders were optimistic and enthusiastic about the prospect of developing career pathways further and of working towards creation an integrated health and social care support worker role in Derbyshire. |
| System-level impacts:<br>• Increased integration of health and social care service delivery.<br>• Cost savings/resource sparing.<br>• Increased retention of workers in health and social care posts.<br>• Improved continuity of care for health and social care service users.<br>• Improved quality of care for health and social care service users. | - | • As discussed in Section 4.2, it was unlikely that the Scheme itself would be large-scale enough to achieve the system-level impacts included in the logic model, especially not in the timescales for the pilot period. As such, the evidence of progress towards these impacts is relatively limited though there is some evidence that participating apprentices have acquired skills to enable them to support more integrated health and social care delivery if the system is adapted to enable this |

## 5.3 Progress towards outputs

### 5.3.1 Apprentice participation and progression

Figure 9 summarises apprentices' participation and progress on the Scheme. It indicates that:

- The initial output of 10 apprentices participating in the Scheme was not fully achieved because nine applicants were recruited to the Scheme as opposed to the intended 10, and because only seven of those recruited actually went on to participate in the Scheme and proved eligible to complete it.
- All seven apprentices who participated in the Scheme and were eligible to complete it went on to achieve the Care Certificate and completed at least three placements each. However, two apprentices chose to leave the Scheme prior to achieving further progression milestones.
- The five apprentices who completed the Scheme each completed all five placements and achieved the Level 2 Diploma in Care.

The attrition of apprentices from the Scheme therefore constitutes the main reason why some participation and progression outputs were not fully achieved.

*Figure 9: Summary of apprentice participation and progress*

| Number of applicants who… | Derbyshire cohort | Derby City cohort | Entire Scheme |
|---|---|---|---|
| Applied to the scheme | 30 | Not known | Not known |
| Were accepted onto the Scheme | 4 | 5 | 9 |
| Participated in the Scheme and were eligible to complete it | 4 | 3[26] | 7 |
| Achieved the Care Certificate | 4[27] | 3 | 7 |

[26] Five apprentices were originally recruited for this cohort. However, one apprentice did not commence the Scheme because they accepted another job offer elsewhere very shortly before the Scheme began. A second apprentice commenced the Scheme but was aged under 18. After they had begun it transpired that they were ineligible to undertake placements at some placement hosts (DHU Health Care CIC and DCHS) as a result of their age and would therefore be unable to complete the Scheme. They were transferred to a generic apprenticeship programme at UHDB NHS FT. DCHS have since altered their policies on this but apprentices under 18 remain ineligible to undertake placements at DHU Healthcare CIC.

[27] One apprentice had in fact already completed their Care Certificate prior to participating in the Scheme.

| Number of applicants who… | Derbyshire cohort | Derby City cohort | Entire Scheme |
|---|---|---|---|
| Completed five placements | 2[28] | 3 | 5 |
| Achieved the Level 2 Diploma in Care | 2 | 3 | 5 |
| Left the Scheme prior to completion | 2 | 0 | 2 |

### 5.3.2 Training development and delivery

The training package for apprentices was successfully developed and delivered to participating apprentices. It was perceived as a strength of the Scheme by both apprentices and stakeholders, as discussed in Section 6.3.7.

However, the Scheme documentation shared with Cordis Bright did not include a document mapping out all the selected training units and a training schedule for the whole Scheme in one place. This would have been helpful in providing an accessible overview of the training component of the apprenticeship, useful to (prospective) apprentices, partners involved in scheme and wider stakeholders with an interest in the Scheme.

**Recommendation:** It would beneficial to develop a full training overview and schedule if this is not already available. This could be shared with applicants, apprentices, Scheme delivery partners, and any other stakeholders with an interest in integrated health and social care training.

### 5.3.3 Provision of administrative, pastoral and employability support to apprentices

There was evidence from a range of sources that support was provided to apprentices during their time on the Scheme and that this included administrative, pastoral and employability support. The apprenticeship coordinator role was key to the delivery of this support. In fact, the role was recognised as a pre-requisite to successful delivery of the Scheme and as one of the main strengths in implementation, as discussed in Section 6.3.3.

Reviewed documentation and interviews with apprentices confirmed that a number of activities to help them with finding employment in the sector following the Scheme were delivered, particularly:

- Insight days into careers in the sector, with talks from various health and social care professionals including Allied Health Professions, care roles and

[28] The remaining two apprentices each completed three placements before leaving the Scheme prior to completion.

nursing. Interview techniques and CV- and application-writing skills were also covered, and professionals conducting mock interviews throughout the day.

- Fortnightly 'job alert' e-mails to apprentices highlighting a selection of the latest vacancies across health and social care partners, split by Derby City/South Derbyshire and Chesterfield/North Derbyshire. Apprentices were also signposted towards job vacancy portals[29].

- Additional optional support with CV and application-writing skills, including CV-writing packs from the National Careers Service.

## 5.4 Progress towards outcomes which were feasible within the timescales

### 5.4.1 Apprentices gain the required capabilities in both health and social care, in order to work in an integrated role

> *[They've] been able to draw upon all [their] experiences and use the knowledge [they've] gained along the way and apply that to different settings – I'm blown away by how much [they] knew and [were] able to use those transferable skills specifically from the placements [they] completed.*
>
> Professional stakeholder

> *I have learnt so much and I've made myself realise that I can go into lots of different environments and meet lots of different people and can just slot in and crack on and do different job roles, which has increased my confidence a lot and has made me really proud of myself.*
>
> Apprentice

Completing the Scheme successfully equipped apprentices with the capabilities to enable them to work in both health and social care. For instance, all interviewed apprentices and the majority of stakeholders strongly agreed that the Scheme had given apprentices the skills and confidence needed to work in both health and social care roles. As evidence of this, stakeholders highlighted that apprentices had been able to demonstrate their skills and confidence during placements, and that the five apprentices who completed the Scheme achieved their Level 2 Diploma in Care.

Most significantly, four of the five apprentices who completed the Scheme had secured employment in health (three apprentices) and social care (one apprentice) at the end of the Scheme and the fifth expressed their intention to

[29] As stated in the MOU, each participating JUCD partner organisation committed to signposting suitable vacancies within their respective organisations to all apprentices.

apply for a position in health[30]. The roles they had secured included healthcare assistant, care assistant, clinical physiologist assistant and therapy assistant. In most cases, these roles are with an organisation in which the apprentice undertook a placement. Two of these apprentices also reported that they had a longer-term plan to continue training whilst working and had identified courses they wanted to pursue.

Beyond enabling apprentices to work in roles in both health and social care, there was also evidence that the Scheme increased their understanding of how different parts of the health and social care system fit together across a patient's journey:

> *[The Scheme] gives an understanding about what's out there - if someone with learning difficulties comes in to hospital for an operation, I know what is needed for someone, I can tailor things to his needs better, because I have experience working with learning disabilities now so I know how the hospital experience needs to be adapted for that person. It has helped to see different parts of someone's health journey fit together.*
>
> Apprentice

This arguably equips them better for integrated roles, and also makes it more likely that they would take a more holistic approach to care and would be better equipped to work in partnership with colleagues in different roles and parts of the system.

### 5.4.2 Understanding of the training requirements for integrated health and social care workers is enhanced and used for sector improvement

Evidence from consultation showed that developing and delivering the Scheme increased understanding of integrated training requirements specifically for those entering at apprentice level and helped local partners to agree and articulate these. However, the intended outcome of using this increased understanding for sector improvement was likely to be challenging to achieve within the timescales for the pilot.

Firstly, training requirements are likely to be different for different integrated roles. Therefore work would be required beyond the scope of the Scheme itself in order to identify demand, gaps and opportunities to introduce specific integrated health and social care roles, and to determine and map the particular training requirements for each role. This element is discussed further in Section 5.5.1.

As a result of the wider work required to understand training requirements for integrated roles at different points in the system, it is unlikely that any increased

[30] In addition, one of the apprentices who left the Scheme prior to completion was also offered positions in health and social care but was unable to take up a position at present due to personal circumstances.

understanding would have resulted in sector improvement at this stage. Indeed, the majority of stakeholders felt unable to comment on this outcome.

### 5.4.3 Improved collaboration around integrated training and working

> *I think it's made massive progress and has brought a lot of organisations together. It's more than just the apprenticeship programme, we've been able to start working in partnership with care programmes we didn't know existed. It has gone beyond the initial aims of the programme, and been really worthwhile, it means we've been able to collaboratively work together as a system.*
>
> Professional stakeholder

In addition to the intended outcomes specified in the logic model, the Scheme and related work also contributed to a positive unintended outcome in improving collaboration between partners in the health and social care system, particularly around integrated training and working. Stakeholders highlighted examples of how collaboration had improved during the process of developing and delivering the Scheme, such as:

- Improving partners' understanding of the different organisations and different parts of the health and social care sector, as well as their conception of the system as a whole:

  > *I've worked for NHS, so I get their pressures and challenges, but the opportunity to sit round the table with people who work in a social care environment has been a massive benefit, because we've learnt to see things from a different point of view.*
  >
  > Professional stakeholder

- The sharing of best practice and expertise amongst partners.

- Professional networking among partners, for example with different partners providing careers talks for one another and collaborating around recruitment.

  > *The apprenticeship scheme has been the catalyst for other initiatives to integrate training and development across health and social care. We now take a more joined up approach to [promoting] health and social care career opportunities and pathways, […] all get involved in each other's CPD days, [and are] joining up to deliver a one-stop work experience opportunity portal.*
  >
  > Professional stakeholder

- Providing evidence and a foundation for integrated working to grow, in alignment with the wider direction towards health and social care integration.

  > *Breaking down some barriers to show that we can work on these things on a larger level, getting people thinking in terms of working*

> *together more across systems, and maximising opportunities to get things integrated.*
>
> Professional stakeholder

## 5.5 Progress towards outcomes which were infeasible during the timescales

### 5.5.1 Integrated health and social care roles are professionalised and a career pathway is established, with appropriate opportunities for progression

*Summary*

At this stage, there was limited evidence that the Scheme has led to the professionalisation of integrated health and social care roles, including a career pathway and progression opportunities. However, achieving this outcome was likely to take longer than the timescales for the pilot Scheme and was also likely to require wider strategic work outside of the Scheme itself.

There is nevertheless some evidence that the Scheme has supported progress towards elements of this outcome, or has provided an example of how similar Schemes might support delivery of elements of this outcome in the future. This evidence is considered separately in relation to each of the three sub-components of the outcome outlined in Section 4.8.

*An improved recruitment process, reaching a wider and more diverse pool of candidates*

> *I was looking for jobs, […] and I knew I wanted to move into health and social care, but I didn't know where to start*
>
> Apprentice

It was not possible to establish whether the Scheme had resulted in an improved recruitment process, beyond the Scheme itself. However, apprentices who were recruited had varying levels of experience in health and social care and varied in terms of whether they had specific career goals at the time of starting the Scheme. For some, this was their first experience in the sector. This could indicate that the Scheme itself was attractive to candidates who might not otherwise have applied for roles in the sector.

*Roles for integrated health and social care workers are established in Derbyshire*

All apprentices who completed the Scheme found progression opportunities in health and social care after the Scheme, suggesting that the Scheme enabled participating apprentices to achieve career progression. However, these progression opportunities were not necessarily in integrated roles, tending to be either in health or in social care. Indeed, creating a more clearly defined career pathway for apprentices to progress into an integrated role was a potential area for development for the Scheme and is discussed in detail in Section 6.4.7.

There is no evidence at this stage that the Scheme resulted in the establishment of integrated health and social care roles in Derbyshire, although bringing together partners with a specific focus on training and development for integrated roles is likely to have been a positive step in encouraging reflection on demand, gaps and opportunities for such roles. The extent of future progress towards this outcome will depend on the appetite and resources of partners to identify, develop and introduce integrated roles in the future. On the whole stakeholders were optimistic and enthusiastic about the prospect of developing career pathways further and of working towards creation an integrated health and social care support worker role in Derbyshire.

*The profile of the apprenticeship Scheme is raised*

The Scheme proved attractive to candidates who applied for it, with at least 35 applicants for the 10 places[31]. Apprentices who took part in the Scheme highlighted that the varied nature of the apprenticeship formed a key part of its appeal, as well as its perceived suitability for people who had not yet determined their preferred career path.

> *I chose the Scheme because of the variety of things we would get to do. I didn't know what I wanted to do, and I thought that this would give me a good scope.*
>
> Apprentice

Within the evaluation resource and methods it was not possible to establish the extent to which the Scheme was valued and accepted by health and social care provider organisations across Derbyshire[32], although it was clear that stakeholders who took part in the evaluation recognised the Scheme's value and achievements.

At the time of reporting, it was not known whether the Scheme would be continued beyond the initial pilot period and therefore embedded in regular training options. The majority of stakeholders who took part in the evaluation acknowledged the Scheme's merits and there was a consensus that it could be sustainable in the longer-term following some adaptations. Considerations for sustaining the Scheme or a similar initiative are outlined in detail in Section 6.5.

## 5.6 Progress towards impacts

As discussed in Section 4.2, it was unlikely that the Scheme itself would be large-scale enough to achieve the system-level impacts included in the logic model, especially not in the timescales for the pilot period. As such, the evidence of progress towards these impacts is relatively limited though there is some

[31] This total is likely to be an under-estimate because it only includes those who applied to Derbyshire County Council and those who were accepted by UHDB NHS FT. Data on the total number of applicants via UHDB NHS FT were not available.

[32] In order to establish this, additional evaluation resource and methods would have been required, such as a survey of local health and social care providers.

evidence that participating apprentices have acquired skills to enable them to support more integrated health and social care delivery if the system is adapted to enable this.

When reflecting on the skills and capabilities gained by apprentices during the apprenticeship, stakeholders and apprentices noted that the Scheme supported them to gain a more rounded view of service users' journeys through health and social care and to understand different services in relation to each other and the system as a whole. This has the potential to enable these apprentices to deliver better continuity and quality of care for health and social care service users. Therefore the Scheme could feasibly contribute to achieving these impacts if it were delivered on a larger scale over a longer period of time, and thus provided this training to a greater number of new recruits to health and social care. However, for this impact to be achieved at a level which changes continuity and quality of care across the system, the Scheme would also need to, to be reinforced by continuous professional development for former apprentices and targeted training for other relevant roles and levels, and to be accompanied by wider initiatives focusing on quality and continuity of care.

Equally, the Scheme may have the potential to support the increased retention of workers in health and social care posts if it is continued and delivered at a larger scale. For example, a minority of stakeholders argued that exposing apprentices to a range of settings and organisations within the sector enabled them to understand the range of roles and progression routes available to them, and thus made it more likely that they would identify a role of interest to them initially and also be inclined to switch roles if they were not satisfied with their initial role. In addition, a minority of stakeholders suggested that the Scheme increased awareness of social care roles, thus helping helped to redress the balance in terms of lower recruitment and retention to these roles when compared to equivalent roles in health. However, as with other impact areas, the Scheme would need to operate alongside other recruitment and retention initiatives for the impact to be felt across the system.

At this stage, there was no evidence that the Scheme has resulted in increased integration of health and social care delivery, or has led to any cost savings/resources sparing which might potentially result from greater integration.

**Recommendation:** It would beneficial to develop approaches to monitoring performance against its intended outcomes and impacts, and particularly those which will only be evident in the longer-term. Key steps include:

- Ensure that the outcome or impact is SMART and directly linked to the inputs and activities of the Scheme.
- Determine indicators which would capture data on the outcome or impact.
- Review the best approaches to collecting data against these indicators, and to isolate the impact of the Scheme from other factors which might impact on them.
- Allocate responsibility for collating and monitoring this data.

# 6 Implementation of the Scheme

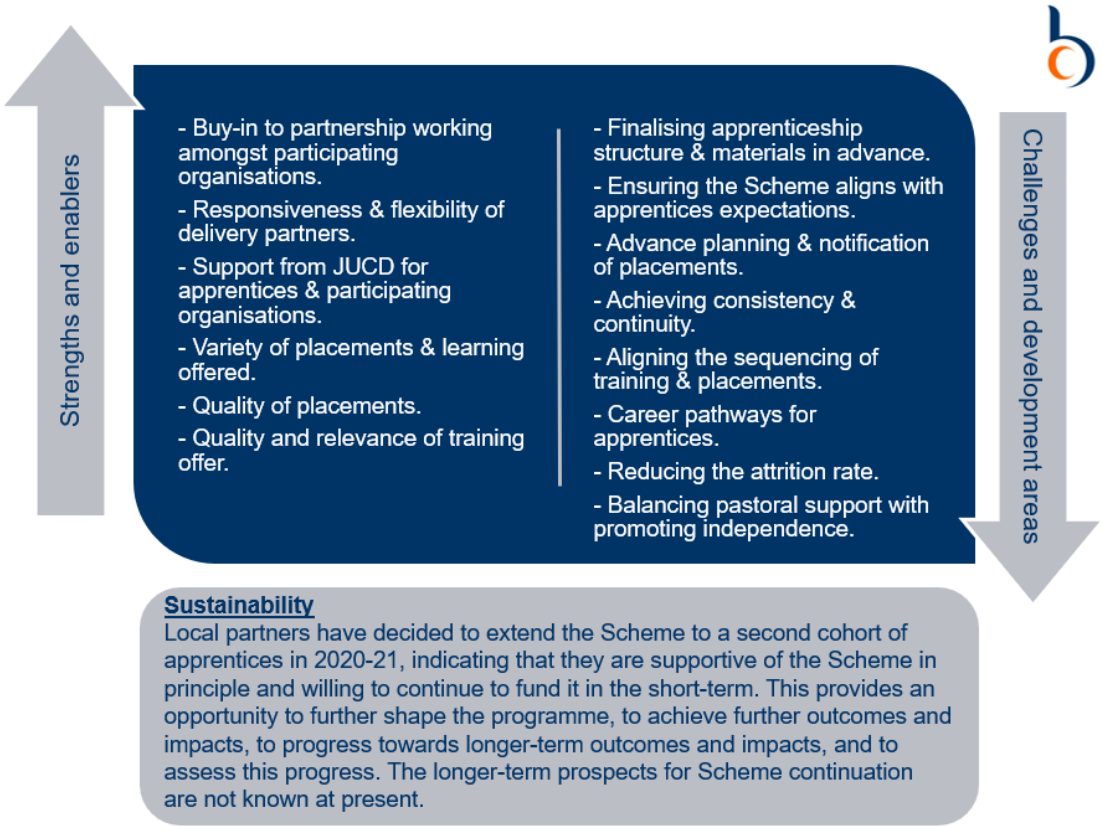
## 6.1 Introduction

This chapter explores the implementation of the Scheme and, in particular, strengths and enabling factors in delivery, challenges and areas for development, lessons for future implementation and sustainability. It is based primarily on evidence from consultation with stakeholders and apprentices.

## 6.2 Key findings

Figure 10 summarises the key evaluation findings relating to implementation.

*Figure 10: Key findings for implementation of Scheme and evidence*




## 6.3 Strengths and supporting factors

### 6.3.1 Summary

The evaluation identified a range of key strengths and supporting factors of the Scheme. These factors supported effective delivery of the Scheme, enabling it to achieve several of its intended outputs and outcomes, as well as additional unintended outcomes which could be built upon in the future and align with the aims of greater integration of the health and social care system in Derbyshire. It

would therefore be beneficial to replicate or build in these elements in future similar Schemes, in both Derbyshire and elsewhere. The main strengths and supporting factors were:

- Buy-in to partnership working amongst participating organisations.
- Responsiveness and flexibility of delivery partners.
- The support provided by JUCD to apprentices and participating organisations.
- The variety of experiences and learning offered to apprentices.
- The quality of placements.
- The quality and relevance of the training offer.

### 6.3.2 Buy-in to partnership working amongst participating organisations

Partnership working between the range of health and social care organisations involved in developing and delivering the Scheme was generally effective and supported the Scheme's implementation and achievements. Indeed, a majority of stakeholders recognised this as a strength in implementation. It was evident in the high level of buy-in to piloting the Scheme from all participating organisations, clear communication between partners during the development and implementation of the Scheme, and the establishment of effective working relationships which were new between many of the partners involved. The key contributing factors to effective partnership working were:

- A sufficiently long period of time for gaining buy-in initially.
- Endorsement from senior leaders at the STP/Integrated Care System (ICS) level, such as the Workforce Board.
- Commitment to the purpose of the Scheme.
- Collectively developing and agreeing upon governance and operational arrangements and protocols, such as a Memorandum of Understanding (MOU) and an employment contract. Stakeholders emphasised that these outputs could be used beyond the Scheme and transfer into a range of health and social care settings.
- Regular meetings between participating organisations and JUCD.
- Transparent communication and a shared positive attitude towards collaborative problem-solving during meetings.

### 6.3.3 Responsiveness and flexibility of delivery partners

The ability and willingness of delivery partners to adapt approaches in response to challenges and learning during early implementation was a strength of the

Scheme. The Scheme encountered a number of challenges relating to its nature as a pilot, and partners flexibility and responsiveness enabled them to navigate these challenges. For example, handover meeting minutes indicated that further action was planned in response to issues, queries, and feedback that were raised by apprentices or stakeholders.

### 6.3.4 Support from JUCD for apprentices and participating organisations

The support provided by JUCD to apprentices and to participating organisations, was a vital supporting factor in the successful delivery of the Scheme. This support was primarily delivered by the apprenticeship coordinator role, making it crucial to identify resource for a similar role in any future iterations of the Scheme. All apprentices and the majority of stakeholders recognised the importance of this role, highlighting that it:

- Offered a single point of contact for all queries, thereby enabling effective communication and timely problem solving amongst all those involved in with the Scheme.
- Provided much-needed pastoral support to apprentices via phone and face-to-face meetings, which was particularly important because the rotational structure of the Scheme could demand a level of resilience and adaptability from apprentices which may at times be challenging and because apprentices did not always have the support of an allocated mentor or buddy at each placement (as discussed in Section 6.4.5).
- Coordinated regular meetings between all partner organisations involved where feedback from apprentices was raised and addressed.

**Recommendation:** It is important to identify resource and responsibility for delivering a coordinator role to offer administrative, practical and pastoral support to apprentices and partner organisations involved in delivery. In particular, the co-ordinator would need to have significant capacity and appropriate training and support to provide the pastoral element of the role, which proved to be an extensive component of the role during the pilot.

### 6.3.5 The variety of experiences and learning offered

> *Anybody who's done what we've just done would be able to go out there and do a full range of different care roles. From job applying, there has been a vast array of jobs that I've thought, 'I could do that,' which wouldn't have been the case if I'd just been on one role.*
>
> Apprentice

The variety of experiences and learning offered by the Scheme was a key strength. Such variety was important in attracting apprentices to apply for the Scheme and also in exposing them to a wide range of settings, roles and experiences whilst on the Scheme. For example, appraisal forms completed by apprentice hosts indicated that apprentices undertook activities including

producing care plans, providing home care, taking physical observations, handling patient data, and providing one-to-one emotional wellbeing support.

This increased apprentices' understanding and skills in delivering care in these settings, and also allowed them to sample different settings and roles in order to determine whether they would like to progress into them in the future. In addition, it increased the resilience and confidence of apprentices, as a result of rotating around a range of environments. In some instances, apprentices and stakeholders highlighted that this had led them to consider working in settings and roles that they would not previously have considered:

> *I never thought I could work with adults with learning disabilities at the start, but I took to it really well.*
>
> Apprentice

### 6.3.6 Quality of placements

> *The placements are good, you do learn a lot about a bit of everything.*
>
> Apprentice

> *People were brilliant, they all wanted to show us what they do and include us. I was never made to feel in somebody's way, I always felt like I'd been able to learn and be useful and appreciated by everybody.*
>
> Apprentice

In general, the quality of placements was a strength of the Scheme, although some apprentices experienced challenges in some placements. In addition to the variety offered by the rotational nature of the Scheme, discussed in Section 0, apprentices also recognised the supportive and welcoming nature of staff at placements as a key factor in their appeal.

Being supernumerary throughout their placements was a key supporting factor which enabled apprentices to learn and to gain a range of experiences within each placement:

> *It does give you the confidence to do things because you're supernumerary the whole apprenticeship - so you can go 'I want to and watch that interesting thing' - you have the ability to gain confidence by popping in and out with different things*.
>
> Apprentice

Handover and review meetings were also a positive element of. In particular, these meetings allowed apprentices to discuss and track positive progress made and areas for improvement, and to find out more information about upcoming placements.

### 6.3.7 Quality and relevance of training offer

> *I find that really helpful to meet with an assessor, if it wasn't for coming in, we wouldn't get the diploma units. It's quite in depth and hard to do but once the assessor explains the question in a better way, we can understand the questions better.*
>
> Apprentice

> *We've done a lot over the course of it, all the mandatory training that we needed to do plus additional things you probably wouldn't get to experience in just one role or just mandatory HCA [Health Care Assistant] training, like SCIP [Strategies for Crisis Intervention and Prevention] training in Derby City.*
>
> Apprentice

The training offer was also a key strength of the Scheme. For example, all apprentices highlighted the quality and relevance of the training they received, as well as the support from assessors. They noted several elements of this, such as:

- The weekly or fortnightly in-person sessions with training providers.
- Support from training providers with understanding the course requirements and how to translate practical learning gained during placements into the formats required by training assessors.
- The opportunity to receive training delivered by placement hosts.
- The overall mix of practical and theoretical training they received.

This enabled apprentices to consolidate their learning and their understanding of how the training modules mapped onto experiences they had gained during placements.

## 6.4 Challenges and areas for development

### 6.4.1 Summary

The evaluation also identified a number of challenges encountered during the delivery of the Scheme, as well as areas for development if the Scheme is continued or similar initiatives are implemented in the future. In several cases, the challenges were identified by those delivering the Scheme and steps were taken to address them. They are nevertheless included as they provide useful learning for others who might be considering the introduction of similar initiatives, either locally or elsewhere. The main challenges and areas for development were:

- Finalising the apprenticeship structure and materials prior to introducing the Scheme.
- Ensuring the Scheme aligns with apprentices' expectations.

- Advanced planning and notification of placements.
- Delivering consistency and continuity across employers, placement hosts and training providers.
- Aligning the sequencing of training and placements.
- Developing specific career pathways for apprentices following the Scheme.
- Reducing the attrition of apprentices from the Scheme.
- Balancing adequate pastoral support with promoting independence and resilience

### 6.4.2 Finalising the apprenticeship structure and materials in advance

Due to the pilot nature of the Scheme and the relatively short timescales for development prior to employing the first cohort of apprentices, some elements of the Scheme were still being finalised or were adapted whilst the Scheme was underway. This is perhaps inevitable within a pilot and provides a positive indication of partners' flexibility and willingness to trial and adapt approaches. However, it also presented a challenge in determining and clearly and consistently communicating timetables, roles and responsibilities to partners and apprentices prior to the Scheme or with enough notice to allow them to prepare for their input. This presented knock-on challenges in managing apprentices' and partners' expectations of the Scheme, enabling partners to adequately prepare for their roles in delivery, and ensuring consistency of delivery across employers, training providers and placement hosts. These knock-on challenges are discussed in more detail in sections 6.4.3 to 6.4.5.

### 6.4.3 Ensuring the Scheme aligns with apprentices' expectations

The evaluation found a number of instances where the delivery or outcomes of the Scheme did not meet apprentices' original expectations or where they were unsure of what to expect from the Scheme. One reason for this, as noted in Section 6.4.2, was that some elements of the Scheme were not finalised when the cohort was first recruited and therefore some aspects were subject to change during the delivery period. Another reason was that the information provided to apprentices during recruitment or the early stages of the Scheme did not always outline the Scheme in adequate detail or address potential areas of misunderstanding.

> *They gave us an idea of what we were going to be doing, but it wasn't very specific at all, they didn't say that it was mainly going to be with the elderly, where we would be working or what kind of roles we'd be doing, before we started*
>
> Apprentice

For example, some apprentices reported that they were unclear about what form their final assessment would take until quite shortly in advance of the

assessment. Equally, they provided examples of ways in which expectations they had formed during the recruitment and induction stages of the Scheme were inaccurate. These related mainly to the requirements for taking part, the different roles they would have a chance to shadow, and the existence of an integrated role for them to progress into following the Scheme. This latter element was also recognised by stakeholders as a challenge in developing the Scheme and is addressed in more detail in Section 6.4.7. Providing more detailed information to apprentices during recruitment and induction could mitigate this.

**Recommendation:** It is important to provide prospective apprentices with accessible and transparent information about the requirements, structure, opportunities and progression routes involved in the Scheme. Ideally, this would include written information that they could review in advance and verbal information via a meeting or presentation during which they could ask questions and seek clarification as required.

### 6.4.4 Advanced planning and notification of placements

> *Once we were there, they didn't know what we could or couldn't do, and what to do with us. Because they didn't know we were coming we were just stuck in one place*
>
> Apprentice

Another challenge which was related to the limited timescales for developing and agreeing the Scheme prior to delivery was in ensuring that delivery partners and apprentices were notified of placement timetables and requirements far enough in advance. This impacted on apprentices' and placement hosts' ability to prepare for placements and on apprentices' sense that they understood their trajectory across the apprenticeship. It also affected consistency and continuity across placements, which is discussed further in Section 6.4.5.

Apprentices provided examples of being told about the location and working days of upcoming placements very shortly in advance of starting the placement. This made it challenging for them to make arrangements to attend the placement, such as organising childcare. If the Scheme is to be accessible to a wide range of candidates, the ability to support apprentices to plan their involvement alongside other aspects of their lives is crucial.

Similarly, stakeholders noted that on some occasions late notice about placements meant that key staff at placement hosts were unaware of the Scheme and its aims at the time when apprentices started their placements, or that this information had not been cascaded to all relevant staff at the placement host. On these occasions there was thus limited advanced planning about who would act as the main point of contact for apprentices and how apprentices would spend their time on their placement. Consequently, opportunities for apprentices to shadow roles and learn by experience were missed and they sometimes did not feel well supported or appreciated in some placement settings.

There were also examples where shift patterns within a placement setting did not align with apprentices' contracted 9am-5pm shift pattern. This resulted in apprentices missing key parts of service delivery within those settings (such as morning rounds and waking residents up in care homes). Greater advanced notice about placements might have enabled apprentices to plan for different working patterns within these placement settings, and therefore to experience these aspects of service delivery.

**Recommendation:** It is important to provide all apprentices and placements hosts with advanced notice of placement schedules. This should include, as a minimum: placement start and end dates, location, working days and hours.

### 6.4.5 Achieving consistency and continuity across employers, placement hosts and training providers

> *The understanding of what our job role is has sometimes been a little bit vague - they've not known whether to treat us more like nurses or HCAs and it has been a little bit off-pitched sometimes*
>
> Apprentice

It proved challenging to ensure consistency of the apprenticeship offer and delivery across employers, placement hosts and training providers. Again, this related in part to the Scheme being a pilot and having limited set-up time prior to the first cohort of apprentices starting. Apprentices and stakeholders reported several specific differences in approaches, which led to a disparity in the experiences of different apprentices and the perceived value of different placements. These differences included:

- Differences in terms and conditions across the two employers and between employers and placement hosts. This resulted in discrepancies in policies and procedures, such as annual leave policies, which then had to be navigated as they became evident and impacted on apprentices.
- Differences in the level of understanding about apprentices' roles during placements and the purpose of the placements, including: a lack of clarity about the tasks that apprentices were able to perform on placements and some placements not recognising that apprentices were intended to be supernumerary and therefore not factored into core delivery[33].
- Varying levels of support being offered to apprentices by placement hosts, including: some organisations not allocating a single point of contact and/or mentor to apprentices; these lead staff members not being present on a regular basis when apprentices were on placement; and/or staff members who

[33] In addition, initially apprentices' uniforms were from their employer and therefore often did not match the uniforms of their placement host. Some apprentices commented that this contributed to confusion about their roles staff and service users in placement host settings. This was subsequently addressed as placement hosts were encouraged to provide uniforms to apprentices for the duration of the placement where appropriate/available.

participated in handover meetings not having had contact with apprentices on a regular basis.

- Inconsistencies in how placement hosts and training providers recorded and shared information about apprentices' progress. For example, a minority of apprentices reported that they had needed to repeat very similar core training across a range of placements in order to be deemed competent to undertake certain tasks[34].

The challenge of inconsistency across placements was identified by partners during the delivery period and number of actions were taken to tackle it, including:

- Developing a FAQ document for staff working in placement host settings to inform them about the Scheme and their role as a placement host[35].

- Individual placement hosts implementing mechanisms to cascade information about the Scheme to relevant staff within their own organisations, with a particular emphasis on informing those staff members who will be working alongside apprentices on placement. One example is presenting information about the Scheme during staff meetings.

- Inviting operational staff from the hosts for upcoming placements to attend handover meetings from an apprentice's previous placement.

Some differences in approach across the different organisations are likely to be a necessary component of a Scheme involving placements in multiple settings and providers. Indeed, allowing apprentices to experience different organisational cultures and approaches is also a strength of the Scheme. However, if greater consistency of the overall offer and experience of apprentices could be achieved this would likely represent an improvement to the Scheme. For example, the repetition of core organisational training across multiple placement hosts may indicate inconsistent understandings within these organisations about the supernumerary nature of apprentices' roles, and detract unnecessarily from time apprentices could otherwise spend learning.

**Recommendation:** It would be beneficial to explore and agree an employment, training and placement offer which is as consistent as possible across organisations. Key considerations are likely to include consistency of: employment terms and conditions, training provision (on- and off-placement), placement structure and support offered by placement hosts. This should include a single point of contact within each placement host, as well as allocated mentors/buddies for individual apprentices.

[34] Some stakeholders highlighted the wider issue of the need to standardise training across the sector and to establish mutual trust in different organisations' training. This was raised during a meeting between JUCD, an apprentice, and their employer.

[35] Separate FAQ documents were developed for statutory and private, voluntary and independent (PVI) organisations which might act as placement hosts.

**Recommendation:** To maximise consistency of delivery and experience, all partner organisations should be provided with an accessible and comprehensive summary of the Scheme and their roles and responsibilities within it. This could be based on the FAQ documents which were already developed during the pilot period.

### 6.4.6 Aligning the sequencing of training and placements

During delivery of the Scheme, the sequencing of placements and training modules for the Level 2 Diploma in Care did not always align. This created challenges for apprentices when synthesising their learning, relating learning from the training to their current placement experiences, and preparing for assessments. For example, some apprentices completed mental health focussed placements many months before or after studying mental health modules.

Additionally, some placement hosts were not aware of the key competencies which apprentices were expected to gain during that placement and therefore were less able to facilitate or appropriately pitch placement-based learning. For instance, one apprentice commented that training received via placement hosts was sometimes pitched at a higher level than the Level 2 Diploma in Care which *"could be overwhelming for […] people who are not so confident"*.

One solution to this challenge was recognised by interviewed stakeholders. This is mapping out placements alongside training modules prior to beginning the Scheme. This would enable partners to:

- Plan sequencing as efficiently as possible.
- Inform placement hosts of the key learning apprentices are expected to gain during each placement, in order to help them to plan any placement-based training elements.
- Enable training providers to understand how each placement will support learning outcomes and to factor this into training delivery and assessment timing.
- Determine whether there is a value to varying placement length in some placements, for example by extending placements which have the greatest potential to offer learning opportunities that align with the requisite training modules.

**Recommendation 9** It would be beneficial to map training modules alongside placement opportunities in order to develop a schedule where placement-based learning aligns as closely as possible with off-placement training for the Level 2 Diploma in Care and with the expectations and timings for assessment. This links to the recommendation in Section 5.3.2.

### 6.4.7 Career pathways for apprentices following completion of the Scheme

> *I definitely thought there was going to be a job at the end of it specifically tailor made from what we've been doing to bring all the skills we've been learning together as one role.*
>
> Apprentice

A key area for development for the Scheme was in developing a specific and integrated role into which apprentices could progress following completion of the Scheme. Stakeholders had anticipated that the Scheme would result in the development of this type of progression route for apprentices, and apprentices also reported their expectation that there would be a specific integrated role open to them after the apprenticeship.

In fact, a specific integrated progression route for apprentices was not identified or developed during the Scheme delivery period. Several stakeholders reported that developing a role like this would be an important mechanism for achieving intended impacts related to improving retention in the sector. Apprentices also reported that the absence of a specific role had reduced their satisfaction with the Scheme because they felt that they had been misled about the guaranteed nature of post-apprenticeship employment.

As detailed in section 6.5.2, the Scheme is being extended to a second cohort in 2020-21. The proposal for this cohort refers to an enhanced community centred worker role, which is currently being explored across Place and Primary Care Networks. This would be an integrated role and, if established, could provide a progression route for apprentices who complete the Scheme.

Developing an integrated role would realistically always have taken longer than the time available to the pilot, but stakeholders were optimistic that joint working by partners to develop and deliver the Scheme had laid solid foundations for future work to develop integrated roles.

> *I think and hope that organically through being involved in the apprenticeship, partners will start to think about an integrated role. The more we know and develop, that would be a good thing.*
>
> Stakeholder

In addition to requiring a longer timeframe, developing an integrated role or roles is likely to require wider strategic work by partners to understand demand, gaps and the most appropriate opportunities to introduce integrated roles within the health and social care system.

**Recommendation:** Whilst outside of the scope of the Scheme itself, if there is appetite and resource to develop integrated roles, partners may wish to undertake a consultation and/or needs assessment exercise to identify and map the demand, gaps and most appropriate opportunities to introduce integrated roles within the health and social care system.

### 6.4.8 Reducing the attrition rate of apprentices

The attrition rate from the Scheme was relatively high because nine apprentices were originally recruited for the Scheme and five completed it. In addition to the improvement suggestions highlighted in the previous sections, which might have reduced attrition of those who commenced the Scheme, other ways in which attrition could have been addressed include:

- Ensuring that only eligible candidates were recruited to the Scheme. One candidate was recruited who was aged under 18 and therefore had to be transferred onto another apprenticeship as they were ineligible to undertake placements with some of the participating hosts.
- Identifying a back-up pool of appropriate candidates during recruitment, who could be offered a place if a member of the original cohort left the Scheme in the early stages.
- Speeding up recruitment and HR processes to enable candidates to commence the Scheme more quickly after application. For example, one successful applicant dropped out of the Scheme before it began as they found another opportunity elsewhere.
- Involving training providers in the recruitment process. This could harness training providers' knowledge and experience of recruiting apprentices and also highlight to applicants the training commitment required with taking for the Scheme.

### 6.4.9 Balancing adequate pastoral support with promoting independence and resilience

Whilst the pastoral support offered via JUCD was a strength of the Scheme, a minority of stakeholders also emphasised that it would be useful to develop mechanisms to support the independence and resilience of apprentices to meet the requirements of the apprenticeship. For example, one stakeholder suggested that group reflective practice sessions, similar to clinical supervision sessions, could be a solution, as *"it can really help raise confidence levels by tackling issues between them rather than raising it to a line manager".*

## 6.5 Sustainability

### 6.5.1 Summary

Local partners have decided to extend the Scheme to a second cohort of apprentices in 2020-21, indicating that they are supportive of the Scheme in principle and willing to continue to fund it in the short-term. The longer-term prospects for Scheme continuation are not known at present. However, its delivery for a second cohort provides an opportunity to further shape the programme, to achieve further outcomes and impacts, and to progress towards longer-term outcomes and impacts. Ongoing monitoring of the outputs, outcome

and impacts of the Scheme will be crucial in determining whether there is a business case for its longer-term continuation.

### 6.5.2 Extension of Scheme to a further cohort

In February 2020, partners decided to implement the Scheme with a second cohort of apprentices in 2020-21. This reflects the fact that the majority of stakeholders were enthusiastic about the merits of the Scheme and expressed that they would like to see an integrated training scheme continue in some form.

Continuing with a second cohort will provide an opportunity to further shape the programme based on learning from the implementation of the Scheme with the first cohort and the findings of this evaluation. For example, the proposal for this second cohort includes moving towards a single employer and education provider, which might address some challenges around consistency of delivery and also provide some economies of scale. In addition, the intention is to include placements in existing integrated teams and teams that are harder to recruit to. This might help to address shortages in specific areas of the health and social care workforce by exposing apprentices to roles in these areas, which may encourage them to apply for permanent positions in similar roles in the future (if roles at the appropriate level are available).

The Scheme's continuation for a further year may also provide the opportunity to achieve further outcomes and impacts as the Scheme becomes more embedded and is delivered at a slightly larger-scale, and to make and assess further progress towards some of the longer-term aims of the Scheme. However, there remain outcomes and impacts from the original logic model which are unlikely to be achieved and evidenced within the timescales for a second cohort or the scale at which the Scheme is being implemented.

### 6.5.3 Challenges to sustaining the Scheme on an ongoing basis

The key challenge to continuing the Scheme on an ongoing basis is gaining and maintaining buy-in to participate and direct funding inputs from different local partners. In particular, identifying organisations to act as employers for apprentices may prove challenging. The input required from these organisations to cover the necessary HR, administrative and logistical functions is high in relation to the small number of apprentices participating in the Scheme. To a certain extent, the same might also be true for placement hosts. Stakeholders also reported that supporting the integrated apprentices proved more resource-intensive than supporting apprentices on other Schemes. In part, this might relate to the pilot nature of the Scheme and the required resource might therefore reduce if the Scheme were continued and became more embedded. However, it might also be a facet of the small-scale nature of the Scheme and economies of scale might be achieved if it were delivered at a larger scale.

As discussed in section 4.5.1, the provider share of funding for the first cohort in 2018-19 was funded by delivery partners on a fair share basis. However, this proportional approach to funding was challenged by some partners and created some tensions within the partnership. As a result, partners plan to revise the funding approach for the second cohort, with an equal proportion of the provider

share apportioned to each funding organisation. Reaching an agreement about the funding approach may go some way to mitigate the challenges in maintaining partner buy-in and funding.

In addition, it proved challenging during the pilot to articulate the direct benefits of participation in the Scheme for partners. In turn, this linked to the fact that the onward career pathways for apprentices are undefined and that therefore it is difficult at this stage to maintain that the Scheme will prepare apprentices for specific integrated roles or that specific organisations (which might host or interact with these roles) will benefit from new employees or more integrated services staffed by them.

**Recommendation:** To help with recruitment of partners to the Scheme or similar initiatives, it might be useful to signpost potential partners to the role of the Scheme in improving collaboration between partners around integrated training and working, and the benefits of this for partners. These outcomes and benefits are discussed is more detail in section 5.4.3.

It is also possible that the Scheme will not result in direct benefits to all partners involved in implementing it, even if it is of benefit to the health and social care sectors as a whole. It is therefore important to appeal to partners by outlining ways in which the Scheme can contribute to positive system-wide outcomes and to increase partners' commitment to supporting these outcomes. For example, stakeholders highlighted that building increased strategic commitment to the wider integration agenda and workforce development could make it easier to introduce or maintain similar schemes in the future.

Similarly, determining whether the Scheme provides value for money is a challenge which could compound difficulties gaining buy-in. Ongoing monitoring of longer-term outcomes and impacts might serve to provide evidence of value for money (e.g. if former apprentices remain in health and social care, progress into integrated roles, and thereby support greater integration). However, it is also likely that the Scheme would need to be delivered on an ongoing basis and at a larger scale for any positive longer-term outcomes and impacts that may be achieved to be felt at system level.

### 6.5.4 Suggestions for building on the Scheme

Stakeholders highlighted a range of possible approaches to sustaining the Scheme or a developing a similar initiative. These included:

- Exploring an alternative funding source for the Scheme, such as the STP/ ICS, or making private sector providers the only type of participating organisation.
- Offering placements to existing health apprentices, social care apprentices, or staff in entry-level roles in health and/or social care, to enable them to accrue some of the benefits of completing placements in different types of settings.
- Pitching the Scheme at Level 3 or 4 instead and framing it as a way for staff already working in the sector to continue their career development.

# Appendix A: Partnership organisations within JUCD

The partnership organisations which comprise JUCD are:

- Chesterfield Royal Hospital NHS Foundation Trust.
- Derby and Derbyshire Clinical Commissioning Group.
- Derby City Council.
- Derbyshire Community Health Services (DCHS)
- Derbyshire County Council.
- Derbyshire Healthcare.
- DHU Health Care CIC.
- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB NHS FT).
- A range of private, voluntary and independent providers.

# Appendix B: Roles and organisations of stakeholders consulted during the evaluation

*Figure 11: Stakeholders consulted during the evaluation*

| Relationship to Scheme | Organisation | Number of interviews | Role(s) |
|---|---|---|---|
| Scheme lead | Joined Up Careers Derbyshire | 2 | • Programme Lead<br>• Programme Support Officer |
| Employer and placement host | Derbyshire County Council | 1 | • Service Director in Adult Care, Commissioning and Performance |
| | University Hospitals of Derby and Burton NHS Foundation Trust | 1 | • Apprenticeships and Vocational Development Lead |
| Scheme Oversight and development | Derbyshire County Council | 2 | • Analyst in Public Health Team<br>• Member of Commissioning, Communities and Policies Team |
| | Health Education England | 1 | • Locality Manager |
| | Skills for Care | 1 | • Locality Manager |
| Placement host | Chesterfield Royal Hospital NHS Foundation Trust | 1 | • Apprenticeship Programme Coordinator |
| | Derby City Council | 1 | • Unit Manager, Perth House |

| Relationship to Scheme | Organisation | Number of interviews | Role(s) |
|---|---|---|---|
| | Derbyshire Community Health Services/ Derbyshire Healthcare Foundation Trust | 1 | • Wider Workforce Coordinator |
| | Inspirative Arts | 1 | • Manager |
| Training provider | Derby College | 1 | • Account Manager, Business Development Unit |
| | Derbyshire Adult Community Education Service | 1 | • Programme development worker in Apprenticeship team |
| **Total** | | **14** | |

# Appendix C: Components in Care Certificate

The following mandatory options comprise the Care Certificate which apprentices must complete in the first three months of their apprenticeship:

- Understand your role.
- Your personal development.
- Duty of care.
- Equality and diversity.
- Work in a person-centred way.
- Communication.
- Privacy and dignity.
- Fluids and nutrition.
- Safeguarding adults.
- Safeguarding children.
- Basic life support.
- Health and safety.
- Handling information.
- Infection prevention and control.
- Awareness of mental health, dementia and learning disabilities.

Figure 12 lays out the schedule for the delivery of the Care Certificate used by DACES, indicating that 13.5 days were required for the Care Certificate training.

*Figure 12: Modules of the Care Certificate programme*

| Care certificate module | Number of training days |
|---|---|
| Introduction to Adult Care | 2.0 |
| Safeguarding – alerting others to abuse | 1.0 |
| Moving and Handling Core Knowledge | 2.0 |
| Personal Safety | 0.5 |
| Infection Control | 0.5 |
| Tissue Viability | 0.5 |
| Safe Administration of Medication | 1.0 |
| First Aid | 1.0 |
| Assisting with Medication in the Community | 1.0 |
| Person Centred Recording | 0.5 |
| Fire Safety & Evacuation | 0.5 |
| Principles of the Mental Capacity Act and Deprivation of Liberty Safeguards | 1.0 |
| Caring Safely | 1.0 |

# Appendix D: Training modules in Level 2 Diploma in Care

Figure 13 lists the mandatory units of the Level 2 Diploma in Care, the credits they are worth, and the guided learning hours allotted for each unit.

*Figure 13: Mandatory units of the Level 2 Diploma in Care*

| Mandatory unit | Credits | Guided learning hours |
|---|---|---|
| Safeguarding and protection in care | 3 | 26 |
| Responsibilities of a care worker | 2 | 16 |
| Communication in care settings | 3 | 20 |
| Duty of Care | 1 | 7 |
| Handle information in care settings | 1 | 10 |
| Personal Development in Care settings | 3 | 23 |
| Equality and inclusion in care settings | 2 | 17 |
| Health, Safety and well-being in care settings | 4 | 33 |
| Implement person centred approaches in care settings | 5 | 39 |

Figure 14 lists the possible optional modules which could be completed as part of the Level 2 Diploma in Care[36]. Those highlighted in lilac were completed by apprentices during the Scheme, having been selected by those designing and delivering the Scheme.

*Figure 14: Optional units of the Level 2 Diploma in Care*

| Group B units | Group C units |
|---|---|
| Understand Mental Wellbeing and Mental Health Promotion | Administering Medication to Individuals |
| Understand Mental Ill Health | Providing Support for Therapy Sessions |

[36] A minimum of 22 credits must come from optional units, at least 14 of which must come from group B modules and a maximum of 8 of which must come from group C modules. The credit value for optional units ranges from 2 to 6 credits per unit, and the number of guided learning hours per optional unit ranges from 9 to 46 hours.

| Group B units | Group C units |
|---|---|
| Principles of the Mental Capacity Act 2005 | Provide Support to Manage Pain and Discomfort |
| Awareness of Dementia | Contributing to Monitoring the Health of Individuals Affected by Health Conditions |
| The Person-Centred Approach to the Care and Support of Individuals with Dementia | Supporting Individuals to Carry Out their Own HealthCare Procedures |
| Understanding the Role of Communication and Interactions with Individuals who have Dementia | Support Individuals to Access and Use Information about Services and Facilities |
| Introduction to Personalisation in Care | Supporting Individuals who are Distressed |
| Causes and Spread of Infection | Supporting Individuals to Eat and Drink |
| Cleaning, Decontamination and Waste Management | Support Individuals to Meet Personal Care Needs |
| Understanding the Context of Supporting Individuals with Learning Disabilities | Support Individuals to Manage Continence |
| Principles of Positive Risk Taking for Individuals with Disabilities | Providing Agreed Support for Foot Care |
| Awareness of Autistic Spectrum Conditions | Undertake Agreed Pressure Area Care |
| Introduction to Physical Disability | Obtain and Test Capillary Blood Samples |
| Introduction to the Impact of Acquired Brain Injury on Individuals | Obtaining and Testing Specimens from Individuals |
| Awareness of Sensory Loss | Safe Movement and Handling of Individuals in Accordance with Own Care Plan |
| Understanding How to Work in End of Life Care | Working in Partnership with Families to Support Individuals |
| Recognising and Managing the Symptoms of Stroke | Promoting Positive Behaviour |
| Awareness of Diabetes | Supporting Families of Individuals with Acquired Brain Injury |

| Group B units | Group C units |
|---|---|
| Understand Parkinson's for Care staff | Contribute to Supporting Individuals in the Use of Assistive Technology |
| | Prepare for and Take Physiological Measurements |
| | Contribute to the Effectiveness of Teams in Care Settings |
| | Promoting Nutrition and Hydration in Care Settings |
| | Assessing the Needs of Carers and Families |
| | Monitoring and Maintaining the Environment and Resources during and after Healthcare activities |
| | Support Individuals Undergoing Healthcare Activities |
| | Prepare Individuals for Healthcare Activities |
| | Assist the Practitioner to Carry out Healthcare Activities |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